Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 1st October 2019 commencing at 10:00

Venue: Tony Bell Board Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (1000 – 1015)							
1.	**19/20/165**	**10:30**	**Apologies.**	Chair	To note apologies: Kerry Byrne Claire Dove Kate Warriner	**N**	For noting
2.	**19/20/166**	**10:31**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**19/20/167**	**10:32**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Tuesday 3rd September 2019.**	**D**	Read Minutes
4.	**19/20/168**	**10:35**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Verbal
5.	**19/20/169**	**10:40**	**Key Issues/Reflections and items for information.**	All	Board to reflect on key issues & discuss any queries from information items	**N/I**	Verbal
Operational Update							
6.	**19/20/170**	**11:00**	**Winter Plan 2019.**	A. Bateman	To assure the Board as to the robustness of preparations for Winter pressures 2019	**A**	Presentation
Strategy							
7.	**19/20/171**	**11:10**	**'Our Plan' – Strategic Plan to 2024 - (Final Draft).**	D. Jones	For approval.	**D**	Report
8.	**19/20/172**	**11:20**	**LTP Submission.**	D. Jones	To provide the Trust Board with an update.	**N**	Presentation
Delivery of Outstanding Care							
9.	**19/20/173**	**11:30**	**Change Programme Progress Report:**	J. Grinnell/ E. Saunders	To receive an update on programme assurance.	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			- **Deliver Outstanding Care: CQC Road Map.**				
10.	**19/20/174**	**11:35**	**Corporate Report:** - **Community.** - **Medicine.** - **Surgery.**	Execs L. Cooper A. Hughes C. Duncan	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.	**A**	Read report
11.	**19/20/175**	**11:50**	**Clinical Quality Assurance Committee:** - **Chair's highlight report from the meeting on 18.09.19.** - **Minutes from the meeting held on 17.07.19.**	A Marsland	To receive a highlight report of key issues from the September meeting and the approved minutes from July 2019.	**A**	Read minutes
Safe							
12.	**19/20/176**	**11:50**	**Serious Incident Report.**	H Gwilliams	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	Read report
Caring							
13.	**19/20/177**	**12:00**	**Inspiring Quality Progress and Next Steps:** - **Patient Shadowing.**	N Murdock/ W Calvert	To brief the Board as to how patient shadowing will contribute to the achievement of patient experience aims within Inspiring Quality	**A/D**	Presentation
Effective							
14.	**19/20/178**	**12:10**	**Ward to Board.**	D. Perry	To provide an update on the Orthopaedic Department.	**A**	Presentation
15.	**19/20/179**	**12:20**	**Quarterly Mortality Report.**	N Murdock	To provide the quarterly update from the Chair of the Hospital Mortality Review Group	**A**	Read report
Lunch (12:40 – 13:10)							
Game Changing Research and Innovation							
16.	**19/20/180**	**13:10**	**Research Delivery Plan Update.**	N. Murdock/	To receive the research strategy quarterly report	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
				J. Taylor			
The Best People Doing Their Best Work							
17.	**19/20/181**	**13:20**	**The People Plan.**	M. Swindell	For approval.	**A**	Read report
18.	**19/20/182**	**13:30**	**Workforce and Organisational Development Committee:** - **Chair's highlight report from the meeting held on 19.09.19.** **Minutes from the meeting held on 26.07.19.**	C Dove	To receive a highlight report of key issues from the September meeting and the approved minutes from July 2019.	**A**	Read report
Sustainability Through External Partnerships							
19.	**19/20/183**	**13:35**	**Update on Specialist Trust Group and system governance.**	L. Shepherd/ J. Grinnell	To update the Board on the initiatives underway	**N**	Verbal
20.	**19/20/184**	**13:40**	**Liverpool Integrated Care Partnership.**	D. Jones	To provide the Board with an update on the Liverpool Integrated Partnership workshops/next steps.	**N**	Verbal
21.	**19/20/185**	**13:45**	**UNICEF Child Friendly City.**	L. Cooper	To provide the Board with an update	**N**	Presentation
22.	**19/20/186**	**13:55**	**Change Programme Progress Report:** - **Growing External Partnerships**	J. Grinnell	To receive an update on programme assurance.	**A**	Refer to item 9.
Strong Foundations							
23.	**19/20/187**	**14:10**	**Corporate Report Performance Metrics** **- 2019/2020 Financial Recovery.**	J. Grinnell	To receive an update on the current position.	**A**	Read report
24.	**19/20/188**	**14:05**	**Change Programme Progress Report:** - **Strong Foundations.**	J. Grinnell	To receive an update on programme assurance.	**A**	Refer to item 9.

