**BOARD OF DIRECTORS PUBLIC MEETING**

**Thursday 29th April 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.** | **21/22/01** | **9:15<br>(1 min)** | **Apologies.** | Chair | To note apologies. | **N** | For noting |
| **2.** | **21/22/02** | **9:16<br>(1 min)** | **Declarations of Interest.** | All | Board members to declare an interest in particular agenda items, if appropriate. | **R** | For noting |
| **3.** | **21/22/03** | **9:17<br>(3 min)** | **Minutes of the Previous Meeting.** | Chair | To consider and approve the minutes of the meeting held on: **Thursday 25th March 2021.** | **D** | Read minutes |
| **4.** | **21/22/04** | **9:20<br>(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 Recovery Plan 2021/22** | | | | | | | |
| **5.** | **21/22/05** | **9:25<br>(55 mins)** | • **Planning Guidance update.**<br>• **Update on the 'Brilliant Basics' Programme.**<br>• **Access and Restoration update.**<br>• **Staff/Patient Safety:**<br>- **IPC assurance**<br>- **Covid-19 Vaccine update.**<br>- **Staff Safety Metrics.**<br>• **COVID Risk Register.** | D. Jones<br>J. Grinnell/ KPMG<br>A. Bateman<br>B. Larru<br>M. Swindell<br>M. Swindell<br>J. Grinnell | To set the context for April's strategy session.<br>To provide an update on the 'Brilliant Basics' programme.<br>To provide an update on access and restoration of services.<br>To provide the Board with an update on IPC.<br>To provide an update on the Covid-19 vaccine for staff.<br>To provide an update on staff absences and testing.<br>To discuss the current key risks. | **I**<br>**I**<br>**A**<br>**A**<br>**A**<br>**A**<br>**A** | Presentation<br>Presentation<br>Read report<br>Read report<br>Presentation<br>Presentation<br>Read report |

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| VB no. | Agenda Item | Time | Items for Discussion | Owner | Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N) | | Preparation |
|---|---|---|---|---|---|---|---|
| **Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led** | | | | | | | |
| **6.** | **21/22/06** | **10:20 (10 mins)** | **Serious Incident Report.** | N. Askew | To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour. | **A** | Read report |
| **7.** | **21/22/07** | **10:30 (40 mins)** | **Corporate Report - Divisional updates:**<br>- **Medicine.**<br>- **Community & Mental Health.**<br>- **Surgery.**<br>**Cumulative Corporate Report Metrics - Top Line Indicators:**<br>• **Quality.**<br>• **Safety.**<br>• **Effective/Responsive.** | U. Das<br>L. Cooper<br>A. Bass<br>N. Murdock<br>N. Askew<br>A. Bateman | To receive a report of Trust performance for scrutiny and discussion, highlighting any critical issues. | **A** | Read enclosure |
| **The Best People Doing Their Best Work** | | | | | | | |
| **8.** | **21/22/08** | **11:10 (5 mins)** | **Cumulative Corporate Report Metrics – Top Line Indicators:**<br>• **People.** | M. Swindell | To receive a report of Trust performance for scrutiny and discussion, highlighting any critical issues. | **A** | *Refer to item 7* |
| **9.** | **21/22/09** | **11:15 (20 mins)** | **Alder Hey People Plan Update:**<br>• **Issues that SALS have addressed during 2020/21.**<br>• **BAME Taskforce update.** | M. Swindell<br>M. Swindell<br>C. Dove | For information and discussion.<br>To provide a breakdown of the issues that SALS have addressed during 2020/21.<br>For information and discussion. | **A**<br>**A**<br>**A** | Read report<br>Read report<br>Verbal |
| **Sustainability through Partnerships** | | | | | | | |
| **10.** | **21/22/10** | **11:35 (10 mins)** | **Level 1 CHD Partnership update.** | N. Murdock | To provide an update on the Level 1 CHD partnership risk and management approach being undertaken by | **A** | Read report |

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| | | | | | the Level 1 Partnership in relation to backlogs. | | |
| **Strategic Update** | | | | | | | |
| **11.** | **21/22/11** | **11:45 (20 mins)** | **Alder Hey in the Park Campus Development update:**<br>• **Update on the Plans for the Nursery.** | D. Powell<br><br>M. Swindell | To receive an update on key outstanding issues/risks and plans for mitigation.<br>To provide an update on progress. | **A**<br><br>**A** | Read report<br><br>Verbal |
| **Lunch (12:05pm-12:30pm)** | | | | | | | |
| **Strong Foundations (Board Assurance)** | | | | | | | |
| **12.** | **21/22/12** | **12:30 (10 mins)** | **Financial Update, M12.** | J. Grinnell | To provide an overview of the position for Month 12. | **A** | Presentation |
| **13.** | **21/22/13** | **12:40 (5 mins)** | **Recognition of the Trust as a Going Concern.** | J. Grinnell | For assurance purposes. | **A** | Read report |
| **14.** | **21/22/14** | **12:45 (10 mins)** | **Risk Management Strategy; including Risk Management Policy and Procedure.** | J. Grinnell | For ratification. | **D** | Read report |
| **15.** | **21/22/15** | **12:55 (5 mins)** | **Board Assurance Framework Report.** | E. Saunders | To provide assurance on how the strategic risks that threaten the achievement of the Trust's strategic plan are being proactively managed. | **A** | Read report |
| **16.** | **21/22/16** | **13:00 (20 mins)** | **Board Assurance Committees; report by exception:**<br>• **Audit Committee:**<br>- **Chair's Highlight Report from the meeting held on the 22.4.21.**<br>- **Approved minutes from the meeting held on the 21.1.21.** | K. Byrne | To escalate any key risks, receive updates and note approved minutes. | **A** | Verbal/ read approved minutes |

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| | | | • **Resources and Business Development Committee:**<br>- **Chair's verbal update from the meeting held on the 26.4.21.**<br>- **Approved minutes from the meeting held on the 22.3.21**<br>• **Safety & Quality Assurance Committee:**<br>- **Chair's verbal update from the meeting held on the 21.4.21.**<br>- **Approved minutes from the meeting held on the 24.3.21.**<br>• **Innovation Committee:**<br>- **Chair's verbal update from the meeting held on the 19.4.21.**<br>- **Approved minutes from the meeting held on the 8.2.21.** | I Quinlan<br><br><br><br><br><br><br>F. Beveridge<br><br><br><br><br><br><br>S. Arora | | | |
| **Items for information** | | | | | | | |
| **17.** | **22/22/17** | **13:20 (4 mins)** | **Any Other Business.** | All | To discuss any further business before the close of the meeting. | **N** | Verbal |
| **18.** | **21/22/18** | **13:24 (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, 27th May 2021, 9:00am-1:00pm, via Microsoft Teams.**

| REGISTER OF TRUST SEAL |
|---|
| **The Trust Seal was used in April 2021:**<br>Ref No: 369 – Galliford Try – Parent company guarantee to employer (under contract) for new buildings. |

| SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION | |
|---|---|
| Corporate Report | Executive Leads |
| CQC Action Plan | E. Saunders |
| Financial Metrics, M12 | J. Grinnell |

Alder Hey Children's NHS
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**PUBLIC MEETING OF THE BOARD OF DIRECTORS**

Confirmed Minutes of the meeting held on **Thursday 25th March 2021 at 9:00am,** via Microsoft Teams

| | | | |
|---|---|---|---|
| **Present:** | Dame Jo Williams | Chair | (DJW) |
| | Mr. N. Askew | Chief Nurse | (NA) |
| | Mrs. S. Arora | Non-Executive Director | (SA) |
| | Mr. A. Bateman | Chief Operating Officer | (AB) |
| | Prof. F. Beveridge | Non-Executive Director | (FB) |
| | Mrs. K. Byrne | Non-Executive Director | (KB) |
| | Mrs. C. Dove | Non-Executive Director | (CD) |
| | Mr. J. Grinnell | Director of Finance/ Deputy Chief Executive | (JG) |
| | Mrs. A. Marsland | Non-Executive Director | (AM) |
| | Dr. F. Marston | Non-Executive Director | (FM) |
| | Dr. N. Murdock | Medical Director | (NM) |
| | Mr. I. Quinlan | Vice Chair/Non-Executive Director | (IQ) |
| | Mrs. L. Shepherd | Chief Executive | (LS) |
| | Mrs. M. Swindell | Director of HR & OD | (MS) |
| **In Attendance:** | Mr. A. Bass | Director of Surgery | (AB) |
| | Ms. L. Cooper | Director of Community Services | (LC) |
| | Dr. U. Das | Director of Medicine | (UD) |
| | Mr. M. Flannagan | Director of Communications | (MF) |
| | Dr. A. Hughes | Deputy Medical Director | (AH) |
| | Mrs. D. Jones | Director of Strategy and Partnerships | (DJ) |
| | Mrs. C. Liddy | Director of Innovation | (CL) |
| | Mrs. K. McKeown | Committee Administrator (minutes) | (KMC) |
| | Mr. D. Powell | Development Director | (DP) |
| | Ms. E. Saunders | Director of Corporate Affairs | (ES) |
| | Mrs. K. Warriner | Chief Digital and Information Officer | (KW) |
| **Apologies** | Prof. M. Beresford | Assoc. Director of the Board | (PMB) |
| **Item 20/21/275** | Dr. B. Larru | Director of Infection Prevention Control | (BL) |

**Staff Story**

The Board received presentations from both of Alder Hey's winning teams of the 2020 HSJ Awards, which highlighted the work that has taken place to achieve this accolade:

- Digitising Patient Services Initiative (*Kate Warriner, Christopher Grimes, Leila Brown and Molly Wardle*).
- Staff Engagement Award (*Dr.Jo Potier, Dr Lalith Wijedoru and Dr Sarah Robertson*).

Kate Warriner advised the Board that the Digital team were delighted to have won the award and thanked all those involved for their hard work and support with the presentation.

Melissa Swindell thanked everyone for putting their faith in the SALS team to progress this area of work. It was reported that funding has been provided for Sarah Robertsons' role and an additional post in the SALS team. Melissa Swindell paid tribute to Jo, Lalith and Sarah for the instrumental work that has taken place during 2020/21.

On behalf of the Board, the Chair thanked both teams for sharing their success and advised that Board members are very proud of what has been achieved in such a short period of time.

**20/21/268 Welcome and Apologies**

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

**20/21/269 Declarations of Interest**

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

**20/21/270 Minutes of the previous meetings held on Thursday 25th February 2021**
**Resolved:**
The minutes from the meeting held on the 25.2.21 were agreed as an accurate record of the meeting, pending a small number of amendments that would be advised of outside of the meeting.

**20/21/271 Matters Arising and Action Log**

*Matter Arising*

There were none to discuss.

*Action Log*

**Action20/21/249.1:** *Covid-19 Risk Register (Advise of the timeline of the independent review that is taking place into Manchester University NHS Foundation Trust's cardiology RTT waiting list that was overlooked)* – Work is taking place to address the backlog of referrals, with additional sessions being scheduled to take place on a Saturday. It was reported that the Chief Operating Officer for Manchester University NHS FT is aware of the concerns that have been raised and it has been agreed that joint meetings will take place on a monthly basis going forward. It was agreed to provide a further update on this matter during April's Trust Board meeting. **ACTION TO REMAIN OPEN**

**Action 20/21/252.1:** *Mortality Report, Q2 (National changes to the Child Death Mortality Process – Acquire written confirmation from David Levy's office acknowledging that the Trust's system is fully compliant and in line with the new national guidance)* – It was reported that the Trust is awaiting a reply from David Levy's office. **ACTION TO REMAIN OPEN**

**20/21/272 Covid-19 Assurance Plan – Alder Hey's Plans for Recovery**

The Board was provided with an overview of Alder Hey's plans for recovery. A number of slides were shared with the Board which provided information on the following areas:

- *What is next for the Trust?*
  - Current context.
  - The roadmap to recovery.
  - The Trust's plan and next steps.
- *The landscape:*
  - Staff welfare and resilience.
  - The need to improve access for children and young people (CYP).
  - A potential summer of high respiratory syncytial virus (RSV).
  - Living with Covid.
  - Driving forward the Trust's wider objectives.

- Safe recovery between April and June will focus on infection, prevention and control (IPC), the environment, staff and service restoration.
- *Environment themes:*
  - The aim is to ensure an environment which maintains safety for all and maximises use for patients, families and the Trust's staff.
  - There will be a focus on patient waiting areas, breakout space/changing areas for clinical staff and office space/breakout space for non-clinical staff.
  - *Two parts to review* - The Trust will look at what can be achieved quickly and what will take more time and require investment and/or changes to the building.
  - *Next steps* – A working group will be formed to review all space on the main site and off site to maximise usage whilst maintaining safety.
- *Infection Prevention and Control:*
  - Continue with universal precautions when providing care to patients.
  - Continue to follow hands/face/space and the universal use of face masks across the organisation.
  - No planned changes to the current visiting restrictions.
  - Continue with staff and patient testing.
  - Review flow and environmental factors such as the use of screens to maximise the use of space safely.
  - Continue to prepare for any future waves or increases in other respiratory illnesses such as RSV.
  - Prepare for the flu vaccination programme.
  - Continue the fit testing programme.
  - *Next steps* – IPC involvement in planning for environment and services. Ensure adequate team resources to maintain additional services such as patient testing.
- *People:*

  The three themes relating to people are;
  - *Rest* – Physical and emotional rest, annual leave.
  - *Connect* – Social activity, health and wellbeing conversations.
  - *Share* – Reflective spaces (Team Time/Schwartz), learning opportunities (Ground Truth and debriefing).
  - It was reported that Health and wellbeing conversations will take place during April 2021 and flexible working arrangements will be in place from June 2021.

*Brilliant Basics update*

The Director of Finance shared a number of slides to provide an update on the Brilliant Basics programme. The following points were highlighted:

- Key themes/design principles.
- Setting the Executive priorities.
- Aligning Executive and Divisional activities.
- Performance routines and governance.
- Strategy into Action is a key workstream of the Brilliant Basics programme; prioritisation, validation, communication and performance management.
- The strategic priorities are; access, staff, partnerships, research and innovation. The 'Must Dos' are; growing capacity, safety, looking after our people, starting well/prevention, paediatric role in Cheshire and Merseyside/North West, green sustainability, commercial research unit, Launch Pad, Ai HQ.

- Executive Scorecard - Managing strategic objectives will be done using a bottom up/top down process.
- Setting priorities through the Executive Scorecard will provide a monthly snapshot on whether the organisation is improving towards the strategic priorities.
- Developing Board to Ward improvement through Brilliant Basics - Phase 1 of the Brilliant Basics programme has started to create the 'Alder Hey way' of doing improvement to be considered and expanded across more teams during Phase 2.
- Cascading priorities to the wider organisation – This cascade will allow the translation of strategy into action and ensure the Divisions are the 'engine room' of the planning process.

Fiona Beveridge referred to the bespoke support to be provided for 7 'challenged specialities' with focus on outpatient recovery (*slide 13*) and queried as to how the Board will be updated on progress. It was reported that these seven specialities that have a backlog of patients will require additional support from colleagues to support improvement at pace. Work has commenced in respect to the mapping of interventions and performance to address this area of work with respective teams. The Board was advised that the Trust is challenging itself via a rigorous but balanced approach across the organisation. Attention was drawn to the challenge boards that will bring to life the work that is taking place. A further update on the cascading of priorities to the wider organisation will be provided during April's Trust Board meeting.

**20/21/272.1 Action: JG**

Kerry Byrne asked as to whether the Trust has any idea as to how the programme is being received by staff and queried as to how the organisation is managing the balance in terms of recovery. It was reported that the Trust has adapted the programme to focus on the areas that need to be addressed imminently whilst wrapping the programme around problem solving to ensure staff feel assured and confident as the programme progresses. Lisa Cooper pointed out that the programme will bring a change in culture across the organisation and will take time to embed. It was felt that the organisation needs to be mindful of the speed that it is progressing at and a suggestion was made to test it out on a weekly basis with frontline staff.

The Chair thanked the Executives for sharing Alder Hey's plans for recovery and providing an update on the Brilliant Basics programme. The Chair felt that the Trust is making progress at the right pace whilst supporting staff and seeing positive outcomes for CYP. It was also felt that the opportunity for the Divisions to set the pace will be really helpful.

*Access and Restoration*

The Board received a summary of the progress that has been made in restoring services between August 2020 and February 2021. The following highlights were shared with the Board:

- It was reported that the Trust's goal is to achieve a zero backlog in respect to patients waiting for an appointment and therefore is focussing on restoring to 100% of activity levels in outpatients.
- The Trust has consolidated evening sessions into Tuesday, Wednesday and Thursday and is booking further ahead to the 19.6.21.

- It has been agreed to undertake an additional six theatre lists on a Saturday every fortnight until the 19.6.21, prior to the lifting of restrictions on the 21.6.21.
- It was reported that there has been a recent surge in patients attending ED. It was confirmed that the Trust is still providing timely care.
- There has been an increase in the number of patients waiting over 52 weeks, driven by an increase in the number of patients waiting for admitted care in surgical services. The Board was advised that the Trust has undertaken detailed modelling to determine the capacity required to clear the waiting list backlog. The Board was informed of the clearance timescales for each of the specialities.

Fiona Marston queried Alder Hey's plans with regard to the anticipated increase in RSV infections. It was reported that the Trust is looking to implement a summer plan that reflects the organisation's winter plan. Current IPC measure will continue to remain in place and the public health message will need to be very clear.

Staff/Patient Safety

*Covid-19 Vaccine Update*

It was reported that 87% of the Trust's workforce has received the first dose of the vaccine, and it was indicated that 83% of BAME colleagues have received the first dose too. The Board was advised that there are a number of staff members who have declined the vaccine for reasons that they don't wish to disclose, with some members requesting additional information. It was confirmed that the second part of the vaccination programme has commenced, and attention was drawn to the fact that there hasn't been one dose of vaccine wasted.

*Staff Safety Metrics*

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

- Overall absence – under 6.5%.
- Non-Covid absence - 4.5%.
- It was reported that the shielding guidance ceases on the 31.3.21, therefore the Trust is working through a process to ensure all colleagues who have been shielding have a full risk assessment prior to their return. There will be a process in place to help staff return to work safely and effectively. It was confirmed that all cases will be managed on an individual basis.

Covid-19 Risk Register

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

- Attention was drawn to risk reference number 2183 'risk that staff, patients and the public will not be able to socially distance whilst waiting in ED' – It was reported that this risk has increased to a high as a result of increasing ED attendances and a reduced capacity in the waiting room due to building work. Assessment with an external agency is planned to take place imminently to review use of perspex screens and air filtration systems to help mitigate the risk.

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- The Board was advised that the risk register reflects a reducing risk profile and as the Trust develops its roadmap the shape of the Covid risks will adapt.

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

**20/21/273 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 1.2.21 and the 28.2.21. The following points were highlighted:

- The Board was advised that there were no new Serious Incidents reported in month.
- It was reported that there are eight ongoing incidents currently under review, of which, two have been signed off and submitted to the CCG (StEIS reference; 2020/23808 and 2020/15939).
- StEIS Reference 2020/16210: *Patient death following catastrophic and irreversible brain haemorrhage* – This investigation requires input from an external impartial expert which has been arranged, and a six-week extension has been agreed by Liverpool CCG.
- It was confirmed that the updates from the incidents that have been closed will be presented during April's Trust Board meeting

**Resolved:**
The Board received and noted the contents of the Serious Incident report for February 2021.

**20/21/274 Position Statement for PALS and Complaints, Q3**

The Trust Board received the Q3 position statement for PALS and complaints which provided an update and assurance on the performance against complaints and PALS targets, a thematic analysis of the top reasons for complaints and PALS, action taken as a result of concerns raised, and proposed developments planned for Q4 2021 and Q1 2021/22. The following points were highlighted:

- It was reported that the number of formal complaints being received by the Trust is continuing to decline but there has been a slight increase in informal concerns.
- *Three-day acknowledgment* – In Q3, 44 out of 45 (98%) formal complaints received were acknowledged withing 3 working days.
- *Compliance with 25-day response* – 40 of the 45 complaints received in Q3 were responded to during the same quarter, with 12 (30%) complaints being responded to within 25 days. The Board was informed that the NHS timeframe for responding to complaints is six months, but it was pointed out that the Trust has set an internal timeframe in the Complaints and Concerns Policy to respond to formal complaints within 25 days. Further work is required around culture and responsiveness to families within that 25 day period.
- *Complaints upheld* – In Q3, 20 (50%) complaints were not upheld following investigation and the outcome of those have been shared with the respective families. 7 (17%) complaints were partially upheld and 13 (32%) were fully upheld.

- *Second stage complaints* - In terms of the level of satisfaction with the quality and the content of the initial complaint response, in Q3, 7 families informed the Trust that they were not satisfied with the outcome of their initial complaint response. This equates to 9% (7 of 74) of the Trust's complaints that have gone on to a second stage resolution during Q3. It was reported that the second stage complaints relate exclusively to the Neurology, Tics and Tourettes service.
- *Referrals to Parliamentary and Health Service Ombudsman (PHSO)* - There have been no onward referrals to the PHSO during Q3. There is one ongoing investigation related to the Surgical Division which has been delayed due to the pandemic.
- *PALS concerns* – For Q3, 61% of the PALS issues that are logged with the organisation are responded to within 5 days working days. Further work is required to improve compliance as it was pointed out that the KPI for this area of work is 90%.
- *Compliments* - 50 compliments have been recorded on the system for Q3. Attention was drawn to the importance of capturing all of the thank you cards and notes that are received by the wards. The Board was advised that some thought is going to be given in respect to a system that will accurately capture compliments.
- *Themes* – The themes of complaints in Q3 relate to two main areas; Neurology, Tics and Tourettes service and the re-scheduling/cancellation of appointments. It was reported that the Scheduling team are working hard to address concerns/issues raised in respect to outpatients
- *Actions and learning from complaints* - The Board was provided with an overview of the improvements that have been made to services as a result of concerns raised. It was pointed that improvement is required in terms of metrics, especially around timely responses. As work progresses, a detailed improvement plan will support the Complaints service going forward.

  The Board was advised of the necessity for a review of systems, processes and people. It was also pointed out that work needs to take place around culture to ensure that the organisation has a culture of instant resolution wherever possible by staff members on the wards and the PALS service. The Trust would also like to see a real focus on early intervention with families and the de-escalation of formal complaints where possible. Attention was drawn to the pilot work that has taken place in the Division of Surgery which has produced positive outcomes as a result of families being contacted by service managers/matrons to discuss their concerns thus enabling a number of complaints to be downgraded/resolved as the outcome has been met.

  Going forward, complaints will be monitored on a monthly basis via the Divisions from a performance perspective, and learning will be demonstrated via; 1. The capturing of actions of individual complaints to provide assurance that the organisation has addressed the work that it set out to do in response to the complaint 2. Wider learning across specialities, Divisions and the organisation in response to concerns and complaints that arise.

The Chair queried the timeline for undertaking the review. It was reported that the review of systems, processes and people will take place during the next one to two months. In terms of responsiveness, this work is underway with the support of the Associate Chief Nurses and it was pointed out that there has been an improvement across three of the Divisions during February. From a Ulysses

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perspective work is required before being able to move to a fully digital end to end service for complaints therefore this action will take longer to address. It was confirmed that a full action plan with time frames will be submitted with the PALS and Complaints report for Q4.

Fiona Marston referred to the complaints that the Trust has received relating to the Neurology, Tics and Tourettes service and queried as to whether this is impacting families uniformly or case by case. It was reported that a decision was made to investigate each concern on an individual basis to assess the impact rather than providing a standard response around the cessation of the service. The Board was advised that this area of work has been difficult to control as Alder Hey is not in control of the cessation of the service, but assurance has been provided by the Division of Medicine confirming that each patient has either had an onward referral or has been referred back to a GP/appropriate paediatrician for management of their condition.

**Resolved:**
The Board noted the position statement for PALS and Complaints, Q3

**20/21/275 DIPC Report, Q3**

The Board received an update on IPC from the Director of Infection, Prevention and Control, Beatriz Larru. A number of slides were shared with the Board which provided information and the following points were highlighted:

- It was reported that there has been an increase in the documenting of CLABSIs; target figure of 12, actual figure of 16. The Board was advised that work is taking place to look at how the organisation records surgical site infections.
- 85% of staff have received a Covid-19 vaccination.
- Fit testing has reduced from 85% to 75%. It was confirmed that the team is working with the Community Division to address this matter.
- All policies and guidelines are being adapted/updated to meet national guidance.
- There have been zero Covid-19 outbreaks in February.
- All adults were discharged by the 19th of February (67% survival rate).
- *The potential future of the Covid-19 pandemic* – It was reported that discussions have taken place around the planning for the possibility that Covid-19 will persist and become a recurrent seasonal disease, and attention was drawn to the possibility of other respiratory viruses increasing, such as RSV, once restrictions are lifted.
- *Lessons learnt from Covid*-19 that need to be included in the immediate recovery plan:
  - Importance of screening and isolating patients with communicable diseases; screening based on presence of symptoms and screening based on risk of being infectious. The Board was advised of the difficulties of doing this in ED when attendance is high, therefore the team is working with ED to try and determine which patients ae more infectious/less infectious.
  - The IPC team are looking towards bringing new technologies into the Trust to support rapid testing for diagnosing patients.
  - Isolate patients based on symptoms.
- *Immediate actions:*
  - Local data is reviewed on a weekly basis, when the Trust's prevalence figures fall to less than 1% in different areas, for example, the green pathway will be re-started in theatres.

- Uniform recommendations.
- Maintain safety in breakout areas.
- Improve waiting areas.

The Chair thanked Beatriz Larru and her team for the continued support and the work that has taken place to keep patients, families and staff safe. Louise Shepherd drew attention to the importance of following the advice of the IPC team and felt that it really helps to hear from the experts in this field.

**Resolved:**
The Board noted the infection, prevention and control update.

**20/21/276 Update on the Current Demand and Access to Locality Based Specialist Mental Health Services and Eating Disorder Service**

The Board was provided with an update on the current access times for Locality Based Specialist Mental Health Services and the Eating Disorder Service, the current position statement relating to capacity and demand challenges, and the workforce requirements to reduce and maintain waiting times to the agreed internal standard presented at the Trust Board in June 2020. The following points were highlighted:

- The Board was advised that at this moment in time the service is unable to meet its internal waiting time and standards due to resource/investment that is required from the CCGs and the significant increase in demand as a result of seeing more children with complex issues since the pandemic.
- *Eating Disorder Service* - It was reported that there has been a significant increase in children and young people presenting with eating disorders. This is a regional and national issue in both CYP and adult services. The impact of lockdown on this cohort of patients who were potentially recovering from an eating disorder has been significant. The Board was advised that during Covid-19 the service has seen the highest number of paediatric admissions for young people with an eating disorder since the service commenced. It was pointed out that admissions to Alder Hey paediatric wards are as a result of patients requiring medical intervention/support.
- It was pointed out that for the first time in February 2021 the service hasn't achieved the nationally mandated waiting time target and is modelling a 30% increase in referrals for community based mental health services.
- *Locality Based Mental Health Services* – There has been a significant increase in referrals since September 2020 for CYP. Attention was drawn to the latest figures for access waiting times; Choice is at 56.5% in Liverpool and 72.7% in Sefton. Partnership is at 72.5% in Liverpool and 58.5% in Sefton. It was reported that there have been a number of CYP presenting who require an urgent appointment within a two-week period, along with children who have complex mental health issues who aren't known to the service.
- The Board was advised of the actions that have taken place to ensure that CYP continue to access services. The introduction of a 'Calm and Connected' Covid-19 peer support group has been really successful in supporting CYP whilst awaiting an appointment. It was reported that the service was successful in acquiring funding from the National Lottery to run this group.
- In order to meet the predicted 30% increase in demand and complexity of CYP presenting to the Trust's locality based mental health services an investment is required in workforce; 12.0 wte Mental Health Practitioners, 1.0 wte Consultant Psychiatrist. It was reported that this information will be

submitted to the CCGs for review as part of the Trust's contracting arrangements.

A discussion took place around funding and the resources required for expanding services, addressing the increase in demand and the backlog. It was reported that a 30% increase in demand has been predicted and it is expected that this increase will continue over the next two years. It was felt that the real challenge is the complexity of CYP who have never been known to the service before. Attention was drawn to the workforce issue and the importance of acquiring funding to address this matter via the CCGs/ICS.

Louise Shepherd pointed out that one of the four core themes for CYP is mental health and advised that mental health services are being thought of across the Liverpool and Sefton patch. It was reported that Alder Hey is increasingly being seen as the leader of CYP and mental health across the patch and it was felt that there is an opportunity for the Trust to take the next step towards providing that leadership across a broader geography and indeed the North West. The Board was informed that this area of work will be discussed further during April's strategy session.

**Resolved:**
The Board received an update and noted the significant increase and impact on Eating Disorder services and community mental health services. It was noted that the services will not meet the agreed internal waiting time standards.

**20/21/277 Cumulative Corporate Report – Top Line Indicators**

*Quality and Safety:*

- There has been a decline in performance in the administration of antibiotics to sepsis patients for both inpatients and ED. For assurance purposes, it was reported that ED have met the 60 minute timeframe of 100% for patients presenting with sepsis during the last three weeks. In terms of inpatients work is ongoing with support from the Sepsis Team and a plan is in place to address this matter.
- There is a continued and sustained improvement in Play which is nearly at target, and the educational elements of patient experience has exceeded its target.
- It was reported that medication errors are to be addressed via the Brilliant Basics programme, quality priorities and the quality hub. Targeted and focussed work on the reduction of medication errors will continue over the coming months.

Anita Marsland queried as to whether a report on sepsis should be submitted to the Board in light of the decline in performance figures for this area of work. It was reported that targets not met in respect to the administration of antibiotics within 60 minutes were administered within a 90-minute period and there were reasons for this. Nicki Murdock agreed to review this matter.

**20/21/277.1 Action: NM**

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

**20/21/278 Cumulative Corporate Report – Top Line Indicators**

*People*

- There has been a reduction in compliance of mandatory training as a result of not being able to deliver face to face training. There is a plan in place to resolve this issue.
- The Trust continues to maintain a focus on sickness absence levels.

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

**20/21/279 Alder Hey People Plan**

**Resolved:**
The Board received and noted the Alder Hey People Plan.

*Staff Recovery and Reward Plan*

The Board was advised of the approach that the Trust will be taking in order to fully support its staff members physical and psychological recovery through the pandemic and beyond. It was reported that the Staff Recovery and Reward Plan provides the depth and outline of the people update that was provided under agenda item 20/21/272.

**Resolved:**
The Board received and noted the Staff Recovery and Reward Plan and endorsed/ supported the approach and activities as outlined in the paper.

*NHS Staff Survey 2020/21 Results*

It was reported that the National Staff Survey results have been officially published. The outcome of the survey is really positive for the Trust and shows great progress, with over 2000 members of staff having responded. It was found that there were significant improvements in all bar two themes, which remained static.

The Board was informed that the Health Service Journal (HSJ) has recognised Alder Hey as one of the top ten trusts for engagement and one of the top ten most improved trusts for staff engagement and its work on equality, diversity and inclusion.

The next steps will be for the Divisions to have local conversations with their teams. Divisions have received packs and a guide on how to have a conversation about the survey results and by the end of March each department will receive their local data set. It was pointed out that if there are less than 11 staff members within a team/department who have responded to the survey the Division won't receive any local data due to confidentiality reasons. It was pointed out that the Trust is just under its target of 80% of staff recommending Alder Hey as a place to work. It was felt that this is testament to the organisation wide effort/work that has taken place over the last twelve months to achieve this position.

The Chair commended the fantastic work that has taken place which is reflected in the wonderful results of the staff survey. The Chair drew attention to the things that have happened over the last twelve months that have underpinned the way in which staff feel about working for Alder Hey, and in terms of the Divisions there are opportunities to think about building upon the progress that has already been made.

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**Resolved:**
The Board received and noted the 2020/21 National Staff Survey results.

**20/21/280 EDI Taskforce Report**

The Board received the final report of the EDI Taskforce. A number of slides were shared to provide the following information:

- The Trust's commitments were agreed in October 2020 which resulted in commissioning Claire Dove CBE, Non-Executive Director to chair a special taskforce to agree the steps the Trust needed to take to remove processes and barriers in Alder Hey that could sustain systemic racism.
- *Feedback from Listening Events:*
  - Recruitment; improve the ways in which people can access opportunities and find roles, include BAME colleagues on interview panels, better recruitment training.
  - Work with local communities to promote education and employment opportunities, including volunteer opportunities.
  - Better access to training and development opportunities for staff.
  - Provision of mentors for new starters.
  - Better support for managers, including EDI training.
  - More definitive behavioural guidance for parents and visitors.
  - General awareness, culture awareness of colleagues and understanding of different cultures.
  - Racist abuse from other staff (unconscious bias) to overt racism from the public.
- Melissa Swindell advised of the large piece of work that is taking place around recruitment. It was reported that recruitment has been split into three sections; attraction, process and retention. Conversations have taken place with universities/local groups and it has been agreed that there will be a designated person who will progress this area of work on behalf of the specialist trusts.
- *Governance:* Work has taken place to look at how and where the Trust recruits for diversity to the Governors, Board and Leadership team using different agencies. The taskforce is looking at how Alder Hey is going to attract people from BAME backgrounds and is currently developing a programme of awareness training.
- *People:* Recruitment plan and implementation, overhaul of apprenticeships/traineeships which has resulted in 10 apprenticeships nursing opportunities. Building relationships with community organisations, schools and universities. A review of publicity documents is going to take place in order to reflect/encourage diversity of volunteers.
- *Communication and Engagement:* Listening events, Black History Month blogs, Claire Dove's AGM keynote speech, Schwarz Rounds, 'A Face Like Mine' campaign and public/staff facing communications.
- *Next Steps:*
  - Reporting back to the groups who came to the listening events.
  - 'International Nurses Day', celebrating diversity and linking in with St. Georges Hall in terms of the unveiling of the Mary Seacole Statue.
  - A blog is being circulated this week which will provide updates.
  - A presentation is to be shared with all on progress to date.
  - Funding has been received to help re-establish the BAME Network. Claire Dove drew attention to the importance of keeping up the

momentum of this work and agreeing as to who is going to drive the network forward.

Anita Marsland endorsed the contents of the report and highlighted the importance of continuing and supporting this work to ensure a change in culture. Fiona Marston reiterated Anita's comments and felt that the listening sessions have been key for staff. That need is still there, which has been identified via feedback, therefore it is imperative that this is kept as a priority whilst encouraging new staff members to come forward.

Shalni Arora referred to having a plan for this area of work which incorporates metrics and suggested building this into the strategy with a clear two to three year plan with measurables on progress to enable the Trust to track the impact that has been made.

Fiona Beveridge commended the work that has taken place and endorsed the comments that were made. In terms of looking ahead, it was suggested that a similar exercise take place in relation to patient/service user experience to see if everyone is experiencing the same level of service, regardless of background. Thought will need to be given in respect to how this will be addressed, i.e. start to think about whether data is already being collected or lay some early foundations in terms of monitoring complaints and concerns. Claire Dove advised that the Trust needs to work with staff members to ensure that they fully understand some of the issues that black children and their families experience. It was pointed out that this will be incorporated in the training that is taking place in May.

Lisa Cooper advised that the feedback from staff who had attended the listening events has been overwhelmingly positive. Attention was drawn to the changes that have been made to the recruitment process in the Community Division. It was reported that as of the 1.9.20 it is mandatory requirement to have a representative from the BAME network sit on each interview panel and EDI questions are now asked during interviews, this applies to all roles.

Louise Shepherd thanked everyone involved in progressing this work, pointing out that it feels organic, real and has changed Alder Hey completely. Attention was drawn to the importance of building this work into the Trust's plan for 2021/22 to retain the momentum and ensure that the focus isn't lost. Thought will need to be given to this to make sure it is meaningful for staff and additional resources will be required in terms of sustainability.

On behalf of the Board, the Chair thanked Claire Dove and all those involved in the Taskforce and the work that has taken place since October 2020. The Chair referred to the need for Trust wide anti-racist training and queried as to whether this should commence with the Board from a leadership perspective. The Chair asked that this be prioritised.

Claire Dove concluded that it will be amazing if opportunities can be created to enable people to grow, whilst inspiring our young people. It was pointed that if the Trust can get the blue print right to address systemic racism it can then be applied to resolve other issues around inequality.

**Resolved:**
The Board noted the EDI Taskforce report

**20/21/281 Freedom to Speak Up (FTSU)**

The Board was provided with a summary of the actions taken by the FTSU team in the last quarter and to outline the actions planned for the coming six to twelve months.
period. The following points were highlighted:

- *FTSU champions* – To date there have been 25 requests received to become a champion from colleagues in a variety of areas, with representation from a good selection of roles. The Board was advised of the poor response from the Trust's BAME network. Following an intelligence gathering exercise it was found that BAME colleagues, especially junior members, weren't keen to join certain groups, for example, unions/FTSU Champions as there was a feeling that it may have a detriment on their future development. Attention was drawn to the importance of addressing this issue so that BAME colleagues feel comfortable and encouraged to become FTSU Champions, etc.
- *FTSU connection with BAME colleagues* – The recent expression of interest for FTSU Champions was communicated Trust-wide; however, a personal request is going to be sent to BAME colleagues, as this group is under represented with the current FTSU Champion team. It is hoped that this request will produce a positive response and interest in the role.
- *Triangulation of data* – Work is taking place with the Deputy Director of HR and the SALS team to triangulate data and intelligence to help identify areas of concern, trends and themes within the Trust taking into account Ulysses, Raise it, Change it, and exit interviews. It was reported that a piece of work has taken place around exit interviews to make sure that they are fit for purpose and lessons are learnt from them.
- *FTSU Guardian Survey 2020* – Attention was drawn to the importance of focussing on detriment as this one of the recommendations that arose following the survey. Work is going to take place to look at an appropriate model for a follow-up process with staff to see if they have suffered any detriment as a result of speaking up.
- *FTSU, Raise It Change It, Ulysses* – There is to be a re-launch of FTSU and Raise it, Change it using Ulysses as a platform. Once the tool is in place, reporting and follow up will become much easier and more robust.
- *FTSU Index* – It was reported that the results of the NHS Staff Survey for 2020 indicates an increase in the Trust's FTSU index, as the four questions used to create the data have all increased since the 2019 staff survey. The Board was advised that the National Guardians office are going to conduct a case study on the Trust's FTSU index as it is one of the most improved across the UK. It was confirmed that this case study will be reported nationally.
- *Guardian Report content, Q3* – It has been identified that some concerns were being raised via the SALS service and not captured under FTSU. This has since been reviewed and the link to FTSU will be via a signposting process from SALS. It was reported that there has been an increase in concerns raised under FTSU during Q4, with 12 being received to date.

Anita Marsland commended the large amount of work that has taken place during the last year to reach this position, and thanked Kerry Turner and Erica Saunders for progressing this area of work. Anita Marsland felt that a strategic piece of work needs to take place in terms of FTSU in order to provide clarity and assurance to the Board that the team is undertaking pertinent work.

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Erica Saunders advised that the Board self-review tool will be revisited, and a revised self-assessment and gap analysis will be included in the next FTSU report to provide further clarity in terms of next steps.

The Chair thanked Kerry Turner for the update and advised of her delight that the Trust has been recognised nationally for its FTSU work.

**Resolved:**
The Board received and noted the contents of the FTSU report.

**20/21/282 Position Statement – Research and Innovation**

The Board received an update on the Alder Hey Innovation and Research position statement for March 2021. A number of slides were shared which provided information on the following areas:

- Three key messages within the Innovation Strategy; what the strategy entails, key drivers of the strategy, delivery of the strategy.
- Innovation Strategy position statement;
- ***What ('the dream')*** – The strategy aims to position Alder Hey as a world leader for child health and a child health campus for research and innovation discoveries saving lives and creating a healthier future. The Strategy's mission statement is 'Today's child, tomorrow's healthier adult'.
- ***Why (*****children and young people are 30% of the population today but 100% of the future)** – There is a real need and opportunity to address local inequalities and global child poverty. The Innovation Strategy has been aligned to 'Starting Well' as part of research and the first phase will focus on mental health, obesity and respiratory. There is a national movement around inequalities and there is a real opportunity for Alder Hey to be an exemplar as part of the national direction of travel. The strategy will aim to have a measurable impact commencing locally but will create a repeatable model that the Trust will scale nationally whilst making its innovations available globally for CYP. Alder Hey is looking to establish itself as a thriving innovation business arm. This will enable the strategy to monetarise innovations, create a sustainable business model, commercialise innovations and use the revenues to create a bigger pipeline of innovations that can be deployed.
- ***How (democratize healthcare with Alderhey@anywhere)***
  - ❖ *Ecosystem* – Liverpool City region innovation Beacon asset.
  - ❖ *Partners* – Strategic partners, large corporates start-up, SME, academic.
  - ❖ *Pipeline* – Health-Tech pipeline (establish AI CoE and Med-Tech rapid evaluation CoE)
- ***Recap*** – It is the Trust's goal to have a global impact on 2.2 billion CYP and to have a £20m innovation revenue.
- ***Report on Saving and improving lives: The future of UK clinical research delivery***. The Board was advised that this document is going to be critically important for setting the direction of the Research Strategy over the next 5 years. It sets out to learn the lessons of how we managed as a country to develop and deliver Covid-19 research at high volume and pace during the pandemic. This work has established us as an international leader for research but there were a number of things that were done differently during the last 12 months and as a community we are very keen to learn those lessons and draw on them to continue to develop and expand clinical research at volume and pace in the years to come.
- Sustainable, supported workforce.

- Transplant and establish talent and grow our own.
- NIHR Clinical Research Facility (CRF) renewal.
- Innovation in devices: Embedded in the CRF.
- New opportunities – Genomic medicine.
- Develop a digital infrastructure; research relevant data strategy, insight from internal data, e.g. imaging AI, data insight from population health.

Shalni Arora advised the Board that the Trust has been nominated for an HSJ award for the use of the HoloLens in cardiac services. It was felt that this reflects the strategy in action in terms of what has been achieved in a very short space of time.

Claire Dove queried as to whether the Trust is linking the global element of the strategy with the SUG's sustainable development rules as this is key when carrying out this type of work on a national basis. Claire Liddy agreed to look into this matter.

**20/21/282.1 Action: CL**

The Chair thanked Claire Liddy and Jo Blair for sharing their presentation with the Board. The Chair commended the amount of work that has taken place and the progress that has been made in a short timeframe.

Louise Shepherd paid a special tribute to Jo Blair for the work that she has conducted around research and the linking of innovation with research which has helped transform the views of many colleagues in the Trust. It has also provided a more comprehensive view of how these two areas of work fit together and how that work can be strengthened. Attention was drawn to the importance of understanding the report that has recently been published, as referenced in the presentation, in order to agree in terms of what this means for the Trust. The Board was advised that this area of work will be addressed during April's strategy session.

**Resolved:**
The Trust Board received and noted the position statement for Research and Innovation.

**20/21/283 Alder Hey in the Park Campus Development Update**

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

- *Schemes* - It was reported that the new Neonatal Unit, the Clinical Hub and the Dewi Jones constructions are making good progress and are on track to be delivered. The Board was advised that the insurers have requested a change to the roof material on the Clinical Hub and the Dewi Jones construction due to the timber frame and the insulation material proposed posing a fire risk. This may cause a cost increase to change at such a late date.
- *Park Reinstatement Phase 1* - The planned work to sow the grass seed is scheduled for the 25.3.21 and it was confirmed that the Community Benefits Society is now in shadow form and is up and running. The society has been liaising with universities to discuss the possibility of having an intern assist with the park projects. Attention was drawn to the bid that has been submitted to Sport England for funding which is supported by a number of the Trust's clinicians.
- *North East Plot Development* – The Step Places plans are being submitted to the Planning Committee in June 2021 and the Trust is working with Step Places on the ideas that the Trust has had for patient/family accommodation.

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

**20/21/284 Financial Update**

*2020/21 Interim Financial Plan*

The Board was provided with an update on the 2020/21 forecast year end position. The report that was submitted outlines the planning principles that underpin the 2021/22 plan. It was pointed out that 2021/22 national framework and guidance is yet to be released and therefore at this stage the plan is in draft form and will likely change over the coming months once clarity is received.

An interim plan has been developed for 2021/22 using the national principles and focussing on areas that are within Alder Hey's control and that can be influenced. It was reported that fixed block income levels will be rolled over from Q3/4 of 2020/21, with no inflation applied until confirmed by NHSI/E and any continued impact of Covid-19 will be funded through ongoing Covid allocations via the systems. There is also an assumption that there is going to be a full year's allocation of funding for mental health services.

Attention was drawn to the current forecast overall deficit of £8.5m to March 2022 which is driven largely by an underlying deficit that the Trust had prior to the funding mechanism that was implemented following the pandemic, and a number of forthcoming cost pressures in investment areas. The Board was advised of the risk in respect to bridging any potential deficit plan given the nature of the funding envelope. The Board was also informed of a further risk that relates to the progressing of capital schemes due to capital envelopes being managed via a system lens going forward. It was confirmed that a more detailed report will be submitted to the Board in April following receipt of the national framework and guidance.

A discussion took place around investment strategy constraints and it was agreed to build this into deliberations once the Trust has received the guidance/plans.

**20/21/284.1 Action: JG**

*Position for M11*

In Month 11 the Trust reported £0.4m deficit, £0.6m ahead of base plan, in line with a revised plan of £4.5m. The actual YTD is £3.6m deficit, in line with the latest plan submitted. It was confirmed that the Trust has received full cash funding for annual leave. The Board was advised that the revised forecast for Alder Hey for the 2020/21 year end is now a breakeven position. The Trust is anticipating strong cash balances and will meet its capital programme.

On behalf of the Board, the Chair thanked all those involved in delivering a breakeven position for the 2020/21 financial year.

**Resolved:**

The Trust Board noted:

- The 2020/21 reforecast plan of a breakeven position.
- The interim 2021/22 plan for an £8.5m deficit and the planning principles adopted, noting the risks and opportunities and that further revisions will be made once national guidance is finalised.
- The draft 2021/22 capital plan with a total spend of £29.5m.

**20/21/285 Draft Risk Appetite Statement**

The draft risk appetite statement was submitted to the Board to seek views and support for the proposed risk appetite statements detailed in the report. The Board was asked to discuss and agree the qualitative risk appetite for each risk category.

The Board received an overview of the purpose/rationale for establishing a risk appetite approach and the benefits of the tool in terms of framing and understanding the approach that the organisation is going to take Trust wide to proactively manage and mitigate risks, and importantly the risk that Alder Hey is willing to live with. A discussion took place and the following points were raised:

- The Chair pointed out that the identification of risk across Alder Hey is variable and felt that it would be really helpful to have a common framework that can be embedded Trust wide.
- Kate Warriner felt that the Trust is a very ambitious organisation and stretches itself, especially in terms of research, digital and innovation but with that comes a certain element of risk around those domain areas. It was felt that there was a slight gap in the risk appetite narrative and it was suggested including narrative under risk appetite level 4 'Seek' to state that in terms of taking some risks within the constraints the Board is willing to accept this in those domain areas. Kerry Byrne pointed out that there is a descriptor under the proposed appetite for innovation but there isn't one for digital, therefore it was agreed to review the risk appetite matrix to ensure that each of the areas can identify with one of the categories of risk appetite.

**21/22/285.1 Action: ES**

- John Grinnell felt that some of the areas conflict with each other in terms of Board appetite and aren't always isolated into a single area, for example, innovation, digital and financial reputation which compete with each other on occasions. Attention was drawn to the complexity of this work and the need for recognising that this is a large piece of work that will take a period of time to embed across the organisation. It was agreed that further discussions will take place during April's strategy session.
- Louise Shepherd stated that she welcomed this piece of work and that it would be a useful next step on the Trust's improvement journey in terms of risk management; she raised a question in terms of how the risk appetite relating to reputation has been described and how it could lead to misinterpretation. It was agreed to revisit the narrative.

**21/22/285.2 Action: ES**

**Resolved:**
The Board received and noted the contents of the Board Risk Appetite Statement and approved the framework for determining risk appetite. It was confirmed that the framework will be tested during April's strategy session whilst taking into account the feedback that has been provided during today's Board meeting.

**20/21/286 Board Assurance Framework**

**Resolved:**
The Board received and noted the contents of the Board Assurance Framework report as at the end of February 2021.

**20/21/287 Board Assurance Committees**

*RABD* – The approved minutes from the meeting that took place on the 22.2.21 were submitted to the Board for information and assurance purposes. During the meeting on the 22.3.21 the Committee discussed the interim 2021/22 financial plan and received an overview of the financial action plan for the Division of Surgery. It was reported that the Digital Collaboration Case was approved, as was the proposal for additional office accommodation. The Green Strategy is to be revisited and information was shared in respect to the potential licencing agreement to manufacture transparent masks with a local company.

*SQAC* – The approved minutes from the meeting that took place on the 17.2.21 were submitted to the Board for information and assurance purposes. It was reported that during the meeting on the 24.3.21 the Committee received updates on quality priorities, complaints and IPC. A discussion took place around transition issues particularly in respect to demonstrating and documenting the Trust's compliance with NICE guideline 43. The Committee was also provided with an overview of the work that is taking place and the new system that has been implemented to ensure that the Trust has oversight in terms of policies and procedures that are lapsing and need to be reviewed. The Divisions raised concerns about recovery from a staff sustainability perspective, and it was confirmed that the Community Division has resolved the issues relating to missing prescription; from the 1.4.21 prescriptions will be delivered via courier.

*People and Wellbeing Committee* – The approved minutes from the meeting that took place on the 25.1.21 were submitted to the Board for information and assurance purposes. It was reported that during the meeting on the 23.3.21 discussions took place around flexible working arrangements, bringing staff back on site safely, DBS checks and the live topic of the nursery. It was confirmed that work and listening sessions are going to take place in terms of staff with disabilities.

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

**20/21/288 Any Other Business**

There was none to discuss.

**20/21/289 Review of the Meeting**

The Chair thanked everyone for their contributions during the meeting. It was pointed out that the Trust has delivered a whole range of things during what has been a very difficult but successful year, and this is testament to the CEO and the Executive Team. The Chair paid tribute to the Non-Executive Directors who have been really supportive whilst having to work in a very different way as a result of the pandemic. A lot has been achieved this year which was highlighted in the progress of the EDI Taskforce work.

Louise Shepherd agreed that it has been a difficult year, but the Executive team have felt really supported by the Board throughout and offered thanks for this.

**Date and Time of Next Meeting:** Thursday the 29th April 2021 at 9:00am via Teams.

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

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| **Actions for the 29th April 2021** | | | | | | | |
| 03.03.20 | 19/20/346 | Key Issues/Reflections and items for information | Invite the new Nurse cohort from India to the Trust Board lunch and write a thank you letter to Barclays Bank for their support in setting up bank accounts for the new members of staff. | Pauline Brown | 25.2.21 | Closed | This item has been deferred until further notice due to the Covid-19 crisis. **24.4.21** - A number of nurses from the new nurse cohort from India have been invited to April's Trust Board to share their overall experience of joining the Trust last year and how they have coped during the pandemic, etc. **ACTION** |
| 02.06.20 | 20/21/60.1 | Freedom to Speak Up | Compile a breakdown of the issues that SALS have addressed during the current year. | Kerry Turner | 29.4.21 | Closed | **23.1.21** - This item has been deferred to March due to the governance light committee approach that has been taken as a result of the 3rd wave of the pandemic. **19.3.21** - A report will be submitted to the Board on the 29.4.21. **24.4.21** - This item has been included on April's agenda. **ACTION CLOSED** |
| 26.11.20 | 20/21/188.1 | Board Assurance Framework | Submit the Risk Management Strategy to the Board for ratification in January. | Erica Saunders | 29.4.21 | Closed | 23.1.21 The Risk Management Strategy is to be submitted for ratification in March 2021. 19.3.21 - The Risk Management Strategy has been deferred until April 2021. **24.4.21** - This item has been included on April's agenda. **ACTION CLOSED** |

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

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| 25.2.21 | 20/21/249.1 | Covid-19 Assurance Plan – Alder Hey's Response to the Third Wave | *Covid-19 Risk Register* - Advise of the timeline of the independent review that is taking place into Manchester University NHS Foundation Trust's Cardiology RTT waiting list that was overlooked. | Nicki Murdock | 29.4.21 | Closed | **19.3.21** - A verbal update will be provided on the 25.3.21. **25.3.21** – Work is taking place to address the backlog of referrals, with additional sessions being scheduled to take place on a Saturday. It was reported that the Chief Operating Officer for Manchester University NHS FT is aware of the concerns that have been raised and it has been agreed that joint meetings will take place on a monthly basis going forward. It was agreed to provide a further update on this matter during April's Trust Board meeting. **28.4.21** - This action will be addressed during the agenda. |
| 25.2.21 | 20/21/249.2 | Covid-19 Assurance Plan – Alder Hey's Response to the Third Wave | *Covid-19 Risk Register* - Submit a report on the lines of accountability and governance arrangements in place for the RMCH/Alder Hey partnership in order to provide clarity on the risks that the Trust Board is managing. | Nicki Murdock | 29.4.21 | Closed | **24.4.21** - This item is included on the agenda. **ACTION CLOSED** |
| 25.2.21 | 20/21/252.1 | Mortality Report, Q2 | *National Changes to the Child Death Mortality Process* - Acquire written confirmation from David Levy's office acknowledging that the Trust's system is fully compliant and in line with the new national guidance. | Nicki Murdock | 29.4.21 | On Track | **19.3.21** - A verbal update will be provided on the 25.3.21. **25.3.21** - It was reported that the Trust is awaiting a reply from David Levy's office. **ACTION TO REMAIN OPEN** |
| 25.3.21 | 20/21/272.1 | Brilliant Basics Update | Provide a further update on the cascading of priorities to the wider organisation, during April's Trust Board meeting. | John Grinnell | 29.4.21 | Closed | **24.4.21** - This item has been included on the agenda. **ACTION CLOSED** |
| 25.3.21 | 20/21/277.1 | Cumulative Corporate Report – Top Line Indicators | *Quality and Safety* - Decide as to whether a report on sepsis should be submitted to the Board in light of the decline in performance figures for this area of work. | Nicki Murdock | 29.4.21 | On Track | |

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

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| 25.3.21 | 20/21/282.1 | Position Statement – Research and Innovation | Look at linking the global element of the Innovation Strategy with the SUG's sustainable development rules. | Claire Liddy | 29.4.21 | On Track | |
| 25.3.21 | 20/21/284.1 | Financial Update | Build investment strategy constraints into deliberations once the Trust has received guidance and plans from NHSE/I. | J. Grinnell | 29.4.21 | Closed | **26.4.21** - This has been built into plans submitted as part of the 2021/22 planning round. **ACTION CLOSED** |
| 25.3.21 | 20/21/285.1 | Draft Risk Appetite Statement | Review the risk appetite matrix to ensure that each of the areas for innovation, research and digital can identify with one of the categories of risk appetite. | Erica Saunders | 29.4.21 | Closed | **24.4.21** - This action will be addressed during the strategy session on the 29.4.21. **ACTION CLOSED** |
| 25.3.21 | 20/21/285.2 | Draft Risk Appetite Statement | Revisit the narrative relating to reputation. | Erica Saunders | 29.4.21 | Closed | **24.4.21** - This action will be addressed during the strategy session on the 29.4.21. **ACTION CLOSED** |
| **Actions for the 27th May 2021** | | | | | | | |

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

| 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 | 27.5.21 | 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. **26.4.21** - A themes and trends analysis will be included in May's report. **ACTION TO REMAIN OPEN** |
| 25.2.21 | 20/21/252.2 | Mortality Report, Q2 | *Adult Covid Deaths* - Conduct a deep dive into the six Covid-19 adult deaths that took place at Alder Hey during the pandemic and submit a report to the Board on the overall outcome, in April/May 2021. | Nicki Murdock | 27.5.21 | On Track | |

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

# BOARD OF DIRECTORS

**Thursday 29th April 2021**

| | |
|---|---|
| **Paper Title:** | **Access and recovery of services for children & young people** |
| **Report of:** | **Adam Bateman**<br>**Chief Operating Officer** |
| **Paper Prepared by:** | Lachlan Stark, Associate Chief Operating Officer Planning & Compliance |

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

## 1. Introduction

In March we provided more elective and outpatient care and treatment to children and young people than in any other month since the onset of the pandemic. Our recovery of planned care services is strong and has been achieved at pace. In emergency care we saw a sharp rise in attendances to the Emergency Department, associated with the re-opening of schools and easing of restrictions.

