Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 7th April 2020 commencing at 10:00

Venue: Lecture Theatre 4, Institute in the Park and via 'Microsoft Teams'

AGENDA

VB no.	Agenda Item	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
1.	**20/21/01**	**Apologies**	Chair	To note apologies: Hilda Gwilliams	**N**	For noting
2.	**20/21/02**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**20/21/03**	**Minutes of the Previous Meeting**	Chair	To consider and approve the minutes of the meeting held on: **Tuesday 3rd March 2020.**	**D**	Read Minutes
4.	**20/21/04**	**Matters Arising and Action Log**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Read log
5.	**20/21/05**	**Revised governance arrangements – reducing the burden**	E Saunders/ J Grinnell	To brief the Board on changes to NHS governance arrangements.	**N/I**	Presentation/ National Position
6.	**20/21/06**	**CEO update**	L Shepherd	To receive a highlight report	**N**	Verbal
Current Operational Update						
7.	**20/21/07**	**Coronavirus/Covid-19:** • **System context – Alder Hey's role.** • **Strategic Aims of COVID plans.** • **COVID Programme structure.** • **COVID Operational Plan.** • **COVID Performance scorecard.**	LS/DJ JG JG AB JG	To present current position with management plans.	**A**	Presentation Presentation Presentation Read report Presentation

VB no.	Agenda Item	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
Strategic Update						
8.	**20/21/08**	**Board Assurance Framework**	Executive Leads	To provide assurance on how the strategic risks that threaten the achievement of the trust's strategic operational plan are being proactively managed.	**A**	Read report
9.	**20/21/09**	**Alder Hey in the Park Campus Development update** **Liaison Committee** **- Minutes from the meeting held on 10th December 2019**	D. Powell	To receive an update on key outstanding issues / risks and plans for mitigation. To receive the approved minutes from December 2019.	**A**	Read report
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led						
10.	**20/21/10**	**Corporate Report - Divisional updates:** - **Medicine** - **Surgery** - **Community & Mental Health** **Executive exception report:** - **Quality** - **Performance** - **Finance** - **People**	A. Hughes A. Bass L. Cooper P Brown A Bateman J Grinnell M Swindell	To receive the monthly report of Trust performance for scrutiny and discussion against CQC domains: **Safe, Caring, Effective, Responsive and Well Led,** highlighting any critical issues/actions needed **by exception.**	**A**	Read report
11.	**20/21/11**	**Serious Incident Report**	P Brown	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
12.	**20/21/12**	**Quarterly Mortality Report**	N Murdock	To receive the quarterly report	**A**	Read report
13.	**20/21/13**	**Clinical Quality Assurance Committee:** - **Chair's highlight report from the meeting held on 31.03.20** - **Approved CQAC minutes from the meeting held on 12.02.20**	A Marsland	To receive a highlight report of key issues from the March meeting and the approved February minutes.	**A**	Read report

VB no.	Agenda Item	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
The Best People Doing Their Best Work						
14.	**20/21/14**	**Workforce and Organisational Development Committee:** - **Approved minutes from the meeting held on 10.12.19**	C Dove	To receive a update of key issues from the March meeting	**A**	Verbal
Game Changing Research and Innovation						
		No items this month				
Sustainability through Partnerships						
		No items this month				
Strong Foundations						
15.	**20/21/15**	**Resources & Business Development Committee Report:** - **Chair's highlight report from the meeting held on 25.03.20** - **Approved RABD minutes from the meeting held on 26.02.20**	I. Quinlan	To receive a highlight report of key issues from the February meeting and the approved January minutes.	**A**	Read report
Items for information						
16.	**20/21/16**	**Any Other Business**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
17.	**20/21/17**	**Review of meeting**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief	**N**	Verbal
Date And Time of Next Meeting: Tuesday 5th May 2020 at 10:00am, Tony Bell Board Room, Institute in the Park and via Teams						

REGISTER OF TRUST SEAL

The Trust Seal was used in March 2020:

- Deed of Guarantee for SPV (Energy Costs)
- Deed of variation for Land Eaton Road
- Second Deed of variation for at Eaton Road
- Reversionary Lease, Alder Road

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Digital Futures	**Kate Warriner**
Research Quarter 3	**Jason Taylor**
Finance Metrics Month 11	**John Grinnell**

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Confirmed Minutes of the meeting held on **Tuesday 3rd March 2020 at 10:00am,**
Tony Bell Board Room, Institute in the Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mrs S Arora	Non-Executive Director	(SA)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	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 H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr F Marston	Non-Executive Director	(FM)
	Dr N Murdock	Medical Director	(NM)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
In Attendance:	Mr A Bass	Director of Surgery	(AB)
	Ms L Cooper	Director of Community Services	(LC)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
	Mrs K Warriner	Chief Information Officer	(KW)
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Prof F Beveridge	Non-Executive Director	(FB)
	Miss J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
Agenda item:	Sue Brown	Assoc. Development Director	
	Russell Gates	Assoc. Development Director (Commercial)	

Patient Story
As the family had been unable to attend the patient story for this meeting would not go ahead and the family would be invited to a future meeting.

19/20/343 Declarations of Interest
There were none to declare.

19/20/344 Minutes of the previous meetings held on Tuesday 4th February 2020
Resolved:
Apart from a typographical error on page two the Trust Board approved the minutes from the last meeting held on 4th February 2020.

19/20/345 Matters Arising and Action Log
19/20/45: Hilda Gwilliams updated the Board noting meetings would continue with the school to increase the criteria and would be monitored via the Clinical Quality Assurance Committee. This action would now be closed.

19/20/315: Claire Liddy, Director of Operational Finance and Innovation had responded to whether there are opportunities to provide learning through Alder Play.

Alder Play is currently in the early stages of development, it is likely Alder Play would be able to provide learning however it would not be ready for at least 12 months. Due to this the action was closed.

19/20/346 Key Issues/Reflections and items for information

The Chair and the Chief Executive thanked all those involved in preparing for the CQC Well Led Inspection. A positive feedback letter had been received and the official rating would be published over the next few months.

The Board reflected on the KPMG Inspiring Quality Readiness Assessment session that had taken place immediately prior to the Board meeting, noting the current position and process to be followed over the coming weeks.

Hilda Gwilliams and Kate Warriner had attended the North West Costal Research Innovation Awards where Alder Hey had been successful in two categories: Patient Safety Innovation Award - early detection of deterioration in children in hospital to prevent critical care transfer – the DETECT study; and the Award for Reducing Health Inequalities: The Asthma Mapping Project.

Erica Saunders reported that Hill Dickinson had made a joint entry for an HSJ award on Alder Hey's behalf in the Patient Safety category for the E-consent development. This had been highly commended.

Nicki Murdock had opened the new Junior Doctors' mess yesterday based in the third floor of the Treehouse in the Atrium. Feedback from the juniors had been well received.

Alfie Bass reported on the Vein of Galen surgery service that is being developed. As this is at an early stage Alfie undertook to provide further updates once the service was more developed.

Hilda Gwilliams spoke of the new nurse cohort that had come from India to work at Alder Hey. Hilda noted the wraparound of services that had come together to support the nurses. This had included donated warm clothing items, changes to the canteen menu and members from Barclays bank providing support with opening bank accounts. It was agreed the new cohort of nurses would be invited to the April Board lunch and a letter would be sent to Barclays Bank thanking them for their support. Claire Dove said there would be an International Women's Day event at Blackburne House and agreed to send an invite to Hilda Gwilliams to forward on to the new cohort of nurses.
Action: HG/CD

Louise Shepherd reported on the newly appointed Chief Executive Jackie Bene for the Cheshire and Merseyside Health and Social Care Partnership. Jackie is due to start her new role in May 2020.

19/20/347 Operational update

Adam Bateman referred to the campus development noting the requirement for a number of teams including Scanning and Transcription to change location. These changes would be done jointly with the Executive support from HR and Digital to ensure as little disruption as possible.

An update was received on the Best in Outpatients project and the digital changes that have been implemented to improve the service.

Listening sessions have been held in relevant areas to try to improve the timing of basic medicines being available within 30 minutes following a prescription being issued.

There have been further pipe leakages both in ED and Radiology. Whilst there has been minimal damage or disruption the Board were reminded of the continued corroded pipe risks and the discussions that had taken place to ensure mitigation. John Grinnell advised Project Co is meeting on Wednesday 4th March 2020 and further decisions will be made around how best to move forward.

Resolved:
The Board received the Operational update.

19/20/348 Coronavirus outbreak

Nicki Murdock briefed the Board as to the progress made since the February Board meeting. Communication from NHS England is for all hospitals to ensure they have a number of isolation areas.

One area of concern is training staff to use Personal Protective Equipment (PPE); a plan for this is being developed with the Infection, Prevention and Control team.

The topic for the monthly Chief Executive staff briefing session to be held on Wednesday 4th March theme will be Coronavirus, including myth busting and protocols for staff.

John Grinnell went through the financial risk in relation to the need to respond to Coronavirus, noting it would continue to be monitored.

The first paediatric case had been confirmed in Newcastle today.

Hilda Gwilliams spoke of the partnership working that was taking place across healthcare service to provide support as and when required.

Resolved:
The Board noted plans in place for managing the Coronavirus, a further update will be received at the April meeting.

19/20/349 Strategic Programme Progress Report

John Grinnell presented the above report for February 2020 noting the close of 2019/20 programme and development and agreement of 2020/21 priorities. Key highlights from the report included:

- Journey to Outstanding: As the CQC Well Led Assessment had now concluded this aspect of the programme in its current form would be closed.
- Catering Project: All benefits have been tracked with a number of those showing positive trends; this project would be closed.
- E Rostering: PID has been completed with stakeholder engagement.

Going forward refocus would be given to revisiting possible models for International and Private Patients' provision.

Resolved:
The Board noted progress against the Change Programme.

19/20/350 Board Assurance Framework (BAF)

Erica Saunders presented the Board Assurance Framework noting the new area of activity associated to responding to the Coronavirus and the risks and impact of this. It would agree this would be opened as a new strategic risk.

Lisa Cooper provided a verbal update regarding improvements planned in relation to ASD and ADHD waiting times. An update paper will be presented to April Trust Board.
Action: LC

Resolved:
The Board received the BAF February 2020 report, noting the updated position.

19/20/351 Alder Hey in the park Campus Development
Alder Hey in the Park Site Development Update
Change Programme: Park, Community, Estates and Facilities
David Powell introduced Russell Gates who will be providing support to David and the team in relation to the new build projects over the next 6 months.

Park Reinstatement
Phase 1 of the park had been completed within the timescales set. There are concerns in relation to the timescale being met for phase 2. David Powell highlighted the areas of concern, noting work would continue towards the current deadline of June 2020 however July 2020 may be more realistic.

Alder Centre
David Powell reported that occupation of the building will entail a further delay. The external works package costs have not yet been fully agreed. The complex issues of the project's current position were noted. Occupation will therefore likely occur towards the end of May/beginning of June instead of mid-April. The Alder Centre and Community Cluster projects will continue to be managed through Resources and Business and Development Committee. The Board noted the importance of delivering the requisite quality within this project and that this may impact a delay.

North East Plot
Demolition of a number of areas on the plot is due to commence this month, a meeting to approve this is to be held later today.

19/20/352 Neonatal Partnership Update
Adam Bateman presented slides from the options appraisal meeting; three options had been looked into with the preferred option being B. Slides showing what the preferred option would look like, its cost and where it would be based if approved were noted.

The Neonatal timescales would be presented at the Resources and Business Development Committee on the 25th March 2020 and at the Trust Board on 7th April 2020.

The Liverpool Women's NHS Foundation Trust had opened the new Neonatal unit last month. The Chair had been invited to visit the new unit noting the engagement that had been carried out to develop the joint service.

Resolved:
The Board noted the current position of the Neonatal Partnership with a further update to be received at the April Trust Board.

19/20/353 Corporate Report

The Board received the month 10 report.

The three Divisional Directors presented highlights and challenges for the month against the Safe, Caring, Effective, Responsive and Well Led domains.

Medicine – Adrian Hughes
Safe
There had been 0 never events, 0 incidents resulting in severe or permanent harm, 0 pressure ulcers (category 3 and 4), 0 hospital-acquired infections for MRSA and C.difficile. Inpatients treated for sepsis within 60 minutes was 100%.

An update was received on both the moderate harm incidents and an incident of permanent to moderate harm; the latter was in relation to an oncology patient receiving an incorrect diagnosis that led to unnecessary treatment. The patient has since received the correct diagnosis and treatment. A level 2 investigation is in progress.

Pharmacy outpatient dispensing times remain challenged at 47% compliance with the 30 minute standard.

Caring
Six complaints and 43 PALS responses were seen in-month; whilst complaint numbers remain low the Division continue to work with the quality team to improve timely and high quality responses.

Effective
ED Performance is at 87.6%, improving by 1.5% since December. Although this figure represents the highest performance since October 2019, this remains below the national standard of 95%. Delivery of the Emergency Care standard continues to be the Division's top operational pressure and priority. An ED action plan continues to make progress, balancing immediate actions such as additional triage capacity (through the staff bank) and maximising primary care capacity, with a longer term proposal to strengthen ED workforce and redesign patient flows.

Responsive
Pathology turnaround times consistently good with notable improvement in urgent requests. However, there was some concern over MRI, CT, ultrasound and Nuclear Medicine internal targets. The Board noted the continued monitoring of the action plan to improve pathology turnaround times.

Well Led
Delivery of the in-month and forecast year-end financial control total.

Surgery – Alfie Bass
Safe
There had been 0 never events, 0 pressure ulcers (category 3 and 4), 0 hospital-acquired infections for MRSA and C.difficile. Inpatients treated for sepsis within 60 minutes was 57% - three patients had not been administered antibiotics within the 60 minute deadline. After looking into this it was apparent two patients did not require the antibiotic and for the 3rd patient administration was 9 minutes overdue; this patient has had no further concerns.

A discussion was held in relation to the metrics and commentary of the report in relation to Never Events. There were no never events in January for Surgery. The commentary states one Never Event however this in relation to February's report and

will be reported at the April Trust Board. The Corporate report will be amended and the correct version will be available on the Trust website.

Caring
There had been a reduction in formal complaints, with the Division only receiving one in January. Whilst complaint numbers remain low the division continue to work with the quality team to improve the timeliness and quality of responses.

Effective
A high number of 28 day breaches wwas reported. Hilda Gwilliams referred to a complex surgery patient who required two consultants, one being external. The difficulties with planning this operation was noted; the case is under review to be re-scheduled as quickly as possible.

Responsive
Challenges included maintaining elective programme while supporting high acuity medical demand in March.

Well Led
Mandatory training has improved to 93%.

Community and Mental Health – Lisa Cooper
Safe
There had been 0 never events, 0 incidents resulting in moderate or severe Harm, 0 pressure ulcers (category 3 and 4).

Caring
An increase in PALS was reported (44) with the main themes relating to access and communication. Going forward Hilda Gwilliams requested that compliments are also included for each of the divisions.
Action: Divisional Directors

Effective
Investment had been agreed by Sefton CCGs for improving ASD and ADHD diagnostic pathways, Eating Disorders and Crisis Care Services for children and young people.

Responsive
All children and young people referred to Eating Disorder Service had been seen within national targets for urgent and routine appointments.

Well Led
Staff turnover continues to be above the Trust target; Divisional plans are in place to support the recruitment and retention of staff.

Executive leads raised items by exception as follows:

Safe
Friends and family recommending Alder Hey are at 94%.

Effective
The scanning service for outpatients has improved; following the commencement of a new outsourced Scanning Bureau turnaround times are now at an average of one day. Plans are in place to support improvements in inpatient scanning over the next month.

Well - Led
In Month 10 the Trust delivered a £1.5m surplus which was (£0.2m) behind plan. This leaves us (£0.1m) behind our year to date plan.

Sickness levels have reduced to 5.7% but are still higher than target.

Resolved:
The Board received and noted the contents of the corporate report for month 10.

19/20/354 Serious Incident Report
The Board received and noted the content of the Serious Incident report for January 2020 with the inclusion of lessons learned. Hilda Gwilliams stated that during this reporting period there were no new Never Events, one new Serious Incident, and two SI's had been closed.

The Serious Incident had been reported under the Corporate Report section for Medicine, this was in relation to an incorrect grading of a tumour eight years ago by another organisation's diagnostic service. Routine practice since that time has changed to two pathologists reviewing samples rather than one, significantly reducing the risk of recurrence. A level 2 Investigation is underway.

Kerry Byrne referred to a table previously included in the report that summarised the number of new incidents, ongoing incidents and the month they were reported; she commented that she had found this helpful and requested that this section be re-instated.
Action: HG

Never Event Action Plan
Alfie Bass presented a report on all Never Events in the last 18 months noting there was no single theme or consistent process issue. A review of each Never Event has taken place with the following actions to be implemented:
- Human Factors training: new training programme
- Team Based Simulation: 5 steps to safer surgery
- Theatre team coaching
- Revised Root Cause Analysis process

Staff engagement meetings are in process and an external review would be commissioned from an organisation with expertise in this area. The Board were advised that this was a five year plan and Trust Board updates would be received intermittently.

Resolved:
The Board received:
- Serious Incident report for January 2020.
- Never Event Action Plan

19/20/355 Complaints Report Quarter 3
The Trust received 28 formal complaints during this period; the main themes were around treatments and procedures. The Trust received 26 formal complaints in the period, this is slightly higher than same quarter last year.

Two complaints had been withdrawn: following numerous attempts to contact the complainant the Quality team have been unable to do so. The CCG and GP have been made aware of this decision, to enable them to inform the family once they are located.

Lisa Cooper referred to the four compliments for the quarter in Community Division, advising the number was low and not accurate; it was noted this would be looked into on the Ulysses system.

Resolved:
The Board received and noted the quarter 3 Complaints report for the period 1st October 2019 – 31st December 2019.

19/20/356 Clinical Quality Assurance Committee

Resolved:
The Board received the Chair's highlight report from the last meeting on 12th February and the approved minutes from the meeting held on 15th January 2020.

19/20/357 People Plan

Melissa Swindell noted the February report that had been previously circulated with the Board papers.

Gender Pay Gap Report

Melissa Swindell gave a presentation noting the legal requirement to publish annually the Trust's gender pay gap report. A snapshot of data has been taken from the Electronic Staff Record to collate mean and median hourly pay and bonuses by gender.

This report demonstrates that the Trust gender pay gap remains mainly within our Medical and Dental staff groups and is reflective of the demographic profile of the workforce within this staff group, which has historically contained a much larger proportion of men. The Medical and Dental female workforce profile is evolving with an increased number of female consultants being appointed

Going forward a number of initiatives are to be implemented to reduce the gender pay gap, this will be monitored through Workforce and Organisational Development Committee.

Health Education England Annual Assessment Action Plan

An update was received on the current position the final plan will be submitted at the end of March and will be presented at the April Trust Board.

Staff Survey 2019 Results

Melissa Swindell went through the published results noting the 11 themes, Alder Hey's scoring, including the highest, lowest and the average performance. This was in comparison to Combined Acute and Community Trusts. The overall response rate at Alder Hey was 62%, this was slightly higher than last year. Overall the position had mainly stayed the same compared to 2018.

Going forward the big conversation methodology is being used to break down the data and assess what actions can be put in place to improve Alder Hey as a place to work.

Resolved:
The Board received:

- The People Plan update for February 2020.
- The Trust Board APPROVED the Gender Pay Gap report to enable it to be published on the Trust and government website in line with statutory reporting guidelines.
- Staff Survey 2019 Results

- Health Education England Annual Assessment Action Plan current position final Action plan to be presented at Trust Board on 7th April 2020.

19/20/358 Workforce and Organisational Development Committee:

Resolved:

The Board received a verbal update from the last meeting held yesterday on 2nd March 2020.

19/20/359 Innovation Committee

Resolved:

The Board received the Chair's highlight report from the last meeting on 17th February and the approved minutes from the meeting held on 10th December 2019.

Shalni Arora noted there are currently no Key Performance Indicators for the committee and they will be developed through the strategy.

19/20/360 One Liverpool Plan – 'Starting Well'

Dani Jones and Louise Shepherd updated the Board on the system wide approach co-ordinating the One Liverpool Plan, Cheshire and Merseyside Health and Social Care Partnership and Liverpool Provider Alliance. More details will be shared with Board as the plans develop.

Resolved:

The Board received an update against One Liverpool Plan – 'Starting Well'.

19/20/361 Liverpool Specialist Trusts Alliance

Louise Shepherd presented a paper and summarised the key points from the last Specialist Trust Collaboration Board to Board workshop held on 24th February, which was facilitated by Sir David Dalton, latterly CEO of the Northern Care Alliance.

The Board discussed the proposed matrix, noting support to pursue more formally collaborative working opportunities set out in the document. CEOs are to establish a joint programme Board to develop this, regular reports will be presented to the Trust Boards. A further event has been proposed for late spring to further develop a strategic collaboration.

Resolved:

The Board supported the proposal to further pursue more formally, collaborative working in the areas identified.

19/20/362 Operational Plan: Including update on 2020/21 Financial Position

Following the February Board update John Grinnell noted the appeal that had been lodged with NHSI in relation to the Financial Improvement Trajectory (FIT) calculation. The appeal has been logged and a response is awaited.

Commissioner contract sign-off is behind plan; NHSE's offer has been received however a concluded position is yet to be agreed.

An update on proposals to monitor the work on sustainability from 2020 to 2025 was presented; a full time role in Finance is dedicated to this.

For a surplus trading position of the draft capital plan deferral of £13m to 2025 is required.

Final Budget is due to be approved on 5th March 2020 subject to (FIT) agreement.

Resolved:
The Board agreed:

1. Roll-over budget approach with a three month process to approve investments subject to contacts and CIP planning
2. Activate Board Sponsored CIP/waste/productivity plan – more for same (will improve run rate)
3. Capital gap – requires prioritisation/slippage approach or Board approval of surplus plan
4. Investments - rigorous approach to ensure clear ROI/impact measurement

A further update will be presented on 7th April 2020.

19/20/363 Green Plan – Project Initiation Document

Mark Flannagan requested Board support on the delivery approach of the Alder Hey Green Plan. The Board noted their support with the development of the plan and whilst a declaration of climate emergency wouldn't be called at the moment it would be monitored and agreed going forward.

Resolved:

The Board noted support with the Alder Hey Green plan with agreement to support a declaration of climate emergency in the future.

19/20/364 Resource and Business Development Committee
Resolved:
The Board received the Chair's highlight report from the meeting held on 26th February and the approved minutes from the meeting held on 22nd January 2020.

19/20/365 Board Reporting Calendar – 2020/21
The Board were asked to review the reporting calendar and inform the Committee Administrator of any changes.

Resolved:
The Board received and noted the Board reporting Calendar for 2020/21.

19/20/367 Corporate Calendar Trust Board and Sub Committee Dates for 2020/21
Resolved:
Board received and noted the Corporate Calendar for 2020/21.

19/20/368 Any Other Business
Additional Board Members Safeguarding Training
The above training had been arranged to take place after today's Board meeting. As the meeting had overrun it was agreed further training dates would be circulated.
Action: JT

19/20/369 Review of the meeting
The Board reviewed the meeting noting the longer period spent on quality was required. Board members were advised to inform the Committee Administrator of timings when requesting agenda items.

Date and Time of next meeting: Tuesday 7th April 2020 at 10:00 in the Tony Bell Board Room, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following on from the meeting held on the 3.9.19

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Action for 2nd April 2020							
07.01.20	19/20/289	Mortality report Quarter 2	To look into the continued reduction of deaths and report back on the findings within the Quarter 3 report	Nicki Murdock/Julie Grice	07.04.20		**7.4.20** - This item has been included on the Trust Board agenda. **ACTION CLOSED**
03.03.20	19/20/354	Serious Incident Report	To re-instate the inclusion of the no of incidents, ongoing incidents and the month they were reported.	Hilda Gwilliams	07.04.20		Completed. **ACTION CLOSED**
Action for 5th May 2020							
03.03.20	19/20/343	Corporate Report	To include compliments received for each Division within the Corporate report	Divisional Directors	07.04.20		**7.4.20** - This item will be included on the Trust Board agenda in May.
Action for 2nd of June 2020							
03.03.20	19/20/346	Key Issues/Reflections and items for information	To invite the new Nurse cohort from India to the Trust Board lunch and to write a thank you letter to Barclays Bank for their support in setting up bank accounts for the new members of staff	Hilda Gwilliams	07.04.20		This item has been deferred until further notice due to the Covid-19 crisis.
03.03.20	19/20/350	Board Assurance Framework	To present a paper on the improvement waiting times that is being developed with the commissioners for ADHD patients	Lisa Cooper	07.04.20		This item has been deferred until further notice due to the Covid-19 crisis.

Status	
Overdue	
On Track	
Closed	

Publications approval reference: 001559

To:
Chief executives of all NHS trusts and foundation trusts
CCG Accountable Officers

Copy to:
Chairs of NHS trusts, foundation trusts and CCG governing bodies
Chairs of ICSs and STPs
NHS Regional Directors

28 March 2020

Reducing burden and releasing capacity at NHS providers and commissioners to manage the COVID-19 pandemic

We wrote to you on 17 March 2020 setting out important and urgent next steps on the NHS response to COVID-19. Following this letter and detailed guidance to GPs we are writing today to provide further guidance to support you to free-up management capacity and resources.

During this challenging period NHS England and NHS Improvement is committed to doing all it can to support providers and commissioners, allowing them to free up as much capacity as possible and prioritise their workload to be focused on doing what is necessary to manage the response to the COVID-19 pandemic. Further information is provided on the following pages.

We will continue to review and monitor the situation and will remain agile in making further changes where necessary.

We appreciate the incredible amount of commitment and hard work going on across the NHS in these challenging times.

Yours sincerely

Amanda Pritchard

Chief Operating Officer, NHS England & NHS Improvement

The system actions

Changing NHS England and NHS Improvement engagement approaches with systems and organisations

Oversight meetings will now be held by phone or video conference and will focus on critical issues. Teams will also review the frequency of these meetings on a case-by-case basis. For our improvement resource, we have reprioritised their work to focus on areas directly relevant to the COVID-19 response:

- GIRFT visits to trusts have been stood down with resources concentrated on supporting hospital discharge coordination
- The outpatient transformation work is focused on video consultation and patient-initiated follow up
- We have prioritised our special measures support in agreement with CQC to ensure we support the most challenged in the right way to help them manage the COVID-19 pressures.

1) Governance and meetings

No.	Areas of activity	Detail	Actions
1.	Board and sub-board meetings	Trusts and CCGs should continue to hold board meetings but streamline papers, focus agendas and hold virtually not face-to-face. No sanctions for technical quorum breaches (eg because of self-isolation) For board committee meetings, trusts should continue quality committees, but consider streamlining other committees (eg Audit and Risk and Remuneration committees) and where possible delay meetings till later in the year. While under normal circumstances the public can attend at least part of provider board meetings, Government social isolation requirements constitute 'special reasons' to avoid face to face gatherings as permitted by legislation All system meetings to be virtual by default	Organisation to inform audit firms where necessary
2.	FT Governor meetings	Face-to-face meetings should be stopped at the current time[1] but ensure that governors are (i) informed of the reasons for stopping meetings and (ii) included in regular communications on response to COVID-19 eg via webinars/emails	FTs to inform lead governor
3.	FT governor and membership processes	FTs free to stop/delay governor elections where necessary Annual members' meetings should be deferred Membership engagement should be limited to COVID-19 purposes	FTs to inform lead governor
4.	Annual accounts and audit	Deadlines for preparation and audit of accounts in 2019/20 are being extended. Detail was issued on 23 March 2020.	Organisation to inform external auditors where necessary
5.	Quality accounts - preparation	The deadline for quality accounts preparation of 30 June is specified in Regulations. We intend it will be deferred	NHSE/I to inform DHSC
6.	Quality accounts and quality	This work can be stopped	Organisations to inform external auditors where necessary

[1] This may be a technical breach of FTs' constitution but acceptable given Government guidance on social isolation

No.	Areas of activity	Detail	Actions
	reports – assurance		
7.	Annual report	We are working with DHSC and HM Treasury on streamlining the annual report requirements – further guidance forthcoming	NHSE/I and DHSC to prepare guidance in due course
8	Decision-making processes	While having regard to their constitutions and agreed internal processes, organisations need to be capable of timely and effective decision-making. This will include using specific emergency decision-making arrangements.	

2) Reporting and assurance

No.	Areas of activity	Detail
1.	Constitutional standards (eg A&E, RTT, Cancer, Ambulance waits, MH LD measures)	See Annex B
2.	Friends and Family test	Stop reporting requirement to NHS England and NHS Improvement
3.	Long-Term Plan: operational planning	Paused
4.	Long-term Plan: system by default	Put on hold all national System by Default development work (including work on CCG mergers and 20/21 guidance). However, NHSE/I actively encourages system working where it helps manage the response to COVID-19, providing support where possible.
5.	Long-Term Plan: Mental Health	NHSE/I will maintain Mental Health Investment guarantee.
6.	Long-Term Plan: Learning Disability and Autism	As for Mental Health, NHSE/I will maintain the investment guarantee.
7.	Long-Term Plan: Cancer	NHSE/I will maintain its commitment and investment through the Cancer Alliances to improve survival rates for cancer. NHSE/I will work with Cancer Alliances to prioritise delivery of commitments that free up capacity and slow or stop those that do not, in a way that will release necessary resource to support the COVID-19 response.
8.	NHSE/I Oversight meetings	Be held online. Streamlined agendas and focus on COVID-19 issues and support needs
9.	Corporate Data Collections (eg licence self-certs, Annual Governance statement, mandatory NHS Digital submissions)	Look to streamline and/or waive certain elements Delay the Forward Plan documents FTs are required to submit We will work with analytical teams and NHS Digital to suspend agreed non-essential data collections.
10.	Use of Resources assessments	With the CQC suspending routine assessments, NHSE/I will suspend the Use of Resources assessments
11.	Continuing Healthcare Assessments	Stop CHC assessments. Capacity tracker, currently mandated for care homes, is now also mandated for hospices and intermediate care facilities
12.	Provider transaction appraisals	Complete April 2020 transactions, but potential for NHSE/I to de-prioritise or delay transactions appraisals if in the local interest given COVID-19 factors

No.	Areas of activity	Detail
	CCG mergers Service reconfigurations	Complete April 2020 CCG Mergers but delay work post April 2020. Expect no new public consultations except in cases to support COVID-19 or build agreed new facilities. We will also streamline or waive, as appropriate, the process to review any reconfiguration proposals designed in response to COVID-19
13.	7-day Services assurance	Suspend the 7-day hospital services board assurance framework self-cert statement
14.	Clinical audit	All national clinical audit, confidential enquiries and national joint registry data collection, including for national VTE risk assessment, can be suspended. Analysis and preparation of current reports can continue at the discretion of the audit provider, where it does not impact front line clinical capacity. Data collection for the child death database and MBRRACE-UK-perinatal surveillance data will continue as this is important in understanding the impact of COVID-19.
15.	Pathology services	We need support from providers to manage pathology supplies which are crucial to COVID -19 testing. Trusts should not penalise those suppliers who are flexing their capacity to allow the NHS to focus on COVID-19 testing equipment, reagent, and consumables.

3) Other areas including HR and staff-related activities

No.	Areas of activity	Detail
1.	Mandatory training	New training activities – refresher training for staff and new training to expand the number of ICU staff – is likely to be necessary. Reduce other mandatory training as appropriate
2.	Appraisals and revalidation	Recommendation that appraisals are suspended from the date of this letter, unless there are exceptional circumstances agreed by both the appraisee and appraiser. This should immediately increase capacity in our workforce by allowing appraisers to return to clinical practice. The GMC has now deferred revalidation for all doctors who are due to be revalidated by September 2020. We request that all non-urgent or non-essential professional standards activity be suspended until further notice including medical appraisal and continuous professional development (CPD) The Nursing and Midwifery Council (NMC) is to initially extend the revalidation period for current registered nurses and midwives by an additional three months and is seeking further flexibility from the UK Government for the future.
3.	CCG clinical staff deployment	Review internal needs in order to retain a skeleton staff for critical needs and redeploy the remainder to the frontline CCG Governing Body GP to focus on primary care provision
4.	Repurposing of non clinical staff	Non-clinical staff to focus on supporting primary care and providers
5.	Enact business critical roles at CCGs	To include support and hospital discharge, EPRR etc

Annex A

Whilst existing performance standards remain in place, we acknowledge that the way these are managed will need to change for the duration of the COVID-19 response. Our approach to those standards most directly impacted by the COVID-19 situation is set out below:

A&E and Ambulance performance - monitoring and management against the 4-hour standard and ambulance performance (Ambulance Quality Indicators: System Indicators) will continue nationally and locally, to support system resilience. Simultaneously, local teams should maintain flexibility to manage demand for urgent care during the emergency period.

RTT – Monitoring and management of our RTT ambitions will continue, to ensure consistency and continuity of reporting and to understand the impact of the suspension of non-urgent elective activity and the subsequent recovery of the waiting list position that will be required. The wider announcements on suspension of the usual PBR national tariff payment architecture and associated administrative / transactional processes mean that, financial sanctions for breaches of 52+ week waiting patients occurring from 1st April 2020 onwards will also be suspended.

Recording of clock starts and stops should continue in line with current practice for people who are self-isolating, people in vulnerable groups, patients who cancel or do not attend due to fears around entering a hospital setting, and patients who have their appointments cancelled by the hospital. The existing RTT recording and reporting guidance is recognised across the country as the key reference point for counting RTT activity and specific clarification of how this should be applied, in the scenarios described above, will be provided in due course.

Cancer – Cancer treatment should continue, and that close attention should continue to be paid to referral and treatment volumes to make sure that cancer cases continue to be identified, diagnosed and treated in a timely manner. Clarification has already been released to the system through the COVID-19 incident SPOC to confirm that appropriate clinical priority should continue to be given to the diagnosis and treatment of cancer with appropriate flexibility of provision to account for infection control. We have also confirmed modifications to v10 Cancer Waiting Times guidance to allow for this to be appropriately recorded. In addition, it has been agreed that the 28-day Faster Diagnosis Standard (which was due to come into effect from Wednesday 1 April) will still have data collected, but will not be subject to formal performance management. The Cancer PTL data collection will continue and we expect it to continue to be used locally to ensure that patients continue to be tracked and treated in accordance with their clinical priority.

Annex B

Data collections/reporting

NHS Digital maintains a significant volume of data which is mandated for return from commissioners and providers[2]. Much of this data is routinely submitted and imposes minimal burden on local systems.

It will be important to maintain a flow of core operational intelligence to provide continued understanding of system pressure and how this translates into changes in coronavirus and other demand, activity, capacity and performance – and in some areas it may be necessary to go further to add to and extend existing collections. For this reason, and to ensure effective performance recovery efforts can begin immediately after the intense period of COVID-19 response activity has subsided, the majority of data collections remain in place.

Notwithstanding the above, a subset of the existing central collections will be suspended, and these returns will not need to be submitted between 1 April 2020 to 30 June 2020:

- Urgent Operations Cancelled (monthly sitrep)
- Delayed Transfers of Care (monthly return)
- Diagnostics PTL
- RTT PTL
- Cancelled elective operations
- Audiology
- Mixed-Sex Accommodation
- Venous Thromboembolism (VTE)
- 26-Week Choice
- Pensions impact data collection
- Ambulance Quality Indicators (Clinical Outcomes)
- Dementia Assessment and Referral (DAR)

[2] https://digital.nhs.uk/isce/publication/nhs-standard-contract-approved-collections

Annex C

Data Security and Protection Toolkit Submission 2019/20

It is critically important that the NHS and Social Care remains resilient to cyber-attacks during this period of COVID-19 response. The Data Security & Protection Toolkit helps organisations check that they are in a good position to do that. Most organisations will already have completed, or be near completion of, their DSPT return for 2019/20.

The submission date for 2019/20 DSPT remains 31 March 2020. However, in light of events NHSX recognises that it is likely to be difficult for many organisations to fully complete the toolkit without impacting on their COVID-19 response. NHSX has therefore taken the decision that:

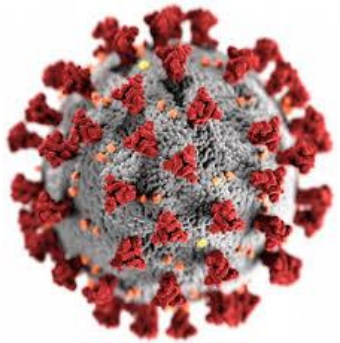
- Organisations that have completed and fully meet the standard will be given 'Standards Met' status, as in previous years.
- Where NHS trusts, CCGs, CSUs, Local Authorities (including Social Care providers), Primary care providers (GP, Optometry, dentist and pharmacies) and DHSC ALBS **do not fully complete or meet the standard because doing so would impact their COVID-19 response this will be considered sufficient and they will be awarded 'Approaching Standards' status** and will face no compliance action. It will be possible to upgrade from 'Approaching Standards' status to 'Standards Met' status through the year. The cyber risk remains high. All organisations must continue to maintain their patching regimes and Trusts, CSUs and CCGs must continue to comply with the strict 48hr and 14 day requirements in relation to acknowledgment of, and mitigation for, any High Severity Alerts issued by NHS Digital (allowing for frontline service continuity).
- Organisations that have not taken reasonable steps to complete their toolkit submission for 2019/20 will be given 'Standards Not Met' and may face compliance activity, as per previous years.

For any queries please contact or for further information please go to https://www.dsptoolkit.nhs.uk/News

TACTICAL	STRATEGIC	PAUSE
Year End: (ES/CL/JG) - Annual Report and Accounts. Financial Strategy (Covid-19).(JG/CL) Commissioner Deals. (CL) Assurance (ES/HG/NM/AB): - Patient Safety. - Corporate Governance. - Board/Sub-committees. - Core metrics Programme Closures (JG). CQC Response (ES/HG/NM). Case Management (MS). Personnel (recruitment/induction etc.) (MS). Health and Safety: - PFI. - Handrails.	Outpatient Reduction. – (KW) Agile. – (KW) Automation. (CL) Innovation/Research. (CL) (Covid-19) AIIQ. (CL) Campus. (DP/RG) • MH • Neo • Park • NE Plot • Car Parking Paediatric Networks (LS/DJ): • Cheshire and Mersey. • Manchester. Neonatal Network SALS. (MS) Tariff (JG) Alder C@re. Never Events – (Alf) Internal Reviews	Quality Improvement. CIP. Planning Round. Business Development. GIRFT. Starting Well. Research and Innovation (non Covid-19). Risk Management Evaluation. Access Targets. e-rostering. Porters - Operational Change Car Parking and Catering Price Increase Green. External Reviews: - Trauma. - Never Events (ES) Urgent Care UNICEF Staff Survey Response PDRs (MS to look at GMC requirements for Medical Staff)

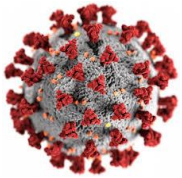
Alder Hey Children's NHS
NHS Foundation Trust

COVID-19
Proposal for revised governance arrangements during the pandemic



Erica Saunders/John Grinnell

7th April 2020

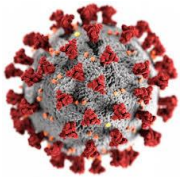


Reducing the Burden

Alder Hey Children's NHS
NHS Foundation Trust

Key Principles & Requirements

- Strategic governance of the 'new' Alder Hey has to be agile
- Clarity of the 'changed' roles and responsibilities
- Revised/streamlined processes for decision making, communication and record keeping/audit trails
- Keep under review and flexible to respond to changing local and national picture
- Must retain fundamentals of good governance, regulation and statutory obligations



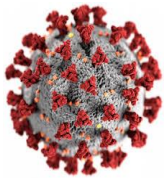
Reducing the Burden

Alder Hey Children's NHS
NHS Foundation Trust

National Position

As per NHSI/E letter of 28 March 2020 – provides permission to:

- Streamline Boards, move to virtual meetings, relax rules re quoracy
- Streamline/delay assurance committees
- Cease governor meetings but keep informed
- Delay annual elections
- Operate revised/extended year-end arrangements/timetable
- Continue only with core data collections (NHS Constitution standards)
- Suspend non-essential HR processes

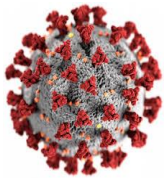


Alder Hey Children's NHS
NHS Foundation Trust

Revised local arrangements

'Front End' – governance lite

- Maintain monthly Board meetings with focus on COVID-19 response and related assurance
- Weekly NED briefing by CEO/Deputy covering main issues
- Key safety metrics and risks to form 2nd part of Board agenda but be discussed by exception
- Any urgent decisions to be taken virtually by core Board members (a minimum of CEO/Deputy plus one other Exec and two NEDs/ Chair), recorded and minuted at next available Board meeting
- Transparency for the Board on:
  - core non-COVID work plan – must do's eg. CQC
  - strategic plan – work on pause
  - recovery plan – prioritisation and timescale

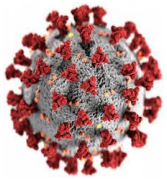


Alder Hey Children's NHS
NHS Foundation Trust

Revised local arrangements

'Back End' – keeping us safe

- Senior support from MIAA in situ
- Scheme of Delegation in process of being revised – sign off by Audit Committee
- Financial governance for COVID – per agreement by RBD
- Delivery of year-end – oversight by Audit Committee
- Maintenance of:
  - BAF
  - risk management function inc cyber
  - BI function to continue performance framework – watching brief
  - IG basics per ICO guidance



Alder Hey Children's NHS
NHS Foundation Trust

Recommendation

The Board is asked:

- to approve the proposed arrangements and
- to receive further updates as the local and national position develops

NHS
Alder Hey Children's
NHS Foundation Trust

Alder Hey COVID-19 EMERGENCY RESPONSE PLAN

Protect Staff | Increase Capacity | Provide Safe Care

Approving Committee:	Clinical Quality Assurance Committee
Ratifying Committee:	Trust Board
Author(s):	Alder Hey COVID-19 Strategic Command Team
Version	Version 1
Date published:	5 April 2020
Date ratified:	*To be reviewed by the Trust*

NHS
Alder Hey Children's
NHS Foundation Trust

Alder Hey in action, March 2020

Alder Hey Children's NHS Foundation Trust

Contents

1. Our mission during COVID-19

As a world-leading children's hospital we are committed to deploying our people, expertise and innovations to treat patients with COVID-19, whilst continuing to treat children and young people who have an urgent or emergency health care need from other diseases and conditions. By protecting staff and increasing capacity we will save lives.

2. Our priorities

Our COVID-19 Emergency Response Plan has three priorities:

- Protect staff
- Increase Capacity
- Provide Safe Care

3. Introduction

The coronavirus (COVID-19) pandemic represents a public health emergency and a once-in-a-generation challenge to health care systems around the world.

Alder Hey will deploy its staff, expertise and innovations to minimise the health care impact of the virus. We will protect our staff, increase our capacity and provide safe care that will save lives.