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
25.	**19/20/189**	**14:20**	**Board Assurance Framework** - **Corporate Risk Register.**	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
26.	**19/20/190**	**14:30**	**Brexit Update.**	J. Grinnell / L. Stark	To provide the Board with assurance in relation to business continuity plans.	**A**	Presentation
27.	**19/20/191**	**14:40**	**Digital and Information Technology Update.**	J. Grinnell	The Board is asked to note the progress	**N**	Read report
28.	**19/20/192**	**14:50**	**Alder Hey in the Park Site Development update.**	D. Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	**A**	Read report
29.	**19/20/193**	**15:00**	**Change Programme Progress Report:** - **Park Community Estates and Facilities**	J. Grinnell	To receive an update on programme assurance.	**A**	Refer to item 9.
30.	**19/20/194**	**15:05**	**Integrated Governance Committee:** - **Chair's highlight report from the meeting held on 11.09.19.** - **Minutes from the meeting held on the 10.07.19.**	K. Byrne	To receive a highlight report of key issues from the September meeting and the approved minutes from July 2019.	**A**	Read minutes
31.	**19/20/195**	**15:10**	**Resources & Business Development Committee Report:** - **Chair's highlight report from the meeting held on 25.09.19.**	I. Quinlan	To receive a highlight report of key issues from the September meeting.	**A**	Read minutes
32.	**19/20/196**	**15:15**	**Any Other Business**	All	To discuss any further business before the close of the meeting.		
33	**19/20/197**	**15:20**	**Review of meeting**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief		
Date And Time of Next Meeting: Tuesday 5th November 2019 at 10:00am, Tony Bell Board Room, Institute in the Park.							

REGISTER OF TRUST SEAL

The Trust Seal was not used in September 2019

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION		
NHS Oversight Framework 2019/20	E. Saunders	To brief the Board on the latest guidance from NHSE and NHSI.
Guidance for Registered Medical Practitioners on the Notification of Deaths Regulations 2019	E. Saunders	To brief the Board on the latest guidance from the Ministry of Justice.

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 3rd September 2019 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 N Murdock	Medical Director	(NM)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
In Attendance:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs P Brown	Director of Nursing	(PB)
	Ms L Cooper	Director of Community Services	(LC)
	Mr C Duncan	Director of Surgery	(ChrD)
	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 S Owen	Deputy Director of HR & OD	(SO)
	Mrs K Warriner	Chief Information Officer	(KW)
Observing:	Mr Oliver Duffy	Account Manager, Liaison Workforce	
	Mr John Mitchell	Account Manager, Liaison Workforce	
	Mr Simon Hooker	Public Governor	
Apologies:	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Mrs M Swindell	Director of HR & OD	(MS)
Agenda item: **138**	David Porter	Sepsis Lead	
138	James Ashton	Sepsis Nurse	
138	Glenna Smith	General Manager, Medicine	
148	Lachlan Stark	Head of Performance and Planning	

Patient Story

Patient Daniel, Mum Joanne, Juliet Weston, Specialist Community Physiotherapist and Sian Calderwood Neonatal Service Manager attended to share their experiences with the Board.