## 2. Summary of progress in restoring services

Our activity volumes August to March are as follows:

| Service | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|
| **Outpatients** | 13,108 | 16,581 | 16,656 | 17,441 | 14,988 | 16,179 | 16,005 | 19,145 |
| **Daycase** | 1464 | 1532 | 1675 | 1780 | 1726 | 1522 | 1609 | 2079 |
| **Elective** | 370 | 378 | 422 | 423 | 400 | 353 | 361 | 471 |
| **IP/DC** | 1,834 | 1,910 | 2,097 | 2,203 | 2126 | 1875 | 1970 | 2550 |
| **Diagnostics** | 1,413 | 1,608 | 1,554 | 1,552 | 1589 | 1556 | 1586 | 1666 |

Activity by point of delivery as a proportion of 2019 activity levels:

| Service | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 |
|---|---|---|---|---|---|---|---|---|
| **Outpatients** | 86% | 87% | 84% | 95% | 95% | 89% | 92% | 97% |
| **Daycase** | 83% | 74% | 85% | 92% | 94% | 81% | 83% | 102% |
| **Elective** | 86% | 88% | 98% | 92% | 102% | 87% | 88% | 91% |
| **IP/DC** | 84% | 76% | 87% | 92% | 95% | 82% | 84% | 100% |
| **Diagnostics** | 92% | 90% | 86% | 90% | 105% | 97% | 98% | 87% |

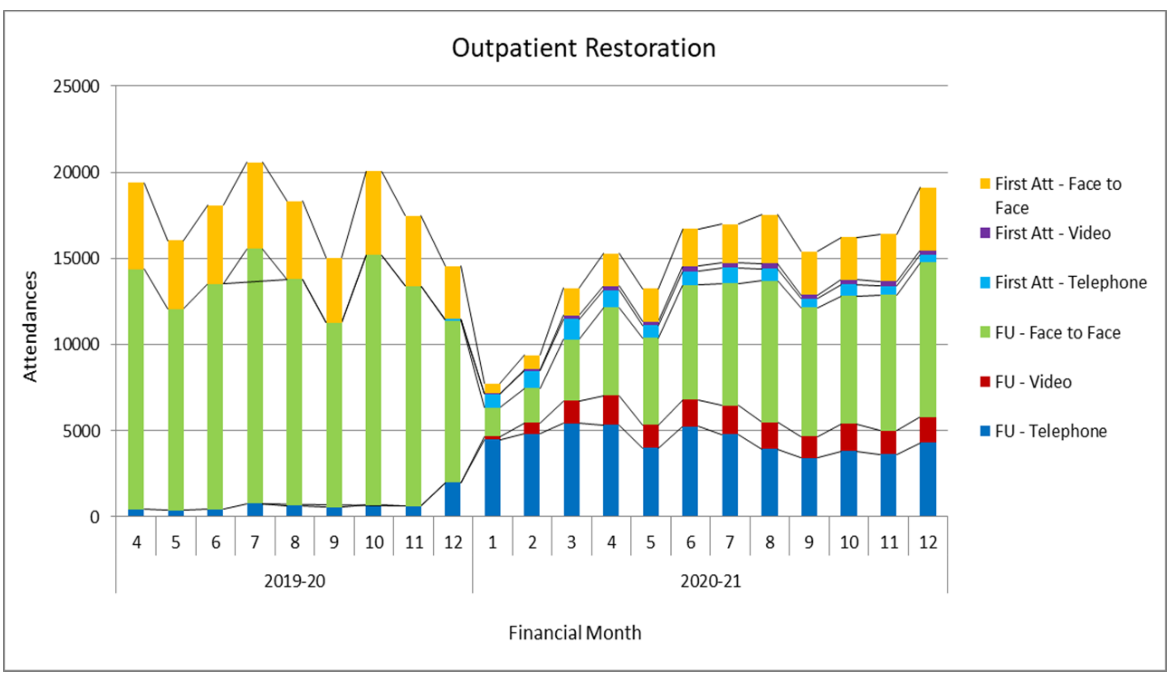
The key highlights from our recovery plan are as follows:

- **Outpatient activity reached 97% of pre-Covid-19 levels**, our best performance to date
- Our **elective planned activity** for inpatient and day case **exceeded pre-Covid-19** levels at **102%,** largely driven by a significant increase in day case activity
- In **diagnostics the highest number of scans performed in the reporting period**, although as a percentage of 2019 levels it reduced to 87%

## 3. Recovery by service area

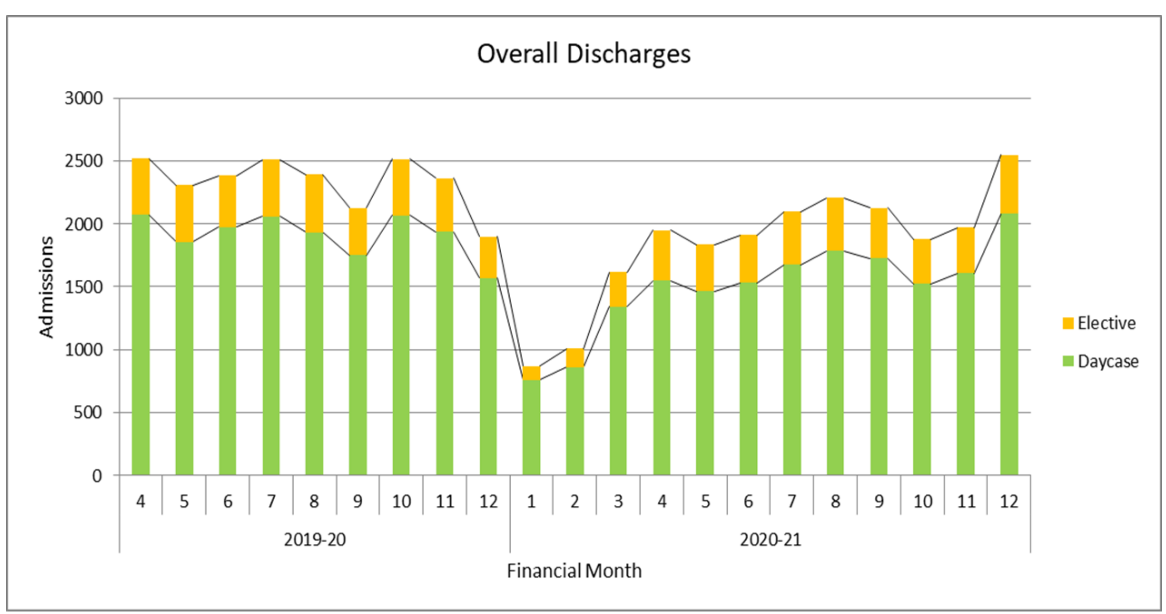
### 3.1 Outpatients

The chart below highlights the trend in outpatients' recovery and the modality of appointments:



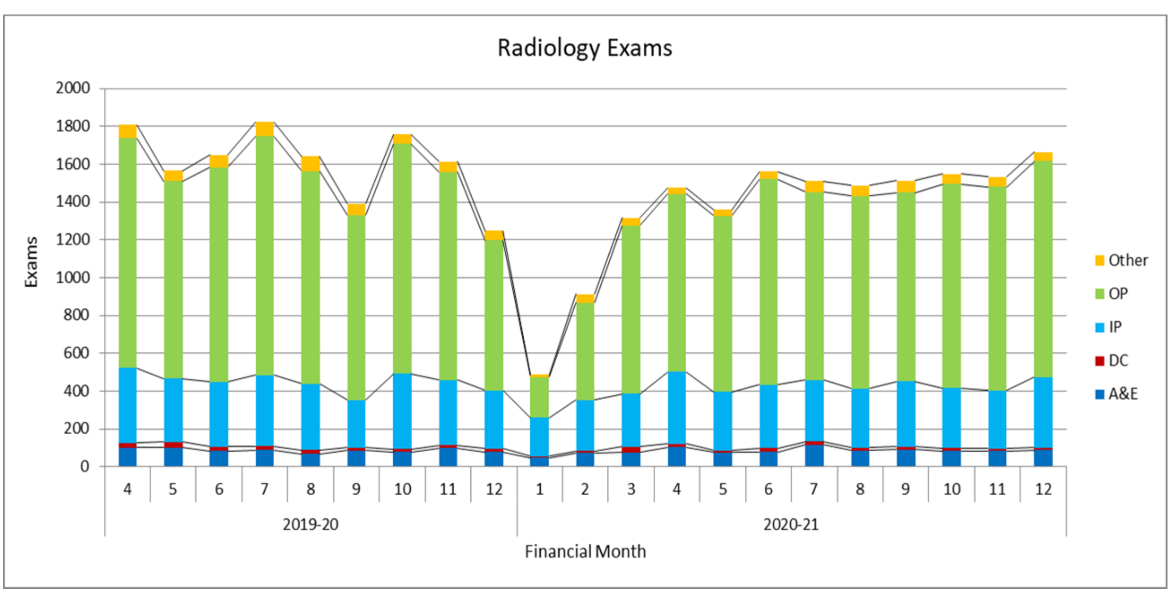

## 3.2 Elective & Day Case Activity

In March we had the full theatre schedule available for the month plus additional weekend activity which in aggregated supported a significant increase in elective and day case activity:




## 3.3 Diagnostics

In **radiology they achieved the highest number of scans performed in the reporting period**, although as a percentage of 2019 levels it reduced to 87%.

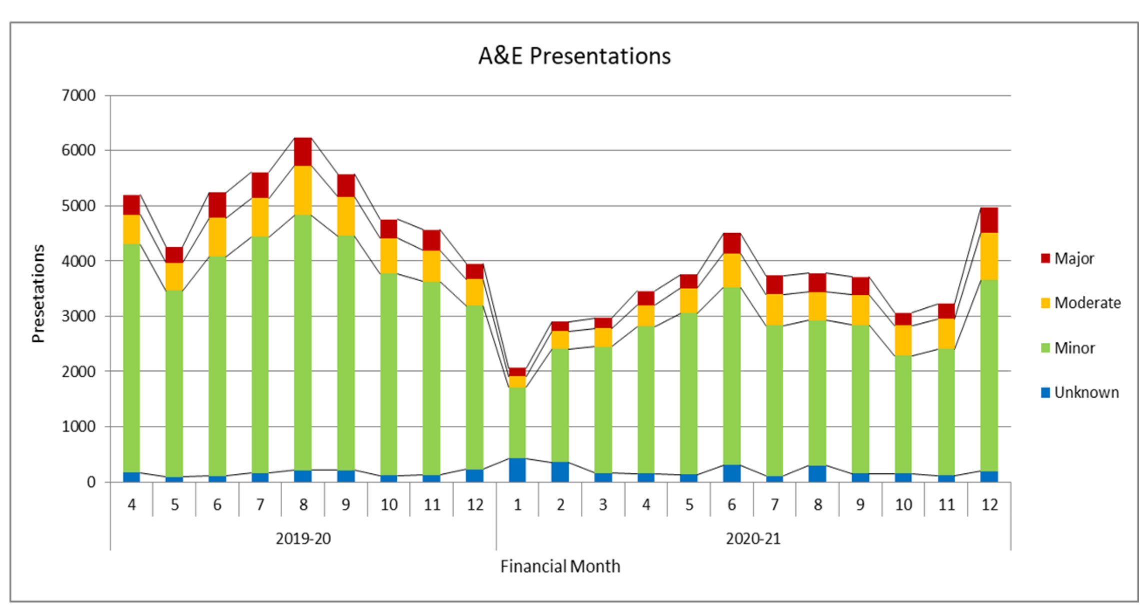



The diagnostic waiting time standard is for 99% of diagnostic procedures to be performed within 6 weeks of request. In March our performance improved to 97.5%:

| DM01 | June | July | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|
| **%perf** | 81.9 % | 82.9 % | 78.9 % | 87.0 % | 91.8 % | 97.1 % | 92.3 % | 93.7 % | 95.8 % | 97.5 % |

## 3.4 ED attendances

In March there was a sharp rise in attendances to the Emergency Department. There was a reduction in the number of patients seen within 4 hrs but we continued to meet the national standard of 95% and remain one of the best performing departments in England. In anticipation of high demand for urgent and emergency are over summer we are developing a summer plan and will be collaborating with partner organisations to review capacity and models of care.

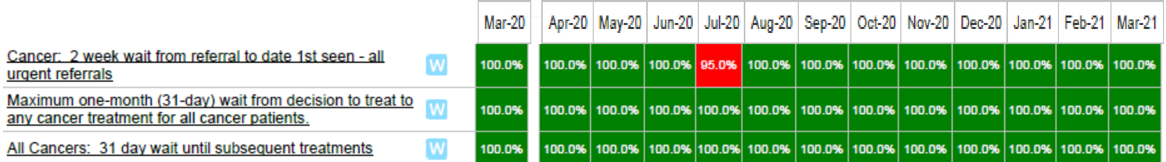


ED 4hr access standard performance:

| | |
|---|---|
| Oct-20 | 96.92% |
| Nov-20 | 97.51% |
| Dec-20 | 98.63% |
| Jan-21 | 98.47% |
| Feb-21 | 97.89% |
| Mar-21 | 95.43% |

## 3.5 Cancer Performance

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



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

## 4. Waiting times for planned care

In March 2021 we submitted our recovery plan to the Cheshire & Merseyside elective recovery and transformation cell. This included a forecast trajectory for clearing the backlog of patients waiting over 52 weeks:

| Pathway | Mar-21 | Apr-21 | May-21 | Jun-21 | Jul-21 | Aug-21 | Sep-21 | Oct-21 | Nov-21 | Dec-21 | Jan-22 | Feb-22 | Mar-22 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Admitted | 348 | 311 | 251 | 176 | 158 | 153 | 122 | 90 | 58 | 54 | 41 | 21 | 6 |
| Non-Admitted | 35 | 39 | 34 | 12 | 6 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Total** | **383** | **350** | **285** | **188** | **164** | **153** | **122** | **90** | **58** | **54** | **41** | **21** | **6** |

Through the annual planning process we will finalise our recovery of services trajectories for the year and will update the Board in May.

In March our waiting time performance is as follows:

| | |
|---|---|
| **Open pathway RTT performance (18 weeks)** | ↑ 67.9% |
| **Total number of patients > 52 weeks** | ↑ 361 |

# BOARD OF DIRECTORS

**Thursday 29th April 2021**

| | |
|---|---|
| **Paper Title:** | **IPC Assurance report** |
| **Report of:** | **Infection Prevention & Control Exceptions** |
| **Paper Prepared by:** | ***Dr Beatriz Larru*** *DIPC*, ***Joanna McBride,*** *Interim ACN Corporate Services,* |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance x<br>Information x<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | N/A |
| **Action/Decision Required:** | To note x<br>]To approve |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** x<br>**The best people** doing their best work x<br>Sustainability through **external partnerships** **x** ☐<br>Game-changing **research and innovation**<br>**Strong Foundations** **x** |
| **Resource Impact:** | |
| **Associated risk (s)** | 637, 795, 2081<br>Risks have been reviewed & 2 further risks closed. |

# INFECTION PREVENTION & CONTROL EXCEPTION REPORT 2020-21 APRIL 2021

Metrics

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 31 March 2021.

| 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*** | ***13*** | ✖ |
| CLABSI (ICU Only) | **Match 2019-20** | ***12*** | ***16*** | ✖ |
| Gram-Negative BSI | **10% Reduction from 19-20** | ***19*** | ***21*** | ✔ |
| RSV | **Match 2019-20** | **7** | ***0*** | ✔ |

**COVID-19 Vaccination**

**Alder Hey Covid Vaccine**

| **No of Staff** | **3890** |
|---|---|
| First Dose Administered | 3365 |
| % Complete | 87 |

| Staff Group | Number of Staff | First Dose Administered | % Complete |
|---|---|---|---|
| Add Prof Scientific and Technic | 315 | 271 | 86 |
| Additional Clinical Services | 501 | 404 | 81 |
| Administrative | 843 | 743 | 88 |
| Allied Health Professionals | 298 | 266 | 89 |
| Estates and Ancillary | 232 | 192 | 83 |
| Healthcare Scientists | 132 | 121 | 92 |
| Medical and Dental | 335 | 302 | 90 |
| Nursing and Midwifery | 1234 | 1066 | 86 |

| | Number of Staff | First Dose Administered | % Complete |
|---|---|---|---|
| BME | 290 | 238 | 82 |

The 2nd dose Alder Hey vaccination programme was completed 31 March 2021. All 3,510 doses were administered (0 wasted) during the 15 day programme. The vaccination team are continuing to support the vaccination partnership at LHCH.

## *Additional Activity/Achievements/Issues*

**Fit Testing**

The table shows the fit-testing figures separated by the divisions who are 'in scope' by division is 90.37% (31 March 2021). All staff (253) who have not had a fit-test who are outstanding have been contacted individually.

| Division | Total in Scope | Long term sick/ML | Total to Fit Test | Number fit tested |
|---|---|---|---|---|
| Surgery | 1171 | 72 | 1099 | 1011 (92%) |
| Medicine | 829 | 73 | 756 | 676 (89.4%) |
| Community | 160 | 4 | 156 | 119 (76.3%) |
| Corporate | 120 | 5 | 115 | 113 (98.3%) |
| | 2280 | 154 | 2126 | 1919 (90.3%) |

**Policy and Guideline**

Covid-19 guidance on PPE, visitation, testing and track and trace updated.

**Track, Trace and Swabbing Team**

This service is embedded and ongoing to meet the needs of the Trust. The Trust in participating in the SMART release programme piloted by Liverpool City council.

**Self-Testing**

The Trust has transitioned to the LAMP asymptomatic testing programme. Currently completed 2,308 have been undertaken (2 positives).

**COVID-19 Outbreaks**

No Outbreaks in March.

**BOARD OF DIRECTORS**

**Thursday 29th April 2021**

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

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

## 1. Purpose

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

## 2. Summary.

There are currently **10** risks identified on the COVID risk register, inclusive of **one** high risk identified on the register (2183). The risk profile is outlined at appendix 1, table 1.

Number of risks closed/transferred from the risk register = **nine** ( cited at table 2.)

Number of new open risks = **0**

Number of risks with an overdue review date = **2**

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

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

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

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

## 3. Themes

### 3.1. Infection to CYP, families and our staff.

**Risk 2183, 4x4=16** *"Risk that staff, patients and the public will not be able to socially distance whilst waiting in ED".* This risk was increased to high on 17th March, due to Increasing attendances and reduced capacity in waiting room, caused by building work target date for completion end of April 2021. Assessment with external agency planned to take place imminent, to review use of Perspex screens and air filtration systems, to help mitigate the risk. Domestic services cover increased in department to minimise risk of infection.

**Risk 2268, 4x2=8:** Staff could be exposed to COVID and therefore could either become infected or be required to self-isolate. All COVID secure risk assessments have been completed and all areas are deemed COVID secure, with action plans to further mitigate risks where relevant. Any breaches in compliance are fed back to relevant managers regularly to ensure addressed. Operational managers are expected to own these assessments, but H&S will continue to floor walk and monitor and assist with any new issues arising.

### 3.2. Access to services

**Risk 2228: 3x3=9** "*Risk of delay in access to Theatre will result in suboptimal outcome for children and Young people*". This risk remains at a risk level of 9 since first identified in July 2020. P code report developed, to enable weekly review of theatre scheduling to ensure the most patients have access to theatre. Draft one of the P code report produced and utilised by teams, further development required. The risk is linked to two high risks on the Corporate Risk Register (CRR), *risk ref 2265: Risk of Children and young people on the waiting list experience an avoidable delay to care* (3x5 = 15) and risk refer 2235: *"risk that patients will not get an outpatient appointment within the clinically appropriate timescale because of the poor data quality of our*

*current outpatient waiting list",* (3x5 =15). Both these risks are being robustly managed, with numerous controls and actions in place to mitigate.

**Risk 2191, 5x2 =10 "***Risk of deterioration of children and young people's mental health state and physical withdrawal symptoms***."** Caused by to the current situation with Covid 19, prescriptions are being sent direct to the patient's home to avoid attendance at clinic to pick the prescription up. Potential delayed receipt / loss of prescriptions sent to the patient's home delaying medication**.** Developmental paeds trialling hospital courier. To review if suitable for expansion into CHAM'S. CAMHS to then access for implementation. Waiting for update on long terms solution via external provider.

**Risk 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. During the most recent this lockdown this group of children were not attending school. Team leaders have been supporting the children and families for their return to school over the past few weeks A task and finish group have been working to ensure any additional support that may be required to assist children regaining their physical condition, with recommencement of therapy.

**Appendix 1 Risk Register Profile – 20th April 2021(Total 10)**

**Table 1**

| Very Low Risk | | | Low Risk | | | Moderate Risk | | | | High/ Extreme Risk | | | | No risk rating |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 8 | 9 | 10 | 12 | 15 | 16 | 20 | 25 | |
| **0** | **0** | **0** | **0** | **0** | **1** | **2** | **4** | **1** | **1** | **0** | **1** | **0** | **0** | **0** |
| **0 (0.00%)** | | | **1 (10%)** | | | **8 (80%)** | | | | **1 (10%)** | | | | **(0.00%)** |

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

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

| Risk reference | Risk description | Target |
|---|---|---|
| **2134 Closed.** | "*Risk of missed or delayed diagnosis for a baby with one of the disorders detected by the Newborn Screening programme".* Actions completed, no gaps identified, controls in place. Risk closed at target | **5x1 =5** |
| **2138 Closed.** | "*Risk that front line nurse availability to work will be significantly compromised during winter 2020 / the second Covid peak and that compliance with national nursing standards for safe staffing levels on wards and departments will not be met (RCN / PICS / BAPM / QNIC / NQB) and / or the ability to have beds / services will be significantly affected.* "Actions completed, no gaps identified, controls in place. Risk closed at target | **3x2 =6** |
| **2166 Closed.** | "*Reduced service to children and young people with a Learning Disability / Autistic Spectrum Condition who may be attending or requiring input from Alder Hey. Reduced physical access to Acute Liaison Team for staff - to support reasonable adjustments to children and young people with a learning disability and /or autism."* Actions completed, no gaps identified, controls in place. Risk closed at target | **3x1 =3** |

| | | |
|---|---|---|
| **2178 Closed** | *"Risk of late or no presentation of C&YP who need treatment".* current score 6, below target risk rating of 9. presenting late ED attends back up to pre-Covid/Winter levels. Actions completed, no gaps identified, controls in place. | **Target 9 Risk closed as rating 2x3 = 6** |
| **2180 Closed** | *"Risk of not securing suitable and sufficient PPE to meet demand, to ensure safety of patients and staff is maintained. "Actions completed, no gaps identified, controls in place. Risk closed at target* | **3x2 = 6** |
| **2267 Closed** | *"Risk of transmission of Covid 19 due to inability to socially distance from colleagues and potential cross contamination from personal clothing*." Actions completed, no gaps identified, controls in place. Risk closed at target | **3x1 =3**<br><br>**Closed below target 2x1 =2** |
| **2161 Closed** | *Due to not having an e-roster system in place and the ESR system not being set up to automatically calculate these payments, there is a risk that pay will not be calculated accurately for the affected employees."* Actions completed, no gaps identified, controls in place. Risk closed at target | **3x3 = 9** |
| **2153 Transferred** | *"The risk to this is that mandatory training compliance falls below the target of 90% and staff and/or patients are put at risk due to staff being non-compliant for mandatory training*." This risk is at target. Further review to be undertaken . Transferred to HR risk register | **2x3 = 6** |
| **2157 Transferred** | "*Inability to meet required staffing levels to support safe and efficient service delivery across clinical and non-clinical departments."* Transferred to HR risk register Current risk rating 3x2 =6 | **2x2 =4** |

**END**

**BOARD OF DIRECTORS**

**Thursday 29th April 2021**

| | |
|---|---|
| **Paper Title:** | Serious Incident Report |
| **Report of:** | Nathan Askew, Chief Nursing Officer |
| **Paper Prepared by:** | Cathy Umbers<br>Associate Director of Nursing and Governance |
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ■ |
| **Background Papers and/or supporting information:** | Seven Steps to Patient Safety. National Patient Safety Agency 2004.<br>Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'.<br>Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015.<br>Serious Incident Framework. Frequently asked questions NHS England 2016.<br>NHS Patient Safety Strategy. NHS Improvement. July 2019.<br>Never Events List ( revised February 2021) |
| **Action/Decision Required:** | To note ■<br>To approve ■ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ☐<br><br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ☐ |
| **Resource Impact:** | n/a |

## 1. Purpose of the report

The purpose of this report is to provide the Trust Board with an overview and performance position for open and closed incident investigations, that met the serious Incident criteria and reported externally to the Strategic Executive Information System (StEIS),

## 2. Summary

**Section 1- StEIS reported incidents performance**
Table 1 shows there were **14** incidents StEIS reported in total during 2019/20, including four Never Events. The start of the financial year 2020/21 shows that in April 2020, there were **four** open StEIS reported incident, of which **three** had been carried forward from the previous financial year. Table 2 shows at the time of reporting there have been a total of **15** StEIS reported incidents this year and **1** 'Never Events'.
.
**Section 2 - open ongoing investigation -** shows there are **five** ongoing StEIS reported incidents, currently under investigation, **four** previously reported to Board,( cited at appendix2) and **one** new Never Event, (cited at appendix 3), reported in month

**Closed investigations** – there were **four** investigations closed during this reporting period (cited at appendix 3).

**Note**: One moderate harm incident reported in month. Investigation progressing.

**Duty of candour;** has been met for all incidents except StEIS 2020/15939. The Consultant Surgeon had known about the incident and informed the family of the potentially unnecessary nephrectomy in March 2020. However, the incident was not reported at that time due to a difference of clinical opinion. Subsequently, the incident was formally discussed during a surgical M&M meeting in August 2020, at which point the Consultant Surgeon agreed that the incident should be reported on Ulysses. The incident was reported on the 20th August 2020 and from this point duty of candour was followed in a timely manner, including discussion with family, formal letter of apology and details about the investigation process.

**Appendix 1**
**Table 1 StEIS reported Incidents and Never Events performance data 2020/21**

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

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

**Table 2 Open ongoing StEIS reported investigations**

| StEIS Reference | Date reported | Incident | Agreed date of completion |
|---|---|---|---|
| 2021/1899 | 24/01/2021 | Unexpected death of a patient (HDU) | 26/06/2021 |
| 2021/1919 | 02/01/2020 | Patient under care of Bangor, who contacted Neurology Team at AHCH for telephone advice. Patient treated according to advice provided, patient suffered raised intracranial pressure requiring shunt, queries around treatment pathway on advice provided. | 14/05/2021 |
| 2020/23828 | 09/12/2020 | Waiting list data quality issues | 18/05/2021 |
| 2020/16210 | 26/08/2020 | Patient death following catastrophic and irreversible brain haemorrhage | 21/05/2021 |

**Table 3 New open StEIS reported investigations**

| StEIS reference & Incident Date | Incident (Never Event) | Duty of Candour |
|---|---|---|
| 2021/17300<br>31/03/2021 | Wrong site block. (no harm incident)<br>72-hour review completed and submitted to CCG and CQC.<br>RCA commenced | Verbal duty of candour completed |

**Table 4 Closed StEIS reported investigations**

| StEIS Reference | Incident | Duty of Candour |
|---|---|---|
| 2020/23808 | Category 3 Pressure Ulcer under halo jacket | Compliant |
| | | **Date submitted to CCG** |
| | | 10/03/2021 (in time) |
| Actions to mitigate risk of recurrence | 1. The Tissue Viability and Neurosurgical nursing and clinical teams to work with Meditech expanse and devise an electronic care plan for patients with Halo Traction. In the interim a paper based clinical care plan will be devised using the most up to date RCN guidelines to support the care and management to nurse children in Halo Traction.<br>2. The clinical care plan will include recommendation of a referral to the Tissue Viability Nursing team for all patients following application of an unfamiliar medical devise for an individual risk assessment and agreed care plan to be completed.<br>3. Care of children in traction to be included on ward-based training programme.<br>4. Training to be provided by the Advanced Nurse Practitioners and Practice Education nurses for Neurosurgery and to be delivered as a minimum of once per year.<br>5. Share guidance with staff. | |
| **StEIS Reference** | **Incident** | **Duty of Candour** |
| 2020/15939 | Unnecessary removal of kidney | Non - compliant |
| | | **Date submitted to CCG** |
| | | 19/03/2021 (in time) |

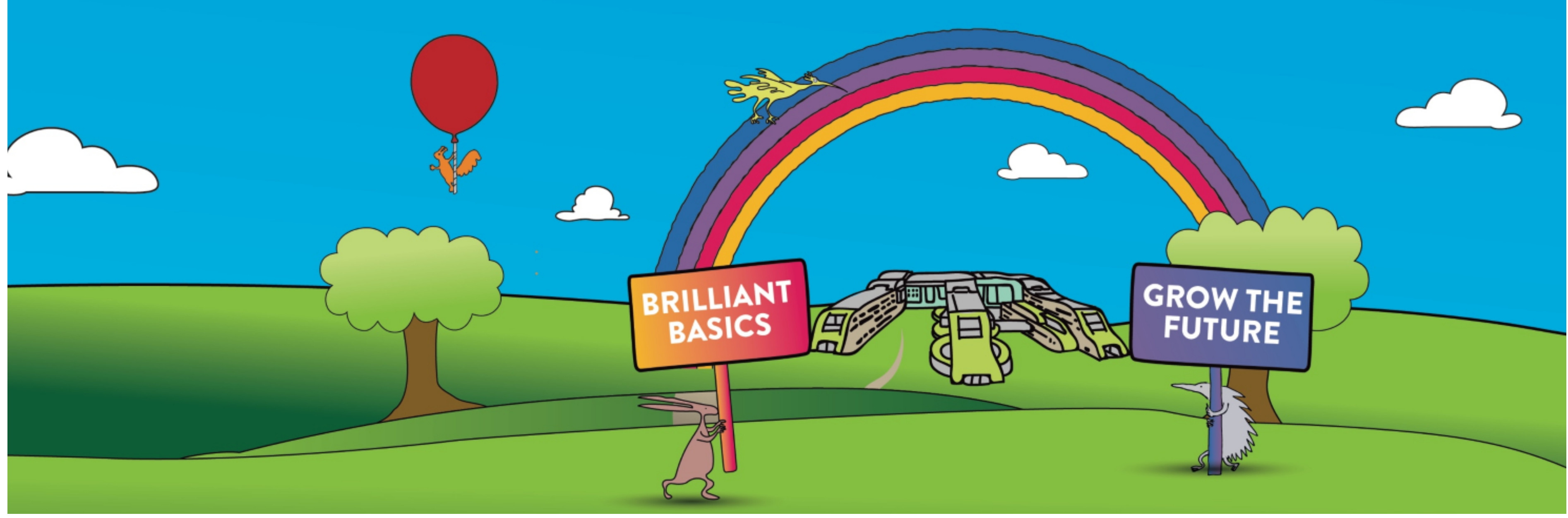
| | | |
|---|---|---|
| Actions to mitigate risk of recurrence | 1. Development of core set of documentation required when any patient is referred and transferred and implement along with clear process.<br>2. Discuss at General Surgery meeting to review business continuity process for when M+M cannot take place within an anticipated timeframe.<br>3. Create standardised MDT proforma for MDT review of patients undergoing Oncological surgery.<br>4. Review to consider acceptable timeframe within which M+M should take place and if there is any national guidance to support this.<br>5. Create standardised MDT proforma for MDT review of patients undergoing Oncological surgery.<br>6. Working group to undertake review of all current standards with are in place in relation to the above recommendations and actions.<br>7. Convene working group to review and develop actions in relation to wider trust review with a view to replicating processes and actions across the Trust. | |
| StEIS Reference | Incident | Duty of Candour |
| 2020/608 | Misdiagnosis of tumour | Compliant<br>Date submitted to CCG<br>31/03/2021 (in time) |
| Actions to mitigate risk of recurrence | 1. Arrange to meet/discuss with the Walton Centre, Clatterbridge Cancer Centre and Betsi Cadwaladr University Health Board to share the learning and recommendations for improvement.<br>2. Review the current MDT model and record any changes within the Neuro-oncology MDT Annual Report 2020/2021.<br>3. Review current documentation and agree a standard for future record keeping, ensuring this is added to the MDT Annual Report. | |
| StEIS Reference | Incident | Duty of Candour |
| 2020/194 | Inappropriate clearance of C-Spine | Compliant<br>Date submitted to CCG<br>31/03/2021 (in time) |

| | |
|---|---|
| Actions to mitigate risk of recurrence | 1. Develop, implement and monitor a robust process that ensures that the TTL reviews all standby/pre-alert record sheets and that this is validated by the TTL's. |

| | |
|---|---|
| | 2. Provide feedback to staff regarding vital sign and pain score<br>3. Review and amend (as required) the current local audit around vital sign and pain score and ensure participation in the RCEM Annual pain scoring audit.<br>4. Provide feedback to staff regarding the escalation process for abnormal observations<br>5. Review and amend (as needed) the current local audit around the escalation of vital signs<br>6. Ensure TTL training is maintained, ensuring training that ttechnical skills are taught alongside non-technical skills (situational awareness).<br>7. Develop, implement and monitor a process around the delegation of roles for staff escorting patients to imaging.<br>8. Through discussion at ED governance group and Major Trauma Service Quality and Safety Group Service ensure that trauma team members are familiar with the departmental and trust trauma guidelines, relevant to their role, and that the TTL is familiar with the departmental, trust and network trauma guidelines to assist them in delivering best practice, specifically NICE Guidance NG41.<br>9. Review and update the Major Trauma pathway.<br>10. Discuss with staff the importance of timely documentation and include audit of retrospective entries to documentation. |

**END**

# TRUST BOARD Report March 2021



How Did We Do?

**Executive Summary** **Month: March** **Year: 2021**

Delivery of Outstanding Care

## Safe

- A really high volume of incidents reported in month (590 2nd highest of the year) and only 1 resulted in moderate harm
- There were 6 medication incidents with one resulting in moderate harm. There were 2 incidents relating to nephrotoxicity
- The one hour targets relating to the treatment of sepsis both within ED and the wider Trust was improved in March
- Ten times medication error workshop planned for the end of April

### Highlight

- 100% of patients were treated for sepsis within 60 minutes in AED
- 0 pressure ulcers reported
- 0 incidents reported resulting in severe/permanent harm and above
- 0 hospital acquired organisms reported in March

### Challenges

- Six errors caused harm in March: 2 patients received overdoses due to calculation errors when preparing doses which required extra blood tests. 2 received overdoses of drugs via infusion pumps: the incorrect drug was used in one case and the rate for another was too high. Both patients experienced adverse effects for a short time. 2 patients experienced kidney injury due to administration of nephrotoxic drugs with one a moderate harm. Both incidents are undergoing RCA investigation and analysis by specialist teams.

The Best People Doing their Best Work

## Caring

- Only Out Patients were above 95% in the Friends and Family survey for recommending the Trust
- Work is ongoing across the Divisions to review the feedback in order to implement actions to improve the compliance
- Highest number of both PALS and Complaints in month reflecting increases in activity. Also PALS office reopened in March
- Work is ongoing to review the PALS and complaints structure and process.

**Highlight**

- 109 PALS referrals the highest number of the year; although proportionally the transition to formal complaints from such a high number of PALS was lower than in previous months, meaning service users were happy with the PALS local resolution.

**Challenges**

- 24 formal complaints in March the highest number of the year

Delivery of Outstanding Care

## Effective

- There has been a notable increase in attendances to the Emergency Department, reaching 90% of pre-COVID-19 levels; despite this, timeliness of care has been maintained for the majority of patients. We are working with system partners to improve access to urgent care and deliver good patient experience.

**Highlight**

- Timeliness of emergency care
- Low number of PICU re-admissions
- Low number of cancelled operations

**Challenges**

- 2 patients waiting beyond 28 days for re-scheduled operation

Delivery of Outstanding Care

## Responsive

- There has been an increase in the number of children and young people waiting over 52 weeks for treatment. As flagged in March, this was anticipated as a number of patients awaiting paediatric dental care have been transferred onto RTT pathways. By the end of April we expect to halve the number of patients waiting over 52 weeks for outpatient consultations, and by the end of Q1 2021-22 we predict that we will start to slowly reduce the total number of patients waiting over 52 weeks. Our recovery of access to services in March was excellent and supports this forecast. We are assured that patients who are prioritised as clinically urgent are receiving treatment within 1 month.

### Highlight

- Access to cancer care
- Improvement in RTT performance
- Improvement in proportion of diagnostics completed within 6 weeks

### Challenges

- The number of patients waiting over 52 weeks for treatment

The Best People Doing their Best Work

## Well Led

### Finance

For the Month of March (Month 12), the Trust is reporting a surplus of £3.7m which is £3.8m ahead of plan. The draft full year position is a small surplus of £0.1m which is £5.3m ahead of plan largely due to NHSI funding the cost of carried forward annual leave yet to be taken (annual leave accrual) and a further reduction in PDC dividend payable, primarily given the Trusts large cash balance to fund the longer term capital programme. It should be noted that this closing full year position is subject to a full external audit, as such it remains provisional at this stage. Cash in the bank at the end of March was £92.7m. The overall capital expenditure for March was £15.3m against a plan of £9.5m, and as a result the total Trust capital spend has exceeded plan by £0.7m for the full year.

### Sickness update

Sickness has continued on a downward trend with the main impact being seen in long term sickness absence, short term sickness has remained static and is still slightly above the trust target of 1%. The HR team continue to work closely with managers and leaders across the Trust to provide advice and guidance and to ensure appropriate support is in place.

### Mandatory Training

Mandatory training has increased again this month, up to 87% overall but still 3% below our Trust target of 90%. We continue to work with SMEs and topic leads to improve compliance and identify ways we can improve hard to reach areas. Areas that are struggling due to current restrictions around face to face training are Facilities and topics that require face to face training due to reduced numbers because of social distancing such as Resus and Practical Moving & Handling.

### PDR

Our new Appraisal is due to launch in April 2021 with the addition of a Wellbeing Conversation as per NHS England guidance, the window will run until the end of July and has a 90% target set. Guidance documents, video content and training via MS Teams have all been set up for staff and managers in preparation to support them with the process.

### Highlight

- Delivered capital programme in line with plan
- Complete the year in surplus
- Continued Reduction in sickness levels

### Challenges

- Access to planned care including an increase in the number of patients waiting over 52 weeks for treatment
- Increase in Was Not Brought rate
- Complete year end external audit.
- Mandatory Training
- PDR rollout

## Research and Development

Month 12 Research Activity:

- 126 research studies currently open (incl. 10 Urgent Public Health studies)
- 105 patients recruited to research studies (5250 in 20/21)

Divisional Participation:

- Division of Medicine – 105 open studies
- Division of Surgical Care – 19 open studies
- Division of Community & Mental Health – 2 open studies

Research Assurance:

- GCP training compliance – 97%
- Research SOP compliance – 96%

### Highlight

- NHS staff survey results show R&D as above organisation average for all domains

### Challenges

- Backlog of paused and new research studies

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Alder Hey Children's NHS Foundation Trust

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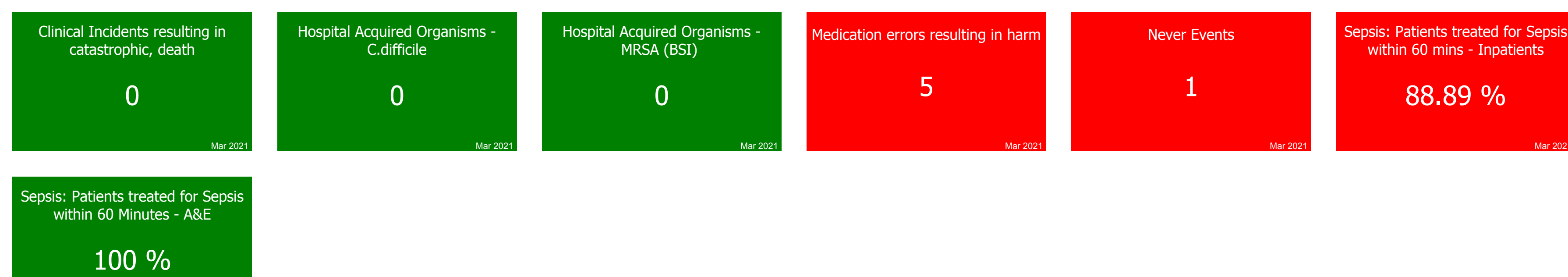
# Leading Metrics

**SAFE**




Sepsis: Patients treated for Sepsis within 60 Minutes - A&E
100 %
Mar 2021

**CARING**

Friends & Family: Overall Percentage Recommended Trust
92.95 %
Mar 2021

**EFFECTIVE**

ED: 95% Treated within 4 Hours
95.29 %
Mar 2021

**RESPONSIVE**

31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)
100 %
Mar 2021

All Cancers: 31 day wait until subsequent treatments
100 %
Mar 2021

Cancer: 2 week wait from referral to date 1st seen - all urgent referrals
100 %
Mar 2021

Diagnostics: % Completed Within 6 Weeks
97.52 %
Mar 2021

Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.
100 %
Mar 2021

RTT: Open Pathway: % Waiting within 18 Weeks
67.90 %
Mar 2021

Waiting Greater than 52 weeks - Incomplete Pathways
361
Mar 2021

Waiting List Size
11564
Mar 2021

**WELL LED**

Cash in Bank (£'000s)
92708
Mar 2021

Control Total In Month Variance (£'000s)
3818
Mar 2021

Mandatory Training
86.83 %
Mar 2021

Safer Staffing (Shift Fill Rate)
93.98 %
Mar 2021

Sickness
4.90 %
Mar 2021

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

# Delivery of Outstanding Care

## SAFE

D Drive W Watch P Programme

| Indicator | Type | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG (Green) | RAG (Amber) | RAG (Red) | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Proportion of Near Miss, No Harm & Minor Harm | D | 100.0% | 99.6% | 100.0% | 100.0% | 98.9% | 99.1% | 100.0% | 100.0% | 100.0% | 99.8% | 99.8% | 99.8% | 99.8% | | >=99 % | N/A | <99 % | ✔ |
| Clinical Incidents resulting in Near Miss | D | 48 | 39 | 48 | 60 | 86 | 54 | 50 | 79 | 102 | 77 | 52 | 65 | 99 | | No Threshold | | | |
| Clinical Incidents resulting in No Harm | D | 238 | 138 | 261 | 285 | 380 | 318 | 339 | 323 | 407 | 311 | 288 | 330 | 394 | | No Threshold | | | |
| Clinical Incidents resulting in minor, non permanent harm | D | 61 | 48 | 57 | 89 | 92 | 83 | 72 | 68 | 84 | 75 | 80 | 78 | 98 | | No Threshold | | | |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 1 | 0 | 0 | 6 | 1 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | | No Threshold | | | |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Medication errors resulting in harm | D | 2 | 1 | 5 | 7 | 6 | 2 | 8 | 1 | 11 | 0 | 6 | 3 | 5 | | <=2 | N/A | >2 | ✔ |
| Pressure Ulcers (Category 3) | W | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Never Events | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 | N/A | >0 | ✔ |
| Sepsis: Patients treated for Sepsis within 60 Minutes - A&E | D P | 83.3% | 60.9% | 95.5% | 96.2% | 79.2% | 77.3% | 85.2% | 74.1% | 79.2% | 73.7% | 89.5% | 80.6% | 100.0% | | >=90 % | N/A | <90 % | ✔ |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | 88.9% | 93.8% | 87.5% | 90.9% | 88.5% | 85.2% | 86.1% | 94.3% | 80.8% | 70.8% | 87.5% | 84.0% | 88.9% | | >=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 | 1 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Hospital Acquired Organisms - MSSA | D | 0 | 1 | 0 | 0 | 1 | 4 | 1 | 0 | 1 | 0 | 3 | 1 | 0 | | No Threshold | | | |

The Best People doing their best Work

## CARING

D Drive W Watch P Programme

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Friends & Family: Overall Percentage Recommended Trust | W | | 96.9% | 94.2% | 94.9% | 94.6% | 93.8% | 90.6% | 94.7% | 93.7% | 91.5% | 95.3% | 94.9% | 92.9% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family A&E - % Recommend the Trust | D | | 96.1% | 92.9% | 92.3% | 90.7% | 91.5% | 84.4% | 92.1% | 89.2% | 91.5% | 93.2% | 93.1% | 88.0% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Community - % Recommend the Trust | D | | 100.0% | 100.0% | 95.2% | 95.2% | 92.3% | 89.1% | 94.7% | 98.8% | 100.0% | 92.7% | 96.7% | 93.0% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Inpatients - % Recommend the Trust | D | | 94.4% | 90.8% | 93.3% | 97.0% | 95.1% | 92.4% | 94.5% | 95.5% | 93.4% | 94.2% | 90.4% | 89.8% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Mental Health - % Recommend the Trust | D | | 100.0% | 90.9% | 100.0% | 100.0% | 82.4% | 92.3% | 89.7% | 91.3% | 100.0% | 96.3% | 90.3% | 87.9% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Outpatients - % Recommend the Trust | D P | | 97.4% | 96.9% | 96.6% | 96.0% | 95.7% | 94.1% | 95.5% | 93.9% | 90.4% | 96.1% | 96.0% | 95.1% | | >=95 % >=90 % <90 % | ✔ |
| Complaints | W | 9 | 7 | 6 | 10 | 5 | 20 | 11 | 19 | 15 | 10 | 15 | 11 | 23 | | No Threshold | |
| PALS | W | 74 | 45 | 44 | 86 | 105 | 105 | 77 | 96 | 72 | 65 | 67 | 88 | 109 | | No Threshold | |

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

| Measure | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | 0.0% | 0.0% | 0.0% | 4.0% | 1.4% | 0.0% | 0.0% | 1.6% | 4.2% | 1.4% | 0.0% | 0.0% | 1.6% | | <=3 % | N/A | >3 % | ✔ |
| ED: 95% Treated within 4 Hours | D | 89.5% | 97.2% | 97.8% | 98.5% | 97.3% | 97.7% | 95.1% | 96.8% | 97.1% | 98.6% | 98.5% | 97.7% | 95.3% | | >=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 | 6 | 5 | 3 | 7 | 18 | 17 | 19 | 16 | 10 | 5 | 7 | 12 | | <=30 | N/A | >30 | ✔ |
| 28 Day Breaches | W | 7 | 24 | 1 | 2 | 0 | 0 | 8 | 2 | 1 | 3 | 3 | 1 | 2 | | 0 | N/A | >0 | ✔ |

Delivery of Outstanding Care

## RESPONSIVE

D Drive W Watch P Programme

| Indicator | Type | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG Green | RAG Amber | RAG Red | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | 96.4% | 91.5% | 93.2% | 94.1% | 99.3% | 95.9% | 95.4% | 95.4% | 95.7% | 97.5% | 99.3% | 93.6% | 95.6% | | >=95 % | >=90 % | <90 % | ✔ |
| IP Survey: % Treated with respect | W | 98.1% | 100.0% | 97.7% | 94.1% | 98.5% | 97.9% | 96.0% | 98.3% | 98.6% | 97.5% | 100.0% | 98.1% | 94.7% | | >=95 % | >=90 % | <90 % | ✔ |
| IP Survey: % Know their planned date of discharge | D P | 91.1% | 87.3% | 95.5% | 95.8% | 98.5% | 93.2% | 97.1% | 96.7% | 97.8% | 95.0% | 98.5% | 98.1% | 94.2% | | >=90 % | >=85 % | <85 % | ✔ |
| IP Survey: % Know who is in charge of their care | W | 96.1% | 88.7% | 90.9% | 90.8% | 91.1% | 99.3% | 98.3% | 100.0% | 99.3% | 91.7% | 100.0% | 94.9% | 96.1% | | >=95 % | >=90 % | <90 % | ✔ |
| IP Survey: % Patients involved in Play | D | 94.2% | 60.6% | 78.4% | 64.7% | 72.6% | 81.5% | 82.3% | 83.3% | 84.9% | 76.7% | 80.3% | 85.9% | 78.2% | | >=90 % | >=85 % | <85 % | ✔ |
| IP Survey: % Patients involved in Learning | D | 79.2% | 74.6% | 61.4% | 84.0% | 83.0% | 78.1% | 75.4% | 88.3% | 71.9% | 81.6% | 94.9% | 92.9% | 90.9% | | >=90 % | >=85 % | <85 % | ✔ |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 86.7% | 66.7% | 58.1% | 45.9% | 39.6% | 43.1% | 48.2% | 54.2% | 59.0% | 60.8% | 61.3% | 63.4% | 67.9% | | >=92 % | >=90 % | <90 % | ✔ |
| Waiting List Size | W | 12,162 | 11,046 | 10,909 | 11,248 | 11,022 | 11,402 | 11,000 | 10,939 | 10,832 | 10,520 | 10,722 | 11,535 | 11,564 | | <=12899 | N/A | >12899 | ✔ |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 5 | 15 | 52 | 82 | 79 | 158 | 131 | 143 | 144 | 182 | 222 | 307 | 361 | | 0 | N/A | >0 | ✔ |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | 100.0% | 100.0% | 100.0% | 100.0% | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % | ✔ |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % | ✔ |
| All Cancers: 31 day wait until subsequent treatments | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % | ✔ |
| Diagnostics: % Completed Within 6 Weeks | W | 100.0% | 42.8% | 67.0% | 81.9% | 82.9% | 78.9% | 91.8% | 96.4% | 97.1% | 92.3% | 93.7% | 95.8% | 97.5% | | >=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% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % | ✔ |
| PFI: PPM% | | 99.0% | 99.0% | 100.0% | 100.0% | 100.0% | 99.0% | 99.0% | 100.0% | 98.0% | 99.0% | 99.0% | 99.0% | | | >=98 % | N/A | <98 % | ✔ |

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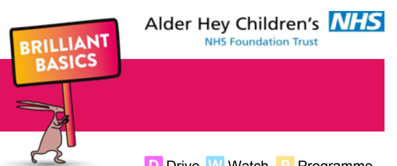
## WELL LED

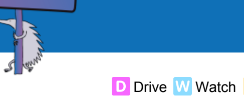



D Drive W Watch P Programme

| Metric | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | 693 | 0 | 0 | 0 | 0 | 0 | 0 | -358 | 332 | 687 | 243 | 591 | 3,818 | | >=-5% | >=-20% | <-20% | ✔ |
| Capital Expenditure In Month Variance (£'000s) | W | 300 | 1,287 | 1,792 | 3,503 | 936 | -483 | 4,518 | 187 | -1,733 | 1,610 | -1,979 | -3,207 | -5,794 | | >=-5% | >=-10% | <-10% | ✔ |
| Cash in Bank (£'000s) | W | 90,030 | 107,738 | 111,270 | 107,221 | 107,221 | 107,763 | 108,756 | 109,084 | 110,503 | 110,776 | 110,776 | 110,871 | 92,708 | | >=-5% | >=-20% | <-20% | ✔ |
| Income In Month Variance (£'000s) | W | 6,889 | 3,146 | -692 | 1,342 | 1,825 | 1,077 | 2,492 | -792 | 748 | 235 | 228 | 2,310 | 15,456 | | >=-5% | >=-20% | <-20% | ✔ |
| Pay In Month Variance (£'000s) | W | -709 | -1,433 | 691 | -312 | -340 | -291 | -1,160 | 20 | 492 | -192 | -373 | -387 | -13,171 | | >=-5% | >=-20% | <-20% | ✔ |
| Non Pay In Month Variance (£'000s) | W | -5,487 | -1,713 | 1 | -1,029 | -1,485 | -786 | -1,333 | 414 | -909 | 644 | 387 | -1,333 | -1,533 | | >=-5% | >=-20% | <-20% | ✔ |
| AvP: IP - Non-Elective | W | 953 | 11 | 0 | 0 | 0 | 0 | -349 | -398 | -456 | -402 | -499 | -450 | 112 | | >=0 | N/A | <0 | ✔ |
| AvP: IP Elective vs Plan | W | 318 | 0 | 0 | -1 | 0 | -1 | 49 | 9 | 11 | 51 | -44 | -14 | 169 | | >=0 | N/A | <0 | ✔ |
| AvP: Daycase Activity vs Plan | W | 1,563 | 0 | 2 | 5 | 2 | 2 | -62 | -183 | 39 | 68 | -341 | -140 | 669 | | >=0 | N/A | <0 | ✔ |
| AvP: Outpatient Activity vs Plan | W | 17,994 | 189 | 340 | 1,097 | 1,460 | 1,459 | 1,216 | -1,087 | 2,324 | 2,631 | -1,125 | 1,535 | 7,593 | | >=0 | N/A | <0 | ✔ |
| PDR | W | 90.1% | 90.1% | 1.3% | 5.4% | 13.4% | 20.7% | 29.5% | 62.6% | 72.4% | 74.6% | 74.4% | 74.4% | 74.4% | | >=90 % | >=85 % | <85 % | ✔ |
| Medical Appraisal | W | 95.1% | 95.6% | 95.6% | 95.6% | 95.6% | 95.6% | 95.6% | 95.6% | 95.6% | 95.9% | 95.9% | 95.9% | 95.9% | | >=95 % | >=90 % | <90 % | ✔ |
| Mandatory Training | W | 93.2% | 92.1% | 90.8% | 91.0% | 90.5% | 90.6% | 89.3% | 88.6% | 85.8% | 85.0% | 86.0% | 85.8% | 86.8% | | >=90 % | >=80 % | <80 % | ✔ |
| Sickness | D | 6.2% | 5.9% | 5.3% | 5.0% | 5.1% | 5.0% | 5.2% | 6.0% | 5.4% | 5.5% | 7.2% | 5.8% | 4.9% | | <=4 % | <=4.5 % | >4.5 % | ✔ |
| Short Term Sickness | D | 2.3% | 1.6% | 1.0% | 0.9% | 1.0% | 1.1% | 1.4% | 1.9% | 1.3% | 1.1% | 2.3% | 1.2% | 1.2% | | <=1 % | N/A | >1 % | ✔ |
| Long Term Sickness | D | 4.0% | 4.3% | 4.2% | 4.1% | 4.1% | 3.9% | 3.9% | 4.1% | 4.2% | 4.5% | 4.9% | 4.6% | 3.7% | | <=3 % | N/A | >3 % | ✔ |
| Temporary Spend ('000s) | D | 1,514 | 990 | 740 | 565 | 934 | 946 | 1,015 | 1,061 | 1,365 | 1,392 | 1,373 | 1,279 | 2,272 | | <=800 | <=960 | >960 | ✔ |
| Staff Turnover | D | 10.3% | 9.8% | 9.8% | 10.0% | 9.6% | 10.1% | 9.8% | 9.5% | 9.3% | 9.2% | 9.3% | 9.2% | 9.1% | | <=10 % | <=11 % | >11 % | ✔ |
| Safer Staffing (Shift Fill Rate) | W | | 92.2% | | 95.6% | 90.3% | 91.3% | 94.2% | 94.2% | 94.9% | 93.6% | 90.5% | 94.5% | 94.0% | | >=90 % | N/A | <90 % | ✔ |
| Domestic Cleaning Audit Compliance | W | | | | 100.0% | 85.6% | 97.0% | 93.8% | 90.0% | 87.5% | 90.4% | 94.4% | | | | >=85 % | N/A | <85 % | ✔ |
| NHS Oversight Framework | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | <=1 | >1 | ✔ |

Game Changing Research & Innovation

R&D




Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Open Studies - Academic | W | 146 | 21 | 23 | 43 | 47 | 50 | 61 | 66 | 71 | 76 | 80 | 80 | 90 | | >=130 | >=111 | <111 | ✔ |
| Number of Open Studies - Commercial | W | 42 | 21 | 19 | 20 | 25 | 27 | 28 | 34 | 37 | 36 | 36 | 36 | 36 | | >=30 | >=21 | <21 | ✔ |
| Number of New Studies Opened - Academic | W | 0 | 4 | 3 | 3 | 1 | 3 | 4 | 1 | 4 | 4 | 1 | 0 | 6 | | >=3 | >=2 | <2 | ✔ |
| Number of New Studies Opened - Commercial | W | 0 | 1 | 0 | 0 | 1 | 2 | 0 | 2 | 1 | 0 | 0 | 0 | 2 | | >=1 | N/A | <1 | ✔ |
| Number of patients recruited | W | 665 | 407 | 537 | 560 | 134 | 508 | 413 | 665 | 832 | 182 | 504 | 403 | 105 | | >=100 | >=86 | <86 | ✔ |

Delivery of Outstanding Care

## 7.1 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Proprtion of Incidents | **Proportion of Near Miss, No Harm & Minor Harm** D<br>Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 99.83 % | R <99 %<br>A N/A<br>G >=99 % | | No Action Required |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in Near Miss** D<br>Total number of Near Miss Incidents reported<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 99 | No Threshold | | |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in No Harm** D<br>Total number of No Harm Incidents reported.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 394 | No Threshold | | |

Delivery of Outstanding Care

## 7.2 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Reducing Harm | **Clinical Incidents resulting in minor, non permanent harm** D<br>Total number of Minor Harm Incidents reported.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 98 | No Threshold | | |
| Incidents: Reducing Harm | **Clinical Incidents resulting in moderate, semi permanent harm** D<br>Incidents reported resulting in moderate harm.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 1 | No Threshold | | |
| Incidents: Reducing Harm | **Clinical Incidents resulting in severe, permanent harm** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 | | No Action Required |

Delivery of Outstanding Care

## 7.3 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Reducing Harm | **Clinical Incidents resulting in catastrophic, death** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 20/21 aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 | | No Action Required |
| Reducing Medication Errors | **Medication errors resulting in harm** D<br>Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 19 - Mar 20, on trajectory with WHO global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% by 2022. 20/21 aim is less than 27 annually for the trust.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 5 | R >2<br>A N/A<br>G <=2 | | Five errors caused harm in March: 2 patients received overdoses due to calculation errors when preparing doses which required extra blood tests. 2 received overdoses of drugs via infusion pumps: the incorrect drug was used in one case and the rate for another was too high. Both patients experienced adverse effects for a short time. 1 patient experienced kidney injury due to administration of nephrotoxic drugs. Incident undergoing RCA investigation and analysis by specialist teams. |
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 3)** W<br>Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 20/21 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 | | No Action Required |

Delivery of Outstanding Care

## 7.4 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | Management Action (SMART) |
|---|---|---|---|---|
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 4)** W<br>Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 20/21 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 0 | R: >0<br>A: N/A<br>G: 0 | No Action Required |
| Never Events | **Never Events** W<br>Never Events. The threshold is based on this event never occuring. 20/21 aim is zero annually.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 1 | R: >0<br>A: N/A<br>G: 0 | Patient attended theatre on 31st March 2021 for elective orthopaedic surgery. The incident was appropriately reported and recorded as a never event, i.e. wrong site block. Following a hot debrief and time out the operating team continued with the correct procedure. The patient recovered well. Duty of candour and 72-hour review process completed in line with Trust policy. Incident reported to StEIS within required timeframes and both the CQC and Liverpool CCG also informed verbally. Level 2 investigation progressing. |
| Sepsis | **Sepsis: Patients treated for Sepsis within 60 Minutes - A&E** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 20/21 aim is 90%.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 100 % | R: <90 %<br>A: N/A<br>G: >=90 % | No Action Required |

Trend charts (Mar-20 to Mar-21), legend: Actual, Average, UCL, LCL, UWL, LWL, Green.