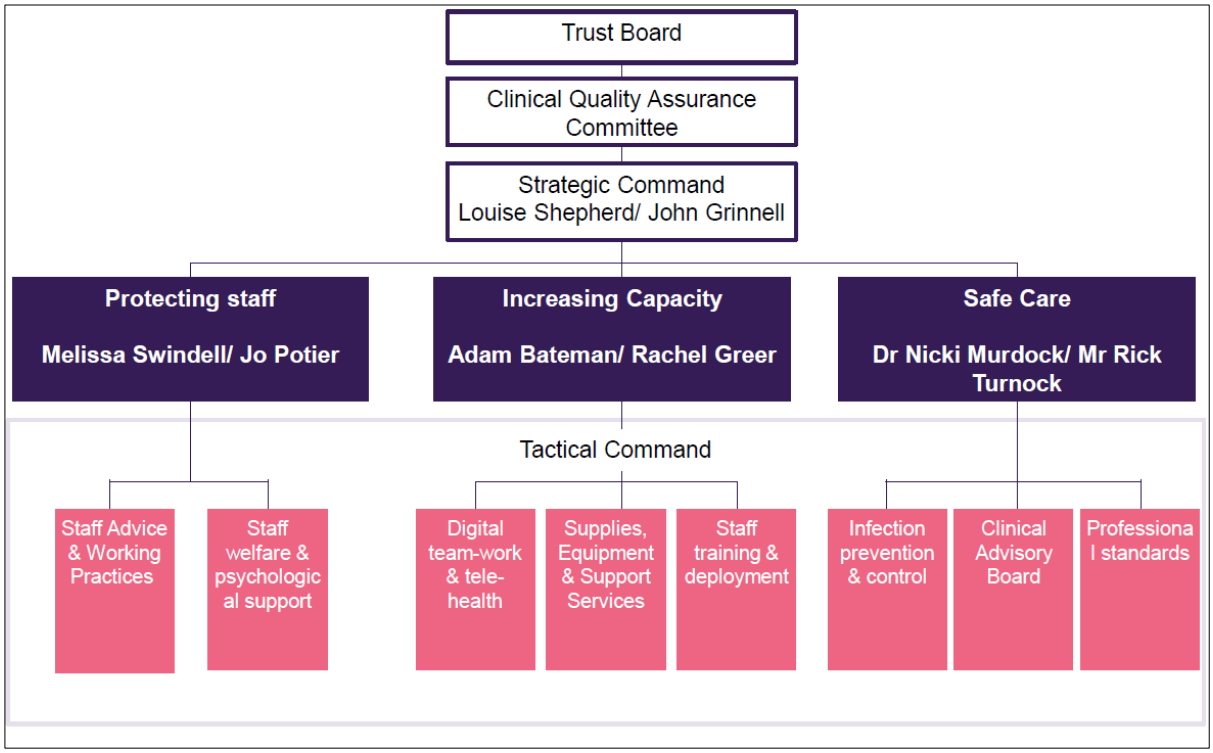
This Plan sets out:

- Our emergency response structure
- The actions we have taken so far and will take to **protect staff**
- The actions we have taken so far and will take to **increase capacity.** The plans will ensure we have capacity to treat patients with COVID-19, whilst continuing to treat children and young people who have an urgent or emergency health care need from other diseases and conditions.
- The actions we have taken and will take to deliver **safe care** during the pandemic, including new clinical governance arrangements during COVID-19.
- Our financial operating model during COVID-19

4. COVID-19 Emergency Response Structure

4.1 COVID-19 Emergency Response reporting structure

Our COVID-19 Emergency Response is led by a **Strategic Command Team** that reports into a Clinical Quality Assurance Committee, a sub-committee of the Trust Board. The response has **three key workstreams**: **Protecting Staff, Increasing Capacity and Providing Safe Care**. There are **eight tactical teams** that are aligned to the three workstreams and overseen by **Tactical Command**, which reports directly into Strategic Command.



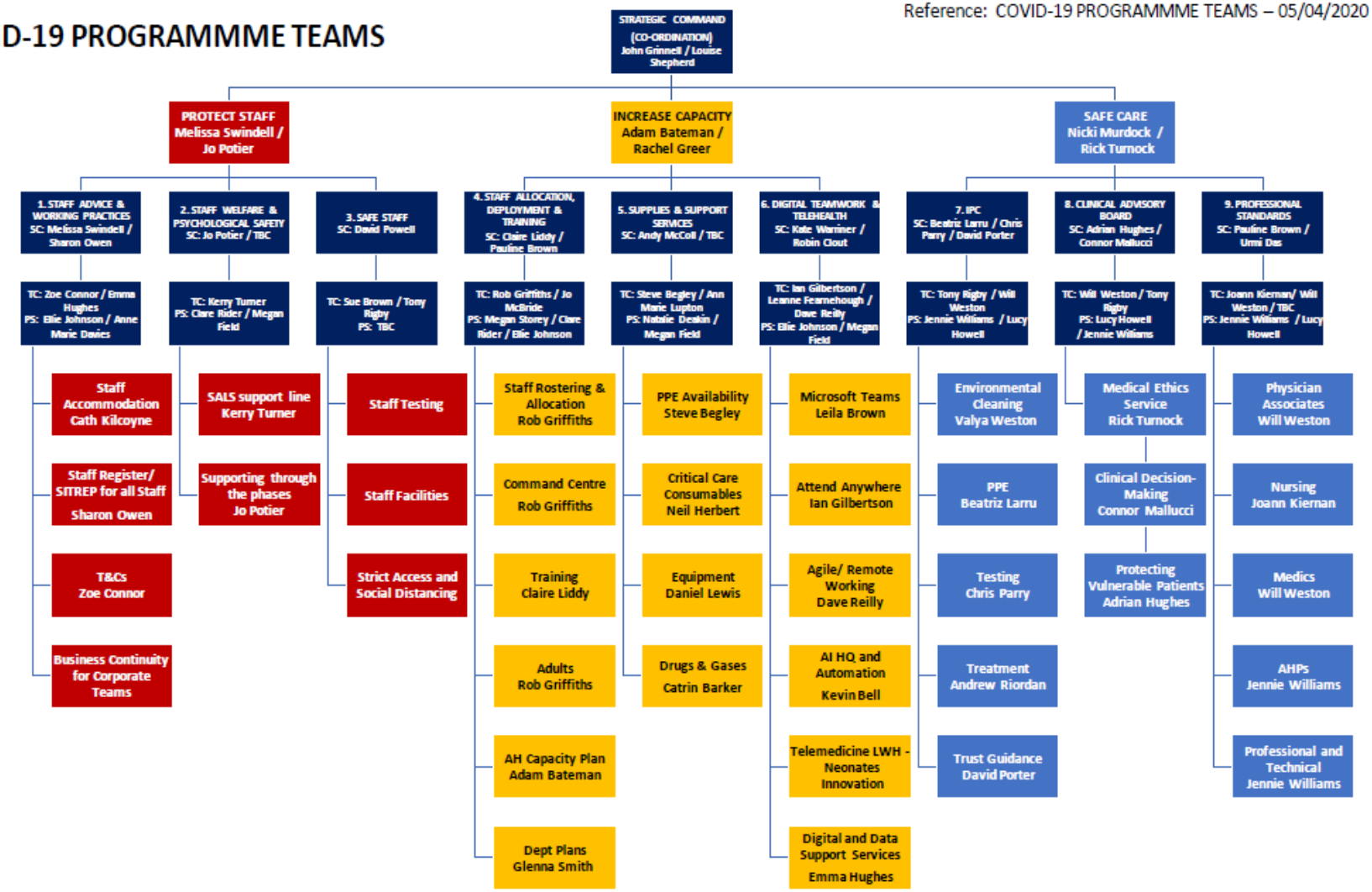
4.2 COVID-19 Emergency Response Tactical Teams

Our COVID-19 Emergency Response Plan is comprised of a number of tactical workstream teams that report directly into Tactical Command. The reporting and deployment arrangements are shown in the diagram below:

Alder Hey Children's NHS Foundation Trust

Reference: COVID-19 PROGRAMMME TEAMS – 05/04/2020 v10.14

COVID-19 PROGRAMMME TEAMS



4.3 Clinical Department plans

All Clinical Departments at Alder Hey have COVID-19 Emergency Response Plans. These plans have prioritised:

- Maintaining urgent and emergency services
- Protecting vulnerable patients
- Increasing capacity
- Protecting staff
- Delivering resilience by splitting into two teams
- Use digital technology for co-working and telehealth
- Preparing for the care of adults

Please see Annex A for links to Departmental Plans.

4.4 Communication and cascade

We have taken action to deliver effective communication and cascade of decisions and key information:

- Daily all-staff virtual briefing at 12.30 hrs via Microsoft Teams
- Daily email update to all staff from the Chief Executive
- Information Hub on the Trust Intranet
- Command Centre Intelligence Hub in the Strategic Command Centre

5. Protect Staff

We want to pay tribute to our remarkable staff. We want to say thank you for what you do, and what you will do. We know that you will need to work differently and you should do so knowing that we will support you with this and you permission to do the right thing.

We will ensure that we protect our staff by providing clear and helpful staff advice, supporting their welfare and psychological safety, and providing a safe environment for staff.

5.1 Staff Advice & Working Practices

We will provide a range of advice to staff to help them manage the changes at work and at home that come from guidelines issued by the Trust and the Government.

We have provided advice to staff on a range of matters including:

- Employee Terms & Conditions, including sick pay
- Personal Protective Equipment
- Keeping them safe – including arrangements to make life a little easier through free meals, car parking and accommodation
- Home working

Staff can obtain advice through the:

- Staff Advice & Liaison Service (see section 5.2 for more details)
- COVID-19 Information Hub, including frequently asked questions
- Daily COVID-19 Staff Briefing
- Live response to staff questions via the daily briefing

We have worked with staff to change working practices where this is needed to keep them safe, reduce the spread of infection or help us to increase capacity. We have taken action to:

- Cancel study leave
- Cancel non-essential training
- Cancel non-essential meetings
- Interact, communicate and meet via Microsoft Teams
- Supporting staff to work from home when their health requires this
- Supporting Corporate services working from home
- Asking staff to undertake new roles
- Asking nursing and medical teams to access critical care skills changes

5.2 Staff Welfare & Psychological Safety

We will recognise the anxiety and distress that COVID-19 will have on our staff and we will take action to provide a staff support plan that will respond to their different emotional and physical experiences.

We have a **Staff Advice & Liaison Service** (ext.: 4511, or T: 0151 282 4511) to provide help and support to staff on a range of a source of support, advice and guidance. The service is available 7 days per week, with ongoing referral on the Alder Centre if counselling is indicated.

Our support will in the **build-up phase** will respond to anticipatory anxiety, general anxiety, stress related to preparation & planning, and distress linked to exposure to social media and public anxiety. The plan to mitigate against these stressors includes:

- Psychoeducation about anxiety and normalisation of feelings via regular communications and briefings, webinars and resources. The main theme is that it's ok not to be ok.
- Counselling service
- Targeted Clinical Health Psychology support to some teams and wards

The second phase is the **acute phase** marked by increased exposure to the distress of others, increased exposure to experiences that create moral/ethical distress, & stress related to concerns about personal safety & safety of loved ones. The plan to mitigate against these stressors and demands includes:

- Action Group to identify and monitor developing physical & psychological needs of front line staff.
- Offer Psychological Debriefing following significant incidents.
- Offer drop-in to SALS and promote peer support networks
- Facilitate access to counselling services (Alder Centre or EAP)

The **post-acute phase** will be marked by exhaustion and exposure to feeling overwhelmed, teams may fragment as the pressure eases, & we are likely to see increased friction between individuals. The plan is to:

- Provide information to all staff regarding likely psychological impacts at this stage
- provide coping skills to prevent escalation
- Use Schwartz Rounds framework to facilitate COVID-19 reflective conversations

5.3 Safe staff

5.3.1 COVID-19 Testing for Staff

From Friday 3 April a staff we have started to provide a staff testing service. To request a test please email COVID19@alderhey.nhs.uk with the subject line 'Staff Testing'.

Testing is most accurate when done on the third day of symptoms.

Testing will be performed on-site at the drive-through facility (previous garage) close to the Emergency Department and behind the COVID-19 POD. Detailed instructions will provided to when you are offered an appointment.

5.3.2 Staff Facilities

We have secured hotel accommodation for staff at the Suites Hotel, Knowsley.

For guidance on booking accommodation please see:

K:\COVID-19\On Call and Staffing\Staff Accomodation.docx

To book a room, staff should email:

COVID19accommodation@alderhey.nhs.uk

We have also provided:

- free car parking
- free hot drinks and one meal per day

We will now make arrangements to provide additional staff changing and shower facilities.

6. Increasing capacity

6.1 Creating capacity

We have taken action to release capacity and staff time as follows:

- From Monday 23 March 2020 all **routine eelective work** has been **cancelled**.
- **Operating theatres** have been **reduced** to emergency and cardiac emergency theatres only leading to the closure of the Day Surgery Unit and Surgical Admissions Lounge.
- Outpatient appointments offered only to patients requiring urgent review
- Closure of Day Surgery
- Closure of Medical Day Case Unit

These actions have led to a significant number of staff being able to access training that supports preparedness for COVID-19 deployment.

6.2 New operating model during COVID-19

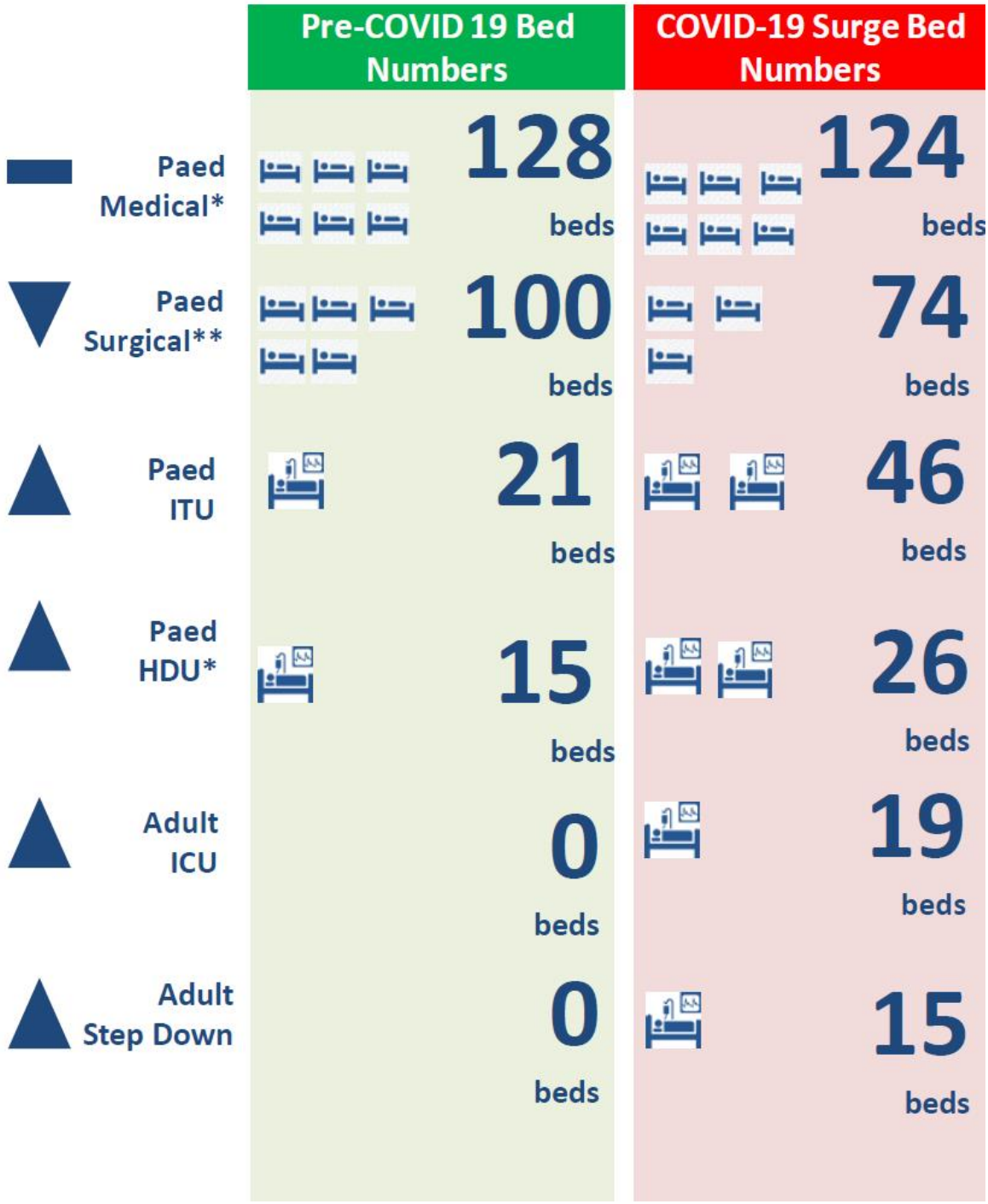
The Alder Hey COVID-19 operating model will provide:

1. A regional paediatric intensive care service for the North West
2. A regional emergency & trauma surgical for paediatrics in the North West
3. Regional paediatric medicine service for complex inpatient admissions
4. Adult intensive care capacity (Level 3)
5. Adult Step-down for internal patients only (Level 1)

The summary of changes to our capacity is contained in the table below:

Summary	Current	Future	Variance
Surgery Wards**	100	74	(26)
Medicine Wards	128	124	(4)
Intensive Care (including adults)	21	65	44
Paediatric HDU	15	26	11
Adult Step-down	0	15	15
Total	**264**	**304**	**40**

Our COVID-19 operating model provides an **additional 44 intensive care beds** (including 19 beds for adults) and **17 high dependency care beds**. The infographic below shows the change to services, and their capacity, during COVID-19:



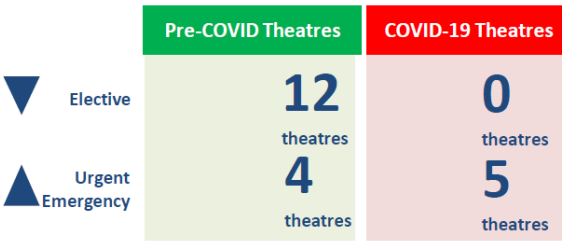
Please see Annex B for the new temporary map of Alder Hey.

Please see Annex C for the detailed COVID-19 Capacity Plan by service area.

6.2.1 Emergency Department (ED)

The Emergency Department is prepared to manage a number of patients with suspected COVID-19 requiring hospitalisation. The Department has been reconfigured with a new layout splitting the department into two functions: febrile/ respiratory area, and non-COVID 19 patients requiring emergency care.

6.2.2 Operating Theatres



With the temporary cessation of elective and routine operating, we will reduce the number of theatres. Nonetheless, we will prioritise the continuation of five operating theatres for emergency & trauma cases, cardiac emergencies and urgent operations.

6.2.3 Outpatients

Face-to-face appointments for routine patients will temporarily be suspended. Where possible, outpatient consultations will be delivered via telephone and telehealth. We will continue to offer face-to-face outpatient appointments for patients requiring urgent assessment.

6.2.4 Community & Mental Health Services

The following critical services will be maintained:

- Statutory safeguarding services
- Tier 4 Mental Health Inpatient Unit (Dewi Jones Unit)
- Mental Health Crisis Care Service
- Supply of medications

Services in the community will focus on providing support to complex and vulnerable children at home, reducing avoidable admissions to hospital and support discharge planning arrangements.

6.3 Staff Allocation & Deployment

6.3.1 COVID-19 Clinical Staff Deployment Plan

- Create a nurse pool
- Ask staff to work differently and take on new roles
- Prioritise the expansion of critical care capacity
- Develop new medical rotas to ensure the increase in capacity and new service configuration can be staffed safely

The key elements of the training and deployment plan are:

- 212 WTE critical care staff pool which is made up of nurses from wards, theatres, CNS and departments in alder hey with skills most aligned to critical care.
- 47 WTE ward pool which is made up of nurses from wards, theatres, CNS and other departments in alder hey with skills most aligned to ward. All staff in this pool have attended a 1 day training programme
- 107 HCA pool which is made up of AHP and other clinical staff. all staff in this pool have attended a 1 day training programme, half day classroom, half day ward orientation
- 18 medical staff to shadow General paediatrics
- 25 medical staff to shadow critical care

Role	Link
Nursing & AHP	Nursing & SHP cover for surge
Medical Staff	Medical cover for surge

6.3.2 New 'Helper' role to support the frontline

We are launching a new role at Alder Hey – our "Yellow Helpers"**.** This role will see non-clinical support staff move to support frontline clinical tasks. The Helpers will take on tasks such as helping put stock away, providing refreshments, collecting menus and giving out meals/collecting dishes. They will not be performing clinical tasks or have patient contact. We will provide a 2-day training programme for this role.

7. Safe Care

7.1 Clinical Management of COVID-19

COVID-19 can be transmissible from person-to-person by the airborne route as well as by direct contact and droplet spread. Control of this disease requires prompt identification, appropriate risk assessment and investigation, management and isolation of possible cases, and careful management of close contacts to prevent onward transmission. Effective infection prevention and control measures, including transmission- based precautions (airborne, droplet and contact precautions) with the recommended personal protective equipment (PPE) are essential to minimise those risks. Appropriate cleaning and decontamination of the environment is also essential in preventing the spread of the virus.

The median estimated incubation time for COVID-19 is five to six days (range 0-14 days). The median age of confirmed cases is 59 years. Initial data indicate that more than 80% of patients have asymptomatic or mild disease and recover, but about 15% may get severe disease including pneumonia and around 5% become critically unwell with septic shock and/or multi-organ and respiratory failure. The case fatality rate is estimated at about 2% overall, but ranges from 0.2% in people under 50 to 14.8% in those over 80, and higher among those with chronic comorbid conditions. Symptomatic and severe disease appears to be less common in children. As yet there is no anti-viral treatment for COVID-19. Treatment is with careful supportive management.

7.1.1 Clinical Management: an evidence-based pathway

Please access the Clinical Pathway here.

7.1.2 Patient Testing

Guidance	Link
Collecting Swabs	Guidelines for taking swabs
Reporting Results	Guidelines on reporting
Sampling	Guidelines for sampling
Care of the deceased with confirmed or suspected COVID-19	Guidelines for care of the deceased

7.2 Infection Prevention & Control

7.2.1 Isolation & cohort arrangements

Please access the plan for cohorting here **<insert link>** (being modified 6.4.20 due to new PPE guidelines).

7.2.2 Guidance on the use of Personal Protective Equipment (PPE)

All staff managing patients with suspected or confirmed COVIS-19 infection will have undergone comprehensive and appropriate PPE training. A minimum of two training sessions are required and the member of staff must be signed-off as competent.

A Quick Reference Guide for PPE arrangements at Alder Hey can be found here .

7.2.3 Supply of Equipment

A dedicated tactical workstream for supply of equipment is operational and focused on:

- PPE for staff, working to target stock levels of >4 weeks for key equipment.
- Medical Equipment, to ensure capital equipment reflects the new operating model, with increased ICU bed capacity and reduced theatre. Reallocation of existing equipment (e.g. from theatres), hire and purchase options are considered, along with the additional need due to accepting adult patients (e.g. mix of cots vs full size beds).
- General Medical Supplies, to ensure consumables available to deliver patient care – including for adult patients
- Medicines, Medical Gases, and Laboratory supplies.

A digital dashboard is live to track available supplies.

The group is utilising links with Innovation and the Alder Hey Charity, alongside regional procurement networks to maximise sources and suppliers.

7.3 Clinical Advisory Board

The Clinical Advisory Board aims to provide support, guidance and frameworks for clinicians to make difficult clinical decisions both proactively and reactively in the face of the pandemic.

The board is composed of three component parts which feed into each other as depicted in the diagram above, with further detail below. The intentions and progress for each of the three component parts are described herein.

7.3.1 Protecting Vulnerable Patients Forum

A forum, chaired by Dr Adrian Hughes (Divisional Director for Medicine), has been established to identify vulnerable cohorts of patients who need to be protected and supported to retain access to urgent care during the pandemic.

7.3.2 Clinical Decision-Making Group

A Clinical Decision-Making Group has been established, chaired by Professor Conor Mallucci, Consultant Neurosurgeon, that will use will guide proactive clinical decision-making.

This group will meet daily to discuss difficult clinical decisions based on single patient cases or groups of patients where ethical issues have been encountered or predicted. Decisions will be taken with reference to available healthcare resource across the region.

Clinical decisions will be documented for medical legal purposes and education.

7.3.3 Clinical Ethics Service

A Clinical Ethics Service (CES) has been established to help an individual clinician or team to make the right decision with an individual child and their parents/those able to consent based on sound ethical principles and in a rational and compassionate way.

The CES will be comprised of three parts:

i. **Clinical Ethics Committee** will consist of a multidisciplinary group of both lay and professional members, many of whom have advanced training in decision-making and ethics. Membership will consist of lay members, including a previous parent, an academic philosopher, bioethicists, physicians, surgeons, anaesthetists, nurses, member/s of the spiritual care team, ethicists and legal experts all of whom have qualifications and/or experience in ethical matters.

ii. **Rapid Response Service**: an accessible service 24/ 7 service to advise clinicians seeking applied ethical support.

iii. **Education and Research Entity** (working in collaboration with the Alder Hey Academy and Alder Hey research unit), providing ethics drop in session, for junior staff.

A COVID-10 Treatment Decision-Making Framework has been produced. Please note this is currently awaiting ratification.

7.4 Professional Standards

We recognise that in highly challenging circumstances, professionals may need to depart from established procedures in order to care for patients and people using health and social care services. Regulatory standards set by the professional body councils are designed to be flexible and to provide a framework for decision-making in a wide range of situations. They support professionals by highlighting the key principles which should be followed, including the need to work cooperatively with colleagues to keep people safe, to practise in line with the best available evidence, to recognise and

work within the limits of their competence, and to have appropriate indemnity arrangements relevant to their practice.[1]

7.4.1 Professional standards for medical staff

All doctors are expected to follow GMC guidance and use their judgement in applying the principles to the situations they face, but these rightly take account of the realities of a very abnormal emergency situation. We want doctors, in partnership with patients, always to use their professional judgement to assess risk and to make sure people receive safe care, informed by the values and principles set out in their professional standards. [2]

We will be flexible in our approach and the expectations of routine requirements. Healthcare professional regulators, including the GMC, have already committed to take into account factors relevant to the environment in which the professional is working, including relevant information about resources, guidelines or protocols in place at the time. Due consideration should and will be given to healthcare professionals and other staff who are using their skills under difficult circumstances due to lack of personnel and overwhelming demand in a major epidemic. This may include working outside their usual scope of practice.

7.5 Physician Associates

Physician Associates are medically trained, generalist healthcare professionals, who work alongside doctors (both physicians and surgeons) and provide medical care as an integral part of the multidisciplinary team. PAs are dependent practitioners working with a dedicated medical supervisor, but are able to work autonomously with appropriate support.

In the anticipated severe shortage of clinical staff and to meet the longer term strategic workforce goals of the organisation, Alder Hey needs to embrace the role of the Physician Associate (PA) and employ 20 PAs in order to:

[1] https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus
[2] https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/supporting-doctors-covid-19-letter-11-march-2020.pdf

8. Communication

8.1 Public Information

Website

The Alder Hey **website** has been updated to provide information on COVID-19 to the public, families and patients. Guidance includes:

- General advice on keeping safe during COVID-10
- Information on service updates and patient visiting arrangements
- Mental health advice for patients and families

Social media

Public information updates and statements will be shared across our social media channels

Day to day social content will continue but the focus will shift to developing content that:

- Supports COVID-19 messaging
- Reassure patients and families
- Support those in isolation
- Mental health
- Staff morale

Social media channels will be **monitored routinely** and where possible, responses given to patients and families.

8.2 Staff Information

Please see section 4.4 for communication and cascade of messages to staff.

9. Financial Framework

The operational planning process for 20/21 has been suspended and a new 20/21 national financial framework has been put in place that responds to the COVID-19 emergency and focuses on providing stability for providers by moving to a block payment system between April and July.

9.1 Financial Reporting during COVID-19

We will report to the Trust Board, at an organisational level, the monthly financial position which will include the following key metrics:

- Business as usual I&E
- COVID 19 specific expenditure and forecast
- Statement of Financial Position
- Treasury Management – cash flow and forecast
- Capital plan

9.2 COVID 19 Financial Approval Process

NHSI/E has advised that any reasonable costs incurred as a result of COVID-19 will be fully reimbursed through a monthly submission process. We are responding to a high number of requests to incur additional financial expenditure which require rapid turnaround response. Whilst it is expected for some relaxation of the business as usual arrangements, it is critically important that we abide by the stewardship requirements of `Managing Public Money`.

In order to maintain accurate records and ensure an appropriate decision making process is followed, the following approvals have been put in place, however they will be carried out in an agile way to ensure a timely response:

Revenue Expenditure

- Tactical Command to approve expenditure up to £50k
- Strategic Command to approve expenditure up to £250k
- Panel consisting of board members to approve expenditure > £250k

Capital Expenditure

NHSI have released guidance specifically related to capital expenditure

- <£250k Trusts have approval to incur reasonable COVID-19 capital expenditure with retrospective approval and reimbursement via a claim form submitted to NHSI regional team
- >£250k Trusts are required to submit a bid template to NHSI for all capital over £250k prior to commitment of spend. A turnaround of 48 hours is expected on all capital bids >£250k

All approved expenditure related to COVID-19 will be charged to the dedicated cost centre codes.

Annex A: Departmental Plans

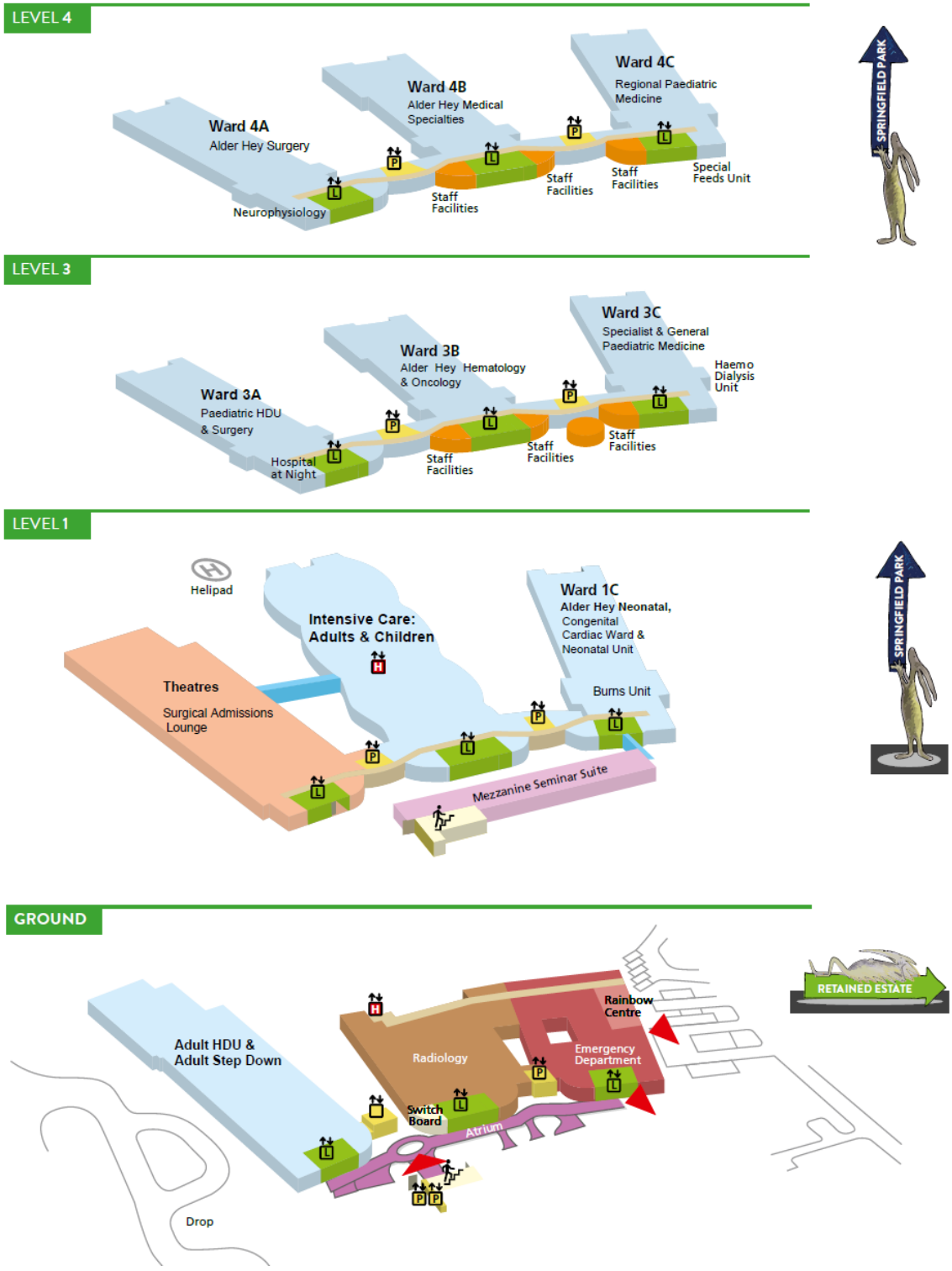
Surgery	Hyperlink
Admissions	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Admissions - COVID-19.docx
Anaesthetics	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Anaesthetics - COVID-19.docx
Audiology	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Audiology and Audio vestibular Plan - COVID-19.pdf
Burns	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Burns - COVID-19.docx
Cardiac Services	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Cardiology&Cardiac Surgery - COVID-19.docx
Dental OMFS	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Dental OMFS - COVID-19.docx
ECG	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\ECG - COVID-19.docx
ENT	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\ENT - COVID-19.docx
Gait	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\GAIT - COVID 19.docx
Major Trauma	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Major Trauma - COVID-19.docx
Neurosurgery	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\NEURO - COVID 19.docx
Ophthalmology	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Ophthalmology - COVID 19.docx
Orthopaedics	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Orthopaedics - COVID-19.docx
Orthotics	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Orthotics - COVID-19.docx
Paediatric Surgery	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Paediatric Surgery - COVID-19.docx
Plastics	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Plastics - COVID 19.docx
Spinal	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Spinal - COVID-19.docx
Theatres	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Theatres - COVID-19.docx
Urology	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Urology Nurses - COVID-19.docx
Ward 1C	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Ward 1C - COVID-19.docx
Ward 3A	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Ward 3A - COVID-19.docx
Ward 4A	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Ward 4A - COVID-19.docx
Burns Unit	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Ward Burns Unit - COVID-19.docx
Neonatal Ward	K:\COVID-19\SOP-Guidance\Local Plans\Surgery\Ward Neonatal Unit 1- COVID-19.docx

Medicine	Hyperlink
The Alder Centre	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Alder Centre - COVID-19.docx
Allergy	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\ALLERGY - COVID-19.docx
Dermatology	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\DERMATOLOGY - COVID-19.docx
Diabetes	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Diabetes - COVID-19.docx
Dietetics	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Dietetics - COVID-19.docx
Emergency Department	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Emergency Department - COVID-19.docx
Endocrine	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\ENDOCRINE - COVID-19.docx
Gastro	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Gastro - COVID -19.docx
General Paediatrics	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Gen Paeds- COVID-19.docx
Haematology	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\HAEMATOLOGY - COVID-19.docx
Immunology	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\IMMUNOLOGY NURSING - COVID-19.docx
Laboratories	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Laboratories - COVID-19.docx
Metabolic	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\METABOLIC - COVID-19.docx
Renal	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\NEPHROLOGY & RENAL UNIT - COVID-19.docx
Neurology	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\NEUROLOGY - COVID-19.docx

EEG / NeuroPhysiology	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\NEUROPHYSIOLOGY EEG - COVID-19.docx
OT	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\OCCUPATIONAL THERAPY - COVID-19.docx
Oncology	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\ONCOLOGY NURSING - COVID-19.docx
Palliative Care	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\PALLIATIVE CARE - COVID-19.docx
Pharmacy	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Pharmacy - COVID-19.docx
Physio	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\PHYSIO - COVID-19.docx ..\SOP-Guidance\Local Plans\Medicine\Physiotherapy Surge Plan - COVID-19.docx
Psych Services	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\PSYCH SERVICES - COVID-19.docx
Radiology	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\RADIOLOGY - COVID-19.docx
Respiratory	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Respiratory - COVID-19.docx
Rheumatology	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\RHUEMATOLOGY - COVID-19.docx
SALT	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\SALT - COVID-19.docx
Ward 4B	K:\COVID-19\SOP-Guidance\Local Plans\Medicine\Ward 4B - COVID-19.docx

Community& CAMHS	**Hyperlink**
ASD / ADHD	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\ASD ADHD - COVID-19.docx
CCNs	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\CCN's - COVID-19.docx
Community SALT	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Community SALT - COVID-19.docx
Community Therapies	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Community Therapies - COVID-19.docx
Complex Discharge	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Complex Discharge Team - COVID-19.docx K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Complex Discharge SOP COVID-19.docx
Crisis Care & EDYs	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Crisis Care and EDY's - COVID-19.docx
Developmental Paediatrics	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Developmental Paediatrics - COVID-19.docx
Dietetics	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Dietetic COVID-19 v1.docx
Dietetics Sefton	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Dietetics Sefton - COVID-19.docx
DJU Waterloo Site	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\DJU Waterloo Site - COVID-19.docx
LD / ASC Community CAMHS	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\LD-ASC Team Community CAMHS COVID-19.docx
Community Physio	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Liverpool Comm Physio - COVID-19.docx
Liverpool Fresh CAMHS	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\L'pool Fresh CAMHS COVID-19.docx
Physio / OT North Sefton	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Physio OT North Sefton - COVID-19.docx
Sefton CAMHS	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Sefton CAMHS - COVID-19.docx
SALT Sefton	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Speech Therapy Sefton - COVID-19 (2).docx
Statutory Services	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Statutory Services - COVID-19.docx
Transition	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Transition COVID-19.docx K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\Transition SOP COVID 19.docx
WRC	K:\COVID-19\SOP-Guidance\Local Plans\Community & Mental Health\WRC - COVID-19.docx

Annex B: Surge capacity model



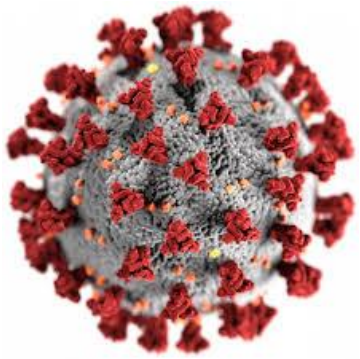
NHS
Alder Hey Children's
NHS Foundation Trust

Annex C: COVID-19 Capacity Plan

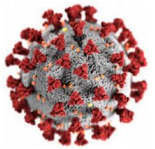
	Current	Future (COVID-19 Surge)	Current	Future	Variance
Division of Surgical Care					
Paediatric Intensive Care	1B	1B	21	46	25
Adult Intensive Care	[redacted]	1B	0	19	19
Paediatric High Dependency Care	1B	Ward 3A	15	26	11
Adult Step-down	[redacted]	DSU Recovery	0	15	15
Surgery	3A	Ward 4A plus escalation into Ward 3A & 1C	32	6	(26)
	4A		32	32	0
	1C		0	17	17
Burns	Burns Unit	EDU	5	4	(1)
Cardiac	1C	Ward 1C	22	11	(11)
Neonatal Unit	1C	Ward 1C & Liverpool Women's NICU	9	4	(5)
Division of Medicine					
Medical Day case	MDU	Ward 3C	0	4	4
Ward 4B	4B	Ward 4B	24	24	0
Oncology & Oncology Day Case	3B	Ward 3B	23	23	0
Specialist & General paediatric medicine'	3C	Ward 3C	32	28	(4)
General Paediatrics (regional)	4C	Ward 4C	32	32	0
Renal Unit	Renal Unit	Renal Unit	5	5	0
EDU	EDU	EDU	12	8	(4)

Alder Hey Children's NHS
NHS Foundation Trust

COVID 19 Programme



Trust Board
07.04.2020

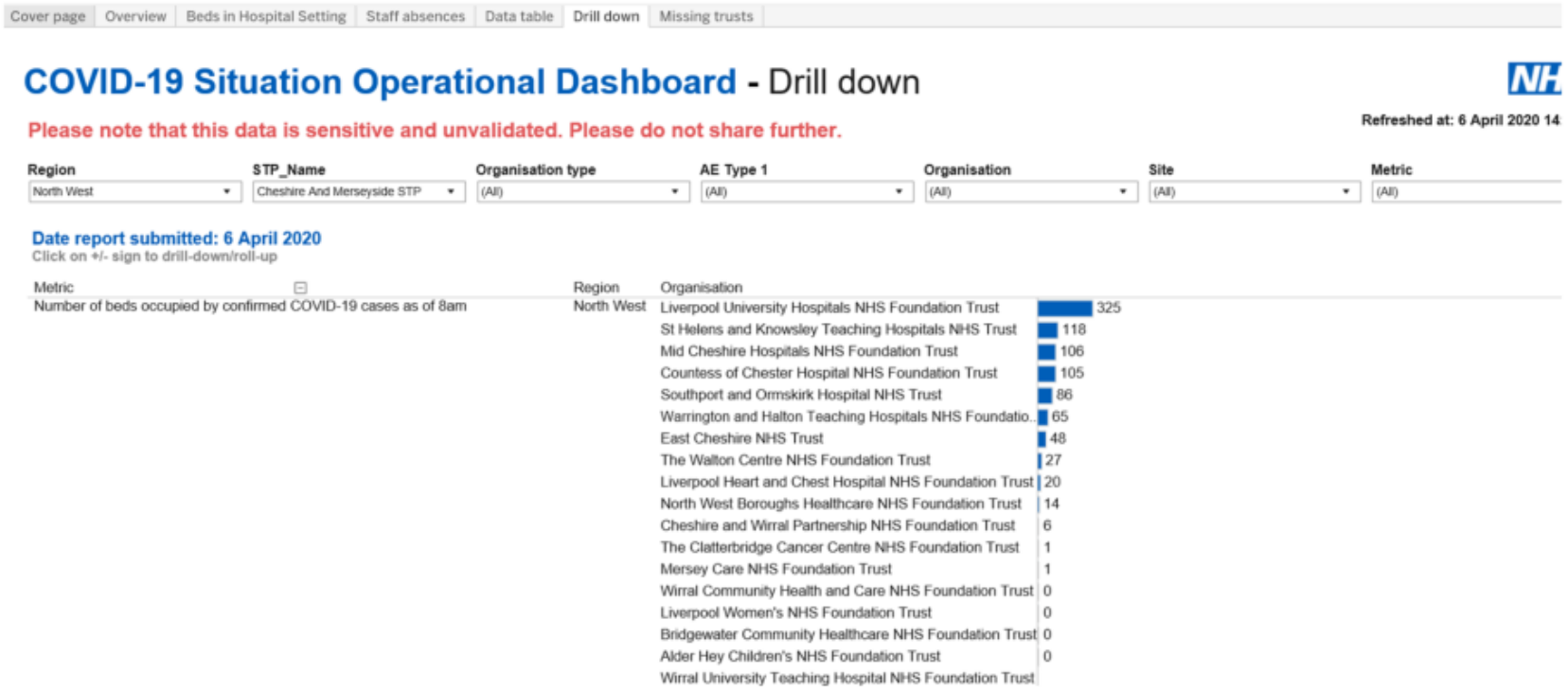


Context

North West	• Current Modelling (Imperial): • **NW needs 5 x Critical Care** (CC) capacity to meet demand • Expected peak– **13th April**
Cheshire & Merseyside	• **200** – Current L2 & 3 CC beds (inc. specialist trusts) • **1000** – CC capacity required to meet anticipated demand • **500** – Identified increased ventilator spaces across C&M • **500** – Shortfall – meet via acquisition of new equipment (National)
Specialist Trusts	• **Alder Hey** designated regional centre for Paediatrics (at "Opel 4" – see next slides) • **LHCH** designated regional centre for Cardiac emergencies • **Walton Neuro** not designated as regional centre
Additional Capacity	• Plans to open beds at **new Royal** (inc. new Clatterbridge) • Plans for **NW "field hospital"** (Manc). Step Down/Step up facility (keep CC capacity on acute sites)

Local Numbers (snapshot @ 6.4.20)

Confirmed COVID Cases (in any Bed)



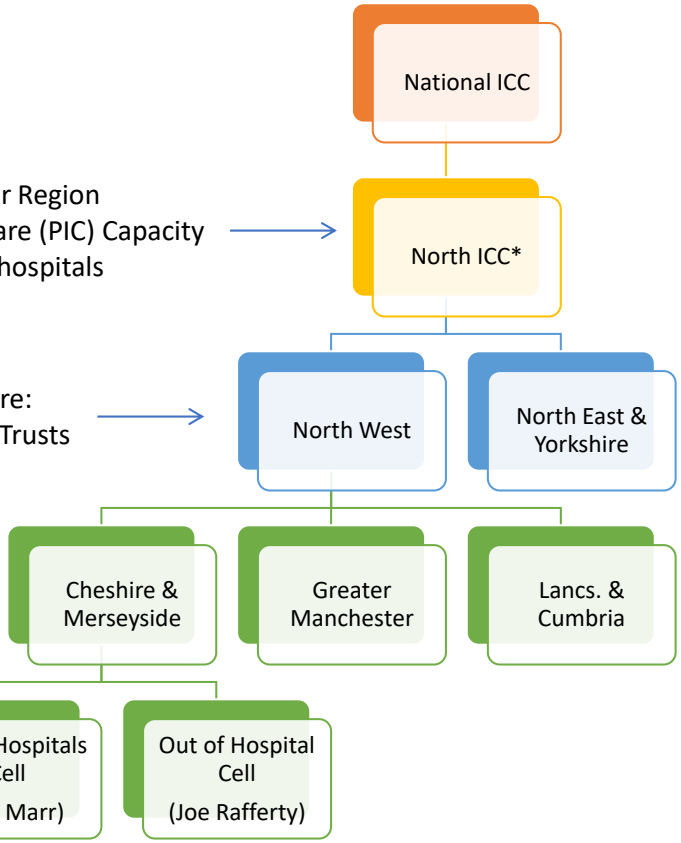
Incident Command & Control (ICC)