Daniel was born at 24 weeks + 4 days, birth weight 700g. Due to his premature birth Daniel has been both an Inpatient and Outpatient. Daniel spent Christmas here at Alder Hey; at this time Joanne was informed that Daniel had hearing issues. Daniel also has problems feeding and had a PEG fitted to support him with this. Despite Daniel's health issues, he is a strong happy boy and is doing well.

Overall Daniel was in Neonatal Intensive Care for over five months. Once Daniel had been discharged he attended appointments on average four times per week. Joanne said the bookings team worked with her to have two appointments on the same day if possible.

Joanne spoke positively about the service they had received from Alder Hey and could not identify anything that she would wish to see improved.

Sian spoke about the transition in services from neonatal to acute paediatrics, how her post had been developed to support patients and their families and the positive difference this had made.

Daniel will also be supported with education and learning going forward.

The Chair thanked everyone for sharing their story today and wished Daniel and his family well going forward. Louise Shepherd noted Sian's post and said it was great to hear the further support that is provided in the transition to patients and their families.

19/20/134 Declarations of Interest

There were none to declare.

19/20/135 Minutes of the previous meetings held on 2nd July 2019

Resolved:

The Trust Board approved the minutes from the last meeting held on 2nd July 2019.

19/20/136 Matters Arising and Action Log

All other actions had either been completed or are on the agenda for a further update.

19/20/137 Key Issues/Reflections and items for information

The Chair welcomed Shalni Arora to her first Trust Board meeting in her role as Non-Executive Director. Shalni thanked the Board for their welcome noting her background as a qualified accountant, now entrepreneur.

The Chair referenced the changes to the agenda format noting the purpose for this was provide more focus to reports and enable more time for discussion by circulating appropriate items as supporting documentation. The introduction of a formal review at the end of each meeting was aimed at ensuring board members are getting what they need from meetings. Timings of items would be logged going forward this will be reviewed during a 12 month period to highlight items that invoke long/short discussions.

Item 15 Paying Patients had been circulated on the first draft of the agenda with a later decision to remove this item to allow for further discussion with the Executive team.

Trust Strategy had not been included on the agenda however it would be discussed separately after the meeting.

Louise Shepherd noted the decision made going forward to include an item on Operational matters. Adam Bateman briefed the Board on a number of business continuity issues that had taken place over the summer, highlighting support from staff to find a safe and effective resolution. On behalf of the Board the Chair thanked Adam Bateman for his leadership of these challenges as well as all of those involved in keeping all services running smoothly while the issues were resolved.

Action: JT

An update was received on the Radio 4 programme relating to organ retention as part of the 'Reunion' series. The show will be aired this Sunday at 11:15am; communication on this will be circulated to staff.

Lisa Cooper reported on the LGBT+ events that took place in July as well as the launch of the Rainbow pledge within the Trust. The Rainbow Badges initiative gives staff a way to show that Alder Hey offers open, non-judgemental and inclusive care for children, young people and their families who identify as LGBT+.

Nicky Murdock reported on the Health Education England visit/self-assessment that is taking place in October 2019. Nicki also noted that a number of new Paediatricians and Surgeons were starting work at the Trust this week.

Hilda Gwilliams informed the Board of the visit from the Deputy Chief Nurse, NHS England and the current focus on digital working.

David Powell referred to the 7th May 2019 Board when Professor Richard Cooke had provided an update on the hand hygiene product that had been developed through the Acorn Partnership, a second product was now due to be launched.

Erica Saunders reported on changes to the CQC Inspector for the Trust.

Supporting Documents/Items for Information
The Chair noted the introduction of this item was to circulate these items well in advance where possible:

- **Freedom to Speak up: Guidance for Board on NHS Foundation Trusts**
  Erica Saunders reported that the FTSU Guardian's next scheduled update for the Board would include a self-assessment against the new guidance. Both she and Anita Marsland are due to attend Freedom to Speak Up training in November. FTSU communications were being re-launched with a refresh of the information available on the intranet. Recruitment for additional Champions is ongoing; Anita Marsland had attended her first FTSU Champions meeting last month. Anita encouraged Board members to read the circulated document.