Delivery of Outstanding Care

## 7.5 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Sepsis | **Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 20/21 aim is 90%.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 88.89 % | R <90 %<br>A N/A<br>G >=90 % | | 27 patients identified, 3 delays, no further clinical deterioration, wards have completed feedback forms and actions cascaded to staff. Proactive approach again to escalation and management, a number of patients with difficult access given IM Antibiotics and access gained later. Improved overall performance. Collaborative working with Acute Care Team identified in a number of cases. |
| Mortality | **Number of children that have experienced avoidable factors causing death - Internal** W<br>Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 20/21 is zero.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 | | No Action Required |
| Reducing Infections | **Hospital Acquired Organisms - MRSA (BSI)** D<br>The threshold is based on this event never occuring. 20/21 Aim is zero annually.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 0 | R >0<br>A N/A<br>G 0 | | No Action Required |

Delivery of Outstanding Care

## 7.6 - QUALITY - SAFE

D Drive W Watch P Programme

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

The Best People doing their best Work

## 8.1 - QUALITY - CARING

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Friends & Family | **Friends & Family: Overall Percentage Recommended Trust** W<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 92.95 % | R <90 %<br>A >=90 %<br>G >=95 % | | Overall percentage has decreased from 94.9% to 92.95% from February 2021 to March 2021. There were 1,836 responses for March 2021. Medicine had a total of 873 responses with 37 negatives (4.2%), Surgery had a total of 695 responses with 21 negatives (3%), and Community had a total of 238 responses with 14 negatives (5.9%). Only 4.1% of overall percentage accounted for poor or very poor scores. |
| Friends & Family | **Friends & Family A&E - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 87.97 % | R <90 %<br>A >=90 %<br>G >=95 % | | Overall percentage has decreased by 5.8% from February 2021. There were 316 responses for March 2021. 22 (6.96%) responses were either poor or very poor. When all respondents were asked how we could have improved, 49 (15.5%) mentioned communication surrounding waiting times; 22 (7%) mentioned the attitude of triage staff as being unwelcoming; six (1.9%) mentioned the provision of food/drink as they wait, and six (1.9%) mentioned lack of play/activities whilst they wait. |
| Friends & Family | **Friends & Family Community - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 93 % | R <90 %<br>A >=90 %<br>G >=95 % | | Overall percentage has decreased by 3.7% since February 2021. There were 238 responses for March 2021, 13 more than the previous month. There were 14 (5.88%) responses that were either poor or very poor in March 2021. Through comment analysis, there were no clear themes or trends identified when respondents were asked 'How could we improve?'. Out of the 14 poor or very poor responses, four responses came via the Blood Test Clinic, three via ASD Service Liverpool Community, two via the Laser Clinic, and two via Sefton CAMHS. |

The Best People doing their best Work

## 8.2 - QUALITY - CARING

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Friends & Family | **Friends & Family Inpatients - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 89.76 % | R <90 %<br>A >=90 %<br>G >=95 % | Chart (86–100; Mar-20 to Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green) | Overall percentage has decreased by 0.64% since February 2021. There were 205 responses for March 2021. Out of these responses, there were 13 poor or very poor responses which accounted for 6.34%. Comment analysis from all responses when asked how inpatient services could be improved found a demand for more comfortable waiting areas for parents. There were also nine comments surrounding waiting times and the lack of food as a result. |
| Friends & Family | **Friends & Family Mental Health - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 87.88 % | R <90 %<br>A >=90 %<br>G >=95 % | Chart (70–120; Mar-20 to Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green) | Overall percentage has decreased by 2.44% since February 2021 to 87.88%. There were two (6%) very poor responses out of a total of 33 responses. Comment analysis from all responses does not identify any recurring themes. One very poor response was a result of no clinician turning up to appointment at Sefton CAMHS. |
| Friends & Family | **Friends & Family Outpatients - % Recommend the Trust** D P<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 95.06 % | R <90 %<br>A >=90 %<br>G >=95 % | Chart (85–105; Mar-20 to Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green) | No Action Required |

The Best People doing their best Work

## 8.3 - QUALITY - CARING

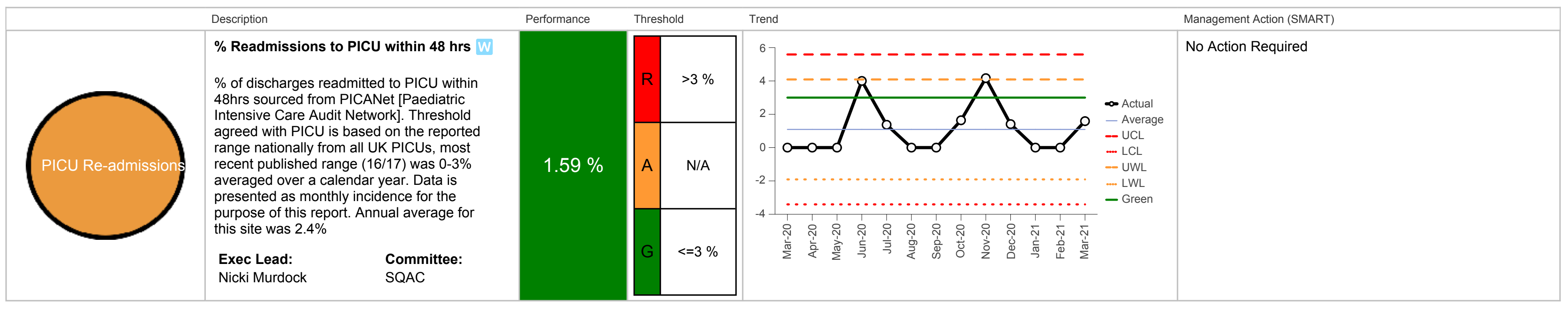
D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Complaints | **Complaints** W<br>Total complaints received.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 23 | No Threshold | 30, 20, 10, 0, -10; Mar-20, Apr-20, May-20, Jun-20, Jul-20, Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green | |
| PALS | **PALS** W<br>Total number of PALS contacts.<br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 109 | No Threshold | 150, 100, 50, 0; Mar-20, Apr-20, May-20, Jun-20, Jul-20, Aug-20, Sep-20, Oct-20, Nov-20, Dec-20, Jan-21, Feb-21, Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green | |

Delivery of Outstanding Care

## 9.1 - QUALITY - EFFECTIVE

D Drive W Watch P Programme



| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| PICU Re-admissions | **% Readmissions to PICU within 48 hrs** W<br><br>% of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4%<br><br>**Exec Lead:** Nicki Murdock<br>**Committee:** SQAC | 1.59 % | R: >3 %<br>A: N/A<br>G: <=3 % | | No Action Required |

Delivery of Outstanding Care

## 10.1 - QUALITY - RESPONSIVE

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Inpatient Survey: Choices | **IP Survey: % Received information enabling choices about their care** W<br>Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 95.63 % | R<br>A<br>G | <90 %<br>>=90 %<br>>=95 % | | No Action Required |
| Inpatient Survey: Respect | **IP Survey: % Treated with respect** W<br>Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 20/21 is 100%.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 94.66 % | R<br>A<br>G | <90 %<br>>=90 %<br>>=95 % | | Overall percentage of patients that report that they have been treated with respect was 94.66%, a decrease of 3.42% from February 2021. Out of a total of 208 responses, 195 felt like they had been treated with respect. Out of the 13 negative responses, five were from Ward 3A. There is no comment analysis to suggest any clear indication as to why overall percentage in this area has dropped. Surgery had 94.44% of respondents who reported that they were treated with respect. However, Medicine had 95.16% in this area. |
| Inpatient Survey: Date of Discharge | **IP Survey: % Know their planned date of discharge** D P<br>Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 94.17 % | R<br>A<br>G | <85 %<br>>=85 %<br>>=90 % | | No Action Required |

Delivery of Outstanding Care

## 10.2 - QUALITY - RESPONSIVE

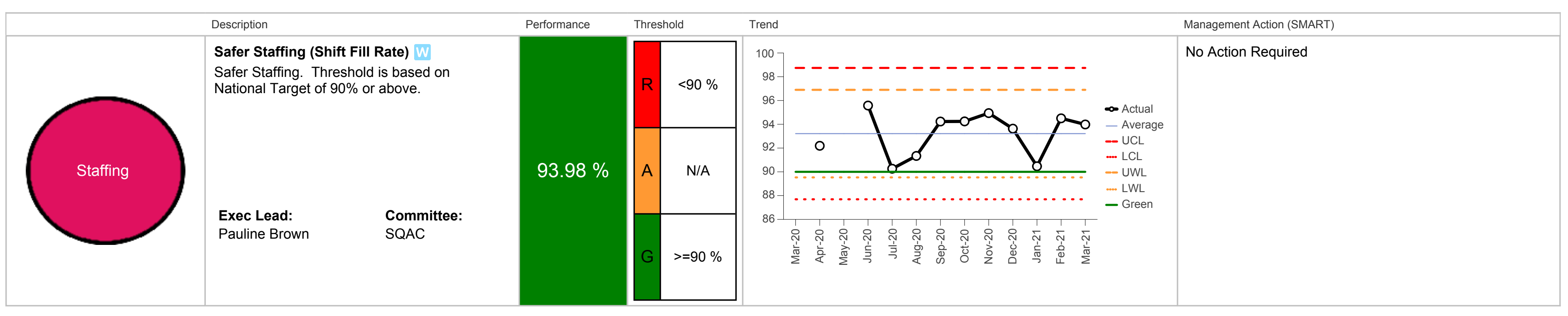
D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Inpatient Survey: In Charge of Care | **IP Survey: % Know who is in charge of their care** W<br>% of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 20/21 aim is 95% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 96.12 % | R<br>A<br>G | <90 %<br>>=90 %<br>>=95 % | | No Action Required |
| Inpatient Survey: Play | **IP Survey: % Patients involved in Play** D<br>% of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 78.16 % | R<br>A<br>G | <85 %<br>>=85 %<br>>=90 % | | The percentage of patients that reported engagement with play this month was 78.16%, a decrease of 7.74% from February 2021. There were 209 responses during March 2021. 47 of those responses said that they did not have access to play/activities. Of the 47 responses, 49% (23) came via Surgical Daycare, and 15% (7) came via Ward 3A. |
| Inpatient Survey: Learning | **IP Survey: % Patients involved in Learning** D<br>% of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 20/21 aim is 90% or above.<br>**Exec Lead:** Nicki Murdock **Committee:** SQAC | 90.91 % | R<br>A<br>G | <85 %<br>>=85 %<br>>=90 % | | No Action Required |

Trend charts (Mar-20 to Mar-21): legend — Actual, Average, UCL, LCL, UWL, LWL, Green.

## 11.1 - QUALITY - WELL LED

D Drive W Watch P Programme



| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Staffing | **Safer Staffing (Shift Fill Rate)** W<br>Safer Staffing. Threshold is based on National Target of 90% or above.<br><br>**Exec Lead:** Pauline Brown<br>**Committee:** SQAC | 93.98 % | R | <90 % | | No Action Required |
| | | | A | N/A | | |
| | | | G | >=90 % | | |

Delivery of Outstanding Care

## 12.1 - PERFORMANCE - EFFECTIVE

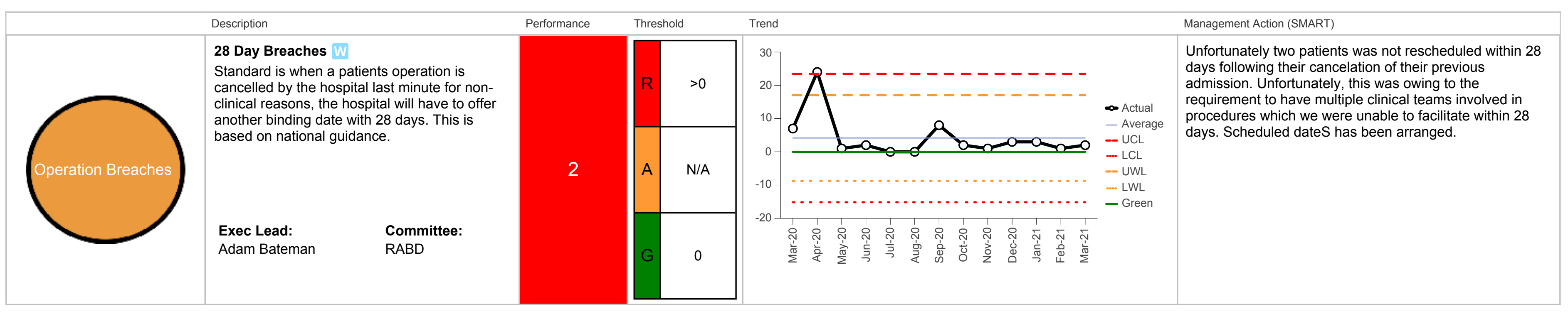
D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| ED 4 Hour Standard | **ED: 95% Treated within 4 Hours** D<br>Threshold is based on National Guidance set by NHS England at 95%.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 95.29 % | R: <95 %<br>A: N/A<br>G: >=95 % | | No Action Required |
| ED 12 Hr Waits | **ED: Number of patients spending >12 hours from decision to admit to admission** W<br>Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 0 | R: >0<br>A: N/A<br>G: 0 | | No Action Required |
| Cancelled Operations | **On the day Elective Cancelled Operations for Non Clinical Reasons** D<br>Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 12 | R: >30<br>A: N/A<br>G: <=30 | | No Action Required |

Delivery of Outstanding Care

## 12.2 - PERFORMANCE - EFFECTIVE

D Drive W Watch P Programme



| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Operation Breaches | **28 Day Breaches** W<br>Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 2 | R >0<br>A N/A<br>G 0 | | Unfortunately two patients was not rescheduled within 28 days following their cancelation of their previous admission. Unfortunately, this was owing to the requirement to have multiple clinical teams involved in procedures which we were unable to facilitate within 28 days. Scheduled dateS has been arranged. |

Delivery of Outstanding Care

## 13.1 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| RTT | **RTT: Open Pathway: % Waiting within 18 Weeks** W<br>Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 67.90 % | R<br>A<br>G | <90 %<br>>=90 %<br>>=92 % | | Performance continues to improve with notable progress against our restoration targets. Continued challenges remain primely within surgical specialities. Within increase surgical capacity from March this is anticipated to improve further over coming weeks. |
| Waiting Times | **Waiting List Size** W<br>National threshold as part of the 18/19 NHSI plan. The target is to maintain reduction of the total waitlist size from March 2018.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 11564 | R<br>A<br>G | >12899<br>N/A<br><=12899 | | No Action Required |
| Waiting Times | **Waiting Greater than 52 weeks - Incomplete Pathways** W<br>Total number of more than 52 weeks for first treatment on an incomplete pathway. The threshold is based on this event never occuring. 20/21 aim is zero annually.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 361 | R<br>A<br>G | >0<br>N/A<br>0 | | Continued increase in the number of C&YP who are waiting over 52 weeks to receive treatment. The majority of these patients are waiting for surgical treatment. All of which have received a clinical review and plans are in place in attempt to treat these patients as soon as possible. A reduction in theatre schedule during Jan & Feb has posed a greater challenge in treating patient, an increase in the theatre schedule commenced in March including the addition of weekend sessions. Some of these children have also been established via additional validation associated with the Safe WL Programme. |

Delivery of Outstanding Care

## 13.2 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

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

Trend charts (Mar-20 to Mar-21). Legend: Actual, Average, UCL, LCL, UWL, LWL, Green.

Delivery of Outstanding Care

## 13.3 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Cancer RTT | **31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W<br>Threshold is set at 100% which a stretch target set higher than national performance.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 100 % | R<br>A<br>G | <100 %<br>N/A<br>100 % | 200, 150, 100, 50, 0; Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green | No Action Required |
| Diagnostics | **Diagnostics: % Completed Within 6 Weeks** W<br>Threshold is based on National Guidance set by NHS England at 99%.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 97.52 % | R<br>A<br>G | <99 %<br>N/A<br>>=99 % | 140, 120, 100, 80, 60, 40, 20; Mar-20 Apr-20 May-20 Jun-20 Jul-20 Aug-20 Sep-20 Oct-20 Nov-20 Dec-20 Jan-21 Feb-21 Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green | For March our Endoscopy performance was below the standard as we are still recovering from the reductions in theatre capacity during the adult patient mutual aid period. This is likely to be reflected in future months due to the decontamination failure in April that will lead to more patients waiting over the 6 week standard. |

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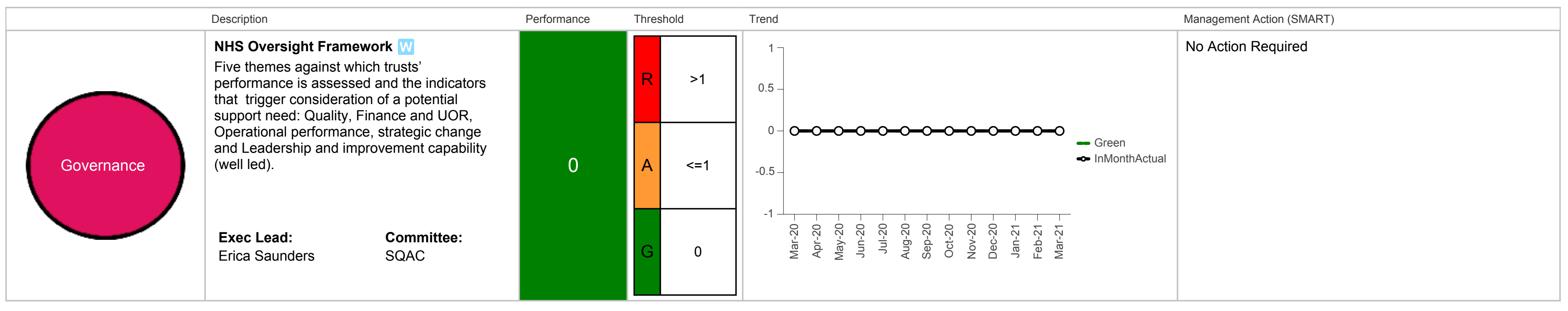
## 14.1 - PERFORMANCE - WELL LED

D Drive W Watch P Programme



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

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## 15.1 - PEOPLE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Personal Development | **PDR** W<br>Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July).<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 74.43 % | R <85 %<br>A >=85 %<br>G >=90 % | | Our new Appraisal is due to launch in April 2021 with the addition of a Wellbeing Conversation as per NHS England guidance, the window will run until the end of July and has a 90% target set. Guidance documents, video content and training via MS Teams have all been set up for staff and managers in preparation to support them with the process. |
| Appraisal | **Medical Appraisal** W<br>Trust Target for compliance for medical staff, which is on a rolling 12mth period.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 95.90 % | R <90 %<br>A >=90 %<br>G >=95 % | | No Action Required |
| Training | **Mandatory Training** W<br>This is a Trust target that measures all required training including Resuscitation.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 86.83 % | R <80 %<br>A >=80 %<br>G >=90 % | | Mandatory training has increased again this month, up to 87% overall but still 3% below our Trust target of 90%. We continue to work with SMEs and topic leads to improve compliance and identify ways we can improve hard to reach areas. Areas that are struggling due to current restrictions around face to face training are Facilities and topics that require face to face training due to reduced numbers because of social distancing such as Resus and Practical Moving & Handling. |

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## 15.2 - PEOPLE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Sickness | **Sickness** D<br>% of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics<br>**Exec Lead:** Melissa Swindell **Committee:** PAWC | 4.90 % | R<br>A<br>G | >4.5 %<br><=4.5 %<br><=4 % | | Sickness has continued on a downward trend with the main impact being seen in long term sickness absence, short term sickness has remained static and is still slightly above the trust target of 1%. The HR team continue to work closely with managers and leaders across the Trust to provide advice and guidance and to ensure appropriate support is in place. |
| Sickness | **Short Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting less than 28 days<br>**Exec Lead:** Melissa Swindell **Committee:** PAWC | 1.16 % | R<br>A<br>G | >1 %<br>N/A<br><=1 % | | as above |
| Sickness | **Long Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting 28 days or more<br>**Exec Lead:** Melissa Swindell **Committee:** PAWC | 3.74 % | R<br>A<br>G | >3 %<br>N/A<br><=3 % | | as above |

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## 15.3 - PEOPLE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Temporary Spend | **Temporary Spend ('000s)** D<br>Indicates the expenditure on premium temporary pay spend and monitors the reduction.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 2271.93 | R<br>A<br>G | >960<br><=960<br><=800 | Mar-20 to Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green | Our temporary spend is monitored and discussed regularly between the Senior HR and Finance Teams. |
| Staff Turnover | **Staff Turnover** D<br>Trust Target which is based on a rolling 12mth period<br>**Exec Lead:** Melissa Swindell<br>**Committee:** PAWC | 9.08 % | R<br>A<br>G | >11 %<br><=11 %<br><=10 % | Mar-20 to Mar-21; Actual, Average, UCL, LCL, UWL, LWL, Green | No Action Required |

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## 16.1 - FINANCE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **Control Total In Month Variance (£'000s)** W<br>Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | 3,818 | R <-20%<br>A >=-20%<br>G >=-5% | | No Action Required |
| Finance | **Capital Expenditure In Month Variance (£'000s)** W<br>Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -5,794 | R <-10%<br>A >=-10%<br>G >=-5% | | |
| Finance | **Cash in Bank (£'000s)** W<br>Variance from Cash plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | 92,708 | R <-20%<br>A >=-20%<br>G >=-5% | | No Action Required |

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## 16.2 - FINANCE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Finance | **Income In Month Variance (£'000s)** W<br>Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | 15,456 | R<br>A<br>G | <-20%<br>>=-20%<br>>=-5% | | No Action Required |
| Finance | **Pay In Month Variance (£'000s)** W<br>Variance from pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -13,171 | R<br>A<br>G | <-20%<br>>=-20%<br>>=-5% | | |
| Finance | **Non Pay In Month Variance (£'000s)** W<br>Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -1,533 | R<br>A<br>G | <-20%<br>>=-20%<br>>=-5% | | |

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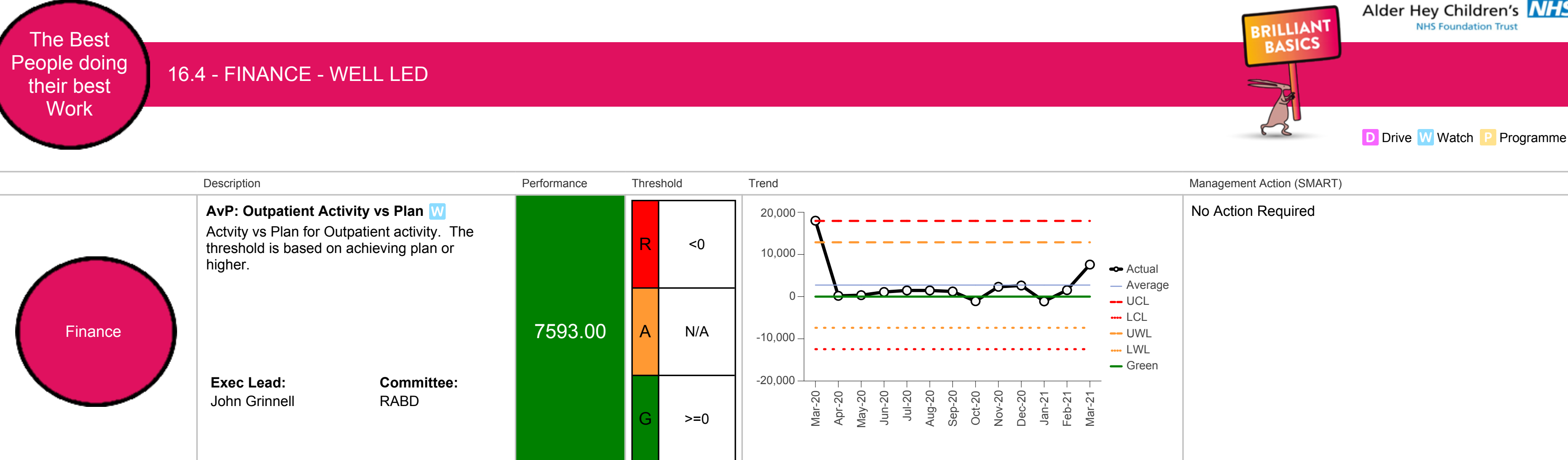
## 16.3 - FINANCE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **AvP: IP - Non-Elective** W<br>Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | 112.00 | R <0<br>A N/A<br>G >=0 | | No Action Required |
| Finance | **AvP: IP Elective vs Plan** W<br>Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | 168.79 | R <0<br>A N/A<br>G >=0 | | No Action Required |
| Finance | **AvP: Daycase Activity vs Plan** W<br>Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | 668.80 | R <0<br>A N/A<br>G >=0 | | No Action Required |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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
7593.00
R <0
A N/A
G >=0
20,000
10,000
0
-10,000
-20,000
Mar-20
Apr-20
May-20
Jun-20
Jul-20
Aug-20
Sep-20
Oct-20
Nov-20
Dec-20
Jan-21
Feb-21
Mar-21
Actual
Average
UCL
LCL
UWL
LWL
Green
No Action Required

Game Changing Research & Innovation

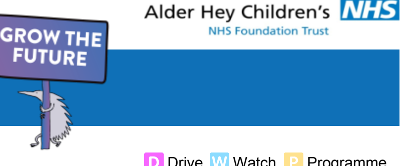
## 17.1 - RESEARCH & DEVELOPMENT - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Clinical Research | **Number of Open Studies - Academic** W<br>Number of academic studies currently open.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 90 | R | <111 | | Pipeline of new and suspended studies in the process of being opened or reactivated in line with delivery capacity. |
| | | | A | >=111 | | |
| | | | G | >=130 | | |
| Clinical Research | **Number of Open Studies - Commercial** W<br>Number of commercial studies currently open.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 36 | R | <21 | | No Action Required |
| | | | A | >=21 | | |
| | | | G | >=30 | | |
| Clinical Research | **Number of New Studies Opened - Academic** W<br>Number of new academic studies opened in month.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 6 | R | <2 | | No Action Required |
| | | | A | >=2 | | |
| | | | G | >=3 | | |

Game Changing Research & Innovation

## 17.2 - RESEARCH & DEVELOPMENT - WELL LED

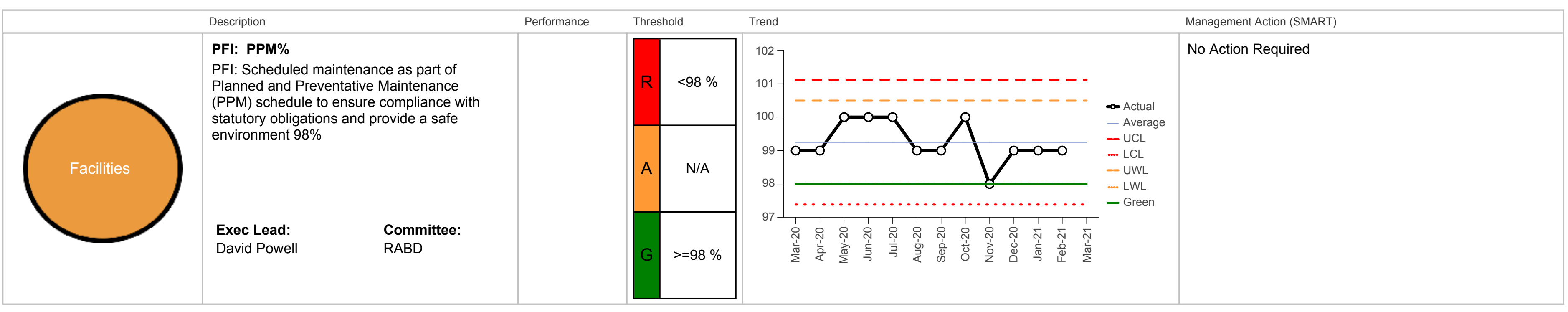



D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Clinical Research | **Number of New Studies Opened - Commercial** W<br>Number of new commercial studies opened in month.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 2 | R <1<br>A N/A<br>G >=1 | | No Action Required |
| Clinical Research | **Number of patients recruited** W<br>Number of patients recruited to NIHR portfolio studies in month.<br>**Exec Lead:** Jo Blair<br>**Committee:** RMB | 105 | R <86<br>A >=86<br>G >=100 | | No Action Required |

## 18.1 - FACILITIES - RESPONSIVE

D Drive W Watch P Programme



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

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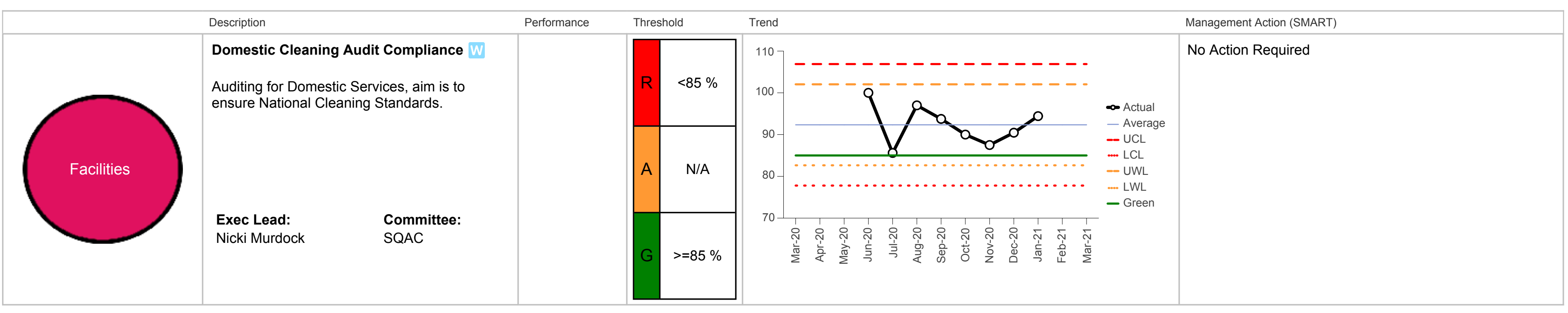
## 19.1 - FACILITIES - WELL LED

D Drive W Watch P Programme



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

# All Divisions

D Drive W Watch P Programme

## SAFE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 10 | 33 | 45 | No Threshold | | |
| Clinical Incidents resulting in No Harm | D | 84 | 121 | 172 | No Threshold | | |
| Clinical Incidents resulting in minor, non permanent harm | D | 34 | 19 | 38 | No Threshold | | |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 1 | 0 | No Threshold | | |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | N/A | >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | N/A | >0 |
| Medication errors resulting in harm | D | 0 | 2 | 3 | No Threshold | | |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Never Events | W | 0 | 0 | 1 | 0 | N/A | >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | | 87.5% | 90.9% | >=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 | 3 | 12 | 7 | No Threshold |
| PALS | W | 40 | 36 | 27 | No Threshold |

## EFFECTIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | | | 1.6% | <=3 % | N/A | >3 % |
| ED: 95% Treated within 4 Hours | D | | 95.3% | | >=95 % | N/A | <95 % |
| ED: Number of patients spending >12 hours from decision to admit to admission | W | | 0 | | 0 | N/A | >0 |

# All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 0 | 1 | 11 | No Threshold | | |
| 28 Day Breaches | W | 0 | 0 | 2 | 0 | N/A | >0 |

## RESPONSIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | | 95.2% | 95.8% | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | | 95.2% | 94.4% | >=95 % | >=90 % | <90 % |
| IP Survey: % Know their planned date of discharge | D P | | 91.9% | 95.1% | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | | 95.2% | 96.5% | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | | 85.5% | 75.0% | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | | 80.0% | 95.8% | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 66.1% | 93.0% | 61.6% | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 909 | 2,273 | 8,700 | No Threshold | | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 0 | 4 | 357 | 0 | N/A | >0 |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | | 100.0% | | 100 % | N/A | <100 % |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | | 100.0% | | 100 % | N/A | <100 % |
| All Cancers: 31 day wait until subsequent treatments | W | | 100.0% | | 100 % | N/A | <100 % |
| Diagnostics: % Completed Within 6 Weeks | W | | 97.7% | 94.1% | >=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 | -41 | -577 | -856 | No Threshold |
| Income In Month Variance (£'000s) | W | 150 | 170 | 152 | No Threshold |
| Pay In Month Variance (£'000s) | W | 137 | -139 | -549 | No Threshold |
| Non Pay In Month Variance (£'000s) | W | -329 | -608 | -459 | No Threshold |

# All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| AvP: IP - Non-Elective | W | | 65 | 47 | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 0 | 77 | 91 | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | | 382 | 284 | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 772 | 2,026 | 2,609 | >=0 | N/A | <0 |
| PDR | W | 83.1% | 74.2% | 66.1% | >=90 % | >=80 % | <85 % |
| Medical Appraisal | W | 100.0% | 94.1% | 96.8% | >=95 % | >=90 % | <90 % |
| Mandatory Training | W | 89.3% | 88.5% | 87.8% | >=90 % | >=80 % | <80 % |
| Sickness | D | 4.0% | 4.2% | 5.8% | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 0.9% | 1.1% | 1.5% | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 3.0% | 3.1% | 4.3% | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 141 | 261 | 560 | No Threshold | | |
| Staff Turnover | D | 9.8% | 6.3% | 7.7% | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 100.2% | 93.9% | 93.7% | >=90 % | >=80 % | <90 % |

## Medicine Division

| | | |
|---|---|---|
| **SAFE** | 1 moderate incident reported in March 2021 – being progressed as RCA Level 1<br><br>Weekly incident review group now well established to review incident themes for rapid learning and dissemination across the Division. | **Highlight**<br>• Reduction in the number of open incidents<br>• 70% of incidents being closed now include lessons learnt<br>**Challenges**<br>• Management of open actions following patient safety incident investigations: 4x RCA 2 with 21 open actions, 2x RCA 1 with 5 open actions , 6x 72 hour reviews with 31 open actions and<br>5x AAR with 3 open actions |
| **CARING** | 12 complaints plus 3 second stage complaints received in March 2021 – specialty hotspots: Emergency Department and Neurology<br><br>33 PALS contacts made in March 2021 | **Highlight**<br>• Divisional Complaints Officer named as 'Star of the Week' for her commitment to support patients, families and staff through the complaint process<br>**Challenges**<br>• Complexity of some of the PALS contacts resulting in the Division taking longer than the 5 working day standard to resolve |
| **EFFECTIVE** | WNB rate remains static at 9.39%. Specialties with challenged recovery working with outpatient improvement team to improve both triaging of new referrals and work around patient initiated follow up to ensure capacity is being used effectively.<br><br>ED and Gen Paeds teams working with nursing and operational teams to plan for expected spikes in summer attendances. | **Highlight**<br>• ED target met for 20/21 year<br>• ED performance met for March 21 despite increases in demand.<br>**Challenges**<br>• Maintaining ED performance if attendances continue at March levels. |
| **RESPONSIVE** | Outpatient RTT performance continues to improve at 94%. Ongoing validation of both OP and IP patient lists are expected to continue to flag longer waiting patients.<br><br>Radiology department finalising contract for outsourcing of MRI/CT reporting where demand outstrips capacity in team to ensure reporting turnaround times can be maintained. | **Highlight**<br>▪ Significant improvement on IP Survey for Play responses – now at 89.29%<br>▪ RTT combined performance now at 90% against 92% target.<br>**Challenges**<br>▪ Managing long waiting patients identified through ongoing validation. 5 patients on our waiting list have currently waited more then 52 weeks.<br>▪ 6/52 performance at 96%<br>▪ Reporting turnarounds in radiology for outpatient scans. |
| **WELL LED** | Sickness absence has improved across both short and long term measures and we expect this to continue.<br><br>Divisional focus on non-face to face mandatory training completion whilst we work to address challenges with face to face provision. | **Highlight**<br>• Overall sickness 4.37% - 2% improvement since January.<br>**Challenges**<br>• Mandatory training performance 88.51% |

Alder Hey Children's NHS Foundation Trust

# Medicine

D Drive W Watch P Programme

## SAFE

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 15 | 13 | 19 | 18 | 30 | 19 | 16 | 29 | 34 | 23 | 17 | 24 | 33 | | No Threshold |
| Clinical Incidents resulting in No Harm | D | 71 | 33 | 64 | 75 | 105 | 75 | 93 | 69 | 125 | 98 | 89 | 93 | 121 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 7 | 12 | 13 | 19 | 26 | 21 | 16 | 11 | 18 | 19 | 22 | 19 | 19 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication errors resulting in harm | D | 0 | 1 | 5 | 3 | 2 | 0 | 4 | 0 | 0 | 0 | 4 | 1 | 2 | | No Threshold |
| Medication Errors (Incidents) | | 15 | 13 | 25 | 29 | 27 | 23 | 18 | 24 | 31 | 36 | 34 | 28 | 39 | | 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 | | 2 | 1 | 1 | 0 | 0 | 2 | 2 | 0 | 0 | 1 | 0 | 2 | 3 | | 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 | 88.9% | 100.0% | 83.3% | 92.3% | 100.0% | 84.6% | 91.7% | 100.0% | 75.0% | 90.9% | 83.3% | 84.6% | 87.5% | | >=90 % N/A <90 % |
| Pressure Ulcers (Category 3 and above) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - C.difficile | D | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - CLABSI | | 0 | 1 | 1 | 1 | 0 | 2 | 0 | 0 | 0 | 2 | 2 | 2 | 1 | | No Threshold |
| Hospital Acquired Organisms - MSSA | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 1 | 0 | | No Threshold |
| Cleanliness Scores | | | | | 98.5% | 97.7% | 97.8% | 98.0% | 98.0% | 96.0% | 95.1% | 98.4% | 97.2% | 98.6% | | No Threshold |
| Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region. | | 99.7% | 99.3% | 99.3% | 99.6% | 99.8% | 99.8% | 99.8% | 99.8% | 99.7% | | | | | | >=95 % N/A <95 % |
| Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed. | | 55.7% | 55.7% | 57.4% | 60.0% | 63.8% | 63.8% | 63.8% | 49.3% | 64.6% | 71.3% | 53.9% | 68.2% | | | >=50 % N/A <50 % |
| Pharmacy - Dispensing for Out Patients - Routine within 30 minutes | | 58.0% | 65.0% | 65.0% | 64.0% | 78.5% | 84.0% | 77.3% | 85.0% | 85.0% | 85.0% | 85.0% | 84.0% | | | >=90 % N/A <90 % |
| Pharmacy - Dispensing for Out Patients - Complex within 60 minutes | | 67.0% | 67.0% | 69.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 77.0% | | 100.0% | 100.0% | | | >=90 % N/A <90 % |

## CARING

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints | W | 4 | 6 | 2 | 6 | 1 | 11 | 7 | 8 | 7 | 6 | 8 | 3 | 12 | | No Threshold |
| PALS | W | 34 | 13 | 18 | 21 | 32 | 49 | 27 | 24 | 28 | 27 | 22 | 18 | 36 | | No Threshold |

## EFFECTIVE

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | | 1,548 | 839 | 994 | 1,435 | 1,667 | 1,570 | 2,279 | 2,016 | 2,089 | 1,690 | 2,070 | 1,660 | 2,160 | | No Threshold |
| ED: 95% Treated within 4 Hours | D | 89.5% | 97.2% | 97.8% | 98.5% | 97.3% | 97.7% | 95.1% | 96.8% | 97.1% | 98.6% | 98.5% | 97.7% | 95.3% | | >=95 % N/A <95 % |
| ED: Percentage Left without being seen | W | 2.7% | 0.2% | 0.8% | 1.1% | 1.5% | 0.8% | 2.0% | 0.8% | 1.0% | 0.6% | 0.5% | 0.7% | 2.2% | | <=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 | 7.4% | 8.2% | 8.4% | 7.5% | 7.8% | 8.3% | 7.0% | 7.9% | 7.8% | 7.9% | 9.0% | 7.9% | 7.5% | | No Threshold |

# Medicine

D Drive W Watch P Programme

| Metric | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ED: Number of patients spending >12 hours from decision to admit to admission | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 |
| Theatre Utilisation - % of Session Utilised | W | 76.2% | 73.9% | 76.7% | 75.4% | 82.0% | 82.1% | 81.3% | 83.6% | 82.2% | 84.7% | 84.0% | 87.0% | 82.6% | | >=90 % | >=80 % | <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 0 | 1 | 2 | 0 | 0 | 3 | 2 | 1 | 1 | 2 | 0 | 0 | 1 | | No Threshold | | |
| 28 Day Breaches | W | 0 | 0 | 1 | 2 | 0 | 0 | 3 | 2 | 0 | 0 | 1 | 0 | 0 | | 0 | N/A | >0 |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | | 67 | 175 | 1 | 2 | 12 | 55 | 20 | 33 | 20 | 47 | 16 | 14 | 18 | | No Threshold | | |
| OP Appointments Cancelled by Hospital % | | 25.9% | 46.0% | 21.8% | 15.6% | 13.1% | 11.4% | 12.2% | 11.2% | 12.3% | 13.6% | 12.1% | 12.1% | 11.9% | | <=5 % | N/A | >10 % |
| Was Not Brought Rate | W P | 10.7% | 7.2% | 8.2% | 11.0% | 11.3% | 11.8% | 11.7% | 11.2% | 9.6% | 10.6% | 9.9% | 9.4% | 9.1% | | <=12 % | <=14 % | >14 % |
| Was Not Brought Rate (New Appts) | W | 15.0% | 15.5% | 13.2% | 14.3% | 14.8% | 13.2% | 15.8% | 12.3% | 11.4% | 11.5% | 12.0% | 10.9% | 9.6% | | <=10 % | <=12 % | >12 % |
| Was Not Brought Rate (Followup Appts) | W | 9.8% | 5.7% | 7.2% | 10.2% | 10.6% | 11.5% | 10.9% | 10.9% | 9.1% | 10.4% | 9.4% | 9.1% | 9.0% | | <=14 % | <=16 % | >16 % |
| Coding average comorbidities | | 5.18 | 5.54 | 5.46 | 5.39 | 5.33 | 5.28 | 5.17 | 5.31 | 5.45 | 5.50 | 5.45 | 5.54 | 5.41 | | No Threshold | | |

## RESPONSIVE

| Metric | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Convenience and Choice: Slot Availability | | 66.7% | | | | | | | | | | | | | | | | |
| IP Survey: % Received information enabling choices about their care | W | 95.0% | 95.0% | 100.0% | 81.5% | 100.0% | 95.6% | 92.9% | 92.9% | 96.9% | 95.8% | 100.0% | 96.4% | 95.2% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | 98.1% | 100.0% | 100.0% | 88.9% | 96.8% | 97.8% | 100.0% | 97.2% | 100.0% | 95.8% | 100.0% | 100.0% | 95.2% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Know their planned date of discharge | D P | 91.2% | 90.0% | 97.1% | 85.2% | 100.0% | 93.3% | 95.2% | 88.9% | 100.0% | 91.7% | 96.9% | 98.2% | 91.9% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | 95.0% | 87.5% | 97.1% | 85.2% | 90.3% | 100.0% | 97.6% | 100.0% | 100.0% | 87.5% | 100.0% | 92.9% | 95.2% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | 93.1% | 60.0% | 74.3% | 63.0% | 77.4% | 80.0% | 88.1% | 77.8% | 84.4% | 81.2% | 75.0% | 89.3% | 85.5% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | 76.1% | 77.5% | 68.6% | 77.8% | 87.1% | 82.2% | 76.2% | 63.9% | 62.5% | 81.2% | 93.8% | 94.6% | 80.0% | | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 88.1% | 68.8% | 60.1% | 46.3% | 40.6% | 45.0% | 55.5% | 68.0% | 81.0% | 86.1% | 89.5% | 90.8% | 93.0% | | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 3,361 | 3,381 | 3,266 | 2,791 | 2,484 | 2,420 | 2,151 | 1,916 | 1,778 | 1,785 | 1,731 | 2,110 | 2,273 | | | | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 16 | 4 | | 0 | N/A | >0 |
| Waiting Times - 40 weeks and above | | 14 | 90 | 121 | 127 | 147 | 181 | 137 | 81 | 63 | 24 | 9 | 37 | 11 | | | | |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | 100.0% | 100.0% | 100.0% | 100.0% | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % |
| All Cancers: 31 day wait until subsequent treatments | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % |
| Diagnostics: % Completed Within 6 Weeks | W | 100.0% | 39.1% | 64.9% | 82.1% | 84.6% | 77.9% | 91.4% | 96.2% | 97.7% | 91.7% | 94.6% | 96.0% | 97.7% | | >=99 % | N/A | <99 % |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 0.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % |
| Pathology - % Turnaround times for urgent requests < 1 hr | | 86.1% | 90.3% | 90.4% | 90.0% | 90.4% | 92.7% | 89.7% | 90.0% | 90.6% | 90.4% | 90.4% | 90.4% | 91.9% | | >=90 % | >=85 % | <90 % |
| Pathology - % Turnaround times for non-urgent requests < 24hrs | | 100.0% | 100.0% | 100.0% | 100.0% | 99.9% | 100.0% | 100.0% | 100.0% | 99.8% | 100.0% | 99.9% | 100.0% | 100.0% | | >=90 % | >=85 % | <90 % |
| Imaging - % Report Turnaround times GP referrals < 24 hrs | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | >=95 % | >=90 % | <95 % |
| Imaging - % Reporting Turnaround Times - ED | | 95.0% | 100.0% | 100.0% | 100.0% | 100.0% | 98.0% | 100.0% | 100.0% | 97.0% | 95.0% | 99.0% | 99.0% | 100.0% | | >=90 % | >=85 % | <90 % |
| Imaging - % Reporting Turnaround Times - Inpatients | | 86.0% | | 98.0% | 98.0% | 97.0% | 97.0% | 98.0% | 93.0% | 98.0% | 92.0% | 99.0% | 98.0% | 99.0% | | >=90 % | >=85 % | <90 % |
| Imaging - % Reporting Turnaround Times - Outpatients | | 75.0% | 100.0% | 98.0% | 97.0% | 81.0% | 69.0% | 71.0% | 74.0% | 72.0% | 51.0% | 75.0% | 77.0% | 58.0% | | >=85 % | N/A | <85 % |
| Imaging - Waiting Times - MRI % First Diagnostics seen within 6 weeks | | 84.0% | 16.8% | 63.6% | 62.6% | 82.4% | 59.1% | 98.0% | 98.8% | 100.0% | 94.2% | 100.0% | 95.0% | 98.0% | | >=99 % | N/A | <99 % |
| Imaging - Waiting Times - CT % First Diagnostics seen within 6 weeks | | | 11.6% | 17.2% | 35.4% | 88.2% | 77.8% | 100.0% | 100.0% | 100.0% | 90.0% | 100.0% | 100.0% | 100.0% | | >=99 % | N/A | <99 % |

# Medicine

D Drive W Watch P Programme

| | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Imaging - Waiting Times - Ultrasound % First Diagnostics seen within 6 weeks | | 21.6% | 70.7% | 83.8% | 86.4% | 95.0% | 92.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | >=99 % N/A <99 % |

## WELL LED

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -81 | -2,544 | -1,842 | -1,048 | 278 | -1,111 | -1,201 | -264 | 153 | 41 | 189 | 160 | -577 | | No Threshold |
| Income In Month Variance (£'000s) | W | 271 | -2,416 | -2,220 | -1,103 | 347 | -1,170 | -622 | -647 | 561 | 142 | 10 | 36 | 170 | | No Threshold |
| Pay In Month Variance (£'000s) | W | -297 | 59 | 99 | 92 | 196 | 62 | -211 | -143 | 338 | 30 | -61 | -52 | -139 | | No Threshold |
| AvP: IP - Non-Elective | W | 610 | 0 | 0 | -1 | 0 | 1 | -222 | -333 | -421 | -355 | -411 | -410 | 65 | | >=0 N/A <0 |
| AvP: IP Elective vs Plan | W | 87 | -1 | -1 | 0 | 0 | 0 | 24 | 7 | 25 | 46 | 2 | 42 | 77 | | >=0 N/A <0 |
| AvP: OP New | | 852.00 | 3.00 | 7.00 | 3.00 | 0.00 | 14.00 | -460.00 | -17.00 | 49.00 | -119.05 | -323.00 | -59.00 | 363.00 | | >=0 N/A <0 |
| AvP: OP FollowUp | | 3,620.00 | 8.00 | 32.00 | 33.00 | 67.00 | 37.00 | 1,297.00 | 690.00 | 847.00 | 1,076.29 | 615.00 | 883.00 | 1,638.00 | | >=0 N/A <0 |
| AvP: Daycase Activity vs Plan | W | 980 | 0 | 1 | 2 | 0 | 2 | 15 | -5 | 141 | 105 | -74 | 52 | 382 | | >=0 N/A <0 |
| AvP: Outpatient Activity vs Plan | W | 5,600 | 11 | 39 | 36 | 70 | 53 | 587 | 192 | 678 | 741 | -301 | 627 | 2,026 | | >=0 N/A <0 |
| PDR | W | 87.1% | 87.1% | 3.1% | 10.7% | 12.1% | 23.0% | 21.8% | 60.2% | 69.1% | 74.6% | 74.2% | 74.2% | 74.2% | | >=90 % >=85 % <85 % |
| Medical Appraisal | W | 94.9% | 96.0% | 96.0% | 96.0% | 96.0% | 96.0% | 96.0% | 96.0% | 96.0% | 94.1% | 94.1% | 94.1% | 94.1% | | >=95 % >=90 % <90 % |
| Mandatory Training | W | 93.1% | 92.3% | 91.9% | 91.6% | 91.3% | 91.3% | 89.9% | 90.2% | 88.9% | 86.7% | 88.1% | 87.1% | 88.5% | | >=90 % >=85 % <80 % |
| Sickness | D | 6.0% | 5.6% | 4.8% | 5.4% | 5.6% | 5.1% | 5.0% | 5.8% | 4.7% | 4.9% | 6.3% | 5.1% | 4.2% | | <=4 % <=4.5 % >4.5 % |
| Short Term Sickness | D | 2.4% | 1.6% | 0.9% | 1.0% | 0.9% | 1.1% | 1.4% | 2.2% | 1.5% | 1.2% | 2.0% | 1.4% | 1.1% | | <=1 % N/A >1 % |
| Long Term Sickness | D | 3.6% | 4.0% | 3.9% | 4.4% | 4.7% | 4.1% | 3.6% | 3.6% | 3.3% | 3.7% | 4.3% | 3.7% | 3.1% | | <=3 % N/A >3 % |
| Temporary Spend ('000s) | D | 347 | 201 | 157 | 108 | 167 | 217 | 266 | 235 | 239 | 213 | 247 | 267 | 261 | | No Threshold |
| Staff Turnover | D | 9.8% | 9.6% | 9.1% | 8.2% | 7.5% | 7.5% | 6.6% | 6.6% | 7.0% | 7.3% | 6.9% | 6.7% | 6.3% | | <=10 % <=11 % >11 % |
| Safer Staffing (Shift Fill Rate) | W | | 96.5% | | 97.7% | 96.4% | 94.9% | 94.9% | 93.2% | 93.6% | 93.2% | 91.2% | 97.8% | 93.9% | | >=90 % >=85 % <90 % |

## Surgery Division

| | | |
|---|---|---|
| **SAFE** | • Increase in clinical incidents resulting in near miss 48>34>25<27<45<br>• Increase in clinical incidents resulting in No harm 185>140>108<141<172<br>• Increase in Clinical Incidents resulting in minor, non-permanent harm 49>42>35>27<38<br>• 0 clinical incidents resulting in moderate, semi-permanent harm<br>• No Clinical Incidents resulting in severe, permanent harm<br>• No Clinical incidence recorded catastrophic, death<br>• No pressure ulcers, cat 3 & 4<br>• 1 never event | **Highlight**<br>• Improvement in patients treated for sepsis within 60 mins 91.7%>83.3%<90.9%<br>• No hospital acquired organisms for 3 consecutive months<br>• Cleanliness scores maintained at 97%<br>**Challenges**<br>• Increase in medication errors 70>42>25<40<47<br>• 3 medication error that resulting in harm 11>0<1<2<3 |
| **CARING** | • Further increase in formal complaints received 4>2:2<3<7<br>• Slight increase in PALS from 12<20<27 | **Highlight**<br>• Launch of Johnsons Baby and Alder Hey Children's Charity national campaign for the NICU build<br>**Challenges**<br>• Providing access within a timely manner for elective patients |
| **EFFECTIVE** | • One patient readmitted to PICU within 48 hours 4.2% >1.4%>0%<1.6%<br>• 3 patients waited over 28 days from their cancelled procedure to be rescheduled 3>2>1<3<br>• Reduction in WNB rate increased 10.5%>8.3%>8.0%<br>• Reduction in hospital-initiated clinic cancelations 50<37 | **Highlight**<br>• Maintained improvement in Theatre Utilisation 85%<88%<90%:90%<br>• CCAD cases 25<26<31<br>**Challenges**<br>• Significant increase in referrals received 2758>2612<2787<3931<br>• Increase in number of elective cancelations on the day 15>8>5<6<12 |
| **RESPONSIVE** | • Increase % Received information enabling choices about their care 99%>92%<96%<br>• Patients who noted that they were treated with respect 100% >97%>94%<br>• Patients knew their planned date of discharge 98.4%<99%>98%>95%<br>• Patients noted that they knew who was in charge of their care 100%>96%:96%<br>• Increase in patients noted they were involved in learning 95.2%>92%<96%<br>• Continued growth in patients waiting to commence treatment (Waiting list size)7858<8132<8432<8700 | **Highlight**<br>• Improvement in RTT% 55%<56%<61%<br>• Increase number of theatre sessions delivered including weekend working<br>**Challenges**<br>• Increase in patients waiting over 52 weeks for treatment 221<291<357<br>• Increase OP and IP capacity required to recover waiting time position |
| **WELL LED** | • Number of PDR's completed 66%<br>• Medical appraisals maintained at 97%<br>• Mandatory training maintained at 87%<br>• Slight reduction in staff turnover 7.7%<br>• Slight reduction in long term sickness 5.4%>4.3%<br>• Maintained reduction in short term sickness 3%>1.6%:1.5% | **Highlight**<br>• Improvement in activity levels against plan for Inpatients and outpatients<br>• Further reduction in overall sickness 8.3%>6.9%>5.8%<br>**Challenges**<br>• Establishing increased capacity which is sustainable for all staff groups |