- Decisions re: Incident Level ("OPEL") for Region
- Management of Paediatric Intensive Care (PIC) Capacity
- Mutual Aid provided across Children's hospitals

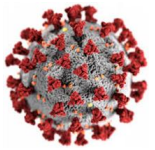
- Decisions re: Specialist Trusts

- Critical Care Bed management & resource distribution

- Decisions re: Mutual Aid & Local resources



*Developing picture – NW SpecComm currently agreeing North ICC governance



Alder Hey Role

During OPEL 3 Surge:

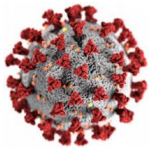
- **NOW!**
- Alder Hey to receive;
- All new NW Paediatric Burns patients
- All Paediatric Critical Care transfers from a North West DGH
- Capacity otherwise sought across North as in normal PIC surge

During OPEL 4 Surge:

- Alder Hey to provide;
- Paediatric Major Trauma
- Paediatric Cardiac
- Paediatric Urgent and Emergency Surgery
- Paediatric Critical Care for the North West
- Capacity otherwise sought across the North as in normal PIC surge

To remain at RMCH:

- Haem/Onc
- Neonatal Surgery
- Time critical Major Trauma that could not safely be diverted to Alder Hey
- Critical care to support the above (c. 4 beds)



Our AH Medical offer

Clinical MDT

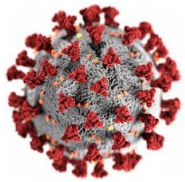
(To agree transfer of patients into Alder Hey)

Single Point of Access

(one Medical, one Surgical)

Repatriation post-Covid-19

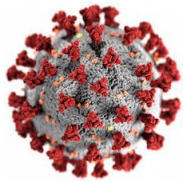
(not service change)



INCREASE CAPACITY

SAFE CARE

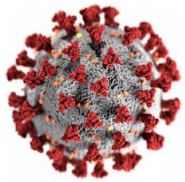
SAFE STAFF



INCREASE CAPACITY

AIMS

1. We can triple our Critical Care Capacity to support the wider NHS system	2. We have Sufficient Teams in place to meet the COVID response	3. We can safely care for Positive or Suspected COVID-19 Adults and Children	4. We have adapted our Environment so that it is Age Appropriate
Adam Bateman	Claire Liddy	Adam Bateman	Adam Bateman



INCREASE CAPACITY

SUCCESS FACTORS

Alder Hey Children's NHS Foundation Trust

1. Triple our Critical Care Capacity

- Maximum capacity for L2/3 patients
- Maximum capacity for patients who require a ventilator (65)
- Adequate oxygen supply
- Access to adequate ventilation
- Access to all critical care consumables required

2. Sufficient Teams in place

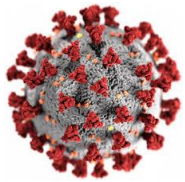
- Sickness due to COVID-19 is minimised
- All teams have a plan to ensure business continuity through COVID-19 pandemic
- Clinical Teams refocussed to new model
- Bank of helpers available to help clinical staff 'Alder Hey Buddies'

3. Safely care for Positive or Suspected COVID-19 Adults and Children

- Staff have access to all necessary PPE
- Access to all critical care consumables required (for children and adults)
- Staff have been trained and upskilled to necessary requirements (including simulation events and adult trained nurses)
- Collaborate with UHL to help support adult requirements

4. Adapted our Environment to ensure age appropriate

- Separate as best we can Adults and Children
- Create an Acute step down ward for patients who cannot be discharged straight home
- The flow around the hospital minimises the risk of contamination

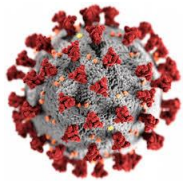


INCREASE CAPACITY

MEASURES OF SUCCESS

Alder Hey Children's NHS Foundation Trust

INCREASE CAPACITY		BASELINE	CURRENT	TARGET
1. Triple our Critical Care Capacity	No. of L2/L3 Beds	36	107	107
	No. of Ventilators	NA	65	75
	Oxygen Supply	NA	Adequate oxygen supply identified	Adequate Oxygen Supply
2. Sufficient Teams in Place	No. of staff PPE trained	0	67%	100%
	No. of staff FIT tested	0	57%	100%
	No. of staff upskilled to work on Critical Care	0	248 (98%)	254
	No. of staff trained to work on wards	0	122 (109%)	112
	No. of HCAs upskilled	0	92 (81%)	114
	No. of staff recruited and trained for 'Alder Hey Helpers'	0	0	269
	Deployment - Roster Fill Rate	NA	TBC	90%
	No. of Business Continuity Plans complete	0	70 Clinical 10 Non-Clinical	70 Clinical x Non-Clinical
3. Safely care for Positive or Suspected COVID-19 Adults and Children	No. of days of Critical Care Consumables	0	TBC	29+ Days
4. Adapted our Environment for Adults	No. of beds available in adult step down ward	0	15	15

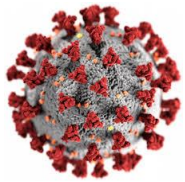


Alder Hey Children's NHS
NHS Foundation Trust

SAFE STAFF

Aims

1. We have Adapted so that our Staff are able to support Alder Hey's response to COVID-19	2. We are doing our utmost to ensure that our staff are physically as safe as they can be	3. We are doing our utmost to ensure that our staff are as psychologically well as they can be	4. Our Innovation Culture rapidly deploys solutions to keep staff safe and help beat COVID-19
Kate Warriner	David Powell	Melissa Swindell	Claire Liddy



SAFE STAFF

SUCCESS FACTORS

Alder Hey Children's NHS Foundation Trust

1. Adapted so that our Staff are able to Support

- All staff who can work from home encouraged and facilitated to do so
- All clinical staff are encouraged and facilitated to hold consultations virtually

2. Ensure our staff are physically as safe as they can be

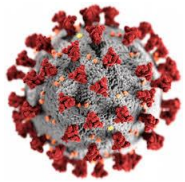
- Social distancing is actively policed and enforced across the Trust
- Hand sanitiser is available at an increased number of locations
- Staff can access overnight accommodation
- Free meal and drink for staff (delivered)
- Embedded staff testing
- Enhanced laundry / wash facilities

3. Ensure our staff are as psychologically well as they can be

- 24/7 counselling and support line
- Staff Advice Liaison Service (SALS) helpline available
- Wider support package available to staff

4. Maximising our Innovation Culture

- Enhancing current and new innovations to help us in the fight against COVID-19
- Seek immediate solutions to daily COVID-19 challenges e.g. Innovation procurement activities for scarce supplies

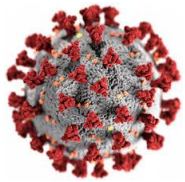


SAFE STAFF

MEASURES OF SUCCESS

Alder Hey Children's NHS Foundation Trust

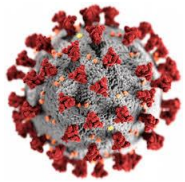
SAFE STAFF		BASELINE	CURRENT	TARGET
1. Adapted so that our Staff are able to Support	No. of staff working from home	50 (est.)	1000	NA
	Microsoft Teams Created (Total)	100	600	NA
	Microsoft Teams - 121 Calls (Rolling 7 day Total)	80	622	NA
	Microsoft Teams - Channel Messages (Rolling 7 day Total)	118	1759	NA
	Microsoft Teams - Chat Messages Calls (Rolling 7 day Total)	449	4447	NA
	No. of active Microsoft Team users	172	1828	NA
2. Ensure our staff are physically as safe as they can be	No. of days supply of gloves	NA	14 Days	29+ Days
	No. of days supply of FFP3 masks	NA	81 Days	29+ Days
	No. of days supply of surgical masks	NA	1342 Days	29+ Days
	No. of days supply of gowns	NA	195 Days	29+ Days
	No. of days supply of visors	NA	85 Days	29+ Days
	No. of days supply of goggles	NA	77 Days	29+ Days
	Number of additional cleaning staff	NA	138	165
	Number of manned hand sanitiser stations	NA	4	5
	Number of temporary showers installed.	NA	0	55
	% of staff unavailable to work due to COVID-19 related sickness	0%	10.42%	>20%
	No. of rooms available to staff overnight	NA	21	30
3. Ensure our staff are as psychologically well as they can be	No. of COVID 19 related calls to the SALS support line	0	60	NA
	No. of staff accessing counselling/support due to COVID 19	NA	TBC	NA
	% of staff who feel psycholgically supported during this time by the Trust	NA	TBC	NA
4. Maximising our Innovation Culture	No. of innovations enhanced and facilitated to help us in the fight against COVID-19	NA	TBC	NA



SAFE CARE

AIMS

1. We have put mitigations in place to ensure that the Children we are not seeing are Safe	2. We have clear Professional and Ethical Decision Making processes in place	3. We are doing our utmost to protect our most Vulnerable Children in the hospital and in the community	4. We are following all the latest IPC guidance and planning to flex our Professional Standards if required
Dani Jones	Adrian Hughes	Adrian Hughes	Pauline Brown

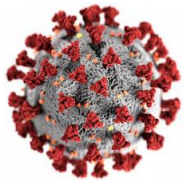


SAFE CARE

SUCCESS FACTORS

Alder Hey Children's NHS Foundation Trust

1. Children we are not seeing are Safe	2. Clear Professional and Ethical Decision Making processes	3. Protect most Vulnerable Children	4. IPC and Professional Standards
▪ Model to ensure we are alerted to a deteriorating child and mechanisms for escalation ▪ Robust process for triage prior to cancellations ▪ Monitoring with PCNs ▪ Work with primary care to ensure families continues to access services	▪ Forum established in partnership with the University of Liverpool to assist with ethical decision making ▪ Support for clinical decision making available 24/7	▪ Risks identified for cohorts of our vulnerable patients and support provided to patients and families to mitigate them ▪ Provide alternative ways for assessment, treatment and aftercare to reduce risk to vulnerable patients ▪ Discharge as many vulnerable children as possible	▪ Clear profession standards in place for evolving context ▪ PPE Guidance and training in place ▪ Clear IPC support for all teams ▪ No hospital acquired infections ▪ Clear testing regime in place for staff and patients

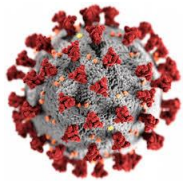


SAFE CARE

MEASURES OF SUCCESS

Alder Hey Children's NHS Foundation Trust

SAFE CARE		BASELINE	CURRENT	TARGET
1. Children we are not seeing are Safe	No. of virtual consultations	0	TBC	NA
	No. of urgent face to face consultations	0	TBC	NA
2. Clear Professional and Ethical Decision Making processes	Ethics committee established	NA	COMPLETE	NA
	Rapid decision making forum established	NA	COMPLETE	NA
3. Protect our most Vulnerable Children	No. of vulnerable patients identified and offered advice and guidance	0	TBC	TBC
4. IPC and Professional Standards	No. of bespoke PPE advice sessions delivered	0	17	NA
	No. of staff tested for COVID 19	0	TBC	NA
	No. of hosptal acquired infections	NA	TBC	TBC
	No. of Physician Associates recruited	0	11	11



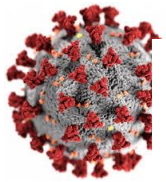
POST COVID 19

AIMS

1. We are ahead of the curve post COVID-19 (recovery)

2. We optimise and sustain key strategic developments propelled by COVID-19

3. We maintain good practices developed as a result of COVID 19



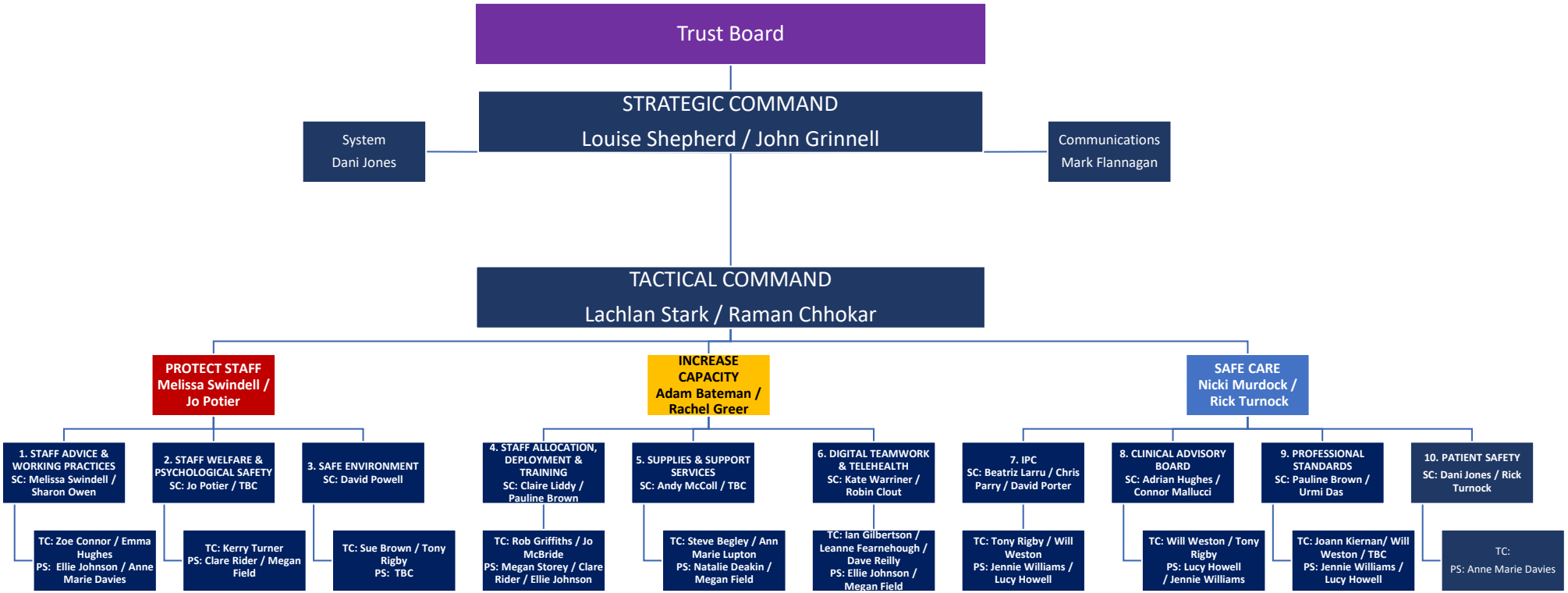
Alder Hey Children's NHS
NHS Foundation Trust

COVID-19 Capacity Model

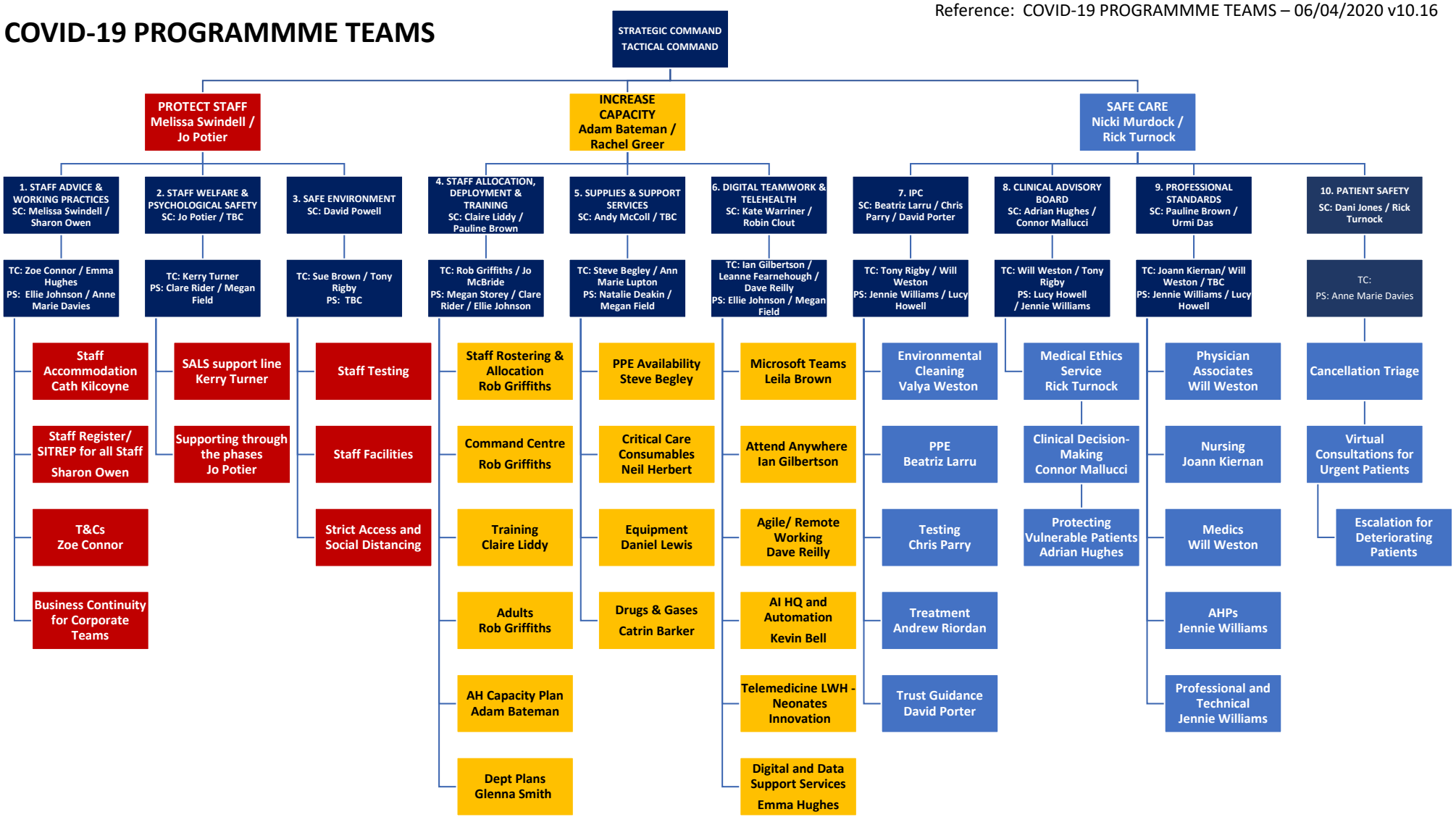
	Pre-COVID 19 Bed Numbers	COVID-19 Surge Bed Numbers
Paed Medical*	128 beds	124 beds
Paed Surgical**	100 beds	74 beds
Paed ITU	21 beds	46 beds
Paed HDU*	15 beds	26 beds
Adult ICU	0 beds	19 beds
Adult Step Down	0 beds	15 beds

	Pre-COVID Theatres	COVID-19 Theatres
Elective	12 theatres	0 theatres
Urgent Emergency	4 theatres	5 theatres

COVID-19 REPORTING STRUCTURE



COVID-19 PROGRAMMME TEAMS



NHS
Alder Hey Children's
NHS Foundation Trust

MSD MEDICAL SERVICES DIRECTORATE
Clinical Ethics

Decision Making Template for Treatment during COVID 19 Pandemic

Patient Info: Name: Number: Ward: Referring clinician: Age:	**Hospital Admission Date:** **Date of onset of symptoms:** **Date of assessment:** **Time of assessment:** **Assessment number:** *(for repeat assessments)*

1. **Evidence: Background Clinical Information**

Factors in patient's acute condition and long term health relevant to decision about escalating treatment

Acute Problem:	
Background Medical History:	
COVID status:	Suspected/Awaiting result Confirmed NEGATIVE Confirmed POSITIVE

2. **Evidence: Ability to recover from this critical illness based on evidence**

Factors reflect functional reserve, long term trajectory of underlying condition, technology dependence

Factors that may make recovery from acute illness less likely. Score each factor: Not present = 0, Mild = 1, Moderate = 2, Severe = 3 (see separate notes for help with scoring)			
Neurodisability		Malignancy	
Chronic lung disease		Renal failure	
Long term ventilation		Gut dysmotility/dysfunction	
Congenital heart disease/pulm hypertension		Devices – eg tracheostomy, gastrostomy, Broviac	
Immunodeficiency / immunosuppression		Acute organ system failure	
Any other relevant factors			

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3. Evidence: Parent/patient values and wishes

Consider with parents / those with parental responsibility (and the chid if appropriate), what is important to them regarding their child's treatment and potential outcomes. Please note advance care plan if one is available. If no information is available say why

3.1. Benefits of escalating treatment:

Benefit that is achievable, harm that is avoidable, and how likely these are:

3.2. Burdens of escalating treatment:

Burden that is likely, benefit that may be prevented, and how likely these are:

4. Recommendation:

Goals:	
Treatments:	

5. Decision based on goals and treatments (options)

☐ Admission to Critical Care.
☐ Treatment on ward. Re-refer if deteriorates.
☐ Treatment on ward. Not for Critical Care - Specify limits to further escalation of treatment/support
☐ Treatment on ward. Palliative Care
☐ Treatment at home – consider what support will be required for this

Delivery of care Is a Critical Care bed available now?	**YES/NO**
If no bed available now, has coordinator been informed?	**YES/NO**
Has internal escalation plan been activated?	**YES/NO**

6. Decision-makers

☐ Parents/Others with parental responsibility If not involved why not?
☐ Other family members: specify

Clinician Signature:
Role and GMC number:

Other clinicians involved in making the decision:

Further information – see notes dated:

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7. **Ethical framework to guide clinical decision making**

The level of intervention may need to be based on more utilitarian-type principles than normal – *e.g. doing the greatest good for the greatest number of people.* This means replacing our usual focus on doing what is in an individual's best interests by considering distributive justice (the socially just allocation of resources).

8. **What ethical values or principles are at stake?**

Balancing four dynamic interlinked principles:

- **Beneficence (benefits)**
  - Review benefits of treatment
- **Non-maleficence (burden)**
  - Review burdens of treatment
- **Autonomy**
  - Personal freedom to choose / competence / Transparency
  - Review decision makers
- **Justice**
  - Justice social or distributive justice
  - Fairness / Equality & Equity / Non-discrimination / Resources

9. **How do these apply to the case?**

10. **Consider options available – do they conflict with ethical values/guidance/legislation?**

Review treatment options – conflicts?	
What is the most ethically acceptable option – why?	
What is the most ethically unacceptable option – why?	

11. **Evaluate and test your preferred option using the Ethics Grid:**

Outcome:	
Can proceed with decision for treatment	
Cannot proceed with decision for treatment	
Need rapid access to ethical support	
Rapid access – discussed with:	
Support / advice given	

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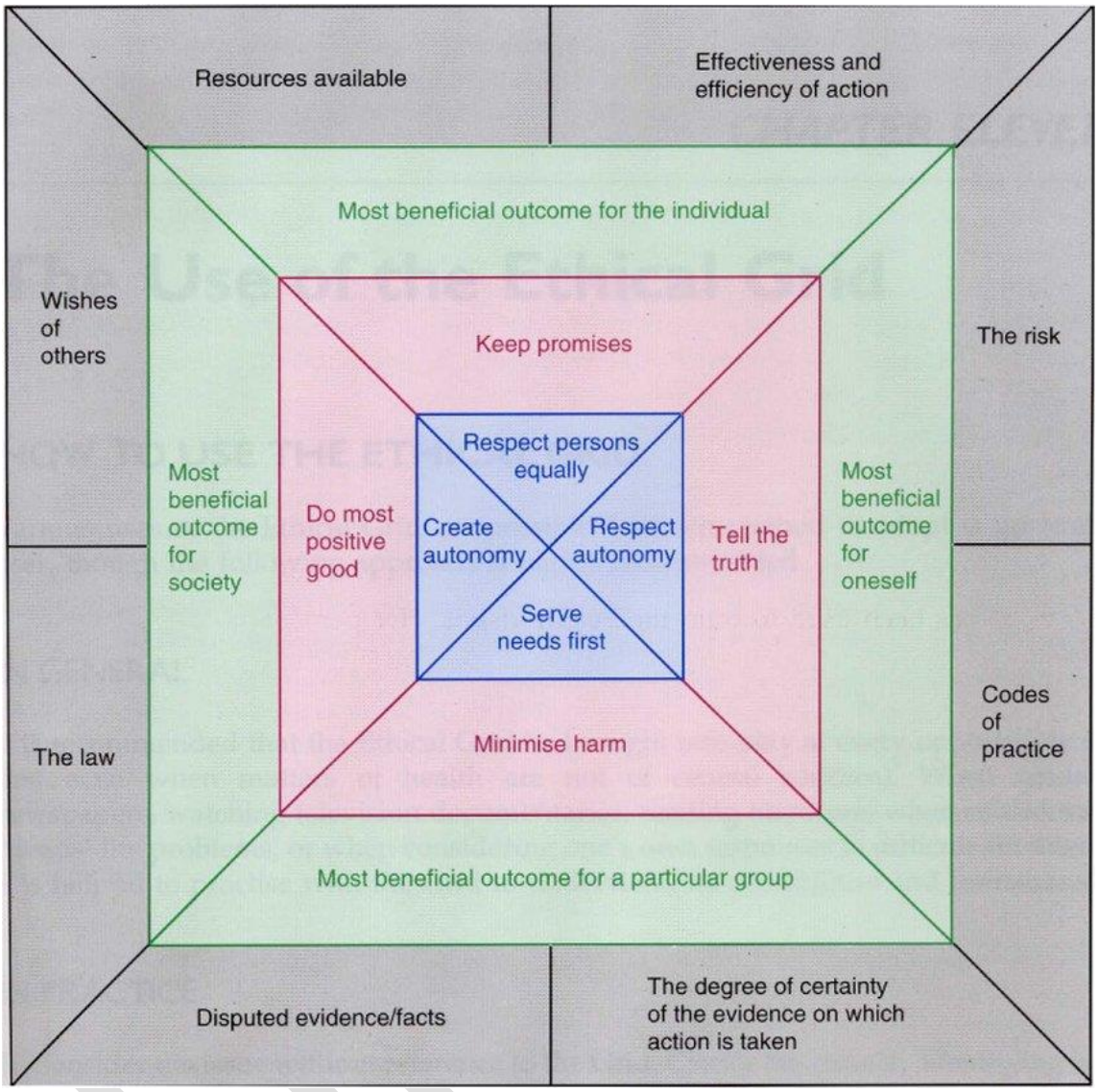

Use grid to challenge your option, not to confirm it- Work from Grey to Blue:

- **Grey = Practical issues**
- **Green = Consequences**
- **Pink = Duties & Motives**
- **Blue = Core ethical concepts**
  - **Create Autonomy**
    - **Having opportunities / Realising potential /Quality of life / best interests**
  - **Respect Autonomy**
    - **Patient preferences**
  - **Respect Persons**
    - **Anti-discrimination**
  - **Serve needs first**
    - **Needs before wants; needs as opposed to affluence**

12. **IDEA Framework**

I: Identify the facts

Medical indications	Patient preferences
Quality of life / Best interests	Contextual Features
	Availability of resources

D: Determine the relevant ethical values and/or principles

What are the relevant values and /or ethical principles at stake? *Note if values are in conflict*	
Principle / Value	Application to case

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E: Explore options

Consider whether options conflict with ethical values/principles and/or guidance/legislation		
Options	Strengths	Weaknesses
What is the most ethically acceptable option? Why?		
What is the most ethically unacceptable option? Why?		

A: Act on your decision & evaluate

Develop an action plan
Evaluate the plan
Self evaluate your decision

DRAFT

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 7 April 2020

Paper Title:	**2019/20 Board Assurance Framework Year-End Review (and March update)**
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Executive Team and Governance Manager

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

Board Assurance Framework 2019-20

Year End Review (and March 2020 update)

1. Introduction

The BAF is a tool for the Board to corporately assure itself about successful achievement of the organisation's strategic objectives and how the risks to delivery are managed and mitigated.

The BAF directly underpins the Annual Governance Statement (AGS) and is the subject of annual review by Internal and External Audit, with the former providing a formal opinion on the fitness for purpose of the process and approach. This assessment comprises a view on the BAF's structure, the Board's engagement with it and the quality of the content.

The Framework aims to allow the Board to monitor progress against the Trust's four strategic aims:

1. Delivery of outstanding care
2. The best people doing their best work
3. Sustainability through external partnerships
4. Game-changing research & innovation

Following approval of the Trust's Strategic Plan – 'Our Plan' 2019-2024 in November 2019, Board Members will recall the workshop session held in December 2019 to discuss and shape a new Board Assurance Framework to reflect how the Board intends to mitigate strategic risks that are likely to threaten the achievement of the trust's strategic plans and provide assurance that long term objectives are being proactively managed, in accordance with the agreed risk appetite in each area.

2. Key issues

The Board must satisfy itself that appropriate and timely action is being taken to sufficiently mitigate the risks to the achievement of the Trust's objectives.

The BAF continues to be utilised interactively and is used by the Trust Executive Team, the Board and its sub-committees to better drive the management and mitigation of our key risks.

This report provides a comparison of the BAF at the start and end of 2019/20; an analysis of progress thorough the year and a table that shows links between the BAF and associated corporate risks.

3. BAF at start of financial year 2019-20 (30 April 2019)

BAF Risk Register - Overview at 30 April 2019
3.4: Financial Environment (S) 1.3: New Hospital Environment (S)
2.3: Workforce Equality, Diversity & Inclusion (S) 3.2: Service sustainability and Growth. (S)
1.1: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regula (S)
3.1: Failure to fully realise the Trust's Vision for the Park (S) 4.1: Research, Education & Innovation (S)
1.4: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (B)
2.1: Workforce Sustainability (S) 2.2: Staff Engagement (S) 4.2: IT Strategic Development. (S)
1.2: Achievement of national and local mandatory & compliance standards (B)

4. BAF at end of financial year 2019-20 (1 April 2020)

BAF Risk Register - Overview at 2 April 2020
3.4: Financial Environment (W)
1.3: Sustaining operational and clinical delivery during the Corona Virus Pandemic and protecting our staff and families (S)
3.1: Failure to fully realise the Trust's Vision for the Park (W)
3.2: Failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well (S)
2.1: Workforce Sustainability and Development (S) 2.2: Employee Wellbeing (S)
2.3: Workforce Equality, Diversity & Inclusion (S) 1.1: Inability to deliver safe and high quality services (S)
4.1: Research & Innovation (S)
1.2: Inability to deliver accessible services to patients, in line with national standards, due to rising demand (S)
4.2: Digital Strategic Development and Operational Delivery (S)
1.4: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (S)

5. Comparison of ratings: start and end of financial year (April 2019 and March 2020)

Ref	Risk Title	Risk Rating: I x L	
		Current: Apr 19 : **Mar 20**	Target: Apr 19: **Mar 20**
STRATEGIC PILLAR: Delivery of Outstanding Care			
1.1 (HG)	**Inability to deliver safe and high quality services** *(previously = Achievement of Outstanding Quality for Children and Young People as defined by Care Quality Commission regulations)*	3x3 = 3x3	2x2 = 2x2
1.2 (AB)	**Inability to deliver accessible services to patients, in line with national standards due to rising demand** *(previously = Achievement of national and local mandatory & compliance standards)*	3x3 = 3x3	3x2 = 3x2
1.3 (AB)	**Sustaining operational and clinical delivery during the Corona Virus Pandemic and protecting our staff and families**	N/A : 5x4	N/A : 3x3
1.4 (JG)	**Sustaining operational delivery in the event of a 'No Deal' exit from the European Union**	4x4 > 3x2	3x3 > 3x1
STRATEGIC PILLAR: The Best People doing their Best Work			
2.1 (MS)	**Workforce Sustainability and Development** *(previously = Workforce Sustainability)*	3x3 < 4x3	3x2 < 4x2
2.2 (MS)	**Employee Wellbeing** *(previously = Staff Engagement)*	3x3 < 3x4	3x1 < 3x3
2.3 (MS)	**Workforce Equality, Diversity & Inclusion**	3x4 = 3x4	3x1 < 3x2
STRATEGIC PILLAR: Sustainability through External Partnerships			
3.1 (DP)	**Failure to fully realise the Trust's Vision for the Park**	3x3 < 3x4	3x2 = 3x2
3.3 (DJ)	**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.** *(previously = Service Sustainability & Growth AND Developing the Paediatric Service Offer - amalgamated)*	4x3 = 4x3	4x2 = 4x2
3.4 (JG)	**Financial Environment**	4x4 = 4x5	4x3 = 4x3
STRATEGIC PILLAR: Game-Changing Research & Innovation			
4.1 (DP)	**Research & Innovation**	3x3 = 3x3	3x2 = 3x2
4.2 (KW)	**Digital Strategic Development and Operational Delivery** *(previously = IT Strategic Development)*	3x3 < 4x2	3x3 > 3x2

6. Analysis of the risk ratings

It can be difficult to effectively score and update the ratings of BAF risks, because of their very nature they are often a composite of a number of lower level risks: the risk rating score is therefore largely indicative at any point in time and any consideration of progress at the end of a year represents a direction of travel rather than an absolute score. However, the following observations can be made:

Of the twelve risks on the BAF, 6 didn't change their current rating during the course of the year. The risk relating to BREXIT was downgraded upon the UKs exit from the EU owing to the eleven month transition period within which plans will be developed and finalised in readiness for full exit on 31 December 2020.

There are currently two high (red) rated risks facing the Trust:

- Financial Environment (4x5); and
- Sustaining operational delivery during the Corona Virus Outbreak (5x4)

One risk was closed in-year which related to the hospital environment; any risks remaining that pertain to the hospital environment are captured within individual (corporate) risks.

The full Board Assurance Framework for the month of March can be found at Appendix B.

7. Summary of BAF - at 1 April 2020

The diagram below shows that two risks increased in score in month.

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
		Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care					
1.1 HG	**Inability to deliver safe and high quality services**	3x3	2x2	STATIC	STATIC
1.2 AB	**Inability to deliver accessible services to patients, in line with national standards, due to rising demand**	3x3	3x2	STATIC	STATIC
1.3 AB	**Sustaining operational and clinical delivery during the Corona Virus Pandemic and protecting our staff and families**	**5x4**	3x3	-	**NEW**
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**	3x2	3x1	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work					
2.1 MS	**Workforce Sustainability and Development**	4x3	4x2	STATIC	STATIC
2.2 MS	**Employee Wellbeing**	3x4	3x3	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	3x4	3x2	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships					
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	3x4	3x2	STATIC	**INCREASED**
3.2 DJ	**Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships**	4x3	4x2	STATIC	STATIC
3.4 JG	**Financial Environment**	**4x5**	4x3	STATIC	**INCREASED**
STRATEGIC PILLAR: Game-Changing Research And Innovation					
4.1 CL	**Research & Innovation**	3x3	3x2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Operational Delivery**	4x3	4x2	STATIC	STATIC

8. Changes since 3 March 2020 Board meeting

External risks

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

  Risk reviewed; Covid-related delays to actions. Risk score remains static given strategic nature of 3.2, and all system partners experiencing same delays. Situation to be closely monitored and assessed each month.

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

  Given the rapid development of the response required to the Covid pandemic, activities attributed to this risk have been paused, with a view to review in June 2020.

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

  Following review with specialty leads no issues identified.

- ***Sustaining operational and clinical delivery during the Corona Virus Pandemic and protecting our staff and families (AB)***

  COVID-19 programme to be reviewed at Trust Board each month.

Internal risks:

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

  The onset of the COVID-19 public health emergency is having an adverse effect on access to care because of the need to direct staff and capacity to deal with the pandemic. Focus is on maintaining access to care for children who require urgent treatment. The Emergency Department, as part of its improvement plan, is focused on improving time-to-triage. Nonetheless, a huge effort has gone in to redesigning the ED layout to be COVID-19, and to support the testing of suspected patients. This effort has detracted from wider waiting time improvement efforts. In learning disability services a significant investment has been secured to increase the workforce and reduce waiting times. There is now an improvement trajectory to reduce waiting times such that all new referrals triage within 12 weeks and diagnosis within 18 weeks from April 2020, subject to re-assessment of trajectory following COVID-19.

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

  Risk reviewed - no change to score in month but progress made re International recruitment and CQC compliance. All actions remain on track

- ***Financial Environment (JG)***
  Risk reviewed in month, score increased to 20 to recognise uncertainties relating to COVID-19

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Review with regard to Covid 19 planning.

- ***Digital Strategic Development and Operational Delivery (KW)***
  BAF Risk viewed, significant progress made in 19/20 with technology roadmap divisional integration and resilience / cyber. A number of risks significantly mitigated.

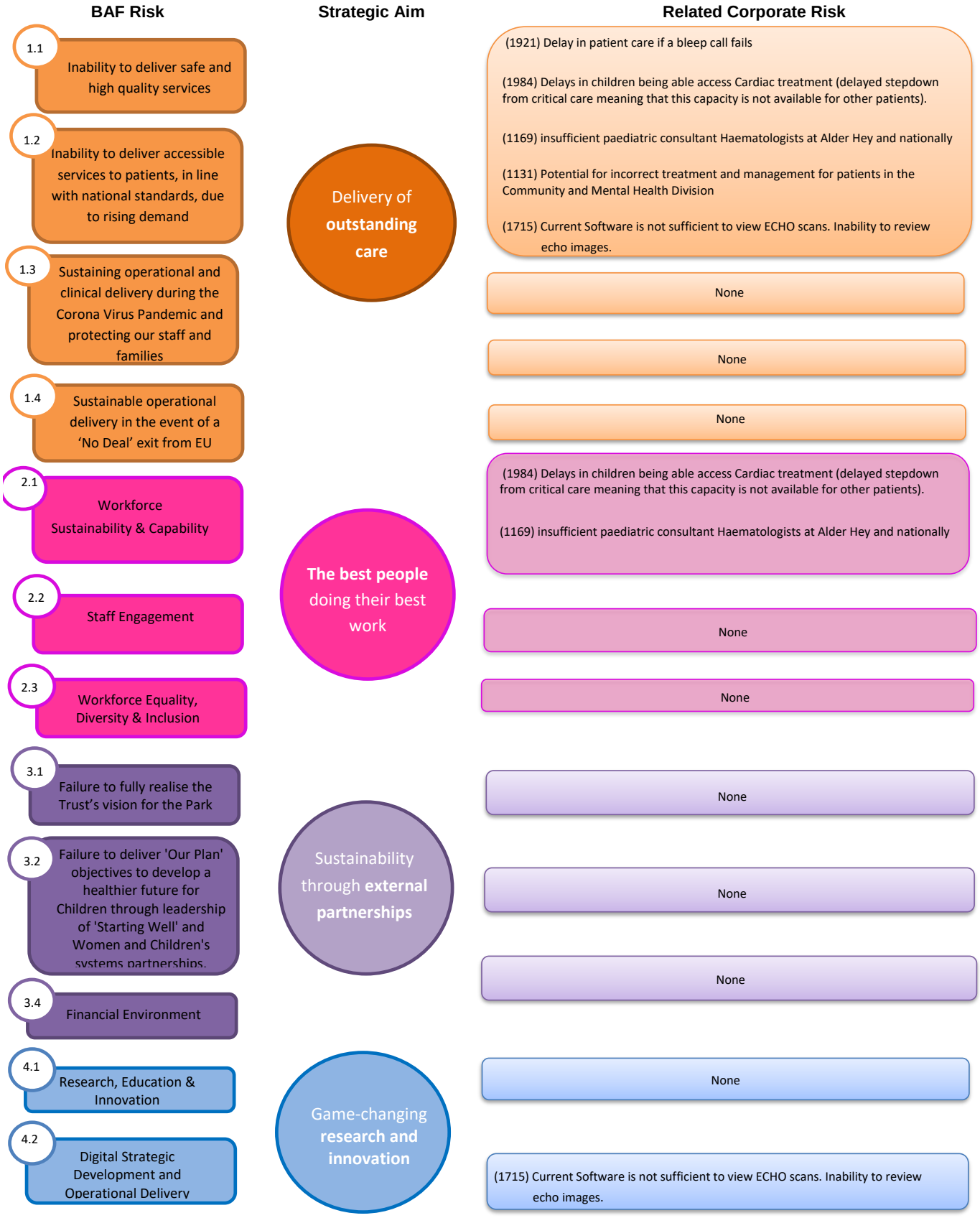
- ***Workforce Sustainability and Development (MS)***
  Given the rapid development of the response required to the Covid pandemic, activities attributed to this risk have been paused, with a view to review in June 2020.

- ***Employee Wellbeing (MS)***
  This workstream has been accelerated specifically by the need to support staff through the COVID pandemic. SALS is being progressed, as is the implementation of the wellbeing team.

- ***Research & Innovation (CL)***
  Risk reviewed; no change to score; actions on track.

Erica Saunders
Director of Corporate Affairs
7 April 2020

Appendix A. Links between BAF and high scored risks – as at 1 April 2020



Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 1921, 1131, 1984, 1715		
Exec Lead: Hilda Gwilliams	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. International recruitment in line with UK Guidance International nurses commenced in post Feb 20	30/04/2020	Profiling placements for the imminent EHU students completing their programmes. Main area of focus will be the medical division as international recruitment services the surgical division. The expectation is 25 recruits in April 2020.
Alignment of workforce plans across the system	30/06/2020	Discussions taking place to address demand surges and associated pressures

3. Confirm EHU graduate numbers qualifying in April 2020 and allocate to medical areas.	16/03/2020	Action incorporated into action 9408 (alignment of workforce plans across the system)

Executive Leads Assessment
March 2020 - Philip O'Connor Risk reviewed - no change to score in month but progress made re International recruitment and CQC compliance. All actions remain on track
February 2020 - Hilda Gwilliams Risk Reviewed - no change to score in-month. Actions remain on track
January 2020 - Hilda Gwilliams Risk revised following Board Workshop in line with 'Our Plan' to 2024. Confirmation of international recruitment completed and additional highly skilled nursing recruits joining the Trust in February 2020.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver accessible services to patients, in line with national standards, due to rising demand		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: 1524		
Exec Lead: Adam Bateman	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. 5 year workforce plan, model of care and investment case for the urgent and emergency care	30/11/2020	Outline business case has been prepared detailing workforce requirements over the next 3-5 years to redesign the emergency care pathway within the department, with a view to address the high volume of low acuity patients that present to an acute care setting. The case also considers our opportunity to work with primary care partners in light of the system's Urgent Care Review and the opportunity to link into Alder Hey's future building programme.
2. Increase in capacity and new pathways of care in community paediatrics for ASD & ADHD diagnostics	30/06/2020	Impact of COVID-19 has resulted in more activities within the ASD/ADHD assessment service being carried out via telephone and video call. Use of further external support being progressed to ensure delivery of activity during Q1 20/2. Staffing levels to support service is impacted by staff absence and requirement to support acute. Monitoring in place to ensure any impact is

		understood and acted on within Division.
4.Completion of detailed actions for specialties with a Challenged Action Board	31/12/2020	Challenge Action Boards reviewed at Operational Delivery Board and Executive Directors Meeting to monitor and support progress
3. Additional workforce capacity in Specialist Mental Health Services and new pathways	30/06/2020	The service has successfully recruited to additional posts across all areas including Educational Mental Health practitioners (EMHPs) and a number of apprenticeship appointments have been made. This will support the delivery of capacity and new pathways in the service. Impact of COVID-19 has resulted in some clinical activity being converted to telephone and video clinics.

Executive Leads Assessment

April 2020 - Adam Bateman
The onset of the COVID-19 public health emergency is having an adverse effect on access to care because of the need to direct staff and capacity to deal with the pandemic. Focus is on maintain access to care for children who require urgent treatment.

The Emergency Department, as part of its improvement plan, is focused on improving time-to-triage. Nonetheless, a huge effort has gone in to redesigning the ED layout to be COVID-19, and to support the testing of suspected patients. This effort has detracted from wider waiting time improvement efforts.

In learning disability services a significant investment has been secured to increase the workforce and reduce waiting times. There is now an improvement trajectory to reduce waiting times such that all new referrals triage within 12 weeks and diagnosis within 18 weeks from April 2020, subject to re-assessment of trajectory following COVID-19.

February 2020 - Adam Bateman
ED waiting time performance in January improved to 87.6%. There has been a delay in completion of the ED business case as the new Clinical Director and ACOO evaluate demand, workforce requirements and model. The case will be concluded in March. As pressures have lessened and flow in ED has improved relative to November we have stood down the incident management group and are managing this as business as usual. In ED we are increasing staffing levels to have a second triage nurse and to appoint additional ANPs to reduce time to treatment. In order to further support patient flow in ED, we have agreement through the Best in Acute Care Group a new Paediatric Assessment Unit. The business case will be submitted in March and the pilot is expected to start in July 2020.