- **Election Results 2019**
  The Board received the above results noting the three re-elected and five new governors. Two members from the patient forum had been elected to patient seats. Erica Saunders advised training and support would be provided to them both. Four seats remain vacant and a by-election would take place.

- **Serious Incident Report**
  The report for July included: two new serious incidents, four ongoing and none closed, there were no new or ongoing safeguarding or never events. The Chair asked if details on lessons learnt could be included going forward.
  Action: HG

- **Complaints Report Quarter 1 and Infection Prevention and Control Quarter 1**
  The Board had received both reports in advance and there were no further comments or questions.

19/20/138 Inspiring Quality Progress and Next Steps:

Clinical Cabinet
Nicki Murdock's paper set out proposals for the introduction of a Clinical Cabinet as the next phase of implementation of Inspiring Quality. It was intended that this body

would meet six times per year to represent clinicians across the Trust, providing independent and impartial strategic advice on issues that potentially affect quality, affordability and efficient patient care.

Resolved:
The Trust Board APPROVED the establishment the Alder Hey Clinical Cabinet.

Seven Day Service
Following an action from the July Board meeting, Nicki Murdock presented a further paper on how a seven day service would be implemented at Alder Hey. Going forward the Board would receive bi-annual updates. Guidance from NHS England recognised that not all patients need to be seen every day, the practicalities of this was being worked through. The Chair asked going forward for a timeline to be included on what had been implemented and future goals.

19/20/38.1 Action: NM

The Board discussed Alder Hey running as a seven day service and the implications of this.

Resolved:
The Trust Board noted the current position and agreed to receive a further update at the March Board.

Sepsis update
David Porter gave a briefing on the current sepsis position and showed data collated against CQUIN 2A for both inpatients and Emergency Department (ED). The figures demonstrate the 100% target set by NHS England.

CQUIN 2B data shows administration of antibiotics within 60 minutes for both inpatients and ED. David Porter provided narrative against the figures, adding the increase of patients with no link to Sepsis.

The Board heard about the changes implemented into the electronic process so that doctors are now able to read nurses' comments. The Board noted the importance for clinicians to be able to read previous notes. Nicki Murdock highlighted that 100% of patients were given antibiotics within 60 minutes last month.

David Porter described ongoing areas of work, including collation of live Sepsis status in ED. It was noted this was being worked through, however due to changes needed from Meditech this would take some time to implement.

A discussion was held on Sepsis training and how this is reported regularly as part of the Sepsis updates into Clinical Quality Assurance Committee. The Chair asked Divisions to review their compliance against sepsis training and encourage staff/areas outstanding to complete. Sharon Owen noted HR team support would continue to be provided with this.

19/20/38.2 Action: Divisions

On behalf of the Board the Chair thanked the team and all those involved with reducing the risks associated with Sepsis.

Resolved:
The Board received and noted the Sepsis update.

19/20/139 People Strategy Update

The Board received and noted the contents of the People Strategy report for July 2019. The following points were highlighted and discussed:

- The national NHS Staff Survey is due to be launched at the end of the month.
- As part of the Trust focus on supporting mental health and wellbeing a series of training sessions in conjunction with the charity MIND have been arranged for October 2019.
- EU staff continue to receive information and support on Brexit
- Meetings have been taking place to prepare for the OFSTED Inspection of the apprenticeship programme at Alder Hey, possibly taking place this month. It was noted that Claire Dove has agreed to be interviewed by OFSTED as a member of the Board and chair of the Workforce Committee.
- The latest Mandatory Training report shows overall compliance is currently at 91.16% as of 16th of August 2019, up from 90.8% at the end of July.

Resolved:
The Trust Board received and noted:
- People Strategy report for July 2019.