Alder Hey Children's NHS
NHS Foundation Trust

# Surgery

D Drive W Watch P Programme

## SAFE

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 22 | 18 | 18 | 30 | 40 | 26 | 24 | 31 | 48 | 33 | 25 | 26 | 45 | | No Threshold |
| Clinical Incidents resulting in No Harm | D | 114 | 76 | 95 | 114 | 173 | 147 | 141 | 152 | 189 | 142 | 107 | 142 | 172 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 37 | 22 | 26 | 48 | 48 | 51 | 40 | 38 | 46 | 42 | 36 | 27 | 38 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 1 | 0 | 0 | 4 | 1 | 0 | 0 | 0 | 1 | 1 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | | 0 N/A >0 |
| Medication errors resulting in harm | D | 2 | 0 | 0 | 4 | 4 | 1 | 4 | 1 | 11 | 0 | 1 | 2 | 3 | | No Threshold |
| Medication Errors (Incidents) | | 38 | 16 | 22 | 34 | 60 | 36 | 38 | 38 | 70 | 43 | 24 | 40 | 47 | | No Threshold |
| Pressure Ulcers (Category 3) | W | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Never Events | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 N/A >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | 88.9% | 88.9% | 91.7% | 88.9% | 83.3% | 85.7% | 75.0% | 86.7% | 90.0% | 53.8% | 91.7% | 83.3% | 90.9% | | >=90 % N/A <90 % |
| Pressure Ulcers (Category 3 and above) | | 0 | 1 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - C.difficile | D | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MSSA | D | 0 | 1 | 0 | 0 | 1 | 4 | 1 | 0 | 1 | 0 | 2 | 0 | 0 | | No Threshold |
| Cleanliness Scores | | | | | 97.9% | 98.4% | 96.0% | 98.2% | 98.0% | 96.0% | 97.9% | 98.9% | 97.0% | 97.9% | | No Threshold |

## CARING

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints | W | 3 | 1 | 2 | 2 | 0 | 7 | 2 | 10 | 4 | 2 | 2 | 3 | 7 | | No Threshold |
| PALS | W | 20 | 13 | 7 | 37 | 39 | 33 | 22 | 29 | 22 | 23 | 11 | 21 | 27 | | No Threshold |

## EFFECTIVE

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Readmissions to PICU within 48 hrs | D | 0 | 0 | 0 | 2 | 1 | 0 | 0 | 1 | 2 | 1 | 0 | 0 | 1 | | No Threshold |
| % Readmissions to PICU within 48 hrs | W | 0.0% | 0.0% | 0.0% | 4.0% | 1.4% | 0.0% | 0.0% | 1.6% | 4.2% | 1.4% | 0.0% | 0.0% | 1.6% | | <=3 % N/A >3 % |
| Referrals Received (Total) | | 2,819 | 1,370 | 1,784 | 2,257 | 2,844 | 2,608 | 3,200 | 3,035 | 2,960 | 2,785 | 2,654 | 2,828 | 3,946 | | No Threshold |
| Theatre Utilisation - % of Session Utilised | W | 86.2% | 66.4% | 68.1% | 86.6% | 88.6% | 89.1% | 88.8% | 89.2% | 88.6% | 85.0% | 87.6% | 90.3% | 90.1% | | >=90 % >=80 % <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 36 | 5 | 3 | 3 | 7 | 15 | 15 | 18 | 15 | 8 | 5 | 7 | 11 | | No Threshold |
| 28 Day Breaches | W | 7 | 24 | 0 | 0 | 0 | 0 | 5 | 0 | 1 | 3 | 2 | 1 | 2 | | 0 N/A >0 |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | | 140 | 194 | 2 | 0 | 16 | 70 | 52 | 58 | 38 | 45 | 38 | 50 | 37 | | No Threshold |
| OP Appointments Cancelled by Hospital % | | 28.6% | 55.9% | 30.3% | 17.4% | 15.1% | 12.0% | 11.4% | 11.1% | 11.9% | 10.6% | 10.6% | 10.8% | 12.1% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate | W P | 10.6% | 9.3% | 9.2% | 7.0% | 8.2% | 9.1% | 9.4% | 9.0% | 8.8% | 10.1% | 10.4% | 8.2% | 8.0% | | <=12 % <=14 % >14 % |
| Was Not Brought Rate (New Appts) | W | 11.3% | 10.0% | 10.7% | 8.2% | 10.0% | 10.6% | 11.6% | 9.5% | 9.6% | 11.5% | 11.5% | 10.6% | 8.6% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) | W | 10.4% | 9.1% | 8.5% | 6.6% | 7.6% | 8.5% | 8.7% | 8.9% | 8.5% | 9.6% | 10.0% | 7.3% | 7.7% | | <=14 % <=16 % >16 % |
| Coding average comorbidities | | 4.23 | 5.20 | 4.89 | 4.19 | 4.06 | 4.50 | 4.46 | 4.39 | 4.40 | 4.48 | 4.39 | 4.44 | 4.49 | | No Threshold |
| CCAD Cases | | 36 | 21 | 26 | 24 | 29 | 23 | 30 | 31 | 27 | 26 | 25 | 26 | 31 | | No Threshold |

# Surgery

D Drive W Watch P Programme

## RESPONSIVE

| Measure | Type | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Convenience and Choice: Slot Availability | | 64.6% | | | | | | | | | | | | | | | | |
| IP Survey: % Received information enabling choices about their care | W | 97.5% | 87.1% | 88.7% | 97.8% | 99.0% | 96.0% | 96.2% | 96.2% | 95.3% | 99.2% | 99.0% | 92.0% | 95.8% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | 98.0% | 100.0% | 96.2% | 95.7% | 99.0% | 98.0% | 94.7% | 98.8% | 98.1% | 99.2% | 100.0% | 97.0% | 94.4% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Know their planned date of discharge | D P | 91.1% | 83.9% | 94.3% | 98.9% | 98.1% | 93.1% | 97.7% | 100.0% | 97.2% | 98.4% | 99.0% | 98.0% | 95.1% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | 97.0% | 90.3% | 86.8% | 92.4% | 91.3% | 99.0% | 98.5% | 100.0% | 99.1% | 95.9% | 100.0% | 96.0% | 96.5% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | 95.0% | 61.3% | 81.1% | 65.2% | 71.2% | 82.2% | 80.5% | 85.7% | 85.0% | 72.1% | 81.9% | 84.0% | 75.0% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | 81.7% | 71.0% | 56.6% | 85.9% | 81.7% | 76.2% | 75.2% | 98.8% | 74.8% | 82.0% | 95.2% | 92.0% | 95.8% | | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 89.0% | 69.0% | 59.6% | 47.8% | 40.3% | 43.2% | 46.8% | 50.9% | 53.4% | 54.3% | 54.5% | 56.2% | 61.6% | | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 7,567 | 6,655 | 6,630 | 7,186 | 7,431 | 7,840 | 7,737 | 8,127 | 8,221 | 7,858 | 8,132 | 8,432 | 8,700 | | | | |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 0 | 7 | 31 | 60 | 137 | 121 | 135 | 143 | 147 | 183 | 221 | 291 | 357 | | 0 | N/A | >0 |
| Diagnostics: % Completed Within 6 Weeks | W | 100.0% | 100.0% | 92.9% | 66.7% | 53.3% | 100.0% | 100.0% | 100.0% | 87.5% | 100.0% | 50.0% | 90.0% | 94.1% | | >=99 % | N/A | <99 % |

## WELL LED

| Measure | Type | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -1,187 | -4,229 | -3,714 | -1,773 | -1,983 | -1,540 | -1,990 | -487 | 54 | -502 | -245 | 11 | -856 | | No Threshold | | |
| Income In Month Variance (£'000s) | W | -502 | -4,173 | -4,172 | -1,908 | -1,964 | -1,428 | -1,460 | 15 | 1 | 34 | 0 | 83 | 152 | | No Threshold | | |
| Pay In Month Variance (£'000s) | W | -241 | -133 | -111 | 32 | 67 | 35 | -457 | -68 | -67 | -398 | -364 | -169 | -549 | | No Threshold | | |
| AvP: IP - Non-Elective | W | 343 | 0 | 0 | 1 | 0 | -1 | -127 | -65 | -35 | -47 | -89 | -47 | 47 | | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 230 | 1 | 1 | -1 | 0 | -1 | 25 | 3 | -16 | 4 | -47 | -56 | 91 | | >=0 | N/A | <0 |
| AvP: OP New | | 2,003.00 | 4.00 | 11.00 | 16.00 | 27.00 | 31.00 | -668.00 | -1,255.00 | -627.00 | -463.19 | -967.00 | -442.00 | 599.00 | | >=0 | N/A | <0 |
| AvP: OP FollowUp | | 5,634.00 | 18.00 | 37.00 | 35.00 | 52.00 | 90.00 | -601.00 | -1,603.00 | -265.00 | -180.57 | -1,668.00 | -751.00 | 1,622.00 | | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | 581 | 0 | 1 | 2 | 1 | 0 | -78 | -178 | -102 | -37 | -268 | -192 | 284 | | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 8,790 | 22 | 48 | 51 | 77 | 124 | -1,702 | -3,560 | -1,246 | -774 | -3,181 | -1,423 | 2,609 | | >=0 | N/A | <0 |
| PDR | W | 94.3% | 94.3% | 0.0% | 1.1% | 17.1% | 24.7% | 35.5% | 57.8% | 67.5% | 67.6% | 66.1% | 66.1% | 66.1% | | >=90 % | >=85 % | <85 % |
| Medical Appraisal | W | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 94.1% | 96.8% | 96.8% | 96.8% | 96.8% | | >=95 % | >=90 % | <90 % |
| Mandatory Training | W | 92.1% | 90.6% | 88.5% | 89.6% | 89.1% | 89.3% | 88.0% | 87.1% | 84.8% | 85.6% | 86.7% | 86.9% | 87.8% | | >=90 % | >=85 % | <80 % |
| Sickness | D | 6.3% | 6.6% | 6.6% | 5.7% | 5.7% | 6.0% | 6.1% | 6.9% | 5.8% | 6.2% | 8.4% | 6.9% | 5.8% | | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 2.2% | 1.7% | 1.5% | 1.1% | 1.4% | 1.4% | 1.7% | 2.1% | 1.2% | 1.3% | 3.1% | 1.5% | 1.5% | | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 4.2% | 4.8% | 5.1% | 4.7% | 4.3% | 4.6% | 4.4% | 4.8% | 4.6% | 4.8% | 5.3% | 5.4% | 4.3% | | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 504 | 457 | 322 | 204 | 310 | 332 | 286 | 446 | 505 | 415 | 434 | 382 | 560 | | No Threshold | | |
| Staff Turnover | D | 10.6% | 10.4% | 9.8% | 9.4% | 9.6% | 9.5% | 9.4% | 8.7% | 8.3% | 7.9% | 8.1% | 8.1% | 7.7% | | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | | 90.3% | | 94.4% | 86.8% | 89.1% | 93.6% | 94.4% | 95.3% | 93.5% | 89.6% | 92.7% | 93.7% | | >=90 % | >=85 % | <90 % |

## Community & Mental Health Division

| | | |
|---|---|---|
| **SAFE** | Lessons learned:<br><br>**Incident 48104 – ASD/ADHD** - Child prescribed instant release methylphenidate instead of prolonged release.<br><u>**Lesson**</u> - For all prescribers to re check formulation of medications prescribed after they have been written and for Medications Clerk to re check prescriptions before sending prescription out. | **Highlight**<br>• Zero incidents resulting in moderate or severe harm<br>• Zero incidents resulting in death<br>• Zero Pressure Ulcers (Category 3 and above)<br>• 158 incidents reported in March<br>**Challenges**<br>• 37 minor harm incidents in month relating to an increase in self harm incidents at Children's Tier 4 Inpatient Unit |
| **CARING** | Lessons learned:<br><br>As a result of a complaint, the importance of taking care when considering the questions to be asked of young people in sessions, particularly in relation to sensitive issues e.g. drug use. | **Highlight**<br>• 12 Excellence Reports recorded<br>• 55 Compliments recorded<br>• FFT Scores – for OPD and Community services, scores remain over 90%.<br>• Sub-group of the Divisional Governance Group focusing on Patient Experience is being set up<br>**Challenges**<br>• Increase in PALS in March (40) compared to 15 in January. Communication issues and medication concerns being the main themes.<br>• 4 new complaints received in March. Themes regarding perceived lack of communication and disputing of clinical information and decision making. |
| **EFFECTIVE** | Crisis Care continue to provide a 24/7 with a continued increase in calls (806) which is the highest number of calls recorded to date. | **Highlight**<br>• Focus on ensuring no child is unaccounted for from clinic during March 2021 with over 3,500 records validated.<br>**Challenges**<br>• Referrals to Locality Mental Health Services continue to increase (33% increase between February and March) which is impacting on access times |
| **RESPONSIVE** | Improvements in waiting times across the division:<br>• No child or young person waiting over 52 weeks for treatment in any of the community pathways<br>• Continued improvement in RTT for Community Paediatrics 66% for March | **Highlight**<br>• No urgent breaches for Eating Disorders pathway<br>• ASD and ADHD new pathways continue to deliver against the maximum 30-week timescale and continue to reduce the pre-April 2020 cohort |

| | | |
|---|---|---|
| | | **Challenges**<br>• Access times for specialist community Mental Health continue to be monitored closely due to impact of increased referrals. In March the RTT (referral to first partnership) within 18 weeks was 67%<br>• Waiting times for Liverpool SALT are above 18 weeks. Improvement plan in place to address this and monitored via Divisional access to care meeting |
| **WELL LED** | The division achieved financial balance for 2020/21<br><br>Appointment of clinical leadership posts:<br>• ASD<br>• Community Physiotherapy & Occupational Therapy | **Highlight**<br>• Staff sickness has reduced to 4.2%<br>• Medical Appraisal rates are at 100%<br>• Staff survey response rate 58%<br>**Challenges**<br>• Mandatory training remains 89% and there is a focus through individual team managers to address this. |

Alder Hey Children's NHS Foundation Trust

# Community

D Drive W Watch P Programme

## SAFE

| Measure | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 5 | 4 | 6 | 6 | 8 | 4 | 8 | 16 | 10 | 15 | 4 | 5 | 10 | | No Threshold |
| Clinical Incidents resulting in No Harm | D | 42 | 29 | 92 | 84 | 83 | 73 | 88 | 84 | 76 | 53 | 64 | 75 | 84 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 4 | 4 | 3 | 10 | 6 | 5 | 9 | 11 | 12 | 9 | 11 | 21 | 34 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication Errors (Incidents) | | 6 | 6 | 7 | 6 | 11 | 10 | 20 | 33 | 26 | 16 | 19 | 17 | 23 | | No Threshold |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 3 and above) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Cleanliness Scores | | | | | 78.3% | 100.0% | | 98.8% | 98.8% | | | | | 100.0% | | No Threshold |
| CCNS: Advanced Care Plan for children with life limiting condition | | 8 | | | | | | | | | | | | | | No Threshold |
| CCNS: Supported early discharges from hospital care | | | 100.0% | 100.0% | 100.0% | | | | | | | | | | | No Threshold |
| CCNS: Prescriptions | | 17 | 16 | 12 | 15 | | | | | | | | | | | No Threshold |

## CARING

| Measure | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints | W | 2 | 0 | 2 | 2 | 4 | 2 | 2 | 1 | 4 | 2 | 5 | 4 | 3 | | No Threshold |
| PALS | W | 18 | 19 | 19 | 26 | 29 | 22 | 26 | 32 | 17 | 15 | 14 | 37 | 40 | | No Threshold |

## EFFECTIVE

| Measure | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | | 796 | 434 | 465 | 620 | 876 | 635 | 856 | 979 | 1,050 | 848 | 774 | 875 | 1,085 | | No Threshold |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | | 19 | 17 | 0 | 0 | 4 | 25 | 25 | 18 | 2 | 5 | 7 | 10 | 7 | | No Threshold |
| OP Appointments Cancelled by Hospital % | | 18.4% | 24.3% | 11.8% | 6.4% | 6.3% | 10.5% | 10.1% | 10.0% | 11.4% | 8.2% | 12.6% | 9.5% | 12.0% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate (New Appts) | W | 9.6% | 9.3% | 10.2% | 11.4% | 10.6% | 10.4% | 6.9% | 11.5% | 8.2% | 7.3% | 10.2% | 21.1% | 34.3% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) | W | 10.8% | 13.0% | 14.8% | 14.3% | 15.1% | 13.6% | 14.0% | 13.3% | 11.1% | 12.9% | 13.5% | 14.2% | 23.3% | | <=14 % <=16 % >16 % |
| Was Not Brought Rate (New Appts) - Community Paediatrics | | 9.1% | 9.3% | 12.5% | 11.5% | 8.9% | 12.1% | 9.1% | 14.6% | 10.0% | 9.8% | 11.6% | 31.8% | 48.6% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) - Community Paediatrics | | 8.2% | 13.2% | 13.3% | 11.1% | 14.7% | 14.1% | 17.5% | 15.0% | 12.1% | 14.7% | 19.1% | 23.0% | 47.5% | | <=14 % <=16 % >16 % |
| Was Not Brought Rate (CHOICE Appts) - CAMHS | | 24.9% | 26.1% | 22.4% | 28.3% | 25.7% | 23.6% | 9.7% | 12.8% | 13.3% | 13.6% | 19.7% | 11.5% | 18.8% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (All Other Appts) - CAMHS | | 12.1% | 13.6% | 15.8% | 16.0% | 15.9% | 13.9% | 13.1% | 13.3% | 11.6% | 13.2% | 12.0% | 11.0% | 14.9% | | <=14 % <=16 % >16 % |
| CAMHS: Tier 4 DJU % Bed Occupancy At Midday | | 82.5% | 90.5% | 91.2% | 85.7% | 87.6% | 75.6% | 91.4% | 107.8% | 91.0% | 109.7% | 110.1% | 106.6% | 114.3% | | No Threshold |
| CAMHS: Tier 4 DJU Bed Days | | 296 | 322 | 386 | 360 | 380 | 328 | 384 | 470 | 382 | 478 | 476 | 420 | 496 | | No Threshold |
| Coding average comorbidities | | 5.00 | 3.00 | 3.00 | | 2.00 | 6.00 | | 4.50 | 3.33 | 3.00 | 3.00 | | 4.00 | | No Threshold |
| CCNS: Number of commissioned packages | | 10 | 9 | 9 | 9 | | | | | | | | | | | No Threshold |

## RESPONSIVE

| Measure | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: Tier 4 Admissions To DJU | | 1 | 1 | 1 | | 1 | 1 | 1 | | 2 | 2 | | 1 | | | No Threshold |
| CAMHS: Referrals Received | | 315 | 110 | 163 | 259 | 262 | 257 | 356 | 348 | 416 | 340 | 268 | 351 | 469 | | No Threshold |

Alder Hey Children's NHS
NHS Foundation Trust

# Community

D Drive W Watch P Programme

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: Referrals Accepted By The Service | | 169 | 67 | 93 | 144 | 154 | 146 | 268 | 193 | 232 | 198 | 158 | 182 | 252 | | No Threshold |
| CAMHS: % Referrals Accepted By The Service | | 53.7% | 60.9% | 57.1% | 55.6% | 58.8% | 56.8% | 75.3% | 55.5% | 55.8% | 58.2% | 59.0% | 51.9% | 53.7% | | No Threshold |
| Convenience and Choice: Slot Availability | | 100.0% | | 100.0% | | | | | | | | | | | | >=96 % N/A <96 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 69.3% | 44.3% | 42.5% | 34.0% | 32.3% | 38.1% | 40.2% | 49.2% | 64.3% | 64.4% | 66.2% | 64.5% | 66.1% | | >=92 % >=90 % <90 % |
| Waiting List Size | W | 1,234 | 1,010 | 1,013 | 1,184 | 1,032 | 1,109 | 1,051 | 795 | 756 | 800 | 785 | 911 | 909 | | No Threshold |
| Waiting Greater than 52 weeks - Incomplete Pathways | W | 5 | 8 | 21 | 22 | 12 | 6 | 10 | 2 | 1 | 1 | 0 | 0 | 0 | | 0 N/A >0 |
| CAMHS: Crisis / Duty Call Activity | | | 288 | 422 | 413 | 550 | 494 | 516 | 596 | 718 | 697 | 649 | 804 | 806 | | No Threshold |
| CAMHS: RTT (First Partnership) % waiting within 18 weeks | W | 58.6% | 53.0% | 53.6% | 49.3% | 44.0% | 53.2% | 59.1% | 68.8% | 70.0% | 69.9% | 65.9% | 67.9% | 67.3% | | >=92 % >=90 % <88 % |
| ASD: Completed Pathways | | 57 | 24 | 25 | 79 | 120 | 137 | 107 | 117 | 98 | 45 | 54 | 62 | 95 | | No Threshold |
| ASD: Completed Pathway Compliance (% within 18wks) | | 70.2% | 83.3% | 72.0% | 54.4% | 65.0% | 75.2% | 76.6% | 95.7% | 87.8% | 86.7% | 53.7% | 90.3% | 78.9% | | >=92 % >=90 % <90 % |
| EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) | P | | | 90.0% | 87.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 91.7% | 100.0% | 46.2% | | No Threshold |
| EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) | P | | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | >=95 % >=92 % <92 % |
| CCNS: Number of Referrals | W | 131 | 107 | 134 | 149 | 188 | 122 | 144 | 146 | 151 | 127 | 119 | 139 | 169 | | No Threshold |
| CCNS: Number of Contacts | D | 986 | 748 | 859 | 812 | 1,083 | 803 | 1,035 | 1,038 | 877 | 844 | 783 | 826 | 896 | | No Threshold |

## WELL LED

| | | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | Jan-21 | Feb-21 | Mar-21 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | 165 | -92 | -27 | 175 | -26 | 0 | -70 | 369 | 270 | 45 | 321 | 221 | -41 | | No Threshold |
| Income In Month Variance (£'000s) | W | 330 | -30 | -64 | 139 | -49 | -44 | 96 | 397 | 155 | 75 | 148 | 996 | 150 | | No Threshold |
| Pay In Month Variance (£'000s) | W | 412 | 18 | 131 | -29 | -64 | -98 | -31 | -81 | 30 | 12 | 65 | -81 | 137 | | No Threshold |
| AvP: OP New | | 454.00 | 0.00 | 1.00 | 3.00 | 0.00 | 0.00 | 181.00 | 121.00 | 185.00 | 114.43 | 77.00 | -81.00 | -11.00 | | >=0 N/A <0 |
| AvP: OP FollowUp | | 2,759.00 | 1.00 | 9.00 | 11.00 | 4.00 | 10.00 | 671.00 | 653.00 | 901.00 | 1,055.48 | 642.00 | 835.00 | 783.00 | | >=0 N/A <0 |
| AvP: Outpatient Activity vs Plan | W | 3,213 | 1 | 10 | 14 | 4 | 10 | 842 | 770 | 1,085 | 1,168 | 721 | 753 | 772 | | >=0 N/A <0 |
| PDR | W | 91.3% | 91.3% | 2.1% | 9.8% | 16.6% | 23.1% | 41.3% | 73.4% | 81.9% | 81.9% | 83.1% | 83.1% | 83.1% | | >=90 % >=85 % <85 % |
| Medical Appraisal | 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% | | >=95 % >=90 % <90 % |
| Mandatory Training | W | 94.7% | 93.8% | 93.0% | 92.8% | 92.1% | 92.0% | 91.4% | 91.7% | 89.2% | 88.4% | 89.2% | 88.6% | 89.3% | | >=90 % >=85 % <80 % |
| Sickness | D | 6.3% | 4.0% | 3.5% | 2.7% | 2.5% | 2.7% | 3.8% | 4.0% | 4.3% | 4.5% | 5.6% | 4.7% | 4.0% | | <=4 % <=4.5 % >4.5 % |
| Short Term Sickness | D | 2.8% | 1.4% | 0.8% | 0.5% | 0.7% | 0.9% | 1.3% | 1.6% | 1.2% | 0.9% | 1.9% | 1.0% | 0.9% | | <=1 % N/A >1 % |
| Long Term Sickness | D | 3.5% | 2.6% | 2.7% | 2.2% | 1.8% | 1.9% | 2.5% | 2.5% | 3.2% | 3.6% | 3.7% | 3.7% | 3.0% | | <=3 % N/A >3 % |
| Temporary Spend ('000s) | D | 183 | 122 | 47 | 21 | 189 | 194 | 169 | 173 | 212 | 355 | 226 | 169 | 141 | | No Threshold |
| Staff Turnover | D | 10.8% | 10.2% | 11.5% | 11.5% | 10.8% | 10.7% | 10.5% | 9.8% | 9.1% | 8.8% | 9.4% | 9.6% | 9.8% | | <=10 % <=11 % >11 % |
| Safer Staffing (Shift Fill Rate) | W | | | | 96.2% | 99.5% | 99.8% | 99.8% | 100.1% | 98.5% | 98.6% | 99.9% | 99.4% | 100.2% | | >=90 % >=85 % <90 % |

# Research Division

| | | |
|---|---|---|
| **SAFE** | • Divisional Mandatory training demonstrates good compliance<br>• All current risks compliant with review dates<br>• CRF ICP (compliant)<br>• All patients screened for potential COVID 19 prior to hospital visit using telephone triage<br>• CRF ward compliant with all standards on Trust Dashboard<br>• Good uptake from Staff covid vaccine<br>• All Areas have been certified Covid Secure<br>• Phlebotomy samples (Healthy Control Samples)<br>• CRD now in attendance at weekly meeting of harm | **Highlight**<br>• Mandatory Training > 94%<br>• GCP training 97%<br>• SOP compliance 96%<br>• ANTT compliance 100%-CRF Ward<br>• Good catch recognised at Patient safety Meeting re CRF ward under safety<br>**Challenges**<br>• PDR rates 87% below Trust Target of 90%<br>• Reduced space on CRF due to footfall.<br>• Research blood samples for multiple trials<br>• Delays with recruitment to children's vaccine study<br>• 0 incident reported |
| **CARING** | • 0 complaints received<br>• Patient centred follow up care for patients on clinical trials<br>• Patient feedback used to improve quality of patient care and experience<br>• Plans underway to capture experience patient experience data<br>• Recognition of outstanding care by Covid team for care delivered to patients under research opportunities | **Highlight**<br>• X 0 Complaints<br>• New Children's PRES developed for 20/21, currently being rolled out<br>• Positive results from last survey reported<br>• Good catch recognised at Patient safety Meeting under caring (covid team)<br>**Challenges**<br>• More work to do on local patient internal audits<br>• Low numbers of electronic survey questionnaires from patients on system |
| **EFFECTIVE** | • Studies selected based on best possible outcomes for children and young people.<br>• Current portfolio regularly reviewed using NIHR stratification to allow for UPH prioritisation studies whilst maintaining all studies in level 2.<br>• No housekeeping allocated to CRF ward. Nursing staff arranging and collection meals for patients.<br>• Clinicians encourage children and young people to make informed decisions about participating in studies.<br>• CRD performance reports and meetings restarted to review portfolio | **Highlight**<br>• Project restart 80% NIHR CRN ambition achieved at 81%<br>• Recruitment figures for UPH studies recognised by CRN<br>• X 10 UPH studies open within Trust<br>• Successful completion of Pilot of Lateral Flow Testing (LAVA study) with second phase in set up<br>**Challenges**<br>• CRF housekeeping<br>• LAVA 2 study delayed<br>• Siren had been extended and increased national priority<br>• Delivery workforce capacity to allow the opening of new studies<br>• Diversity of portfolio studies to include Starting well |
| **RESPONSIVE** | • All Staff Risk Assessments completed as required<br>• New local systems and processes have been implemented to improve safety of staff, promote better team working to ensure safe staffing and cover for sickness, leave.<br>• H&S Covid RA's completed for all areas of research<br>• Coordinated and partnership working with local providers to offer joint training programmes. | **Highlight**<br>• Agile working implemented to reduce footfall<br>• A.H supporting the wider system with Covid UPH activity<br>• Partnership working with external partners<br>• Research nurses supported mass vaccination programme internal clinics and other sites such as LCHC<br>• Adolescent vaccine study in set up to be open to recruitment mind March |

| | | |
|---|---|---|
| | | **Challenges**<br>• Last minute requests for external support<br>• Effective clinical space to deliver HCW study clinics |
| **WELL LED** | • PDR compliance remains at 87%<br>• LTS absence rates have improved staff are supported through line managers and staff support.<br>• Staff survey results for 2020 improved<br>• Engagement with partners in relation to upcoming starting well initiatives. | **Highlight**<br>• Division supporting staff with Flexible working<br>• Overall sickness absence levels have improved across the division<br>• support arranged for staff with SALS<br>• CRD above Trust target in all areas of staff survey<br>• CRN overspend rectified through VCF<br>**Challenges**<br>• Reduced staffing due to a number of staff using up AL<br>• Annual leave carry over for some staff<br>• LTS numbers reducing but still above Trust Target<br>• Correct model for the future to be established |

**BOARD OF DIRECTORS**

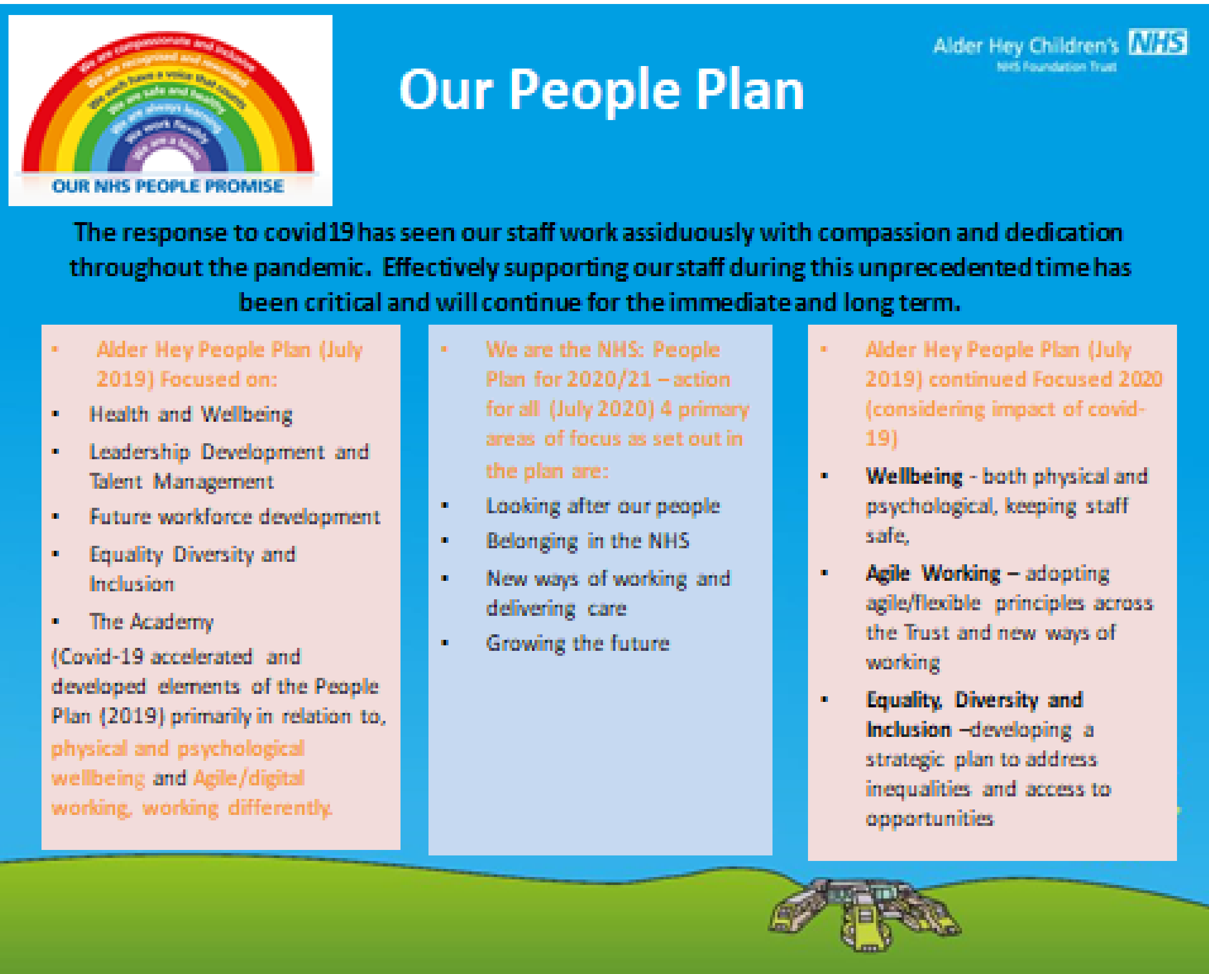
**Thursday 29th April 2021**

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

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

## 1. Purpose

The purpose of this paper is to provide the Board with a strategic update on the Alder Hey People Plan and our response to the requirements of the national NHS People Promise.




## 2. Wellbeing

### 2.1 Staff Advice and Liaison

The Staff Advice and Liaison service continues to grow and develop with the majority of support focusing around staff experiencing stress and anxiety. As the service continues to embed into the organisation the referrals being received by the team are becoming increasing complex. To ensure staff receive the best possible support SALS are working in partnership with teams such as HR and Clinical Health Psychology.

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

The SALS service was awarded the HSJ staff engagement award on 17th March 2021.

The judges said *"the winner's enthusiasm and passion was evident and they demonstrated a very person centred approach with good levels of sharing across the systems. It was refreshing to see the improvements grow organically within the organisation which has contributed to large increases in staff recommending Alder Hey as a place to work. The creation of SALS (like PALS) has proven to be a good creative initiative for staff support."*

### 2.2 Health Wellbeing Steering Group

The Health and Wellbeing Steering group relaunched in 2021 focusing on the implementation of the People Plan. The key actions from the steering group are:

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

### 2.3 Health and Wellbeing conversations

Every member of staff is encouraged to have a wellbeing conversation as part of their PDR this year. This initiative comes from NHS England and is expected to be of substantial benefit to staff given the challenges we have all faced over the last 12-18 months. Guidance on these conversations and how to undertake them has been provided for both staff and Managers. In addition to managers conducting these wellbeing conversations a number of wellbeing coaches are in place across the organisation to support these wellbeing conversations.

### 2.4 Staff Availability

The staff availability position into April 2021 continues to improve with overall absences and COVID-19 related absences both decreasing.

**Table 1 - Sickness position as of 23rd April 2021**

| Reason | Trust | |
|---|---|---|
| | % | No of Staff |
| Non Covid Related Sickness | 4.45% | 178 |
| Covid Related Sickness | 0.23% | 9 |
| Absence Related to Covid - not inc sickness | 0.35% | 14 |
| Absence Related to Covid Inc Sickness | 0.58% | 23 |
| All Absence (total of above) | 5.03% | 201 |

Following the announcement by the Government of the Roadmap for the easing of lockdown measures on 22nd February 2021 the HR team are supporting managers with the return to work of those staff who have been shielding. There is an action plan in place for all staff who have been shielding in respect of their return to their substantive roles. 65 shielding staff have returned to work thus far, there are 18 staff who have been shielding who are imminently due to return, further to additional occupational advice and support.

## 3. Equality, Diversity & Inclusion

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

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

## 4. Governance and Ongoing Business

### 4.1 Case Management

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

In March 2021 there are 16 cases currently ongoing as detailed below.

**Table 2- Employee relations activity per division as of 23rd April 2021**

| Division | MHPS | Disciplinary | Grievance | B&H | Appeal | ET | Total |
|---|---|---|---|---|---|---|---|
| Surgery H/C 1326 | 3 | 3 | 1 | 1 | 1 | 1 | **10** |
| Medicine H/C 1223 | 1 | 0 | 1 | 0 | 0 | 0 | **2** |
| Community H/C 687 | 1 | 0 | 0 | 0 | 1 | 1 | **3** |
| Corporate & Research H/C 695/65 | 0 | 1 | 0 | 0 | 0 | 0 | **1** |
| Grand Total | **5** | **4** | **2** | **1** | **2** | **2** | **16** |

### 4.2 Training

As of the 6th April 2021, Mandatory Training was at 87% overall, 3% below the Trust target of 90%. We continue to work with staff and managers to ensure training compliance is up to date via our monthly reporting to divisions and departments and through directly contacting staff who were not 100% compliant.

Our key areas of focus continue be annual Resuscitation training (BLS & PLS/APLS Update) and supporting our Estates and Ancillary staff to be able to access training.

The Learning and Development Team have been working with the Resus team to re-develop their training calendar for the 2021/22 to ensure there is appropriate capacity for staff to attend and maintain their compliance whilst still meeting the social distancing guidelines required under COVID-19.

In terms of supporting our Estates and Ancillary staff, we have asked all of our Subject Matter Experts to consider alternative delivery methods to support this area of the Trust such as workbooks, socially distanced face to face sessions, recorded videos etc and are collating their responses before arranging alternative training for this staff group with the departmental leads.

## Table 3- Mandatory Training compliance 6th April 2021

| Trust | Overall Mandatory Training |
|---|---|
| Trust | 86.64% |
| **Division** | **Overall Mandatory Training** |
| 411 Alder Hey in the Park | 80.66% |
| 411 Community | 89.18% |
| 411 Corporate Other Department | 86.63% |
| 411 Facilities | 50.40% |
| 411 Finance | 84.43% |
| 411 Human Resources | 88.64% |
| 411 IM&T | 94.28% |
| 411 Innovation | 70.65% |
| 411 Medicine | 88.35% |
| 411 Nursing & Quality | 88.24% |
| 411 Research & Development | 95.07% |
| 411 Surgery | 87.70% |

# BOARD OF DIRECTORS

**Thursday 29th April 2021**

| | |
|---|---|
| **Paper Title:** | **Update on Staff Advice and Liaison Services Themes** |
| **Report of:** | **Dr Jo Potier and Mrs Jeanette Chamberlain** |
| **Paper Prepared by:** | Mrs Jeanette Chamberlain |

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

## 1. Introduction

The purpose of this Board paper is to inform the Board of Directors of the work that SALS have undertaken in the last twelve months as well as describe some of the themes that staff are presenting with as they access the service.

## 2. Background

After its quiet launch in January 2020, where relationships were built and strengthened with other internal support services and positive news about the service was spread via word of mouth, Covid 19 increased the work, the resource and the visibility of SALS almost overnight. Staff support and the SALS were positioned in the key messages in daily briefings from the Chief Executive with a strong emphasis on psychological safety and wellbeing throughout the acute phase. To meet the rising demand for support, the team was fortunate to be joined by another staff member (seconded into the role, now about to start full time from June 2021) and a trainee Clinical Psychologist working alongside the Associate Director of Organisational Development. Through Phase 1 and 2 of the pandemic, we were able to:

- Offer a responsive, compassionate safe space for all members of staff who needed support
- Offer rapid mental health support (including crisis support) where needed
- Design and development of a brand/image
- Grow an active social media presence for the service (staffadvice@alderhey)
- Plan and structure how we continue to deliver & develop excellent services for our staff going forward and in what order
- Offer a same day service for staff that need support and care.
- Project lead for the implementation of a ‘Project Wingman’ Lounge
- Developed a project team for the cascade of ‘Alder Hey Thank you boxes’ for each and every member of staff.
- Work with the learning and development team/OD to develop specific leadership sessions ‘Keeping going together’

- Grow our ‘Strong Foundations’ training for leaders and managers and adapt this to more virtual on line training.
- Be part of the BAME network groups and be instrumental in thinking about what work we needed to do to support our colleagues
- Develop a legacy Wingman Lounge
- Develop and embed a bereavement co-ordination function for the organisation
- Working in partnership with the Project Ares team at Liverpool University on the development and implementation of a **Ground Truth** after action review tool
- Helping us think about and shape what our virtual ‘coffee room’/’common room’ looks like
- Running our first, and Wingman’s first - virtual ‘Project Wingman Virtual’ Session to shielded staff
- Supported our first virtual ‘Project Wingman’ session to the Community staff who weren’t able to access this initiative because of their location.
- Presented to the organisation via a briefing **Compassion at Christmas**
- Run virtual common rooms during lockdowns out of hours, to enable staff to feel connected.
- Supported staff during the Third Wave, working in collaboration with our clinical health psychology colleagues to develop a wraparound plan for staff who may be affected by us receiving a 2$^{nd}$ cohort of adult patients.
- Support teams develop memorial plans for members of their teams.
- Developed a plan around ***Rest, Connect and Share*** to inform and help shape the organisational thinking about recovering from the pandemic.
- Thinking about development of a ***SALS Pal model*** a network of friends around the organisation who share the SALS ethos and can support staff locally, and who can also receive support and supervision from our SALS psychologists when needed.
- SALS was one of the four components which underpinned our submission and subsequent achievement of winning this year’s **HSJ Award** for Staff Engagement.
- Restarted and led on **The Health and Wellbeing steering group**
- Launched **Wellbeing Conversations**

- Attend Trust Induction as well as individual team meetings to inform them about SALS so that more staff are aware of the service and can refer themselves to us.
- Working with our **Wellbeing Guardian,** Fiona Marston to develop what the role looks like and to review our Health and Wellbeing Diagnostic Tool in line with improvements that we can make in the organisation.
- Working alongside the Alder Centre to review staff support pathways and develop a proposal going forward for staff support in the future.

Since March 2020 (up until April 2021) the service has now had over 1,200 contacts and has supported staff in all parts of the organization and across the range of clinical and non-clinical roles. We know anecdotally from contacts in other organizations that staff at Alder Hey have felt cared for and their wellbeing supported through the pandemic and the SALS has received positive feedback internally and regionally. It has been imperative that we have had full support from the Board which has helped us manage the resources needed for the service in line with its growing capacity and we thank the Board for this.

There are a wide range of complex difficulties that staff come to SALS to talk about. We have increasingly been supporting staff who are going through some formal process within the trust ensuring that we are looking after their emotional wellbeing and working closely with our HR colleagues, ensuring that we are able to keep the members of staff updated with timescales. To support with this we have developed a regular SALS/HR business meeting where we are able to learn from each other and understand what is helpful for both staff members and the organization as a whole.

Whilst we do see contacts who are coming to see us to help them with work based issues (e.g. under/over payments, retire and return planning ,or relationship issues within their own teams) the vast majority of staff who come to SALS are suffering with complex emotional issues.

Over the past two months (since February 2021) we have seen staff in crisis with complexities in their personal lives which are either only just coming to light, or that

they have never really spoken to anybody about before. We know that we have had more contacts since the beginning of lockdown in January and now that external restrictions are lifting, we are starting to see more and more staff referring themselves into the service. This is because we know that staff have been 'holding on and getting through' or in survival mode. There is a process where people go through a period of 'doing' and slowly move into a state of 'feeling' and this is certainly some of the trends we are starting to see in SALS. We are also mindful of specific 'COVID' anniversaries that may be important or relevant for staff that may trigger some difficult emotions. The team offer a great deal of support and input to some of these staff, often liaising with external agencies in order that staff can get the right place to be offered the support, care and treatment that they need, developing Wellbeing Action Plans to support them staying in work or undertaking Stress Risk Assessments as well as developing individualized safety plans. SALS will often regularly meet these members of staff until we know that they are in the right place for treatment and they no longer need our ongoing support. It's true to say that once a member of staff touches SALS it's not very often that we don't seen them again for other help and support. SALS are seeing more staff presenting with complex OCD which has again required dedicated input with external agencies and offering psychological input from ourselves in order that the staff member feels well enough to stay in work whilst waiting to access the correct services.

Recognising the complexity of the cases that we are supporting with, we have also reached out to gain some bespoke training for ourselves as a team, and have recently had Suicide Awareness training, which we also opened up to HR colleagues and SALS are now working with the Cheshire and Merseyside Resilience Hub to form a plan about trauma based support modules that can be offered to all of the staff support teams within Alder Hey. The team is also working closely with colleagues in the Alder Centre and HR to develop structured pathways for staff presenting in crisis.

**Most Common Themes**

| Staff in Crisis (Presenting with suicidal ideation) |
|---|
| Development or management of OCD |
| Trauma |
| Workplace Issues |
| Relationship issues within workplace |
| Isolation due to COVID and lockdown |
| Bereavement |
| Supporting staff on Long Term sick and facilitating a return to work and often undertaking Stress Risk Assessments with staff |
| Supporting staff through disciplinary processes |
| Domestic Abuse |

## 3. Conclusion

The level of contacts that we have seen in SALS has now reached 1200 (at our last Board presentation we had seen 500 contacts) and the staff are presenting to the service are presenting with very complex multi-faceted issues that require ongoing help and support. The team is still managing to respond to referrals and queries on the same day and offer initial contact appointments the same week. Once the establishment in the service is increased, following recruitment (in June) the team wants to really start to look at preventative sessions across the Trust in able to help staff to help themselves to prevent them reaching further difficulties or reaching crisis. The team would like to **thank the board for their ongoing commitment and support to the service.**

**4. Recommendations**

Members of the SALS team would be happy to attend Board later on in the year to update further on the service and present research/evidence from the service if required.

# BOARD OF DIRECTORS

**Thursday 29th April 2021**

| | |
|---|---|
| **Paper Title:** | **Risk of Manchester Cardex Backlog related to ACHD service** |
| **Report of:** | **Nicki Murdock Medical Director** |
| **Paper Prepared by:** | Nicki Murdock Medical Director, Abby Phillips, deputy Director Strategy |

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

## 1. Introduction

The Liverpool Partnership vision for the ACHD service is:

***We will deliver a lifetime of high quality easily accessible personalised care to CHD patients, through our clinical partnership.***
(North West ACHD Partnership Governance Model, April 2019)

There is a risk that the ACHD Partnership "Manchester Cardex Backlog" will not be addressed in a timely way and that patients may have suffered harm whilst on this list.

## 2. Background

In May 2016 NHS England (NHSE) published national standards and service specifications for Adult Congenital Heart Disease Services (ACHD). The standards cover the entire pathway of care from diagnosis through to treatment and care in the home. They describe three levels of service provision. The standards-based commissioning approach aims to achieve high quality, safe, resilient and sustainable services.

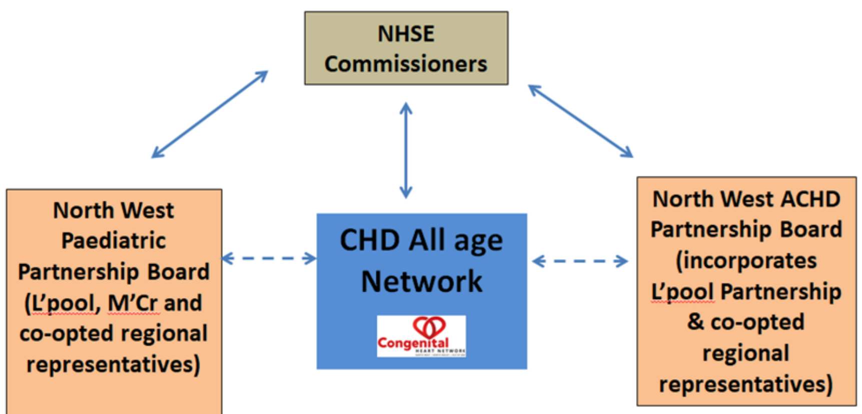
In 2017 NHSE decided on the commissioning arrangements for ACHD services following a public consultation. They commissioned Liverpool Heart and Chest NHS Foundation Trust (LHCH) to provide Level 1 ACHD Services in the North West with Manchester University Hospitals NHS Foundation Trust (MUHFT) providing level 2 services as part of an integrated CHD service across the North West. Alder Hey Children's Hospital NHS Foundation Trust (AHFT) was established as the level 1 Paediatric CHD service provider in the region.

In July 2018 the national specialised commissioning team (SMT) issued Specialised Services Circular 1888 (SSC1888) which advised on the requirement for level 1 services to develop formal networking arrangements and meet the requirements within the service standards. Consequently, the North West Operational Delivery Network (ODN) was established.

Level 1 ACHD services were re-provided in Liverpool following a transition period overseen by NHSE in 2018, with services launched in early 2019.

The North West has a partnership of four trusts delivering level 1 ACHD services with one trust (MUHFT) delivering the level 2 service with the support of the Liverpool Partnership. A similar arrangement exists for paediatric CHD services with (AHFT) providing the level 1 service and outreaching to level 2 and other District General Hospital sites in the North West.

To ensure robust, safe and sustainable services which meet national standards, the Liverpool partners agreed a collaborative service delivery model and established a memorandum of understanding (MoU) to underpin the arrangements for effective working.




The Liverpool ACHD Partnership Board is accountable for all clinical services delivered. It has a role in overseeing the delivery of services across the Liverpool Partnership within the financial resources provided. It agrees the strategic direction of the Partnership and provides assurance at Board level to the four constituent organisations.

**Manchester Cardex Backlog**

In 2018 there was the death of a patient who was under the care of Manchester Foundation Trust (MFT), they had not been listed on the PAS dataset, it was noted that the patient had not been seen for a number of years – the patient had been referred to the coroner with correspondence being sent to the Medical Director at Bolton Hospital. Following review of the service it was transferred from MFT to LHCH.

The patient was found to be on a Cardex System, this was an older database which was utilised by the MFT team as a data repository but has been "lost" to oversight. Damien Cullington (DC), Clinical Lead for ACHD at LHCH, searched the Cardex system in July 2020 and 5,200 were labelled as being ACHD – however not all of the patients had been true ACHD patients. Once the duplications had been removed and it was compared to the PAS database, 3,019 patients were found who had not been listed on the original PAS dataset.

DC noted a significant amount of the patients had multiple comorbidities, they had severe congenital conditions. This was an historical list that had been created 15 years ago – it was an operational list as opposed to a waiting list. LHCH had made NHSE aware of this and continue to supply an updated list of the numbers weekly to NHSE as the backlog is worked through.

**Clinical overview of backlog and risk**
LHCH had been given the PAS download of ACHD patients that were residents from the previous level one service which was at Manchester. Prioritisation process of the patients needed to be done and this was done by a medical assessment – the assessment was based on the patient's anatomy and the duration of their wait. The validation exercise was completed in February 2020. All

issues that were outlined had been dealt with as a matter of urgency as this was a priority for LHCH.

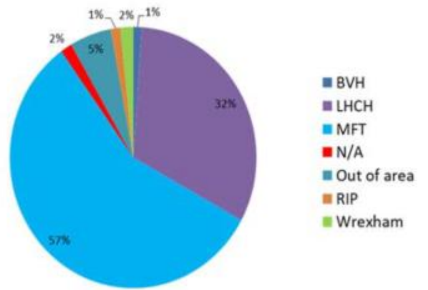
Out of the 3,165 patients that were left on the waiting list, 342 of those had deceased, had been duplicated, were non ACHD patients or they had moved and were under the care of another CHD provider. Those deceased have been reviewed and no concerns raised. In other words the delay had not contributed to their death. Following a further clinical validation and data being cleansed there were 2,618 patients left on the waiting list.

DC noted that there was a slow steady progressive decline in those who had been determined to be urgent both at MFT and LHCH. Waiting list initiatives had been set up on a Saturday for the remainder of 2020 and into 2021 – all of the remaining urgent patients were to have been seen as quickly as possible. The relationship between the two Trusts had grown significantly with both Trusts understanding the numbers, work was to be done on the joint trajectory and Jonathan Mathews, Divisional Head of Operations for Medicine at LHCH. MG was responsible for the quality of the service and was happy to support DC with clinical prioritisation.

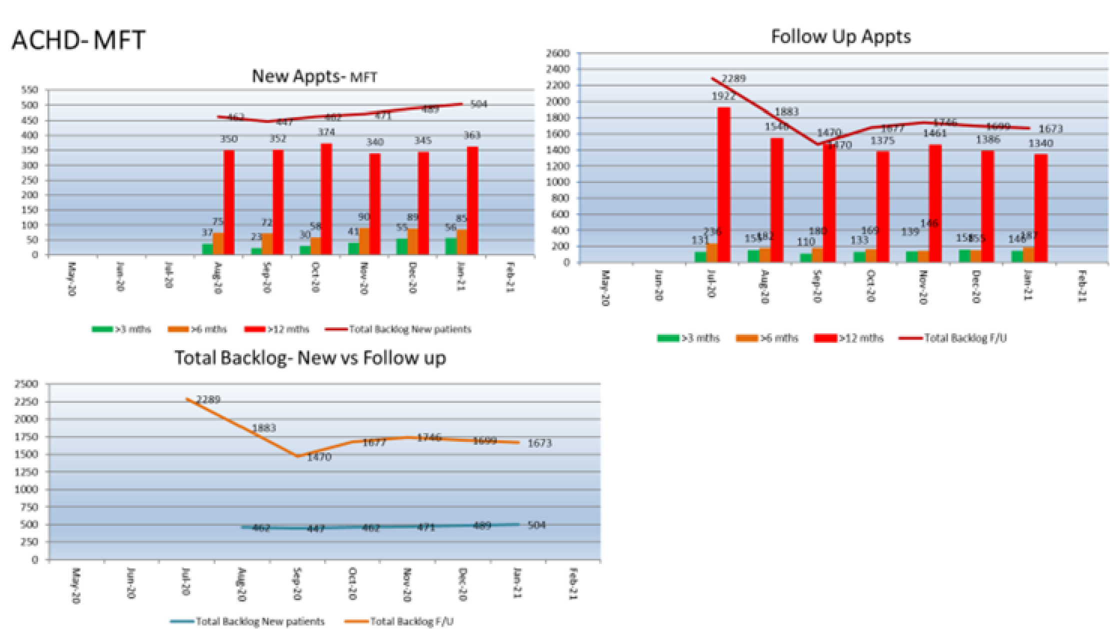
A review of all ACHD consultant job plans had been completed to help with broader working across the patch and an expansion of consultant body which had enabled more clinics to be performed, there had also been an increase in consultant activity across MFT and LHCH.

In relation to challenges, the data that has been requested from NHSE for those patients who had been waiting more than three months, more than six months and more than 12 months differed from what was clinically validated. The agility of extracting data from PAS in order for patients to be tracked efficiently proved a significant challenge . There was a continuous cleansing process taking place all the time for those patients who had been seen elsewhere and had not been discharged and those patients who had moved elsewhere and should have been discharged, this was achievable thanks to the amount of clinics and consultants that were available.

Work continues on the backlog which has been reduced but has also caused pressure on the new patient wait list. Below are the latest figures for the backlog showing a reduction of the numbers. All patients who have died on the backlog are being reviewed by DC to identify any avoidable deaths, none have been identified yet. An updated position will be presented at the next meeting in July 2021.




| | |
|---|---|
| BVH | 9 |
| LHCH | 251 |
| MFT | 451 |
| Out of Area | 43 |
| RIP | 10 |
| Wrexham | 13 |
| Total | 789 |




## 3. Conclusion

The risk is being managed by LHCH by reviewing every patient on that list. Each patient triaged for review in clinic. LHCH and MFT are running extra clinics to see as many patients as possible as quickly as possible. NHSE is being kept informed of progress regularly.
Going forward there is only one waiting list across the North West.

The risk is currently rated as 12. Possible(3) x Major(4)

## 4. Recommendations

That the board accept the risk and that further update is provided in August 2021.

**BOARD OF DIRECTORS**

**Thursday 29th April 2021**

| | |
|---|---|
| **Report of** | Development Director |
| **Paper prepared by** | Associate Development Director- (20/04/2021)<br>Russell Gates |
| **Subject/Title** | Development Directorate<br><br>Campus Development report on the Programme for Delivery |
| **Background papers** | Nil |
| **Purpose of Paper** | The purpose of this report is to update the Trust Board on the Campus delivery. |
| **Action/Decision required** | The Board is asked to acknowledge the content of the report, the current status, risks and actions. |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | ➢ Delivery of outstanding care<br>➢ Sustainability through external partnerships |
| **Resource Impact** | Capital projects budget. |

## Campus Development report on the Programme for Delivery

## April 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 1 of 2021/22 the programme Delivery Timetable RAG rates projects against planned commencement date.

### 2. Programme Delivery Timetable

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

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

An Executive design review group has been set up first meeting took place in December 2020; the next meeting will occur in April 2021, it entails a quarterly review of the whole campus development to ensure executive contribution and agreement.