January 2020 - Adam Bateman
Overall access to planned care and cancer care is outstanding and in line with national standards at the aggregated level. Nonetheless, in community paediatrics there are delays to follow-up appointments and long waiting times for ASD and ADHD diagnosis.
We have faced exceptional pressures in the Emergency Department due to unprecedented volumes of patients attending which has led to an increase in the number of patients waiting over 4 hours for treatment. Maintaining safe emergency care has been our top priority and we have taken a number of exceptional actions to enhance staffing levels (HCA in waiting room and additional night shift) and increase capacity (Daily emergency access clinic and respiratory physiotherapy appointments).

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Sustaining operational and clinical delivery during the Corona Virus Pandemic and protecting our staff and families		
Related CQC Themes: Responsive, Safe, Effective, Well Led, Caring		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Adam Bateman	Type: External,	Current IxL: 5x4	Target IxL: 3x3	Trend: STATIC

Risk Description

Failure to safeguard the organisation's ability to deliver services safely and protect our staff and families during the coronavirus (COVID-19) outbreak.

Existing Control Measures	Assurance Evidence (attach on system)
Formal strategic and tactical command arrangements in place	agendas & minutes
Detailed COVID-19 Plan agreed and being deployed	
Work programme on keeping our staff safe enacted	
Plan to establish adult invasive capacity progressed	

Gaps in Controls / Assurance

Regional plan required to formally establish to designate Alder Hey as 1 of 5 national providers of last resort for PICU
Adult trained physicians to support management of adult HDU & Step-down area
Number of ventilators (10 short)- national procurement request submitted
Recovery plan (protecting staff and recovering access times for patients) for post-COVID-19

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
System wide response for pandemic influenza, focused on the continuity of public and critical services	29/05/2020	
From 13 March 2020 our Personal Protective Equipment (PPE) training will be modified to be COVID-19 PPE specific, and consistent with the latest Public Health England guidance.	29/05/2020	
Increased testing aligned to national guidance	29/05/2020	
Restricted visiting; this will allow us to reduce the possibility of the virus inadvertently being bought into the hospital and help to keep our vulnerable children safe.	29/05/2020	
Non-Clinical Corporate Services Working from Home where possible	29/05/2020	
Internal Response Plan - Strategic Command Team in place	29/05/2020	
Workstream established to review external supplies. Group meeting three times per week to review key actions, decisions and risks/issues/opportunities	29/05/2020	
All elective surgery being clinically led with prioritised step down of non urgent work - clinical prioritisation leadership structure in place and ethics	29/05/2020	
Staff being redeployed where possible support potential surge	30/06/2020	
Clinical Advisory Board in place covering clinical prioritisation, ethics, vulnerable children and infection prevention control	30/06/2020	
Staff welfare and guidance workstream established	30/06/2020	

Executive Leads Assessment

March 2020 - John Grinnell
COVID programme to be reviewed at Trust Board each month

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Risk Description
Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity. 11 month transition period underway within which plans will be developed and finalised in readiness for full exit on the 31st Dec 2020.

Existing Control Measures	Assurance Evidence (attach on system)
National NHS EU coordination centre established to oversee planning and provide support to local teams to resolve escalating issues. Internal team in place to implement operational guidance.	Internal team meets regularly; work stream leads identified; risk assessments undertaken. Assurance framewroks completed and submitted to NHSE.

Gaps in Controls / Assurance
There maybe some very limited supply issues when we move from transition at the end of December 2020 but there is no immediate risk to supply other than business as usual fluctuations which would be considered as normal within the current risk profile.

Executive Leads Assessment
February 2020 - Lachlan Stark Following review with specialty leads no issues identified
January 2020 - Lachlan Stark 11 month transition period underway within which plans will be developed and finalised in readiness for full exit on the 31st Dec 2020.
December 2019 - John Grinnell Risk reviewed in line with 31 January 2020 scheduled exit. Business to remain 'as is' given 12 month transition period. Business continuity plans to remain in place ready for resurrection if required.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 1984, 1169		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.
2. Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. This includes the introduction of a pilot wellbeing team to support the management of sickness absence. Target is 4% absence rates across the organisation.	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.
4. Succession planning to be completed for the Executive Team. To be rolled out to the Divisional senior management teams in January 2020	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.

Executive Leads Assessment

March 2020 - Melissa Swindell
Given the rapid development of the response required to the Covid pandemic, activities attributed to this risk have been paused, with a view to review

in June 20.
February 2020 - Sharon Owen reviewed Actions and actions on track
January 2020 - Melissa Swindell Risk reviewed and updated to reflect changes. All gaps in controls have associated actions
November 2019 - Sharon Owen Risk reviewed actions remain on track, risk rating remains the same.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 2.2	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Employee Wellbeing		
Related CQC Themes: Effective, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x4	Target IxL: 3x3	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Develop a proposal to implement a SALS service	30/06/2020	SALS is being progressed, as is the implementation of the wellbeing team.
2. Appoint to the wellbeing team	30/06/2020	Team Leader appointed; team to be appointed Jan 2020
3. Detailed action plan in response to 2018 HEE visit. Use of £60k welfare monies to re-purpose a new JD mess. JD Forum refreshed	30/06/2020	JD mess agreed, will be fully in place February 2020

Executive Leads Assessment

March 2020 - Melissa Swindell
This workstream has been accelerated specifically by the need to support staff through the COVID pandemic. SALS is being progressed, as is the implementation of the wellbeing team.

February 2020 - Sharon Owen
Risk reviewed, all actions on track. Lead for wellbeing team appointed to and some of the team. Hope all team will be in post ready to launch 1st April 2020.

January 2020 - Melissa Swindell
Risk reviewed and updated to reflect changes. All gaps in controls have associated action plans

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Work with the BME and Disability Networks to develop specific action plans to improve experience.	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.
1. Work with Community Engagement expert to develop actions to work with local community	30/06/2020	activities attributed to this risk have been paused, with a view to review in June 20.

Executive Leads Assessment

March 2020 - Melissa Swindell
Given the rapid development of the response required to the Covid pandemic, activities attributed to this risk have been paused, with a view to review in June 2020.

February 2020 - Sharon Owen
Risk reviewed, actions updated

January 2020 - Melissa Swindell
Risk reviewed and updated to reflect changes. All gaps in controls have associated actions

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.1	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: David Powell	Type: Internal, Known	Current IxL: 3x4	Target IxL: 3x2	Trend: INCREASED

Risk Description

Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Heads of Terms agreed with LCC for joint venture approved	
Campus Steering Group	Reports into Trust Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Capacity Lab have been engaged for a period of 3 months to complete a piece of work/proposal for setting up a Community Interest Company as well as supporting the Trust to bring partners on board with the development and providing some financial contributions	
Planning application for full park development.	Full planning permission gained in December 2019 for the park development in line with the vision, awaiting written confirmation.
Weekly review of status in respect of Covid 19 impact	Meeting record

Gaps in Controls / Assurance

1. Fully reconciled budget with Plan.
2. Risk quantification around the development projects.
3. Absence of final Stakeholder plan

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Complete cost plan	30/04/2020	
2. Agree Park management approach with LCC	29/06/2020	Outline process agreed with LCC
Prepare Action Plan for NE plot development	20/04/2020	
Complete market test and scheme rationalisation and secure sign off	09/04/2020	Cluster schemes prepared for market test
Prepare revised plan for park clearance	31/03/2020	
Prepare plan to respond to impact of the virus	24/04/2020	

Executive Leads Assessment

March 2020 - David Powell
Review with regard to Covid 19 planning.

February 2020 - David Powell
Review prior to March Board

January 2020 - David Powell
Programme Review paper prepared for January Board including risk assessment

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
6. Develop Operational and Business Model to support International and Private Patients	01/06/2020	
1. Strengthening the paediatric workforce	31/03/2020	6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'. In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements.
2. Develop Sefton and Knowsley plans for C&YP - align with One Liverpool where possible/appropriate	03/07/2020	Positive progress in Sefton with development of Children's Partnership Board; delay to progress expected due to Covid though plans in place to resume once appropriate (assume 3mths)
3.Collaboration with LCCG and system leaders to develop 28/02/2019 next stage of One Liverpool; develop the programme of work for C&YP / Starting Well - Children's transformation partnership to take a leadership role	03/07/2020	System already experiencing delay to progress due to COVID; assume 3 months impact, though this will be assessed monthly.

4.Continue to develop joint partnership hosting arrangements for existing and pending ODNs with RMCH	03/07/2020	Significant progress in ODN development planning at North West Paediatric Partnership Board in March. Spec Com agreement to delay subsequent actions during Covid; assume 3mth delay initially (to be reviewed monthly).
5.Develop Business Model to support centralisation agenda and Starting Well	03/07/2020	Development of governance for Starting Well underway which is a step towards defining business model. however, impact of COVID will cause a delay in progress; currently working to assumption 3 months delay (to be reviewed monthly).

Executive Leads Assessment
March 2020 - Dani Jones Risk reviewed; Covid-related delays to actions. Risk score remains static given strategic nature of 3.2, and all system partners experiencing same delays. Situation to be closely monitored and assessed each month.
February 2020 - Dani Jones Risk reviewed; updates to actions and controls re: Starting Well. No change to score in month.
January 2020 - Dani Jones Refresh of risk title, descriptor and actions following Our Plan and subsequent risk review with Trust Board. Risk score reviewed and no change in month.

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 3.4	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell	Type: Internal, Known	Current IxL: 4x5	Target IxL: 4x3	Trend: INCREASED

Risk Description

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

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

Gaps in Controls / Assurance

1. Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan.
2. Affordability of Capital Plans
3. Cost of Winter escalating
4. Long Term Plan shows £3-5m shortfall against breakeven
5. Impact of COVID-19

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
5.Long Term Financial Plan	30/06/2020	Financial gap remains unresolved as progress with NHSI has been paused due to COVID-19. Financial planning formally paused
3. Five Year capital plan	30/06/2020	Given COVID-19 longer term financial plans on hold and suggest this is revisited when the COVID-19 position is clearer.
1. Tracking actions from Sustainability Delivery Group	31/03/2020	Significant divisional improvements made which will be finalised as part of year end position given COVID-19 further action paused at this stage.
2. Develop fully worked up CIP programme - £1.5m gap	31/03/2020	CIP fully met
4. Cost of Winter	30/06/2020	Winter pressures superseded by COVID-19, will revisit as part of 2010/21 operational plans
6. Childrens Complexity tariff changes	30/06/2020	Case for 2020/21 on pause pending COVID-19. Longer term tariff work continues with a due for completion June 2020
5. Develop COVID-19 financial plan to align to revised commissioner and central finding arrangements	30/04/2020	

Executive Leads Assessment

March 2020 - John Grinnell
Risk reviewed in month, score increased to 20 to recognise uncertainties relating to COVID-19

February 2020 - Claire Liddy
Month 10 financial results are a £0.2m adverse variance in month and £1.8m forecast risk to control total. Clinical and corporate divisions have been set improvement targets which are being tracked.

January 2020 - John Grinnell
Divisional forecast demonstrating £2.5m shortfall against plan despite CIP projections. Winter pressures are offsetting some improvements which is

becoming the biggest risk to our delivery. Contract position is showing a nett underperformance so risk profile lower. Actions in Q4 include recovery action plans and a stretch target for each Divisional area. Focus is now turning to bridging our gap in our 20/21 plan. Key elements will be our escalation of the impact of tariff on our ability to meet plan and also us focussing on key transformational schemes that will drive efficiencies. Capital plan remains a concern given reduced funding available and control of the capital budget lines which are showing pressure.
November 2019 - John Grinnell Latest forecast is a £2.4m deficit from control total. Corporate and Divisional recovery schemes being focussed on. Increased risk relating to winter pressures and financial performance that have yet to be fully scoped.
October 2019 - John Grinnell Risk reviewed - no change to score in-month. Half yearly forecast still showing £2.8m gap. Some progress being made on recovery actions to bridge however, further step-up required. Further assessment to be undertaken at M7.
September 2019 - John Grinnell Sustainability recovery group continues to meet weekly with an action focus on closing £3.4m gap. Significant progress being made through the targeted recovery plan

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

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

Risk Description
Failure to grow research & innovation due to potential gaps in capacity and funding

Existing Control Measures	Assurance Evidence (attach on system)
RABD review of commercial contracts per SFI. Trust Board oversight of shareholding and equity investments.	Reports to RABD / Trust Board and associated minutes
Programme assurance via regular Programme Board scrutiny	Reports to Programme Board and associated minutes
Establishment of Research Management Board	Research Management Board established.
Establish Innovation Board Committee	Committee oversight of Innovation strategy with NED expertise
Innovation team re-organised and funded to ensure adequate capability. Establish role of Managing Director of Research and Innovation to provide unified vision.	
Alder Hey Innovation LTD governance manual established	

Gaps in Controls / Assurance
Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Complete collaboration contract with University of Liverpool. This is a strategic agreement - deadline reset to March 2020 as part of 3 year join planning with UoL VP. Create standard approach to agree 3 year strategic R&I roadmaps with each University Partner	31/03/2020	Plans, data and costs now exchanged but final agreement still to be reached. Longstop date Dec 2019, but conclusion expected before this; timescale therefore revised.
Agree incentivisation framework for staff and teams: for research time & innovation time.	31/03/2020	Research time now under pilot phase. Innovation and addressing a culture of innovation to be included in innovation 10 year strategy production. Innovation Committee strategy session planned in Q4 2019/20.

Executive Leads Assessment
March 2020 - Jason Taylor Risk reviewed. No change to score; actions on track.
February 2020 - Claire Liddy Risk reviewed; no change to score; actions on track
January 2020 - Claire Liddy Updated and reviewed as risk static

Board Assurance Framework 2020-21

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development and Operational Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 1715		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x2	Target IxL: 3x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

Lack of secondary data centre / disaster recovery - significant progress with new arrangements in place
Cyber security investment for additional controls approved - dashboards and specialist resource in place
Transformation delivery at pace - integration with divisional teams and leadership from divisional CCIOs

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of cyber actions including managed service and cyber accreditation	30/04/2020	Working towards cyber essential accreditation in early 2020/21
Integration with divisions, clinical leadership strengthened, clarity and ownership of plans	31/03/2020	Significant progress, key roles in place
Testing and commissioning of secondary data centre	30/04/2020	Significant progress, equipment in place, commissioning live environment, progressing with suppliers.

Executive Leads Assessment

March 2020 - Kate Warriner
BAF Risk viewed, significant progress made in 19/20 with technology roadmap divisional integration and resilience / cyber. A number of risks significantly mitigated.

February 2020 - Kate Warriner
Reviewed BAF including key actions which are on track. Good progress being made.

January 2020 - Kate Warriner
BAF reviewed. Good progress in relation to risk areas. Plans in place for 2020 delivery.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
7th April 2020

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

Alder Hey Children's NHS
NHS Foundation Trust

Board of Trust Directors Report

Campus Development report on the Programme for Delivery

7th April 2020

1. Introduction

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

As of the March Board and coming to the end of Qtr4 for 19/2020 the programme Delivery Timetable will rag rate projects from there 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										
Acquired buildings occupation										
Police station (LF) occupation										
Decommission & Demolition Phase 3 (Oncology, boiler hse, old blocks)										
Main Park Reinstatement (Phase 2/90%)										
Infrastructure works & commissioning										
Clinical Hub Construction										
Clinical Hub Occupation										
Dewi Jones Construction										
Dewi Jones Occupation										
Demolition Phase 4 (Final)										
Final Park Reinstatement (Phase 3)										
Neonatal Development Tendering and Design										
Neonatal Construction										
Neonatal Occupation										

The Initial Park reinstatement is now at risk due to the Demolition Contractor closing the site due to Government guidelines on Covid 19 to close all non-critical sites. This impacts on the reinstatement works as the site is not clear of all the old buildings.

The Alder Centre construction is now rated as amber due to the impact of Covid 19 beginning to give rise to late deliveries of materials and lower levels of labour to maintain social distancing. At the March 26th site meeting, the contractor expressed a desire to continue but if this continues the Trust

will be required to pay for delays from an already stretched budget without much progress on site. The Trust team are exploring a suspension of works until the Covid 19 impact has passed.

Clinical Hub and Dewi construction will not commence before the end of Qtr 1, hence the red RAG rating. A delayed start is almost inevitable due the impact of Covid 19, the team will get price, scope and contract agreed by the end of April ready for a contract signature so that a start can be made once Covid 19 effect has passed.

3. Capital Cost

The development team fully appreciate the relevance of projects costs extending beyond available budget and how this could impact the overall capital monies available to the Trust and therefore will continue to value engineer and reduce costs wherever possible without deterring from the quality of the developments. The development team are negotiating hard with potential and current contractors to reduce costs across all developments. The finance department is fully supporting the Team in monitoring and taking relevant actions to stay within the financial envelope available.

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

Table 2.

Estates Savings Target	Budget	Dec Estimate	Dec Comments
The Park	1,750	3,000	Phase 2 estimate as at the end of March 2020 is in line with the Dec estimate of C. £3m
Alder Centre	1,681	1,931	Budget under pressure to c £70k - under review with the design team
C Cluster Hub	18,822	20,572	Market test is being reviewed -value engineering being worked thro' with contractor
C Cluster Dewi			Additonal 50k cost for comepletion of PCSA
Infrastructure - Utilities	1,200	1,200	
Landscaping	481	500	
Attenuation	600	600	
Infrastructure - Roads (inc s278)	858	858	
Demolition and decomm	2,356	2,656	Asbestos levels over estimated provision
Relocations	1,227	1,227	
Neonatal	11,869	13,569	2 options under consideration, awaiting analysis to confirm preferred option
Institute retention	0	0	
Development team	1,100	1,631	Under review with proposed rationalisation
Community/Off site	300	300	
NE Site Development	0	0	
Institute re-works	360	360	
Office Requirement	2,700	2,970	
Medical Records	0	0	
Staff removals	250	250	
Car Park	100	100	
	45,654	**51,724**	
Revised Budget	45,615	51,724	
Under/(Over) Budget	**-39**	**6,109**	

4. Project updates

Park Reinstatement Phase 1

Current status	Risks & Issues	Actions/next steps
Beech Demolition LTD has demobilised from site until Covd 19 has passed. This has a direct impact on the completion of demolition works and will impact on the Park reinstatement work. A revised end date is difficult to predict. Capacity Lab have been working on a programme for delivery of the full park reinstatement over a further two phases producing the tender documentation for engaging partners who can support funding for elements of the long-term vision. There were some planning conditions which we are just in the process of implementing e.g. tree protection.	The impact of Covid 19 has halted demolition work which prevent the start of the reinstatement work. Presence of asbestos and other contaminants in the ground could be disturbed by development works to Phase one of the park plan. (Risk 2116- Score 6)	The Park reinstatement works is under review to make the work as efficient as possible to keep the project in budget. Capacity lab engage with groundworks on a regular basis

Alder Centre

Current status	Risks & Issues	Actions/next steps
Construction of the Alder Centre Building currently is in delay which may extend due to the restrictions of progressing work on site due to COVID19. There are delays in supplies to site and the project will become more costly in prelims if there is on site workforce without progression of works. The change from last month's report is that occupation of the building will entail a further delay as the external works package costs have not yet been fully agreed. This is due to the complexity of the perimeter wall and specifically the section directly facing the park as this backs onto a Haha (drainage boundary	Delay to works due to COVID 19 Landscaping and external perimeter wall construction will not be delivered in line with occupation dates. (2101- score of 9)	Price and programme to be determined and agreed with contactor by first week in March.

solution). The delay is also impacted by the construction of the Gabion wall (part of Community Cluster- retaining wall for the under-croft car park to ensure the access path to the Alder Centre is safe. Occupation will therefore likely occur towards the end of May/beginning of June instead of mid-April. This does not present us with an issue as the Critical date for the completion of the move is 30th June. Infrastructure plan- Temporary infrastructure ducts have now been laid for water, power and data. The landscaping design is being scaled back to a simpler design to enable works to commence within the current budget available. Dates for meeting in the run up to the move with the Alder centre team with divisional input have now commenced.	New service model structure currently not agreed and worked up across the Alder Centre Unit. (Current Manager vacancy)	Ensure the Division address the vacancy /cover and service model is fully developed and agreed prior to occupation of the new building. **Plan now agreed with the division for work to be completed before occupation.**

Acquired Buildings Occupation (neighbouring sites)

Current Status	Risks/issues	Action/next steps
410 Prescot Road- currently in the process of being purchased. Some minor refurbishment works are currently being costed and will be covered from the allocated budget. Expected completion on acquiring the building was the end of January 2020 however Solicitors are awaiting some outstanding information from the Vendors. Development team in regular contact with the solicitor and estate agents for r updates on progress.	Resistance from staff to move to either location. (2102 risk score 9)	Director led group has been set up; there is a need to agree all relocation of staff/services and manage the change process appropriately.
Knotty Ash Nursing Home Transaction/purchase completed and we are now the registered owner of the property. Initial refurbishment/re-design plans have been drawn up by the Mersey Design Architects, with the aim of temporarily re-	Medical records storage exceeds the space available.	IM&T currently working up a programme for digitisation of all stored records.

locating some services to allow demolition and park advancement to occur late this year. Ultimately this building will provide accommodation for corporate functions in two years' time. A workshop with a number of executive colleagues occurred on 25th February to plan out realistic department re-locations/changes. Executive sign off for the planned moves will occur week commencing 2nd March which will enable the tender package to go to the market for the refurbishment works. In the meantime, an Asbestos survey has been ordered and a price for strip out of the current building is being obtained.	Refurbishment works not delivered to planned timetable.	Tendering of works to commence as soon as possible after exec approval for the move plan.

Police Station (lower floor) occupation

Current status	Risks/issues	Actions/next steps
The Trust is currently in discussion with the Police service for planned occupation of 2/3rds of the lower floor from July 2020 under a lease agreement. This will then allow for relocation of some corporate services from the current retained estate buildings.	Police do not release the space while decisions are made in regards to additional police funding and its use. (2088 risk rating 8) This will mean a delay to the old management block being vacated and therefore delay to demolition of the building.	Weekly discussion and communication with the police estates departments. Development team are currently working up the contingency plan.

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

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

Park reinstatement Phase 2/3

Current status	Risks/issues	Actions
Capacity Lab have been engaged to provide a team of people to replace the Park Co-ordinator for the next 6 months (with option to extend) to work up a plan with a partnership approach to generate funding and work with all stakeholders across the community and wider region. It is anticipated the partnership model will bring in the additional funding requirement.	Funding required is not delivered through the partnership approach. (relates to risk 1241 actions) LCC do not agree to a future Community Interest Company for Sustainability.	Weekly review of the programme and progress with Capacity Lab, with weekly presence on site. Maintain regular discussion with LCC, make contact with Neil Coventry until such a point in time the Lead for leisure Services is appointed.

Infrastructure works & commissioning

Current status	Risks/issues	Actions
Masterplan of Infrastructure works is currently being prepared, planning application to be submitted in April and out for tender in May 2020.	Nil at present time.	Ensure timely process /programme is adhered to.

Clinical Hub and Dewi Jones Construction

Current status	Risks/issues	Actions
Costs have been received from Galliford Try but need further assessment and incorporation of Value Engineering to bring the project with the budget. With agreement from RABD this will take place through the month of April to be ready to enter in to a contract, subject Covid 19, in May. The extended piece of work which includes detailed Room data sheets across the development has now commenced with clinical teams and will occur over an 8 week period. Market testing for component packages is out to the market currently and due to conclude in the week commencing 2nd March 2020. List of value engineering options has been completed; this could translate into some reduction in space of the proposed Orthotics area. (Shell and core only). Currently assessing costs and plans by two competitors for construction of the Gabion wall.	Final construction cost of project exceeds the allocated budget. (1948 risk rating 9) Delay to full contract agreement. (2106 risk rating 12)	There is anticipated short list of further items. Which could be value engineered out in the first instance to bring the project cost down. Detailed work on package costs to be assessed and modified where ever possible. Board approval prior to final contract signature/sign off will occur in April/May. Continue with weekly meetings with Galliford Try.

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.(2003 risk rating 12)	Monitor demolition budget management on a monthly basis and work up contingency plan.

Neonatal Development

Current status	Risks/issues	Actions
Design brief has been developed. The outstanding elements to be agreed is the approach from the PFI perspective (we have received their feasibility study), our approach to procurement which will depend on any agreement with the PFI and the location of the new unit. Exercise completed what space could be utilised on ward 1C and integrated with a new build. An Option appraisal has been developed, looking at three options: • Option 1. New build at Level 1c which utilises some space from EDU (Clinically preferred option) • Option 2. Extension to the end of 1c (current neonatal unit, least preferred option by clinicians) • Option 3. New build to level 1 PICU, this would extend between finger 1-2 **Option 2** now ruled out due the complexity of access to services such as Theatres and ITU. **Options 1 & 3** is being further progressed following feedback from the clinical teams.	Costs of new unit exceed current financial envelope. Cost of PFI management of the Process versus VAT savings. Not reaching agreement with PFI risks a workable interface with the CHP being achieved. In decision on final location Planning permission fails to be achieved within the timescale of the overall programme delivery.	Division of Surgery to take a revised and final Business Case to the Trust board for approval, date to be confirmed. Ask GD to work up current option 1 to RIBA Stage 1, which would provide Gross Internal Floor Area (GIFA), Schedule of Accommodation (SOC), room adjacencies and estimated Cost in readiness for next stage. **Complete.** Maintain open communication with the LCC planning departments.

The development team are preparing to progress to stage 2 design for the development.		Move to next stage of the design process.

North East Plot Development

Current status	Risks/ Issues	Actions/next steps
Stepplaces the Developer who has purchased the north east plot of land is currently in discussion with the Trust on how the development could support some of Alder Hey's vision for the future some of the discussions currently include development of : • A Gym • A Nursery with an increase potentially of 40 providing 100 places in the future • Science/Knowledge building • Varied accommodation's which could be offered to staff, trainees etc.... • Supported living accommodation and homes retirement/ ADHD/Disabled Children and families • Provision of commercial opportunities to compliment the Eaton road current offering.	Local community resistance to Trust non-development aspects and planning submission.	PWC engaged to look at other opportunities for using the site for other complimentary uses. Maximise our offering/ support /negotiation on development content and opportunities. Appoint to a commercial part time role to lead on the East Plot development on behalf of the Trust. **Complete**

Car Parking

Current status	Risks/Issues	Actions/next steps
There is a requirement to reduce the overall parking spaces on the current estate with particular need on the retained estates and the temporary car	Car parking cannot sustain a	Car parking group to continue to

parking solution in situ (from a planning perspective we have permission to utilise the large temporary car until the end of 2021.

Spaces reduced (number)	Date	Which part of the site/ Additional detail
50-60	16th March 2020	Overflow at Catkin.
97	30th June 2020	Catkin (effectively close this car park and reallocate some patient spaces with in the temp car park with a direct path to new entrance into the catkin building)
91	30th June 2020	Temp car park reduction
248 in total		
187	Dec 2021	When the Cluster opens we have 68 spaces in the under croft, but under planning conditions we have to close the Temp car park.

This will prove to be very challenging and the car parking group is looking at a number of options to incentivise staff to use alternative modes of transport or alternative ways of working. Mott MacDonald a travel consultancy have also been engaged to advise Alder Hey on proven methods for reduced parking.

Future Board reports will provide updates on progress.

reduction to current Numbers by June 30th 2020

Staff resistance to change.

Travel plan from Mott MacDonald does not provide realistic and evidenced solution.

work with Mott MacDonald and internal group members to produce an overall plan.

Communications

Current status	Risks / issues	Actions/next steps
Draft Comprehensive Communication plan developed which requires finalising and Trust Board Sign off. Fortnightly meetings between development team and Communications department are now in place.	Loss of reputation, locally and regionally. Lack of engagement internally and externally	Maintain links with Friends of Springfield park groups and actively support their development work. Team brief to include updates on campus/park development. Feature paper/spread in Qtr. 4 aiming to communicate over all campus development plans incorporating an easy to read roadmap.

5. Trust Board of Directors

The Trust Board of Directors is requested to receive and acknowledge the update provided.

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

Title	**Liaison Committee Meeting Minutes**	
Date / time	Tuesday 10 December 2019, 1230hrs	
Location	Executive Meeting Room, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool L12 2AP	
Present	**Trust:**	Stuart Atkinson (Trust Associate Director of Estates) **SA** Rachel Lea (Trust Associate Director of Development) **RL** Graeme Dixon (Head of Building Services) **GD**
	Project Co Directors:	Alan Travis (Laing O'Rourke, Explore Investments) **AT**
	Other Project Co Attendees:	Andrew Saunders (Project Co Representative) **AJS** Carl Roberts (Interserve FM) **CR**
Apologies	Louise Shepherd (Trust CEO) **LS** John Grinnell (Trust Deputy CEO & Finance Director) **JG** David Powell (Development Director) **DP** Claire Liddy (Trust Representative) **CL** Andy Pearson (John Laing Investments Ltd) **AP** Neil Woodburn (John Laing Investments Ltd) **NW** Tristan Meredith (Interserve Developments) **TM**	

Item	**Discussion**	**Action**
1.0	**Quorum** – the meeting was quorate as defined within clause 12.1 of the PA.	**Note**
2.0	**Previous Minutes dated 22 July 2019** – The previous minutes were accepted as an accurate record of the meeting. **16 April 2019; Action 3.2** – A number of Energy Performance Contract ('EPC') meetings had taken place, the most recent being 29 November 2019. **22 July 2019; Action 3.2** – Confirmation of Trust membership remained outstanding. RL agreed to review and confirm arrangements so as the Terms of Reference ('TOR') could be adjusted, and in turn published.	**Closed** **RL**

	22 July 2019; **Action 3.3** – SA advised the group that his suggested reporting template did not meet the requirements of the Liaison Committee. It was agreed that specific reporting requirements would be addressed (in good time) to both SA and AJS in advance of future meetings.	**Closed**
	22 July 2019; Action 3.4 – SA and AJS agreed that the survey element of the "Partnership Charter" would be reviewed and resurrected at the discretion of the Liaison Committee.	**Closed**
	22 July 2019; Action 4.1 – AJS advised that an EPC proposal had been issued to the Trust, and the same was discussed during a meeting on 29 November 2019. GD confirmed that energy efficiency data had been shared with Trust colleagues.	**Closed**
3.0	**Draft Terms of Reference**	
3.1	Attendees acknowledged that the draft TOR is in an agreed format. Confirmation of Trust membership is to be advised.	**Note**
4.0	**Key Issues / Hot Topics**	
4.1	Executive to Executive meeting A high-level discussion took place summarising correspondence exchanged and actions arising following the meeting of 15 October 2019. Attendees acknowledged that a further meeting of the Executives would take place on 17 January 2020.	**Note**
4.2	Energy Centre CR advised attendees that the output from the Service Providers Energy Centre review is due at the end of January 2020 and this review would inform an options appraisal. CR agreed to update Committee members as and when required.	**CR**
	GD acknowledged that progress was being made however users were still experiencing issues with theatres achieving the required temperatures. CR acknowledged this point and agreed to develop an action plan in response to the same.	**CR**
4.3	Pipework corrosion AJS advised that a Written Scheme of Examination ('WSE') had been developed in conjunction with Alliance, Phase 1 works are expected to run for 47no. days. SA recorded that good progress had been made in the period.	**Note**
4.4	August 2019 performance The Trust and Project Co recalled their respective positions, both parties recorded their willingness to promptly resolve the issue at hand. A high-level discussion took place in relation to next steps, SA and AJS agreed to convene separately to progress a resolution.	**SA & AJS**

4.5	Neonatal Intensive Care Unit ('NICU') Attendees acknowledged that Project Co's feasibility study was nearing completion and would be issued during w/c 16 December 2019. Project Co confirmed their willingness to work with the Trust on the development of a new NICU. Committee members agreed that a workshop should be held to discuss strategy and exchange expectations.	**SA & AJS**
5.0	**Any Other Business**	
5.1	N/A	**Note**
6.0	**Next Meeting**	
6.1	4 March 2020; 1300hrs – Executive Meeting Room	**Note**

ALDER HEY CHILDREN'S HEALTH PARK

MEETING OF THE LIAISON COMMITTEE

AGENDA – 4 March 2020; 1300HRS

1. Quorum
2. Previous Meeting Minutes
   - 2.1 Accuracy & Approval
   - 2.2 Actions
3. Key Issues / Hot Topics
4. Any Other Business
5. Next Meeting

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report February 2020

How Did We Do?

Executive Summary **Month: February** **Year: 2020**

Alder Hey Children's NHS NHS Foundation Trust

Delivery of Outstanding Care

Safe

- One moderate harm incident reported in February (reference 40425) on the Paediatric Critical Care Unit (PICU), currently being investigated.
- One 'Never Event' reported in February 2020 within the Surgical Division, specifically the Theatre department.
- All moderate harm incidents and 'Never Events' are reviewed discussed at the weekly patient safety meeting. The findings, lessons learned and actions for improvement are shared via Division governance processes and uploaded on the Trust intranet for Trust wide sharing and learning.

Highlight

- Continued uptrend of numbers of patients treated for sepsis in AED.
- Best performance of the year for inpatients treated for sepsis within 60 mins.

Challenges

- There were 2 hospital acquired MSSA infections in February both were fully investigated with associated actions defined.

The Best People Doing their Best Work

Caring

- The number of complaints in February remains low at 10.
- % of people in inpatients who would recommend the Trust remains high at 95.7%.

Highlight

- OPD strongest performance of the year so far at 96.1% in relation to % of people who would recommend the Trust.

Challenges

- % who would recommend the Trust from mental health is well below the target figure at 80%.

Delivery of Outstanding Care

Effective

- ED waiting times are 86.8% and remain below the national target of 95% but is a strong performance in relation to the national picture.
- Winter pressures continue to impact on on the day cancellations of elective surgical cases and 28 day breaches.
- Average scanning turnaround times for inpatients remain high at 76 days but for outpatients has achieved the target for the second month in a row.

Highlight

- 0 patients readmitted to PICU within 48 hours.
- 0 patients spending greater than 12 hours from decision to admit to admission.
- Average scanning turnaround times for outpatients only 2 days.

Challenges

- On the day elective cancelled ops for non- clinical reasons up to 41 in month.
- 28 day breaches remain high at 4 for the month of February although down from 10 in January.

Delivery of Outstanding Care

Responsive

- Access to planned care remains very good. There are zero patients waiting over 52 weeks.
- Cancer waiting times and % of diagnostics completed within 6 weeks are 100%.
- Good patient feedback survey results, with the exception of patients involved in learning.

Highlight

- Cancer waiting times
- Access to planned care
- % CYP received information enabling choices about their care excellent at 97.8%

Challenges

- PFI PPM is down below the target figure at 95% for the first time this year
- CYP involved in learning is down to 78%. The Chief Nurse is working with the Head teacher to address this.

The Best People Doing their Best Work

Well Led

In Month 11 we achieved a (£0.3m) deficit which was (£0.5m) behind the plan. This leaves us (£0.6m) behind our year to date.

Activity levels were behind plan in all POD's with the exception of Outpatients which was 2% ahead of plan. A&E activity was 7% behind plan whilst Elective activity was 1% behind plan and Non Elective was 11% behind plan.

Pay was (£0.6m) overspent in the month particularly relating to underachieved CIP in this cost area. Temporary staffing expenditure remains high at £1m in the month.

The CIP target for the year of £6m has now been fully identified relating to improved use of our estates overhead and depreciation charges.

Cash holdings are £86.3m which is significantly higher than plan driven mainly by capital slippage.

A concerted effort has meant we continue to achieve mandatory training levels again. It is key that this is sustained.

Completion of PDR's are just ahead of the target of 90% and a concerted effort is required by all areas to maintain and improve this further. Additionally medical appraisals have improved and now exceed 90%.

Sickness levels remain high at 5.7%. There is work underway to support specific teams where sickness levels are high.

Highlight

- PDR's
- Mandatory training

Challenges

- Sickness levels
- Year-end control total

Game Changing Research and Innovation

Research and Development

- CQC Well Led Inspection – increased emphasis on clinical research.
- Annual Planning Round Preparation

Highlight

- Hosting Biomedical Research Centre strategy event

Challenges

- Impact of COVID-19 upon research activity

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Leading Metrics

SAFE

Clinical Incidents resulting in catastrophic, death	Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - MRSA (BSI)	Medication errors resulting in harm	Never Events	Sepsis: Patients treated for Sepsis - A&E
0	0	0	2	1	86.49 %
Feb 2020	Feb 2020	Feb 2020	Feb 2020	Feb 2020	Feb 2020

Sepsis: Patients treated for Sepsis within 60 mins - Inpatients
88.24 %
Feb 2020

CARING

Friends & Family: Overall Percentage Recommended Trust
94.26 %
Feb 2020

EFFECTIVE

ED: 95% Treated within 4 Hours
86.81 %
Feb 2020

RESPONSIVE

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

Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	RTT: Open Pathway: % Waiting within 18 Weeks	Waiting Greater than 52 weeks	Waiting List Size
100 %	92.04 %	0	12895
Feb 2020	Feb 2020	Feb 2020	Feb 2020

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	NHSI Use of Resources	Safer Staffing (Shift Fill Rate)	Sickness
76536	-497.61	95.10 %	3	92.85 %	5.70 %
Feb 2020	Feb 2020	Feb 2020	Feb 2020	Feb 2020	Feb 2020

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG			Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	99.3%	100.0%	100.0%	100.0%	99.5%	99.4%	99.8%	99.3%	100.0%	99.8%	99.2%	99.0%	99.6%		>=99 %	N/A	<99 %	✔
Clinical Incidents resulting in Near Miss	D	84	76	59	83	58	114	52	63	63	70	44	75	71		>=92	>=88	<88	✔
Clinical Incidents resulting in No Harm	D	249	280	301	296	296	323	287	277	330	296	219	336	333		>=254	>=242	<242	✔
Clinical Incidents resulting in minor, non permanent harm	D	84	104	94	108	77	62	70	72	91	89	94	91	85		<=86	N/A	>86	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	1	0	0	0	1	4	1	1	0	1	2	4	1		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	1	0	0	1	1	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	D	2	0	0	0	1	0	0	1	0	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	D	4	2	6	3	3	1	1	2	6	3	3	0	2		<=4	N/A	>4	✔
Pressure Ulcers (Category 3)	W	0	0	0	0	1	0	1	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	2	0	0	1	0	1		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis - A&E	D P	71.1%	79.4%	58.8%	71.1%	65.2%	79.3%	76.7%	77.8%	78.4%	84.2%	76.7%	83.9%	86.5%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	82.1%	73.3%	81.8%	71.4%	90.9%	80.0%	100.0%	94.1%	100.0%	93.8%	87.5%	87.5%	88.2%		>=90 %	N/A	<90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	1	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	0	1	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	D	0	4	1	1	0	0	1	1	0	1	0	0	2		<=1	N/A	>1	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	90.1%	93.2%	91.1%	90.8%	89.7%	90.6%	92.4%	93.5%	92.9%	91.6%	92.2%	94.3%	94.3%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	80.3%	89.5%	78.8%	87.7%	80.4%	82.8%	88.1%	91.1%	83.6%	80.9%	80.8%	88.0%	87.6%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	100.0%	98.6%	88.4%	100.0%	93.8%	92.9%	92.9%	91.9%	95.0%	94.1%	91.9%	92.0%	91.8%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	96.2%	97.8%	97.3%	90.6%	90.1%	93.2%	92.5%	95.5%	96.5%	95.9%	95.9%	97.1%	95.7%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	76.9%	82.9%	80.8%	88.7%	100.0%	33.3%	78.8%	88.5%	66.7%	89.1%	73.1%	90.7%	80.0%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	89.1%	91.1%	92.7%	91.7%	93.5%	91.2%	94.4%	93.8%	95.3%	94.5%	95.7%	95.6%	96.1%		>=95 % >=90 % <90 %	✔
Complaints	W	9	16	7	9	6	15	13	12	4	15	8	9	10		No Threshold	
PALS	W	97	95	110	103	121	128	93	130	120	105	67	122	113		<=88 <=98 >98	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	1.8%	2.5%	2.7%	2.1%	1.3%	5.3%	4.1%	0.0%	1.2%	0.0%	0.0%	1.6%	0.0%		<=3 %	N/A	>3 %	✔
ED: 95% Treated within 4 Hours	D	90.6%	95.6%	93.5%	91.3%	89.3%	91.7%	94.6%	88.9%	86.8%	79.2%	85.9%	87.3%	86.8%		>=95 %	N/A	<95 %	✔
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	1	0	1	0	0	0	0	0	0	0		0	N/A	>0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	10	12	9	24	15	37	35	18	34	44	36	20	41		<=20	N/A	>20	✔
28 Day Breaches	W	1	1	0	0	1	2	0	1	0	2	7	10	4		0	N/A	>0	✔
Average Scanning Turnaround - Inpatient	D	44.00	49.00	49.00	50.00	55.00	55.00	65.00	71.25	73.00	74.00	64.00	70.00	76.00		<=7	N/A	>7	✔
Average Scanning Turnaround - Outpatient	D	26.00	23.00	24.00	21.00	23.00	23.00	31.50	32.25	9.00	10.00	24.00	1.00	2.00		<=5	N/A	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	94.9%	95.7%	98.3%	96.6%	97.5%	97.6%	95.7%	97.7%	95.7%	96.7%	96.5%	97.3%	97.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	99.3%	99.5%	99.3%	99.0%	98.1%	99.2%	97.5%	98.4%	97.7%	97.6%	98.5%	98.7%	97.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	82.8%	80.6%	88.8%	84.1%	87.9%	87.8%	87.1%	89.2%	92.2%	92.6%	90.2%	90.5%	89.6%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	94.3%	93.4%	99.3%	90.5%	96.3%	90.8%	98.0%	98.4%	93.7%	98.3%	96.8%	98.0%	97.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D					93.3%	94.5%	95.3%	91.5%	92.1%	93.9%	91.2%	95.6%	92.5%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D					70.9%	75.6%	72.1%	68.3%	73.5%	68.3%	85.4%	85.4%	78.0%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.0%	92.0%	92.0%	92.0%	92.1%	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	12,888	12,746	12,871	12,876	12,843	12,883	12,874	12,826	12,754	12,827	12,879	12,885	12,895		<=12899 N/A >12899	✔
Waiting Greater than 52 weeks	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	96.4%	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	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	99.6%	99.5%	100.0%	99.8%	100.0%	99.8%	100.0%	99.7%	100.0%	100.0%	99.7%	100.0%	100.0%		>=99 % N/A <99 %	✔
PFI: PPM%		100.0%	98.0%	98.0%	98.0%	98.0%	100.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	95.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG	Comments Available
CIP In Month Variance (£'000s)	W	-74	-75	-163	-54	-47	-26	176	-165	-22	57	-147	-297	-228		>=-5% >=-20% <-20%	✔
Control Total In Month Variance (£'000s)	W	-433		-394	-165	596	-848	852	94	-240	-205	358	-207	-498		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	259	1,610	1,030	640	728	694	1,239	865	1,909	-115	624	3,126	3,820		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	W	22,068	33,699	34,361	34,449	37,415	79,086	80,174	80,807	81,847	77,896	75,657	76,536	76,536		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	W	355	19,495	-612	21	846	-52	1,348	666	1,103	1,387	1,479	1,404	18		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	W	-850	-495	183	-25	-130	-260	273	143	-254	-39	-89	394	-627		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	W	63	-942	34	-161	-119	-537	-769	-715	-1,090	-1,552	-1,031	-2,004	111		>=-5% >=-20% <-20%	✔
NHSI Use of Resources	W	1	1	1	3	3	3	3	3	3	3	3	3	3		<=3 N/A >3	✔
AvP: IP - Non-Elective	W			53	58	109	158	132	54	-19	-97	-109	-229	-123		>=0 N/A <0	✔
AvP: IP Elective vs Plan	W			-45	-23	-41	-79	18	-66	-67	29	-43	-52	-27		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	W			-53	-133	-240	-45	79	58	-76	-32	-20	-6	34		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	W			935	344	1,622	2,416	3,008	2,665	3,507	2,461	1,733	3,373	2,625		>=0 N/A <0	✔
PDR	W	92.2%	92.2%	4.8%	20.7%	47.3%	86.4%	89.3%	89.3%	89.3%	89.3%	89.3%	90.1%	90.1%		>=90 % >=85 % <85 %	✔
Medical Appraisal	W	100.0%	100.0%	99.7%	98.1%	97.8%	95.7%	96.6%	93.8%	88.5%	69.7%	63.8%	82.7%	90.6%		>=95 % >=90 % <90 %	✔
Mandatory Training	W	88.8%	89.6%	90.0%	88.4%	90.5%	90.8%	91.9%	91.1%	91.3%	91.5%	92.1%	94.3%	95.1%		>=90 % >=80 % <80 %	✔
Sickness	D	5.7%	5.3%	5.2%	5.5%	5.2%	5.2%	5.0%	5.2%	5.7%	5.6%	6.5%	5.8%	5.7%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	D	1.7%	1.6%	1.5%	1.5%	1.4%	1.3%	1.0%	1.4%	1.8%	1.9%	2.0%	1.7%	1.6%		<=1 % N/A >1 %	✔
Long Term Sickness	D	3.9%	3.7%	3.7%	4.0%	3.9%	3.9%	4.0%	3.8%	3.9%	3.7%	4.5%	4.1%	4.1%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	D	958	1,269	1,039	994	820	972	896	1,051	840	928	833	775	974		<=800 <=960 >960	✔
Staff Turnover	D	9.5%	10.0%	9.8%	9.9%	9.8%	9.4%	10.0%	10.4%	10.2%	10.2%	10.5%	10.8%	10.8%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	W	92.8%	95.4%	95.3%	95.2%	92.6%	92.0%	93.5%	90.8%	92.2%	96.2%	91.6%	90.6%	92.8%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	W	95.0%	86.0%	81.5%	100.0%	81.2%	97.2%	92.5%	90.5%	100.0%	82.0%	100.0%	100.0%	97.7%		>=85 % N/A <85 %	✔
Performance Against Single Oversight Framework Themes	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	121	153	154	158	161	158	172	161	162	167	172	166	165		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	26	60	59	59	58	57	59	38	42	45	46	46	46		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	5	3	1	5	4	2	3	2	2	5	6	3	1		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	1	4	2	1	2	2	2	1	2	6	3	0	1		>=1	N/A	<1	✔
Number of patients recruited	W	211	314	234	221	350	431	165	941	1,228	1,180	1,094	982	917		>=200	>=171	<171	✔