19/20/140 Update on Specialist Trust Group and System Governance

An update was received on progress made to date on corporate functions and a single leadership estates service being developed between Alder Hey and Liverpool Heart and Chest NHS Foundation Trust.

A single service procurement team was also in process of being in place from the end of September between Alder Hey and the Walton Centre.

Locations in the city centre are being looked for possible future corporate collaborations.

Resolved:
The Board noted the development of the Specialist Trust Group.

19/20/141 Liverpool Integrated Care Partnership

Resolved:
Dani Jones went through progress to date noting the refresh of the One Liverpool plan, this is due to be approved by the partnership at their meeting on 17th October 2019.

Claire Dove suggested that a timeline of areas achieved and future goals would be useful going forward.

Resolved:
The Board noted the current position of the Liverpool Integrated CarePartnership.

19/20/142 Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital

Adam Bateman presented the revised paperwork for both Alder Hey and Liverpool Women's Hospital Board.

A leadership team for the Neonatal Partnership is now in place:
Chris Dewhurst – Clinical Lead
Jo Minford - Deputy Clinical Lead
Sian Calderwood – Lead Service Manager

Negotiations with NHS England to close the financial gap continue. A Consultant Neonatologist has been appointed to provide additional cover.

The Memorandum of Understanding was being revised to reflect the partnership's name, brand and governance structure. The document is undergoing partnership approval, with completion estimated by the end of September 2019.

There are currently ten Neonatal nurses working across the two sites. Hilda Gwilliams asked for assurances that staff working across both sites receive training to ensure competence with specialist equipment where there are differences.

The next Neonatal Partnership Board is due to take place in December 2019, Claire Dove has agreed to attend as the Non-Executive lead for the Trust.

Hilda Gwilliams noted the large population who will access the city's Neonatal services and asked if these changes have been communicated with the public. Adam Bateman made reference to the communication team that includes staff members from both sites.

Going forward it was agreed a meeting would be arranged for both Chairs and Chief Executives. It was also agreed that staff from Liverpool Women's would be welcomed to the site. Nicki Murdock asked that staff from PICU are also thanked for their input.

Resolved:
The Board noted progress of the Neonatal Partnership.

19/20/143 Programme Assurance Update

A paper had been circulated on progress to date and the transition to delivery of benefits. A revised delivery dashboard will be presented to the sub-committee relevant to each programme. The Clinical Quality Assurance Committee is now undertaking quarterly deep dives into the projects assigned to it; it was agreed that this would be replicated to all sub-committees as well as the Board.
Action: Natalie Deakin

Resolved:
The Trust Board received progress to date on programme assurance.

19/20/145 Corporate Report

The Board received the revised report for month 4 with focus on Divisions under the main clinical domains of Safe, Caring, Effective and Responsive.

Community – Lisa Cooper

Safe

A grade 3 pressure ulcer had been logged as an incident highlighting the lack of tissue viability support within the community. Safety Huddles at 8:30am have been introduced to tackle this issue as well as other.

Caring

The Division is now receiving FFT information via the Meridian system with the roll out of one terminal in the Catkin building.

There had been a reduction in the number of PALS related to communication and appointments in Community Paediatrics; this will continue to be reviewed.

Effective

QNIC Accreditation (gold standard) has been received for the Dewi Jones Unit.

Responsive

There had been a significant reduction in the number of children who have waited over 40 weeks to access Community Speech and Language Therapy service in Sefton

The Board noted the increased demand for Children and Young People's Mental Health Services and the current limited access to these services in the community.

Medicine – Adrian Hughes
Safe
Zero never events, pressure ulcers and hospital-acquired infections (MRSA, C. difficile) for over 12 months.

Patients treated for Sepsis within 60 minutes in the last 2 weeks was at 100%.

Caring
Complaints have reduced from 6 to 2 in the last few months, however contacts with PALS has increased. Going forward compliments given to the Medicine Division will be included.