## 3. Project updates

### Park Reinstatement Phase 1

| Current status | Risks & Issues | Actions/next steps |
|---|---|---|
| Planned works to sow the grass seed are complete and beginning to flourish.<br><br>The formation of the Multi-Use Games Area (MUGA) is still in delay and materials are currently in storage for when a decision is reached. The planning application for siting the MUGA will be made once the current purdah period is over.<br><br>Work continues by Capacity Lab and the local community in the setting up of a Charitable Benefit Organisation. Members of the Friends and Community of Springfield parks groups have had an opportunity to walk the development over the last month. | Location of Multi-Use Games Area (MUGA). (Risk 2348, risk rating 9)<br><br>Public perception that the park phase one is not being delivered. | Continued meetings with planners, residents and LCC parks officers to resolve the location.<br><br>Capacity lab continues to engage with groundworks on a regular basis and involve stakeholders. |

### Acquired Buildings Occupation (neighbouring sites)

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

## Police Station (lower floor) occupation

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

## Relocations

| Current status | Risks/issues | Actions |
|---|---|---|
| The offsite building is being pursued with the lease expected to be signed in late April, minor adaptations carried out through May/early June ready for occupation in mid-June. | Timely relocation and redirection of services are delayed (2104 risk rating 9 and 2105 risk rating 12) | Take recommendation to lease an offsite building to Resource and business development for approval. |

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

| Current status | Risks/issues | Actions |
|---|---|---|
| The Oncology and genetics buildings have now been demolished. The management block, estates and the boiler house are in the process of being demolished. | Asbestos removal cost/time | Complete required works to make the land safe.<br>Work with Finance colleagues to find the additional financial commitment and reduce the financial risk. |

## Park reinstatement Phase 2/3

| Current status | Risks/issues | Actions |
|---|---|---|
| An exercise on the costing is currently in progress and when concluded will go to the Resource and Development Group for review in May.<br>The formation of the levels for phase 2 of the new park have begun whilst costs for the landscaping are agreed.<br><br>Capacity Lab have two major parties interested is supporting enhancement to the park through provision of a café/changing area. They are currently looking at how a modular design could make this an affordable option and will be looking at an initial design with the local stakeholder over the next 6 weeks and have it costed. | Funding required is not delivered through the partnership approach. (relates to risk 1241 , score 16)<br>Budget for Phases 2 & 3 is inadequate. | Working with landscape designer to reduce costs within the parameters of the Land Exchange Agreement.<br><br>Capacity lab continues to hold regular discussion with LCC and also keep the local community up to date with progress.<br><br>Share the design and costs with interested parties in view they could agree to fund the development. |

## NEW Mini Master Plan for Eaton Rd frontage

| Current status- | Risks/issues | Actions |
|---|---|---|
| Turkington Martin, have been engaged for the initial design which will take in the Blue Light Road, the landscape surrounding the new Builds (Institute, Alder Centre and Cluster). Work on the design continues, with involvement of the Arts group.<br>A review and report has been commissioned by Curtins (Traffic management consultants). Results of the analysis confirmed that no offsite highways work will be required. This will now be incorporated into the design so that budget estimates can be completed. | If not planned appropriately is could cause traffic congestion in the future. (Risk 2354, risk rating 8) | Continue design work incorporating advise on traffic management from Curtins.<br>Confirm total costs and identify any gaps in the allocated budget. |

### Infrastructure works & commissioning

| Current status | Risks/issues | Actions |
|---|---|---|
| The programme for the new infrastructure is progressing in line with the overall delivery programme for the campus developments.<br><br>Electricity new supplies;<br>• Placement of a new sub-station and HV switch near the Cluster is in design. It is likely the existing generator (near the ED car park) will be relocated to serve the retained estate buildings.<br>• Tender for the works has been issued, slightly behind programme. | Early indication is that to complete all of the work will exceed budget. Awaiting tenders to confirm.<br><br>Must maintain programme to avoid delays to the cluster and neonates projects | Value engineer the proposed plans with the architect.<br>Explore estimated costs and market test/tender.<br><br>Monitor the programme interfaces between projects. |

### Clinical Hub and Dewi Jones Construction

| Current status | Risks/issues | Actions |
|---|---|---|
| Contract with Galliford Try remains on programme with good visible progress.<br><br>Insurers have requested a change to the roof material/system, due to the timber frame and the insulation material proposed posing a fire risk. Instruction issued to change roof insulation material has led to a £340k additional cost. Further VE of the remaining components of design underway to support the increased costs. | Ongoing design development potentially could raise issues of quality leading to increases on cost. Late change leads to delays and additional costs.<br>Increased costs and delays. | Continue with weekly meetings with Galliford Try and challenge design where necessary.<br><br>Working with insurers and our broker to mitigate additional costs and any delays. |

### Demolition Phase 4 (Final)

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

### Neonatal Development

| Current status | Risks/issues | Actions |
|---|---|---|
| Design for a PAU alongside the EDU on the ground floor is complete with just bed bay orientation under review. Tender is planned for the end of May, subject to business case approval. | Project Co engagement extending the programme and increasing costs. | Continue working with Project Co to mitigate impact. |
| Concerns about medical oxygen and medical air capacity on site have been analysed and subject to final checks appear to be adequate for the new facility removing the concerns regarding additional medical air plant and associated costs. | Planning and any unknown Section.106 or section S.278 costs | Work with LCC planners to minimise impact |
| Draft building contract and deed of Variation with Project Co needs to be agreed by mid-May. Currently no issues expected. | Potential lack of capacity for increased demand for medical oxygen (risk 2353, rating 20) and medical air (risk 2355, rating 16) | Finalise Investigation in to capacity and future supply demand of evaporator and Medical Air Plant. |
| External cladding proposals under review with the Trust's architectural adviser to agree final material/colour choice. | Planning permission fails to be achieved within the timescale of the overall programme delivery. | Maintain open communication with the LCC planning departments. |
| Three parties interested in the construction Interserve, Morgan Sindell and Galliford Try | | |

## North East Plot Development

| Current status- static | Risks/ Issues | Actions/next steps |
|---|---|---|
| **StepPlaces,** the Developer who has purchased the north east plot of land, is currently in discussion with the trust on how the development could support. Several work streams are taking place to review potential service enhancements. Business cases for each of the work streams will be brought forward over the next 4 to 6 months. | Change process with Staff will present some challenges | Maximise our offering/ support /negotiation on development content and opportunities.<br>Work through each work stream and provide a business case for each to demonstrate requirements, sustainability and affordability.<br><br>Produce robust business cases to highlight any issues/risks.<br><br>Ensure Colleagues from HR are involved in any proposed changes along with all stakeholders. |

## Communications

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

**Car Parking**

| Current status | Risks/Issues | Actions/next steps |
|---|---|---|
| The Trust has now opened the Thomas Lane car park which is being leased from Liverpool City Council. The car park provides 134 spaces and will be open from 6am-6pm Monday to Friday.<br><br>A new member of staff is being sought commence work on how we can implement a green travel plan. | Staff resistance to change.<br><br>Travel plan from Mott MacDonald does not provide realistic and evidenced solution. | Review car parking requirements in view of the home working currently in play due to COVID 19 and what the future requirements might look like.<br><br>Car parking group to continue to work with Mott MacDonald and internal group members to produce an overall green travel plan. |

## 4. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided as of 19th April 2021.

# BOARD OF DIRECTORS

**Thursday 29th April 2021**

| | |
|---|---|
| **Paper Title:** | **Going Concern Assumption – 2020/21 Financial Statements** |
| **Report of:** | For Trust board to consider the key points in relation to Alder Hey Children's NHS Foundation Trust 2020/21 annual accounts being prepared on a Going Concern basis |
| **Paper Prepared by:** | Ken Jones, Associate Director of Finance |

| | |
|---|---|
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | The Trust board are requested to consider the points noted in this paper and to confirm that they consider it appropriate for the Trust to prepare its 2020/21 financial statements on a going concern basis, and to recommend this decision to the Audit & Risk Committee for approval. |
| **Action/Decision Required:** | To recommend ■<br>To approve ☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ■<br>**Strong Foundations** ■ |
| **Resource Impact:** | Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust. |

## 1. Purpose

This paper is intended to provide the key reasons as to why the Trust Board should support and recommend to the Audit & Risk Committee that the 2020/21 annual accounts and associated financial statements should be prepared on a going concern basis and for the Board to formally minute that they consider it appropriate for the Trust to prepare its 2020/21 financial statements on this basis.

## 2. Background

The Trust is compliant with the Department of Health and Social Care (DHSC) guidelines preparing the 2020/21 financial accounts on a going concern basis. Going concern is a fundamental principle in the preparation of financial statements. Under the going concern assumption, a Trust is viewed as continuing in operation for the foreseeable future with no necessity of liquidation or ceasing trading. A key consideration of going concern is that the Trust has the cash resources to meet its obligations as they fall due for the foreseeable future. For these purposes, ‘foreseeable future’ is considered to be twelve months from the date of signing of the annual accounts.

International Accounting Standard 1 – presentation of financial statements (IAS 1) requires the Trust directors to assess and satisfy themselves that it is appropriate to prepare financial statements on a going concern basis. The 2020/21 DHSC Group Accounting Manual (GAM) sets out the interpretation of going concern in the public sector context.

Directors’ assessment of going concern

The specific factors that the Directors should consider in respect of their assessment of going concern are:

- Financial conditions
- Operating conditions
- Other conditions such as serious non-compliance with regulatory or statutory requirements

After making enquiries the directors have a reasonable expectation that the Trust will remain in operation for the foreseeable future. The Trust has a proven track record of consistently meeting the performance and control totals set by the regulator and over the last 5 years has delivered significant surpluses to support the sustainability of the Trust.

As a specialist provider of children’s services, the Trust is commissioned to provide services across the North West Region and nationally for highly specialised services and it is expected that NHS funding will flow from commissioners, at similar levels to that previously provided for all of these specialist services. There remains a firm requirement to still provide the services.

The Trust currently has a significant level of its own cash resource available demonstrating strong liquidity.

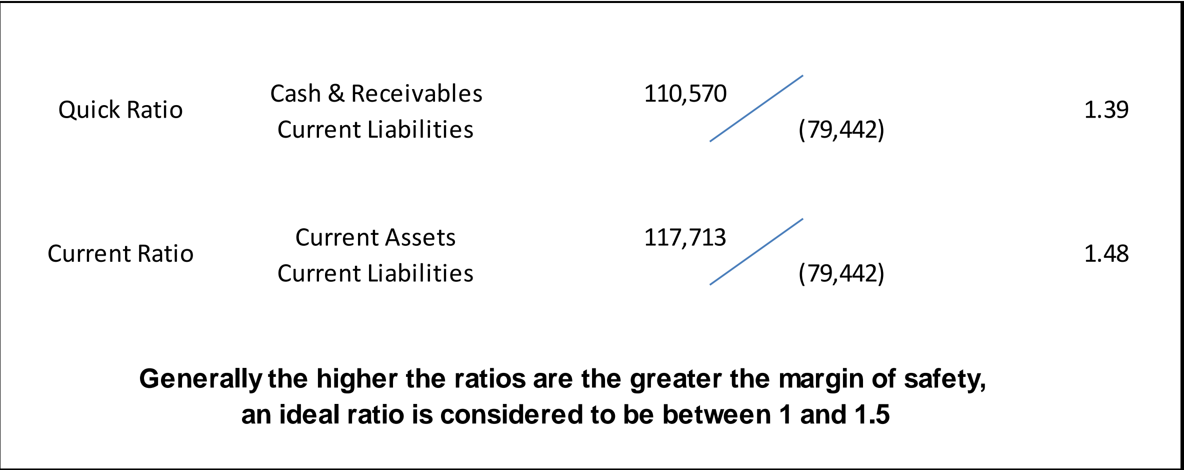
Due to the recent pandemic, early in 2020/21 a block funding agreement was put in place which remained in place for the entire financial year and expenditure in relation to COVID 19 costs were reimbursed in full by NHSI.

It has now been decided at National level that these block funding arrangements will remain in place for “at least” the first half of 2021/22 and will be transacted in this same manner. Plans are currently being compiled on both a Trust basis and at a Cheshire & Merseyside ICS level.

As such the Trust board can take assurance that it is reasonable to expect that 2021/22 funding will also continue into the second half of the financial year on a similar basis.

Prior to the pandemic, the Trust had a strong business plan in place to secure sustainability and these plans are in the process of being re-based incorporating the new funding mechanisms so as to ensure the long term sustainability of the Trust is maintained.

The Trust has calculated a number of liquidity ratios based upon is provisional closing Statement of Financial Position at 31st March 2021 and these are as follows –



| | | | | |
|---|---|---|---|---|
| Quick Ratio | Cash & Receivables / Current Liabilities | 110,570 | (79,442) | 1.39 |
| Current Ratio | Current Assets / Current Liabilities | 117,713 | (79,442) | 1.48 |

**Generally the higher the ratios are the greater the margin of safety, an ideal ratio is considered to be between 1 and 1.5**

The Trust has also completed a scenario analysis to assess operational liquidity for the next 12 months to March 2022 and consider what level of cash the Trust could close the financial year 21/22 with, expressed as a percentage of current levels and this is shown in Appendix A.

The outcome of this analysis demonstrates that in all scenarios, the level of cash available at the end of next financial year is likely to remain significant therefore all examples fully support the Directors assessment that a Going Concern basis should be adopted.

## 3. Conclusion

After making appropriate enquiries, the Directors have a reasonable expectation that Alder Hey Children’s NHS Foundation Trust will have adequate resources to continue in operational existence for the foreseeable future, being a period of at least twelve months from the date of approval of the financial statements. On this basis, the Trust has adopted the going concern basis for preparing the financial statements.

# Appendix A – Liquidity Scenario Analysis

**Going Concern Liquidity Scenario Testing for 21/22 - (H1) to 30th September 2021 & (H2) to 31st March**

| | Base Case | | Upside Case - Capital Restraint | | Downside Case - CIP not delivered | |
|---|---|---|---|---|---|---|
| | £'000 | £'000 | £'000 | £'000 | £'000 | £'000 |
| Bank & cash balance per March - As at 31/03/21 | | 92,708 | | 92,708 | | 92,708 |
| **Trust Operations H1:** | | | | | | |
| Indicative Block Income - H1 | 155,656 | | 155,656 | | 155,656 | |
| Indicative Expenditure - H1 | (159,260) | | (159,260) | | (159,260) | |
| CIP Target - H1 | 3,000 | | 3,000 | | 3,000 | |
| Capital Expenditure April - September 21 | (9,460) | | (9,460) | | -9,460 | |
| | | (10,064) | | (10,064) | | (10,064) |
| **Downsides:** | | | | | | |
| CIP Not delivered | | | | | | (3,000) |
| **Mitigations:** | | | | | | |
| Capital restraint 21/22 - uncommitted capital spend | | | | 2,269 | | |
| **Projected Cash Balance 30/9/21** | | 82,644 | | 84,913 | | 79,644 |
| **Trust Operations H2:** | | | | | | |
| ProjectedBlock Income - H2 | 155,656 | | 155,656 | | 155,656 | |
| Projected Expenditure - H2 | (159,260) | | (159,260) | | (159,260) | |
| CIP Target - H2 | 3,000 | | 3,000 | | 3,000 | |
| Capital Expenditure October 21 - March 22 | (16,849) | | (16,849) | | (16,849) | |
| | | (17,453) | | (17,453) | | (17,453) |
| **Downsides:** | | | | | | |
| CIP Not delivered | | | | | | (3,000) |
| **Mitigations:** | | | | | | |
| Capital restraint 21/22 - uncommitted capital spend | | | | 5,311 | | |
| **Projected Cash Balance 31/3/22** | | 65,191 | | 72,771 | | 59,191 |
| % of current cash balance | | 70% | | 78% | | 64% |

Publication reference: B0525

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1 April 2021

To: NHS provider and commissioner organisations Chief Financial Officers / Directors of Finance

Dear Colleague,

**Updated guidance on assessing going concern**

The purpose of this letter is to explain updates to guidance being issued to NHS finance teams this week in a form that can be shared with other stakeholders (for example non executive directors) where an organisation may wish to do.

Local auditors conduct their work with reference to auditing standards which apply to all types of entity. Auditors are required to evaluate management's adoption of the going concern basis and management's assessment of any material uncertainties over that basis that may require disclosure.

The Public Audit Forum issues guidance to auditors on how auditing standards should be applied in the public sector. Its publication 'Practice Note 10'[1] was revised in late 2020. This updated guidance to auditors, approved by the Financial Reporting Council, explains that where the applicable financial reporting framework provides that the anticipated continued provision of services is a sufficient basis for going concern, then this should determine the extent of the auditor's procedures on going concern. This is the case in the NHS, with the DHSC Group Accounting Manual (GAM) and NHS foundation trust annual reporting manual (FT ARM) both based on the HM Treasury Financial Reporting Manual (FReM) where this definition applies.

This means that, for the 2020/21 year end onwards, while management in NHS bodies will still need to document their basis for adopting the going concern basis, this assessment should solely be based on the anticipated future provision of services in the pubic sector. This means that it is highly unlikely that NHS organisations would have any material uncertainties over going concern to disclose. If you think this applies to your organisation, please contact NHS England and NHS Improvement using the relevant email address in the header to this letter. Updated

[1] https://www.public-audit-forum.org.uk with link to Practice Note 10 document at bottom of page

versions of the DHSC GAM and FT ARM issued this week provide further guidance. This will also mean that auditors' work on going concern is now equally straightforward with limited audit work necessary.

Where organisations are disclosing circumstances of a completed or planned change in organisational form (ie legal demise of an entity and continued provision of services by another entity), this disclosure should be cross-referenced in the statement on going concern.

There are separate requirements relating to financial sustainability as part of auditors' work to evaluate the entity's value for money in its use of resources. The scope of auditors' work in this area has changed from 2020/21. More detail is provided in the National Audit Office (NAO)'s audit code and associated guidance. The DHSC GAM and FT ARM explain the different focus of these two areas of work given the specific definition of going concern in operation in the public sector.

Please ensure your organisation has considered this updated guidance and notes our guidance that disclosures of material uncertainty on going concern are unlikely to be required from this forthcoming year end.

Yours sincerely

Adrian Snarr
Director of Financial Control

**BOARD OF DIRECTORS**

**Thursday, 29th April 2021**

| | |
|---|---|
| **Paper Title:** | Risk Management Strategy |
| **Report of:** | John Grinnell, Deputy Chief Executive/Director of Finance |
| **Paper Prepared by:** | Cathy Umbers, Associate Director of Nursing and Governance |

| | |
|---|---|
| **Purpose of Paper:** | Decision ■<br>Assurance ■<br>Information ☐<br>Regulation ■ |
| **Background Papers and/or supporting information:** | Trust Strategic Objectives<br>The Trust Plan<br>Risk Management Policy and Procedure<br>Risk Assessment Policy - RM4<br>Board Assurance Framework Policy (BAF) – RM 58R<br>CQC standards<br>NHSi "Oversight Framework"<br>The Management of Health and Safety at Work Regulations 1999<br>The Health and Safety at Work etc. Act 1974<br>Alder Hey Children's NHS Foundation Trust Constitution. V 11. January 2020. |
| **Action/Decision Required:** | To note ☐<br>To approve ■ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ■<br>**Strong Foundations** ■ |
| **Resource Impact:** | Support resource identification |
| **Associated risk (s)** | NA |

# Risk Management Strategy 2021-2022

**Draft**

| Document Properties | |
|---|---|
| Version: | 15 |
| Name of ratifying committee: | Trust Board of Directors |
| Date ratified: | 29/04/2021 |
| Name of originator/author: | Associate Director of Nursing and Governance |
| Name of approval committee: | Audit and Risk Committee |
| Date approved: | 22/04/2021 |
| Executive Sponsor: | Deputy CEO/Director of Finance |
| Date issued: | April 2021 |
| Review date: | April 2022 |

## 1. Version Control, Review and Amendment Logs

| Version Control Table | | | | |
|---|---|---|---|---|
| **Risk Management Strategy** | | | | |
| **Version** | **Date** | **Author** | **Status** | **Comment** |
| 15 | April 2021 | Associate Director of Nursing and Governance | Current | Rewritten |
| 14.2 | December 2019 | Associate Director of Nursing and Governance | Archived | Executive approval of edits |
| 14.1 | December 2017 | Associate Director of Nursing and Governance | Achieved | Executive approval of edits |
| 14 | January 2017 | Deputy Director of Risk & Governance | Archived | Integrated Governance Committee |
| 13.1 | January 2017 | Deputy Director of Risk & Governance | Draft | For discussion at Audit Committee |
| 13 | January 2017 | Deputy Director of Risk & Governance | Draft | For discussion at IGC / Audit Committee |
| 12 | December 2014 | Interim Governance & Risk Manager | Archived | Amended following comments at IGC, 13/11/14 |
| 11 | November 2014 | Interim Governance & Risk Manager | Archived | To Integrated Governance Committee (IGC), 13/11/14 |
| 10 | April 2014 | Clinical Risk Advisor | Archived | To Corporate Risk Committee, 12/4/14 |
| 9 | March 2013 | Clinical Risk Advisor | Archived | |
| 8 | February 2012 | Clinical Risk Advisor | Archived | To Corporate Risk Committee, 28/02/12 |
| 7 | August 2011 | Risk Manager | Archived | To Board of Directors, 6/9/11 |
| 6 | December 2010 | Risk Manager | Archived | |
| 5 | December 2009 | Head of Integrated Risk Management and Clinical Governance | Archived | |
| 4 | March 2008 | Risk Manager | Archived | |
| 3 | January 2007 | Risk Manager | Archived | |
| 2 | September 2006 | Risk Manager | Archived | |
| 1 | November 2003 | Risk Manager | Archived | |
| 0 | July 2003 | Risk Manager | Archived | |

| Record of changes made to Risk Management Strategy – Version 15 | | | |
|---|---|---|---|
| **Section Number** | **Page Number** | **Change/s made** | **Reason for change** |
| All | All | Rewritten | Out of date. |

## 2. Statement of Purpose

***The Trust Board is committed to ensuring Risk Management is an integral part of the Trust Board , Divisions, Wards, Departments, and Corporate Support Functions objectives and management systems, so that all corporate, clinical, operational and financial risks are eliminated or reduced to an acceptable level with appropriate control measures in place.***

The Trust Vision is to *build a healthier future for children and young people as one of the recognised world leaders in healthcare and research.* Implementation of the Risk Management Strategy and Policy Framework is critical to delivery of the vision, and commitment and engagement from all members of staff is required to ensure children receive high quality, safe, effective care within a culture that values honesty and openness at all levels of the organisation. The Trust Risk Management system will ensure that

- Risks that have the potential to adversely affect the quality of care, safety and wellbeing of people (patients, staff and the public) and on the business, performance and reputation of the Trust, are proactively identified and effectively managed
- Anticipate opportunities or threats and adapt a response through the Trust's explicit Risk Management process.
- Priorities are identified, expressed through objectives, understood and owned by staff and are under continuous review.
- Controls are in place which are effective in their design and application to manage risk to the level of the Trust risk appetite.
- Risk treatment is implemented effectively by risk owners and managers
- Gaps in controls are identified and treated effectively to mitigate risks.
- Risk owners and managers are held to account for the effective implementation of controls.
- Assurances are reviewed and acted on where deficits are identified in line with this framework.
- The escalation process is followed in line with this framework.
- Risk Management systems and processes are embedded at all levels of the organisation including divisions and their associated wards, departments, corporate services, education and development, business planning cycles, service development, financial planning, project and programme management.

The strategic approach reflected in this document strongly supports the requirements of the 'Well Led' Care Quality Commission (CQC) domain underpinned through the medically led devolved governance model, ensuring clear accountabilities at all levels of the organisation and effective processes to measure performance and address concerns in a timely manner.

## 3. Contents


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## 4. Introduction & Purpose

Alder Hey Children's NHS Foundation Trust is committed to a Risk Management Strategy which aims to minimise risk to all its stakeholders, through a comprehensive system of internal control. Accordingly, the Trust takes an integrated approach to Risk Management across the organisation, which incorporates all risks.

The purpose of this strategy is to detail the framework which defines the Trust's governance arrangements in terms of the way the Trust leads, directs and controls risks to its key functions, in order to support the Trust strategic objectives and comply with Health and Safety legislation, its Provider License, CQC regulations and NHS Constitution commitments, all of which are interlocked.

The Trust accepts that it carries a number of risks that have the potential to cause harm to patients, staff and the public or loss of its assets and reputation if not effectively managed and controlled. The Trust further accepts that the nature of health care services means that some risks cannot be eliminated entirely Fundamentally it is essential that the Trust has good Risk Management systems and processes in place, which eliminate risk where possible and reduce the impact of those risks that cannot be eliminated to a 'tolerable' level.

The Trust is committed to understanding the causes of risks that may impact on the organisation's achievement of its stated strategic objectives and addressing the issues to prevent risk from occurring, thereby improving the quality, safety and effectiveness of the services we provide. To achieve this, we will apply a proactive risk-based approach to all aspects of our undertakings, activities and condition of our estate. This will be achieved using the Trust's risk assessment methodology as a tool to identify potential hazards and any associated risks to ensure appropriate control measures are identified and implemented to either eliminate or mitigate risks as far as is reasonably practicable.

## 5. Scope

Everyone employed by the Trust or acting on behalf of the Trust is responsible for Risk Management in the Trust. In practice this means that everyone is responsible for making sure that risks associated with the activities and assets they are responsible for are identified, assessed for hazards and associated risk and managed accordingly.

## 6. Risk Management and Corporate Governance

Corporate Governance is the system whereby the Trust is directed and controlled at its most senior level to achieve the Trust's strategic objectives and meet its standards of accountability and probity. The Trust has adopted an integrated approach to risk management, meaning it has systems, processes and behaviours by which it leads, directs and controls its functions in order to achieve organisational objectives and the safety, quality and value for money of services as they relate to patients, carers, staff, the wider community and partner organisations.

The Trust is required to demonstrate that it is "doing its reasonable best" to manage risks. This is accomplished by ensuring that corporate governance and Risk Management are aligned and integrated.

In practice this means having systems and processes in place to identify, access, mitigate, evaluate, and assign responsibility to manage risks at all levels of the organisation, monitor and aggregate the findings at corporate level. To achieve this the Trust will carry out the following:

- ✓ Integrate Risk Management into all decision-making processes.
- ✓ Integrate Risk Management into all functions including patient safety, health and safety, incidents, complaints, claims, safeguarding, business continuity, quality improvement.
- ✓ Integrate Risk Management with service developments and clinical governance activities to improve patient safety.
- ✓ Implement a consistent approach to investigation of risks, incidents and complaints.

## 7. Trust Objectives

The Trust Board recognises that the implementation of an effective Risk Management Strategy and associated Risk Management processes is essential to the delivery of the Trust's objectives, the development of a positive learning environment and risk aware culture. The tool the Board uses to facilitate this is the Board Assurance Framework (BAF). The BAF contains those principal/strategic risks that without mitigation have the potential to fundamentally impact on the achievement of the strategic objectives. They are agreed annually by the Trust Board and are reviewed at each Board meeting. The BAF underpins the Annual Governance Statement (AGS) and is the subject of annual review by both internal and external audit.

The strategic risks are monitored by the Board's Assurance Committees and reviewed on a monthly basis by the executive team or more frequently if there are any changes in month and updated on the Ulysses Risk Management system, to provide assurance that the risks are being managed and mitigated.

The corporate risk register report details the high-level operational risks which may impact on the BAF risks and these are monitored by the Care Delivery Board and the relevant Board committees. The terms of reference for these committees are detailed at appendix 2. The Audit and Risk committee ensures that the Trust Risk Management Strategy remains effective and as such reviews and monitors the BAF, the corporate risk register and receives reports on all Trust risks.

## 8. Risk Appetite

The Trust recognises that it is not always possible to eliminate risks, nor is it always appropriate. Systems of control need to be balanced in order that innovation and use of resources are supported when applied to healthcare. Therefore, the Trust may be willing to accept a certain level of risk when the cost of mitigating the risk is high when compared to the potential severity of the risk and the likelihood of it occurring.

The Board will set the risk appetite, including tolerance annually, for the risks identified on the BAF. The annual review will be informed by an assessment of the Trust's risk maturity, which in turn enables the Board to determine the Trust's capacity to control risk.

The risk appetite statement will be communicated via governance processes to all staff and stakeholders to formalise and clarify the Trust's overall approach to risk. Additionally, all Trust risks are linked to BAF risks on the Ulysses Risk Management system, risk register module, which will enable staff to identify Trust risk appetite and tolerance for individual risks when they apply the linked BAF risk.

In practice the Trust risk appetite should address several dimensions including the nature of the risks to be assumed, the amount of risk to be taken (tolerance), on the desired balance of risk versus reward.

The Board has completed the annual assessment for the Trust Risk appetite 2021/22 and this will be available for staff to access on the Trust intranet.

The model risk appetite matrix used by the Board to support the development of the Trust risk appetite statement for NHS organisations is located at appendix 3.

## 9. Risk Management Maturity Model

The value of the Risk Maturity Model is that it provides an assessment tool for the organisation to use in order to understand its current Risk Management maturity level. The results together with key performance indicators etc. can then be used to create an improvement plan which will guide us to reach our target maturity level. The more mature the Risk Management system, the better the decision making, with better outcomes for the Trust. Full details of the model are available at appendix 4. The Trust will be undertaking a risk maturity assessment in 2021/22 and develop and implement a plan according to the findings from that assessment.

## 10. The Risk Management Process

The Trust's governance structure has systems in place to identify, assess, manage, evaluate and control risk throughout the organisation. This system provides the Trust with assurance that risks which the Trust could be exposed to are controlled and escalated at the appropriate level. The Trust Risk Management Policy and Procedure is aligned with this Strategy and is available for all staff to access on the Trust document management system.

## 11. Duties, Accountabilities and Responsibilities

### 11.1. Statutory

**Health and Social Care Act;** The Trust is legally required to register with the Care Quality Commission under the Health and Social Care Act 2008 and as a legal requirement of the Trust's registration, must protect patients, workers and others.

**Management of Health and Safety at Work Regulations (1999):** The Trust is required to undertake a suitable and sufficient assessment of risks to the health and

safety of all employees and persons not in its employ to which they are exposed to while at work and arising out of or as a result of Trust activities.

**Health and Safety at work Act 1972 (HASWA):** Section 2 of the act places a duty on the Trust to ensure as far as is reasonably practicable the health, safety and welfare of all employees and anyone who may be affected by its work activities.

### 11.2. Regulation and Assurance

**NHS England (NHSE) and NHS Improvement (NHSI)**: From 1 April 2019 both organisations joined to form one body. NHS Improvement is the sector regulator for health services in England. It authorises and regulates NHS Foundation Trusts, ensuring they are well-led (governance) and run efficiently (financial) in order that they deliver good quality services for patients. NHSI has created a risk-based system of regulation, which determines the intensity of the monitoring it undertakes. The Trust is required to demonstrate compliance with its licence and Oversight Framework.

NHS Improvement established the Oversight Framework to ensure there is clear compliance framework that all trusts can provide assurance that they are operating within their provider license. Therefore, it is essential that the Trust identifies any risks that may impact on its ability to adhere to that framework.

**The Care Quality Commission (CQC):** is the independent regulator of health and social care services in England. The Trust is required to provide robust assurance to the CQC of its compliance against the essential quality and safety standards which include the five domains of safe, effective, caring, responsive and well-led.

**Mersey Internal Audit (MIAA):** is the Trust's independent internal auditor who develop and deliver an annual internal audit programme for the Trust. This includes verifying that the Trust has suitable and effective systems of internal control in terms of Risk Management and that it is effective.

**Ernst & Young:** is the Trust's independent external auditor appointed by the Council of Governors. The external auditors provide an unbiased and independent opinion on the annual report and accounts, which includes the Annual Governance Statement.

### 11.3. Organisation

The Trust manages risk proactively through a number of individuals, specific committees, and groups working together to integrate Risk Management activity across the organisation. The roles and responsibilities of specific individuals and functions are described, including specific Trust Board Assurance Committees

A key component of an effective and mature Risk Management organisation is a culture of knowledge and understanding of Risk Management and leadership. This means that roles and responsibilities need to be clearly defined so that Risk Management is owned by appropriate members of staff and that all staff are encouraged and supported to be risk aware through the promotion of openness and support at every level of the organisation

**Individuals**

**Chief Executive Officer:** has overall accountability for Risk Management and as such has responsibility for maintaining a sound system of internal control that supports the achievement of the Trust objectives. The Chief Executive is also responsible for ensuring the Trust is administered prudently and economically and that resources are applied efficiently and effectively. The Chief Executive has delegated responsibility for risk within the management structure to the executive directors for their respective areas.

**Deputy Chief Executive/Director of Finance** is the executive lead for Risk Management and is accountable to the Board and the Chief Executive for the Trust's Risk Management activities. In addition, the Director of Finance/Deputy CEO is responsible for ensuring that the Trust carries out its business within sound financial governance arrangements that are controlled and monitored through effective audit and accounting systems.

**Medical Director:** is jointly accountable with the Chief Nurse to the Board of Directors and the Chief Executive for clinical Risk Management and Clinical Governance via governance reporting mechanisms. The Medical Director has professional responsibility for medical practice within the Trust.

**Chief Nurse:** is jointly accountable with the Medical Director to the Board of Directors and the Chief Executive for clinical Risk Management and Clinical Governance via governance reporting mechanisms. The Chief Nurse is also responsible for embedding compliance with CQC standards across the organisation. The Chief Nurse is the Trust Caldicott Guardian.

**The Chief Operating Officer**: is accountable to the Board of Directors and the Chief Executive for the management of operational risks and risks relating to facilities services.

**The Chief Digital Officer:** is accountable to the Board of Directors and the Chief Executive for the management of Digital risks.

**The Director for Human Resources and Organisational Development:**
Is responsible for the development and delivery of the Trust's People Plan and Organisational Development Strategy, staff training and management of risk relating to the Trust's workforce and associated policies and as such is accountable to the Board of Directors and the Chief Executive for risks associated with the activities therein. They are also responsible to the Trust Board and the Chief Executive for the management of risk relating to Health and Safety.

**The Director of Corporate Affairs:** is responsible for Information Governance and is the nominated Senior Information Risk Owner.

**Non-Executive Directors:** The Chairman and Non-Executive Director have responsibility for the promotion of Risk Management through their participation in the Trust Board and its Assurance Committees. They have responsibility for scrutinising systems of governance and hold executives to account for their Risk Management responsibilities.

**The Associate Director of Nursing and Governance** is the Trust operational lead for Risk Management, accountable to the Director of Finance/Deputy CEO and has line management responsibility for the Trust's corporate level Risk Management team. She is responsible for ensuring that the Trust's Risk Management systems and processes are effective and operate in accordance with best practice.

**The Divisional Directors:** and their senior teams, including the Associate Chief Operating Officers, Associate Chief Nurses and Risk and Governance Assurance leads, are responsible for ensuring that Risk Management systems within the Divisions are effective and meet the objectives outlined within the Risk Management Strategy and associated Policy and Procedure. Divisional boards and integrated governance assurance groups have a key role in assuring the effectiveness of Risk Management in all their services, including regular scrutiny and validation of divisional risk registers.

**Associate Chief Operating Officers, Associate Chief Nurses and Divisional Risk and Governance Leads:** are accountable to the Divisional Directors for leading, monitoring and reviewing, risk assessments, incidents, claims and complaints and ensure that agreed actions are carried out to completion and feedback is given to staff and provide assurance of compliance via governance and integrated risk based systems.

**The Health and Safety Manager:** is the Trust operational lead for Health and Safety, accountable to the Director of Human Resources and Organisational Development for the management of operational risk relating to Health and Safety. She is responsible for ensuring that the Trust's Health and Safety systems and processes are effective and operate in accordance with statutory requirements.

**All Staff** : have an individual responsibility for the management of risk within the Trust. Managers (clinical and non-clinical) at all levels will understand the Trust's Risk Management Strategy, associated risk procedure and associated policy documents and be aware that they have the authority and duty to manage risk effectively within their area of responsibility.

## Assurance Committees

The Trust Board Assurance Committees' terms of reference is located at Appendix 1.

**The Trust Board** along with the **Council of Governors** sets the Strategic goals and objectives for the organisation. They monitor how the Trust is performing against these objectives and make sure appropriate action is taken where necessary. The Board is structured in line with the Trusts constitution which enables it to comply with its terms of authorisation.

**Audit and Risk Committee:** is responsible for providing the Board with a means of independent and objective review of financial and corporate governance, assurance processes for Risk Management and the control environment across the whole of the Trust's activities. It will also provide the Board with assurance on the delivery of the Risk Management Strategy and the operational management of risks.

**Safety and Quality Assurance Committee**: is responsible for providing the Board with assurance that high standards of care are provided by the Trust, particularly that

robust clinical governance structures, systems and processes are in place Trust wide. They will also provide assurance that controls are in place to identify, prioritise and manage risks arising from clinical care and assurance to the Board on specific clinical risks identified on the BAF.

**People and Well Being Committee**: is responsible for overseeing the implementation and monitoring of the People Plan and organisational development.

It will provide assurance to the Board on workforce issues and specific people risks identified on the BAF. Additionally, it will provide assurance to the Board on the effectiveness of Health and Safety risk management.

**Resource and Business Development Committee**: is responsible for providing Board assurance for financial management of the Trust including key financial assumptions used in strategic and business planning and any associated risks including those identified on the BAF.

**Care Delivery Board - Risk Management:** is responsible for providing assurance to the Audit and Risk committee on the delivery of the Risk Management Strategy and operational management of risks held on the Trust and corporate services risk registers. It is responsible for escalating risks to Audit and Risk committee that are concerning, including those on the BAF, corporate risk register, or risks outside the Trust risk tolerance levels.

**Clinical Quality Steering Group:** is responsible for providing assurance to the Safety and Quality Assurance Committee for clinical quality including patient safety, clinical effectiveness and patient experience. They will also provide assurance that controls are in place to identify, prioritise and manage risks arising from clinical care in line with their work plan responsibilities.

**Information Governance Steering Group:** is responsible for providing assurance that effective arrangements are in place to manage the processing of and control risks to information and data through the Information Governance framework based on legal requirements and Department of Health guidelines.

**Divisions and Corporate Functions - Governance and Quality Assurance boards and groups:** are responsible for providing assurance for local implementation of the Risk Management Strategy and associated policy and procedure and provide formal assurance on progress to the Care Delivery Board and Board Assurance Committees demonstrating that systems and controls are in place to ensure wards and departments and services, are proactively reviewing risks and implementing appropriate mitigating actions.

## 12. Communication, Training and Awareness

The strategy will be widely shared across the organisation utilising electronic means, governance structures, and training sessions. It will form part of the Trust mandatory training sessions, and the Trust Induction package. Additional bespoke Risk Management training sessions will be provided, which all staff are invited to attend.

The Trust will work collaboratively with other local organisations and stakeholders in relation to Risk Management. This will include participating in local and regional forums

related to risk management, working closely with the relevant, Health & Safety Executive, Care Quality Commission, and NHS Improvement/England (NHSi/e) representatives, and working with other local agencies including Clinical Commissioning Groups to identify risks, learn lessons and share good practice.

## 13. Monitoring, Implementation and Review

The Deputy CEO/Director of Finance with the support of the Executive Team will oversee the implementation and monitoring of this strategy.

Monitoring will be reported to the Care Delivery Board, and the Audit and Risk committee on behalf of the Trust Board. Implementation of this Strategy is also formally monitored by the Trust's Internal Auditors (Mersey Internal Audit Agency), as well as external regulators such as CQC, NHSI and HSE.

Annual review of effectiveness of Board Assurance Committees and groups with responsibility for risk management.

Trust Board annual review of the Board Assurance framework content and process.

This strategy will be reviewed annually or earlier in response to any significant organisational changes.

## 14. References

- The Management of Health and Safety at Work Regulations 1999
- Five steps to risk assessment HSE. INDG 163
- The Health and Safety at Work etc. Act 1974
- ISO 31000: 2009 – Risk Management– Principles and Guidelines
- Alder Hey Children's NHS Foundation Trust Constitution. V 11. January 2020.
- Risk Management Policy and Procedure
- Board Assurance Framework Policy (BAF) – RM 58Risk Assessment Policy - RM4

## 15. Associated Documentation

- Step by Step guide to managing Risks on the Risk Register. February 2018
- Risk Matrix (5x5) and risk scoring guide for Risk Assessments. November 2020
- SMART actions guide. July 2019
- The Manual Handling Operations Regulations 1992
- Provision and use of Work Equipment Regulations 1992
- The Lifting Operations and Lifting Equipment Regulations (LOLER) 1998
- Workplace (Health, Safety and Welfare) Regulations 1992
- Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 1995
- Reducing Error & Influencing behaviour HSG48
- Health and Safety Policy - RM1
- Slips, Trips and Falls Policy - RM30

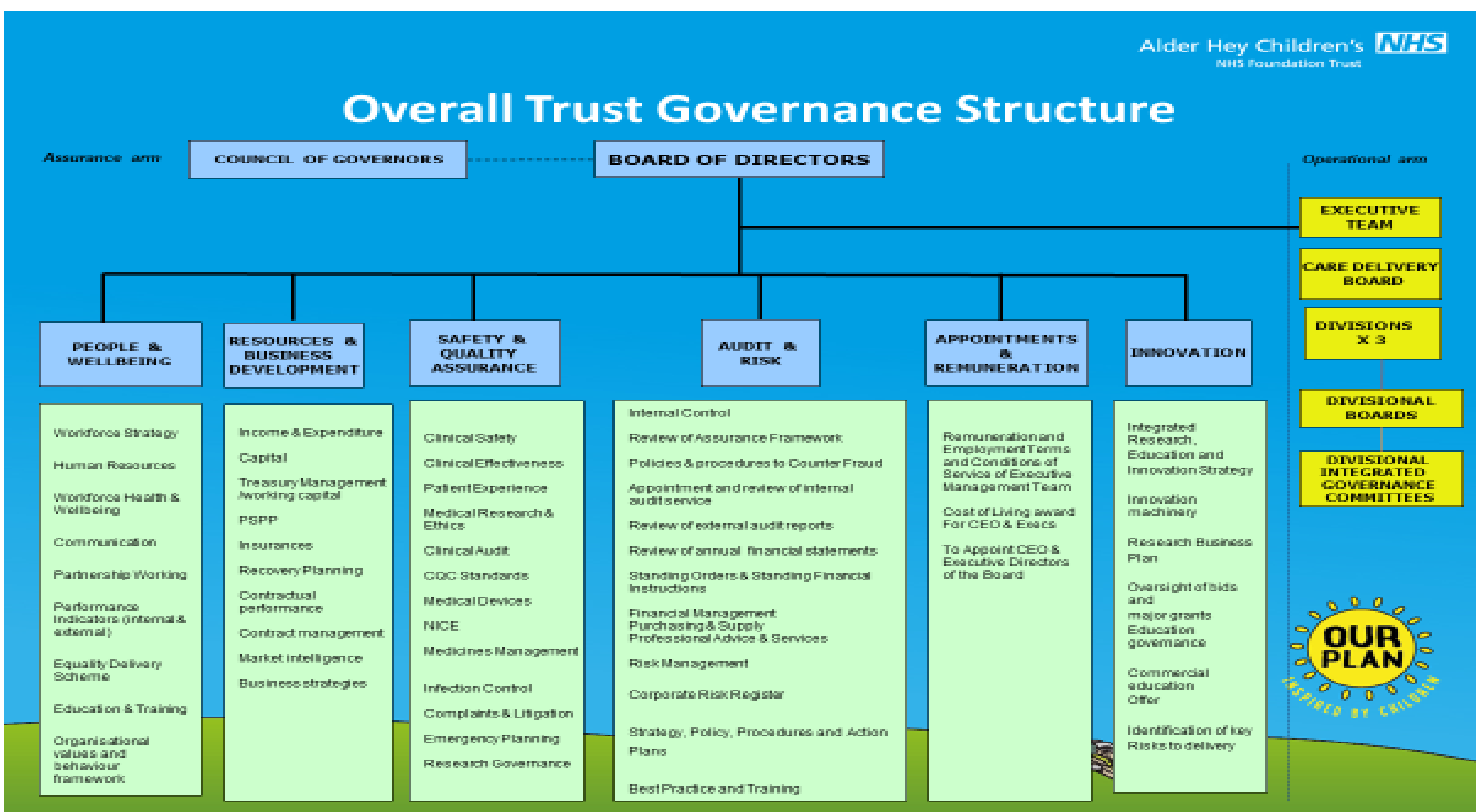
- COSHH Policy - RM13
- Fire Policy - RM11
- Manual Handling of Loads and People Policy - RM10
- Security Policy - RM48
- Incident Reporting and Management Policy Inclusive of Serious Incident Procedure RM RM2
- Complaints and Concerns Policy RM6
- Claims Policy RM7
- Safeguarding Children Policy - M3
- Business Continuity Policy – RM5
- Business Continuity Plan
- Sickness Absence and Management of Attendance Policy - E4
- Mandatory Training Policy - E21
- Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy - RM9
- Policy on the Management of External Agency Visits, Inspections and Accreditations - M43

## 16. Definitions

Refer to Trust Risk Management Policy and Procedure - Appendix 5.

## 17. Appendices

### 17.1. Appendix 1 - Trust Committee Governance Structure



## 17.2. Appendix 2; Terms of reference - Board Assurance Committees

### 17.2.1. Audit and Risk Committee (ARC)

Has been delegated authority by the Trust Board to carry out the following duties:

The Committee shall review the establishment and maintenance of an effective system of governance, Risk Management and internal control, across the whole of the organisation's activities (both clinical and non-clinical); including its subsidiaries, that supports the achievement of the organisation's objectives. In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, Risk Management and internal control, together with indicators of their effectiveness. This will be evidenced through the committee's use of an effective workplan to guide its work and that of the audit and assurance functions that report to it. As part of its approach, the Committee will have effective relationships with other key committees (for example, the Safety and Quality Assurance Committee) so that it understands processes and linkages.

**Governance**

The Committee will review the adequacy and effectiveness of:

- All risk and control related disclosure statements (the Annual Governance Statement), together with any accompanying Head of Internal Audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the Board.
- Statements within the quality account together with the external audit assurance.
- The policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and related reporting and self-certification.

**Clinical Audit**

Whilst the Committee is responsible for overseeing the effectiveness of internal control for the whole of the organisation's activities, in practice the detailed oversight of clinical activities is undertaken by the Safety and Quality Assurance Committee through the activity of Clinical Audit. The Safety and Quality Assurance Committee's

Terms of Reference includes:

- In conjunction with the Audit Committee, commission and direct a Clinical Audit Programme to provide assurance of clinical quality.
- Responsible for monitoring the assurance provided via the quarterly Clinical Audit and Effectiveness Report and the Annual Clinical Audit Forward Programme and Update.

In reviewing the work of the Safety & Quality Committee and issues around clinical risk management, the Committee will wish to satisfy itself on the assurance that can be gained from the Clinical Audit function. This will be achieved by:

- Receiving the Annual Work Programme of Clinical Audit, and at the end of the year a summary of the results from completing the work programme including the implementation status of recommendations made.
- Receiving throughout the year from the Safety & Quality Committee notification of any significant findings arising from Clinical Audit's work.

The Safety & Quality Committee will also seek the input of the Committee in commissioning the Clinical Audit Annual Work Programme and include within its' Annual Report a section on its' oversight of Clinical Audit providing assurance as to its' effectiveness.

**Counter Fraud**

The Committee shall satisfy itself that the organisation has adequate arrangements in place for countering fraud and shall review any follow-on actions required of the counter fraud work. This will be achieved by:

- Reviewing the systems, plans and actions taken to develop an anti-fraud culture.
- Reviewing the detailed Counter Fraud Plan.
- Consideration of reports produced by the counter fraud service.
- Ensuring that the counter fraud function has appropriate standing within the organisation.

**External Audit**

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the committee will receive the work and findings of the External Auditor appointed by the Governors of the Trust and consider the implications of, and management's responses to, their work. This will be achieved by:

- Consideration of the appointment and performance of the External Auditor as far as the rules governing appointment permit.
- Discussion and agreement with the External Auditor, before the audit commences, of the nature and scope of the audit as set out in the Annual Plan and ensuring co-ordination, as appropriate, with other auditors in the local health economy.
- Discussion with the External Auditors of their evaluation of audit risks and assessment of the Trust and associated impact on the audit fee.
- Reviewing all external audit reports, including agreement of the Annual Audit Letter before submission to the Trust Board and any work carried outside the annual audit plan, together with the appropriateness of management responses.
- Ensuring that there is a clear policy for the engagement of external auditors to supply non-audit services.

**Financial Reporting**

The Audit Committee shall monitor the integrity of the financial statements of the Trust and any formal announcements relating to the Trust's financial performance.

The Audit Committee shall review the Annual Report and Financial Statements before submission to the Board, focusing particularly on:

- The wording in the Annual Governance Statement and other disclosures relevant to the Terms of Reference of the Committee.
- Changes in, and compliance with, accounting policies and practices.
- Unadjusted misstatements in the financial statements.
- Significant judgements in the preparation of the financial statements.
- Significant adjustments resulting from the audit.
- Any Letter of Representation.
- Qualitative aspects of financial reporting.

The Committee should ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to review as to completeness and accuracy of the information provided to the Board.

**Other**

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation and consider the implications to the governance of the organization. These will include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/inspectors (e.g. Care Quality Commission (CQC), NHS Resolution, etc.), professional bodies with responsibility for the performance of staff or functions (e.g. Royal Colleges, accreditation bodies, etc.). in addition, the Committee will review the work of other Committees within the organisation, whose work can provide relevant assurance to the Audit and Risk Committee's own scope of work. This will particularly include the Safety & Quality Committee, Resources and Business Development Committee, Workforce and Organisational Development Committee and Innovation Committee who will provide an annual report on their work.

**Management**

The Committee shall request and review reports and positive assurances from Directors and Managers on the overall arrangements for governance, Risk Management and internal control. They may also request specific reports from individual functions within the organisation as they may be appropriate to the overall arrangements. The Committee will receive assurance on compliance with Standing Financial Instructions.

**Raising Concerns ('Whistleblowing')**

The Committee shall review the effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties and ensure that any such concerns are investigated proportionally and independently.

### 17.2.2. Safety and Quality Assurance Committee (SQAC)

Has been delegated authority by the Trust Board to carry out the following duties:

- Ensure that the key risks to safety and quality are identified and monitored by the Committee via the Board Assurance Framework and underpinned by detailed assurance reports as appropriate.
- Assess the quality and equality impact of proposed service developments or service changes, including those arising from external strategic change programmes such as reconfiguration of clinical pathways, national initiatives such as Getting it Right First Time, and Sustainability and Transformation Partnership (STP) led changes in clinical services.
- On behalf of the Board, champion and oversee the Trust's Quality Assurance Round programme, ensuring that themes and risks are captured and actioned as appropriate.
- Ensure that robust quality governance structures, processes and controls are in place that reflect national guidance and best practice
- Oversee the production of the Annual Quality Account and review the final draft prior to submission to the Board for approval
- Ratify on behalf of the Board of Directors all Trust wide policies pertaining to safety and quality.
- Ensure that all areas addressed through the Committee contribute where appropriate to the Annual Governance Statement.

- Undertake an annual self-assessment of activities of the assurance committee as contained within the terms of reference.
- Provide input to the Audit Committee on matters within its terms of reference.
- Identify resource implications of introducing quality and safety initiatives and managing high risk clinical issues and take recommendations to the Board of Directors.
- Seek assurance on matters identified by the other Board assurance committees and remitted to SQAC as appropriate.

**Safety**

- Develop the Strategy for patient safety and ensure that the Trust has the right structure and environment to deliver it.
- Agree and monitor specific high-level safety KPI's to achieve the Trust's ambition of Zero Harm.
- Champion and drive the Trust's safety culture, by gathering information effectively, analysing it appropriately and taking actions to improve patient safety, to create the environment to continuously learn, learn the lessons from others and provide assurance to the Board.
- Monitor the management of high-profile inquests, complaints, incidents and legal cases and receive completed SUI/RCA reports and case reports.
- Maintain oversight of key issues e.g. sepsis, mortality as identified through incidents, reviews and other mechanisms.
- Ensure corporate and Divisional review of all confidential enquiries, national service frameworks and other national clinical guidance and that recommendations for action are considered and implemented as appropriate within the Trust.
- Ensure that the Trust works collaboratively with relevant external statutory bodies in line with national legislation, reviews any relevant reports and implements associated guidance in a timely manner.
- Undertake a review of progress of clinically related action plans as delegated by the Board.
- Monitor strategic safety risks on behalf of the Board.

**Quality**

- Oversee the development and implementation of the next phase of the Trust's Quality Strategy
- Monitor any current CQC action plan and obtain assurance evidence that all requirements have been fully met
- Oversee compliance with CQC Standards and other statutory and mandatory requirements and evidence-based guidance that pertain to the delivery of clinical services.
- Ensure the development and implementation of clinical outcome measures for all services and receive benchmarking data with peers where available.
- In conjunction with the Audit Committee, commission and direct a clinical audit programme to provide assurance of clinical quality
- Ensure the effectiveness of the organisational arrangements for measuring and acting on feedback from our patients and families and that the methodologies used are in line with best practice nationally and internationally.
- Oversee the development of effective working relationships with organisations that represent patients in order to maximize engagement opportunities.

- Receive and review evidence and assurance from appropriate internal sub-committees and working groups.
- Monitor strategic quality risks on behalf of the Trust Board.

### 17.2.3. People and Well-being Committee

Has been delegated authority by the Trust Board to carry out the following duties:

- To oversee the development and implementation of the Trust's People Plan, to assure the Trust Board that the Strategy is implemented effectively and supports the Trust's vision and values.
- To monitor strategic workforce risks and report these to the Trust Board via the Board Assurance Framework.
- To obtain assurance that the Equality, Diversity and Inclusion plans are being effectively implemented
- To monitor compliance against strategic Health & Safety requirements, to ensure that the Trust is meeting its statutory obligations in relation to Health & Safety, and that plans are effectively implemented
- To ensure mechanisms are in place to support the development of leadership capacity and capability within the Trust, including talent management.
- To ensure robust and proactive plans are in place to support the personal and professional development of all staff.
- To monitor the overall resilience of the organisation and staff and support the development of a positive and healthy culture through appropriate measurement of engagement and wellbeing.
- To ensure the optimum design and development of the workforce to ensure that the Trust has productive, engaged staff with the right skills, competencies and information to deliver outstanding care.
- To ratify new and existing HR/Health and Safety policies and procedures, based on changes to legislation/regulations or best practice following development at other committees (Policy Review Group/JCNC/LNC) and reflect the Trust's People and OD Strategy.
- To ensure effective arrangements to support partnership working with Trade Unions.
- To ensure that all legal and regulatory requirements relating to the workforce are met.
- To gain assurance that the Trust has an appropriate pay and reward system that is linked to the delivery of the Trust's strategic objectives and desired behaviours.
- To provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that they are dealt with in line with policy and national guidance.
- To monitor education, training and learning activities to ensure it complies with required regulations i.e. Learning and Development Agreement, Education Outcomes Framework Deanery, GMC Standards, CQC, Health Education England. Receive regular reports from Education Governance Group.
- Ensure that the Trust is meeting its legal obligations in relation to equality and diversity. This will include overseeing the development of the workforce elements of the Equality Delivery Scheme (EDS), Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) action plans and ensure the effective implementation of the EDS by receiving regular reports against the action plans.
- Ensure robust and proactive plans are in place for supporting innovative approaches to diversity and inclusion, ensuring we support all staff from all backgrounds to have a positive experience working at Alder Hey.
- Obtain assurance that the organisational Values and Behaviours Framework continues to be embedded and championed across the Trust.

- Ensure that processes are in place to support the mental and physical health and wellbeing of Trust staff. Monitor and review the Trust's Occupational Health Service, receiving reports where required.
- Ensure delivery of an improved Strategy for internal communications, and monitor progress against this Strategy. To advise of any significant issues identified through internal communications.

**Performance Indicators**

To monitor progress on achieving workforce standards and targets. To ensure timely and appropriate information is provided to the Trust Board to fulfil governance and monitoring duties, including:

- Absence
- Management and Leadership Development
- PDR/appraisal
- Education, Learning and Development activity
- Occupational Health and wellbeing activity
- Equality, Diversity and Inclusion activity
- NHS staff survey/internal engagement measures

The Committee will also agree and monitor the work programmes of various sub-committees and working groups reporting to the Committee, ensuring that action plans complement each other. Where new groups are established this will mean confirming the terms of reference and action plans of the sub-groups.

#### 17.2.4. Resource and Business Development Committee

Has been delegated authority by the Trust Board to carry out the following duties:

**Finance & Performance**

- To agree annually the top 5 risks to finance and performance for inclusion in the work plan
- To receive and consider the annual financial plan for revenue and capital and make recommendation to the Board.
- To advise the Board on all proposals for major Capital expenditure over £500,000 and to approve proposals under £500,000
- The Committee will review the Trust's performance against key financial and external targets, including performance ratings (e.g. NHS Improvement metrics).
- To monitor progress against CIP targets, working with the Clinical Quality Assurance Committee to ensure any risks to service quality are addressed
- Ensure appropriate contracting arrangements are in place and review overall performance against contract.
- To review PFI compliance and performance against the agreed metrics ensuring remedial actions are taken as appropriate.
- Advise the Board on best practice and policy in relation to performance and financial management, including latest NHS Improvement guidance.
- Examine specific areas of financial risk within the Board Assurance Framework and highlight these to the Board as appropriate.
- To review Productivity and Efficiency.
- To review the Trust's procurement policies and functions and ensure they are fully aligned with the savings plan.