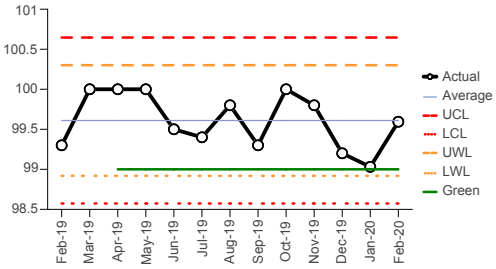
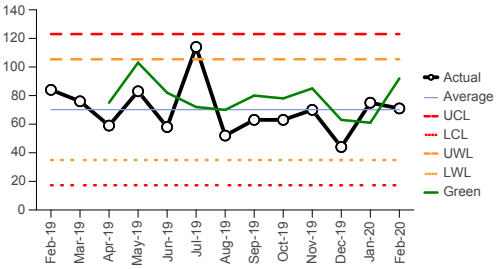
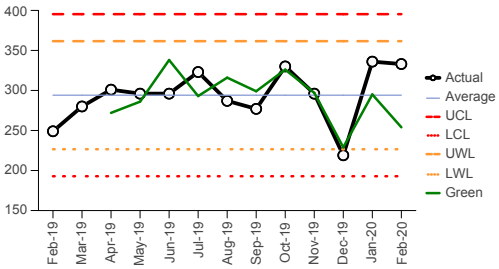
Delivery of Outstanding Care

7.1 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	99.59 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19. 19/20 aim is to see more than 5% reported than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	71	R <88 A >=88 G >=92		The divisions receive weekly reports of all 'near miss' incidents, incidents reported to enable prioritisation of reviews and ensure lessons are learned actions for improvement are implemented in a timely manner and feedback to staff (to minimise risk) and reporters Also to enable monitoring of trends and themes and actions for improvement to be implemented accordingly. Progress with improvements expected to be included in monthly CQSG division governance reports.
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19. 19/20 aim is to see more than 5% reported than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	333	R <242 A >=242 G >=254		No Action Required

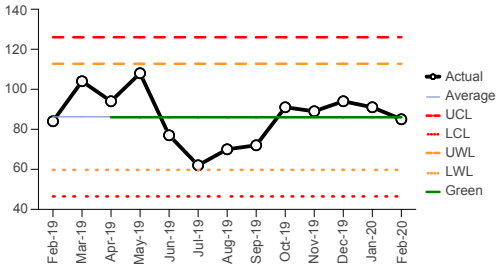
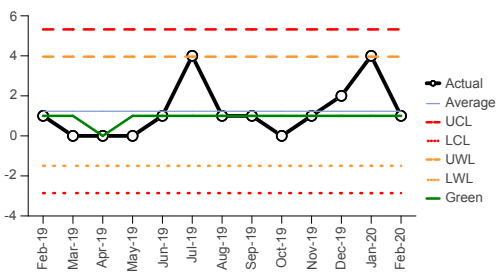
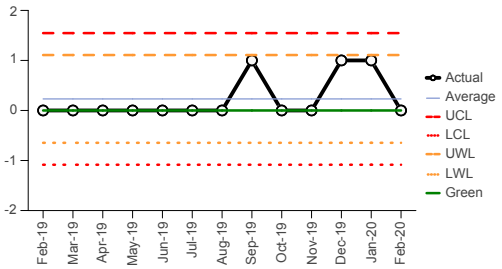
Delivery of Outstanding Care

7.2 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. The threshold is based on a reduction for the period Apr 18 - Mar 19. 19/20 aim is to see volume reported less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	85	R >86 A N/A G <=86		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 18 - Mar 19. 19/20 aim for the trust is 11 or less, annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

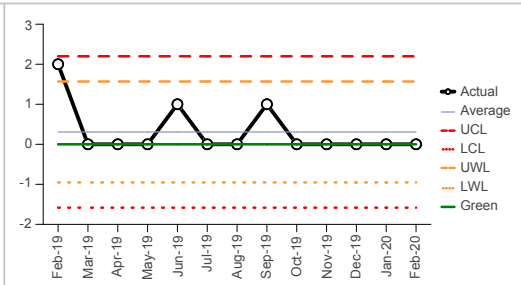
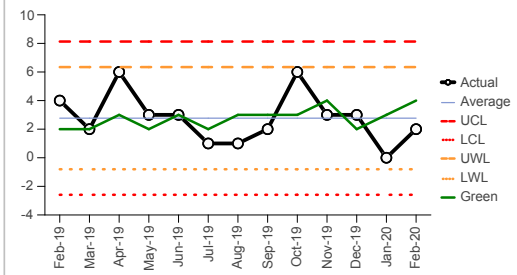
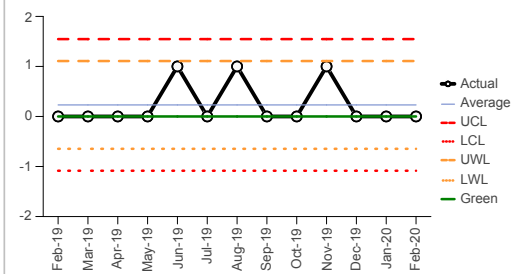
Delivery of Outstanding Care

7.3 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 18 - Mar 19, on trajectory with WHO global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% by 2022. 19/20 aim is less than 34 annually for the trust. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	2	R >4 A N/A G <=4		The moderate harm incident is subject to RCA level 1. A 72 hr review has been done. NEWTS have been contacted for their involvement in the incident.
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

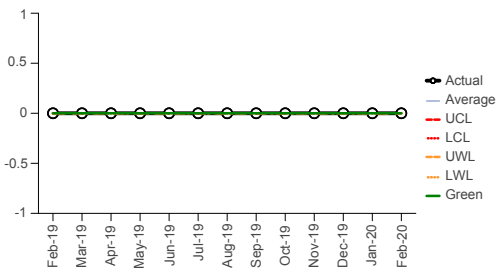
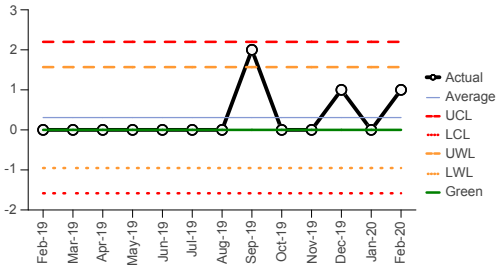
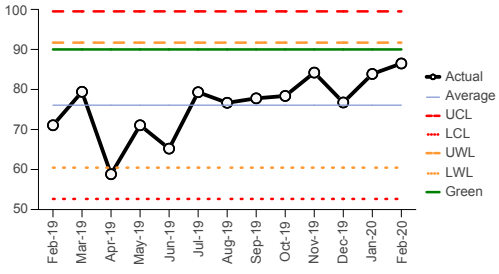
Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	1	R >0 A N/A G 0		The Trust has developed a Trust wide action plan to address the issues pertaining to Never Events, to ensure lessons are learned actions for improvements are implemented. Included in the plan is assessment of trends and themes, completing audits in line with the Trust plan, working with partner Trusts to develop new working processes, through training in Human factors, Simulation and Coaching. Progress with the plan is monitored via the divisions governance processes, Clinical Quality Steering group and Clinical Quality Assurance Committee (Board sub-committee.
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	86.49 %	R <90 % A N/A G >=90 %		Continued postitive trend in patients treated fr sepsis admin of IVAB. Strong leadership in the ED depertment about the importnace of this. Ongoing reviews of cases and lessons learnt. For future months to monitor the sepsis status against current data collection method. This will be reviewd the Sepsis Steering Group

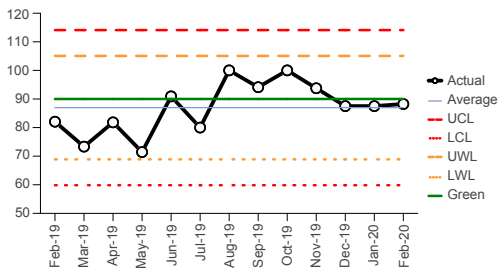
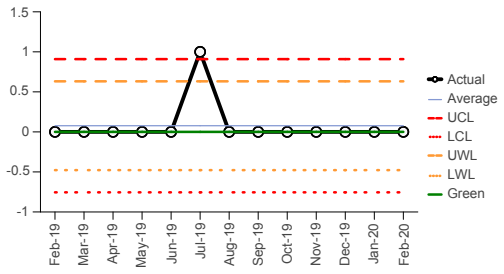
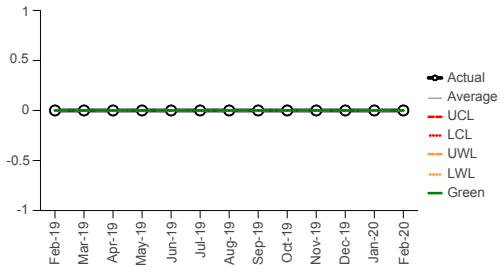
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	88.24 %	R <90 % A N/A G >=90 %		Continued awareness about Sepsis management across the trust. Two delays no harm to patients both treated but unclear times recorded in documentation. Learning fed back to teams about this. Good compliance with sepsis bundle management not just administration of IVAB.
Mortality	**Number of children that have experienced avoidable factors causing death - Internal** W Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 19/20 is zero. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

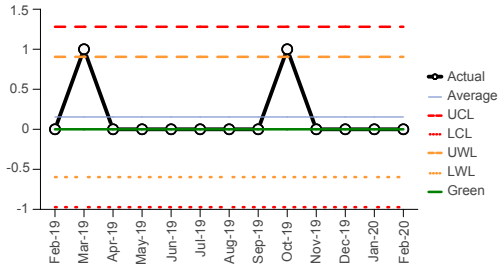
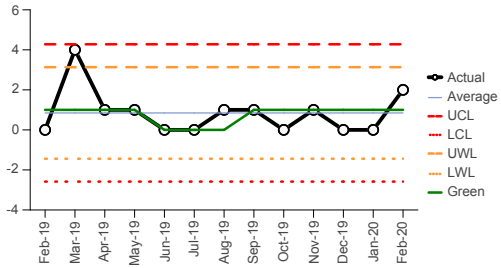
Delivery of Outstanding Care

7.6 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - C.difficile** D The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MSSA** D Hospital Acquired Organisms - MSSA . 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	2	R >1 A N/A G <=1		Remain within target for 2019-20. All MSSA bactereamia cases continue to be monitored on a weekly basis and any hsopital aquired cases are reviewed via a nursing/medical RCA and discussed at a review panel.

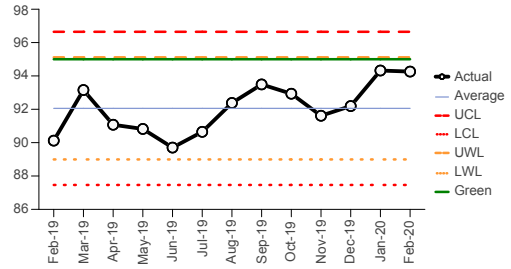
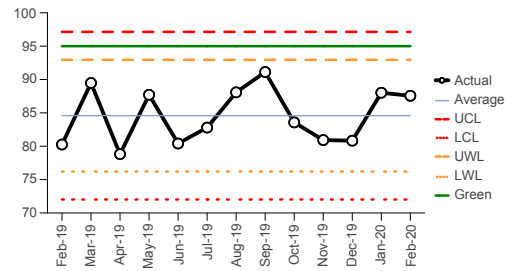
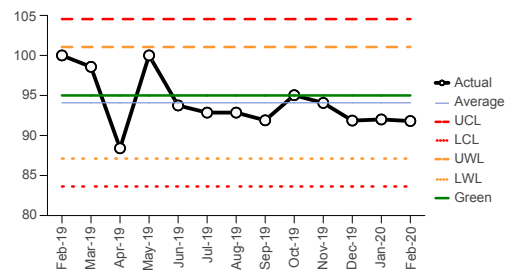
The Best People doing their best Work

8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family: Overall Percentage Recommended Trust** W Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	94.26 %	R <90 % A >=90 % G >=95 %		Recommend remain stable at the highest % in a year. Only very minimal fluctuation within the divisions. Completion rate reduced by 0.04% with text messaging the primary source of responses
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	87.56 %	R <90 % A >=90 % G >=95 %		0.46% decrease in recommend with a 14% reduction in completion rate. Trends this month include toys within waiting area, attitude of triage and communication of waiting times. Positive feedback in response to volunteers offering refreshments in waiting area and providing play/interaction
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	91.80 %	R <90 % A >=90 % G >=95 %		Only slight difference of 0.2% this month. Care and staff attitude remain positive. 2 services scored less than 95% recommend this month – ADHD Liverpool and Fresh CAMHS. Car park facilities and charges and lack of privacy at reception desk highlighted

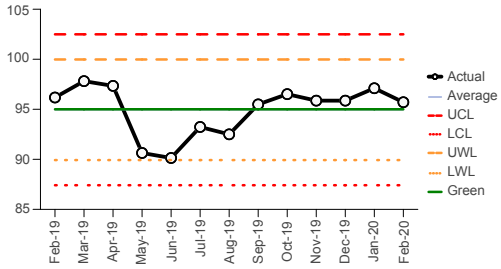
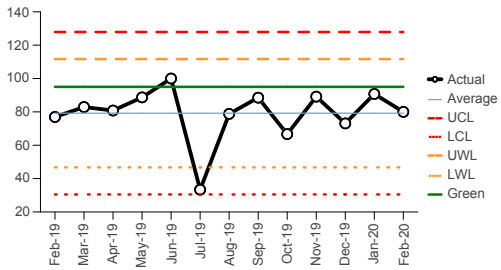
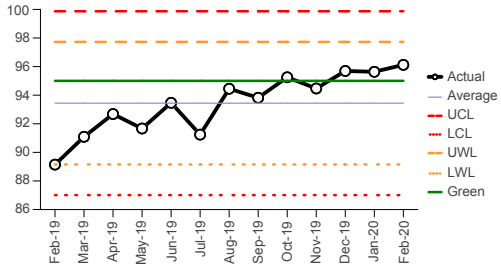
The Best People doing their best Work

8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	95.70 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	80 %	R <90 % A >=90 % G >=95 %		Recommend reduced by 10.74% whilst completion rates have fallen by 63%. Only 1 response would not recommend the Trust – 1 did not know and 7 neither unlikely or likely.
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	96.12 %	R <90 % A >=90 % G >=95 %		No Action Required

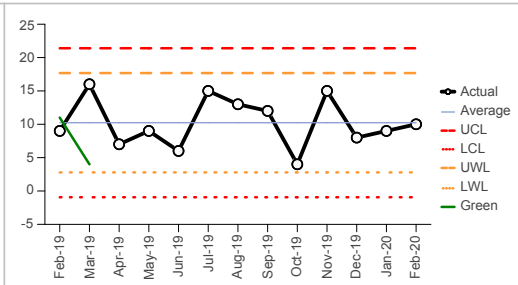
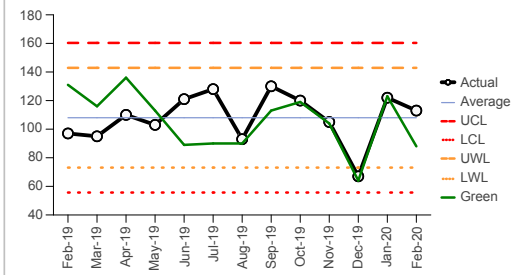
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	10	No Threshold		
PALS	**PALS** W Total number of PALS contacts. Threshold is based on a 10% Reduction on 18/19. 19/20 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	113	R >98 A <=98 G <=88		Community division complaints centre on 3 main trends: difficulties arranging/collecting prescriptions, Phlebotomy clinic change of system and being turned away, also waiting time for appointment. Within Surgery cancelled appointments/surgery account for over a third of complaints – with the issue of receiving confirmation but not cancellation sms raised. Waiting time for appointment is the predominant complaint for Medicine, with delayed treatment and communication failure secondly.

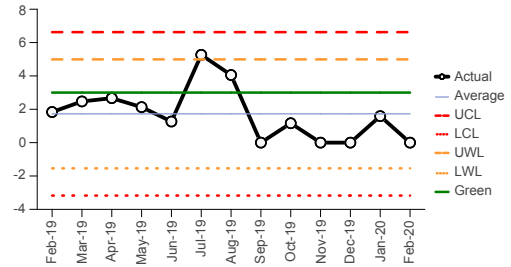
Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

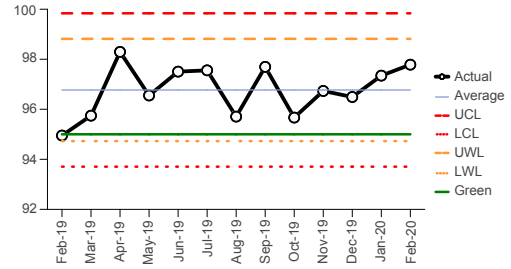
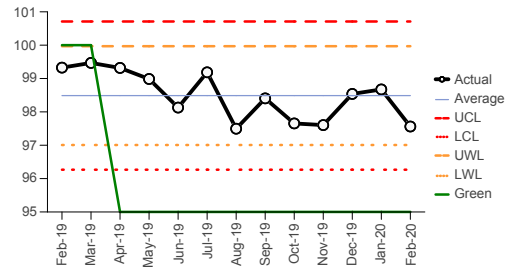
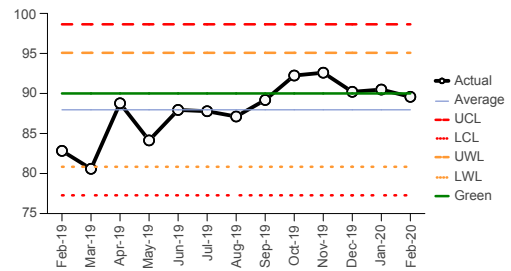
Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	97.78 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 19/20 is 100%. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	97.56 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	89.58 %	R <85 % A >=85 % G >=90 %		0.9% decrease this month. On analysis PICU/HDU figures of 66.6 and 62.5 respectively impact on overall figures. Question to be amended to include discharge or move to another ward for these areas.

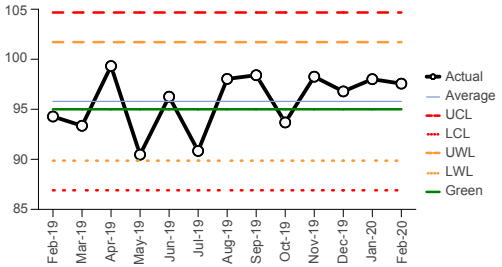
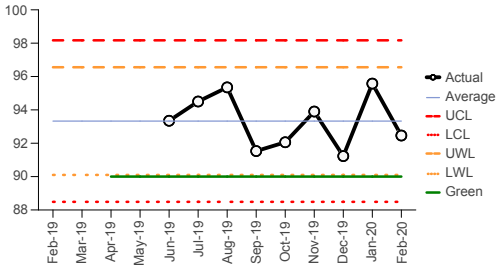
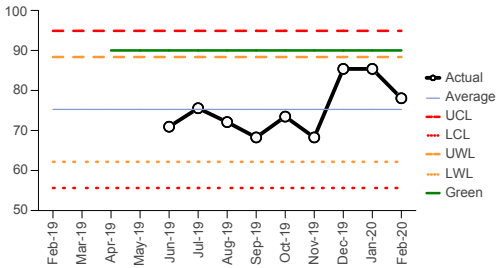
Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	97.56 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	92.46 %	R <85 % A >=85 % G >=90 %		No Action Required
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	78.05 %	R <85 % A >=85 % G >=90 %		Figures this month include half term holiday and therefore reduced figures where expected.

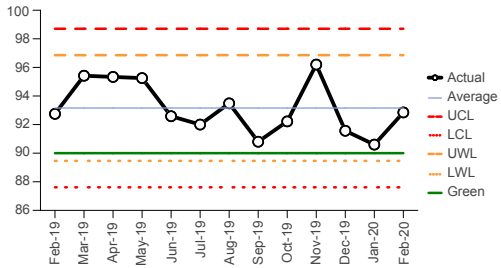
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	92.85 %	R <90 % A N/A G >=90 %		No Action Required

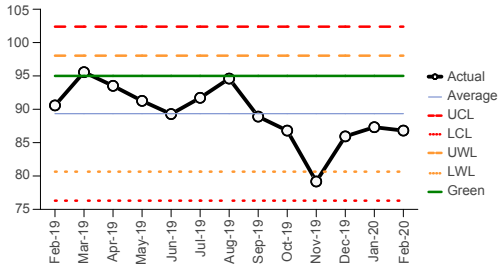
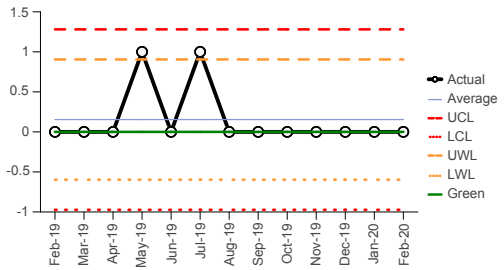
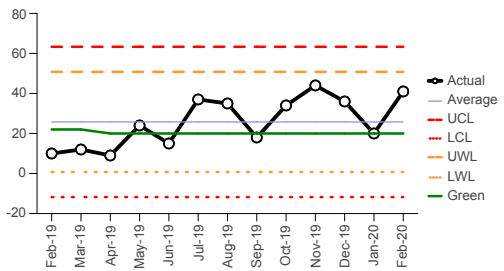
Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	86.81 %	R <95 % A N/A G >=95 %		ED performance deteriorated from the previous month by 0.6%. Emergency care demand and admissions remain high reflecting both the increase in demand and acuity of patients. Along with the sustained pressure on inflow, staffing in the department remains challenged on a daily basis. The Trust continues to respond through recognising this as a moderate business continuity incident; deploying additional resources where possible and supporting ED through the development of a Acute Care Strategy that looks closely at future workflows and staffing models.
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 16% based on 18/19 overall performance. This is inline with trajectory from Oct 18 - Mar 19 **Exec Lead:** Adam Bateman **Committee:** RABD	41	R >20 A N/A G <=20		The number of on-the-day cancelations for surgery grew significantly in Feb. The primary reasons related to limited critical care and ward bed availability. Critical care experienced an extremely busy two week period escalating to RED continually for a number of days resulting in reduced capacity for elective procedures to take place. In addition ward staffing has been a challenge for the surgical wards, a number of high acuity patients have been admitted requiring increased levels of nursing care. The division have undertaken an exercise to plan elective programmes more efficiently.

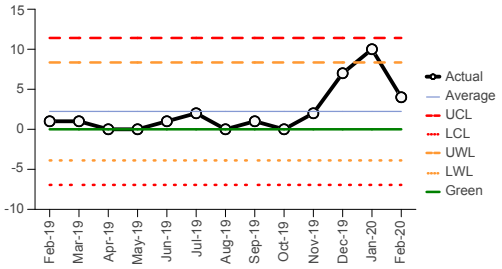
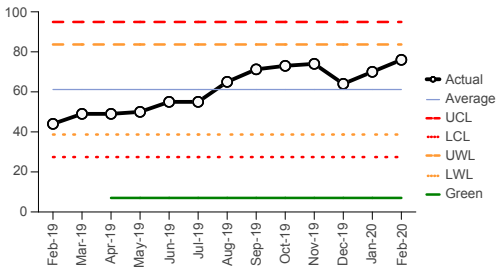
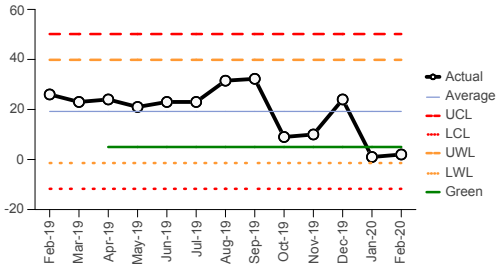
Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

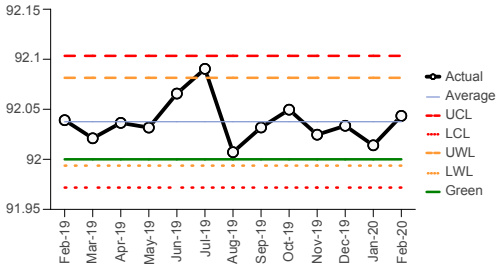
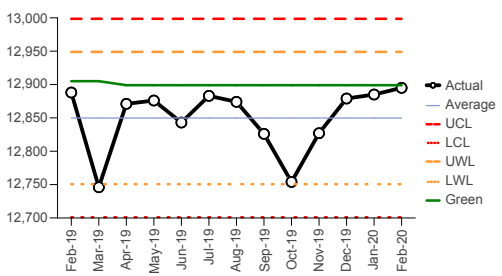
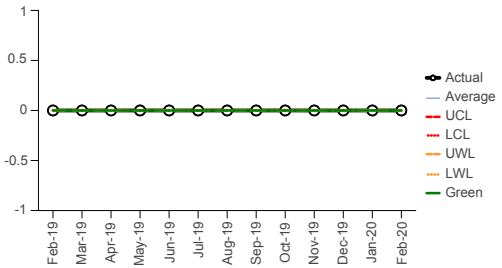
	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	4	R >0 A N/A G 0		Patient not rescheduled within 28 days following an on-the- day cancelation of their procedure reduced by 6. Only 4 patients were not rescheduled within this timeframe demonstrating and improved position within the division with further work underway to ensure this continues for March.
Scanning	**Average Scanning Turnaround - Inpatient** D Days from being clinically coded following inpatient discharge to episode notes being scanned and uploaded on to the viewing system (Image Now). Average based on working days. **Exec Lead:** Adam Bateman **Committee:** RABD	76	R >7 A N/A G <=7		As of Monday 9th we reported on the SLA being at 51 days, the outsourced scanning bureau is now scanning in patients and therefore the SLA is reducing, anticipated to be in to a steady state during March.
Scanning	**Average Scanning Turnaround - Outpatient** D Days from Clinic attendance to episode notes being scanned and uploaded on to the viewing system (Image Now). Average based on working days. **Exec Lead:** Adam Bateman **Committee:** RABD	2	R >5 A N/A G <=5		No Action Required

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

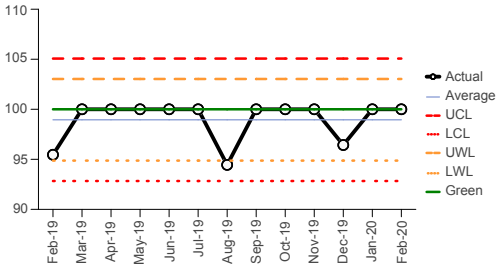
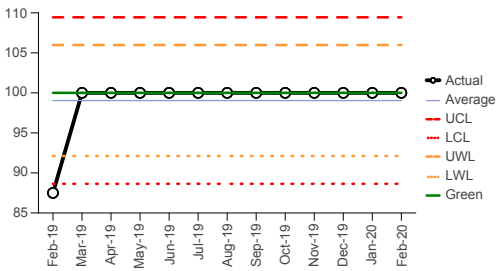
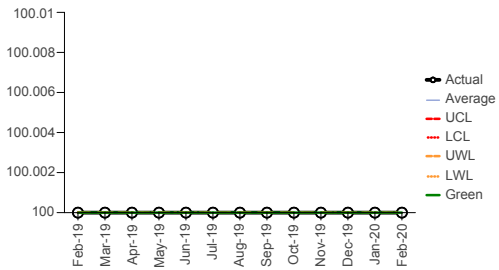
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.04 %	R <90 % A >=90 % G >=92 %		No Action Required
Waiting Times	**Waiting List Size** W National threshold as part of the 18/19 NHSI plan. The target is to maintain reduction of the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12895	R >12899 A N/A G <=12899		No Action Required
Waiting Times	**Waiting Greater than 52 weeks** W Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 19/20 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

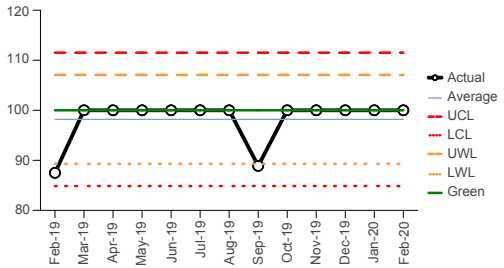
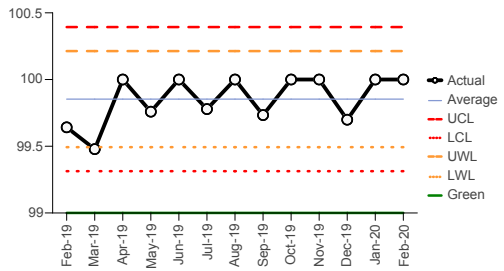
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

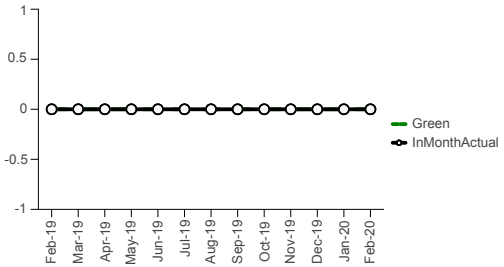
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <99 % A N/A G >=99 %		No Action Required

The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

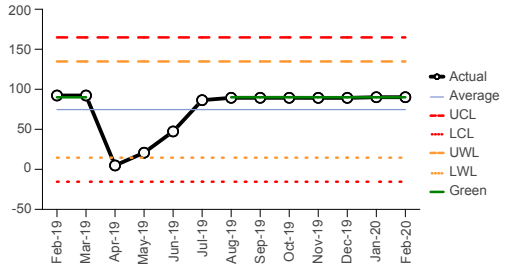
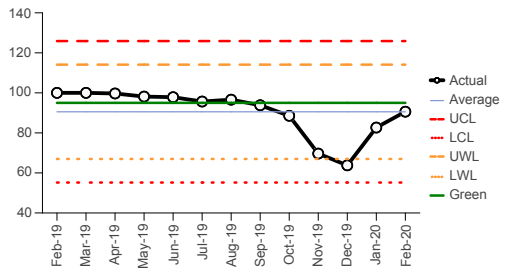
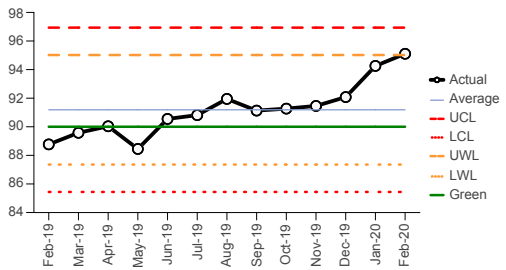
The Best People doing their best Work

15.1 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	90.07 %	R <85 % A >=85 % G >=90 %		No Action Required
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	90.59 %	R <90 % A >=90 % G >=95 %		All appraisals are on target to be completed by the end of March 20
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	95.10 %	R <80 % A >=80 % G >=90 %		No Action Required

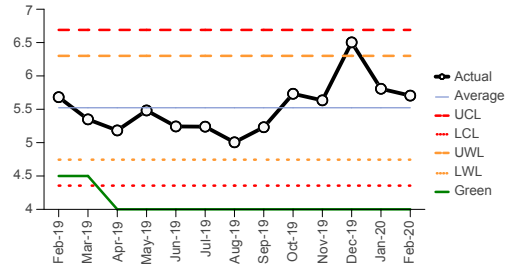
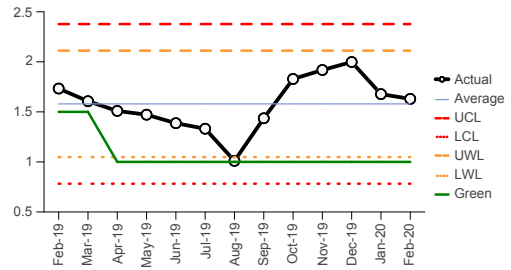
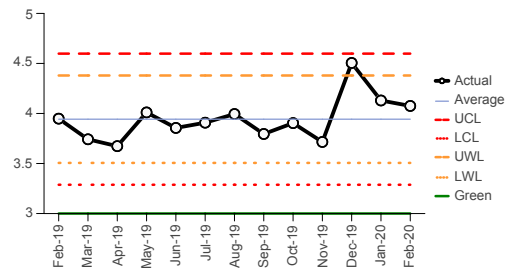
The Best People doing their best Work

15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.70 %	R >4.5 % A <=4.5 % G <=4 %		Since December, sickness absence figures have decreased each month, as we move through the winter period, as expected. The month of February shows sickness absence at 5.64%, which is a 1% decrease since December and a 0.20% decrease since January. The composition of sickness absence is still mostly due to long term occurrences. The Trust has recently conducted a thorough review of the Sickness Absence Management Policy, to ensure the guidelines are supportive, informative and provide robust governance.
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.63 %	R >1 % A N/A G <=1 %		As above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	4.08 %	R >3 % A N/A G <=3 %		As above

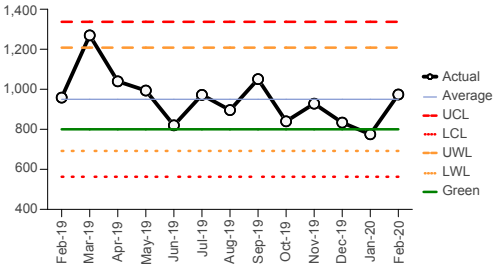
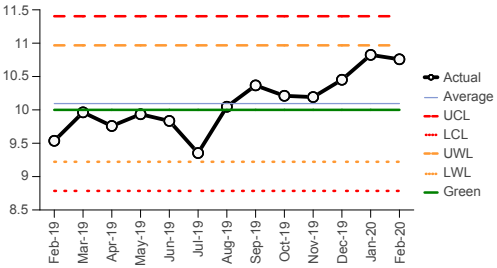
The Best People doing their best Work

15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	973.80	R >960 A <=960 G <=800		Business Partners together with Finance Accountants and Associate COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & Deputy Directors of HR & Finance.
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	10.76 %	R >11 % A <=11 % G <=10 %		Turnover remains slightly above the Trust target of 10%, there have been 21 leavers in the month of February with voluntary resignation being the most common reason for leaving.

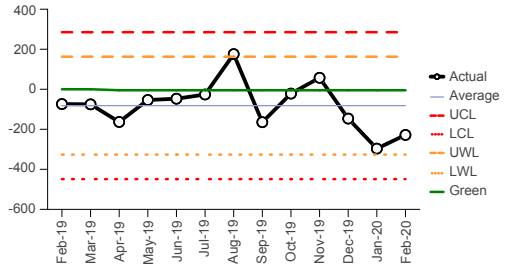
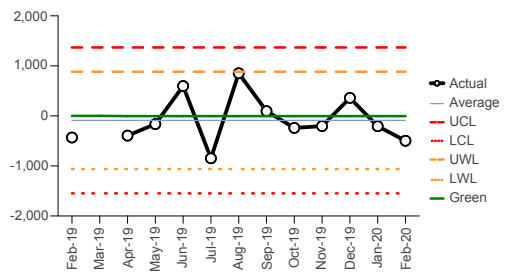
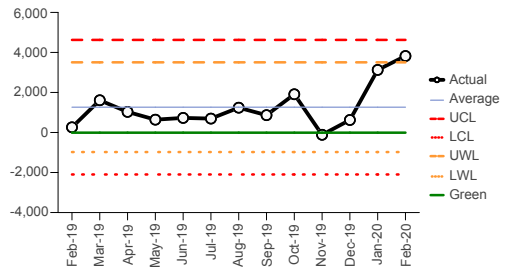
The Best People doing their best Work

16.1 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**CIP In Month Variance (£'000s)** W Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month. **Exec Lead:** John Grinnell **Committee:** RABD	-228	R <-20% A >=-20% G >=-5%		The CIP for the month of February is £0.2m behind plan. The CIP target for the year is £6m and the Trust is forecasting full achievement of the CIP for 19/20.
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-498	R <-20% A >=-20% G >=-5%		The Trust achieved a £0.3m deficit in February which was £0.5m behind the plan. This related to overspends in the Medicine and Surgical divisions.
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	3,820	R <-10% A >=-10% G >=-5%		No Action Required

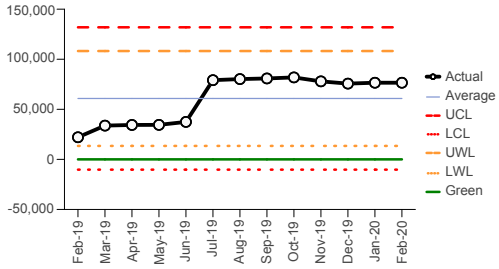
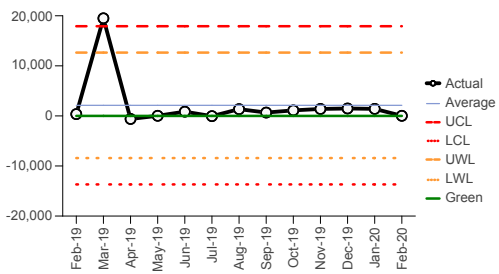
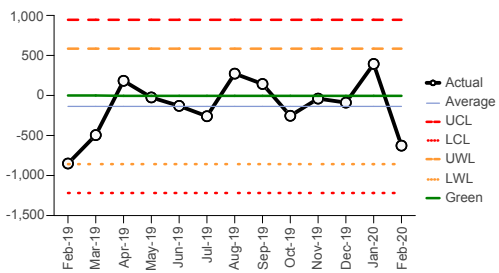
The Best People doing their best Work

16.2 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Cash in Bank (£'000s)** W Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	76,536	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	18	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Pay In Month Variance (£'000s)** W Variance from pay plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-627	R <-20% A >=-20% G >=-5%		No Action Required

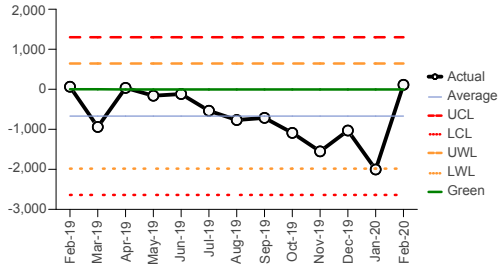
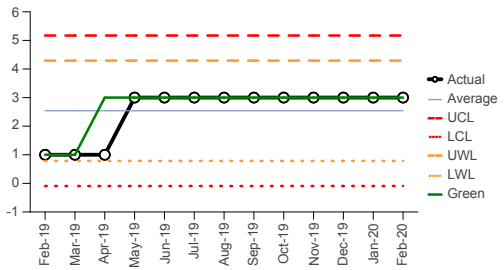
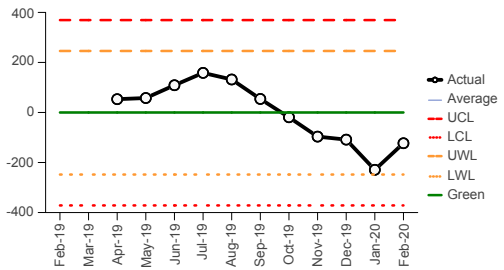
The Best People doing their best Work

16.3 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	111	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**NHSI Use of Resources** W NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	3	R >3 A N/A G <=3		No Action Required
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-123.01	R <0 A N/A G >=0		The most significant adverse variances are in resp medicine (down 67 spells) and A&E (down 40 spells).

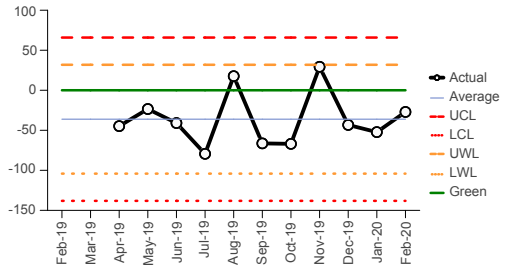
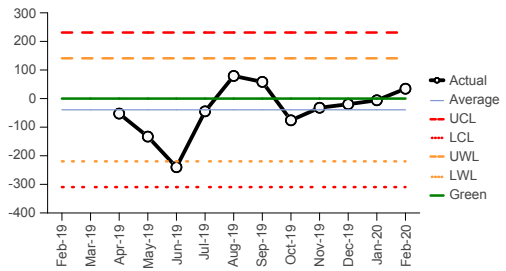
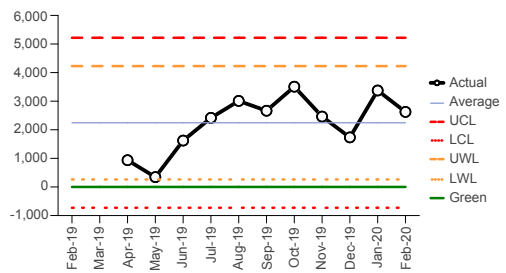
The Best People doing their best Work

16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-27.10	R <0 A N/A G >=0		Most significanct adverse variance is in sleep studies, down by 25 spells
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	34.46	R <0 A N/A G >=0		No Action Required
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	2624.83	R <0 A N/A G >=0		No Action Required

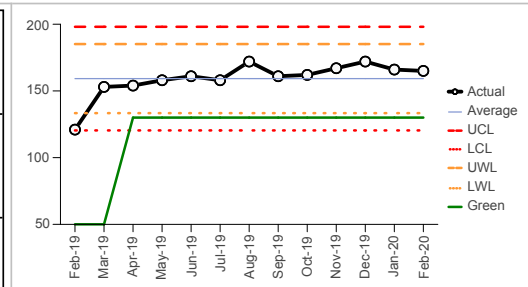
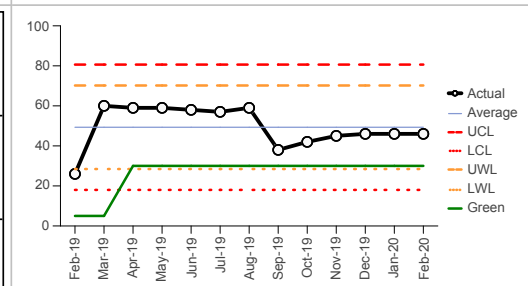
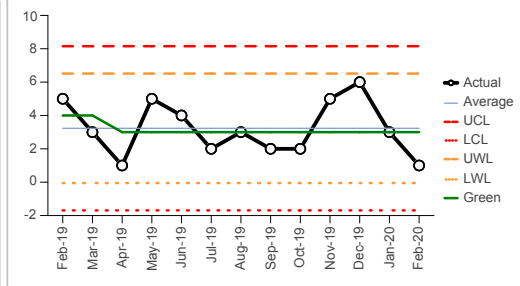
Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	165	R <111 A >=111 G >=130		No Action Required
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	46	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	1	R <2 A >=2 G >=3		The Division is on profile to deliver the target of 36 academic studies within 19/20. To date, 34 academic studies have been opened within the financial year.