Effective
The four hour ED Standard continues to be a challenge, but has improved by over 2% on the previous month. An ED improvement plan is in place, which along with recommendations from a separate workforce plan, will bring about sustainable positive change.

Transcription of notes is now available electronically within two working days.

Surgery – Christian Duncan
Safe
No never events.

Caring
92% of patients reported involvement in play and being aware of their discharge date through the Friends and Family test.

Responsive
Improvements continued to be seen in terms of cancelled operations for non-clinical reasons.

The Board noted the improved report.

Hilda Gwilliams noted the improvement within play but commented that separate reports for learning are not received from the school, it was agreed this would be looked into outside of the meeting.
Action: HG

The Board noted the metrics needed to continue to be redefined; in particular around the large number of students at Alder Hey and a way of including their feedback.

Finance
For month 4 a £0.1k deficit was reported which was £0.8k behind plan. John Grinnell briefed the Board on the recovery plans that are being put into place to bring the situation back on track.

Resolved:
The Board received and noted the contents of the Corporate Report for month 4.

19/20/146 Board Assurance Framework (BAF)

The Board received the August report, it was agreed that going forward risk updates for Brexit and IT would be added.

The Board discussed the pension risk associated with those consultants who were facing large tax charges upon reaching their lifetime allowance and the potential impact on services where individuals needed to reduce hours worked. A quality impact assessment is to be completed.
Action: AH/CD/LC

Resolved:
The Trust Board approved and noted the content of the revised BAF noting the transitional phase into the new financial year and the updates that had now been completed.

19/20/147 Board Assurance Framework Policy

Resolved:
The Board received and APPROVED the Board Assurance Framework Policy.

19/20/148 Brexit update

Lachlan Stark noted the guidance from the government remains to be prepared for the country to leave the European Union with or without a deal on 31st October 2019.

An exercise requested by the centre for hospitals to test themselves against plans has been completed. Any concerns that had been raised are being worked through. The established work-streams are meeting bi-weekly to address gaps and risks as they are identified.

If Brexit goes through on 31st October, freedom of movement will cease on 1st November as Britain becomes a 'third country'. The Trust's 65 members of staff who are EU nationals continue to be contacted and offered support.

It was noted the flu vaccines had been ordered however there would be a delay until November 2019 due to identifying the strain of flu and the correct vaccine for it.

A regional workshop is to be held on 9th September 2019, walkabouts are to be re-instated and the communications plan commenced.

Resolved:
The Board noted preparations in place for Brexit on 31st October 2019.

19/20/149 Digital Update and Digital Futures

'Digital Futures' had been included as appendix 1 within the report.

An update was received on the ongoing implementation of the GDE Programme and accreditation of HIMSS Level 6 and 7.

Work has progressed to commence planning of the Meditech Expanse programme initiation. This programme will see a major upgrade to the Trust's Electronic Patient Record system. Indicative dates have been identified as September 2020 and work is ongoing with the supplier to progress with planning for the programme which has been formally initiated.

Resolved:
The Trust Board noted:

- Progress with the mobilisation of the digital futures strategy
- Progress with operational IT developments
- Major digital programme progress
-

19/20/150 Proposed Change to Board Composition

The paper went through the recommendation approved by the Council of Governors to increase the Non-Executive Directors to the maximum of seven provided for under the constitution to include a representative from the University of Liverpool.

The Board noted Alder Hey work with a number of universities and queried how they would also have access to the Board.

Resolved:

The Board noted the proposed change to the composition of the Non-Executive cohort on the Board and mandated the Nominations Committee to undertake the appropriate recruitment process on its behalf with the recommendation that the successful candidate builds a relationship with the other universities that partner with Alder Hey.

19/20/151 Alder Hey in the Park Site Development Update

David Powell made reference to the two red rated projects:

New schemes: Community Cluster
The project has been re-designed and it was unknown whether the re-design is within budget.

Securing Neighbourhood sites
Due to the commercial sensitivity of this item, it was noted this would be discussed under part 2.