**Business Development**

- To review the Trust's Operational Plan and to advise the Board in respect of that plan
- To advise the Board and maintain an oversight on all major investments and business developments
- To monitor performance of the business development plans
- To scan the environment and identify strategic business risks within the Operational Plan and report to the Board on the nature of those risks and their effective management
- To oversee delivery of the marketing Strategy, including brand management, market positioning, marketing activity, market research and competitor analysis.
- To advise and provide insight to the board on changing dynamics in the market and stakeholders

**IM&T**

- To have an oversight of the 'Digital Futures' Strategy
- To advise the Board of digital developments
- To seek assurance that Digital Transformation programmes are delivered in accordance with agreed milestones to have oversight on operational IT performance

To identify key risks within the Board Assurance Framework associated with the delivery of the 'Digital Futures' Strategy and ensure these are reported to the Board.

The Committee will ensure that the minutes of its meetings are formally recorded and submitted to the Board along with a Chair's report identifying key areas for the Board's attention highlighting any issues that require disclosure or require executive action.

The Resources and Business Development Committee has no established sub-committees, but it will receive information and assurances from the following:

- Marketing and Business Development Committee
- Procurement Advisory Group
- Capital Projects Group
- Care Delivery Board

The Committee will also receive regular reports on performance metrics which will include information compiled from Divisions

The Care Delivery Board shall operate to an agreed monthly business cycle to ensure oversight of the Trust's top five priorities: Safety, Access, Staff Partnerships, Research and Innovation.

Each meeting will begin with a brief update on key operational metrics and issues; the remainder of the business will by rotation focus on:

- Access to care and finance
- Safety of patient care
- People, and Research
- Risk management

**Care Delivery Board** key duties and responsibilities include, but not be limited to the following:

**Oversee the delivery of high standards of care and performance**

- To use the performance dashboard and corporate performance report to monitor performance against safety, responsiveness, effectiveness, caring, people, use of resources and Strategy.

- To agree clear plans and actions to support improvements in performance where recovery is required

- To monitor the delivery of the annual Operational Plan as submitted to NHSI/E.
- To produce and share ideas, plans and investment cases that will support the delivery of performance standards
- To ensure that operational delivery plans are sufficiently robust and integrated to meet performance standards.

**Review investment cases**

- To have delegated authority to approve or reject investment cases with a value of £0.1-£0.5m.

- To review investments greater than £0.5m and inform Resource & Business Development Committee as to whether the Board recommends approval.

**Operational Risk Oversight**

- Processes, structures and responsibilities for identifying and managing risks at all levels of the organisation from wards and departments to Board Committees.
- The continuing evolution of Risk Management processes across the Division's and Corporate Functions.
- Ensure that key risks to innovation are identified and monitored by the Committee via the Board Assurance Framework and underpinned by detailed assurance reports as appropriate.
- Discuss risks for escalation to / de-escalation from the Corporate Risk Register
- Update on corporate risks relevant to the Division or corporate Function
- Feedback from Integrated Governance Committee (IGC), Clinical Quality Assurance Committee (CQAC), Clinical Quality Steering Group (CQSG), Weekly Meeting of Harm (Whom) and any other meetings as appropriate
- Recognition and triangulation of themes/trends from incidents, claims, complaints and PALS
- Sharing of lessons learned from investigations, root cause analyses, inspections and compliance reports
- Compliance with CQUINs, NICE guidance, CAS Alerts, and other relevant quality related mandates
- Clinical Audit and Health & Safety related issues

Division governance leads will establish cross Division working practices that will provide an opportunity for detailed discussion of local risk related matters and challenges experienced in the implementation of the Risk Management Strategy & Policy framework, including responses to specific quality and risk related issues. This will ensure learning and good practice is shared widely and can be implemented Trust wide.

## 17.3. Appendix 3

# RISK APPETITE FOR NHS ORGANISATIONS
## A MATRIX TO SUPPORT BETTER RISK SENSITIVITY IN DECISION TAKING

TO USE THE MATRIX: IDENTIFY WITH A CIRCLE THE LEVEL YOU BELIEVE YOUR ORGANISATION HAS REACHED AND THEN DRAW AN ARROW TO THE RIGHT TO THE LEVEL YOU INTEND TO REACH IN THE NEXT 12 MONTHS. 0 - 6

| Risk levels ▶ / Key elements ▼ | 0 **Avoid** Avoidance of risk and uncertainty is a Key Organisational objective | 1 **Minimal (ALARP)** (as little as reasonably possible) Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential | 2 **Cautious** Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward. | 3 **Open** Willing to consider all potential delivery options and choose while also providing an acceptable level of reward (and VfM) | 4 **Seek** Eager to be innovative and to choose options offering potentially higher business rewards (despite greater inherent risk). | 5 **Mature** Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust |
|---|---|---|---|---|---|---|
| Financial/VFM | Avoidance of financial loss is a key objective. We are only willing to accept the low cost option as VfM is the primary concern. | Only prepared to accept the possibility of very limited financial loss if essential. VfM is the primary concern. | Prepared to accept possibility of some limited financial loss. VfM still the primary concern but willing to consider other benefits or constraints. Resources generally restricted to existing commitments. | Prepared to invest for return and minimise the possibility of financial loss by managing the risks to a tolerable level. Value and benefits considered (not just cheapest price). Resources allocated in order to capitalise on opportunities. | Investing for the best possible return and accept the possibility of financial loss (with controls may in place). Resources allocated without firm guarantee of return – 'Investment capital' type approach. | Consistently focused on the best possible return for stakeholders. Resources allocated in 'social capital' with confidence that process is a return in itself. |
| Compliance/ regulatory | Play safe, avoid anything which could be challenged, even unsuccessfully. | Want to be very sure we would win any challenge. Similar situations elsewhere have not breached compliances. | Limited tolerance for sticking our neck out. Want to be reasonably sure we would win any challenge. | Challenge would be problematic but we are likely to win it and the gain will outweigh the adverse consequences. | Chances of losing any challenge are real and consequences would be significant. A win would be a great coup. | Consistently pushing back on regulatory burden. Front foot approach informs better regulation. |
| Innovation/ Quality/Outcomes | Defensive approach to objectives – aim to maintain or protect, rather than to create or innovate. Priority for tight management controls and oversight with limited devolved decision taking authority. General avoidance of systems/ technology developments. | Innovations always avoided unless essential or commonplace elsewhere. Decision making authority held by senior management. Only essential systems / technology developments to protect current operations. | Tendency to stick to the status quo, innovations in practice avoided unless really necessary. Decision making authority generally held by senior management. Systems / technology developments limited to improvements to protection of current operations. | Innovation supported, with demonstration of commensurate improvements in management control. Systems / technology developments used routinely to enable operational delivery. Responsibility for non-critical decisions may be devolved. | Innovation pursued – desire to 'break the mould' and challenge current working practices. New technologies viewed as a key enabler of operational delivery. High levels of devolved authority – management by trust rather than tight control. | Innovation the priority – consistently 'breaking the mould' and challenging current working practices. Investment in new technologies as catalyst for operational delivery. Devolved authority – management by trust rather than tight control is standard practice. |
| Reputation | No tolerance for any decisions that could lead to scrutiny of, or indeed attention to, the organisation. External interest in the organisation viewed with concern. | Tolerance for risk taking limited to those events where there is no chance of any significant repercussion for the organisation. Senior management distance themselves from chance of exposure to attention. | Tolerance for risk taking limited to those events where there is little chance of any significant repercussion for the organisation should there be a failure. Mitigations in place for any undue interest. | Appetite to take decisions with potential to expose the organisation to additional scrutiny/interest. Prospective management of organisation's reputation. | Willingness to take decisions that are likely to bring scrutiny of the organisation but where potential benefits outweigh the risks. New ideas seen as potentially enhancing reputation of organisation. | Track record and investment in communications has built confidence by public, press and politicians that organisation will take the difficult decisions for the right reasons with benefits outweighing the risks. |
| APPETITE | NONE | LOW | MODERATE | HIGH | SIGNIFICANT | |

'Good is only good until you find better' – Maturity Matrices are produced under licence from the Benchmarking Institute.

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## 17.4. Appendix 4 - Risk Management Maturity Model: Assessment Criteria

| High Level Characteristics > | 1 - Risk naïve | 2 - Risk aware | 3 - Risk defined | 4 - Risk managed | 5 - Risk enabled |
|---|---|---|---|---|---|
| | *The Trust has little or no awareness of the importance of risk management/ No formal approach developed for Risk Management as part of an integrated governance model.* | *The Trust is aware of Risk Management responsibilities and needs to embed systems/ Scattered silo-based approach to risk management.* | *The Trust has considered Risk Management and put in place strategies which are communicated.* | *Board and all staff are aware of the importance of and how the Trust handles Risk Management/ Board and staff at all levels actively consider and manage risk in all areas of activity.* | *Risk appetite defined and used to drive Board agenda. / Risk Management fully embedded into day to day workings of the Trust. / Learning lessons and providing feedback key part of approach.* |
| | **Reactive** >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> **Proactive** | | | | |
| **Specific Key Characteristics : Leadership & Management** | | | | | |
| **Appropriate Risk Management culture for an NHS Trust.** | Focus is primarily on responding to crises at an operational level with little strategic oversight. | People tend to be risk averse. Risks are identified primarily at the operational and project level with no effective escalation to senior levels. | Risk Management is done proactively to anticipate risks and develop mitigation plans. Risk implications are considered in all major decisions. | Risks are always managed effectively and at the most appropriate level. People are encouraged to be innovative. The organisation fosters a culture of continuous learning. | Risk Management is effective at every level in the Trust and is integrated with related governance issues and other disciplines across the organisation. |
| **A Risk Management Strategy and associated policies have been put in place across the Trust.** | Central risk team establishes a minimum of mandated policies, but these are not communicated to staff. | Risk Management Strategy has been put in place, but there are no Risk Management guidelines at Business Unit (BU)/ programme level and below | Divisions, Service, programmes appoint a Risk Lead who facilitates the awareness of and compliance to the Risk Management Strategy at a local level | Local Risk Leads liaise with the central risk team to ensure that staff at all levels are aware of their roles and responsibilities. Compliance to the Strategy monitored by Care Delivery Board and Audit and Risk Committee | Risk Management Strategy has been approved and owned by the Board and is underpinned by detailed systems & process, guidelines, training and awareness initiatives. |
| **Risk Management is clearly linked to business planning and performance management** | Risk Management is not linked with, or forms part of the business planning and or performance management process. | Risks relating to the planning activity of the Board are identified as part of the annual development of the BAF. No linking of risk to business planning and performance at BU level. | Risk Management is an integral part of strategic and business planning at Board, corporate, Division and local level with risks identified as the planning process unfolds. No link to performance management. | Risks associated with the management of performance are reviewed and monitored by appropriate Board Committees, e.g. RABD, S , and WAD). | Risks on the Corporate Risk register are reviewed in total by THE Care Delivery Board and disseminated to the appropriate Board Assurance Committee |

| High Level Characteristics > | 1 - Risk naïve | 2 - Risk aware | 3 - Risk defined | 4 - Risk managed | 5 - Risk enabled |
|---|---|---|---|---|---|
| | *The Trust has little or no awareness of the importance of risk management/ No formal approach developed for Risk Management as part of an integrated governance model.* | *The Trust is aware of Risk Management responsibilities and needs to embed systems/ Scattered silo-based approach to risk management.* | *The Trust has considered Risk Management and put in place strategies which are communicated.* | *Board and all staff are aware of the importance of and how the Trust handles Risk Management/ Board and staff at all levels actively consider and manage risk in all areas of activity.* | *Risk appetite defined and used to drive Board agenda. / Risk Management fully embedded into day to day workings of the Trust. / Learning lessons and providing feedback key part of approach.* |
| | **Reactive** | >>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>> | | | **Proactive** |
| **Arrangements have been established for overseeing all aspects of risk management.** | There is no evident overseeing by the Board or Executives of the management of risk within the Trust. | There is a central risk team and an operational Risk Management committee, chaired by an Executive. There are local risk meetings at Division and service level that feed into the risk committee. | Audit and Risk Committee chaired by a non-Exec with supporting committees which provides assurance to the Board on the BAF, corporate risk register and embedding risk management. | The Audit Committee receives reports from IGC and challenges the overall systems and processes relating to Risk Management and the effectiveness thereof. | Clear reporting lines and responsibility for performance related risks across the various Board Committees. |
| **An effective Board Assurance Framework (BAF) has been established.** | There is a basic BAF but there are no structured systems in place to collate the Trusts corporate risks and link those to the risks on the BAF or to those at BU/programme level. | There is a corporate risk register (CRR) derived from escalated risks from each Divisions, Service, programme but it is not linked to the risks on the BAF. | The BAF is updated quarterly by the Board but does not drive its agenda or those of its Committees. Each risk on the BAF is linked to several risks on the CRR. | The BAF is reviewed at each Board meeting following review at Care Delivery Board and Audit Committee. It is utilised by the Board to aid its decision making. | The BAF is utilised by the Board in order to provide structure to Board and Committee meetings and provide clear challenge of issues and decisions. |
| **Appropriate Risk Management training is provided at all levels of the Trust.** | No formal Risk Management training takes place. | Central risk team attend relevant external training events. Risk features as part of mandatory training cycle | Risk Management awareness is included as part of the induction process. Awareness session is backed up material available on Trust Intranet. | Risk Management training sessions are held and promoted via Risk leads in each Divisions, Service, programme. | On-going Risk Management training is provided as appropriate for all staff (including the Board). |
| **Specific Key Characteristics : Roles & Responsibilities** | | | | | |
| **Responsibility for Risk Management has been clearly defined at all levels of the Trust.** | Risk Management is seen as being the sole responsibility of the central risk team/ risk manager. | Risk Leads established in each Division but with little support in terms of resource and commitment. | Responsibility for risk has been clearly defined within each Divisions, Service, and programme and has appropriate commitment and resources to back that up. | Responsibility for Risk Management is defined within job descriptions and forms part of each Divisions, Service, programme and individual performance assessment criteria. | Board level responsibility/ sponsorship for risk has been clearly defined. There are clear lines of accountability for risk throughout the Trust. |

| High Level Characteristics > | 1 - Risk naïve | 2 - Risk aware | 3 - Risk defined | 4 - Risk managed | 5 - Risk enabled |
|---|---|---|---|---|---|
| | *The Trust has little or no awareness of the importance of risk management/ No formal approach developed for Risk Management as part of an integrated governance model.* | *The Trust is aware of Risk Management responsibilities and needs to embed systems/ Scattered silo-based approach to risk management.* | *The Trust has considered Risk Management and put in place strategies which are communicated.* | *Board and all staff are aware of the importance of and how the Trust handles Risk Management/ Board and staff at all levels actively consider and manage risk in all areas of activity.* | *Risk appetite defined and used to drive Board agenda. / Risk Management fully embedded into day to day workings of the Trust. / Learning lessons and providing feedback key part of approach.* |
| | **Reactive** | **>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>** | | | **Proactive** |
| **Employees are clear regarding their role in managing risk.** | Employees do not see themselves as being accountable for managing risk. Roles and responsibilities are not documented, and are unclear | Roles and responsibilities established in Risk Management Strategy &Policy Framework but no guidelines at what that means to staff. Senior members of staff receive some basic briefing, | Responsibilities and accountabilities for managing risk are clear, well communicated, understood and followed. | Management of risk is embedded in managers/ senior clinical/ technical staff' behaviour and their accountabilities are an integral part of their job descriptions. | Management of risk is embedded in behaviour at all levels of the organisation. Every employee sees himself / herself as a risk manager. |
| **Specific Key Characteristics : Systems & Processes** | | | | | |
| **Processes have been defined to systematically identify, record, assess and analyses risks on a continuous basis.** | There are no formal Risk Management processes in place | A system of risk registers has been established and is managed by the central risk team and progress reported to an operational risk committee but not the Board. | Each Divisions, Service, programme has its own risk register which feeds into a corporate register maintained by the central risk team with reports provided to Care Delivery Board and Audit and Risk Committee | Effective escalation and de-escalation of risks to /from wards/ departments up to each Divisions, Service, programme Care Delivery Boar, Audit and Risk Committee and Board | The whole system of Risk Management is continuously monitored and reviewed by Executives, Audit and Risk Committee and the Board in order to learn and improve. |
| **Risks are regularly reviewed by the Trust.** | There is no effective review process in place | Risks are reviewed on an ad hoc basis in specific areas by the central risk team. No challenge to/ from the Executives or the Board. | Risk system set up to enable managers have access to or request updates on risks relating to their areas of responsibility. | Each Division, Service, programme has its own Risk/ Quality/ Governance meeting where risks are reported to and reviewed on a regular basis with exception reports going to Audit and Risk Committee Meetings should challenge progress and lessons learned as appropriate. | There is a thorough process of review embedded in the organisation. Trust Board and its assurance committees receive reports on specific risks and associated actions from Car Delivery Board and Audit and Risk Committee. Lessons learned features on every Board agenda. |

| High Level Characteristics > | 1 - Risk naïve | 2 - Risk aware | 3 - Risk defined | 4 - Risk managed | 5 - Risk enabled |
|---|---|---|---|---|---|
| | *The Trust has little or no awareness of the importance of risk management/ No formal approach developed for Risk Management as part of an integrated governance model.* | *The Trust is aware of Risk Management responsibilities and needs to embed systems/ Scattered silo-based approach to risk management.* | *The Trust has considered Risk Management and put in place strategies which are communicated.* | *Board and all staff are aware of the importance of and how the Trust handles Risk Management/ Board and staff at all levels actively consider and manage risk in all areas of activity.* | *Risk appetite defined and used to drive Board agenda. / Risk Management fully embedded into day to day workings of the Trust. / Learning lessons and providing feedback key part of approach.* |
| | **Reactive** | **>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>** | | | **Proactive** |
| **Effective aggregated analysis of risks** | Risks, incidents, claims, complaints and PALS; reported separately without any triangulation across and between them. | Risks and incidents linked via RM system. Some annual aggregated analysis at corporate level but not within each Divisions, Service, programme. | Complaints and PALS link into risks and incidents via RM system/ inter team liaison. | Quarterly aggregate analysis at Divisions of risks, incidents, claims, complaint, PALS and associated lessons learned, presented at Divisions Risk/ Quality/ Governance meetings with reports to Board. | Aggregate analysis of risks, incidents, claims, complaints, PALS and associated lessons learned reported to Board. |
| **Management report risks to Executives where responses have not managed the risks to a level acceptable to the Board.** | No apparent/ regular reporting or review of high-level risks | High level risks reported to operational risk committee on basis of highest scores, but the Board not generally aware of those risks. | Unclear and informal escalation process from Ward to Board means that confusing/ incomplete information may reach the Board. | Streamlined process for reporting and escalation of risks from Ward/ department/ project to each Divisions, and then to Care Delivery Board, Audit and Risk Committee and Board. | Board members are continually updated on current state of corporate risks, BAF including any urgent ones being escalated, any requiring urgent action and any emerging risks which may cause significant problems. |
| **All significant new projects are routinely assessed for risk.** | Project teams do not consider risks to the project or the wider implications to the Trust. | Risks are assessed from project point of view but not for the wider impact on the Trust. No appreciation of project risks by Executives or Board. | Project teams assess risks from project and operational perspectives, reporting on progress to appropriate Project/ Programme Board but not into mainstream risk reporting cycle. | Effective escalation of risks from projects and work streams with Programme Board escalating their top programme risks to Integrated Governance Committee with most strategic ones being considered for the BAF. | Project risk assessments consider opportunities as well as conventional risks.<br>Board Committees receive update on progress on the major programmes and challenge on their risks as appropriate. |
| | | | | | |

| Specific Key Characteristics : Monitoring and Feedback | | | | | |
|---|---|---|---|---|---|
| **Measurement and monitoring** | No measurement framework is in place to assess Risk Management practices. | Number of internal and external reviews provide a range of opinions but no one overall framework to evaluate progress | Risk Management Improvement Plan (RMIP) developed, updated and progress reported via Integrated Governance Committee with assurance report to Audit Committee. | RM Maturity Model developed to provide cross Trust measurement and monitoring of the effectiveness of the embedding of Risk Management in each Divisions, Service, and programme. Key Performance Indicators established for each Division/ programme on risk and governance matters. | Performance against indicators is measured and results are tracked over time. Action plans are developed to improve performance and action is taken as required. Performance indicators and benchmarks are refined and updated. |
| **Managers provide assurance on the effectiveness of their risk management.** | No but typically not asked for either. | Risk Manager reports to operational Risk Management committee on activity within the year. | Central risk team and Risk Leads take forward actions from the RMIP and provide feedback to Integrated Governance Committee with assurance reports to Board and Audit Committee. | Risk Leads report to their Divisions, Service, programme /Governance meeting on the effectiveness of the Risk Management processes within their Division, Service, programme | For all risks there is a clear reporting structure for responsible officers to assure Board via governance structures that risks are being managed as agreed. |
| **Assurances are received regarding the effectiveness of the Trusts Risk Management system.** | No effective assurance processes in place, nor are any sought from Executives or the Board. | Internal assurances on Risk Management process are received via the central risk team and operational Risk Management committee. | The Trust receives regular assurance both internally and externally regarding the effectiveness of its Risk Management system. | Action plans and feedback from internal and external reviews are formally documented and progress monitored. | The Trust has clear mechanisms in place to proactively seek assurance in respect of risk management. Assurances are identified, monitor and reviewed with feedback used to further enhance the arrangements in place. The Board would typically be challenging Executives as appropriate on all matters risk. |

## 17.5. Appendix 5 – Equality Analysis

| 2. Equality Analysis (EA) for Policies | | |
|---|---|---|
| The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions:<br>a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010.<br>b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it<br>c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.<br>Please refer to guidance when completing this form | | |
| **Policy Name** | Risk Management Strategy | |
| **Policy Overview** | This document sets out the Trusts strategic direction for Risk Management and the systems of internal control to achieve compliance | |
| **Relevant Changes** (if any) | Document rewritten | |
| **Equality Relevance** Select LOW, MEDIUM or HIGH | LOW | |
| If the policy is LOW relevance, you **MUST** state the reasons here. | The Strategy applies to all members of staff working in Alder Hey Children's NHS Foundation Trust including permanent, temporary, locums, voluntary, work experience and bank staff, including contractors and partners involved in Trust's business Having considered the equality implications of this Strategy, they are of low relevance. | |
| **Form completed on:** | Date: 14/04/2021 | |
| **Form completed by:** | Name: Cathy Umbers | Job Title: Associate Director of Nursing and Governance |

| Approval & Ratification of Equality Analysis | | |
|---|---|---|
| **Policy Author:** | Name: Cathy Umbers | Job title: Associate Director of Nursing and Governance |
| **Approval Committee:** | Audit and Risk Committee | Date approved: 22/04/2021 |
| **Ratification Committee:** | The Trust Board | Date ratified: 29/04/2021 |
| **Person to Review Equality Analysis:** | Name: Cathy Umbers | Review Date: 29/04/2024 |
| Comments: | Click here to enter text. | |

# RM5 - RISK MANAGEMENT POLICY & PROCEDURE

DRAFT

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## 1. Version Control, Review and Amendment Logs

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## 3. Quick Reference Guide

### Risk Management at a Glance

#### 1. WHAT IS RISK MANAGEMENT

Risk management is the process by which risks are identified, assessed, recorded, mitigated, monitored & reviewed, and communicated. A risk is the threat that an event or action will adversely affect the ability to achieve our objectives

#### 2. WHY IS IT SO IMPORTANT?

Failure to effectively identify and address issues at an early stage can lead to unnecessary adverse events affecting patient safety, staff welfare or the Trust's performance. Good risk management is a preventative measure to stop bad things from happening.

#### 3. WHO IS RESPONSIBLE FOR IT?

**Everyone** It is essential that we all remain alert to issues which may have a negative impact on patients, staff or the Trust. We must also take personal responsibility for reporting such issues and acting upon them.

#### 4. HOW DO I IDENTIFY & MANAGE RISKS?

##### IDENTIFY

**How should I identify risks?**
Risk assessments can be done through a specific ***planned*** process at corporate, division or ward/department level. It is, however, essential for us all to be alerted to risks on an ***ongoing*** basis to ensure that we respond promptly to any emerging issues.

**What types of risk should I identify?**

- Risks to providing ***patients*** with safe, effective and personal care.
- Risks to providing ***staff*** with a safe and rewarding work environment.
- Risks to **the Trust** achieving its broader operational and financial objectives.

**What specific issues should I consider that could lead to risk?**

- Have you ***observed*** ay practice or behaviour which creates a risk for patients, staff or the Trust?
- Do you have ***information*** which indicates that there may be a risk for patients, staff or the trust?
- Are you aware of any ***incidents*** where appropriate action has not been taken to prevent a recurrence?
- Have you received any ***feedback*** or **complaints** from patients or staff which have not been adequately addressed?

##### ASSESS/RECORD

All risks that cannot be addressed immediately should be recorded on Ulysses. Having identified a risk, the impact and the likelihood of the potential event needs to be assessed having regard to the descriptors set out in the table below.

| Likelihood | IMPACT | | | | |
|---|---|---|---|---|---|
| | **Insignificant**<br>__Patients__<br>Minimal impact on patients.<br>__Staff__<br>Minimal impact on staff.<br>__Trust__<br>Day to day operational challenges. | **Minor**<br>__Patients__<br>Minor injury or harm to patients requiring minimal intervention.<br>__Staff__<br>Temporary staffing issues resulting in increasing pressures on staff and challenges in maintaining service quality.<br>__Trust__<br>Temporary restrictions to service delivery with limited impact on stakeholder confidence. | **Moderate**<br>__Patients__<br>Moderate injury or harm to patient(s) requiring clinical intervention.<br>__Staff__<br>Short term staffing issues resulting in low staff morale or restrictions to service quality.<br>__Trust__<br>Short term failure to deliver key objectives with temporary term adverse local publicity. | **Severe**<br>__Patients__<br>Serious or permanent harm to patient(s).<br>__Staff__<br>Medium term staffing issues resulting in very low morale or significant reduction in service quality.<br>__Trust__<br>Medium term failure to deliver key objectives with ongoing adverse publicity or negative impact on stakeholder confidence. | **Catastrophic**<br>__Patients__<br>Avoidable death of patient(s).<br>__Staff__<br>Long term staffing issues resulting in poor morale, staff welfare issues or fundamental reduction in service quality.<br>__Trust__<br>Continued failure to deliver key objectives with long term adverse publicity or fundamental loss of stakeholder confidence. |
| **Almost Never**<br>This potentially will never happen/occur | 1 | 2 | 3 | 4 | 5 |
| **Unlikely**<br>Do not expect it to happen/occur, but it may do so | 2 | 4 | 6 | 8 | 10 |
| **Likely**<br>Might happen/occur occasionally | 3 | 6 | 9 | 12 | 15 |
| **Highly Likely**<br>Will probably happen/occur | 4 | 8 | 12 | 16 | 20 |
| **Almost Certain**<br>Very likely to happen/occur possibly frequently | 5 | 10 | 15 | 20 | 25 |

##### MITIGATE/ESCALATE/COMMUNICATE

**When is action required?**
An action plan is required to mitigate all risks that cannot be resolved immediately. The actions must be recorded on Ulysses and must be SMART

**How do I escalate high risks?**
Escalation will be based on the grade of the risk as illustrated in the diagram below.

- Board Assurance Framework
- Corporate Risk Register (CRR)
- Division /corporate Services Risk Register
- Ward/department Risk Register

It is important to note that the escalation of a risk does not negate the responsibility of the identified risk manager for specific risks or governance group to pursue and follow-up identified risks.

**How are risks reviewed and followed up?**
Divisions, corporate functions, wards/departments are responsible for reviewing their risks on a regular basis. Risks will also be reviewed via the Trust governance systems including board sub-committee's The Trust executive team will review serious risks as part of its regular performance review.

## 4. Introduction & Purpose

This risk management policy and procedure is aligned to the Risk Management Strategy with the aim to minimise risk to all stakeholders through a comprehensive system of internal control. The policy and procedure provides practical guidance on process and procedure for risk management within the Trust.

Alder Hey Children's Hospital NHS Foundation Trust is committed to creating a culture of good risk management through simple processes that will identify, analyse, evaluate, control and monitor risks, with the overall aim of delivering safe, high quality effective care and create a safe environment for patient's staff and the public.

Risk management is about continually asking and answering the following questions
**Context** – What is the objective or goal we wish to achieve?
**Identify** - What is the risk(s) associated with that objective or goal?
**Analyse** – What would be the impact if the risk occurred and what would be the likelihood of the risk occurring at that impact?
**Evaluate** – What is the capacity, appetite and tolerance of the Trust for the identified risk(s)?
**Treat** – How should we respond to the risk?
**Escalate** – What is our escalation process (ward to board)?
**Monitor** – How do we assure ourselves we are managing our risks effectively?
**Communicate** – Are we communicating our risks via the right channels?

## 5. Scope

This Policy & Procedure applies to all Trust employees and staff working on behalf of the Trust. This included permanent, temporary, locums, voluntary, work experience and bank staff, contractors and partners involved in Trust's business

## 6. Duties and Responsibilities

### Risk Owner

Risks will be assigned to a named individual, who is responsible for ensuring the risk is managed, including ensuring controls and actions are in place to mitigate the risks and reporting on the risk. High/extreme risks will be owned by executive directors. Any changes of risk ownership will be discussed and agreed with the new proposed risk owner

### Risk Manager

The risk manager is assigned to manage a risk by the risk owner, following discussion and agreement. The risk manager is responsible for completing the risk assessment, with relevant expert support. They report to the risk owner and are responsible for ensuring the risk is identified on the register, reviewed and updated in a timely way, ensuring actions are progressing and inform the risk owner of any change in status of

the risk. Changes to risk manager during the lifetime of the risk will be discussed and agreed with the new proposed risk manager.

**Risk Action Owner;**
Risk action owners are chosen for their expertise in the subject matter and are responsible and have the authority to address deficits. All risks have action owners with whom the risk manager has agreed the action specifics (SMART), including target completion dates. The action owner thus has delegated responsibility for ensuring the delivery of a task or activity that will help to mitigate the risk and provide regular reporting on progress, including documenting this clearly on the risk register and attaching relevant reports, meeting minutes etc, to support progress reporting.

**Note:** Refer to Risk Management Strategy for duties and responsibilities of individual staff and committees/groups.

## 7. The Risk Management Process

### 7.1. Establishing the Context

We need to have a clear understanding of the Trusts strategic and operational objectives, the external environment, the internal environment and the organisations approach to risk management. The external context will include, but is not limited to social and cultural, political, economic, the competitive environment, whether local, regional, national and/or international. Also consider key drivers and trends impacting on the strategic objectives and relationships, perceptions and values of external stakeholders.

### 7.2. Risk Identification

Risk assessments can be taken through a specific planned process at corporate, division, ward/department level, for example Health and Safety. However, it is essential for us all to be alerted to risks on an ongoing basis, to ensure that we respond promptly to any emerging issues. The risk identification wheel at Appendix 1 will support the identification of different sources through which risk can arise in the organisation.

The types of risks that should be identified are:
Risks to providing patients services which do not meet national and local quality standards, as identified by the Care Quality Commission (CQC) in the five domains of safe, effective, caring, responsive to people’s needs and well-led.

- Risks to providing patients with a safe environment
- Risks to providing staff with a safe working environment
- Risks to the Trust achieving its broader operational and financial objectives and managing the Trust reputation.

Should there be a situation/issue where immediate action to mitigate the risk is required and the action has been taken, this does not need to be recorded on the risk register. However, all risks that cannot be addressed immediately will be recorded on the risk register on Ulysses (electronic risk management system).

### 7.3. Risk Assessment

It is essential all risks are assessed in an objective and consistent manner, if they are to be managed effectively and to guide operational, project and programme planning and resource allocation.

Risks are first assessed on what would happen (impact/consequence) should the risk occur and the probability (likelihood of the risk happening). When assessing what the impact/consequences of the risk could be if it happened, consider what the impact would be in most circumstances within your environment and what is reasonably foreseeable.

When assessing how likely a risk is to occur, take into account the current environment. Consider the adequacy of the controls already in place within the environment, which could address the causes of the risk and therefore the likelihood of the risk being realised, for example systems, processes, policies, current practice training etc.

Not all risks can be dealt with in the same way. The 5 'T''s' provide the options available when considering how to manage risk:

- **Tolerate:** the consequences and likelihood of the risk is accepted
- **Treat:** actions are carried out to reduce the consequences or likelihood of the risk (this is the most common action)
- **Transfer:** shifting the responsibility or burden for loss to another party e.g. the risk is insured against or subcontracted to another party.
- **Terminate:** an informed decision not to become involved in a risk situation e.g. terminate the activity.
- **Take the opportunity:** actively taking the advantage, regarding the uncertainty as an opportunity to add benefit.

The assessment is completed by scoring the impact multiplied by the likelihood. In addition, to the matrix in the quick reference guide at the beginning of this document, an additional more detailed 5x 5 matrix is available at Appendix 2. The risk score will inform the risk owner at what level of the organisation and to whom the risk needs to be escalated.

Refer to the Trust Risk Assessment Policy for further guidance on the risk assessment process including the 5 steps to follow in the risk assessment process.

### 7.4. Risk Registers

Wards/department, divisions and corporate service risk registers (repository of risks) are 'live' records that support safety and sound risk management. They contain all unresolved risks identified to services (both clinical and non-clinical) Also as a minimum when reporting a risk onto Ulysses the risk will contain:

- Date risk first identified
- Date of last review
- Trust objective
- CQC domain

- Risk cause
- Risk description
- Risk impact/consequences
- Current controls in place
- Current gaps
- Actions to address gaps
- Initial risk rating
- Current risk rating
- Target risk rating
- Expected review date
- Risk manager
- Risk owner
- Assurance

The risk needs to be described clearly to ensure there is a common understanding by stakeholders of the risk. The recommended format for risk descriptions is to identify the cause, the event and the effect. The Bow Tie tool identified at Appendix 3 can be used to describe the risk and structure statements. When wording the risk, it is helpful to think about it in three parts. There is a risk (event) that …… this is caused by ……… and would lead to an impact/consequence on …….

### 7.5. Risk Analysis (Scoring)

Having identified a risk, the impact of the potential event and the likelihood of the event occurring will be assessed having regard to the impact descriptors in the risk matrix, Appendix 2.

The impact score will be dependent on what the impact (what could happen should the risk occur) would be in most circumstances within the current environment and what is reasonably foreseeable, rather than defaulting to the 'worst case scenario'.

The likelihood scoring is dependent on firstly the inherent risk without any controls in place. The current likelihood scoring is dependent on adequacy of existing controls, for example systems, policies, training, and current practice.

Having assessed the impact and likelihood Ulysses will calculate the risk grading. All risks reported to Ulysses will have three scores as set out below

| | |
|---|---|
| Inherent (gross) risk score | Is the level of risk score when the risk is first identified and reported before the effect of the mitigation |
| Current risk score | Is the score at the time of the last review taking into consideration the controls in place?<br><br>The minimum review timescale for risks on the register is monthly or more frequently if there is any change in the risk status, for example if mitigating actions completed and identified as controls that will mitigate the risk, or the environment has changed resulting in an increase in the risk score requiring further action to mitigate. |

| Target (mitigated) risk score | Is the estimated exposure arising from a specific risk after implementing the proposed controls and actions contained in the action plan |
|---|---|

### 7.6. Escalation Process

The Board Assurance Framework (BAF) is submitted to the Trust board at each Board meeting and is monitored through Board Assurance Committees

Any risk scoring 15 or above is escalated to the corporate risk register and with agreement of relevant executives would recommend risks being added to the BAF.

The Trust executive team will review serious risks as part of their regular performance review.

Any risks 15 or above (corporate or divisional) added to the corporate risk register and any risks that cannot be managed locally (above tolerance) at division or corporate function level will be escalated to the Care Delivery Board.

Risks scoring 8 and above that cannot be managed at ward/department level will be escalated to the divisional or corporate function governance assurance group.

It is important to note that the escalation of a risk does not negate the responsibility of the individual risk manager for that risk, or the ward/department, division or corporate function to pursue or follow up identified risks including associated actions, where they have identified responsibility on Ulysses.

Refer to the Trust Risk Assessment Policy for further guidance on authority to manage risk and the escalation process.

### 7.7. Action Planning

Following completion of the risk assessment, consideration will be given to whether the risk requires further management action that will minimise the impact and likelihood of the threat. A risk should be scored on Ulysses for each risk that cannot be resolved immediately, to either eliminate, minimise or accept the risk.

The focus of the actions is to address the gaps in controls identified during the assessment process. The actions will be recorded on Ulysses together with the risk grading following completion of the action plan. It is expected that actions will be Specific, Measurable, Realistic Achievable Time bound, (S.M.A.R.T), to enable stakeholders have confidence that the goal will be reached. When the actions are completed, they then become controls that will mitigate the risk.

The risk manager with the agreement of the risk owner will assign risk action owner(s) who understand the required action and is capable of delivering the required outcome. The risk manager and risk action owner(s) will agree the detail of the mitigating action and the expected completion date(s). The risk action owner will update on progress via the risk register and the risk manager will:

- Review the progress of all mitigating actions
- Ensure completed actions are recorded as an existing control
- Record the review by entering the review date and amend current risk grading appropriately.

It is not always possible to identify and then fully implement actions that eliminate or minimise risk. Where this is the case, it is essential the significance of the remaining risk is understood, and the Trust confirms it is prepared to accept that level of residual risk. Acceptance of risk level is determined by the Trust risk appetite and tolerance.

Risk action plans are an important performance measure and are incorporated into performance management via the Trust executive team

### 7.8. Monitoring and Closure

Risks registers should be a standing item at ward/department, division, corporate function and Trust governance committee agenda. This ensures that risks are consistently identified, monitored and re-evaluated throughout the year. Once all possible actions have been completed and the risk is at the identified target or eliminated the risk on Ulysses will be closed.

## 8. Management of Trust Wide Risks

Trust wide risk is an integral part of the system of internal control and defines risks that cross a number of divisions and/or corporate functions and which may impact on the Trusts ability to deliver its objectives. Ownership and management of Trust wide risks sits with the person who has primary organisational responsibility for the risk domain, this could either be at corporate function level or division level. Risks may be owned and managed in a division or corporate function but can have actions assigned to a number of staff in other divisions or corporate functions. It is important that when risk actions are assigned to action owners this is discussed and agreed with them before adding to the risk register.

## 9. Monitoring, Implementation and Review

The Associate Director of Nursing and Governance will oversee the implementation and monitoring of this policy.

Monitoring will be reported to the Care Delivery Board, and the Audit and Risk committee on behalf of the Trust Board.

This policy will be reviewed every three years or in response to any significant organisational changes.

## 10. Communication

This Policy & Procedure will be communicated to staff via the following means

- Dissemination and sharing via representatives at approving group
- Divisional notification via relevant Divisional Board/Quality Board and corporate function governance processes.

- Email via communications to all staff
- Available on the Trust document management system

## 11. References

- Risk Management Strategy
- Risk Assessment Policy - RM4

## 12. Associated Documents

The Management of Health and Safety at Work Regulations 1999
- Five steps to risk assessment HSE. INDG 163
- The Health and Safety at Work etc. Act 1974
- ISO 31000: 2009 – Risk Management – Principles and Guidelines
- Alder Hey Children's NHS Foundation Trust Constitution. V 11. January 2020.
- The Management of Health and Safety at Work Regulations 1999
- Five steps to risk assessment HSE. INDG 163
- The Health and Safety at Work etc. Act 1974
- ISO 31000: 2009 – Risk Management – Principles and Guidelines
- Alder Hey Children's NHS Foundation Trust Constitution. V 11. January 2020.
- Step by Step guide to managing Risks on the Risk Register. February 2018
- Risk Matrix (5x5) and risk scoring guide for Risk Assessments Guide. November 2020
- SMART actions guide. July 2019
- Incident Management Policy inclusive of Serious Incident Management Procedure and AAR procedure. January 2020
- The Manual Handling Operations Regulations 1992
- Provision and use of Work Equipment Regulations 1992
- The Lifting Operations and Lifting Equipment Regulations (LOLER) 1998
- Workplace (Health, Safety and Welfare) Regulations 1992
- Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 1995
- Reducing Error & Influencing behaviour HSG48
- Health and Safety Policy - RM1
- Slips, Trips and Falls Policy - RM30
- COSHH Policy - RM13
- Fire Policy - RM11
- Manual Handling of Loads and People Policy - RM10
- Security Policy - RM48
- Incident Reporting and Management Policy Inclusive of Serious Incident Policy RM RM2
- Complaints and Concerns Policy RM6
- Claims Policy RM7
- Safeguarding Children Policy - M3
- Business Continuity Policy – RM5
- Business Continuity Plan
- Sickness Absence and Management of Attendance Policy - E4

- Mandatory Training Policy - E21
- Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy - RM9
- Policy on the Management of External Agency Visits, Inspections and Accreditations - M43

## 13. Appendices

### 13.1. Appendix 1 – Risk Identification Wheel

## 13.2. Appendix 2 - Risk Matrix

The risk matrix used by Alder Hey Children's Hospital NHS Foundation Trust is based on the Australian / New Zealand standard (AS/4360:1999 – Risk Management), which is the system recommended for the NHS to use by the Department of Health.

### Consequence Score

The consequence (impact) scores are derived by choosing the most appropriate domain for the identified risk from the left hand side of the table by working along the columns in same row to assess the severity of the risk on the scale of 1 to 5, to determine the consequence score, which is the number given at the top of the column.

| | **Consequence score (severity levels) and examples of descriptors (this is not exhaustive)** | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Impact on the safety of patients, staff or public (physical/ psychological harm)** | Minimal injury requiring no/minimal intervention or treatment.<br><br>No time off work | Minor injury or illness, requiring minor intervention<br><br>Requiring time off work for >3 days<br><br>Increase in length of hospital stay by 1-3 days | Moderate injury requiring professional intervention<br><br>Requiring time off work for 4-14 days<br><br>Increase in length of hospital stay by 4-15 days<br><br>RIDDOR/agency reportable incident<br><br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability<br><br>Requiring time off work for >14 days<br><br>Increase in length of hospital stay by >15 days<br><br>Mismanagement of patient care with long-term effects | Incident leading to death<br><br>Multiple permanent injuries or irreversible health effects<br><br>An event which impacts on many patients |
| **Quality/ complaints/ audit** | Peripheral element of treatment or service suboptimal<br><br>Informal complaint/inquiry | Overall treatment or service suboptimal<br><br>Formal complaint (stage 1)<br><br>Local resolution<br><br>Single failure to meet internal standards<br><br>Minor implications for patient safety if unresolved<br><br>Reduced performance rating if unresolved | Treatment or service has significantly reduced effectiveness<br><br>Formal complaint (stage 2) complaint<br><br>Local resolution (with potential to go to independent review)<br><br>Repeated failure to meet internal standards<br><br>Major patient safety implications if findings are not acted on | Non-compliance with national standards with significant risk to patients if unresolved<br><br>Multiple complaints/ independent review<br><br>Low performance rating<br><br>Critical report | Totally unacceptable level or quality of treatment/service<br><br>Gross failure of patient safety if findings not acted on<br><br>Inquest/ombudsman an inquiry<br><br>Gross failure to meet national standards |

| **Human resources/ organizational development/ staffing/ competence** | Short-term low staffing level that temporarily reduces service quality (< 1 day) | Low staffing level that reduces the service quality | Late delivery of key objective/ service due to lack of staff<br><br>Unsafe staffing level or competence (>1 day)<br><br>Low staff morale<br><br>Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/service due to lack of staff<br><br>Unsafe staffing level or competence (>5 days)<br><br>Loss of key staff<br><br>Very low staff morale<br><br>No staff attending mandatory/ key training | Non-delivery of key objective/service due to lack of staff<br><br>Ongoing unsafe staffing levels or competence<br><br>Loss of several key staff<br><br>No staff attending mandatory training /key training on an ongoing basis |
|---|---|---|---|---|---|
| **Statutory duty/ inspections** | No or minimal impact or breech of guidance/ statutory duty | Breech of statutory legislation<br><br>Reduced performance rating if unresolved | Single breech in statutory duty<br><br>Challenging external recommendations/ improvement notice | Enforcement action<br><br>Multiple breeches in statutory duty<br><br>Improvement notices<br><br>Low performance rating<br><br>Critical report | Multiple breeches in statutory duty<br><br>Prosecution<br><br>Complete systems change required<br><br>Zero performance rating<br><br>Severely critical report |
| **Adverse publicity/ reputation** | Rumours<br><br>Potential for public concern | Local media coverage – short-term reduction in public confidence<br><br>Elements of public expectation not being met | Local media coverage – long-term reduction in public confidence | National media coverage with <3 days service well below reasonable public expectation | National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House)<br><br>Total loss of public confidence |
| **Business objectives/ projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget<br><br>Schedule slippage | 5–10 per cent over project budget<br><br>Schedule slippage | Non-compliance with national 10–25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met | Incident leading >25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met |
| **Finance including claims** | Small loss Risk of claim remote | Loss of 0.1–0.25 per cent of budget<br><br>Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget<br><br>Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br><br>Claim(s) between £100,000 and £1 million<br><br>Purchasers failing to pay on time | Non-delivery of key objective/ Loss of >1 per cent of budget<br><br>Failure to meet specification/ slippage<br><br>Loss of contract / payment by results<br><br>Claim(s) >£1 million |
| **Service/business interruption Environmental impact** | Loss/interruption of >1 hour<br><br>Minimal or no impact on the environment | Loss/interruption of >8 hours<br><br>Minor impact on environment | Loss/interruption of >1 day<br><br>Moderate impact on environment | Loss/interruption of >1 week<br><br>Major impact on environment | Permanent loss of service or facility<br><br>Catastrophic impact on environment |

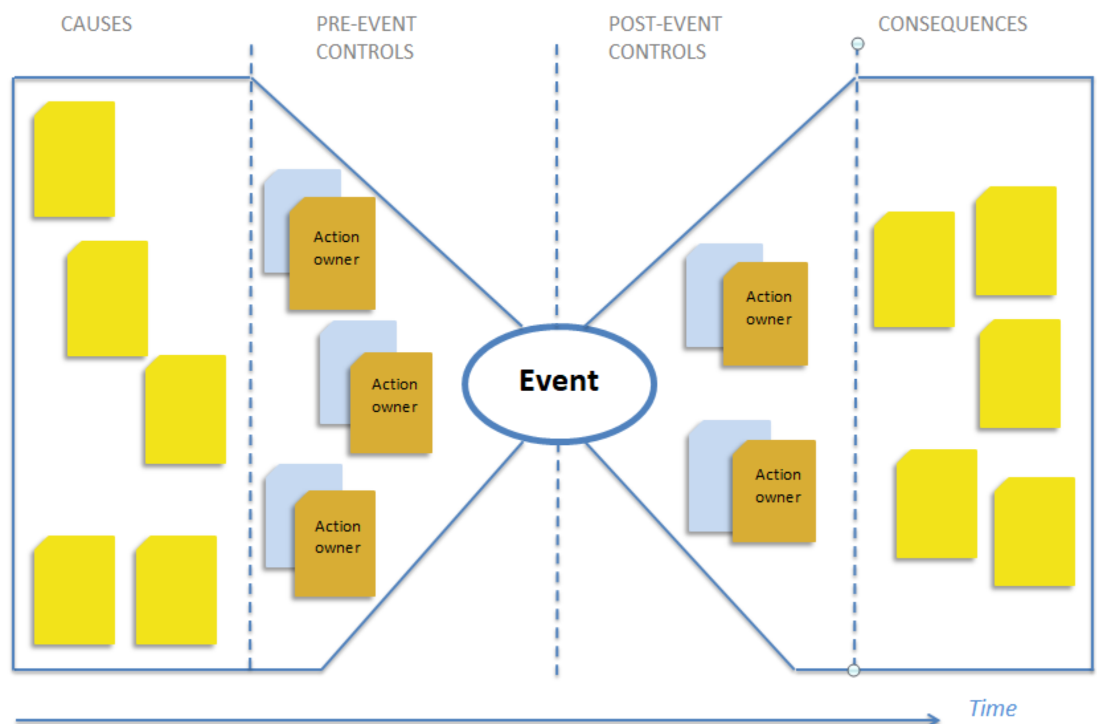
**Likelihood score (L)**

What is the likelihood of the risk being realised?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency. Alternatively, the probability chance of occurrence is also a useful method for identifying likelihood of risk being realised.

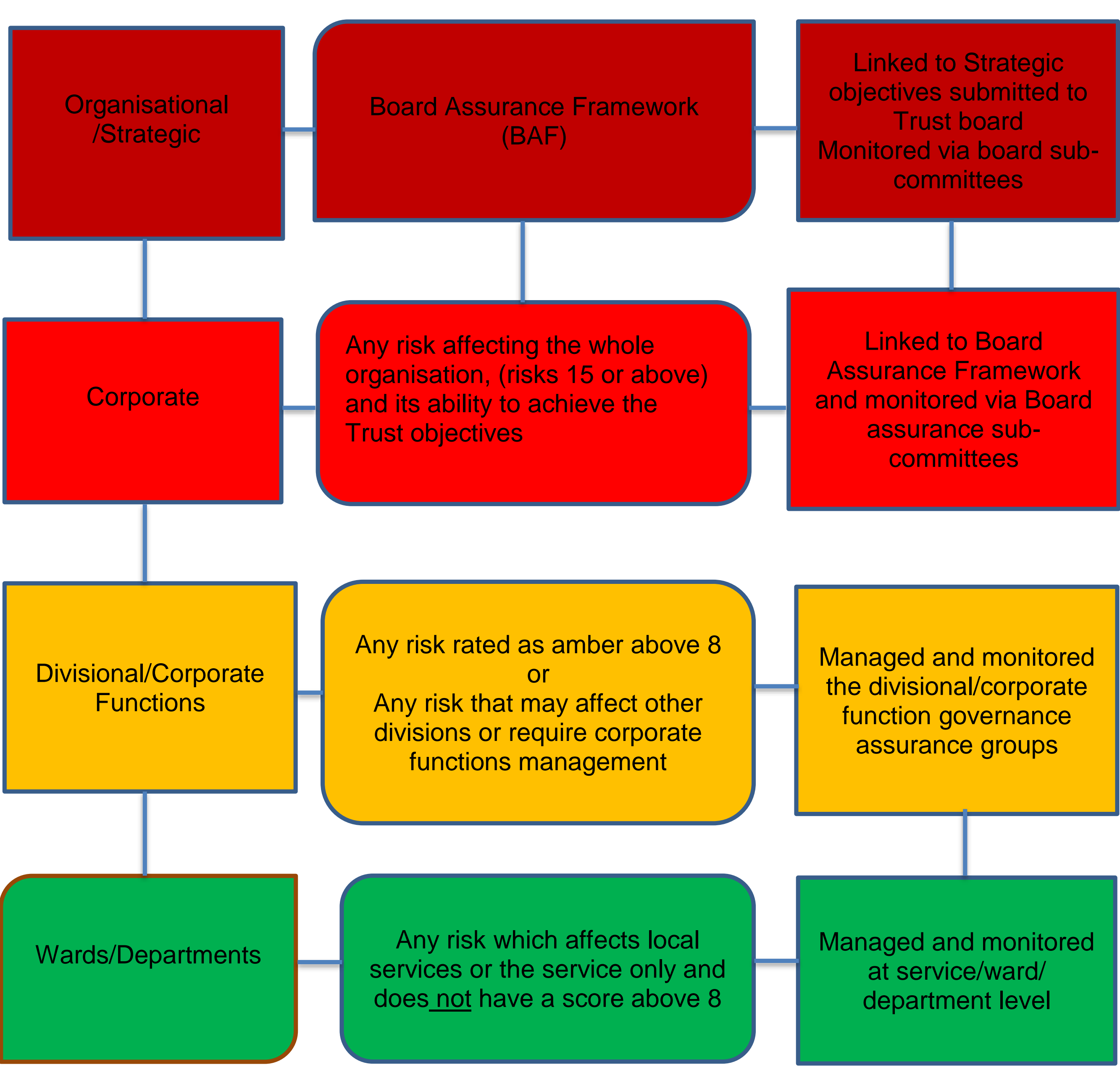
| **Likelihood score** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **Frequency** | This will probably never happen/recur | Do not expect it to happen/recur but it is possible it may do so | Might happen or recur occasionally | Will probably happen/recur but it is not a persisting issue | Will undoubtedly happen/recur, possibly frequently |
| **Probability chance of occurrence** | Less than 20% | 20-40% | 40%- 60% | 60%- 80% | Greater than 80% |

## 13.3. Appendix 3 Bow Tie Tool




**1.** Add Event in the centre box – State the risk and context for the risk
**2.** List causes in the left-hand section
**3.** List consequences in the right-hand section
**4.** Then think about the control measures – Proactive (Pre-event) and Reactive (Post-event) controls.
**5.** Then draw the links between the proactive controls and causes
**6.** Draw the links between the reactive controls and consequences
**7.** Look for causes or consequences with no controls – a control that has many causes
**8.** Decide which of the controls are in place (those are controls) and those that are not in place (those are actions)
**9.** Decide your level of confidence in the controls – Giving assurance to risk owner that the risk is manageable
**10.** Allocate action owners to the actions and put in place an action plan.