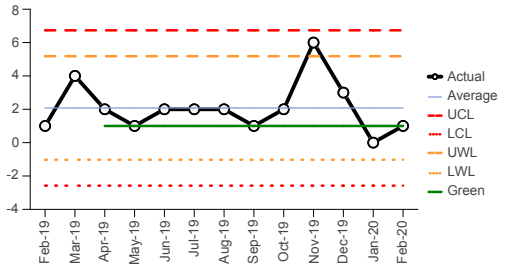
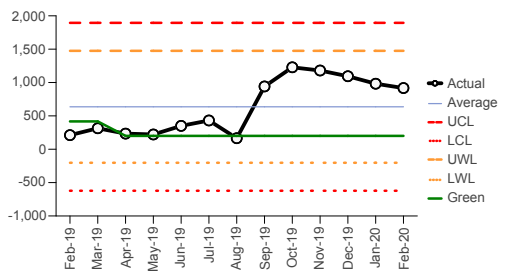
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	1	R <1 A N/A G >=1		The Division has exceeded its target of delivering 12 commercial studies within 19/20. To date, 21 commercial studies have been opened within the financial year.
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Matthew Peak **Committee:** REIC	917	R <171 A >=171 G >=200		No Action Required

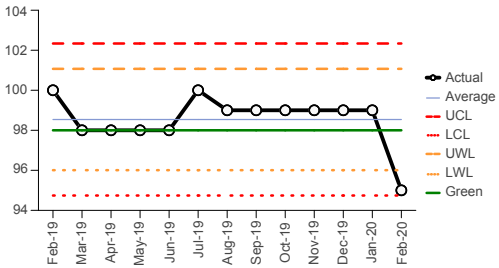
Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	95 %	R <98 % A N/A G >=98 %		The outstanding 5% of PPM's were completed within the first 3 days of March 2020.

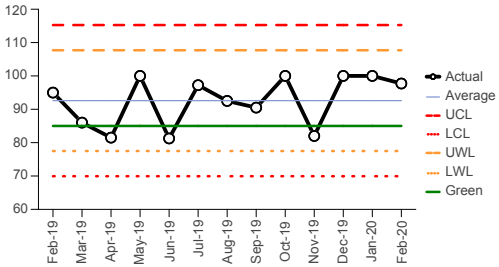
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, aim is to ensure National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	97.72 %	R <85 % A N/A G >=85 %		A number of the areas floors were found to be below standard and we are reviewing how we clean them and the products used.

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	5	27	30	No Threshold
Clinical Incidents resulting in No Harm	D	57	94	164	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	9	19	45	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0 / N/A / >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0 / N/A / >0
Medication errors resulting in harm	D	0	1	0	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		100.0%	80.0%	>=90 % / N/A / <90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0 / N/A / >0
Hospital Acquired Organisms - MSSA	D	0	0	2	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	3	5	2	No Threshold
PALS	W	35	44	31	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			0.0%	<=3 % / N/A / >3 %
ED: 95% Treated within 4 Hours	D		86.8%		>=95 % / N/A / <95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0 / N/A / >0

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	4	37	No Threshold		
28 Day Breaches	W	0	0	4	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		97.1%	98.2%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		97.6%	97.5%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		83.5%	93.2%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		97.1%	97.9%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		92.9%	92.2%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		78.2%	77.9%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	75.1%	92.2%	94.4%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,161	3,495	8,238	No Threshold		
Waiting Greater than 52 weeks	W	0	0	0	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		100.0%	100.0%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		100.0%		100 %	N/A	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	-65	-350	-186	No Threshold
Income In Month Variance (£'000s)	W	91	80	392	No Threshold
Pay In Month Variance (£'000s)	W	-87	-62	-405	No Threshold
Non Pay In Month Variance (£'000s)	W	-70	-368	-172	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W		-110	-13	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	-38	11	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		10	24	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	616	324	1,040	>=0	N/A	<0
PDR	W	91.3%	87.1%	94.3%	>=90 %	>=80 %	<85 %
Medical Appraisal	W	91.2%	91.5%	89.7%	>=95 %	>=90 %	<90 %
Mandatory Training	W	95.9%	94.6%	92.9%	>=90 %	>=80 %	<80 %
Sickness	D	4.4%	6.3%	5.9%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.1%	1.9%	1.9%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.3%	4.4%	4.0%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	148	267	397	No Threshold		
Staff Turnover	D	12.3%	9.7%	11.2%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	94.1%	94.6%	91.9%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Zero Never Events; Cat 3 and 4 Pressure Ulcers; Hospital-acquired Infections For MRSA and C Difficile.	**Highlight** ▪ 100%: Inpatients treated for Sepsis within 60 mins. ▪ Improved cleanliness score to 98.3%. ▪ No clinical incidents resulting in permanent or severe harm ▪ Zero never events, hospital-acquired infections (MRSA, C. difficile) for over 12 months. **Challenges** ▪ Pharmacy outpatient dispensing times remain challenged at 53% compliance with the 30 minute standard but has improved from 47% in January
CARING	5 complaints and 44 PALS responses.	**Highlight** ▪ Overall complaint numbers remain low **Challenges** ▪ Complaints have increased from < 2 complaints per month for the last five months. Plan to engage with the new quality team to improve response times and follow up actions.
EFFECTIVE	ED Performance is at 86.8%, deteriorating slightly against January (87.3%). Delivery of the Emergency Care standard continues to be the Division's top operational pressure and priority. An ED action plan continues to make progress, balancing immediate actions such as additional triage capacity (through staff bank) and maximising primary care capacity, with a longer term proposal to strengthen ED workforce and redesign patient flows.	**Highlight** ▪ Was Not Brought rate remains below 12% at 10.9% for February (9.2% in Jan) ▪ Coding comorbidity average remains is 5.05, above 4.4 for 7th consecutive month. ▪ Theatre utilisation has improved by 5.1% to 85.8% utilisation. **Challenges** ▪ ED performance (see to the left). ▪ Clinic session utilisation deteriorates to 84.3%
RESPONSIVE	Pathology turnaround times consistently good with notable improvement in urgent requests. Concern over MRI, CT, Ultrasound and Nuclear Medicine. Action plan to address this involves recruitment of additional radiologists as well as Outsourcing presented at Divisional Board on 21/01/2020. Outsourcing has now commenced and the action plan is to be refreshed.	**Highlight** ▪ Inpatient reporting turnaround times have improved to 90% after four months and for just the 3rd time in 12 months ▪ RTT target consistently achieved for over 12 months though acknowledge that some areas still require focus. ▪ Overall waiting list size down by over 400 patients compared to the previous month and 12 month average ▪ Diagnostic target consistently achieved for over 12 months

		Challenges ▪ Slot availability has fallen below 90% ▪ Imaging waiting times, particularly MRI (see left) as well as CT, ultrasound and nuclear medicine
WELL LED	Shift fill rate above 90% at 94.6% in February for 14 consecutive months. Significant improvement in divisional risk management resulting in review of all overdue risks in month.	**Highlight** ▪ Delivery of the in month and forecast year end financial control total. ▪ Mandatory training is above 90% for 9th consecutive month and is at 94.6% in February ▪ Medical appraisals reach 91.5% **Challenges** ▪ Sickness levels remain high at 6.3% leading to a small creep in temporary staffing expenditure.

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	36	30	19	29	20	36	11	20	16	25	20	35	27		No Threshold
Clinical Incidents resulting in No Harm (D)	89	89	103	88	78	106	76	69	87	74	69	132	94		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	24	37	38	25	23	20	9	19	21	16	23	24	19		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	0	0	0	1	0	0	1	0	1	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	1	1	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	1	0	0	0	1	0	0	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	2	1	4	3	0	0	0	0	3	0	2	0	1		No Threshold
Medication Errors (Incidents)	31	34	51	40	24	37	32	21	30	20	22	47	30		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	1	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
Acute readmissions of patients with long term conditions within 28 days	3	2	2	3	3	4	4	1	8	5	3	5	1		No Threshold
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)		63.2%	100.0%	66.7%	85.7%	83.3%	100.0%	87.5%	100.0%	90.0%	100.0%	100.0%	100.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	1	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	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	6	1	0	0	2	1	1	2	1	3	1	1	1		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	1	0	0	0	0	1	0	0	0	0	0	0		No Threshold
Cleanliness Scores	97.1%	98.6%	97.2%	98.3%	91.8%	96.4%	98.5%	98.6%	97.9%	97.4%	98.3%	97.8%	97.6%		>=90 % >=80 % <80 %
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.			99.5%	99.5%	99.7%	100.0%	99.5%	99.6%	99.7%	99.7%	100.0%	99.9%			>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.			65.6%	55.0%	55.0%	58.9%	58.9%	58.9%	58.9%	58.5%	58.5%				>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes	63.0%	62.0%	63.0%	54.0%	63.0%	52.5%	52.5%	62.0%	59.0%	50.0%	62.0%	47.0%	53.0%		>=90 % >=80 % <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	67.0%	95.0%	60.0%	75.0%	100.0%	87.5%	87.5%	63.0%	100.0%	92.0%	89.0%	84.0%	88.0%		>=90 % >=80 % <90 %

CARING

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Complaints (W)	2	4	2	1	3	2	4	7	0	1	2	6	5		No Threshold
PALS (W)	37	23	40	34	38	40	33	40	42	38	21	43	44		No Threshold

EFFECTIVE

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Referrals Received (Total)	1,940	2,185	2,025	2,118	1,972	2,204	1,708	1,781	2,100	1,926	1,823	1,997	2,195		No Threshold
ED: 95% Treated within 4 Hours (D)	90.6%	95.6%	93.5%	91.3%	89.3%	91.7%	94.6%	88.9%	86.8%	79.2%	85.9%	87.3%	86.8%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	5.5%	3.4%	3.9%	5.2%	6.8%	4.9%	3.6%	6.1%	5.9%	9.3%	7.0%	4.0%	3.8%		<=5 % N/A >5 %
ED: All handovers between ambulance and A & E - Waiting more than 30 minutes (W)			1	0	1	1	1	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 N/A >0
ED: Re-attendance within 7 days of original attendance (%) (W)	8.1%	8.5%	8.5%	7.8%	8.3%	7.8%	7.8%	8.9%	8.6%	9.8%	8.7%	8.3%	8.0%		<=10 % <=12 % >10 %

Medicine

D Drive W Watch P Programme

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
ED: Number of patients spending >12 hours from decision to admit to admission W	0	0	0	1	0	1	0	0	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised W	83.4%	83.6%	81.8%	83.3%	82.9%	83.6%	86.2%	80.2%	83.9%	79.3%	78.9%	80.7%	85.8%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons D	2	0	1	1	1	2	5	2	3	4	1	2	4		No Threshold
28 Day Breaches W	1	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Clinic Session Utilisation D P	86.7%	87.2%	85.3%	85.2%	84.7%	85.5%	81.5%	85.3%	84.6%	85.8%	80.9%	87.2%	84.3%		>=90 % >=80 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	58	32	64	62	62	40	43	39	38	42	26	22	41		No Threshold
OP Appointments Cancelled by Hospital %	15.2%	13.5%	17.1%	17.9%	16.0%	14.6%	16.1%	13.0%	15.1%	13.9%	15.1%	12.9%	15.4%		<=5 % N/A >10 %
Was Not Brought Rate W P	11.9%	9.6%	10.8%	10.7%	9.9%	11.0%	12.1%	9.8%	9.5%	9.8%	11.6%	9.2%	10.9%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) W	13.8%	10.6%	13.6%	13.6%	10.1%	13.2%	14.7%	11.0%	12.7%	11.8%	14.2%	11.5%	14.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) W	11.2%	9.3%	9.9%	9.7%	9.9%	10.3%	11.2%	9.3%	8.5%	9.2%	10.8%	8.5%	9.9%		<=14 % <=16 % >16 %
Coding average comorbidities	4.01	3.93	4.39	4.37	4.40	4.49	4.66	4.43	4.69	4.70	4.80	4.74	5.04		No Threshold

RESPONSIVE

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Convenience and Choice: Slot Availability	87.5%	78.0%	63.1%	66.8%	64.5%	64.7%	72.9%	74.9%	84.7%	85.6%	82.7%	95.9%	89.6%		>=96 % N/A <96 %
IP Survey: % Received information enabling choices about their care W	89.7%	94.2%	98.6%	94.8%	97.9%	97.4%	95.4%	99.0%	93.8%	96.1%	94.6%	95.5%	97.1%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect W	100.0%	99.4%	99.3%	98.6%	97.9%	99.5%	97.0%	99.0%	97.2%	96.6%	97.7%	98.9%	97.6%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge D P	75.0%	76.0%	85.0%	82.1%	82.8%	84.1%	83.8%	89.0%	87.7%	87.1%	92.7%	86.4%	83.5%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care W	92.2%	92.9%	98.6%	91.5%	95.8%	88.4%	97.0%	98.4%	97.6%	98.3%	92.7%	97.7%	97.1%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play D					92.7%	94.7%	94.4%	93.8%	88.6%	91.0%	90.4%	94.4%	92.9%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning D					69.4%	86.2%	75.1%	68.1%	72.0%	68.1%	81.6%	81.6%	78.2%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	92.5%	93.9%	94.6%	94.3%	94.7%	94.3%	93.5%	92.9%	93.5%	93.9%	94.2%	94.0%	92.2%		>=92 % >=90 % <90 %
Waiting List Size W	3,398	3,355	3,434	3,771	3,565	3,762	3,501	3,195	3,213	3,332	3,420	3,043	3,495		No Threshold
Waiting Greater than 52 weeks W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Waiting Times - 40 weeks and above	22	15	7	5	5	7	11	9	10	18	1	2	9		No Threshold
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	96.4%	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	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
All Cancers: 31 day wait until subsequent treatments W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Diagnostics: % Completed Within 6 Weeks W	100.0%	99.6%	100.0%	100.0%	100.0%	99.8%	100.0%	99.7%	100.0%	100.0%	99.7%	100.0%	100.0%		>=99 % N/A <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %
Pathology - % Turnaround times for urgent requests < 1 hr	89.4%	90.8%	92.4%	91.0%	92.7%	93.4%	90.8%	91.7%	91.5%	90.9%	89.8%	90.2%	91.0%		>=90 % >=85 % <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	99.9%	100.0%	99.9%	100.0%	99.9%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%		>=90 % >=85 % <90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <95 %
Imaging - % Reporting Turnaround Times - ED	88.0%	92.0%	75.0%	83.0%	94.0%	86.0%	96.0%	94.0%	100.0%	92.0%	82.0%	85.0%	88.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Inpatients	82.0%	86.0%	84.0%	84.0%	88.0%	92.0%	82.0%	87.0%	91.0%	85.0%	81.0%	86.0%	90.0%		>=90 % >=85 % <90 %
Imaging - % Reporting Turnaround Times - Outpatients	92.0%	85.0%	88.0%	86.0%	96.0%	92.0%	93.0%	94.0%	87.0%	87.0%	92.0%	89.0%	95.0%		>=85 % N/A <85 %
Imaging - Waiting Times - MRI % under 6 weeks	78.0%	66.0%	67.0%	64.0%	63.0%	73.0%	78.0%	76.0%	92.0%	89.0%	82.0%	64.0%	86.0%		>=95 % >=90 % <95 %
Imaging - Waiting Times - CT % under 1 week	82.0%	89.0%	81.0%	82.0%	85.0%	87.0%	88.0%	84.0%	84.0%	80.0%	89.0%	87.0%	91.0%		>=90 % >=85 % <90 %

Medicine

D Drive W Watch P Programme

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Imaging - Waiting Times - Plain Film % under 24 hours	91.0%	92.0%	91.0%	92.0%	92.0%	92.0%	91.0%	92.0%	89.0%	89.0%	90.0%	91.0%	90.0%		>=90 % >=85 % <90 %
Imaging - Waiting Times - Ultrasound % under 2 weeks	86.0%	81.0%	85.0%	78.0%	90.0%	86.0%	89.0%	88.0%	86.0%	87.0%	88.0%	88.0%	85.0%		>=90 % >=85 % <90 %
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	88.0%	81.0%	100.0%	60.0%	78.0%	68.0%	68.0%	100.0%	82.0%	83.0%	79.0%	61.0%	47.0%		>=95 % >=90 % <95 %

WELL LED

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-242		-140	-302	-215	-308	946	-8	199	66	494	122	-350		No Threshold
Income In Month Variance (£'000s)	W	418	416	-225	-298	86	79	676	-53	595	678	869	1,315	80		No Threshold
Pay In Month Variance (£'000s)	W	-217	-244	-51	98	37	-79	291	129	126	162	-12	21	-62		No Threshold
AvP: IP - Non-Elective	W			17	21	89	111	67	3	-33	-73	-129	-251	-110		>=0 N/A <0
AvP: IP Elective vs Plan	W			-30	-26	-30	-56	-1	-36	-41	-5	-41	-28	-38		>=0 N/A <0
AvP: OP New				-31.10	-56.48	35.41	119.12	177.81	200.81	-45.52	40.78	23.30	107.65	-70.87		>=0 N/A <0
AvP: OP FollowUp				-167.82	-311.12	-78.98	93.27	253.81	244.43	258.99	381.97	241.31	589.30	319.76		>=0 N/A <0
AvP: Daycase Activity vs Plan	W			-6	-119	-154	-65	100	39	-37	-61	21	29	10		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W			-69	-404	22	247	564	458	367	526	331	760	324		>=0 N/A <0
PDR	W	89.2%	89.2%	2.8%	14.1%	37.4%	83.8%	87.8%	87.8%	87.8%	87.8%	87.8%	87.1%	87.1%		>=90 % >=85 % <85 %
Medical Appraisal	W				98.4%	97.6%	93.7%	93.7%	92.1%	88.1%	69.8%	65.1%	84.1%	91.5%		>=95 % >=90 % <90 %
Mandatory Training	W	90.1%	90.7%	90.7%	89.7%	92.0%	91.2%	91.9%	91.4%	91.6%	91.8%	91.6%	94.1%	94.6%		>=90 % >=85 % <80 %
Sickness	D	4.4%	4.8%	4.5%	4.7%	4.6%	5.3%	5.0%	5.3%	5.2%	5.6%	6.1%	5.8%	6.3%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.9%	2.0%	1.6%	1.4%	1.1%	1.6%	1.2%	1.6%	1.3%	2.2%	2.2%	1.8%	1.9%		<=1 % N/A >1 %
Long Term Sickness	D	2.5%	2.8%	2.9%	3.3%	3.4%	3.8%	3.8%	3.6%	3.8%	3.4%	3.9%	4.0%	4.4%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	297	326	270	271	263	247	282	300	284	247	224	252	267		No Threshold
Staff Turnover	D	7.8%	8.1%	8.0%	8.5%	8.8%	8.9%	9.8%	10.6%	9.8%	9.8%	9.5%	9.9%	9.7%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	97.0%	103.2%	100.2%	101.0%	97.5%	97.8%	98.8%	102.9%	99.3%	97.2%	90.7%	91.6%	94.6%		>=90 % >=85 % <90 %

Surgery Division		
SAFE	• One Never event (occurred in Jan, but reported in Feb) • No SUI's • No incidents resulting in sever or permanent harm • No Grade 3/4 Pressure ulcers • Sepsis 80% in Feb	**Highlight** • No Grade 3/4 pressure ulcers (last Grade 3 pressure ulcer in June 2019) • Trialled "ward attender" ANP clinics in MDU rather than SDU (3A) • Commenced implementation of Intellispace (to view Echos) **Challenges** • Never Events: improving safety culture • Compliance against Major Trauma standards • Sepsis: <90% Dec, Jan & Feb
CARING	• Only 2 complaints in Feb, and 1 in Jan • PALS concerns, total 31	**Highlight** • Only 3 complaints in last 2 months **Challenges** • Conclude long term complaints
EFFECTIVE	• Theatre utilisation 89% • Cancelled ops 37 (>20) • 28 CCAD cases, lower than plan due to high volume of ECMO patients in early Feb • Clinic Utilisation > 85%	**Highlight** • 6 months <2% readmission to PICU within 48 hours • Improved theatre utilisation **Challenges** • Cancelled ops remain a challenge
RESPONSIVE	• RTT 94% (national target 92%) • No 52 week breaches this year to date • Continue to achieve 100% for seeing all patient requiring diagnostic tests within 6 weeks since May 2019 • IP survey, all metrics >90% (except for learning)	**Highlight** • Continuing to exceed national waiting time targets **Challenges** • Maintaining zero 52 week breaches, with a number of patients >44 weeks
WELL LED	• Mandatory training: 93% • Sickness – 5.9% (Short term 1.9% and Long Term 4.0%) • Finance: year end forecast deteriorated by £0.5m, due to additional pay costs in Feb and predicted down turn in March activity (related to Covid19)	**Highlight** • Mandatory training 93% **Challenges** • Improvement in sickness rates however remains a challenge for the division • Optimise financial performance against budget • Commenced preparations for Covid19

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	40	34	28	30	20	59	27	29	42	32	19	29	30		No Threshold
Clinical Incidents resulting in No Harm (D)	104	139	143	142	163	144	137	130	145	144	110	141	164		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	34	43	38	67	37	28	39	27	45	52	49	42	45		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	1	0	0	0	1	3	0	1	0	0	2	3	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	1	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	1	0	0	0	0	0	0	1	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	2	1	2	0	3	1	1	1	3	3	1	0	0		No Threshold
Medication Errors (Incidents)	41	44	38	57	49	28	45	24	41	55	27	42	38		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	1	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
Never Events (W)	0	0	0	0	0	0	0	2	0	0	1	0	1		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)		90.9%	75.0%	75.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	60.0%	57.1%	80.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	1	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	0	1	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA (D)	0	3	1	1	0	0	0	1	0	1	0	0	2		No Threshold
Cleanliness Scores	97.2%	98.0%	98.2%	97.7%		97.0%	97.2%	97.7%	97.9%	97.6%	98.0%	99.1%	96.3%		>=90 % >=80 % <80 %

CARING

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Complaints (W)	2	6	1	2	2	8	7	4	1	7	5	1	2		No Threshold
PALS (W)	26	30	33	31	26	42	21	48	40	35	19	27	31		No Threshold

EFFECTIVE

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Readmissions to PICU within 48 hrs (D)	2	2	2	2	1	5	3	0	1	0	0	1	0		No Threshold
% Readmissions to PICU within 48 hrs (W)	1.8%	2.5%	2.7%	2.1%	1.3%	5.3%	4.1%	0.0%	1.2%	0.0%	0.0%	1.6%	0.0%		<=3 % N/A >3 %
Referrals Received (Total)	3,796	4,018	3,754	4,079	3,777	4,159	3,311	3,564	3,847	3,310	2,817	3,681	3,604		No Threshold
Theatre Utilisation - % of Session Utilised (W)	89.4%	90.4%	89.7%	90.0%	88.6%	89.4%	90.8%	88.3%	86.9%	85.6%	83.6%	89.7%	88.6%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	8	12	8	23	14	35	30	16	31	40	35	18	37		No Threshold
28 Day Breaches (W)	0	1	0	0	1	2	0	1	0	1	7	10	4		0 N/A >0
Clinic Session Utilisation (D P)	85.1%	88.7%	87.9%	87.3%	87.3%	89.1%	87.2%	86.6%	87.1%	85.0%	81.6%	86.3%	85.6%		>=90 % >=80 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	74	58	53	41	40	43	37	29	70	57	11	29	41		No Threshold
OP Appointments Cancelled by Hospital %	14.1%	13.6%	13.3%	12.9%	12.7%	11.9%	12.1%	11.9%	12.6%	12.2%	12.9%	13.7%	13.0%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	11.7%	10.6%	11.8%	11.1%	9.5%	9.6%	10.4%	9.6%	9.6%	11.1%	12.7%	9.5%	9.8%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	11.7%	10.8%	11.4%	10.8%	10.5%	10.2%	11.6%	10.1%	10.1%	11.4%	11.8%	9.5%	10.5%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	11.7%	10.5%	12.0%	11.2%	9.1%	9.4%	9.9%	9.4%	9.4%	10.9%	13.0%	9.5%	9.5%		<=14 % <=16 % >16 %
Coding average comorbidities	4.13	3.92	4.09	4.24	4.15	4.13	4.25	4.06	4.15	4.16	4.26	4.14	3.93		No Threshold
CCAD Cases	39	42	30	36	31	43	35	38	35	27	23	32	28		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Convenience and Choice: Slot Availability		90.6%	87.0%	80.0%	76.5%	90.0%	89.7%	82.0%	90.5%	96.9%	99.0%	98.7%	99.0%	89.2%		>=96 % N/A <96 %
IP Survey: % Received information enabling choices about their care	W	98.3%	96.8%	98.0%	97.9%	97.2%	97.7%	95.9%	97.1%	96.8%	97.2%	97.6%	98.5%	98.2%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	W	98.9%	99.5%	99.3%	99.3%	98.3%	99.0%	97.8%	98.1%	98.0%	98.2%	99.1%	98.5%	97.5%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	D P	87.8%	83.8%	92.4%	85.6%	91.3%	90.1%	89.0%	89.3%	95.0%	96.1%	88.7%	93.1%	93.2%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	W	95.6%	93.7%	100.0%	89.7%	96.5%	92.4%	98.6%	98.4%	91.3%	98.2%	99.3%	98.2%	97.9%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	D					93.8%	94.4%	95.9%	90.3%	94.2%	95.7%	91.7%	96.4%	92.2%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	D					72.1%	68.9%	70.4%	68.4%	74.3%	68.4%	87.7%	87.7%	77.9%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	94.0%	94.0%	93.6%	94.0%	94.0%	93.8%	94.1%	94.5%	93.8%	93.7%	94.2%	93.5%	94.4%		>=92 % >=90 % <90 %
Waiting List Size	W	8,221	8,129	8,165	7,712	7,939	7,765	8,266	8,519	8,319	8,157	8,088	8,651	8,238		No Threshold
Waiting Greater than 52 weeks	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Diagnostics: % Completed Within 6 Weeks	W	89.5%	92.3%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

		Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-470		-405	-63	282	-525	455	531	-399	-59	159	-567	-186		No Threshold
Income In Month Variance (£'000s)	W	208	364	-372	159	370	53	775	771	266	580	565	-160	392		No Threshold
Pay In Month Variance (£'000s)	W	-407	-274	23	-7	-34	-165	-117	-116	-286	-213	-37	42	-405		No Threshold
AvP: IP - Non-Elective	W			36	36	20	48	65	51	14	-23	21	21	-13		>=0 N/A <0
AvP: IP Elective vs Plan	W			-15	3	-10	-25	18	-30	-27	29	-2	-26	11		>=0 N/A <0
AvP: OP New				-207.97	-305.45	-342.11	-235.53	-170.56	-324.33	-183.46	-326.84	-254.44	-218.65	-312.44		>=0 N/A <0
AvP: OP FollowUp				487.69	323.90	963.71	1,115.55	1,449.07	1,357.96	1,789.97	851.38	698.95	1,327.64	1,266.14		>=0 N/A <0
AvP: Daycase Activity vs Plan	W			-46	-15	-86	17	-23	18	-42	27	-43	-37	24		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W			419	84	682	1,019	1,647	1,198	1,967	729	529	1,289	1,040		>=0 N/A <0
PDR	W	96.6%	96.6%	11.6%	42.7%	74.4%	93.8%	93.3%	93.3%	93.3%	93.3%	93.3%	94.3%	94.3%		>=90 % >=85 % <85 %
Medical Appraisal	W				97.6%	97.6%	97.0%	98.2%	94.5%	89.6%	67.7%	65.2%	84.1%	89.7%		>=95 % >=90 % <90 %
Mandatory Training	W	88.4%	89.4%	88.8%	87.3%	88.6%	89.3%	90.3%	90.6%	90.3%	89.9%	91.1%	93.0%	92.9%		>=90 % >=85 % <80 %
Sickness	D	6.4%	5.2%	5.2%	6.2%	6.6%	6.4%	5.7%	5.8%	6.2%	5.8%	7.1%	6.4%	5.9%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	2.0%	1.6%	1.5%	1.7%	1.6%	1.6%	1.1%	1.6%	1.9%	1.7%	2.2%	2.0%	1.9%		<=1 % N/A >1 %
Long Term Sickness	D	4.4%	3.6%	3.7%	4.5%	5.0%	4.8%	4.6%	4.2%	4.3%	4.1%	4.9%	4.4%	4.0%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	476	504	440	438	382	442	417	519	419	484	388	344	397		No Threshold
Staff Turnover	D	10.1%	10.5%	10.7%	11.2%	11.5%	10.0%	10.7%	10.7%	10.7%	10.5%	11.1%	11.2%	11.2%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	89.3%	89.4%	91.9%	91.0%	89.1%	89.4%	92.5%	86.1%	89.6%	95.5%	91.7%	89.4%	91.9%		>=90 % >=85 % <90 %

Community & Mental Health Division

SAFE	Lessons learnt from incidents include: - Ensuring phlebotomy carts are locked if leaving clinic room unattended - Staff to remain vigilant and escalate any discrepancies in patient information from partner agencies in a timely manner - Change in process for Eating Disorder referrals received from acute wards to ensure these are actioned daily	**Highlight** • Zero moderate or severe harms • Zero never events • Zero pressure ulcers • Continued low numbers of medication errors (2 in February) **Challenges** • Ongoing challenge gaining Tissue Viability support for community sites
CARING	The Children and Young People's Forum won the 'Growing Sustainably Through Great Partnerships' award at Trust staff awards and celebrated their first birthday	**Highlight** • Reduction in PALs in February (35) compared to January (44) • Lessons learnt include school demographics being checked before appointments start, and community staff have commenced using the interpreter on wheels to avoid cancelling appointments **Challenges** • 2 new formal complaints received in February – one regarding communication and post diagnostic support in community paediatrics, and the other related to community physiotherapy input
EFFECTIVE	Mental Health Act training sessions commenced for all staff, supported by Crisis Care team and Hill Dickinson	**Highlight** • WNB rates for the division were within Trust target (9.6% new, 12% follow up) **Challenges** • Work ongoing to improve clinic utilisation – in community paediatrics cash up improvement are ongoing, specific areas of CAMHS clinic utilisation will go live (none reported currently).
RESPONSIVE	Funding secured for ASD and ADHD service improvements in Sefton	**Highlight** • Improvement in Specialist Mental Health Services RTT (Referral to Partnership) to 59.6% • No urgent breaches for Eating Disorders team • RTT for Eating Disorder routine appointment was 92.9% **Challenges** • Ongoing challenge with Liverpool Speech Therapy waits at 21 weeks – action in place to reduce over next 2-3 months to within 18 weeks.

WELL LED	Alder Hey present at Future of Psychiatry conference with other regional mental health Trusts	**Highlight** • Mandatory training at 95.9% • Sickness has reduced for 4th consecutive month to 4.4% **Challenges** • Staff turnover has remained static at 12.3%

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	3	3	6	15	7	5	7	8	1	6	2	8	5		No Threshold
Clinical Incidents resulting in No Harm (D)	40	41	48	54	41	53	57	68	85	63	30	46	57		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	6	6	6	2	7	8	7	6	11	9	11	6	9		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	0	0	1	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)	9	5	12	6	3	6	5	9	11	8	9	1	2		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					99.5%			98.9%				100.0%			No Threshold
CCNS: Advanced Care Plan for children with life limiting condition	0	0	10	10	10	10	9	8	8	7					No Threshold
CCNS: Supported early discharges from hospital care			100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		No Threshold
CCNS: Prescriptions	0	0	12	24	17	21	32	28	25	21					No Threshold

CARING

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Complaints (W)	4	6	4	4	1	4	2	1	3	5	1	2	3		No Threshold
PALS (W)	29	33	30	30	43	37	28	37	35	22	20	44	35		No Threshold

EFFECTIVE

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Referrals Received (Total)	969	1,086	919	1,068	924	1,034	623	821	1,103	935	786	912	938		No Threshold
Clinic Session Utilisation (D P)	74.5%	85.9%	78.0%	81.3%	80.3%	82.6%	81.6%	83.0%	82.4%	84.0%	79.3%	80.2%	84.1%		>=90 % >=85 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	18	16	20	14	14	8	7	14	20	19	11	18	18		No Threshold
OP Appointments Cancelled by Hospital %	21.4%	22.8%	20.2%	17.1%	18.9%	16.0%	11.2%	12.6%	13.9%	12.7%	12.7%	10.9%	11.2%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts) (W)	10.8%	10.0%	10.8%	11.9%	9.7%	11.3%	9.5%	8.6%	8.9%	11.7%	11.5%	9.7%	9.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	12.6%	11.4%	13.2%	12.4%	11.9%	12.1%	13.6%	11.6%	10.3%	10.7%	13.5%	11.5%	11.5%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	14.9%	13.3%	12.7%	16.0%	12.0%	14.1%	9.6%	10.5%	10.1%	13.9%	13.7%	12.5%	11.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	10.3%	6.9%	12.0%	9.8%	10.3%	8.7%	9.9%	9.5%	9.6%	9.8%	11.5%	9.4%	7.9%		<=14 % <=16 % >16 %
Was Not Brought Rate (CHOICE Appts) - CAMHS	12.6%	14.9%	15.8%	12.9%	13.5%	19.1%	21.0%	10.4%	13.7%	13.8%	16.7%	9.7%	13.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (All Other Appts) - CAMHS	13.9%	13.6%	13.8%	13.9%	12.7%	14.0%	16.4%	13.7%	11.0%	11.8%	15.4%	13.2%	13.9%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	88.8%	118.9%	115.7%	100.0%	91.4%	98.2%	86.2%	84.8%	65.9%	71.0%	77.9%	92.6%	76.8%		No Threshold
CAMHS: Tier 4 DJU Bed Days	346	474	424	404	322	364	310	296	226	238	278	340	256		No Threshold
Coding average comorbidities	1.50	6.00	4.00	2.50	3.00	3.00	5.50	5.00	4.00	1.00		3.00			No Threshold
CCNS: Number of commissioned packages	0	0	10	10	10	10	10	10	10	10	10				No Threshold

RESPONSIVE

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU	2	2			1	1			1		1	1	1		No Threshold

Community

D Drive W Watch P Programme

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
CAMHS: Referrals Received	351	402	325	346	310	326	185	289	418	342	259	352	380		No Threshold
CAMHS: Referrals Accepted By The Service	210	232	190	218	173	175	125	161	251	176	151	205	241		No Threshold
CAMHS: % Referrals Accepted By The Service	59.8%	57.7%	58.5%	63.0%	55.8%	53.7%	67.6%	55.7%	60.0%	51.5%	58.3%	58.2%	63.4%		No Threshold
Convenience and Choice: Slot Availability		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=96 % N/A <96 %
RTT: Open Pathway: % Waiting within 18 Weeks W	78.3%	74.2%	75.2%	74.9%	73.9%	76.4%	71.6%	70.8%	76.1%	76.8%	74.3%	76.3%	75.1%		>=92 % >=90 % <90 %
Waiting List Size W	1,269	1,262	1,272	1,393	1,339	1,356	1,107	1,112	1,222	1,338	1,371	1,191	1,161		No Threshold
Waiting Greater than 52 weeks W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
CAMHS: Crisis / Duty Call Activity	344	425	343	337	343	315	266	294	471	384	250	410	378		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks W			63.6%	66.0%	61.1%	54.7%	49.6%	46.2%	48.9%	49.6%	49.0%	58.3%	59.6%		>=50 % >=45 % <45 %
ASD: Completed Pathways	68	78	68	65	84	45	74	78	97	82	44	47	30		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	41.2%	59.0%	60.3%	30.8%	25.0%	15.6%	28.4%	32.1%	55.7%	47.6%	54.5%	74.5%	66.7%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) P			66.7%	66.7%	70.0%	75.0%	72.7%	75.0%	93.8%	100.0%	100.0%	87.5%	92.9%		>=95 % >=92 % <92 %
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) P			50.0%	50.0%		66.7%	0.0%		0.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=92 % <92 %
CCNS: Number of Referrals W			138	163	156	147	149	133	129	169	107	109	102		No Threshold
CCNS: Number of Contacts D			886	919	894	921	893	913	951	1,094	863	821	808		No Threshold

WELL LED

	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Last 12 Months	RAG
Control Total In Month Variance (£'000s) W	14		-66	75	-12	-13	27	92	-36	22	-9	-58	-65		No Threshold
Income In Month Variance (£'000s) W	61	336	-111	177	36	-47	57	43	74	34	26	104	91		No Threshold
Pay In Month Variance (£'000s) W	-57	-307	181	-69	-64	2	-4	51	-43	15	-30	-90	-87		No Threshold
AvP: OP New			-0.48	-10.08	-5.63	28.14	-4.08	114.22	191.67	180.19	115.32	129.17	165.40		>=0 N/A <0
AvP: OP FollowUp			19.13	103.99	362.17	306.03	145.10	272.13	282.48	425.78	210.82	533.85	449.82		>=0 N/A <0
AvP: Outpatient Activity vs Plan W			19	96	360	337	144	394	478	607	327	663	616		>=0 N/A <0
PDR W	93.7%	93.7%	1.4%	10.8%	48.6%	87.1%	90.1%	90.1%	90.1%	90.1%	90.1%	91.3%	91.3%		>=90 % >=85 % <85 %
Medical Appraisal W				100.0%	100.0%	97.0%	100.0%	97.0%	84.8%	78.8%	51.5%	69.7%	91.2%		>=95 % >=90 % <90 %
Mandatory Training W	89.2%	90.3%	92.2%	89.2%	90.2%	92.0%	93.2%	92.9%	92.7%	93.5%	94.1%	96.7%	95.9%		>=90 % >=85 % <80 %
Sickness D	7.5%	7.4%	6.7%	6.4%	4.9%	4.3%	4.4%	4.2%	6.1%	5.8%	6.3%	4.7%	4.4%		<=4 % <=4.5 % >4.5 %
Short Term Sickness D	1.5%	1.8%	1.4%	1.6%	1.2%	0.9%	0.8%	1.1%	2.4%	2.1%	1.9%	1.2%	1.1%		<=1 % N/A >1 %
Long Term Sickness D	6.0%	5.6%	5.2%	4.8%	3.7%	3.4%	3.6%	3.1%	3.7%	3.8%	4.3%	3.5%	3.3%		<=3 % N/A >3 %
Temporary Spend ('000s) D	106	367	198	226	96	158	122	143	42	104	120	135	148		No Threshold
Staff Turnover D	11.9%	12.8%	11.8%	11.7%	9.9%	10.1%	10.2%	10.6%	10.5%	11.2%	11.7%	12.3%	12.3%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate) W	100.0%	106.0%	100.0%	102.0%	97.0%	87.0%	87.3%	91.2%	87.6%	100.3%	96.7%	101.0%	94.1%		>=90 % >=85 % <90 %

NHS
Alder Hey Children's
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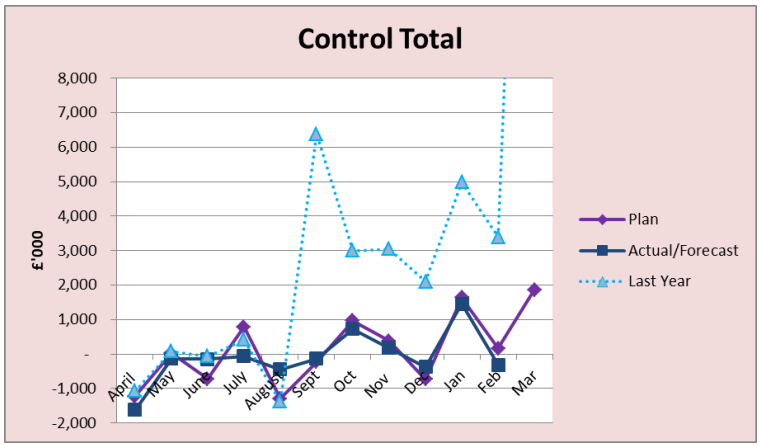
Financial Dashboard -M11 2019/20

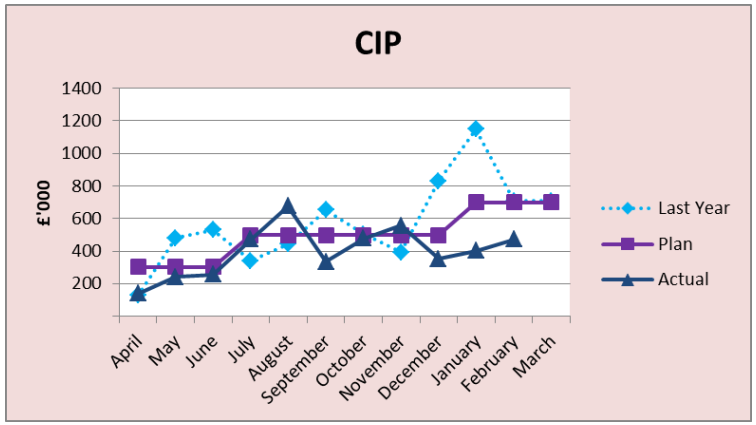
How Did We Do?

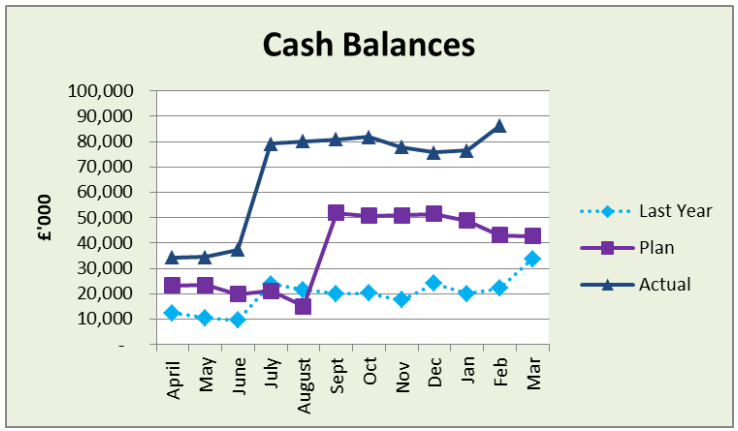
Executive Summary Month: 11 Year: 2020

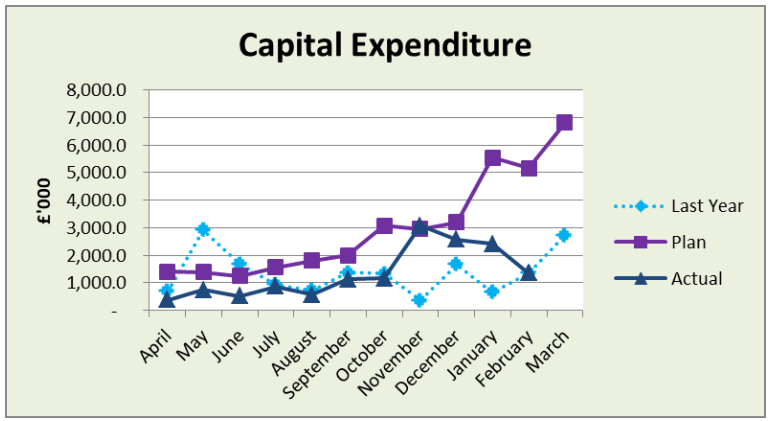
Alder Hey Children's NHS NHS Foundation Trust

Control Total in month	CIP Forecast for year	Use of Resources	Control Total Forecast
(£0.3m)	£6m	3	(£0.8m)
Not Achieved	Achieved	Achieved	Not Achieved

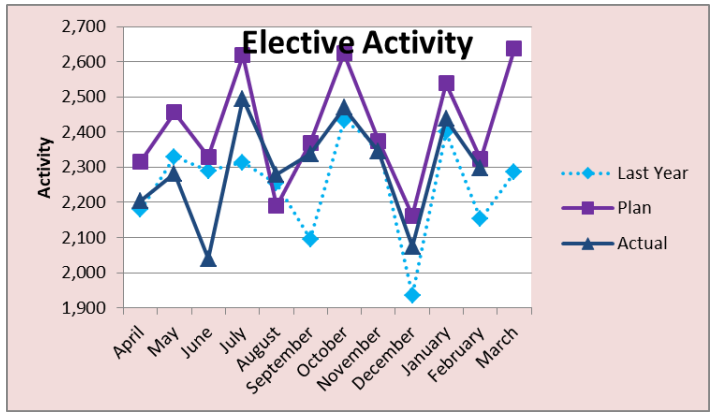


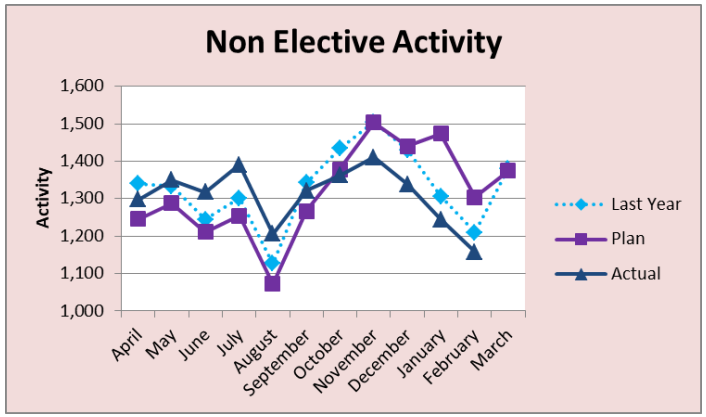


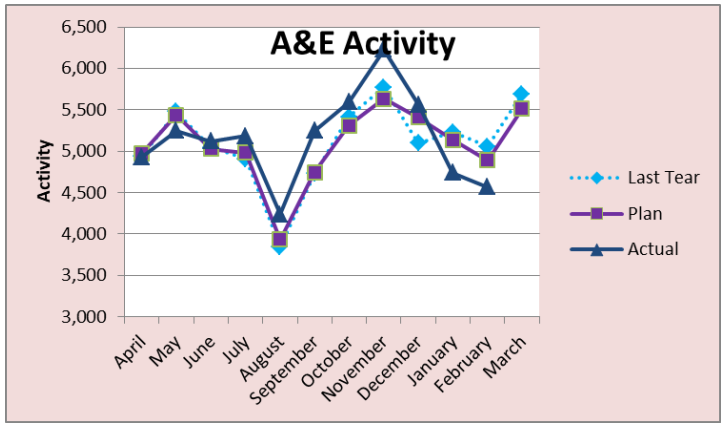


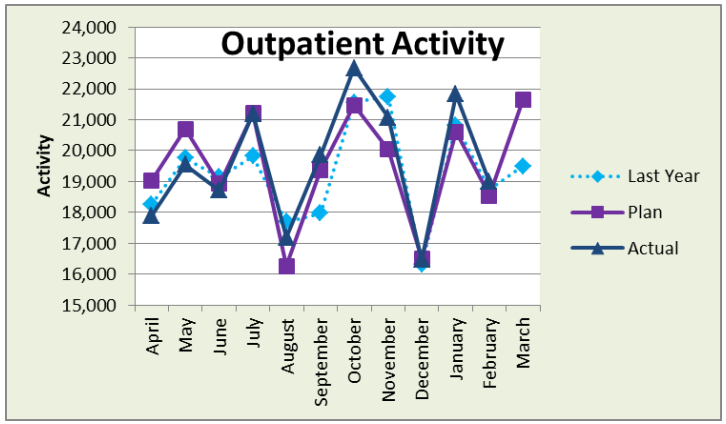


Elective Activity in Month	Non Elective Activity in Month	Outpatient Activity in Month	A&E Activity In Month
2,296	1,157	18,996	4,566
Not Achieved	Not Achieved	Achieved	Not Achieved









NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7th April 2020

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

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1. Purpose of the report

The purpose of this report is to provide the Board with an overview of the current serious incident management position. The report includes learning from serious incidents, 'Never Events', closed since the last reporting period (January 2020) and the immediate learning from serious incidents during this reporting period (February 2020).