Resolved:

The Trust Board received the update on the Site Development.

19/20/152 Committee Assurance Highlight report and minutes

The Board received the re-introduced highlight reports and minutes from the Committees below. It was noted going forward there would be an item at the end of the committee meetings to address the highlight report.

Integrated Governance Committee

The Board received the Chair's highlight report for the last meeting on 10th July 2019 and the approved minutes from the meeting held on 22nd May 2019.

Clinical Quality Assurance Committee

The Board received the Chair's highlight report for the last meeting on 17th July 2019 and the approved minutes from the meeting held on 12th June 2019

Resources and Business Development Committee

The Board received the Chair's highlight report for the last meeting on 24th July 2019 and the approved minutes from the meeting held on 27th June 2019

19/20/153 Board Reporting Calendar

Resolved:

The Board received and approved the Board reporting calendar.

19/20/154 Any Other Business

No other business was discussed.

19/20/155 **Review of meeting**

David Powell noted the change for the corporate report to now have more divisional focus and requested that additional time is given to reflect this.

It was noted the Corporate Risk Register would be presented at the October Board following Integrated Governance Committee meeting in September 2019.

Items for Information: It was queried whether Serious Incident Report and Complaints report should be included in items for information or should be included as their own item to ensure the detail of the reports is received.

Items for the Research and Innovation work-stream are currently being worked through.

Date and Time of next meeting: Tuesday 1st October 2019 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
Actions for July 2019							
28.05.19	19/20/77	Draft Annual Report and Accounts	To arrange a thank you event for achievements within the annual report.	Mark Flannagan	02.07.19		02.07.19: In process
28.05.19	19/20/75	Alder Hey in the Park Site Development Update	To arrange a walkabout of the community cluster site for Non-Executive Directors.	David Powell	T.B.C		On hold until final design is agreed
Action for October 2019							
03.09.19	19/20/38.2	Inspiring Quality Progress and Next Steps	***Sepsis Update*** - Divisions to review their compliance against sepsis training and encourage staff/areas outstanding to complete.	Divisions	01.10.19		
03.09.19	19/20/145	Corporate Report	***Play*** - Look into the possibility of receiving reports from schools on learning.	H Gwilliams	01.10.19		
Action for November 2019							
02.07.19	19/20/100	Output from Strategy session on 25th June 2019	To present a draft plan at the September Board	Dani Jones	05.11.19		03.09.19: This is to be discussed after the Trust Board. The final version will be presented at the November Trust Board meeting
03.09.19	19/20/137	Serious Incident Report	To include lessons learnt within the Serious Incident report going forward.	H Gwilliams	05.11.19		
03.09.19	19/20/146	Board Assurance Framework	The Board discussed the pension risk in association with consultants (high earners) and the impact on services. A quality impact assessment is to be completed.	Christian Duncan/ Lisa Cooper/ Adrian Hughes	05.11.19		
Action for March 2020							
03.09.19	19/20/38.1	Inspiring Quality Progress and Next Steps	***Seven Day Service*** - Timeline to be included in the bi-annual update in respect to implementation of the seven day service and future goals.	Nicki Murdock	03.03.20		
Completed Actions							
03.11.19	19/20/137	Key Issues/Reflections and items for information	To include operational Alder Hey under agenda item 5	J Tsao	01.10.19		Completed

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
Status							
Overdue							
On Track							
Closed							

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	**'Our Plan' – Strategic Plan to 2024 (final draft)**
Report of:	**Trust Board**
Paper Prepared by:	Director of Strategy and Partnerships

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	NHS Long Term Plan and implementation guidance Previous 5 year strategic plan (2014-2019)
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:	As per report

1. Introduction

The attached document represents work undertaken across the Trust with the Clinical divisions to refresh the Trust's strategic plan, ensuring it properly reflects current local and national plans, and gives corporate direction to our services as they continue developing their individual clinical service plans and strategies.