### 13.4 Appendix 4 Risk Escalation Process



### 13.5. Appendix 5 Definitions

| | |
|---|---|
| Board Assurance Framework (BAF) | The BAF is the tool by which the Board corporately assured itself about the successful delivery of the Trusts strategic objectives. The BAF is designed to focus the Board on controlling principle risks threatening the delivery of those objectives. The BAF aligns principle risks, key controls and assurances on the operation of the controls. |
| Risk appetite | The level of risk the Trust is prepared to accept or be exposed to at any point in time |
| Cost | Activities, both direct or indirect, which result in a negative outcome or impact for an individual or the Trust. For example, cost could include money, labour, reputation, political and intangible losses. |
| Hazard | Potential source of harm or adverse health effect |
| Issue | Essentially a risk that has happened |
| Risk | The chance of something happening that will have an adverse impact on the achievement of the Trusts objectives and the delivery of high-quality care. It is measured in terms of consequences and likelihood. |
| Risk Management Process | Systematic application of management policies, procedures and practice to the tasks of establishing the contest of risk, then identifying, analysing, evaluating, treating, monitoring and communicating risk. |
| Material risk | Most significant risks or those on which the Board or equivalent focuses |
| Risk assessment | Overall process of risk identification, risk analysis, risk action and risk evaluation. *Refer to Trust Risk Assessment Policy available on the Trust document management system (DMS)* |
| Risk analysis | A systematic use of the available information to determine how often specific events may occur and the magnitude of the consequences |
| Inherent risk | This is the score assigned to a risk if the controls in place are found to be ineffective or absent. *It involves the use of the 5x5 matrix at appendix 2*. |
| Residual risk | This is also known as the current risk score. It is the score assigned to any risk after the control measures in place are taken into account. It involves the use of the 5x5 matrix with impact and likelihood being adjusted following the inherent risk score. *The scoring 5x5 matrix is provided at appendix 2* |
| Target risk | This is the future risk score assigned to a risk after gaps in control measures have been addressed and outstanding actions implemented. This should reflect the risk tolerance. |
| Risk Tolerance | The boundaries of risk taking outside of which the organisation is not prepared to venture in the pursuit of its objectives, |
| Impact | The potential consequences if the adverse effect occurs as a result of the hazard. |
| Likelihood | A qualitative measure/description or probability of frequency |
| Probability | The likelihood of a specific event or outcome occurring. This is measured by the ratio of specific events or outcomes occurring to the total number of possible events or outcomes. Probability is expressed along a scale ranging from rare to almost certain. Refer to 5x5 risk matrix at appendix 2. |
| Risk Rating | The total score worked out by identifying the consequences and likelihood score and cross referencing with the risk matrix. *Refer 5x5 matrix at appendix 2* |

| | |
|---|---|
| Risk Control | That part of risk management which involves the development and implementation of policies, standards, procedures and/or physical changes to eliminate or minimise adverse events of risk. |
| Adverse events | Any event or circumstances leading to unintended harm and/or suffering which resulted in admission to hospital, prolonged stay, significant disability at discharge or death. |
| Gaps in controls | Processes or activities not yet in place in order to effectively manage the risk |
| Risk actions | A specific, measurable, achievable, relevant and time-specific piece of work that is to be completed, that will address an identified gap in control or assurance. |
| Secondary risks | risks caused by actions/treatment |
| monitor | To check, supervise, observe critically or record the progress of an activity, action or system on a regular basis in order to identify change |
| Controls Assurance | A process designed to provide evidence that the NHS in total (and its constituent parts) is doing its reasonable best to manage, direct and control itself so as to protect itself, its employees, patients and stakeholder's safety and interests against all types of risks. |
| Risk assurance | Evidence that supports the measurement of controls in place, to ensure they are operating effectively, and the desired outcome is being achieved. |
| Inadequate Assurance | When assurance or evidence is limited and cannot provide full assurance that controls are effectively managing the risk. Gaps should be identified and lists with actions to mitigate |
| Gaps in assurance | Lack of measures or evidence to support the measurement of controls |
| Internal assurance | Assurance provided by reviewers, auditors and inspectors who are part of the organisation such as clinical audit or management peer review |
| External Assurance | Independent assurance provided by reviewers, auditors and inspectors from outside the organisation for example the CQC, Commissioners, NHS Improvement. |
| System Failure | A non-conformance with, malfunction or deviation from a defined management system. A system failure may also be defined as inadequate performance, non-participation in or non-application of a defined management system or process. |

### 13.6. Appendix 6 – Equality Analysis

| 3. Equality Analysis (EA) for Policies | | |
|---|---|---|
| The Public Sector Equality Duty (section 149 of the Equality Act 2010) requires public authorities to have due regard for the for need to achieve the following objectives in carrying out their functions:<br>a) Eliminate discrimination, harassment, victimisation and any other conduct that is prohibited by or under the Equality Act 2010.<br>b) Advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it<br>c) Foster good relations between persons who share a relevant protected characteristic and persons who do not share it.<br>Please refer to guidance when completing this form | | |
| **Policy Name** | Risk Management Policy & Procedure | |
| **Policy Overview** | This document sets out the Policy & Procedure for the management of risk at all levels of the organisation, including identification, analysis, evaluation, control and monitoring risks, with the overall aim of delivering safe, high quality effective care and create a safe environment for patients staff and the public. | |
| **Relevant Changes** (if any) | New document | |
| **Equality Relevance**<br>Select LOW, MEDIUM or HIGH | LOW | |
| If the policy is LOW relevance, you **MUST** state the reasons here. | The Policy & Procedure applies to all members of staff working in Alder Hey Children's NHS Foundation Trust including permanent, temporary, locums, voluntary, work experience and bank staff, including contractors and partners involved in Trust's business Having considered the equality implications of this policy, they are of low relevance. | |
| **Form completed on:** | Date: 14/04/2021 | |
| **Form completed by:** | Name: Cathy Umbers | Job Title: Associate Director of Nursing and Governance |

| Approval & Ratification of Equality Analysis | | |
|---|---|---|
| **Policy Author:** | Name: Cathy Umbers | Job title: Associate Director of Nursing and Governance |
| **Approval Committee:** | Audit and Risk Committee | Date approved: 22/04/2021 |
| **Ratification Committee:** | The Trust Board | Date ratified: 29/04/2021 |
| **Person to Review Equality Analysis:** | Name: Cathy Umbers | Review Date: 29/04/2024 |
| Comments: | Click here to enter text. | |

# BOARD OF DIRECTORS

**Thursday 29th April 2021**

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

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

# Board Assurance Framework 2020/21

## 1. Purpose

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

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

## 2. Review of the BAF

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

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

**3. Overview at 13th April 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.

**BAF Risk Register - Overview at 13 April 2021**

1.2: Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVI (S)

3.4: Financial Environment (S)

1.3: Keeping children, young people, families and staff safe during the COVID-19 pandemic (S)

2.3: Workforce Equality, Diversity & Inclusion (S)

3.2: Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well (S)

3.1: Failure to fully realise the Trust's Vision for the Park (S)

4.1: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact (S)

1.1: Inability to deliver safe and high quality services (S)

2.1: Workforce Sustainability and Development (S)

2.2: Employee Wellbeing (S)

4.2: Digital Strategic Development & Delivery (S)

**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 13th April 2021

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

| Ref, Owner | Risk Title | Board Cttee | Risk Rating: I x L | | Monthly Trend | |
|---|---|---|---|---|---|---|
| | | | Current | Target | Last | Now |
| **STRATEGIC PILLAR: Delivery of Outstanding Care** | | | | | | |
| 1.1 NA | **Inability to deliver safe and high quality services** | SQAC | 3x3 | 2x2 | STATIC | STATIC |
| 1.2 AB | **Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care** | SQAC | **4x5** | 3x2 | STATIC | STATIC |
| 1.3 JG | **Keeping children, young people, families and staff safe during COVID-19** | Trust Board | **5x3** | 3x3 | STATIC | STATIC |
| 1.4 JG | **Sustaining operational delivery following the UK's exit from the European Union** | Trust Board | 4x3 | 3x2 | STATIC | STATIC |
| **STRATEGIC PILLAR: The Best People Doing Their Best Work** | | | | | | |
| 2.1 MS | **Workforce Sustainability and Development** | PAWC | 3x3 | 3x2 | STATIC | STATIC |
| 2.2 MS | **Employee Wellbeing** | PAWC | 3x3 | 3x2 | STATIC | STATIC |
| 2.3 MS | **Workforce Equality, Diversity & Inclusion** | PAWC | 4x3 | 3x2 | STATIC | STATIC |
| **STRATEGIC PILLAR: Sustainability Through External Partnerships** | | | | | | |
| 3.1 DP | **Failure to fully realise the Trust's Vision for the Park** | RABD | 3x3 | 3x2 | STATIC | STATIC |
| 3.2 DJ | **Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships** | RABD | 4x3 | 4x2 | STATIC | STATIC |
| 3.4 JG | **Financial Environment** | RABD | **4x4** | 4x3 | STATIC | STATIC |
| **STRATEGIC PILLAR: Game-Changing Research And Innovation** | | | | | | |
| 4.1 CL | **Research and Innovation activities could result in reputational downside or contract risk** | Innov. | 3x3 | 3x2 | STATIC | STATIC |
| 4.2 KW | **Digital Strategic Development and Delivery** | RABD | 4x1 | 4x1 | STATIC | STATIC |

## 5. Summary of March updates:

### External risks

- ***Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships (DJ)***
  Risk reviewed; no change to score in month. Progress in C&M CYP - evidence attached.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Actions progressing against plan

### Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to the adverse impact of COVID-19 on waiting times for elective care (AB)***
  The size of our backlog of long wait patients increased in March and there are 361 patients waiting over 52 weeks for treatment. The increase in the number of patients waiting for treatment is concentrated in admitted care with significant change in Paediatric Dentistry, ENT, Trauma and Orthopaedics. We have formulated an elective recovery plan and submitted this to the regional cell. This contains a forecast which predicts an increase in the number of patients waiting over 52 weeks for admitted care over the next 6 months. In Q3 and Q4 2021-22 we forecast the backlog will start to reduce with the timescale for complete eradication of the backlog over a 12 month's timescale.

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

- ***Keeping children, young people, families and staff safe during COVID-19 (JG)***
  Recovery and Restoration Programme is progressing well with a more detailed roadmap focussing on recovering services, having a safe environment and keeping our staff safe. Environment Group due to conclude next iteration of Covid secure reviews by early May 2021.

- ***Inability to deliver safe and high quality services (NA)***
  Risk has been reviewed. Control updated and gaps in assurance articulated. Risk has been updated following SQAC review

- ***Financial Environment (JG)***
  Risk reviewed and updated to reflect latest position

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Review prior to Campus Steering Group

- ***Digital Strategic Development and Delivery (KW)***
  BAF reviewed, good progress in place

- ***Workforce Sustainability and Development (MS)***
  Recovery plan of some key actions now in place.

- ***Employee Wellbeing (MS)***
  Risk reviewed. Actions updated following establishment of Recovery task group and action plan. No change to risk rating given ongoing uncertainty of impacts on staff health and wellbeing.

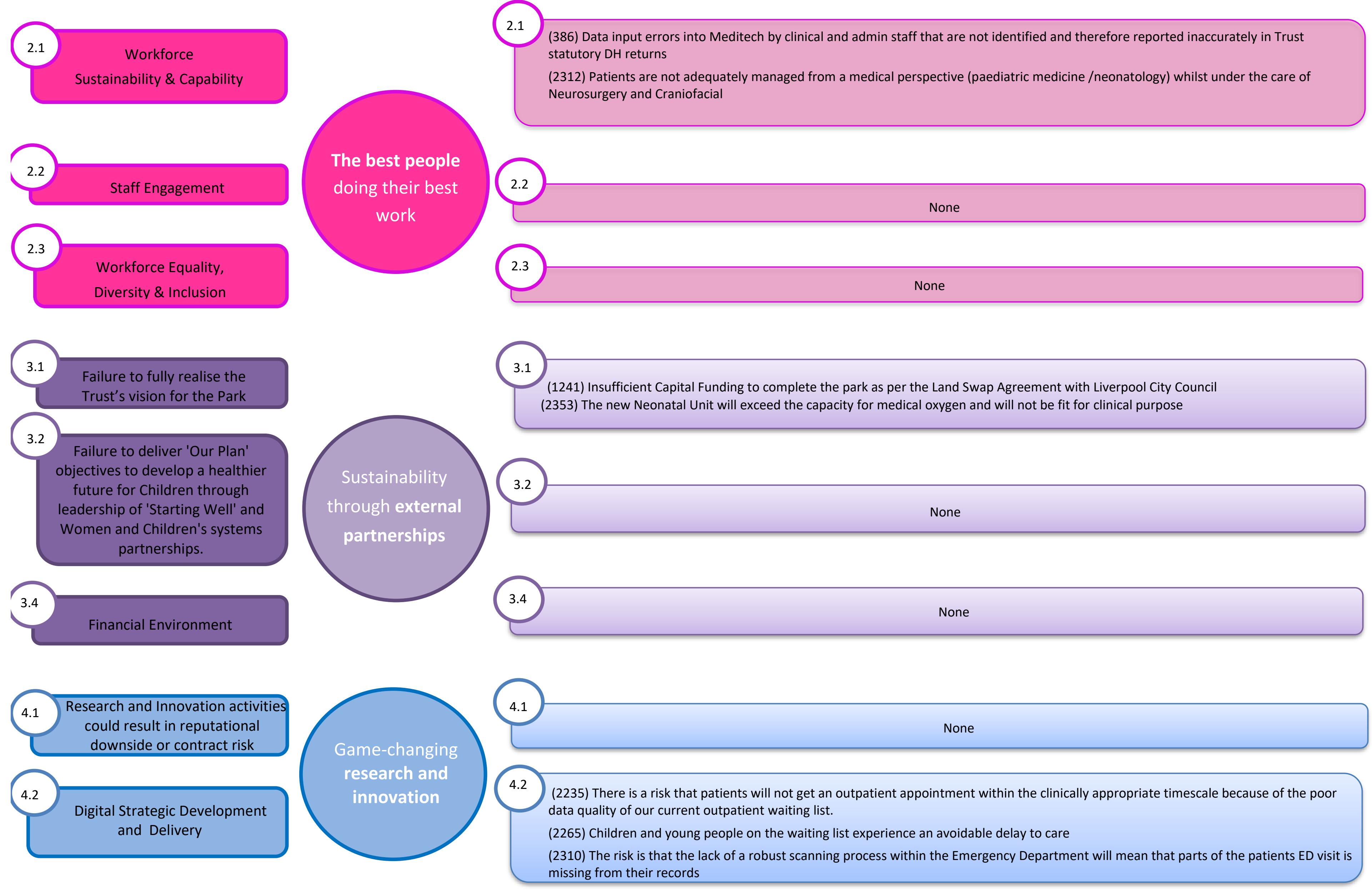
- ***Failure to deliver against the Trust's strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People.***
  Risk reviewed 9/4/21 - no change.

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

## Appendix A

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

| BAF Risk | Strategic Aim | Related Corporate Risk |
|---|---|---|
| 1.1 Inability to deliver safe and high quality services | Delivery of **outstanding care** | 1.1 (2183) Staff, patients and the public will not be able socially distance whilst waiting in ED.<br>(2233) Failure to meet QST Major Trauma peer review standards.<br>(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.<br>(2242) Risk of self-harm due to inappropriate clinical placement<br>(2265) Children and young people on the waiting list experience an avoidable delay to care<br>(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial<br>(2315) Overprescribing (10 times) of medication<br>(2332) Inadequate provision of service delivery if agreement cannot be reached by two main providers of paediatric cardiology care over how best to provide a 'joint approach' to service provision.<br>(2353) The new Neonatal Unit will exceed the capacity for medical oxygen and will not be fit for clinical purpose<br>(2377) Incomplete record of patients treatment, patient could be given the incorrect treatment.<br>(2310) The risk is that the lack of a robust scanning process within the Emergency Department will mean that parts of the patients ED visit is missing from their records<br>(2355) The new Neonatal unit will exceed the capacity for medical air and will not be fit for clinical purpose. |
| 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 | | 1.2 (2233) Failure to meet QST Major Trauma peer review standards. |
| 1.3 Keeping children, young people, families and staff safe during COVID-19 | | 1.3 None |
| 1.4 Sustaining operational delivery following the UK's exit from the European Union | | 1.4 None |


2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
2.1
(386) Data input errors into Meditech by clinical and admin staff that are not identified and therefore reported inaccurately in Trust statutory DH returns
(2312) Patients are not adequately managed from a medical perspective (paediatric medicine /neonatology) whilst under the care of Neurosurgery and Craniofacial
2.2
None
2.3
None
3.1
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
(2353) The new Neonatal Unit will exceed the capacity for medical oxygen and will not be fit for clinical purpose
3.2
None
3.4
None
4.1
Research and Innovation activities could result in reputational downside or contract risk
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
(2310) The risk is that the lack of a robust scanning process within the Emergency Department will mean that parts of the patients ED visit is missing from their records

# Board Assurance Framework 2021-22

| BAF 1.1 | Strategic Objective: Delivery Of Outstanding Care | Risk Title: Inability to deliver safe and high quality services |
|---|---|---|
| Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led | | Link to Corporate risk/s: 2265, 2312, 2315, 2235, 2242, 2355, 2310, 2332, 2233, 2183, 2377 |
| Exec Lead: Nathan Askew | Type: Internal, Known | Current IxL: 3x3 / Target IxL: 2x2 / Trend: STATIC |

**Assurance Committee:** Safety & Quality Assurance Commitee

**Risk Description**

Not having sufficiently robust, clear systems and processes in place to deliver high quality care and consistent achievement of relevant local, national and regulatory quality and experience standards.

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Alignment of workforce plans across the system | 31/03/2021 | Action captured within BAF risk 2.1 |
| The 72hr review process will be followed for all patients who do not receive their antibiotics within the timeframe to identify themes, trends and any trust wide learning which will lead to improvement in compliance with this standard | 01/07/2021 | |
| The Trust will form a complex children programme board to improve the safety and experience of mental health patients within the Trust. Workstreams will be directed by service need and monitored through CQSG | 02/08/2021 | |
| The Quality Hub will work with the Trust Medication Safety Group to identify areas for improvement across a range of areas relating to prescribing, dispensing and administration of medication | 01/09/2021 | |
| A new document management system to be launched All current policies and guidelines to be migrated | 09/04/2021 | |

| | | |
|---|---|---|
| The review and approval process to be updated<br>Monitoring reports to be sent to CQSG monthly<br>Number of out of date documents to be monitored through CQSG<br>Board subcommittees to receive a quarterly report in relation tot he policies and guidelines which they are responsible for | | |

| Executive Leads Assessment |
|---|
| April 2021 - Nathan Askew<br>Risk has been reviewed.  Control updated and gaps in assurance articulated.  Risk has been updated following SQAC review |
| February 2021 - Nathan Askew<br>This risk has been reviewed in the context of the wave three pandemic.  The current mitigations in place are effective at this time.  This risk is planned to be presented to March board following a full review in light of a changed health and social care landscape |
| January 2021 - Nathan Askew<br>The risk has been reviewed in the context of the increasing national pandemic.  increase in COVID transmission has led to an increase in short term sickness and isolation due to exposure.  The Trust are utilising the covid emergency response plan to mitigate this.  This risk will review a full review as we end this wave of the pandemic |

## Board Assurance Framework 2021-22

| 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: 2233, 2270 | | |
| Exec Lead: Adam Bateman | | Type: Internal, Known | Current IxL: 4x5 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** Safety & Quality Assurance Commitee

**Risk Description**

Failure to meet targets and internal performance metrics due to a lack of capacity relative to demand; a loss of capacity during COVID-19 has made access to care extremely challenging. Challenges with data quality could lead to sub-optimal waiting list management and delays to care.

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

**Gaps in Controls / Assurance**

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

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Safe Waiting List Management programme plan to deliver good data quality, clinical reviews, clinical harm review, accurate waiting list reporting and additional RTT training. | 18/06/2021 | |
| Outpatient transformation project supports surgical specialties to increase restoration to > 100% | 01/03/2021 | |
| 12 month elective restoration plan informed by modelling on capacity, demand, waiting times and workforce | 07/12/2020 | |
| Theatres transformation project supports surgical specialties to increase restoration to > 110% | 07/12/2020 | |
| Assessing incentivised models to support an increase in restoration activity levels | 28/02/2021 | finalising contractual agreements with LLP/Independent sector |

**Executive Leads Assessment**

0 - No Reviewer Entered

April 2021 - Raman Chhokar
The size of our backlog of long wait patients increased in March and there are 361 patients waiting over 52 weeks for treatment. The increase in the number of patients waiting for treatment is concentrated in admitted care with significant change in Paediatric Dentistry, ENT and Trauma and Orthopaedics. We have formulated an elective recovery plan and submitted this to the regional cell. This contains a forecast which predicts an increase in the number of patients waiting over 52 weeks for admitted care over the next 6 months. In Q3 and Q4 2021-22 we forecast the backlog will start to reduce with the timescale for complete eradication of the backlog over a 12 months timescale. We have delivered a rapid recovery of activity in outpatients (90%) and inpatients (100%) and we expect this to be sustained throughout the year. We have started to utilise additional capacity through the LLP and waiting list initiatives. Through April to June we continue to have significant additional weekend activity scheduled in theatres to alleviate the pressures on the inpatient waiting list.

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

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

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

# Board Assurance Framework 2021-22

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

**Assurance Committee:** Trust Board

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

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Formal strategic and tactical command arrangements in place | agendas & minutes |
| Detailed COVID-19/ Winter Plan agreed and being deployed | Winter 2020 Plans |
| Work programme on keeping our staff safe enacted | |
| Plan to establish adult invasive capacity progressed | |
| COVID Specific Scorecard in place | Scorecard to Strategic Meetings |
| Work Programme established looking at keeping Children & Young People safe | Agendas / Minutes / Actions |
| | |
| 24/7 CAMHS crisis line in-situ | Staff rota |
| | |
| | |
| | |
| | |
| Specialities have populated vulnerable patient template to outline risk, considerations that may affect current pathway and identify alternative | |
| Continued to update vulnerable shielding patients with guidance and support as per government advice | |
| Face masks introduced for staff and visitors | |
| New environment designed in the hospital and community setting to sustain social distancing and achieve high standards of IPC | |
| PPE suppliers and innovations strategy to ensure adequate supply | PPE predictor 4 week forward look |
| Operational plan to increase restoration of capacity | Tracked weekly though Communication Cell Metric Report in Operational Delivery Board |
| Covid-19 testing service | https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Staff-Testing.aspx |
| Covid-19 test and trace policy | Covid-19 test and trace policy |
| Cheshire & Mersey Gold Command has been recently strengthened | Notes of meeting shared weekly |
| Vaccine deployment programme ready and for deployment | https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Covid-Vaccine.aspx |
| Enhanced staff welfare programme | https://alderheynhsuk.sharepoint.com/sites/COVID19/SitePages/Support%20%26%20Well-Being.aspx |

| Gaps in Controls / Assurance |
|---|
| |

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Increase awareness and vigilance around keeping staff safe from Covid-19 by maintaining social distancing. | 30/04/2021 | New manager support pack to help oversee PPE, social distancing and hygiene compliance issued with ongoing monitoring in place. |
| Oversight Group initiated focussing on redeployment, temporary staffing, sickness, shielding and self-isolation, rota hub deployment, recruitment | 31/03/2021 | |
| Vaccine roll-out | 30/04/2021 | 80% of staff vaccinated with first dose as at 21st Jan 2021. Remaining staff still have access to LHCH/Clatterbridge |

| | | |
|---|---|---|
| | | vaccination hub. Plans for second dose in place. |

| **Executive Leads Assessment** |
|---|
| April 2021 - John Grinnell<br>Recovery and Restoration Programme is progressing well with more detailed roadmap focussing on recovering services, having a safe environment and keeping our staff safe. Environment group due to conclude next iteration of Covid secure reviews by early May. |
| March 2021 - John Grinnell<br>Wave 3 response plan updated at February's Trust Board and signed off. Key ongoing areas of focus are vaccination programme, staff testing, staff resilience and welfare and restoration and recovery. |
| February 2021 - John Grinnell<br>Wave 3 response signed off by Board and implementation going well. Adult critical care facility now in situ and responding to system needs. As predicted, hospital occupancy dropped across the system focus shifting to improving access to services for children & young people. |

## Board Assurance Framework 2021-22

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

**Assurance Committee:** People & Wellbeing Committee

**Risk Description**

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

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

**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
6. DBS renewal programme incomplete- meaning some staff in post do not hold a valid DBS certificate until the programme ahs been complete ( April 2021)

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training | 31/03/2021 | Full review of recovery plan scheduled with HRD and HR deputy 9/03/2021 |
| 3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019 | 30/04/2021 | 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 | 31/05/2021 | Progress against the plan was slower than hoped however this was impacted be pandemic 3rd Wave in Jan 2021. Task and finish group meetings back in the diary to progress action plans. |

## Board Assurance Framework 2021-22

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

# Board Assurance Framework 2021-22

| 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 and taking self-referrals from frontline staff from 12th April | |
| Ongoing monitoring of wellbeing activities and resources via monthly Wellbeing Steering Group | Minutes presented to PAWC |
| Appointment of Wellbeing Guardian to report to Board regarding wellbeing activities and programmes of work | Report in development to assess progress against 9 WB principles outlined in national guidance document |

**Gaps in Controls / Assurance**

1. Need to review staff counselling provision and ensure fit for purpose, coordinated with SALS and sufficient to meet demand going forward
2. Significant gap in predicting what the likely demand for staff support will be over the coming months given the unprecedented nature of this pandemic

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Referrals, triage systems and pathways to be reviewed for all staff counselling between January and March 2021 to determine future service development and delivery that meets demand and is integrated with internal and external counselling provision. | 31/05/2021 | Meeting held on 18th March and agreed that Associate Director of OD and Alder Centre manager to draw up a proposal within the next 3 months regarding ongoing provision of staff counselling and pathways for staff support |
| Liaise with Regional Resilience Hub as it develops and ensure Alder Hey staff can access the screening tools and support can be offered | 01/04/2021 | Meeting with Resilience hub held on 30th March 2021 to explore what they can offer to us as an organisation. Plans in place and a series of 6 sessions booked in to explore options, train in different |

| | | |
|---|---|---|
| | | approaches and plan how to offer to the organisation |
| Paper to be presented on 2.3.21 to execs outlining proposal for helping staff with their Recovery from impacts of Covid. Proposal to develop Recovery working group to develop and monitor action plan to include whole organisation debriefing programme | 30/04/2021 | Plan to be further developed through Health and Wellbeing Conversations launching for all staff from 1st April, surveys asking staff about what would help their recovery, and listening events to ensure vulnerable groups are also focussed on |

| **Executive Leads Assessment** |
|---|
| March 2021 - Jo Potier<br>Risk reviewed. SALS resource action complete. Additional control added following appointment of Wellbeing Guardian. Actions reviewed and progress amended. No change to score. |
| January 2021 - Jo Potier<br>Risk reviewed - no change to score in-month. Thorough review of risk undertaken to amalgamate risk 2181 in order to manage all actions at Executive Level. |
| December 2020 - Melissa Swindell<br>Risk reviewed in month. Score reduced and additional actions identified. |

# Board Assurance Framework 2021-22

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

**Assurance Committee:** People & Wellbeing Committee

**Risk Description**

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 2. Work with the BME and Disability Networks to develop specific action plans to improve experience. | 31/12/2020 | action closed as all actions being refreshed in line with new taskforce and approach to EDI |
| 1. Work with Community Engagement expert to develop actions to work with local community | 31/12/2020 | action closed to be replaced by revised set of actions as a result of the taskforce and new approach to EDI |
| BAME Taskforce established, Claire Dove NED is leading. Taskforce is working to identify the main areas of focus for us to increase representation, improve experience, remove racism | 31/03/2021 | BAME taskforce have now met three times. action plan and ideas progressing/ Board update to be ready for December 2020 |
| Specialist Trusts discussion to explore implementing an EDI team across all four Trusts. | 30/04/2021 | The collaborative with specialists trust has now be agreed. We are actively recruiting to an EDI team to support the specialists Trusts. |

## Board Assurance Framework 2021-22

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

# Board Assurance Framework 2021-22

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

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Complete cost plan | 31/01/2021 | Turkington martin who provided the overall plan/vision for the park have been approached and a meting diarised to start to further develop the plan which can then go to tender, some estimation of cost will be achieved through working the plan up with Turkington Martin ( Landscaping architects) |
| 2. Agree Park management approach with LCC | 01/04/2021 | Discussions with LCC continue and most recently positive feedback on an agreement to lease additional car park space off site at Thomas lane sports field/car park. This is to be be agreed within the next month and lease put into place. A whole internal process on management of this is currently under discussion |
| Prepare Action Plan for NE plot development | 30/06/2021 | Workshop with PWC occurred on the 25th June, outputs to be formulated and fed back to the Trust |
| Complete Eaton Road Masterplan | 29/04/2021 | |

| | | |
|---|---|---|
| Establish Executive Design Group | 31/12/2020 | |
| Create action plan for NE plot | 03/05/2021 | |
| Review model for corporate office activity | 05/04/2021 | |
| Review and update Space Strategy | 30/06/2021 | |
| Action Plan for Community Benefits society | 08/04/2021 | |

| **Executive Leads Assessment** |
|---|
| April 2021 - David Powell<br>Review prior to Campus Steering Group |
| March 2021 - David Powell<br>Prior to March Board |
| February 2021 - David Powell<br>Prior to Feb Board |

## Board Assurance Framework 2021-22

| BAF 3.2 | Strategic Objective: Sustainability Through External Partnerships | | Risk Title: Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's systems partnerships. | |
|---|---|---|---|---|
| Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led | | | Link to Corporate risk/s: No Risks Linked | |
| Exec Lead: Dani Jones | Type: External, Known | | Current IxL: 4x3 | Target IxL: 4x2 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

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

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Divisional Performance Management Framework - includes clear trajectories for challenged specialties to deliver | Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached) |
| Compliance with All Age ACHD Standard | ACHD Level 1 service now up and running; developing wider all-age network to support - agreement to host at Alder Hey |
| Capacity Plan identifies beds and theatres required to deliver BD plan | Daily activity tracker and forecast monitoring performance for all activity. |
| Sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board | Growth of specialist services through partnerships included in approved trust strategic plan to 2024 (Our Plan). Monitored at Programme Board and via Strategy and Operations Delivery Board. |
| Internal review of service specification as part of Specialist Commissioning review | Compliance with final national specifications |
| Compliance with Neonatal Standards | Single Neonatal Services Business Case approved by NHS England. |
| Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate, and support North West in national centralisation agenda | MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly) |
| 'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs | 'Our Plan' approved at Trust Board October 2019 |
| 'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services | Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within. |
| Involvement of Trust Executives, NEDs and Governors in partnership governance arrangements | ToR & minutes - NW Paediatric Partnership Board |
| Gap / risk analysis against all draft national service specification undertaken and action plans developed | Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance |
| Involvement of Trust Executives in partnership governance arrangements | ToR & minutes - NW Paediatric Partnership Board. Hosted ODN Assurance reporting to RABD (2 x per year) |
| Implementation of the 'Starting Well' partnership group for One Liverpool(developing - replaces Children's Transformation Board). SRO Louise Shepherd confirmed. | |
| C&M C&YP Recovery Plan - Alder Hey Leadership ensures alignment with Our Plan | C&M C&YP Recovery Plan Narrative |
| One Liverpool - Provider Alliance action plan | Agreed plan per Provider Alliance 25.9.20 - inclusive of Children, Young People and Families priorities. |
| C&M Children's Transformation Programme - AH hosting agreed and new programme for 2021+ under establishment | Presentation to C&M W&C Programme to agree C&M priorities - led by Alder Hey (Dec 20). Approved paper to C&M HCP re establishment of the new C&M CYP Programme (Nov 20). Programme submission to C&M HCP for set up of new CYP Programme (Mar 21) supported by HCP (ICS) |

**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 |
|---|
| April 2021 - Dani Jones<br>Risk reviewed; no change to score in month. Progress in C&M CYP - evidence attached. |
| March 2021 - Dani Jones<br>Risk reviewed; no change to risk rating in month. Progress re establishment of new C&M CYP Programme, hosted at Alder Hey; evidence attached. |
| February 2021 - Dani Jones<br>Risk reviewed; no change to rating in month. Wave 3 continues to delay local system transformation partnerships, but making progress across the developing C&M CYP Programme and NW Paediatric Partnership. |

# Board Assurance Framework 2021-22

| BAF 3.4 | Strategic Objective: Sustainability Through External Partnerships | Risk Title: Financial Environment | | |
|---|---|---|---|---|
| Related CQC Themes: Safe, Effective, Responsive, Well Led | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: John Grinnell | Type: Internal, Known | Current IxL: 4x4 | Target IxL: 4x3 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 1. RABD to oversee productivity and waste reduction programme | 31/03/2021 | Oversight of the productivity metrics within the divisions are presented to RABD on a quarterly basis and will continue through 21/22. |
| 5. Childrens Complexity tariff changes | 31/08/2021 | Issue now recognised and supported by NHSI/E however due to the rollover of the financial arrangements for H1 of 21/22, additional funding will not be provided and will need to form part of the base line funding for H2 with confirmation expected in Aug/Sept. |
| 4. Long Term Financial Plan | 31/05/2021 | 21/22 draft plan shared at RABD and Trust Board however guidance now released for H1 21/22 with confirmation of rollover financial arrangements. Longer term financial strategy required for H2 onwards and addressing underlying shortfall position. Update to be provided to Trust Board and RABD. |
| 2. Five Year capital plan | 31/05/2021 | Development of a refreshed 5 year capital programme underway to be presented to RABD in May. |

**Executive Leads Assessment**

April 2021 - Rachel Lea
Risk reviewed and updated to reflect latest position

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

## Board Assurance Framework 2021-22

| |
|---|
| February 2021 - Rachel Lea<br>Risk reviewed and risk rating reduced to 16 to reflect reduced risk of 20/21 due financial plan being accepted and confirmation of additional funding. Longer term financial risk remains due to uncertainty within the framework. |
| January 2021 - Rachel Lea<br>The 20/21 framework is now in place for the rest of the year and mitigations have been activated to improve the forecast position and drive cost reduction. 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.<br><br>The framework beyond this year is not yet confirmed  and remains uncertain.  Planning is underway and a 5 year financial model is in progress, to be completed when the guidance is confirmed. The longer term next 5 years is still a significant risk. |
| December 2020 - Rachel Lea<br>The 20/21 framework is now in place for the rest of the year and mitigations have been activated to improve the forecast position and drive cost reduction.<br><br>The framework beyond this year remains uncertain, expected guidance is due to be released mid December. Planning is underway and a 5 year financial model is in progress, to be completed when the guidance is confirmed. The longer term next 5 years is still a significant risk. |

## Board Assurance Framework 2021-22

| BAF 4.1 | Strategic Objective: Game-Changing Research And Innovation | | Risk Title: Failure to deliver against the trust strategy and deliver game changing Research and Innovation that has positive impact for Children and Young People. | | |
|---|---|---|---|---|---|
| Related CQC Themes: Well Led | | | Link to Corporate risk/s: No Risks Linked | | |
| Exec Lead: Claire Liddy | | Type: Internal, Known | Current IxL: 3x3 | Target IxL: 3x2 | Trend: STATIC |

**Assurance Committee:** Innovation Committee

**Risk Description**

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

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Research recovery plan operational | 31/03/2021 | Participating in 7 Urgent Public Health (UPH) Studies.<br>Reactivated 38.9% of Suspended CRN studies.<br>19 New Studies opened - 13 Academic & 6 Commercial. |
| Deployment of ten year Innovation Strategy (2030) | 30/04/2021 | February Innovation Committee will share and agree Innovation Partnerships Strategy for year 1 2021. |

**Executive Leads Assessment**

April 2021 - Claire Liddy
Risk reviewed 9/4/21 - no change.

February 2021 - Claire Liddy
Risk comprehensively reviewed and updated in month. No change to score.

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

# Board Assurance Framework 2021-22

| BAF 4.2 | Strategic Objective: Delivery Of Outstanding Care | | Risk Title: Digital Strategic Development & Delivery | | |
|---|---|---|---|---|---|
| Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led | | | Link to Corporate risk/s: 2265, 2143, 2235, 2310 | | |
| Exec Lead: Kate Warriner | | Type: Internal, Known | Current IxL: 4x1 | Target IxL: 4x1 | Trend: STATIC |

**Assurance Committee:** Resource And Business Development Committee

**Risk Description**

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

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

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Implementation of cyber actions including managed service and cyber essentials accreditation | 31/03/2021 | Cyber actions in place |
| 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**

April 2021 - Kate Warriner
BAF reviewed, good progress in place

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

February 2021 - Kate Warriner
BAF reviewed, all actions on track. Cyber Essentials Accreditation achieved.

# BOARD OF DIRECTORS

**Thursday 29th April 2021**

| **Paper Title:** | **Audit and Risk Committee – Chair's Highlight Report** |
|---|---|
| **Date of meeting:** | 22nd April, 2021 |
| **Report of:** | Kerry Byrne, Committee Chair |
| **Paper Prepared by:** | Kerry Byrne, Committee Chair |

| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ☐ |
|---|---|
| **Summary and/or supporting information:** | This paper provides a summary from the Audit and Risk Committee meeting that was held on the 22nd April, along with the approved minutes from the Audit Committee meeting that was held on the 21st January 2021. |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ☐<br>**The best people** doing their best work ☐<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ☐<br>**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

- Brilliant Basics Programme Update
- Risk Management Strategy
- Risk Management Policy & Procedures
- Board Assurance Framework
- Care Delivery Board update including the Corporate Risk Register
- Analysis of the Trust Risk Register
- Annual Report on Risk Management from the Care Delivery Board
- CQC Action Plan (for actions overseen by ARC)
- Internal Audit Progress Report
- Internal Audit Follow Up Report
- Draft Head of Internal Audit Opinion and Annual Report for 2020/21
- Draft Internal Audit Plan for 2021/22
- Internal Audit Charter
- Anti-Fraud Annual Report for 2020/21
- Anti-Fraud Plan for 2021/22
- External Audit Plan for audit of the 2020/21 financial statements
- Draft Annual Governance Statement
- Draft Annual Report of ARC
- ARC Terms of Reference
- Waiver Activity Report
- Update on the actions from the ARC Self-Assessment
- Potential sources of additional information and assurance for ARC

The following reports were deferred to our May meeting*

- Clinical and Non-Clinical Claims Report
- Presentation on risk management within the Medicine Division
- Data Quality Strategy
- Gifts and Hospitality Register
- Annual Report on the Effectiveness of Project Management

* The May meeting will be rescheduled to June in line with the extended deadline this year for the submission of the financial statements.

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

None

**4. Positive highlights of note**

The Committee recognised and thanked the Executive, Management and the Associate Director of Nursing & Governance for the significant developments in risk management during 2020/21 throughout the Trust including:

- The introduction of the Care Delivery Board which has resulted in increased Executive and Divisional engagement in the risk management process by providing effective oversight of operational risks, the Corporate Risk Register and BAF
- Significant movement in the Corporate Risk Register, and particularly the reduction of long-standing risks
- Improved reporting on risk management to ARC, including trend analyses, distribution of risk scores and insights into key themes arising
- Oversight of individual BAF risks by the Board assurance committees
- Agreement of Risk Appetite Statements

The Committee also recognised and thanked the Executive and Internal Audit for the delivery of a comprehensive programme of internal audit work, despite the considerable operational pressures experienced as a result of the pandemic. In addition, significant progress was made in implementing agreed recommendations, including some that had been long-standing.

The Draft Head of Internal Audit Opinion was substantial assurance meaning that *"there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently*."

**5. Issues for other committees**

None

**6. Recommendations**

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

# Audit and Risk Committee

Confirmed Minutes of the meeting held on **Thursday 21st January 2021**

**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) |
| | Dr. U. Das | Director of Medicine | (UD) |
| | Mr. J Grinnell | Director of Finance | (JG) |
| | Mr. K. Jones | Associate Finance Director | (KJ) |
| | Mrs. V Martin | Counter Fraud Specialist, MIAA | (VM) |
| | 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) |
| **Apologies:** | Mr. A. Bass | Director of Surgery | (AB) |
| | Ms. L. Cooper | Director of Community Services | (LC) |
| | Ms. R. Greer | Assoc. COO | (RG) |
| | Mrs R Lea | Associate Director of Finance | (RL) |
| | Mrs A Marsland | Non-Executive Director | (AM) |
| | Mr R Tyler | E&Y Accounts Manager | (RT) |

**20/21/68 Introduction and Apologies**

The Chair welcomed everyone to the meeting and noted the apologies that were received. It was pointed out that a number of agenda items have been deferred to April due the 'governance lite' approach that has been taken as a result of the third wave. The Chair asked that authors of the reports highlight key points only to allow time for discussion, especially around risk, in order to meet the timeline of the agenda.

**20/21/69 Minutes from the Meeting held on the 19th November 2020**

**Resolved:**

The minutes from the meeting that took place on the 19.11.20 were agreed as an accurate record of the meeting.

**20/21/70 Matters Arising and Action Log**

**Action 19/20/50.6**: *To suggest a mechanism to review the effectiveness of External Audit for the 2019/20 accounts* - The Trust has approached HFMA to enquire as to whether there is any information available in terms of products that other organisations are using to review the effectiveness of External Audit. It was reported that the Trust hasn't received a response as of yet. Hassan Rohimun advised that Ernst and Young don't have any formal information in terms of assessments that would assist the organisation with their request.

The Chair queried as to whether it would be beneficial to liaise with fellow finance colleagues regarding this issue. It was agreed that Ken Jones would link in with the Finance Directors and their deputies to discuss this matter further.
**ACTION TO REMAIN OPEN**
**Action: KJ**

**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)* – Ken Jones has agreed to take on the role of Fraud Champion for Alder Hey but felt that consideration needs to be given in respect to having additional champions across the Trust going forward. The Chair felt that this was an appropriate recommendation as some of the risk relating to fraud will be specific to certain areas of the organisation. It was agreed to look at a process for the nomination of additional Fraud Champions and provide an update on the outcome, during April's meeting. **ACTION TO REMAIN OPEN**

**Action 20/21/29.2**: *Presentation on Risk Management Process (Division of Medicine to present in January)* – This action has been deferred to April 2021. **ACTION TO REMAIN OPEN**

**Action 20/21/45.1:** *Update on the recommendations within the Acorn Report (Agree a date via the Innovation Committee in which to provide assurance to the Audit Committee on any new arrangements that have been made in respect to the three live companies)* – It was confirmed that the Innovation Committee is overseeing the work of the three companies sitting under the Acorn umbrella and legal advice has been sought on the appropriate closure of the previous spin off companies. Following discussion, it was agreed to arrange a meeting to discuss broader governance arrangements in terms of innovation activities. Attendees to be invited to the meeting are Kerry Byrne, Fiona Marston, John Grinnell, Claire Liddy and Rachel Lea. An update will be provided on the 22.4.21.
**Action: KMC**

**Action 20/21/51.1:** *Brilliant Basics Programme (Provide an update on the outcome of the Brilliant Basics pilot that took place in December 2020)* – John Grinnell provided an overview of the purpose of the Brilliant Basics Programme, in terms of risk management. It was reported that there has been a delay in rolling out the programme due to the pandemic. The Trust has progressed certain aspects of the programme, but the broader element has been paused until early March 2020. The Chair asked that an update on progress be provided during each meeting. **ACTION TO REMAIN OPEN**

**Action 20/21/51.2:** *Brilliant Basics Programme (KPMG to liaise with Cathy Umbers to ensure that the Brilliant Basics Programme links in with the Trust's risk management process)* - A meeting is to be scheduled with KPMG in the next two weeks.
**ACTION TO REMAIN OPEN**

**Action 20/21/55.1:** *Board Assurance Framework (Discuss the risk relating to 'Keeping children, young people, families and staff safe' in order to ensure that there is no overlap between this and the 'access' risk owned by Adam Bateman)* - It is necessary to keep both risks separate due to the far reaching impact of the pandemic. It has been agreed that Adam Bateman will continue to keep a focus on BAF risk 1.2 which is the access issue, but the broader Covid impact will need to be split in the risk assessment in terms of

the impact of the vaccination uptake, community prevalence, nosocomial infection, etc. It was pointed out that it would be inappropriate to remove a Covid related risk from the Trust's strategic framework in light of the third wave, but it was confirmed that every effort will be made to have a clearer delineation going forward. **ACTION TO REMAIN OPEN**

**Action 20/21/55.3:** *Board Assurance Framework (Liaise with Claire Liddy to discuss as to whether there is a more apt descriptor for describing the 'Game Changing Research and Innovation' risk under the strategic pillar, in readiness for the next iteration of the Board Assurance Framework)* – A meeting has been scheduled to take place on the 25.1.21 to discuss this matter. It is felt that the organisation is now in a position to articulate the risk given the work that has taken place to develop the Innovation Strategy, therefore the Board Assurance Framework will reflect a much stronger risk which will be clearly set out.
**ACTION CLOSED**

**Action 20/21/57.1:** *Non-Clinical Claims/Clinical Claims (Initial discussion to take place between ES/JG re the examining of clinical and non-clinical claims jointly from a value for money lens to see what the Trust is obtaining from NHS Resolution versus the Trust's solicitors. Following discussion, arrange for a meeting to take place with the Chair to discuss the progression of this piece of work)* – This action has been deferred to April due to operational pressures that are being experienced at the present time as a result of the third wave. **ACTION TO REMAIN OPEN**

**Action 20/21/61.1:** *Progress against actions from the Audit and Risk Committee Self-Assessment (Discuss and agree an appropriate process for the self-assessment of the Trust's Assurance Committees, taking into account the governance reset, and submit a recommendation to the Audit and Risk Committee)* – Work is ongoing to look at the form that this process could take, whilst taking into account the relaxation around some year-end processes/reporting nationally due to the pandemic. It was agreed to circulate an outline of options prior to April's meeting. **ACTION TO REMAIN OPEN**
**Action: GB/JP**

**Action 20/21/61.2:** *Progress against actions from the Audit and Risk Committee Self-Assessment (Discuss the possibility of the Associate Director of Nursing and Governance role moving to one of oversight of risk to enable a 'Risk Management Opinion' to be submitted to the Audit and Risk Committee on an annual basis and over what time frame this can be achieved)* – A meeting has been scheduled to take place on the 27.1.21 to discuss this matter. An update will be provided on the 22.4.21
**ACTION TO REMAIN OPEN**

**Action 20/21/63.1**: *Development of a Robust Process for Gifts and Hospitality (Submit a report on gifts and hospitality declarations using the data from the new electronic system)* – Progress on declarations of interest is continuing, and regular communications are being shared with staff Trust wide. It was pointed out that declarations of gifts and hospitality have reduced but there is a sense that this could be due to national lockdown. Virginia Martin advised that MIAA has received feedback from a number of their clients that they are seeing a decrease in submissions. It was confirmed that a full report on Declarations of Interest/Gifts and Hospitality will be submitted to the Committee in April.
**ACTION TO REMAIN OPEN**
**Action: ES**

**20/21/71 CQC Action Plan 2020**

The Committee received version 6 of 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 – Regulation 17)* - A revised version of the Risk Management Strategy is being progressed following feedback from members of the Audit and Risk Committee. An updated version will be circulated for review in the next two weeks. Attention was drawn to the importance of completing this recommendation by the 26.2.21, as identified in the action plan. It was confirmed that the development of a risk management e-Learning package for staff will follow after ratification of the Risk Management Strategy.

**Resolved:**
The Audit and Risk Committee noted the CQC Action Plan.

**20/21/72 Board Assurance Framework Report**

The Audit and Risk Committee received an overview of the Board Assurance Framework (BAF) as at the 31st of December 2020. The following points were raised:

- It was reported that BAF 1.1 is to be reviewed by the Chief Nurse and a deep dive was conducted into BAF 1.2 by the Chief Operating Officer, during January's Safety and Quality Committee meeting. Attention was drawn to the financial risks presently being faced by the Trust and it was pointed out that a session took place during the last Care Delivery Board in respect to the organisation's Financial Strategy and overriding principles for 2021/22. The other area of uncertainty is the impact that Brexit will have on the NHS supply chain. It was confirmed that the Trust is monitoring this risk.
- The Chair raised concerns about the impending deadline for the introduction of the Cheshire and Merseyside Integrated Care System (ICS), from a governance perspective and queried as to whether this risk needs to be included in the Corporate Risk Register/BAF.

  The Committee was advised that the overall planning framework has been paused and guidance may not be available until May/June 2021. It was pointed out that legislative changes for ICSs won't commence until the 1.4.22 and will run in shadow form for the first twelve months. Erica Saunders drew attention to a number of areas that may cause potential problems, for example, in terms of the way that the ICS Board and Executive is to be constructed, the proposed conflict resolution process and the influence that organisations with the strongest voice are going to have. It was felt that further discussions should take place to review and take stock of this issue to ensure that it is fully articulated.

**20/21/72.1 Action: ES/JG**

- The Chair raised a query in relation to the following risk;
  - *BAF Risk 2.1* – The Chair felt that the lack of a standard methodology for workforce planning presents a considerable gap for the organisation. It was pointed out that this risk has been on the BAF for a long period of time without

any progress, even though it is presently being managed quite well without a methodology. The Committee was informed that the Executive Team have discussed this area of work during a recent 2021/22 planning session. It was reported that the workforce component will be a major feature of the plan and will require a solid framework and method that teaches the Trust about rigor from a planning perspective and therefore the recruitment and numbers that the organisation requires to deliver the activity. Discussions have taken place in respect to each speciality being supported to look at advanced roles that are required to help the organisation meet the challenges that it is facing as a result of the pandemic, backlogs, etc.

Urmi Das advised that a meeting has taken place to discuss Consultant and Physician Associate vacancies. The Medical Director is leading on this area of work and discussions have taken place about having an Executive view on Trust appointments.

The Chair pointed out that this risk sits more in the domain of the People and Wellbeing Committee (PAWC) and was raised by the Audit and Risk Committee from a general risk perspective. It was agreed to refer this risk to PAWC for an update in the next six months.

**20/21/72.2** **Action: ES**

**Resolved:**
The Audit and Risk Committee received and noted the BAF update as at the 31.12.20.

**20/21/73 Trust's Risk Management Report**

The Committee received the Trust's Risk Management Report for the 1.11.20 to the 10.1.21 in order to scrutinise the effectiveness of risk management in the Trust. The assurance presented in this report is a direct reflection of the evidence available on the electronic Ulysses risk management system at the time of reporting. The following points were raised:

- It was reported that there are a number of high/moderate and moderate risks that aren't being mitigated as quickly as the Trust would like. The Divisions and corporate functions are currently working to address this position. The Chair asked for an update on these risks along with a graph to show movement of risks.

**20/21/73.1** **Action: CU**

- The position for risks with an overdue date/risks with no agreed action plan has improved since submission to the Audit and Risk Committee. The Chair asked that the Committee receive an update on this area of work during each meeting.

**20/21/73.2** **Action: CU**

- Table 3 has been incorporated in the report to show the profile of risks for the individual Divisions and Corporate Services. This was in response to a request to highlight increasing/decreasing risks within the Divisions. Fiona Marston felt that this information would be easier to review if there was a timeline incorporated in the report and two graphs to show trends.

**Resolved:**
The Audit and Risk Committee received and noted the Trust's Risk Management Report.

**20/21/74 Update from the Care Delivery Board including Corporate Risk Register**

The Committee was advised that the Corporate Risk Register is to be reviewed by the Executive Team on the 26.1.21 due to December's Care Delivery Board being cancelled. Risks have been validated by respective directors in order to confirm that the risks feel current and are still valid. It was reported that a number of service issues have been addressed via the Safety and Quality Assurance Committee.

The Committee felt assured that work is taking place to reduce risk across the organisation and information is being provided to determine why certain risks are taking longer to mitigate.

Fiona Marston queried the present trend in Covid transmissions in Liverpool and asked as to whether the Trust is being impacted from a staff availability perspective due to the third wave. The Committee was advised that there are signs of a rapid drop in transmission rates across Liverpool regions which has resulted in a plateau in staff absences. It was pointed out that the Trust has established a track and trace department and staff self-testing is also taking place.

The Chair recognised that the Corporate Report is a live document and will change on a regular basis but felt that assurance has been provided that risks are being manged in real time.

**Resolved:**
The Audit and Risk Committee received and noted the Corporate Risk Register.

**20/21/75 Internal Audit Plan for 2021/22**

It was proposed that a meeting take place between MIAA and Alder Hey to have an initial discussion about the Internal Audit Plan for 2021/22 to enable a full draft of the plan to be compiled and submitted to the Audit & Risk Committee in April for approval. Kath Stott agreed to schedule a meeting with Erica Saunders and Ken Jones and then link in with Kerry Byrne, Anita Marsland and Fiona Marston.

**20/21/76 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. The following points were highlighted:

- MIAA issued three final reports, of which, two received a substantial assurance level; Clinical Audit Processes and Data Quality.
- A number of fieldwork reviews will be completed by the year end, with NatSSIPs fieldwork commencing on the 22.1.21 and the implementation of the Data Security Toolkit taking place in February 2021.

- Attention was drawn to the request to defer the Risk Management Review to 2021/22. It was confirmed that MIAA's proposal is to expand stage three of the Assurance Framework Review to address some aspects of risk management, with assurance being provided by the Audit and Risk Committee and the Care Delivery Board that the Trust is managing this area of work. It was reported that this will not affect the issuing of an audit opinion for 2020/21 by MIAA.
- It was confirmed that regular monthly meetings will be take place with the Trust up until April in order to provide an update on the draft Audit Plan for 2021/22, and thanks were offered to management for the help that was provided to MIAA to facilitate audits for the current year's plan.
- John Grinnell informed the Committee of the recruitment of an Associate Director, Paul Morris, who has been appointed to oversee the Trust's Informatics and Data Quality Service and develop this area of work going forward. A report will be submitted to the Audit and Risk Committee in April to highlight initial thoughts on the next steps that need to be taken and provide a draft outline of the Data Quality Strategy.

**20/21/76.1** **Action: PM**

- It was felt that an update on Data Quality should be submitted to the Committee on a regular basis to provide assurance. It was agreed to incorporate this item on the Audit and Risk Committee workplan.

**20/21/76.2** **Action: KMC**

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

**20/21/77 Internal Audit Follow-up Reports**

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

**20/21/78 Anti-Fraud Progress Report, Q3**

The Committee received an update on the anti-fraud work for Q3, which covered the period from the 10.9.20 to the 12.1.21. The update highlighted the activities and outcomes which take account of the current working environment; presented in accordance with the four key areas of the NHS Counter Fraud Authority (NHSCFA) standards. The following points were highlighted:

- It was reported that MIAA Anti-Fraud Service is not in a position to submit a draft of the 2021/22 Annual Plan at the present time. Work will continue to take place with the Trust on the draft plan which will be submitted to the Audit and Risk Committee in April 2021.
- The Chair queried as to whether the issue relating to Fraud Awareness training has been addressed. It was confirmed that Fraud Awareness training has become a mandatory requirement for the Trust and 888 members of staff have completed the training since the beginning of January. It was pointed out that every member of staff is obliged to undertake this training despite having attended a Trust Induction session.

- The Chair referred to the Bribery Review that was detailed in page 7 of the progress update and queried as to whether this will result in a report being submitted to the Committee. It was reported that this exercise will be used to benchmark the majority of MIAA's clients to look at the processes/systems in place for addressing bribery. It was confirmed that a report will be produced following the review.

**Resolved:**
The Audit and Risk Committee received and noted the contents of the Anti-Fraud Progress Report for Q3.

**20/21/79** **Update on Progress (E&Y)**

It was reported that there has been a delay in commencing the draft External Audit Plan for 2020/21 but it was confirmed that meetings have taken place with the Trust to discuss timings for planning procedures.

The Committee was advised that the National Audit Office (NAO) has updated the Code of Audit Practice following consultation. The proposal is to increase the scope of the 'Value for Money Conclusion'. The exact scope hasn't been confirmed as of yet, but Hassan Rohimun agreed to circulate the link for the consultation and keep the Trust updated in terms of the extended reporting requirements.

The Chair queried as to whether the majority of Ernst and Young's work on the draft Audit Plan will be complete by April 2021. It was reported that the planning and interim elements will have been completed by April but the auditing of the Trust's financial statements won't have commenced at that stage. Following discussion, it was agreed that Ken Jones and Hassan Rohimun would meet in order to work towards completing the draft External Audit Plan for 2020/21 in line with the formal submission dates.

The final version of the draft External Audit Plan for 2020/21 will be submitted to the Committee in April for approval.

**20/21/79.1** **Action: HR**

**Resolved:**
The Audit and Risk Committee noted the update received from Ernst and Young.

**20/21/80** **Gifts and Hospitality**

The Committee was advised that the Trust is continuing to focus on 'Declarations of Interest' and 'Gifts and Hospitality'. It was pointed out that this area of work is being driven by the Divisions via their governance meetings, and progress is being made.

**Resolved:**
The Audit and Risk Committee noted the update on 'Declarations of Interest' and 'Gifts and Hospitality'.

**20/21/81** **Progress against actions from the Audit and Risk Committee Self-Assessment**

The Committee received an update on the progress against the actions to date. The following points were highlighted:

- *Introduction of DMO Reporting* – Discussions have taken place with the respective person to look at introducing a reporting process to provide independent assurance to the Committee by the year end. This action is ongoing.
- *Clinical Audit* – It was reported that a discussion took place with Liz Edwards on the 20.1.21 about clinical audit. It was felt that a further discussion needs to take place between Kerry Byrne and Fiona Beveridge to look at what needs to be reported to both committees. This action is ongoing.
- *Draft Risk Appetite* – This will be submitted to the Board in March 2021.

**Resolved:**
The Audit and Risk Committee noted the progress against the actions from the Audit and Risk Committee self-assessment.

**20/21/82** **Accounting Policies**

It was reported that the Accounting Policies and Issues Report is usually submitted to the Committee during Q3 for regulatory/information purposes as it provides detail on the overall consolidation of NHS Annual Accounts, but the Committee was advised that NHSI haven't issued it as of yet.

**20/21/83** **Any Other Business**

It was pointed out that there is an action for April to provide some feedback from Deloitte in respect to the audit taking place around the purchase of PPE during the pandemic. The Committee was advised that as a result of the third wave, Deloitte haven't progressed this work and therefore the Trust hasn't received an update regarding this matter. It was queried as to whether this action should be deferred until the outcome of the audit is available from Deloitte or whether the Trust should conduct a localised piece of work internally. The Chair felt that this action should be reviewed during April's meeting to see if there has been any direction from Deloitte. (Existing Action 20/21/49.1).

**20/21/84** **Meeting Review**

The Chair felt that the agenda focussed on the right area, which was risk, and asked Committee members to feedback their views if they felt that there hadn't been enough time spent on the other areas of the agenda. Erica Saunders drew attention to the importance of hearing from the Divisions on risk during the meeting and queried as to whether some thought could be given to this matter. The Chair agreed to discuss this matter with John Grinnell in order to propose a way forward. An update will be provided on the 22.4.21.