2. Background

All investigations are monitored via the performance assurance meetings with individual divisions, focusing on the management of investigations, including lessons learned and assurance of progress with actions for improvement. In addition, monthly supportive meetings are held with the division's leads and the Associate Director of Nursing and Governance, to assess and monitor progress with investigations and actions for improvement. Furthermore, the divisions present a progress update on investigations and lessons learned to Clinical Quality Steering Group, with exceptions reported to Clinical Quality Assurance Committee. All serious and moderate harm incidents and Never Events are reported and discussed at the weekly Patient Safety meeting, at the time of reporting.

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

Appendix 1 shows the Trust's in financial year (2019/2020), number of serious incidents reported, including Never Events requiring investigation (Serious Incidents Requiring Investigation - SIRI). The cumulative total of serious incidents including Never Events in year is **14**. There were no serious clinical incidents and no serious safeguarding incidents reported in February 2020.

There was **1** Never Event reported during February 2020, i.e. wrong site eye surgery (squint surgery). Duty of candour has been applied fully, in line with regulation 20. The 72 hour review was completed within Trust policy timeframes and submitted to Liverpool Clinical Commissioning Group (CCG). **Appendix 2** provides an overview of immediate lessons learned and actions for improvement to minimise risk of recurrence of the same or similar incidents recurring.

Appendix 3 provides an overview of the completed investigation during this reporting period.

4. Moderate harm incident

There was one moderate harm incident reported during this period (Incident reference: 40425):

Summary

The patient was transferred to Alder Hey Children's Hospital by North West & North Wales Paediatric Transport Service (NWTS). The patient was on Aminophylline (bronchodilator), running at 12mls/hr rate, which was confirmed between the Alder Hey nurse, NWTS nurse and medical team. The infusion was transferred to an Alder Hey pump and the infusion was continued at 12mls/hr. When the infusion was completed a new infusion was prescribed. It was at that time it was noted that there was a discrepancy from the NWTS infusion dose to Alder Hey's normal dose. NWTS dose was 610mg/50mls running at 12ml/hr. Alder Hey Infusion is 500mg/500mls, to give 1mg in 1ml to run at 12mls/hr, according to patients weight. The patient had been given a total of 50mls at the wrong concentration of Aminophylline infusion.

Immediate Lessons learned

- Checking of infusions on arrival – visual check of label at handover- PICU/NWTS
- Protocol for checking/starting infusions - NWTS
- Missing/incorrect information in discharge letter/prescription sheet – Countess of Chester
- There is a different calculation for aminophylline infusions in NWTS

Immediate action for improvement

- The importance of visual check of infusions at admission at safety huddles/handovers, discussed with staff.
- Discussed with staff the importance of Communicate re infusion calculation for aminophylline

An RCA level 1 (concise) investigation is underway at the time of writing this report.

Note: All investigations are compliant with the 60 days' timeframe or completed within the agreed extension period.

Appendix 1

Table 1 StEIS reported Serious Incidents and Never Events performance date

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

Note: Five Incidents were carried over from the previous year, which were completed and closed.

Appendix 2

New SIRI investigation					
StEIS reference	Incident	Duty of Candour in line with regulation 20	Immediate lessons	Immediate actions	Further action to be taken
2020/2282	Wrong site surgery (Squint surgery) The patient was listed on the morning theatre list on the 30/01/20 for right divergent squint surgery. The patient's ID and consent form were checked. The patient was prepped and draped and the time out was completed and surgery commenced. The procedure was undertaken and the patient was subsequently transferred to the theatre recovery suite. The surgeon reviewed his notes and identified that he had completed the incorrect procedure on the patient. The procedure was undertaken on the correct eye; however the Consultant Surgeon went through the incorrect muscle. The patient returned to theatre and the correct procedure was undertaken.	completed	Specific muscle to be operated not noted on consent form. Specific muscle not identified on whiteboard in the operating theatre which would assist the surgeon. The Surgeon sat in wrong position at beginning of case. There was no Registrar available to assist the Surgeon with the surgery.	For Squint surgery the muscle to be operated on is to be identified prior to the commencement of the surgery on whiteboard in the operating theatre – this will be populated by the Surgeon and verified with the assistant. Verbal confirmation of procedures with the team prior to knife to skin (as per the WHO 5 steps to safer surgery) If the surgeon requires assistance for the procedure and does not have a trained surgical first assistant assigned to the case or a registrar, the procedure must not go ahead.	RCA level 2 investigation underway

Appendix 3

Completed SIRI investigation in reporting period					
Steins Reference	Incident	Duty of Candour in line with regulation 20	Lessons learned	Recommendations	Further action for improvement
2019/26251	Never Event - Wrong Tooth Extraction	Yes	The original referral letter should be included in the patient's notes on the day of surgery. Individual Palmer Notation boards to be procured for erection in all theatres that undertake oral surgery and dentistry; there should be a Palmer Notation diagram for each – Surgical removal, non-surgical extractions and conservations (teeth fillings) to avoid confusion. This should be populated prior to the procedure commencing by the surgeon and the assistant. Ensure consent forms include an accurate reflection of the procedures to be carried out.	Formal apology to the patient and their family for the failings identified through this investigation. To provide feedback to the patient, family and staff involved in the incident. The original referral letter should be included in the patient notes on the day of surgery to allow direct comparison with what has been requested following the outpatient appointment. This should be added to the pre-operative checklist. There should be a separate Palmer Notation diagram for 'extractions' and 'surgical extractions' and conservations. Importance of accurate documentation, when completing consent forms for surgical procedures.	A formal apology will be given to the patient and their family. To provide comprehensive feedback to the child and their family about the incident. To provide feedback to the staff involved in the incident, including a copy of the report. The original referral letter from the community will be included in the patient notes on the day of surgery. Amend the checklist to include confirmation of the referral letter in order to cross reference with the operating list and the clinic letter Send out memo and discuss with staff the importance of accurate documentation, when completing consent forms for surgical procedures. Palmer notation boards to be

					procured for all theatres that perform oral surgery and dentistry.

END

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

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

Section two is the Quarter 3 Mortality report which includes a review of statistical analysis in PICU and Cardiac Surgery, followed by more detailed analysis of the place of death, teams involved and specifics about expected v observed deaths.

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

National Changes to the Child death Mortality Process

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

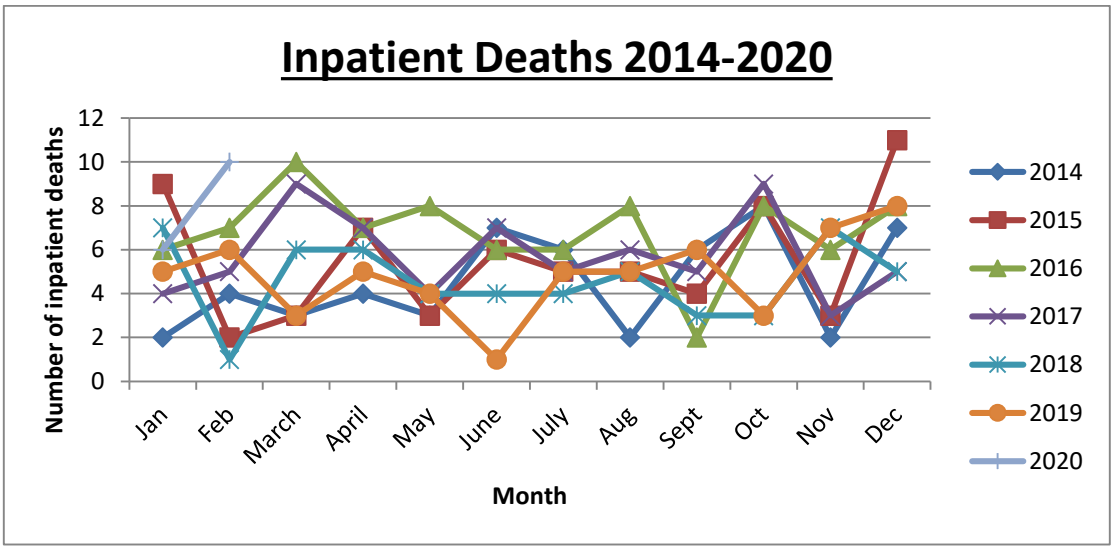
1) improve the experience of bereaved families and professionals involved in caring for children
2) ensure that the information from the child death review process is systemically captured in every case, to enable learning to prevent future deaths.

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

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

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

Mortality Rate Over the last 5 years



Number of Inpatient Deaths by Year and Month 2014 - 2020

	2014	2015	2016	2017	2018	2019	2020
Jan	2	9	6	4	7	5	6
Feb	4	2	7	5	1	6	10
March	3	3	10	9	6	3	
April	4	7	7	7	6	5	
May	3	3	8	4	4	4	
June	7	6	6	7	4	1	
July	6	5	6	5	4	5	
Aug	2	5	8	6	5	5	
Sept	6	4	2	5	3	6	
Oct	8	8	8	9	3	3	
Nov	2	3	6	3	7	7	
Dec	7	11	8	5	5	8	
	54	**66**	**82**	**69**	**55**	**58**	**16**

Reviewing the diagnostic codes for the last 5 completed years, the highest mortality figure was in 2016, where the commonest diagnostic codes were cardiac, congenital, chronic illnesses and infection. 2016 was the last severe outbreak of bronchiolitis and invasive Group A streptococcal disease which impacted on the most vulnerable populations, as indicated by the diagnostic codes. In recent years, the numbers of acute (ED) hospital attendances have been high but for the majority, the severity has been reduced.

The numbers of diagnosed cardiac deaths vary between 10 and 19 over this period. This is a very complex group with children attending AHCH for full assessment of very complex cardiac conditions. It has to be completed in AHCH as it has the facilities to complete them. Therefore children/babies are brought here from all over the region. Unfortunately, in some cases there are no treatment options other than palliation, once the complexity of the cardiac condition is fully understood. It is vital that these children are brought here to have this assessment and the options for treatment explored and the best care offered to the patients and families regardless of the challenges this may create.

In additional neonatal deaths have decreased as a result of the screening undertaken prior to transfer to AHCH. Previously, some neonates arrived in a very precarious state and were not stable enough to undertake the surgery that they had been transferred for. The screening has been effective, as have the closer links developing between AHCH and LWH, improving communication and the care provided.

Alder Hey Discharges 2015 - 2019			
Table 1: All Spells			
Year	**Total Discharged Spells**	**Deceased**	**Deaths per 10,000 Discharges**
2015	36036	65	18.04
2016	40641	82	20.18
2017	42730	69	16.15
2018	43557	56	12.86
2019	43796	58	13.24

Alder Hey Discharges 2015 - 2019			
Table 2: Individuals Only			
Year	**Discharges (Individuals)**	**Deceased**	**Deaths per 10,000 Discharges**
2015	19525	65	33.29
2016	22708	82	36.11
2017	23584	69	29.26
2018	23744	56	23.58
2019	24083	58	24.08

Since 2016, the mortality rate has dropped per 10,000 discharges as the workload has increased. The increase is especially marked relating to all discharged spells (table 1) but it is important to remember that this includes the day case workload, cases which should not have any associated mortality.

These decreases can potentially be explained by the greater screening undertaken by teams prior to transfer to AHCH, ensuring that it is the correct course for both the child and family. The other main factor is the rise in acute attendances with less severe illnesses, resulting in lower mortality overall.

This trend in mortality may change this year as it has already been a very difficult year with 16 deaths to date which includes a higher rate of teenage deaths for a variety of reasons. Clearly COVID-19 may have some impact, although it appears at this time that the paediatric population will hopefully be less significantly impacted than other age groups.

Current Performance

Number of deaths (Jan. 2019 – Dec. 2019)	**59**
Number of deaths reviewed	41
Departmental/Service Group mortality reviews within 2 months (standard)	48/59 (81%)
HMRG Primary Reviews within 4 months (standard)	26/41 (63%)
HMRG Primary Reviews within 6 months	26/30 (87%)

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

The issues facing the group remain the same: a limited number of reviewers, some cases are very complex requiring multiple reviews and this results in a further increased backlog of cases.
The links between all the local DGH's, hospices and Liverpool Women's hospital continue to improve and has enabled sharing of information and learning to occur easily. It is encouraging to see that this has resulted in improvements in the existing processes and progress for the future.

Outputs of the mortality review process for hospital deaths

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

Potentially Avoidable Deaths

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

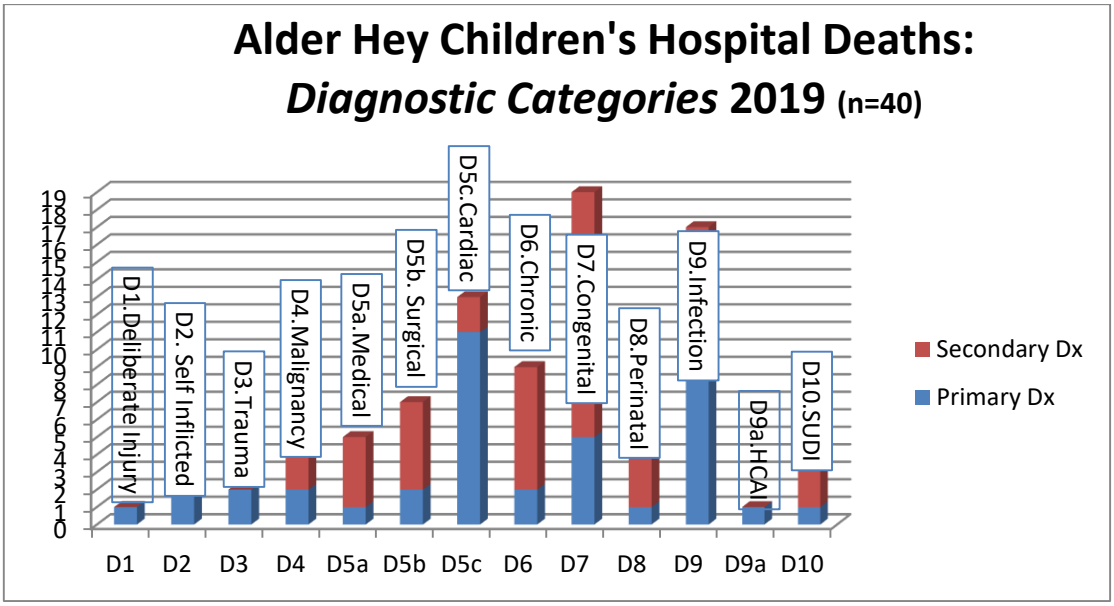
Learning disabilities

The output table of the mortality process above records any children who were identified as having learning disabilities and who have been reviewed so far in 2019.
Currently, of the 41 children reviewed 11 have been identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have learning disabilities and are reported to the LeDeR (Learning Disabilities Mortality Review) database as soon as they are identified. This is a legal requirement for the Trust.

Family

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

Primary Diagnostic Categories



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

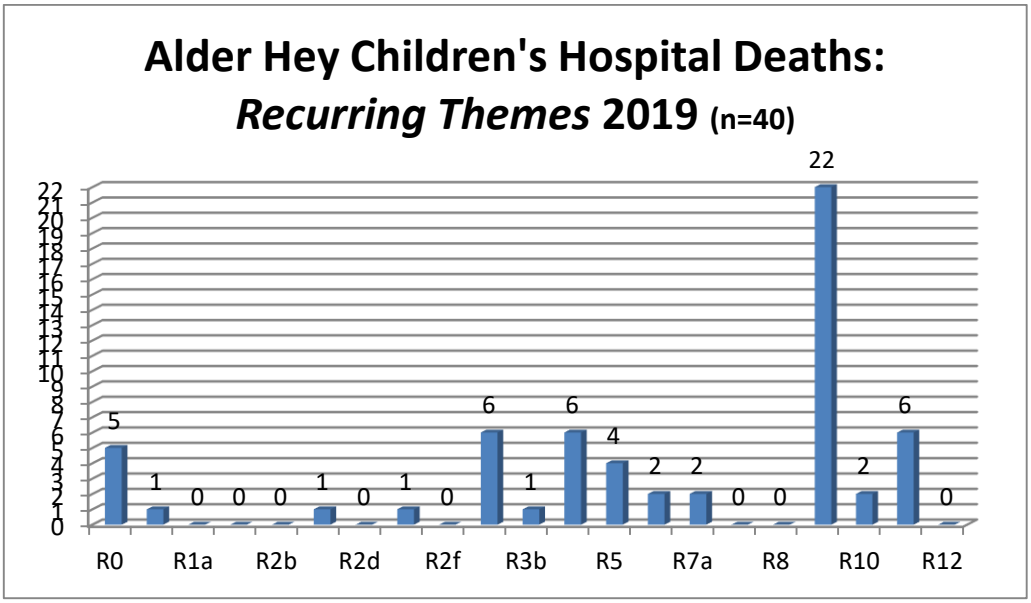
D1.	Deliberately inflicted injury, abuse or neglect
D2.	Suicide or deliberate self-inflicted harm
D3.	Trauma & other external factors – *excludes deliberate self-inflicted harm (D2)*
D4.	Malignancy
D5.	Acute Medical or Surgical condition – subcategory D5a. Medical D5b. Surgical D5c. Cardiac
D6.	Chronic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

Cardiac deaths are the highest diagnostic codes being 28% of all deaths. There have been a number of children on ECMO, (Extracorporeal Membrane Oxygenation - a type of bypass), who were too unwell to receive a heart transplant and others who were too unwell to recover. There is no concerning aspect to these cases and the HMRG checked that it was correct to bring these children to AHCH and start ECMO, which is not a decision taken without considering all options. All ECMO cases are covered in the ECMO meetings to ensure learning and care is improved for the next child/baby requiring it.

The second highest diagnostic code is infection which includes some of influenza deaths, of which this winter, were particularly prevalent and severe. The highest secondary category was chronic medical condition which is to be

expected as the children who die often have underlying conditions which increases their susceptibility to infections such as influenza.

Primary Diagnostic Categories



Recurring Themes

R0.	No RT
R1.	Failure to recognise severity of illness – subcategories: R1a. Failure to ask for Senior/Consultant review
R2.	Possible management issues – subcategories: R2a. before Arrival R2b. Delay in Transfer R2c. in Alder Hey R2d. Delay in supporting services or accessing supporting service R2e. Difference of opinion re: Rx – Patients & families R2f. Difference of opinion re: Rx – Clinical teams
R3.	Communication issues – R3a. Patients & families R3b. Clinical teams
R4.	Death inevitable before admission
R5.	Potentially avoidable death – subcategories: R5a. Alder Hey R5b. Medical R5c. External
R6.	Cause(s) of death issue – subcategories: R6a. Incomplete or inaccurate Death Certificate R6b. Should have had a post-mortem R6c. Not agreed R6d. Failure to discuss with the HM Coroner
R7.	Documentation – subcategories R7a. Recording R7b. Filing
R8.	Failure of follow-up
R9.	Withdrawal
R10.	Example of Good Practice

The commonest recurring theme was the withdrawal of care in 55% of cases. This demonstrates that the intensive care team are providing the best possible care until they feel all treatment options are futile, then with the full agreement of the family, withdrawing intensive care whilst ensuring the child is comfortable.

The next commonest recurrent theme is that death was inevitable prior to admission, this occurred in 15% of cases. This is when despite the AHCH teams provide optimal care there is nothing than can be done to prevent death. This outcome may not be apparent prior to transfer and may require

investigations to be taken in AHCH to complete a full assessment and then discuss all treatment options, or lack of.

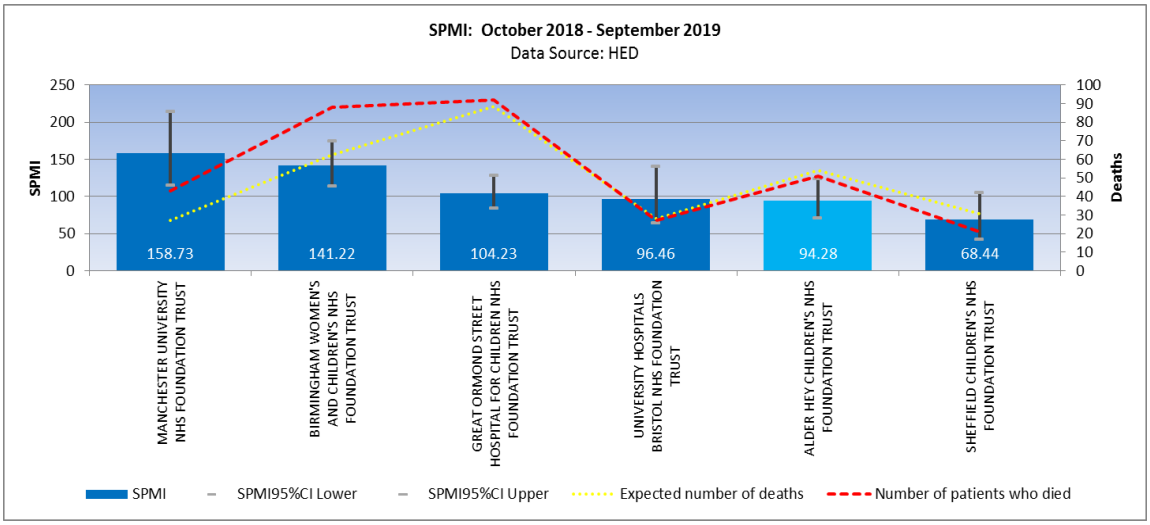
There are no worrying recurrent themes apparent and the two main recurrent themes are consistent in the figures.

Section 2: Quarter 3 Mortality Report: October 2019 – December 2019

External Benchmarking

Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. The most recent data available is for the period 1st October 2018 to 30th September 2019.



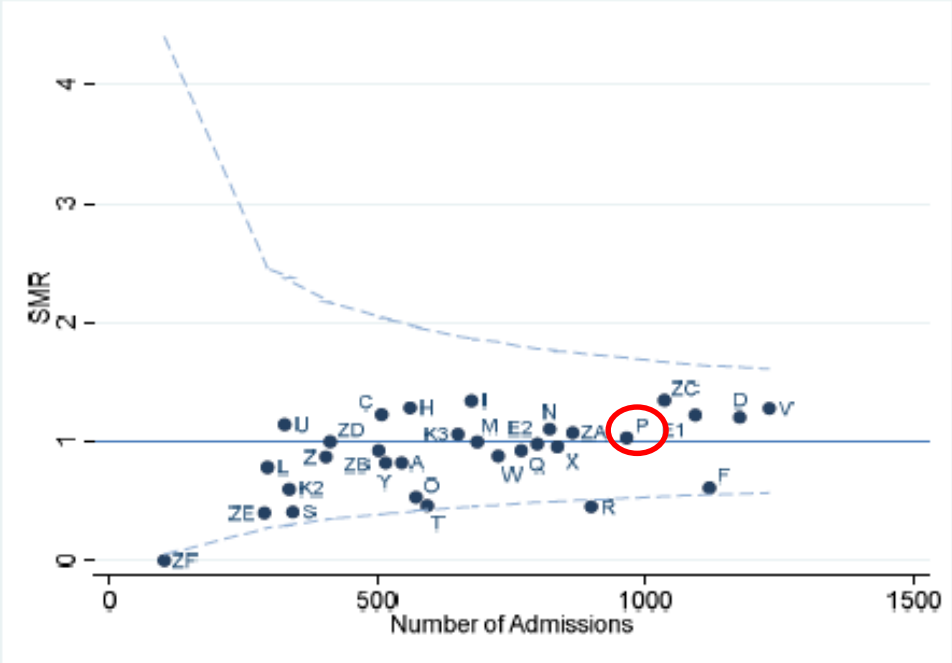
The chart shows that Alder Hey has a lower mortality level than the average NHS performance with 51 deaths against 54.1 expected deaths.

-PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other children's trusts. In the most recent PICANet report (2019 Annual Report of the Paediatric Intensive Care Audit Network January 2016-

December 2018), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.

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

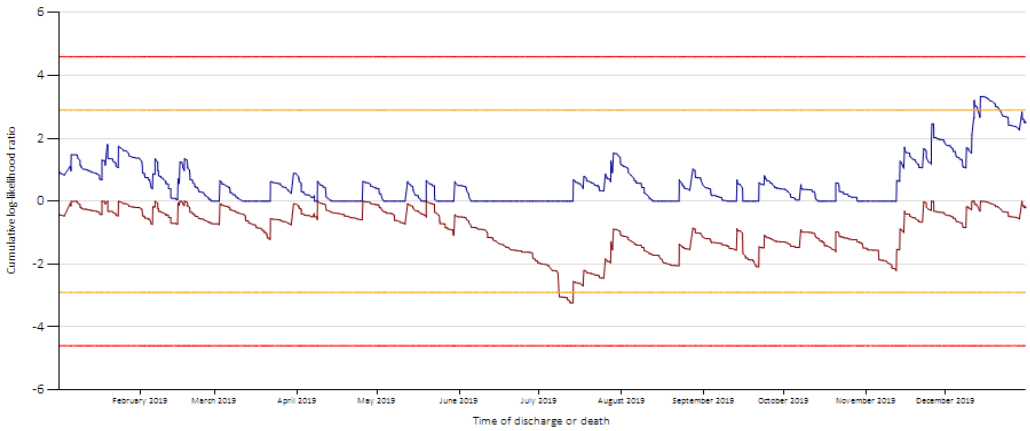


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

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

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

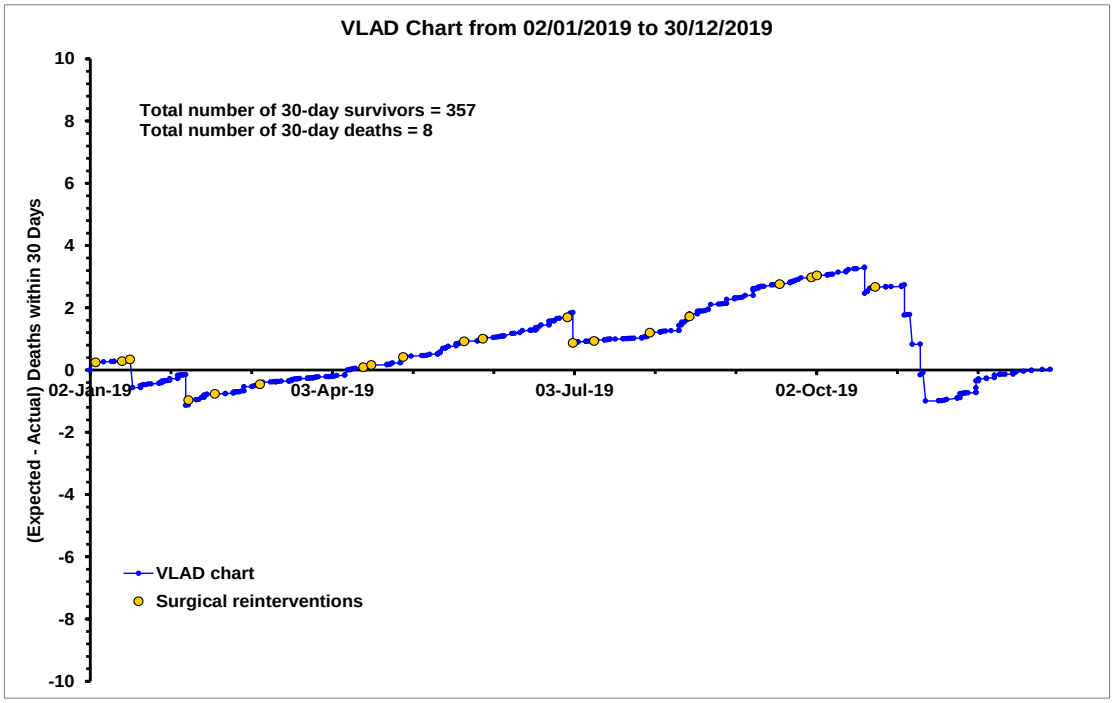


Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero. This data is nationally validated because it is generated by PICANet.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

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

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

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

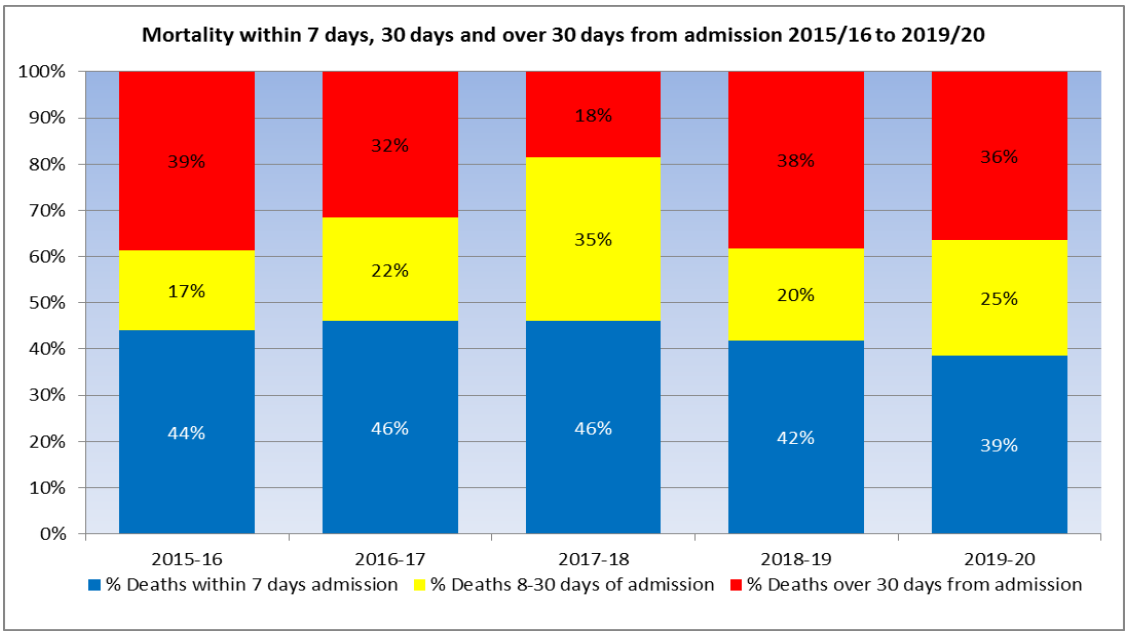


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from January 19 to December 19. The survival rate at 30 days was 97.8% against an expected rate of 97.8%.

Real time monitoring of mortality

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

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



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. In the current financial year (April 19 – December 19) 39% occurred within 7 days of admission, 25% occurred within 8-30 days from admission, and 36% deaths occurred over 30 days from admission.

Conclusion

The HMRG is functioning well, however there have been a number of challenging cases that have resulted in a few cases being not yet fully completed. Our process is robust but also needs to provide the data required to input into the national database. We need to strive to engage clinicians both internally and externally as the links with the CDOP process have changed following the guidelines. We continue to review every in-patient death in HMRG and in addition the majority of deaths have at least one departmental group review.

The process has evolved over the last 5 years or so and the percentage of mortality reviews being completed within the required 4 months has increased rapidly. As the review process has developed the communication within and outside of the organisation improved. The group has expanded to include a greater variety of people with differing roles who help to ensure the review process is more robust.

There is clearly ongoing work to continue to improve the process and increase engagement and communication across the Trust. Learning from deaths is the key goal and we are now trying to ensure that this occurs across the organisation, and with time also spreads out across the region.

References

SPMI - The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 9**

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

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 10**

PRAiS and VLAD charts - The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.
The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance. **Pg 12**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 7th April 2020

Paper Title:	**Clinical Quality Assurance Committee**
Date of meeting:	31st March 2020 - Summary 12th February 2020 – Approved Minutes
Report of:	Clinical Quality Assurance Committee key
Paper Prepared by:	Julie Creevy, CQAC Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Clinical Quality Assurance Committee meeting 31st March 2020 along with the approved minutes from the 12th February 2020 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	None

1. Introduction

The Clinical Quality Assurance Committee is a sub-committee of the Trust Board, and as such provides a regular report to the Board on the main issues raised and discussed at its meetings.

Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of quality including clinical quality, clinical practice and clinical governance arrangements and activities within the Trust.

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

The Board are asked to note that the CQAC agenda was revised, and that the committee took a number of the items as read, given the situation with COVID-19.

- Programme Delivery update
- Inspiring Quality monitoring assurance update
- SAFER closure report
- Best in Acute Care update
- Best in Mental Health Update
- NATTSIP action plan – approved
- CQSG key issues report
- Board Assurance Framework
- Corporate Report – Quality Metrics Divisional Update
- Committee Effectiveness review
- Safeguarding Annual report
- COVID 19 preparations update
- Discussion took place regarding revised quality governance arrangements being considered by the Board for the duration of the COVID-19 pandemic.

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

- Writing to NHSE/I & CCG to outline the Trust plan during COVID-19 with regards to Natssips delivery/Independent External Review with Imperial College.

4. Positive highlights of note

A positive update was received regarding SAFER closure report

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 12th February 2020
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Adam Bateman	Chief Operating Officer
	Denise Boyle	Associate Chief Nurse - Surgical Division
	Pauline Brown	Director of Nursing
	Lisa Cooper	Director - Community & Mental Health Division
	John Grinnell	Director of Finance/Deputy Chief Executive
	Hilda Gwilliams	Chief Nurse
	Adrian Hughes	Director - Medicine Division
	Nicki Murdock	Medical Director
	Tony Rigby	Deputy Director of Risk & Governance
	Erica Saunders	Director of Corporate Affairs
	Melissa Swindell	Director of HR & OD
	Cathy Umbers	Associate Director of Nursing & Governance
	Kate Warriner	Chief Digital & Information Officer

In attendance:
Agenda item:

19/20/	Phil O'Connor	Deputy Director of Nursing
	Elvina White	Care Pathways, Policy & Guidance Manager
	Julie Creevy	Executive Assistant (Minutes)

19/20/155 **Apologies:**

Shalni Arora	Non Executive Director
Alfie Bass	Director, Division of Surgery
Mark Flannagan	Director of Communications and Marketing
Dani Jones	Director of Strategy
Matthew Peak	Director of Research
Jill Preece	Governance Manager
Anne Hyson	Head of Quality – Corporate Services
Fiona Marston	Non Executive Director
Cathy Wardell	Associate Chief Nurse – Medicine Division

19/20/156 **Declarations of Interest**
None declared.

19/20/157 **Minutes of the previous meeting held on 15th January 2020**
Resolved: The minutes of the previous Clinical Quality Assurance Committee meeting were agreed as a correct record. Committee noted that in the absence SA & FM the committee was not quorate, in terms of any decision making required and that policy approval would need to be completed virtually by NEDS.

19/20/158 Matters Arising and Action Log
Action Log

19.20.74 DIPC Report – Committee noted that the discussion meeting with NM and IPC colleagues which was scheduled for 10.1.2020, unfortunately did not take place due to sickness, the meeting is currently being rescheduled.

19.20.104 **Progress from central lines review group** – Committee noted that AB had met with vascular access team in order to develop the service. AB stated that there are short term pressures. AB confirmed that there is a plan to address these pressures and he would provide a further update in due course. AB stated that discussions had also taken place with the medical and surgical lead for vascular access service, with a weekly multi disciplinary team meeting which takes place. AB stated that there is a need for a Business Case to be established, to enable an increase in resources, with the aim of enhancing resources - from 3 staff to 5 staff. AB stated that the meeting had been really positive, with significant progress made. HG stated that the nursing team fully appreciated the medical team support.

Resolved: CQAC agreed that this action would be closed and removed from the action log.

19.20.145 **CQC Insight reports** – ES stated that there are some outstanding actions which she needed to take, and that there are still many inaccuracies within the Insight report. ES stated that there is a need for EM & KE within informatics team to include formally to CQC and that ES is following up on this issue. CQAC noted that there is a requirement for a briefing/cover paper addressing highlights. ES stated that EM had raised this with analytical team in the past.

Resolved: CQAC agreed that this action is to be closed and removed from the action log**. CQAC to receive update at April 2020 meeting.**

19..20.148 **IT Sepsis –** CQAC noted this action was complete and could be closed and removed from the action log.

Resolved: action to be closed action and remove from action log

19.20.150 **Safeguarding Update** – CQAC to receive Quarterly Update at March meeting – CQAC noted that this item was on trajectory to receive update at March 2020 CQAC meeting.

Journey to Outstanding Update
ES provided update on Journey to Outstanding, key issues as follows:-
ES reported that it is currently day 2 of the CQC Well Led interviews. CQC feedback is due on the afternoon of 13th February 2020.
Majority of colleagues who had been interviewed had been given the opportunity to feedback regarding outstanding practice. No data requests had been submitted since 7th February 2020. ES reported that there were no intentions of the inspection team to speak with each of the divisions.

Quality Improvement Progress Reports

19/20/159 Programme Delivery update
JG presented Programme Delivery update – key issues as follows:-

JG stated that the report had particular focus, on Sepsis, DETECT & SAFER With a thorough deep dive/update at the previous CQAC meeting. These projects are noted as progressing extremely well, with the aim that this trajectory continues. JG stated that focus would be given at the next Programme Board in order to review Best in Mental Health and Best in Acute Care, to enable sufficient time is given for thorough discussion at Programme Board, with an update thereafter to CQAC.

JG stated that generally the Outstanding Care domain is performing well.

JG advised that overall the team are working well, with good leadership and support for complex projects.

AM referred to the Sepsis PID for 2020 with regards to sign off at Programme Board. JG stated that the Programme Board had virtually agreed the PID, however there are a couple of areas that were to be reviewed, however no major issues were raised at Programme Board, there were some streaming aspects to be addressed. HG advised that EC sits on the national group, and that international guidance had been published in January 2020, this would impact the PID, as it may result in some changes once adopted in the UK.

AM stated that the Inspiring Quality Programme concluded in November 2019 and referred to phase 2 plan now being developed – and queried whether CQAC should remain sighted on this. CQAC agreed that there is a need to review the Inspiring Quality Plan, and continue to be sighted on this issue with updates as appropriate.

AM thanked JG for update.

19/20/160 Delivery of Outstanding Care

Safe

Transition Update

NM presented Transition Update, key issues as follows:-

- Complex young people from cohort 1 on the Transition Exception Register (TER), had reduced from 52 to 28, due to the following:-
  - Seven young people had commenced on ventilation- therefore would transition to the Ventilation Intensive Care (VIC) Unit at Aintree.
  - Seven young people had sadly passed away.
  - Ten of the lesser complex young people had transitioned.
- NM reported that there had been a joint Partnership for Transition meeting with local adult care providers, which was held on 20th January 2020 with colleagues from Royal Liverpool Foundation Trust, Merseycare, representatives from Sefton CCG and Liverpool CCG in attendance, Chaired by Alder Hey's Medical Director, Transition features heavily in label1 hospital programme, which will be aired in March 2020. All in attendance at the meeting on 20th January 2020 were in agreement with the following:-
  - Cohort 1 young people should be in adult services.
  - Agreement was reached to hold 6 weekly operational meetings for working group, with 3 monthly high level meetings for Executives, with the first Executive level meeting to take place at the end of June 2020, in order to develop Terms of Reference.

- Alder Hey to share cohort 1 information and activity (this item had been completed).
- Continue transition preparation with cohort 2 young people.
- Trust had been successful with the application to Burdett Trust for Grant of £76,558 for a one year pilot of transition preparation in special school Setting. MDT approach, combined with annual health review.

NM stated that there are a number of Alder Hey patients, whereby patients are involved in research, - when follow up goes beyond the age of 18, patients go through transition clinic, NM had been asked whether patients should go onto transition register, NM stated that this felt that this was the wrong approach, and that there is a need need to ascertain a way of recognising this cohort of patients, given that the Register is for really complex children.
AM acknowledged good progress made in terms of Transition.

19/20/161 Effective

CQSG Key issues report

POC presented key issues report, key issues as follows:-

Medication Safety Report – PoC reported that the Medication Safety Officer (DW) had presented briefing paper to CQSG, which reported on an increase in reporting. The target for 2019/20 is to gain a reduction in incidents resulting in minor harm from 2018/19 and have no incidents of moderate harm or above. Initiatives developed to reduce the number of medication errors is incident reporting and awareness, education and regional/national links. A detailed list of improvements was listed within the report. As part of the dedicated work streams the Medication Safety Committee focuses on a number of high risk drugs/classes which pose a high risk to patients or have been implicated in a number of incidents. The Medication Safety Committee had confirmed that the target for the coming year is to reduce medication incidents resulting in harm by 20% in comparison to 18/19 i.e. to have less than 34 incidents reported with associated harm. DW is trying to organise a Patient Safety week. Report noted that there also needed to be extra staffing for medication safety officer. POC confirmed that there was an opportunity through Inspiring Quality for a 6 month secondment of approximately £20,000. NM questioned where the funds had been identified from, POC stated that following discussions with AG, the Inspiring Quality Budget had been identified. NM & POC agreed to follow up discussion regarding this issue offline.

Action: Offline discussion with NM/HG & POC, followed by offline discussion with NM/HG

- RD asked if there was anything the Trust could do to improve on 10 x errors and if there were any reports going to any other groups. POC stated that there had been a number of initiatives to improve the current position, educational events and regional events with national links in order to try to reduce medication errors.

  HG stated that the whole group is coming together regarding key performance indicators. HG stated that she would like the Business Intelligence Team to undertake assurance work regarding whether stretch targets are achievable and sign off. Committee noted that AG and DW to meet with NM and HG. HG explained that there is a need to link in with each of the divisions, to ensure that this is high on each of the division's

agenda. Thought is required regarding process. TR stated that once agreement had been reached regarding key priorities, that this needed to be fed back to TR as this needed to be included within the Quality Account. HG stated that information would feed into the Trust contract. NM queried who is involved in this setting. HG advised that when targets are set for the Trust, the Business Intelligence Team report with relevant contract information, colleagues and that input would also be required from the the divisions, in order to ensure alignment.

All agreed that further thought is required offline, in order to bring together a collective group.

Action: HG/NM would convene a discussion to ensure that feedback is provided regarding the agreed process at March 2020 meeting.

Hospital Mortality Report - JG, Mortality Lead, presented the quarterly report to CQSG which showed an improved position since the last report to 79%. The 6 month figure still remains very good with only 3 cases not complete, one potentially avoidable death, due to there being preventable external factors.

Concern was expressed regarding reporting through the divisions. CU had met with JG, Hospital Mortality Lead regarding concern in terms of closing the loop, during the meeting agreement was reached regarding when sending reports back to the divisions, actions plans would also be included. NM questioned whether this was the right process, and questioned whether HMRG should be tracking actions, NM stated that she didn't feel it appropriate that HMRG are tracking cases and that this should be the governance team.

HG stated that there is a need for a electronic reporting system, in order to capture actions. HG & NM agreed that an offline discussion is required, as there would be a number of issues which would be cross divisional, however there is currently no central hub whereby actions are tracked. HG advised that she is aware of ongoing discussion regarding the creation of M&M module in Ulysses.

Action: offline discussion required with HG, AB and NM.

AH sought clarification regarding divisional reporting, - POC confirmed this is same issue. In terms of shared learning, as majority of issues are cross divisional. CU stated that some of the learning could be transferable, however there is a system needed, in order to ensure trust wide learning. AM stated that learning is a common theme.

HG stated that this is very labour intensive for colleagues. All agreed beneficial for offline meeting to take place, in order agree potential process.

NATSSIP report – POC stated that the Trust had, and continue to receive some external commissioner high level scrutiny regarding lessons learned, process etc. NM, HG & PB undertaking ongoing work on NATSIPs. HG stated that there is a large piece of work continuing with a number of meetings scheduled. NM and HG are due to meet on the afternoon of 12th February 2020, to establish key operational leads and processes. A further meeting is scheduled with NHSI and NHSE on 26th February 2020, with

NATSSIPs also included on the Specialised Commissioners agenda. Both HG & NM are fully sighted on this.

Action: CQAC to receive detailed update from NM & HG at March 2020.

JG, stated that the way in which the report had been written, was extremely helpful in order to ensure clarity of issues raised.

19.20/162 Well Led

Board Assurance Framework
ES presented the Board Assurance Framework update.
ES stated that the committee was good at receiving substantial assurance, on high level risks, and questioned whether the committee should receive a update regarding any residual high risks, in order for the committee to benefit from discussion of those risks, in terms of the impact of those risks. ES stated that the Community Division had continued to address and improve on ASD waiting times. Committee agreed that a future update on bleeps would be beneficial in order to provide assurance regarding safety, in terms of patient's survey. CQAC agreed that it would be sensible to ensure that the committee are sighted on these items and looked forward to receiving a detailed update for next meeting.

Action – Update on residual risks to be received for next meeting

HG advised the committee of successful international recruitment drive which was extremely successful, with 25 new international staff recruited, these staff would predominantly be placed in surgical ward, PICU, HDU. Staff will have a comprehensive support package in place, in order to provide HR support, support with travel arrangements, whole package to support newly recruited staff, including accommodation and banking facilities. CQAC agreed that they would receive a detailed update at March 2020 meeting.

Action: International Recruitment update to be received for next meeting.

ES stated that CQC colleagues had requested information regarding never events, and assurance. HG stated that that the consistent question related to 'what are top 3 risks', and 'how it applies to individual areas of work.

AM stated that the committee regularly discuss BAF and queried whether anything had emerged. EM stated that it was important to ensure the discussion regarding BAF is correct.

CQAC received and noted the Board Assurance Framework.

19.20/163 Corporate Report – Quality Metrics

Divisional Leads presented the Corporate Report – Quality metrics, key issues as follows:-

Surgery Division
DB presented key issues for Surgery, key issues as follows:-

- 1 never event -15 year old patient - dental extraction, 1 baby tooth, impacted tooth and unruptured tooth, wrong tooth was removed. RCA had

been undertaken, DB is currently in the process of quality checking, lessons learnt to be shared as appropriate.

- 2 moderate harms, - 2 year old patient with a chest drain, the chest drain come out whilst in recovery, resulting in child receiving a further anaesthetic. The second incident of moderate harm related to a neonate who had IV infusion, team are currently undertaking a RCA level 2 to fully review circumstances in this case.
- No grade 3 or 4 pressures ulcers, or no other serious incidents to note.
- Sepsis – 60% sepsis regarding 2 children being actively treated 29 mins over target, child unwell and needed IV bolus, child was being managed. Other child had received antibiotics 19 mins over the time limit, staff needed to gain further IV access, child on TPN, drug prescribed, wrong dose, new dose prescribed and rewritten. HG stated that rather than delay medication why the team didn't move to IM, DB agreed that she would establish the background detail to ascertain the reason why the treating team didn't move to IM. Or child who was really sick could have IO. Escalation through IV team – DB would ascertain whether urgent referral was sent to appropriate team.
- 6 complaints received in November 2019, which is same as in December 2019. No themes to note, PALS had reduced in December 2019. DB stated that the team would be reviewing this further, to ascertain any underlying reasons.
- Friends & Family Test - patients involved in learning responses had been low, the Division had now started to see an increase and responses equate to 87.7%. HG stated that she had met with the onsite school Headmaster who provide education provision. Headmaster confirmed that there is criteria, involves length of stay, all are in line with Educational arm. Headmaster had provided specification. HG had shared this with the volunteer group who undertake Family & Friends Audit. HG stated that the team
  may want to review further to ensure that the team are asking the correct questions to the correct cohort of patients. HG stated that the report received from the Headmaster stated Ofsted is 100%. AM stated that this is good progress.

Community & Mental Health Division

LC presented Community & Mental Health Division Report, key issues as follows:-

- No pressure ulcers, no moderate or severe harm incidents.
- 1 complaint due to time of year. PALS stayed at decreased level of 21.
- All complaints related to community paeds, ADHD & ASD, with detailed action plan in place.
- Feedback scores had decreased in community and mental health, with issues regarding CATKIN building and access. Significant improvement had been made during January 2020, still a couple of outstanding issues, regarding the need to maintain robustness of building, LC stated that the weather not helping, however CQAC noted a much improved position.
- Children designs had been finalised. Children being videoed for star awards, and had agreed a set of designs which should be displayed within next couple of weeks. LC stated that JG is aware of issues regarding CATKIN building.

Medicine Division

AH presented key issues within Medicine Division, key issues as follows:-

- No never events
- No grade 3 pressure ulcers
- Treatment sepsis - 100% in December 2019
- ED - 77% in December 2019, which is monitored through weekly comm cell, Division are hoping to see further improvement in due course.
- 113 incidents in December 2019, 70 no harm, 22 minor harm, 1 severe harm reported in December 2019.
- Incident themes relating to medication errors - 31, 1 with harm resulting in double dose of medication for an oncology patient.
- Increase in verbal abuse, with a significant number which related to one patient, who is being actively managed.
- 2 complaints received, 19 PALS, AH stated that the division would focus on improving on complaint response times, in order to further improve response times.
- Effective, - ED remains a significant challenge, in December 2019, 4 hour waiting time increase, compliance increased significantly, action plan in place which is supported by Executive colleagues, and is organisationally supported by division, in order to support ED through current challenges.
- Responsive – Division had seen an improvement regarding patients involved in learning. 1 cancer target, 2 week referral to be seen, had breached as mum had declined the appointment, child was seen the next day.
- Well led – significant progress had been made regarding managing the risk register with 0 out of date reviews.
- HG referred to linking back to next year's KPI's with regards to the Friends and Family Test, as the Trust are not using national methodology, in terms of targets. HG is working with Business Intelligence Team to understand national methodology, most are over 90% with our Trust set an internal stretch target to 100%. Further thought is required regarding how the Trust plans the internal stretch, to ensure correct balance.

  AM stated that this had been a long standing issue, and that the Trust should be aiming to 100%, however CQAC fully recognise that this can be portrayed and interpreted in a different criteria to other Trusts.

  JG stated that it is worth focussing on never events and plans for the future and stated that it would be helpful for CQAC to receive detailed update at March 2020 meeting. HG stated that over a period 18 months there had been a collection of 7 never events, with first cohort related to anaesthetic block, which resulted in an aggregated review, followed by a Quality Summit, which reviewed never events. The Trust had since had a further 2/3 never events which had all had the correct investigations and duty of candour processes followed. HG stated that the Trust had engaged with appropriate colleagues from other acute organisations. HG stated that there is external scrutiny. All 7 cases resulted in no harm. NHSI/NHSE are seeking assurance, to confirm that the Trust had undertaken a deep dive. HG & NM are currently working through the process. HG confirmed that assurance had been provided to regulators and confirmed that an external review would be commissioned. HG stated that both herself and NM would agree on who would be commissioned to undertake the external review. CQAC acknowledged that there is a need for a clear message externally, with the need to commission external support in terms of systems, process, compliance with audit and any learning to be incorporated into plan.

NM stated that in order to provide training for staff, a half day is provided every month for clinical staff/medics and that the session scheduled for March would focus on never events and fully engaging colleagues.
AM stated that there were a set of circumstances which led to the Quality Summit, which resulted in a full and frank summit, with an action plan agreed. CQAC could have confidence that never events would be addressed, with external support.

AB queried for rigour and completeness, whether the action plan would be shared at CQAC. Committee agreed that the action plan should be shared at CQAC, and should form part of CQAC workplan, to receive regular updates.

Action: CQAC to receive first draft of action plan and ongoing systematic update. Initial work completed, should be incorporated into CQAC work plan.

CQAC agreed that this should also be shared at Board of Directors meeting at its March 2020 meeting.

KW stated that this is wider than NATSIPs compliance, and that it should not relate only to Surgery, and that wider oversight would be helpful.

JG stated the need to review associated timelines. Committee agreed that significant trust wide work is required, whilst noting that most Trusts have dedicated resource for NATSSIPS and LOCSIPS.

19/20/164 Quarter 3 Complains Report

PB presented the Quarter 3 Complaints Report, key issues as follows:-

- Comparison of timescales, compared to this time last year, 28 this period, with 26 for the previous period, themes regarding treatment procedure being the highest theme, with consent behind this at 9
- Example of 2 complaints, Complaints by division by quarter, shift for surgery compared to last year, likewise medicine division with considerable decrease.
- Reporting against 3 day acknowledgement - 27 out of 29 responded within 3 days. 2 were answered on day 4 – due to administration error, PALS team are sighted on ensuring prompt response.
- Response time – Medicine Division identified as an area of targeted work in order to improve response times. Ongoing work regarding 25 day reporting, as it is important to answer families as quickly as possible, PB stated that some cases are particularly complex and due to the complexity can take longer to respond to, the Trust always offer the opportunity for families to meet, this can impact deadline. Unless family explicitly say that they do not require a formal written response, the Trust would still respond to a family ahead of any meeting.
  Targeted work to take place in order to reduce timeframes.
- Two complaints had been withdrawn.
- From 28 complaints, 16 complaints were upheld, and 7 complaints were not upheld. Looking at data, this Trust are the highest number of complaints which are upheld, with the Trust always breaking down elements of complaints, ensuring a great deal of rigour which is applied to all elements of complaints.

HG stated the difficulty, as there is a requirement for annual return, PHSO would publish complaints report from, however the report doesn't give the option to articulate partially upheld complaints.

- HG stated that NEDs throughout the year receive a collection of responses to review complaint data as a quality assurance independent check. PB stated that one of the issues that impact the delay is the quality checking process.
- Three complaints were being reviewed by PHSO. PHSO had been on site late last year regarding longstanding case.
- Importance of lessons learned from complaints. Incident regarding chest drain, significant work had been completed regarding standardisation, reviewing policies and procedures, and training for staff.
- Family had attended an Integrated Governance meeting, in order to share patient experience, learning and training within CLEFT team. RD asked whether this needed to be included or reference made in internal reports.
- PALS contact - a decrease of 31.
- 4 compliments received. Compliments are recorded on ULYSSES, whilst compliments had also been shared at Patient Safety meeting, need to increase number of compliments that are uploaded onto system. LC stated that there is a need to further validate the number of complaints received, given the Trust had received 51 previously.

19/20/165 Chaperone Policy

PB presented the Chaperone Policy.

Chaperone Policy is a new policy. PB confirmed that in practice Chaperoning is not new in the Trust and had been around for a long time. Chaperone Policy had been created to ensure context, based on national guidance from GMC, RCN and NMC, Chaperone Policy aims at equal measure to safeguard children & young people and staff, and ensures equal balance.

A working party had been established for some time. Chaperone Policy is based on Cambridge policy, and had been made into workable process for Alder Hey. The Chaperone Policy had been through policy ratification group, and had received executive approval from HG and NM. Working group continue to implement policy. Communication next step, with scoping regarding impact and potential implications with appropriate resources. Training would be imperative for staff. PB confirmed that for informal chaperone, that not a significant amount of training would be required. More training would be required for intimate examinations, to ensure clear understanding and clarity regarding expectations. PB stated that she is attending C&YP forum to obtain children's and young people comments, and seek support regarding use of Apps, posters etc. Clinic letters – PB stated that there is significant work to do following implementation of Chaperone policy.

HG stated that there needed to be the wider discussion; there are national cases, and lot guidance in professional world. NM referred to engagement and asked for clarity regarding C&YP if wide engagement and consultation had already taken place and queried the reasoning for attendance at C&YP Forum. PB confirmed that her attendance at C&YP Forum was to discuss the promotion of communication. All agreed that this was a significant cultural shift, with engagement for the forum regarding resources in order to promote.

JG alluded to PB earlier example regarding a difficult case and sought clarity on process when family decline for child to be chaperoned. PB stated that the Policy details process if child refuses to be chaperoned and stated that it is vital to clearly document information. PB stated that if there is refusal to be chaperoned, the team would look to reschedule a new appointment, and that only in an emergency situation staff would colleagues proceed with examination, colleagues would ensure clinical colleague is present. PB stated that there are a number of colleagues who undertake appropriate training to undertake treatment, with some exceptions, i.e. self-catheterisation. JG questioned process if refusal issue cannot be resolved, if child or family do not want a chaperone and the need for the organisation being very clear and articulating expectations. To proceed in an investigation when child or young person has refused, could be a situation staff member is put in vulnerable position, equal rights for all involved. If staff member feels chaperone is needed it is staff members right to have chaperone. JG stated that there is a need for a clear escalation process within the policy, to refer to in these cases.

PB stated that the Policy refers to risk assessment regarding deferred appointment.

Action: Agreed it beneficial to include escalation narrative to further enhance the policy and provide clarity of process to be followed when refusal is made.

TB stated that as a new policy, queried whether standard documentation could be incorporated within meditech, and queried whether this could also be used as an audit tool.

CQAC all agreed that the Chaperone policy is very detailed.

AM stated that given that the Policy had been signed off by two executives, CQAC were content to ratify the policy, whilst noting the requirement for SA to provide virtual ratification/approval offline.

Action: SA to provide virtual ratification/approval, whilst noting that the narrative would be strengthened to provide clarity on the process in terms of the process to be followed when refusal for chaperone to take place.

Resolved: Committee were content to ratify the Chaperone policy, subject to the above, and subject to receiving virtual ratification from SA.

19/20/166 Clinical Audit Policy

EW presented the Clinical Audit Policy. Clinical Audit Policy had been slightly updated, with minor amendments with regards to timeline for escalation process which had been changed from 4th week to 3rd week, and that the contact list is now separated into those who are sent an email and those who are copied into the email.

Escalation goes to Associate Medical Director, Chief Nurse, Clinical Director for specialty and Clinical Auditor and lead for specialties. Had been operating process for last few weeks. Policy had received a positive response. Divisions are aware, people can update the date if things take longer and date can be

extended. There is flexibility. In an improved position for Quality Account.

Action: CQAC agreed to ratify policy, subject to SA virtual approval.

ES stated that there is a need to be pragmatic – CQAC noted this process is happening in practice, with no clinical change. HG stated that this could be uploaded on the proviso that virtual approval is awaited from SA & FM. CQAC agreed to this approach.

Committee noted that 1.5 refers to 'Monitor' and that this needed to be replaced with NHS Improvement.

Action: ES and JG to undertake a discussion with KB regarding audit alignment and how audit is referenced.

AM stated that through a request via Chair that communication is vital between NEDs in order to ensure future CQAC meetings are quorate and that NED attendance is vital.

Resolved: Following receipt of the Virtual ratification from SA the Committee were content to ratify the Clinical Audit Policy.

19/20/167 Any Other Business

Review of meeting

AM asked CQAC whether they had any comments following the meeting, all agreed that good discussion had taken place and correct actions made with extremely informative information provided.

All agreed that Board of Directors needed to be sight on delivery plan for NATSIPs.

18/19/162 Date and Time of Next meeting

Wednesday 18th March 2020, Tony Bell Boardroom, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

Section 1

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
10th December 2019

Present:	Ms C Dove	Non-Executive Director (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
In Attendance:	Mrs P Brown	Director of Nursing (Deputy for Chief Nurse)	(PB)
	Mrs S Owen	Deputy Director of HR&OD	(SO)
	Ms A Chew	Associate Finance Director	(AC)
	Mrs J Potier	Associate Director of OD	(JP)
	Ms E White	Care Pathways, Policies & Guidance (Part Attendance)	(EW)
	Mrs H Ainsworth	Equality & Diversity Manager	(HA)
Apologies:	Mrs H Gwilliams	Chief Nurse	(HG)
	Ms L Cooper	Director of Children & Young People - CAMHS	(LC)
	Mrs N Murdock	Medical Director	(NM)
	Mr P OConnor	Deputy Director of Nursing	(POC)
	Mrs Kerry Turner	Trust LiA Lead	(KT)
	Mr Ian Quinlan	Non-Executive Director	(IQ)
	Mr Adam Bateman	Chief Operating Officer	(AB)
	Mrs G Thomas	Apprenticeship Delivery Manager	(GT)
	Ms N Deakin	Change Programme Manager	(ND)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/103 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 13th November 2019 and they were approved as an accurate record.			
19/104 **Matters Arising, Actions**	**The Committee considered the following under matters arising, any actions not mentioned will be progressed as part of today's agenda or brought back to a future meeting:** **17/21 Programme Assurance/Progress Update** MKS advised there is no update on this occasion. The DMO have been supporting the development of the CQC 'Road to Outstanding' Project plan. An update will be provided at the next meeting. **19/51 Modern Slavery- 15/08 & 16/02 Develop Values in Procurement** CD advised this action will be picked up in the new year and acknowledged that the Trust			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	needs to aspire to Government processes relating to suppliers and put in place parameters around processes at the Trust. A meeting will be arranged in the new year to progress with Finance/Procurement			
19/105 **Progress Against the People Strategy**	**Marketing & Communications Engagement at Alder Hey Report** The Committee received the Report prepared by the Director of Marketing & Communications. The report is noted as read. MF gave a summary of the activity that had taken place throughout the year with a more formalised process in place. Particular attention was brought to the future plans. The Marketing & Communications Team are now basing staff engagement/communications plans around three core parts of one whole: a Communications Cascade process; a Core Message Guide; and an Annual Communications Calendar. At the request of MKS, wellbeing events are to be included in the Communications calendar (flu campaign etc.). MF advised that the Communications calendar will be completed end of January 2020 and following this will be reviewed at Trust Board each November. CD advised that it is a tough time for many at Xmas i.e. domestic abuse and suggested that the Trust should be signposting appropriate support measures if anyone requires support. Further to this is the challenge of attracting the BME workforce – comms input will be required – to be progressed by CD next year. The Committee **noted** the progress made.			
19/106	**Mandatory Training** The Committee received a report prepared by the Learning & Development Manager. The report provides an update on the current and recent mandatory training compliance trends and areas of focus at the Trust. The purpose of the report is to provide assurance to the Committee. The report is noted as read. In the absence of the Learning & Development Manager, the Deputy Director of HR&OD updated the Committee on progress to-date. The Trusts overall Mandatory Training compliance has been above the 90% target now for the last 6 months, remaining at a consistent 91% compliant throughout this period. Despite reaching the overall target, there continues to be subjects where compliance does not meet the 90% target and also pockets of staff where compliance is lower than 90%. SO advised that the Learning & Development & HR teams are focussing on this group and are in the process of producing an action plan to support increased mandatory training compliance, this will be brought back to the February 2020 Committee. MKS advised that the Medical Director and Divisional Directors have been fully involved in processes to support this. The Committee discussed the various initiatives to support increased mandatory training compliance of this group. A staff communication will be issued this week.	Mandatory Training action plan for Medics	SO	February 2020

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **noted** the progress made.			
19/107	**Staff Survey** The Committee received a report prepared by the Associate Director of Organisational Development. The purpose of the report is to inform the Committee of the progress made to support an increase in completion rates along with the plans put in place to support feedback processes and improve staff experience within the Trust. The report is noted as read. JP advised that the annual Staff Survey window closed on the 29th November 2019. Initial response rate is looking like 62% across the organisation. The final completion rates for Trusts, divisions and departments will be confirmed by our provider Quality Health by the 13th December, with full results due at the end of January 2020. Particular attention was brought to staff that do not have access to a computer and the effort that had taken place to support this and see increased response rates (Porters). JP advised that we are currently exploring a number of different formats for presenting the results data back to divisions and departments to support them in having 'Big Conversations' with their areas, this will help them to identify how they can improve as an area over the next 12 months. Overall Trust themes; both positive and negative will be identified to celebrate success and identify areas of improvement to form the Trust action plan for 2020. MKS advised that our comparator group will change this year to Acute and Community combined Trusts. In the past we have been compared to specialist acute Trusts. Both CD and MKS formally recorded their thanks to all staff and teams involved with this yearly project. The Committee **noted** the information received.			
19/108	**Staff Advice & Liaison Services (SALS) Proposal** The Committee received a report prepared by the Associate Director of Organisational Development. The purpose of the report is to outline the proposals to develop a staff advice service at the Trust. The report is noted as read. JP gave an overview of the proposal and reflected on a staff advice service that performs well at the West Mids Ambulance service. JP acknowledged there is a range of support services at the Trust, however there are still parts of the organisation that don't access these services or face barriers in accessing services available. An enhanced staff support system is proposed to provide advice, guidance and support on a range of domestic and work related issues to complement the support systems already available. The system will combine the best of the staff support currently on offer in the organisation with a number of new elements to bring about the consistency and ease of access that would make staff support at Alder Hey outstanding.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	JP outlined the current benefits that Alder Hey have with a range of support for staff delivered across a number of different services and recognised that many staff continue to struggle despite the support available. The key issues for staff are: not understanding what is wrong, as often what is wrong is a complex mixture of work-related and personal issues; barriers to support – created by perception of what different services are for; insufficiency and inconsistency of provision available to all staff and lack of emphasis on early intervention and prevention. JP proposed that what is needed, therefore, is a single service that offers ALL staff ease of access to advice, guidance and support that empowers them to quickly find the right solutions to the problems that they face and enables them to deliver the work and care that they aspire to as members of the Alder Hey community. JP outlined the proposals for the development of SALS, a service run voluntarily by staff for staff (advisors/peer support), with emphasis on a range of early intervention/signposting for advice. The Committee had an in-depth discussion with the following observations/ concerns/suggestions for progression: • Concern about skill levels of volunteers, ensure stringent vetting process in place • Look at costs - business case - If the service is required, why would it not be supported financially. • The Committee acknowledged it was more of a signposting to the support that is already available and that also, it seems to be the right thing to do. • SO is looking at what other trusts have in place. Neybar has been introduced by a number of Trusts as an employee benefit to help improve financial wellbeing in the workplace. • HA reflected on the Networks and recognised that SALS would be beneficial alongside such networks as BME/Disability Network/LGBTQI+. • LiA – has been empowering staff across the organisation to make changes in their working lives – along with other work underway from various individuals and teams to support staff. Much of this work is now captured by the Health & Wellbeing Group. SALS would at the minimum provide a “brand” and virtual home for all of these interventions. • MF advised of 'helpline' type of service supplied by an external provider, available to staff at previous organisations he had worked at (counselling/legal advice). Suggested it should be part of the strong foundations pillar as is as important as the capital model. The Committee approved the proposal in principal and requested more detail. MKS advised that the next step will be to produce an action plan, outlining all the different elements of SALS proposal, this will be followed by a pilot. CD suggested that any financial advice put in place, should be run as a separate entity.	Produce a SALS action plan	JP	26th February 2020

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/109	**Reciprocal Mentorship Programme (RMP)** The Committee received a presentation from the Equality & Diversity Manager. The purpose of the presentation was to outline the implementation and progression of the mentoring programme launched earlier this year (piloted by the Liverpool University Hospitals and the Walton Centre). It was agreed that the presentation will be issued to the Committee for information. HA gave a short overview and outlined the matching process and meeting recommendations. HA informed the Committee that she appreciated having the support of the Learning & Development manager with the programme. The Committee received feedback from Directors of Marketing & Communication and HR&OD; both advised it was a good piece of work and a fantastic programme. Following completion of the programme, HA advised that affirmative responses was received by participants to the evaluation questions asked. HA advised on next steps, i.e. agree improvements based on all evaluations (inclusive of Liverpool University Hospitals and the Walton Centre) and share stories; a re-launch will take place of RMP in April 2020. CD made a couple of observations, the pen pictures issued for pairings (some are good and some may not be so good) – maybe look at a 'speed-dating' type of pairing process. Values framework – look to embed into the meeting process. The Committee **noted** the content of the report.	Issue the RMP presentation to the Committee	JF/HA	ASAP
19/110 **Key Workforce Risks – Review Of top Workforce Risks action planning against most significant risks**	**BAF Assurance Framework – November 2019** The Committee received a regular (BAF) report under the Strategic Objective 'The Best People Doing Their Best Work'. The report is noted as read. No questions were raised. MKS updated the Committee on recent discussions that had taken place to review the strategic risks for the Board in the context of Our Plan, the refreshed strategy to 2024. MKS advised that the 'pillars' had been discussed relating to workforce risks with the following developments: • Staff Engagement Risk will be developed further as a Staff Wellbeing risk • Equality, Diversity & Inclusion – everyone agreed this risk was important and will remain on the BAF • Workforce Sustainability – this risk will be reviewed in light of recent Board conversations; and will reflect risks to availability but also the development and support for staff MKS advised that a refresh/review of workforce risks will take place for the new year.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **noted** the content of the report.			
19/111	**Key Workforce KPIs – November 2019** The Committee received a regular report prepared by the Deputy Director of HR concerning the key KPIs relating to workforce monitoring for November 2019. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. SO and MKS acknowledged, and apologies to the committee that an incorrect report had been issued to the Committee. The correct version to be issued to the Committee. The Committee **noted** the comments made.	Issue the correct version of this paper to the Committee	JF/SO	ASAP
19/112	**Workforce Risk Report October 2019** The Committee received the Human Resources Risk Register prepared by the Deputy Director of HR. The purpose of the report is to outline the internal monitoring processes for risks and the actions taken to reduce the risk. SO acknowledged that nothing had changed from the previous report. However, following a HR Risk Register meeting that took place on 9th December with the Human Resource leads a full review took place and risk assessed, a further 7 or 8 risks have been identified. Updated HR risk register will be brought back to the Committee. The Committee **noted** the content of the report.	HR Risk Register as a standing agenda item	SO	Feb 2020
19/113 **Sub Committee Minutes**	The Committee received the minutes for the following for information. • LNC 30.07.2019 • JCNC 24.10.2019 MKS advised that the concern relating to pensions and clinicians has been discussed at LNC and a presentation had been taken Board, more information continues to be received from NHS leaders and MKS will be keeping the Board abreast of developments. The Committee **noted** the content.			
19/114 **Legislation, terms & conditions, employment policies/EIAs – review & ratification/approval.**	The Committee received the following policies and Equality Assessments for formal ratification/approval. The Committee attendees noted that WOD was not quorate. MKS advised that she had referred to the Director Corporate Affairs for guidance as to the protocol in this instance. As approval was given by all Committee attendees, it was agreed to obtain virtual approval from the Non-Executive not in attendance (IQ).	Send to Non-Exec for virtual approval	MKS/JF	ASAP

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee reflected on what had taken place to support the progression of policies. • Equality, Diversity & Human Rights • Professional Registration • Stress Policy The above policies have been progressed through the Policy Review Group (PRG). • Violence & Aggression The Committee noted that the above policy had not originally been progressed through PRG as not classed as a specific workforce policy. PB advised that the policy is more clinical focussed. Following cancellation of the Health & Safety Committee due to unforeseen circumstances, the policy was issued virtually to the Committee attendees and feedback incorporated into the policies. MKS advised that a meeting be arranged with HR and Staff Side colleagues to finalise any updates if required. • Control of Contractor • Arson Prevention • CCTV Policy • Estates Maintenance Following cancellation of the Health & Safety Committee due to unforeseen circumstances, the above policies were issued virtually to the Committee attendees for feedback. No feedback was received virtually. SO referred to the Control of Contractors policy and advised there was one small change relating to DBS, conversations have commenced with the Head of Building Services. SO to send the changes onto EW – Policies & Guidance co-ordinator. The Committee **approved** the policies and equality assessments.			
19/115 Board Assurance	The Board Assurance Summary was discussed and completed for submission to the next Trust Board in December 2019.			
19/116 AOB	The Chair thanked the Committee for their contribution to this year's WOD and acknowledged that we have moved on considerably this year. **International Recruitment** The Committee received a verbal update from the Director of Nursing on the recent nurse			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	recruitment process that took place in India. 155 interviews took place, standard of applicants was high with ICU/Neonatal experience. Looked at attrition rates and plotted requirements over the next 18 months. 25 to be deployed next year. A meeting will take place on 11th December to look at how the recruited nurses can be supported following lessons learned in the past.			
Date of Next Meeting	**Monday 2nd March 2020, 3pm-5pm, Venue Tony Bell Boardroom, Institute in the Park**			

Action List

Minute Reference	Action	Who	When	Status
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Noted on 19/09/2019 that DMO support is in place for this ongoing action.	ND MKS		Ongoing Ongoing
People Strategy Overview & Progress Against Strategic Aims				
	Modern Slavery			
19/51	Liaise with Head of Procurement to progress processes, noted on 19.11.2019 that this is linked to 15/08 & 16/02, government process to be progressed.	MKS/CD	Ongoing	Ongoing
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CD	Ongoing	Ongoing
	Equality & Diversity			
17/13 19/68	• Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee • WRES/WDES Updated Plan	HA HA/SM HA	1/4ly Update 6 monthly Review	Ongoing Ongoing
	Education Governance Update			
18/38	• To be a regular item on the Committee Agenda.	HB	Agreed May 2019	Ongoing
19/91	• Update on HEE action plan	HB	February 2020	
	Nurse Associate Recruitment			
19/69	Develop a wider plan	Vikki Hughes	February 2020	
	Mandatory Training & CQC			
19/73	To be standard agenda items going forward	MKS/JF	October 2019	Ongoing
19/106	Mandatory Training Action Plan	SO	February 2020	
	Sickness Absence			
19/93	Update on progress of embedded new process.	SO	February 2020	
	Apprenticeship			
19/90	Update on framework	GT	February 2020	
	Reciprocal Mentorship Programme (RMP)			
19/109	Issue the RMP presentation to the Committee	JF/HA	ASAP	
Key Workforce Risks				

19/61 **19/80**	• Update the narrative on key workforce risks • Produce an updated leavers flowchart • Action from Integrated Governance Committee to be brought to next meeting	SO SO/MKS SO	September 2019 September 2019 October 2019	Complete September/October
19/111	Issue the correct version for November 2019	JF/SO	November	
	BAF			
19/95	• Review workforce sustainability risk, prior to new Trust board	MKS	December 2019	Complete

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 8th April 2020

Paper Title:	**Resource and Business Development Committee Assurance Report**
Date of meeting:	25 March 2020 – Summary 26 February 2020 – Approved Minutes
Report of:	Ian Quinlan, Committee Chair
Paper Prepared by:	Amanda Graham, RABD Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent RABD Committee meeting 25 March 2020 along with the approved minutes from the 26 February 2020 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

1. Introduction

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

Under its terms of reference, the Committee is responsible for reviewing financial strategy, including workforce strategy, performance organisational and business dev elopement and strategic IM&T issues whilst focussing excellence in quality and patient centred care.

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

Committee agreed to focus discussions on the context of COVID-19 and the impact that will have on our key objectives and revised financial and governance arrangement

- Neonatal Unit update
- Cluster / Dewi Jones Unit update
- Finance Report including updates on M11
- COVID-19 Financial Governance Arrangements
- COVID-19 Capital Approvals
- M11 Corporate Report
- Top Risks / Key Priority Areas

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

- Addendum to Neonatal Business case to be brought to April RABD and May Trust Board – some delay due to operational pressures related to COVID
- Focus on ensuring an affordable fixed price is agreed with the contractor for the Dewi/Cluster. Recognition that on-site works highly likely to be delayed due to COVID.
- Year-end position, in particular agreements reached with commissioners and the additional cost of COVID and the associated reimbursement model.
- Detailed discussion regarding new COVID financial arrangements which signal a fundamental shift in approach (to be discussed in detail at Trust Board).
- Capital approval for £1.8m central COVID funding for short and medium term enhanced isolation facilities
- Recognition that wider governance arrangements need to be developed and approved by the Trust Board in relation to managing COVID.

4. Positive highlights of note

- Exceptional response to COVID-19 crisis by staff

5. Issues for other committees

- Audit Committee to note revised final accounts timetable (COVID related)
- Trust Board to recognize impact of COVID on:

- Campus programme
- Revised governance arrangements
- Revised Financial payment mechanisms

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Draft Minutes of the meeting held on Wednesday 26 February 2020 at 9:30pm in Tony Bell Boardroom, Institute in the Park

Present	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Adam Bateman	Chief Operating Officer	(AB)
	John Grinnell	Director of Finance	(JG)
	Claire Liddy	Director of Operational Finance	(CL)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Digital & Information Officer	(KW)
In attendance	Amanda Graham	Committee Administrator (*minutes*)	(AG)
	Rachel Lea	Associate Director of Finance	(RL)
	Sara Naylor	Associate Director of Finance	(SN)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Mark Flanagan	Director of Communications	(MF)
	Stuart Atkinson	Associate Director Estates	(SA)
	Sue Brown	Associate Development Director	(SB)
	Natalie Deakin (part)	Change Programme Manager	(ND)
	Graeme Dixon (part)		(GD)
Apologies	Claire Dove	Non-Executive Director	(CD)
	Dani Jones	Director of Strategy	(DJ)
	Nicki Murdock	Medical Director	(NM)
	David Powell	Development Director	(DP)

19/20/152 **Apologies**
The Chair noted the apologies received from Claire Dove, Hilda Gwilliams, Dani Jones, Nicki Murdock & David Powell.

19/20/153 **Minutes from the meeting held on 22nd January 2020**
Resolved:
The minutes from the meeting held on the 22nd January were approved subject to correct recording of attendees.

19/20/153 **Matters Arising and Action log**
There were no matters arising. The Action Log was updated.

19/20/154 **Declarations of Interest**
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There were no declarations of interest.

19/20/156 **Update of Tariff**
RL presented a recap of history of Children's Tariff changes & the impact on underlying position from November 2018. Following a recent meeting with the regional team, the Trust have lodged a request with NHS E&I for assistance with resolving the funding gap.

JG gave an update on the Children's Alliance recent meetings which have resulted in a project plan and joint piece of work with NHS E&I, due for completion Summer

2020. The previous tariff model works best with high patient numbers and less well with the lower numbers of more complex cases and highly specialised work experienced at Alder Hey. The tariff was also built on an adult model and based on prescribed timescales as against the constant care for a child's stay, high cost of very young patients and increasing longevity of patients' care. There has been a positive feeling from conversations so far and regular updates will be brought to RABD.

ACTION: Monthly updates to be brought to RABD (JG)

19/20/157 Green / Sustainability Strategy

The Committee received a presentation within the meeting pack on the Green / Sustainability Strategy that has previously been given at Trust Board.

19/20/158 Brexit Update

The Committee received a verbal update on Brexit. The Brexit Bill was passed into UK law and then passed into EU law. Subsequently the United Kingdom is no longer a member of the European Union but is still part (subject to certain rules) of the Customs Union. Currently guidance is provided by NHS England, who have stood down all groups, calls etc. Bi-monthly meetings are expected to update on areas such as medicines management where no new guidance & advice is being given. Some changes have been made legally to regulatory issues for Medical Devices. HR impact on 56 staff within the Hospital. Robust plans are in place with regular meetings & leads in place; status is currently very low key, with potential for higher activity later in the year if no deal is agreed. IQ asked whether EU staff would still wish to come for work when their ability to work in the UK is not yet confirmed. LS noted that for Alder Hey the impact has been very low compared to other Trusts.

ACTION: 3-monthly updates to be brought to RABD (LS)

19/20/159 Neonatal Unit Update

The Committee received an update paper on the new Neonatal Unit. Two key elements potentially delayed decisions (decision by NHSE not to fund to national specified standards and discrepancy in funding originally offered by NHSE); also, the new national tariff for neonatal cases has now been brought in which has also impacted on progress.

IQ asked why the floor space had doubled from the original business case; SC noted that changes in the schedule of accommodation, parental accommodation & bereavement facility have now been taken into the unit. AB noted that following visits to other units, aspirations have changed, and it has been accepted that the original case was very crude. JG asked for the revised case to be brought back to March RABD prior to April Trust Board with firm capital piece, clinical assumptions and funding / commissioner piece; CL noted that increase to capital cost has still not been accounted for.

Evaluations & expected costings for the two options for the project will be discussed at a workshop on 26th February 2020. Essentially the new NICU creates physical space to develop other areas within the hospital which need further exploration.

IQ raised concerns regarding the validity of original build budgets that the Board are approving and then proving to be significantly out. He asked that future arrangements are strengthened with independent cost assurance undertaken at feasibility stage. It was agreed going forward that this will be included in any investment proposal.
KW noted that there is a theme going forward for changes to capital schemes, CL supported this and asked for protocol to be brought to this meeting and asked for more analysis on overhead costs and financial impact on the Trust. SB noted that risk analysis has not always been done well and does need to improve.
(SC left)

ACTION: NICU revised case to be brought back to March RABD with firm capital piece, clinical assumptions and funding / commissioner support (SB/SC)

19/20/160 Proposed Write-offs

MK gave an update on the value of current write-offs that have been proposed to a total value of £3,022.87.

19/20/161 Finance Report

CIP in year over-performing, elements of the programme have been supported by non-recurrent corporate measures, to be covered in a later item.
Currently looking to settle outstanding contracts with main Commissioners which will help by having a fixed position.
Debtors are higher than planned partly relating to the option payment on the land which will carry into next year.

19/20/162 Operational Plans and Budgets & CIP Update 20/21

There has been a reconfiguration of the budget to meet new expectations, with some draft profiling that will change following the next iteration.
CIP is expected to be higher than the national figure but some mitigations have been put forward around complex cases and tariff. Recurrent CIP not delivered – next year CIP will include carry forward from current year. Proposing to implement a 5-year plan approach to financial sustainability.
There is a need to be sighted on capital cash affordability.

CL requested approval draft rollover budget plan with the caveats given.
IQ noted that there appears some disfunction between divisions & central capital plans; CL noted not necessarily disfunction, but framework not in place for alignment. JG noted is almost approaching the end of a model set several years ago that has worked previously, and the hospital and divisions have all evolved in that time; now is an appropriate time to review & revise that model. JG has been in contact with other local hospitals and the feeling of fatigue with the existing approach is a common theme.
IQ noted support for a new approach to CIP. IQ queried use of word "draft" in the proposal; CL replied that until we can piece together the contract position, CIP and cost pressure requirements we will not be in a position to finalise the plan for next year. KW noted that there is an opportunity to reset the CIP and to create a new

change programme which aligns with the financial plan. SB noted that the Green Sustainability programme will need some investment and should have savings over the next few years, which will align with the NHS contract requirement.

19/20/163 Top 5 Risks/Key Priority Areas for 2019/20

RABD received the latest updates on the areas below:

PFI
General performance from IFM was good in January achieving 99% PPM compliance.
Energy consumption was 2% above the monthly contractual target and 5% (2Gj), below the annual contractual target.
Ventilation validation of the building is ongoing with no further issues discovered.
The programme has been extended and is now covering 100% of the building rather than the initial 25%.
Fire risk assessments have been completed and the majority of works identified have been actioned.
Critical care pods have seen no further water ingress since the temporary repairs were completed during September 2019 with reparation works to commence Spring 2020.
There has been no further sighting of woodlice or insects during January.
Site wide redecoration is ongoing.
There have been requests for a number of doors within theatres and surrounding areas to be automated due to complaints from staff, with an accident claim ongoing. A specialist report is being commissioned and a paper on automating the doors is to go to IRG. The cost is approximately £195k.

Handrail feasibility paper deferred – to be brought back to future RABD meeting following further discussion.

Two corroded pipework leaks reported during January 2020, increasing to 13 in last 4 weeks, with 10 impacting on heat within a number of zones. SA noted that this is not unique to Alder Hey & the inspection team have identified their priority areas as those where the recent leaks have occurred. AB noted that many months have passed since the initial proposal of testing and the actual start. JG noted there is a liaison meeting due to take place and this will be discussed. Update to be given at next RABD meeting.

AB asked that it be noted that GD & the Estates team had worked extremely well and quickly to get the COVID-19 pod up and running so quickly, particularly with the extreme weather conditions experienced when installing the unit.
(GD left)

CIP
No update (included in Financial Report)

Capital
Paper was received

19/20/164 **Programme Assurance**

The Committee received a Programme Assurance presentation:

Sustainability through External Partnerships

The *Aseptics* project plan is still showing slippage of milestones despite submission of an exception report to reset milestone dates last year.

The *Export Catalyst* ratings for both governance and delivery have now deteriorated as the project life cycle has come to an end with no milestones planned beyond September 19. There is a closure report on SharePoint and an update will be given following the next Programme Board meeting.

Global Digital Exemplar

The governance ratings of the *GDE / HIMMS* programme are satisfactory and the delivery of speciality packages has hit its November target. The next steps for the GDE Programme are to achieve full GDE accreditation and HIMSS Level 7. Evidence on SharePoint now needs to reflect these plans.

Park, Community Estate and Facilities

The governance and delivery ratings for the *Park, Community Estate and Facilities* programme have improved this month.

Overall there are still gaps with regards to the identification and tracking of SMART metrics for all the projects within the programme and a more detailed programme plan would be beneficial to provide full visibility.
(ND left)

19/20/165 **Marketing and Communications Activity Report**

MF gave a brief update on the Marketing & Communications activity over the last month, including tv coverage of a patient's recovery from a large tumour and the annual Staff Awards with a large amount of sponsorship gained from Trust suppliers.

19/20/166 **Digital Update**

KW presented a digital update including highlights of Digital Front Door now moving into development phase; Digital Strategy on going; GDE programme to be closed out following guidance from NHS Digital; HiMMS level 7 looking at October for evaluation but will require some work from Pharmacy to define the scope.

Operational IT work continues on improvement journey with new IT Service provider. Early feedback suggests the new system is being received well by staff. (50% first time, 90% 5 days). Also now have staff satisfaction surveys to give feedback.

Resilience plans continue well, with the Trust now in a much better situation and with the second site now under development.

MIAA undertook an Advisory Audit on core infrastructure late in 2019, with report and recommendations to be brought to a future RABD meeting.

ACTION: MIAA report & recommendations to be brought to future RABD (KW)

19/20/167 Board Assurance Framework (BAF)

ES gave a brief update on the Board Assurance Framework. Brexit to remain on radar. Financial forecast is a concern. Partnership to be revisited. Sickness & Activity will be covered under Corporate Report.

19/20/168 Board Committee Effectiveness Review

The Committee received an overview of the Committee Effectiveness Review and the template for approval. Process has been introduced to provide an annual review & reflection on the performance of the Committee, for completion by all members prior to Year End.

19/20/169 Corporate Report

Workforce – Noted that this is not being included in Corporate Report.
PDR at 98%, green on Medical Appraisal as within timeframe for GMC and at 82.7%, Sickness 6.4% down to 5.7%, have desire to get that down to 4-4.5%. Temporary spend at lowest all year in January; Turnover generally under 10% but currently just under 11%, slight anomaly which will be reviewed. Mandatory training level currently in excess of 90%

(Finance covered previously)

Operations – ED performance remains strong nationally however below standard of 95% of children seen within 4 hours. New approaches to Triage are being introduced with medium term solutions being considered with Walk-in Centres and PCTs for urgent care. Other challenges include ten 28-day breaches of operation cancellation & not rearranged within 28 days; and Scanning, which for OPD is now being done within one day which is excellent; Inpatient scanning soon to be improved following improvements to process and reduction in backlog. All access standards were achieved, Community Division working to improve planned care for LD patients.

19/20/170 Any Other Business

No other business was noted.

19/20/171 Board Assurance Review

The Board Assurance Summary was discussed and completed for submission to the next Trust Board meeting in March.

Date and Time of Next Meeting: Wednesday 25th March 2020, 09:30, Tony Bell Board Room, Institute in the Park.