**20/21/84.1** **Action: KB**

**Date and Time of the Next Meeting:** Thursday 22nd of April, 2:00pm-4:00pm, via Teams.

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

| | | | |
|---|---|---|---|
| **Present:** | Ian Quinlan (Chair) | Non-Executive Director | (IQ) |
| | Shalni Arora | Non-Executive Director | (SA) |
| | Adam Bateman | Chief Operating Officer | (AB) |
| | Claire Dove | Non-Executive Director | (CD) |
| | Dani Jones | Director of Strategy & Partnerships | (DJ) |
| | John Grinnell | Director of Finance | (JG) |
| | Erica Saunders | Director of Corporate Affairs | (ES) |
| | Melissa Swindell | Director of HR & OD | (MS) |
| | Kate Warriner | Chief Digital & Information Officer | (KW) |
| **In attendance:** | Ken Jones | Associate Director Financial Control & Assurance | (KJ) |
| | Robin Clout (part) | Interim Deputy Chief Digital Information Officer | (RC) |
| | Russell Gates | Associate Commercial Director Development | (RG) |
| | Rachel Lea | Deputy Director of Finance | (RL) |
| | Claire Liddy | Director of Innovation | (CL) |
| | Nicki Murdock | Medical Director | (NM) |
| | Justin Wrench (part) | Innovation Consultant | (JW) |
| | Amanda Graham | Committee Administrator (*minutes*) | (AG) |

**20/21/178 Apologies:**

Sue Brown — Associate Development Director (SB)

**20/21/179 Minutes from the meeting held on 22nd February 2021.**

**Resolved:**

The minutes of the last meeting were approved as an accurate record.

**20/21/180 Matters Arising and Action log**

Handrail - JG advised that this is now incorporated into the Children with Complex Behaviours work – action closed.
Green Plan is an agenda item – action closed.
Action Plan for the Division of Surgery is an agenda item – action closed.

**20/21/181 Declarations of Interest**

There were no declarations of interest.

**20/21/182 Finance Report**

**Month 11**

KJ presented the Month 11 Finance Report. £400k deficit this month £600k favourable to our plan, equating to an overall deficit of £3.6m which is £1.5m favourable to our plan. Currently forecasting a deficit of £1.2m relating to Annual Leave which it is expected to be funded awaiting confirmation. Spend on Covid has been consistent with allocation, with pressure starting to fall, there is a healthy cash balance and capital slippage has reduced by £3.2m cumulative.

Cash remains a longer-term pressure; there are significant capital pressures on the estates programme; and risk on future capital allocation.

21/22 Planning and Contracting is expected w/c 29th March.

IQ asked how the Division of Surgery's position has improved this month; KJ replied that there had been improvement in M11, improvement in agency spend and one-off

waiting list premium spends over previous months which had impacted the overall view.

JG suggested bringing a paper to capital programme at the May RABD with a more informed set of figures.

**Action:** Detail & mitigation on capital programme to be brought back to May RABD (RL)

**Write-offs**
IQ asked that a new process was developed to reduce the number of write-offs on training fees. KJ noted that there is now a process of payment up-front for training.

**Resolved:**
RABD received and noted the M11 Finance report. Agreement was given to progress with the write-offs listed.

**20/21/183** **2021/22 Framework & Interim 21/22 Plan**
RL gave an update on the Framework and Interim plan for 21/22.

Detailed planning guidance has not yet been received but is expected by the end of the month. Block funding with fixed funding will continue until September with an efficiency target and an expected recovery target alongside separate funding for access & restoration.

The planning process is ongoing across the Trust to produce the interim plan with a focus on expenditure and a reset to CIP targets for 21/22 with a redistribution between clinical & non-clinical areas.

The interim plan for 21/22 was presented noting that the current deficit figure will likely change once 21/22 allocations have been received. The Capital plan for 21/22 has been reviewed taking into account slippage over previous years and an initial draft figure has been submitted to the ICS. The CIP programme has been reset for this year with 50% of the carry forward from previous year funded. SDG has been reinstated to focus on cost reduction & transformation within the Divisions and cross cutting across all areas.

IQ asked whether this was for approval or as a direction of travel. RL confirmed this update was for noting until confirmation is received.
Discussion took place on CIP allocation and distribution with points raised by KW for consideration, agreed to discuss at SDG and update RABD next month.
CL asked whether there were any "big ticket" items for growth; RL noted that there will be a clinical business development workshop with Divisions to take place.
AB asked whether there should also be a funding & sales strategy to enhance the plan and to reimburse for certain costs for recovery, also a positive expansionary income growth piece within the Sustainability plan, both of which could be tracked through this committee.
DJ noted the fit of those discussions with Exec and Board strategy sessions in late April. MF noted there needs to be full visibility for all about where cost pressures have come from and their impact on the organisation as a whole.
SA asked re the Capital plan, what the figure quoted is based upon and whether that takes into account any best or worst case capital spend; RL noted that some of the estates spend may not fall within 21/22 and be profiled into future years. This will be brought back in more detail next month as noted earlier.

**Resolved:**
RABD received and noted an update against the 2021/22 Financial Framework and Interim 21/22 Plan.

**20/21/184** **Division of Surgery Action Plan**
AM presented the action plan for the financial recovery of the Division of Surgery. IQ asked what the period for the savings and expectation for realisation, AM confirmed that these would be across 21/22; expectation is high for cost reduction & budget realisation with some reservations around securing additional income from Commissioners.
IQ asked that the overall figure be tracked month on month and reported to RABD. JG considered whether overall across the organisation there could be some KPIs around vacancy levels, maternity leave, absence / attendance metrics etc.

**Resolved:**
RABD received and noted the action plan for financial recovery of the Division of Surgery.

**20/21/185** **Productivity:**
**Surgery** – Data was presented to show the positive impact of changes to theatre start times with a Divisional desire to improve the metric further across all specialities, along with tracking improvements to other pre-op planning. Significant improvement was noted within Outpatients.
IQ asked what the percentage of patients discharged between 7am & 12pm could be; AM noted that the national figure aimed for is 30% but there is variance across wards & specialities.

**Medicine** – Data was presented showing a further increase in the numbers of patients treated per clinical session in theatres and in community and the total number of outpatient consultations has increased over the last quarter.

**CAMHS / Community –** Data was presented showing further increased activity and the Division are now seeing and treating more children in the past month than before Covid. Digital consultations have been one of the biggest contributing factors and the service has recovered above and beyond where it was before the pandemic due to workforce investment and rapid digital adoption.

**Resolved:**
RABD received and noted the updates on current productivity within the Divisions.

**20/21/186** **Cash & Capital Updates**
KJ gave a brief update, noting that the main challenges will be on closely monitoring the capital programme and trying to minimize any overspends alongside getting to break-even and delivery of CIP.

**Resolved:**
RABD received and noted the Cash and Capital updates.

**20/21/187** **Campus & Park Updates**
RG gave a brief update on the Campus and Park development works; currently proceeding on the PAU; Oncology & Genetics buildings are being demolished with the boiler house & management block are due for demolition in the next few weeks and the Cluster building is now at roof level. Discussions are ongoing with Liverpool Council around the handover of phase 1 of the Park. There have been some late changes to materials on the Cluster to mitigate future insurance costs.

Work is ongoing on the plans for phases 2 & 3 of the Park.

*MF asked whether Groundwork are involved in the plans for the playground; RG noted that the contractor was involved in the initial design of the playground.*
*CD asked that the beneficiary from any asset lock on the CIC is made clear and that there is clarity in why any decisions have been made to allay any challenge or influence.*

*IQ asked whether there is any option for change in the soil remediation specifics bearing in mind the costs; RG noted that all specifics will be considered.*

*IQ sought assurance on the change in materials for the Cluster building; RG gave verbal assurance that the changes were of benefit.*

**Resolved:**
RABD received and noted the Campus and Park updates.

**20/21/188** **Corporate Office Update**
RG gave an update on plans for the Corporate offices and future working arrangements. A discussion took place around management of the decision-making process and its presentation.

**Resolved:**
RABD received and noted the Corporate Office update.

**20/21/189** **Marketing and Communications Strategy from 2021**
MF presented the Marketing & Communications Strategy from 2021, highlighting key points for consideration.

**Resolved:**
RABD received an update on the Marketing & Communications Strategy.

**20/21/190** **Digital & IT Update February 2021**
KW presented a brief overview of the Digital & IT update, noting the continued improvement across key programme areas and KPIs.

**Resolved:**
RABD received and noted the Digital and IT update report for February 2021.

**20/21/191** **Month 11 Corporate Report**
AB presented the Month 11 Corporate Report, noting improvements in access to cancer care, timely care in ED and improved theatre utilisation as positives for the month. Challenge still remains with children waiting for treatment as a direct contraction of theatre schedules due to admitting adult patient but now that has ceased recovery is rapidly ongoing which is expected to have an impact over the next few months; to support this a formal plan has been presented at Board and to the Cheshire & Mersey hospital cell which will see positive results over the next 2-3 months. However, in some clinical areas the time to wait for treatment is more in line with adult Trusts at up to 12 months.
JG noted Alder Hey's favourable position compared to other specialist Children's Trusts, mainly due to keeping a reduced capacity elective programme running.

**Resolved:**
RABD received and noted the M11 Corporate report.

**20/21/192** **Safe Waiting List Management Update**

AB gave a brief presentation on the Safe Waiting List Management program and updated the meeting on progress with validation work. Regular monitoring meetings with the CCG continue and a more detailed update will be circulated to the Committee.

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

**20/21/193** **PFI Report**

The PFI Report for Month 11 was noted as being within the meeting pack for information.

**Resolved:**
RABD received and noted the M11 PFI report.

**20/21/194** **Alder Hey Green Strategy**

MF gave a brief overview of the Green Strategy, noting that several workstreams have been set up to progress the work with external support available to progress this work if required.
IQ asked when the plan would be available for review and what was the cost of developing the Plan; MF noted that the Plan will come initially in stages along with the timetable and key milestones; costs will be on a draw-down basis that are not yet finalised, agreed and signed off. Initial advice was offered whilst on site and was given pro-bono. Alternative external support options to be explored & considered.

**Action:** Alternative external support options to be explored and considered (JG/MF)

**Resolved:**
RABD received and noted the Green Strategy report.

**20/21/195** **Board Assurance Framework**

ES presented the Board Assurance Framework and noted that there will be a review as part of the strategy session in late April. Recommendations were made for updates on financial risk around CIPs and on campus risk around clear detail overall and within the monthly update to provide more clear assurance.

**Resolved:**
RABD received and noted the BAF update.

**20/21/196** **Digital Collaboration Business Case**

*(KJ & RG left the meeting & RC joined the meeting)*
KW & RC gave an overview of the business case circulated to the membership marked Commercial in Confidence. Agreement was sought for the business case & partnership agreement forming part of the Specialist Trusts Collaboration & Digital Services Collaboration.

**Resolved:**
RABD received and approved the Digital Collaboration business case and recommended its approval by Trust Board.
*(RC left the meeting)*

**20/21/197** **Clear Mask Commercialisation**

*(JW joined the meeting)*

CL & JW KW & RC gave an overview of the business case circulated to the membership marked Commercial in Confidence. Agreement was sought for commercialisation & development of a transparent mask and for delegated authority to be given to a subcommittee to assist with progressing work with preferred bidders and approval of the final agreement.

**Resolved:**
RABD received and approved commercialisation of the Clear Mask work with a one-off bespoke group for diligence with pace to be set up outside the Committee to manage the work, to include IQ, SA, CD, JG, CL and JW.
*(JW left the meeting)*

**20/21/198** **Review of Meeting**
Key points: positive meeting covering serious matters in detail.

**Date and Time of Next Meeting: Monday 26th April 2021, 10:00, via Teams.**

**Safety and Quality Assurance Committee**
**Confirmed Minutes of the meeting held on**
**Wednesday 24th March 2021**
**Via Microsoft Teams**

| | | | |
|---|---|---|---|
| **Present:** | Fiona Beveridge | (Chair) Non-Executive Director | (FB) |
| | Nathan Askew | Chief Nursing Officer | (NA) |
| | Adam Bateman | Chief Operating Officer | (AB) |
| | Kerry Byrne | Non-Executive Director | (KB) |
| | Lisa Cooper | Director - Community & Mental Health Division | (LC) |
| | Urmi Das | Interim Divisional Director for Medicine | (UD) |
| | John Grinnell | Director of Finance/Deputy Chief Executive | (JG) |
| | Dani Jones | Director of Strategy & Partnerships | (DJ) |
| | Beatrice Larru | Consultant, Infectious Diseases | (BL) |
| | Phil O'Connor | Deputy Director of Nursing | (POC) |
| | Nicki Murdock | Medical Director | (NM) |
| | Erica Saunders | Director of Corporate Affairs | (ES) |
| | Melissa Swindell | Director of HR & OD | (MS) |
| | Christopher Talbot | Safety Lead, Surgery Division | (CT) |

**In attendance:**

| | | |
|---|---|---|
| Adrian Hughes | Deputy Medical Director | (AH) |
| Julie Creevy | Executive Assistant (Minutes) | (JC) |
| Cathy Umbers | Associate Director of Nursing & Governance | (CU) |

**20/21/115 Apologies:**

| | | |
|---|---|---|
| Pauline Brown | Director of Nursing | (PB) |
| Robin Clout | Interim Deputy CIO | (RC) |
| Anita Marsland | Non-Executive Director | (AM) |
| Alfie Bass | Divisional Director, Division of Surgery | (AB) |
| Jacqui Pointon | Associate Chief Nurse/Safety Lead | (JP) |
| Cathy Wardell | Associate Chief Nurse, Medicine Division | (CW) |
| Kate Warriner | Chief Digital & Information Officer | (KW) |

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

**20/21/116 Declarations of Interest**
SQAC noted that there were no items to declare.

**20/21/117 Minutes of the previous meeting held on 17th February 2021 –**
**Resolved:** committee members were content to **APPROVE** the minutes of the meeting held on 17th February 2021.

**20/21/118 Matters Arising and Action Log**
**Action Log**
The action log was updated accordingly.

**Matters Arising**

**HCAI Code of Practice Compliance – update to be received at April 2021 meeting.**

**Was Not Brought rate** – SQAC **NOTED** that this would be closed and removed from the action log.

**Quality Improvement Progress Reports**

**20/21/119 Quarter 3 Patient & Family Feedback**

NA presented the Quarter 3 Patient & Family Feedback Report. NA advised that the Patient Experience Team had undertaken a phenominal amount of work during the last 12 months. FFT response rates continue to be good and the Trust had increased satisfaction scores. Education scores are above target.

National Survey results - 50% of the questions stayed the same, with 50% showing improvement. PLACE scores remained good, with some additional work needed in terms of cleaning standards, which is being reviewed. NA advised that there had been a significant amount of work which had been undertaken by the Volunteering Team, who had been put forward for a Queens Award, the Trust are currently awaiting the outcome. KB referred to future Patient & Family reports and requested that a highlight report or presentation be considered for future updates. NA confirmed that he would work with the team, in order to consider and ensure an enhanced report to SQAC.

SQAC RECEIVED and **NOTED** the Quarter 3 Patient & Family Feedback.

**20/21/120 Quality Priorities**

NA advised that the overall project plans are almost near completion. Quality hub had reviewed the programme and are working on the development of associated metrics.

NA advised that the overarching Quality Priorities plan and metrics would be shared at April 2021 SQAC meeting.

FB thanked NA for Quality Priorities update.

**Delivery of Outstanding Care - Safe**

**20/21/121 CQC Action Plan**

ES presented the CQC Action Plan. ES referred to Consent, in terms of an action which had turned to amber. CT advised that significant work is ongoing with regards to Consent. CT stated that it is difficult to obtain assurance in an audit. Division had undertaken a retrospective review regarding Mental Health Capacity and had adjusted the toolkit template. CT advised that there is an issue regarding acquisition of data which surgical colleagues require support from IT colleagues, for the division to analyse information once information had been received from IT.

The Division are undertaking ongoing work with regards to providing podcasts for staff regarding consent, and Surgical colleagues are working with the legal team for relevant information and updates. CT advised that this ongoing work does take time to progress. FB queried whether this would be linked into training/CPD, CT confirmed that this is a free-standing resource, with several external groups providing consent. JG queried what

IT support is required in order to progress this issue. CT confirmed that the division require support from IT in order to create a 'QR' code or a link. JG queried whether a detailed update would be beneficial to SQAC with regards to the consent update.

**Action: CT & JG to undertake a follow up discussion offline, in order to agree how and when this should be reported back to SQAC and to the Board of Directors and liaise with ES as appropriate.**

SQAC RECEIVED and **NOTED** the CQC Action plan, and awaited feedback from JG/CT/ES following offline discussion with regards to future update to SQAC.

FB thanked ES & CT for update.

**20/21/122 CQC Mental Health Act Inspection Report - Tier 4 Children's Inpatient Unit**

LC presented the CQC Mental Health Action Inspection Report – Tier 4 Children's Inpatient Unit which provided an overview of background detail, findings and key areas reviewed. CQC had undertaken an unannounced Mental Health Act monitoring visit off the Tier 4 Children's Inpatient Unit on 26th & 27th January 2021, the monitoring visit took place remotely by Microsoft teams. The CQC had previously inspected Tier 4 Unit on 1st July 2019. The areas inspected as part of the review were – Least restrictive options and maximising independence, empowerment and involvement, respect and dignity, purpose and effectiveness, Efficiency and equality.

The findings of the review overall were positive, with the reviewer requesting additional evidence relating to Education and training provided to staff regarding Autism Spectrum Disorder and Eating Disorders. Whilst also requesting evidence to demonstrate how the unit ensures that care plans reflect patients input, their likes and dislikes, hobbies and interests, that patients have access to meaningful activities and how any feedback is acted on.

KB questioned whether the Trust had received any response to the submitted information, LC confirmed that no response had been received. ES advised that the expectation is that any residual issues would be fedback to the Trust by CQC at a future CQC engagement meeting.

SQAC RECEIVED and **NOTED** the CQC Mental Health Act Inspection Report – Tier 4 Children's Inpatient Unit

**20/21/123 Alder Hey Young People Violence Update (01 September 2020 – 28th February 2021)**

LC presented the Alder Hey Young People Violence Update (01st September 2020-28th February 2021), which provided background detail, progress to date, details of types of attendance, governance and monitoring, Impact of Covid-19, next steps and actions required.

- LC advised that the number of referrals had doubled since September 2020, referrals had been predominantly for young boys, with the youngest patient 10 years old.
- Youth worker has weekly safeguarding supervision through the Trusts safeguarding team and reports all of the data through the national trauma dataset intelligence group that is shared across the region.
- Youth worker had remained back on site since Setember 2020, who works in ED, mental healh services and across the Wards
- From 1st April 2021 the Youth worker role would transfer to a different provider, tender has been awarded to 3rd sector provider to further develop the role and embed the role, with 3 youth violence workers working across the City to support 16-25 year old with 24/7 support

**Resolved**: SQAC RECEIVED and **NOTED** the position in relation to AH Young People Violence Update (01st September 2020 – 28th February 2021).

FB thanked LC for update.

**20/21/124 Quarter 3 Complaints, PALS & Compliments Report**

NA presented the Quarter 3 Complaints , PALS and Compliments Report; key issues as follows

- NA advised that Complaint Reporting is moving to monthly reporting to CQSG to assist in the improvement of the current levels of performance. SQAC would continue to receive quarterly Complaints, PALS & Compliments Report.
- Main reason for informal PALS concerns related to appointments and communication, 50 compliments are recorded centrally in the Ulysses system.
- NA advised that the Trust had good response rates, with compliance with the 3 working day acknowledgement for formal complaints at 98%. Compliance with the internal Trust target of 25 working day response time is 27%, this is a downward trend, with further improvement required.
- The Trust has 1 complaint which continues to be investigated by the PHSO, with no new referrals in the quarter.
- Key themes included an increase in complaints regarding ticks, Tourette's, and appointment and scheduling.
- Chief Nurse had commissioned an improvement programme which would focus on:
  - The process policy and systems
  - The structure and reporting lines of the team
  - Cultural focus on the importance of meeting response times for divisons and how to demonstrate learning form individual complaints and system wide learning across the organisation.

FB requested if NA could give some thought to how SQAC would monitor progress, for this to be captured on the Action log for April 2021 meeting.

KB queried whether SQAC could receive a table detailing total numbers detailing open/closed cases. NA confirmed that he would be happy to review this in order to capture relevant information in future Complaints, PALS and Compliments report.

SQAC RECEIVED and **NOTED** the Quarter 3 Complaints, PALS and Compliments Report.

SQAC supported the Proposed Development in the Management of Complaints & PALS
FB thanked NW for Quarter 3 Complaints, PALS & Complments update.

**20/21/125 Quarter 3 DIPC Report/DIPC Exception Report**

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

- Ongoing work had been progressing with regards to CLABSI's, and how CLABSI's are counted, BL advised that the IPC team are currently preparing a Business Case in order to enhance the surveillance system, which would enable the creation and

generation of reports, IPC team plan to engage with medical and surgical colleagues to engage further with colleagues.

- Covid Vaccination - 84% (3270) of staff had received first dose
- Fit testing – in totality the Trust has fit tested >2,000 staff, when the figures are separated by staff who are 'in scope' by division is 81.7%. BL stated on production of the IPC report that Community - 42.3%, however this had since risen and is currently at 75%.
- Track, Trace and Swabbing Team are fully established with a robust testing programme for patients, staff and families. During January-February 2021 the total number of forms submitted was 1224, swabs taken 1067 and positive results 174.
- Self-Testing, BL advised that from 1st March 2021 the Trust had introduced LAMP asymptomatic testing programme. 1,000 samples had been completed during the last two-week period, with 1 positive result.
- COVID-19 Outbreaks – No outbreaks had been reported during February 2021

FB referred to the plan for counting CLABSI's and questioned whether the Trust is likely to see an increase in CLABSI's given the increase in reporting. BL confirmed that she envisaged that there would be an increase and that a Trust approach is required, rather than Divisional approach. BL stated that she would expect to see a peak in numbers, following by a decrease over time.

FB queried whether the IPC team are seeing the correct level of compliance across the staff groups with regards to LAMP asymptomatic testing. BL stated that on commencing the lateral flow testing 30-40% response/uptake, however the team had seen a decrease in testing, as staff are not participating. Multiple communications had been issued, with the IPC team being extremely adaptable, Survey had been sent to engage staff. BL advised that the feeling of safety drives systematic testing. BL stated that Alder Hey are not unique in this regard.

**Resolved**: SQAC RECEIVED and **NOTED** the assurance provided by the DIPC Exception Report and **NOTED** the ongoing work with regards to CLABSI's and other pathogens and would await future IPC update detailing any impact.
FB thanked BL for DIPC update.

**20/21/126 Safe Waiting List Management Update**

AB presented the Safe Waiting List Management update, which provided comprehensive update. 25,780 Records had been validated; key issues as follows:-

- 104 patients waiting >52 weeks had been added to the waiting list as follows:-
- 70 patients had been treated; 12 patients scheduled to receive treatment within 6 weeks; 2 patients had chosen to delay treatment, 20 patients are awaiting date to be scheduled. 81 of 104 Clinical Reviews had been undertaken,
  No confirmed harm had been identified in these 104 patients waiting > 52 weeks
- During Business as usual the Trust undertake Clinical Reviews - following Clinical Reviews the team had identified possible harm on waiting list for 6 patients requiring further review. If harm is confirmed the Trust would undertake a full harm review document.
- Data Quality workshop had taken place with operational team in order to define the scope of data quality, with BI team to undertake technical evaluation and prepare a development roadmap for the data quality dashboard/reports.
- E Learning package for clinical staff had been rolled out to all validated users from the training database. E Learning package for admin/management had also been rolled out to all validated users.
- Corporate risk register had been updated in March 2021.
- AB confirmed that the scale of validation is on trajectory and is on plan to conclude

validation by the end of May 2021 with regards to outpatient validation

SQAC **RECEIVED** and **NOTED** Safe Waiting List update and **NOTED** good progress made to date.

FB thanked AB for update.

**20/21/127 Transition Update including compliance with NICE Guideline 43: Transition from children to Adults' services for young people using health and social care services**

LC presented the Transition Update including compliance with NICE Guideline 43: Transition from Children's to Adult's services for young people using health and social care services, which provided an update on Transition, Trust Activity levels, Compliance with NG43 and action required, and details regarding next steps, key issues as follows:-

- 100% of Cohort 1 (52 complex young people > 18 years) had undergone detailed transition preparation sessions which include developing with each young person a transition plan, health information passport and route into urgent care plan. 19 young people from Cohort 1 had been successful transition to their GP with support from specialist services.
- 75% of Cohort 2 (23 complex young people 16-18 years) had undergone detailed transition preparation sessions, which included developing with each young person a transition plan, health information passport and route into urgent care plan.
- Significant progress had been made in engaging adult acute and community Trusts with a standard operational policy to support the transition of young people with complex neuro disability, based on a 10 Steps Transition Pathway, will support young people with complex neuro-disability in the Liverpool and South Sefton areas to transition to adult services.
- Community & Mental Health division had been successful with an application to host the Burdett Trust Transitional Regional Nurse Advisor Post. The post supports the standardisation of transition practice in all Trusts covering the North of England.
- Currently the Trust is unable to demonstrate and monitor compliance with NG43 at division and service/speciality level. Further work is required to fully embed the responsibility for the transition of young people to adult services across the divisions, so as to ensure a consistent and cohesive approach which improves the experience of the young people and families involved with 6 short term actions identified in order to support compliance with NG43.
- LC advised that the Lead Nurse for Transition had worked tiresely to date in order to engage adult colleagues, with a meeting scheduled week commencing 29th March 2021 with Merseycare to progress this further.
- LC proposed that SQAC would receive a quarterly Transition update in order to provide SQAC with assurance, FB confirmed this would be acceptable.

KB expressed concern regarding how this would be addressed at system level, if young adults cannot be transitioned to adult services, given that patient numbers would increase. LC stated that there is a need for reporting process for each specialty in order to evidence.

UD advised that adult colleagues are refusing to accept gastro/neurology adult patients with mental health issues. LC and UD agreed to have an offline discussion in order to discuss this issue further.

**Resolved: Offline Discussion to be held with LC & UD**

FB stated that for future Transition Quarterly Reports that it is imperative for input from Divisions, in order for Divisions to update on progress, and highlighted the importance of sufficient time allocated to receive the update.

**Resolved**: SQAC RECEIVED and **NOTED** the Transition update, SQAC to receive quarterly Transition update going forward.
FB thanked LC for update.

***Effective***

**20/21/128** **CQSG Key Issues Report**

NA provided CQSG update, key issues as follows:-

- NA advised on an issue relating to the number of policies and guidelines which are currently passed their review date. In February 2021 the Trust moved to a new improved document management system, which enables improved search facilities for policies and guidelines. During this migration process 200 documents were identified as past their review date. 80 documents relating to Pharmacy, 50 documents relating to Corporate and 70 documents across the three clinical divisions. A Task & Finish Group had been established by the Chief Nurse, in order to monitor progress against guidelines.
  Policy is being reviewed/updated in line with new process. NA advised that the plan is to have the majority of the documents within date by the end of April 2021, with the exception of the Pharmacy Documents, which are required to go through a slightly different process. NA is awaiting Pharmacy trajectory.
- CQSG Terms of Reference and CQSG workplan had been updated. With 1 change regarding the Risk report continuing to report to Care Delivery Board and not CQSG.

FB questioned how the Task and Finish Group focussed on Safety in terms of out of date guidelines. NA advised that the policies were being reviewed in terms of safety. Some had been given initially a short review date which can hopefully be extended following a review.

FB stated that it is her understanding that the system in place will flag guidelines and policy renewal in the future. NA stated that the system will send prompts to policy/author/owner and the relevant Associate Chief Nurse 6 months in advance of expiry.

**Resolved**: SQAC **NOTED** CQSG update.
FB thanked NA for CQSG update.

***Well Led***

**20/21/129** **Board Assurance Framework**

ES presented the Board Assurance Framework detailing updates to the end of February 2021, ES highlighted that the focus had been made regarding Risk 1.1 and Chief Nurse had extensively reviewed this risk. ES advised that there is a Strategy Session scheduled for 23rd April 2021, in order for Executive Colleagues to collectively review the risk profile.

ES advised that there are some revised gaps and assurance and workforce issues which had been heavily dominating that risk had been remitted to Risk 2.1.

ES advised that there are ongoing discussions with executive colleagues regarding the presence of the Covid Risk at strategic level going forward, and similarly the Brexit Risk which would feature in future discussions at Board.
KB referred to Risk 1.1 with some feedback relating to the control measures which would be shared with NA outside the meeting.

**Resolved:** KB to email NA with comments, NA to amend as appropriate

KB referred to policies such as workforce policies and finance policies and queried whether there is a process for RABD, People & Wellbeing Committee in terms of policy schedules. NA stated that the new 'Policy on Policy' document does detail approval and cascade levels. This had been reviewed by Chief Nurse & Medical Director and is currently being reviewed further in order to clearly articulate the terminology used within the document to ensure clarity for staff.

SQAC **NOTED** this is work in progress, and the new document would provide clarity of approval comittees and processes.

SQAC RECEIVED and **NOTED** the BAF update and noted ongoing work.
FB thanked ES for BAF update.

**20/21/130 Divisional reports by exception/Quality Metrics**

***Division of Community & Mental Health***
LC presented the following key issues for the committee's attention:

**Safe**

- The Division has zero incidents resulting in death or severe harm
- The Division had no Category 3 or 4 pressure ulcers.
- The Division commenced CALMS training - for restrictive physical practice training, with 10 staff members trained and an ongoing training programme over the next six months
- Challenges relating to medication incidents and PALS incidents with regards to a delay in families receiving prescriptions from the Trust in the post, which are national, regional and local issues regarding the Royal Mail. From 6th April 2021 the Division will have a courier service to enable collection of prescription from Alder Hey and delivery to Pharmacy.

**Caring**

- 18 compliments recorded
- Family & Friends scores continue to be over 90% for very good and good, with over 96% of C&YP Families rating outpatient as Good or very good in the wider community.
- Increase in PALS - 38 in February relating to medication concerns regarding prescriptions being late and feedback regarding ASD processes, given that when families are not given a diagnosis, families are unhappy, there is a process in place to address this, pathways are improved.
- Booking and scheduling have eradicated the backlog of logging referrals.
- Referrals to locality mental health services and eating disorder services continue to dramatically increase in January & February 2021 with a 30% increase, which is impacting upon waiting times.
- Crisis care had also seen highest number of calls of 798 calls received in February 2021.
- ASD & ADHD pathways continued to maintain 30-week timescale, and the pre

April 2020 cohort continue to decrease in line with agreement with the CCG.

**Well Led**

- Staff sickness is currently at 4.5%
- Mandatory training decreased to 89%, predominantly relating to Resuscitation training, which wasn't undertaken face to face during COVID pandemic, face to face training is now taking place, with sessions facilitated within the Community
- The Division had held first Divisional Schwarz round
- Division had entered a Partnership with the Princes Trust
- From April 2021 the Division will have 8 young adults from a BAME background commencing a work-based programme within the Division

SQAC RECEIVED and **NOTED** the pressure areas regarding increase in referrals for mental health services and eating disorder clinics.

***<u>Division of Medicine</u>***
UD, presented the Quality Metrics Divisional update; key issues as follows:-

**Safe**

- Zero Never Events
- 1 RCA regarding the use of an incorrect device, this is being reviewed, learning had been disseminated, this is ongoing
- 1 MRSA
- ED Sepsis and response time is being reviewed – currently at 84.4%
- Significant reduction in the number of open incidents
- Increase in number of lessons learned and dissemination
- Challenges regarding extension regarding ongoing RCA's, due to availability of external experts, this is being reviewed.

**Caring**

- Communication main theme, currently looking at every complaint actioned within 25 days, 4 complaints relating to ticks and Tourette's and 18 PALS, there is ongoing work to improve communication with families. Challenges remain regarding complexity of complaints.

**Effective**

- ED performance continued to meet pre Covid level at 97%
- Theatre utilisation is lower than planned, ongoing work with Gastro team in order to improve theatre utilisation
- Highlights include good ED performance and theatre utilisation at 87%
- The Was Not Brought Rate had decreased from 13% to 12%

**Responsive**

- Overall improvement regarding RTT compliance, with update of weekend list, RTT 92% and when report written - 95%
- Pathology performance at 6 weeks is on trajectory
- There are no outpatients waiting over 52 weeks, 3 patients waiting over 40 weeks
- Challenges regarding diagnostics waiting time had increased, due to patient cancellation on the day

**Well Led**

- Risk management register is at 100% compliance, currently have 3 risk ratings of high of 15, which is expected to decrease in March 2021

- There had been a decrease in sickness, compared to January 2021
- Challenges regarding policy/guidelines compliance which which are due for renewal - 44%

***Division of Surgery***

CT, Safety Lead for Surgery presented key issues update; key issues as follows:-

**Safe**

- The Division had no Never Events, (this had continued for over 1 year)
- The Division had no Category 3 or 4 pressure ulcers.
- There had been a slight reduction in patients treated for Sepsis within 60 minutes.
- The Division had a slight increase in clinical incidents, resulting in near misses from 25 to 28
- The Division had an increase in clinical incidents resulting in no harm from 108 to 141 in February 2021
- There had been no clinical incidents relating to moderate harm, and no incidents resulting in severe harm.
- Cleanliness Audits are high at 97%
- No hospital acquired organism infections
- Plans had been submitted for refurbishment of the fracture clinic
- Digitalisation of the catheterization pathways in cardiology
- Division had an increase in medication errors, 2 resulting in harm, with ongoing work throughout the Division. Medication Day is currently being planned.

**Caring**

- There had been a slight increase in formal complaints received (2-3)
- PALS had increased from 12 to 20
- The Division are progressing to the planning stage with regards to new build for Neonatal Unit.
- Challenge regarding access to timely care for elective patients, with ongoing work with regards to access and restoration.

**Effective**

- 1 patient had been readmitted to PICU within 48 hours
- There had been an increase in the number of referrals received in Surgery, an increase of 100 referrals – from 2612, to 2787.
- The Division had maintained reduced number of elective cancellations on the day
- Reduction in the Was Not Brought Rate
- Challenges - by the end of the year there is a need to increase number of CCAD
- Further improvements in theatre utilisation currently 90.3%
- No patients are waiting over 28 days following cancelation or procedures

**Responsive**

- Patients noted as being treated with respect
- Commenced the reintroduction of the theatre schedule, increased capacity within theatres.
- Challenges in outpatients with regards to recovery, and patients waiting over 18 weeks had increased, numbers had increased within ENT and Orthopaedics, however CT advised that he suspected this is due to improved data quality The Division are working on reducing waiting times.

**Well led**

- Mandatory training is 86%

- Staff turnover had maintained 8%, with long term sickness 5%. There had been a significant reduction in sickness.
- Challenges remain regarding establishing increased capacity and sustainability for all staff groups, with the need to also maintain health and wellbeing of staff.

FB referred to activity and metrics, and advised that this should be included as a % NA advised that nationally complaints are measured based WTE of workforce. NA would review any local metrics in line with the work on the complaints process and reporting.

**Resolved:** SQAC **NOTED** NA would review local metrics as appropriate.

FB thanked all Divisions for continued ongoing work in order to address current challenges within the Divisions.

**Resolved:** SQAC RECEIVED and **NOTED** Divisional Updates, and **NOTED** continued work to address current challenges.

**20/21/131 Any other business**

None

**20/21/32 Review of meeting**

SQAC welcomed the comprehensive update regarding Alder Hey Young People Violence and Violence related cases

- SQAC welcomed the ongoing work regarding Complaints, and welcomed the move to cultural learning across the Trust in terms of complaints
- SQAC welcomed IPC update with regards to counting the pathogens, and the potential increase in cases given improved data collection
- Good update received regarding Safe Waiting List Management, with assurance regarding progress to date
- Informative Transition report received, detailing NICE Guideline 43, and the wider Challenges
- SQAC welcomed update on CQSG and the update on policies and procedures/guidelines
- SQAC **NOTED** the ongoing challenges regarding restoration within surgery regarding sustainability and staff, together with wellbeing of staff, and the availability of staff within specialisms

- CQAC **NOTED** the continuing pressures regarding COVID 19 pandemic within the Community Division regarding the increase in referrals for mental health services and eating disorder clinics.

FB thanked all for good discussions across a wide range of issues.

**20/21/133 Date and Time of Next meeting**

21st April 2021 at 9.30 via Microsoft Teams

Alder Hey Children's NHS
NHS Foundation Trust

# Innovation Committee

Confirmed Minutes of the meeting held on **Monday 8th February 2021 at 1:00pm** via Teams

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|---|---|---|---|
| **Present:** | Mrs. S. Arora | Non-Executive Director (Chair) | (SA) |
| | Mrs. C Liddy | Director of Innovation | (CL) |
| | Dr. F Marston | Non-Executive Director | (FM) |
| | Mrs. L. Shepherd | Chief Executive | (LS) |
| | Mr. I. Hennessey | Clinical Director of Innovation | (IH) |
| **In Attendance:** | Ms. J. Blair | Acting Director of Research | (JB) |
| | Mr. J. Corner | Digital Salford (External Advisor) | (JC) |
| | Mr. M. d'Abbadie | MSIF (External Advisor) | (MDA) |
| | Mr. M. Flannagan | Director of Communications | (MF) |
| | Mr. R. Guerrero | Clinical Director of Innovation and Consultant Congenital Cardiac Surgeon | (RG) |
| | Mrs. E. Hughes | Assoc. Chief Innovation Officer | (EH) |
| | Mrs. K. McKeown | Committee Administrator | (KMC) |
| | Mr. I. Quinlan | Non-Executive Director | (IQ) |
| | Ms. E. Saunders | Director of Corporate Affairs | (ES) |
| **Observing** | Ms. F. Ashcroft | CEO of Alder Hey Charity | (FA) |
| | Mr. S. Jacobs | Public Governor, Wider North West | (SJ) |
| **Apologies:** | Prof. I. Buchan | Appointed Governor (External Advisor) | (IB) |
| | Mr. J. Grinnell | Director of Finance | (JG) |
| | Mr. J. Hague | External Advisor. | (JH) |
| | Ms. A. Lamb | Programme Director for Health Liverpool Innovation | (AL) |
| | Ms. R. Lea | Acting Deputy Director of Finance | (RL) |
| | Dr. N. Murdock | Medical Director | (NM) |
| | Mr. D. Powell | Development Director | (DP) |
| | Mrs. K. Warriner | Chief Information Officer | (KW) |
| **Item 20/21/61** | Mr. J. Morton | Innovation Consultant | (JM) |

**20/21/57 Apologies**

The Chair noted the apologies that were received.

**20/21/58 Declarations of Interest**

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

**20/21/59 Minutes of the previous meeting held on 7th December 2020**
**Resolved:**
The minutes from the meeting held on the 7th of December were agreed as an accurate record of the meeting.

**20/21/60 Matters Arising and Action log**

*Matters Arising*

There were none to discuss.

*Action Log*

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**For noting**

It has been agreed that all matters relating to the governance of Acorn, Innovation Limited and existing commercial contracts will become the remit of the Resources and Business Development Committee (RABD) and therefore the governance aspect will be overseen by RABD. Any outstanding actions relating to this area of work will be deferred and addressed during the next RABD meeting in March. This will allow the Innovation Committee to focus on the delivery of the Innovation Strategy and horizon scanning.

- **Action 19/20/24:** *Innovation Limited and Acorn General Update (Committee to be provided with an update on Acorn on a regular basis)* – This action has been transferred to RABD. **ACTION CLOSED**
- **Action 20/21/06.1:** *Hy-genie Investment Proposal (relevant information to be shared with Committee members and a report is to be compiled to enable the Committee approval of the requested revenue of £34.5k in return for a future share in the Hy-genie option agreement)* – This action has been transferred to RABD. **ACTION CLOSED**
- **Action 20/21/21.2:** *Hand Hygiene Solutions/Audiology Metrics Limited (Liaise with the investors to request observer status on the Board of each company and request a copy of the business plans and management accounts)* - This action has been transferred to RABD. **ACTION CLOSED**
- **Action 20/21/26.2:** *Board Assurance Framework (Discuss Unilever's policies for managing innovation risks)* – A meetings has been held and the framework has been updated. **ACTION CLOSED**
- **Action 20/21/35.1:** *Commercial Agreement Schedule (Submit a trading account to the Committee at future committee meetings detailing the income that the Trust is receiving from commercial agreements; include an update on a separate sheet of the agreements that aren't generating income)* – This action was superseded by action 20/21/50.1. **ACTION CLOSED**
- **Action 20/21/46.1:** *Innovation Strategy Discussion Update (Refine the Innovation Strategy taking into account the comments of Committee members during December's meeting and include a reference to health outcomes for children and young people)* – This action has been addressed accordingly. **ACTION CLOSED**
- **Action 20/21/48.1:** *Joint Research Projects (Provide an update during February's Committee meeting on the discussions that have been taking place around AI and opportunities for joint appointments with academic partners)* – An update was provided during February's meeting. **ACTION CLOSED**
- **Action 20/21/49.1:** *Health Innovation Liverpool (Arrange regular catch-up meetings between Alder Hey and Amanda Lamb from HIL)* - A meeting has taken place between Claire Liddy, Emma Hughes and Amanda Lamb. A meeting is to be scheduled with the new member of Amanda Lamb's team, the Director of CDC. **ACTION CLOSED**
- **Action 20/21/50.1:** *Business Developments/Partnerships (Submit a 'Corporate Partnership Schedule' to the Committee in February, April and June that includes an update column identifying as to whether agreements are in place, a brief overview of the Heads of Terms so that the committee can be assured that agreements are being signed off and that Alder Hey is only sharing specified information)* – The Corporate Partnership Agreement Schedule was submitted to the Committee during February's meeting. An

updated schedule will be submitted on the 19.4.21 and will continue to be a future standing agenda item **ACTION CLOSED**

- **Action 20/21/50.2:** *Business Developments/Partnerships (Alliance framework agreement be incorporated as part of the Trust's standard documentation)* – An update wasn't provided during February's meeting. **ACTION TO REMAIN OPEN**
- **Action 20/21/50.3:** *Business Developments/Partnerships (As and when required, submit a brief overview of the Heads of Terms for respective partnership agreements to enable Committee feedback prior to sign-off)* – This action has been superseded by action 20/21/67.1. **ACTION CLOSED.**
- **Action 20/21/53.1:** *Innovation Limited Update (Proposal to be submitted to the Committee on the 8.2.21 on the on-going future of Alder Hey Living Hospital Limited confirming as to whether it should be closed down or continue as a wholly owned subsidiary)* – This action has been transferred to RABD. **ACTION CLOSED**

**20/21/61 Children and Young People 'As One' (NHS X) Project Spotlight.**

A number of slides were presented to the Committee to provide an overview of the children and young people 'As One' project. It was reported that the project received funding from NHS England to digitally innovate the CAMHS offering to patients in the Liverpool and Sefton region. Information on the following areas was shared:

- The deliverables and aims of the project.
- Proposed pathway and intervention.
- The use of the single referral form.
- The process for agreeing the digital front door concept.
- An example of the digital resources page for use by patients and their families, along with the accessibility options.
- The current state of the project.
- Key learnings from a challenges and opportunities perspective.
- Future work.

It was reported that the Innovation Hub has been working with CAMHS for a number of years identifying the problems being experienced by patients in respect to accessing mental health services. Securing funding and participating in the project has enabled the Trust to work in a different way as NHS X wanted to almost train trusts around the whole user design and thinking concept. It was pointed out that the Trust was already using this approach for its innovation activities but has benefitted from collaborating with an external organisation, that was arranged by NHS X, as they helped to embed training, thinking and tools that can be utilised going forward. It was confirmed that NHSE would like to use the project as a case study as it encompasses a number of themes; transformational work, clinical models, digital and innovation approach.

Attention was drawn to the digital front door that includes Alder Hey's website, which the Trust has ambitions to have as a global front door with an entry point to access many different products. The Committee was advised that discussions will resume next week around this area of work using existing plans thus ensuring that the organisation has a much more focussed website that has the ability to do more than just signpost.

Fiona Marston queried as to whether the digital platform will help reduce CAMHS waiting times for patients. It was reported that funding from the NIHR grant will be used to look at Was Not Brought (WNB) figures and referrals being received. One of

the aims of the project is to provide patients with access to resources and tools that can be used prior to referral to help reduce any deterioration in mental health whilst waiting for an appointment. Research is also taking place to look at the implementation of digital resources that could help to address an issue that initiated a referral.

Fiona Marston asked if the innovation team will be promoting this project at forthcoming conferences. It was confirmed that the team are in agreement to raise the profile of their work, and Committee members were asked for any advice that they may have that would help promote the innovative work that the team are conducting. Fiona Marston offered to make contact with Jack Morton regarding this matter.

Louise Shepherd highlighted the importance of promoting the work that the Trust has conducted to support the mental health system, along with Alder Hey's role as an integrator of partners. Attention was also drawn to the issue of digital exclusion and it was felt that further work needs to take place to ensure patients aren't excluded from accessing this platform.

The Committee was advised that the innovation team is involved in the Starting Well programme which is being driven by Liverpool Health Partners. Health inequalities is high on the agenda and digital exclusion is part of ongoing discussions, with the possibility of progressing this via NIHR funding.

It was reported that there has been a large cohort of people involved in the children and young people 'As One' project; GPs, schools, teachers and community hubs, with teachers doing everything possible in terms of ensuring children and young people receive relevant information in an appropriate timeframe regardless of their digital access.

A discussion took place around the interoperability of the digital platform that has been created as a result of the project and it was queried as to whether the innovation team has linked in with Cheshire and Merseyside as the Trust is trying to create a more fluid and interoperable approach across these regions. The Committee was advised that discussions haven't taken place with Cheshire and Merseyside to date, but it was felt that this is something that can be looked into further as it was agreed at the beginning of the project that the platform had to be interoperable to ensure progression; further funding, easily accessible, utilised by new partners.

Jon Corner referred to the thirteen organisations that the Trust is working with and queried as to whether a clean data set is being created in terms of the referral process and future Artificial Intelligence (AI). It was reported that interventions have been put in place to make the flow of data cleaner, whilst utilising tools to acquire information on timings and reasons for referrals. The platform will enable the Trust to provide a much cleaner data set whilst having an overarching view of a patient's journey. All self-referrals will be submitted via the Single Point of Access team which will provide a broader set of data from a mental health perspective. The aim is to make the system user friendly to ensure that everyone is able to access the service if required.

Shalni Arora queried the process for promoting the new digital platform. It was reported that external organisations are being asked to raise awareness via their usual channels and the Trust is promoting it via Twitter, social media and word of mouth when patients make contact with Alder Hey. Schools have also been asked to relay information to their children and young people, whilst families and

professionals are being advised to refer via the platform. Work is also taking place around the sustainability of the platform to ensure it maintains the current standard going forward.

**Resolved:**
The Committee received and noted the presentation on the children and young people 'As One' project.

**20/21/62 Innovation Strategy Discussion Update**

It was reported that the Trust is looking to appoint a positioning partner to help create Alder Hey's Innovation Centre brand. The Committee received and noted the specification for the appointment, and it was confirmed that a proposal has been received from three providers. The Trust is looking to appoint the successful partner within the next two weeks.

Following a request from the Chair, the Committee received an update on the Innovation Strategy. It was reported that the Innovation Centre has been socialising the strategy with a number of stakeholders over the last four months. A session took place with the Starting Well team on the 8.2.21 to finalise the document. Proactive feedback was provided that will help ensure that the Trust's strategy interacts with other important strategies in the Liverpool City region.

The next steps are to finalise the narrative in the document by March 2021 and submit the strategy to the graphics design publishing house. The plan is to align the Branding Strategy with the Innovation Strategy so that they dovetail together to provide a clear set of assets that can be used locally and internationally. It was agreed to submit the final version of the Innovation Strategy to the Committee during April's meeting.

**20/21/62.1 Action: CL**

**Resolved:**
The Innovation Committee received and noted the specification for the appointment of a positioning partner along with the Innovation Strategy update.

**20/21/63 Innovation Performance Report**

It was reported that work is taking place to build upon the Impact to Care KPIs, with five new projects being put into the pilot stage of the process across the hospital over the last two months. Attention was also drawn to the delivery highlights of the programmes that will help the Trust deliver its Innovation Strategy; AdvancingS@fety and AccessToC@re. An update on the following areas was shared with the Committee:

*AccessToC@re*

- Asthma Wearable.
- Neurology Cohort.
- Remote Cardiology.
- Education Hololens.
- Virtual Visiting.

*AdvancingS@fety*

- Transparent masks.
- DMS (Clinical Guidelines Portal).

- ERS referrals automation.
- HR contract change requests.
- Finance invoice receipting.
- Inventory Management App.
- Covid-19 Self Testing App.

The Innovation team has been working closely with the organisation's consultants in neurology, cardiology, respiratory, endocrine and obesity to gain a clear understanding of the projects that will feed into the programmes, and the problems that need solving. The Trust is also working with a number of different companies, with clinician involvement, to find a solution for these problems.

The Committee was advised of the development of the transparent Type 11 R Mask which is part of the AdvancingS@fety programme. Information was provided on the USP of the product, the Department of Health and Social Care (DHSC) procurement exercise, product development, intellectual property, the collaboration that has taken place and the commercial prospects of the product.

A discussion took place around the outcomes of the product in the event the Trust isn't selected by the DHSC to proceed to the formal procurement exercise. It was pointed out that the Trust is looking to produce a product for the NHS that is superior and meets the needs. It was reported that the Trust is going to conduct enhanced user testing in terms of the final prototype with a mix of users, this will provide feedback and help confirm as to whether the final example will be the one submitted to DHSC. The Government team are also carrying out similar testing as part of a feedback exercise, therefore the Trust will participate in this too. Fiona Marston pointed out that this product could become global rather than regional and felt that it would be beneficial to ascertain who the top ten companies are that supply masks in order to develop contacts and find a partner to progress this area of work if the Trust is successful in winning a contract.

The Chair requested additional information to help understand the wider commercial strategy for this product, for example, the extent of the market, opportunities, plans for international rollout/international partners, etc. It was agreed to circulate an e-mail w/e 26.2.21 to provide an update on the meeting that is taking place regarding the masks and to provide the additional information that was requested. An update will also be provided to Committee members on the 19.4.21.

**20/21/63.1** **Action: CL**

Fiona Marston referred to the series of bar charts in the presentation that show the progress of the pipeline and asked as to whether it would be possible to present this information in a way that the pipeline aligns with the different specialist groups to see if it links in with the organisation's strategic interests in terms of importance or priority. It was pointed out that this is an action for a later period once the strategy is fully implemented.

**20/21/63.2** **Action: CL**

**Resolved:**
The Innovation Committee received and noted the Innovation Performance update.

**20/21/64** **Joint Research and Innovation Programme Update**

The Committee received an update on the joint Innovation and Research work that is taking place at the present time. A number of slides were shared with the Committee which provided information on the following areas:

- *Alignment of the Innovation and Research work streams*
  - Early identification.
  - Protocol development.
  - Study set up.
  - Delivery.
  - Publication dissemination.
- *Areas of development*
  - Research methodology skills.
  - Expertise in medical device governance.
  - Capacity in CRD for sponsorship and study oversight.
  - Capacity in workforce to develop, deliver and report studies.
- *Research methodology*
  - Experienced investigators in Alder Hey: Mentoring.
  - Teaching and signposting: Research clinics.
  - Collaboration with external partners:
    The Alder Hey offer –
    Honorary and joint appointments.
    Programme of studentships, PhDs, etc.
- Governance capacity.
- *Research workforce proposal*
  - Purchase PI time.
  - Part-time innovation governance post embedded in CRD.
  - Rapid Study Review Board.
  - Strengthen relationship with CORE: Delivery workforce.

**Resolved:**
The Committee received and noted the joint Research and Innovation programme update. It was agreed that a further update would be submitted to the Committee in June 2021.

**20/21/64.1 Action: JB**

**20/21/65 Health Innovation Liverpool Update**

It was reported that the director of the Civic Data Co-operative (CDC) has been appointed. A meeting will take place between the Trust and the new member of Amanda Lamb's team in the next two weeks.

**20/21/66 Commercial and Partner Agreement Schedule.**
**Resolved:**
The Committee received and noted the commercial and partnership agreement schedule.

**20/21/67 Alderhey@anywhere Discovery Partners Update**

The Committee was provided with a detailed account of the various discovery programmes and partnerships that are being progressed to deploy the Innovation Strategy. A number of slides were submitted to the Committee which provided information on the following areas:

- *Strategy deployment;*
  - The Innovation programme house outlines the key projects that have been prioritised as part of the 2030 Innovation Strategy. These projects are the needs and problem statements that have been identified as priority by clinical teams at Alder Hey.
  - The aim of the discovery approach is to use open innovation methodology to solve the problems. The methodology will scout for technology from industry or academia.

  - The approach will also require Alder Hey to partner strategically with relevant large corporates. The aim of these partnerships will be to establish relationships that bring together industry technology and research and development (R&D) capabilities with healthcare needs.
  - The outcomes may result in a variety of deals such as collaboration agreements, JVs, spin out companies or other partnerships that again may result in commercial upside or IP generation.
  - The ultimate goal is to deploy new innovations into Alder Hey that have measurable impact for children and young people and create a repeatable model across the globe.
- *Open innovation system uniquely created by Alder Hey for health;*
  - Step 1 – Problem scoping and process mapping.
  - Step 2 – Design thinking and technology scouting.
  - Step 3 – Project and deal strategy.
- *Alderyhey@nywhere shared vision;*
  - Internet of medical things.
  - Capture, interpret, impact care.
- Update on corporate partnerships.
- Update on the partnerships that are being progressed in relation to the various discovery programmes.

The Committee was asked to provide feedback/comments around some of the choices that have been made to commence the deployment of the strategy

Rafael Guerrero felt that the Trust is on the right track by engaging with corporate partners who will help to address three main areas that the Trust chose as problems to be resolved; acquiring patient information, displaying of patient information and the transporting of patient information from one place to another. It was felt that partnering with a number of organisations will help introduce an alternative to Wi-Fi, for example, 5G and help resolve the wider city region issue of systems not speaking to each other.

Jon Corner commended Claire Liddy and Emma Hughes for the work that has been conducted and felt that the partners that the Trust are liaising with will be conducive to progress. Attention was drawn to two important areas for Alder Hey 1. It was pointed out that visuals and visual technology will be crucial over the next ten years given the Trust's target audience and engagement with young people. It will be necessary to focus on the use of immersive technology and look at how video technology can be used for clinical efficiency and the Trust's engagement process, using 5G radio to enhance the process. 2. The second area relates to data. It was felt that it will be interesting to see how a partnership with a large corporate organisation will progress in respect to the Trust having real control of its data sets in line with its Artificial Intelligence Strategy/Data Strategy.

A question was raised about intellectual property and how it will be split, along with the process and timeline for the agreement of contracts. It was confirmed that the Trust isn't in the final stage of agreement as of yet, but work is being fast tracked over the next two months. The Trust is starting to address Heads of Terms, a strategic vision has been established and is aligned to the strategy and workshops will take place to scope out the projects and the potential grounds for IP**.**

A discussion took place around the speed that the Trust is progressing at, and it was queried as to whether the organisation is taking too much on. It was reported that the Trust is reaching a point where it is prioritising projects and will pause any ongoing engagement in order to deliver the agreed set of projects. The Trust's goal is to pilot a project within respiratory, obesity and cardiac remote monitoring by the

end of March 2021. The Committee was advised of the importance of partners at all levels and it was pointed out that the Trust has prioritised opportunities in order to hone down on the list of partnerships that was presented during the meeting.

Fiona Marston felt that a sense of priority/fit is required to enable members to understand how the choice of partners has been made and thus provide feedback as requested. Attention was also drawn to the importance of addressing partnerships from a commercial perspective, for example, financial projections, R&D provision from partners, generation/contribution of IP. It was suggested that one of the areas that the strategy should focus on is the impact that forthcoming projects/partnerships will have in terms of income to help close the gap between the Trust's shortfall and the funding that is required.

The Chair concluded the discussion by requesting a report on each of the partnerships once they reach the Heads of Terms stage, in order to provide information on the opportunities, financials, commercial opportunities, marketing and IP to enable the Committee to either agree to progress the partnership to the next stage or ask further questions. It was reported that work is taking place via workshops to acquire relevant information and reach the next stage of the process.

**20/21/67.1 Action: CL/EH**

The Chair asked Claire Liddy and Emma Hughes if they required any further input from Committee members. Claire Liddy advised that the feedback had been helpful and was sufficient to be able to move towards the next phase.

**Resolved:**
The Committee received and noted the Alderhey@anywhere Discovery Partners update.

**20/21/68 Board Assurance Framework**

The Committee was advised of the considerable amendments that have been made to the innovation risk, in line with previous discussions. The risk is now significantly different as it has been re-described on the back of the strategy and the areas of work that were included on February's Innovation Committee agenda. The most up to date narrative on the innovation risk will be reflected in the next iteration of the BAF.

**Resolved:**
The Committee received and noted the Board Assurance Framework for December 2020.

**20/21/69 Any Other Business**

There was none to discuss.

**20/21/70 Review of the Meeting**

It was felt that the Committee addressed all key areas during the meeting.

**Date and Time of next meeting:** Monday the 19th April 2021 at 1:00pm, via Microsoft Teams.