2. Context

The Board reviewed the Trust's overarching strategy in April 2016, having come to the end of the strategic plan developed in 2011 which had culminated in the delivery of the new Alder Hey at the end of 2015. The Board believes that the organisation's original purpose and vision remain relevant today and will be fundamentally unchanged to 2024. As such, we have re-committed to our ambition to deliver **'a healthier future for children and young people, as a recognised leader in research and health care".**

Alder Hey's 2024 vision is built upon two strategic aims: 'Doing the Basics Brilliantly' and 'Growing the Future', beneath which sit four key pillars: Delivery of outstanding Care, The best people doing their best work, Sustainability through external partnerships and Game-changing research and innovation. These objectives are enabled by strong foundations, which include our drive for digital excellence, using our buildings and spaces as catalysts for the health and wellbeing for children, young people and families, using our role as an advocate for children and young people to positively impact our local economy and community, and taking action on climate change.

Our strategic plan ('Our Plan') to 2024 outlines this, along with the strategic actions we will take to create a healthier future for children and young people over the next four years.

3. Recommendations

It is recommended that the Trust Board approves the final draft of 'Our Plan'.

The approved plan will subsequently be converted into a designed document ready for widespread circulation amongst staff and partners.

Alder Hey Children's NHS Foundation Trust

FINAL DRAFT 1v9

'Our Plan'

2019/20 – 2023/24

Contents

Foreword

Alder Hey is a special place, made up of extraordinary children, young people, families and exceptional staff. Over the last decade, we have witnessed a transformation in the care we deliver for children and young people. We are continually inspired by them.

At Alder Hey, we are guided by a clear, shared vision, driven and delivered by our teams across the Trust, to **"Build a healthier future for children and young people, as a recognised world leader in research and healthcare".**

Key partners in our efforts are our **Volunteers** and our **Alder Hey Charity**. Every day our volunteers demonstrate our values by working in partnership with staff to support children, young people and families. With the support of our charity we are able to invest and provide added value in a number of key areas including research, patient experience and the arts. We are grateful for their continuing support.

Together, we are building a healthier future for children and young people through;

- **Alder Hey in the Park** - our purpose-built £350m campus devoted to improving children and young people's health. This specialist, digitally-enabled hospital, was **designed by children and young people**. Our children and young people's health campus houses a dedicated **Research, Education and Innovation (RE&I) Institute**, which is home to our **partnership with four Universities** and the **National Institute for Health Research (NIHR)**. Our health campus also plays home to the NHS's only **Innovation Hub** and our dedicated **Clinical Research Facility**. In the coming months our health campus will grow to encompass **specialist mental health**, **neurodevelopmental** and **bereavement services**, all within a **parkland setting** dedicated to **inspiring and supporting children's health and well-being**;

- **Treating more children and young people than ever before**, both at Alder Hey in the Park, in community settings, and across the North West, North Wales and the Isle of Man through specialist networks;

- Our strong and **growing children's community and mental health** services;

- Continuing to **enrol more children in clinical research** than any other NHS provider;

- Being a **recognised leader in digitally-enabled healthcare and innovation**, creating a pipeline of new products and therapies in partnership with children and young people, Industry and Higher Education Institutions that are transforming health outcomes and creating wealth;

- **Recruiting and training more specialist staff** than ever before.

Alder Hey is in a strong position but there is so much more to do if we are to respond effectively to the challenges facing children and young people today; challenges that may be the result of society, austerity, technology and/or the environment they live in. We recognise that we have a massive responsibility to respond to these challenges. We will do this by;

- **Working in close partnership with families and other agencies** to provide truly integrated services and helping to build resilient communities supporting children and young people across our region;

- **Being a strong advocate for children and young people's health and well-being**, actively supporting programmes and system plans that will enable all children to have the best possible start in life and manage their own health and well-being positively as they grow and develop;

- **Remaining at the forefront of the positive technological and medical revolution** that is transforming healthcare and with it, the potential life chances of every child and young person;

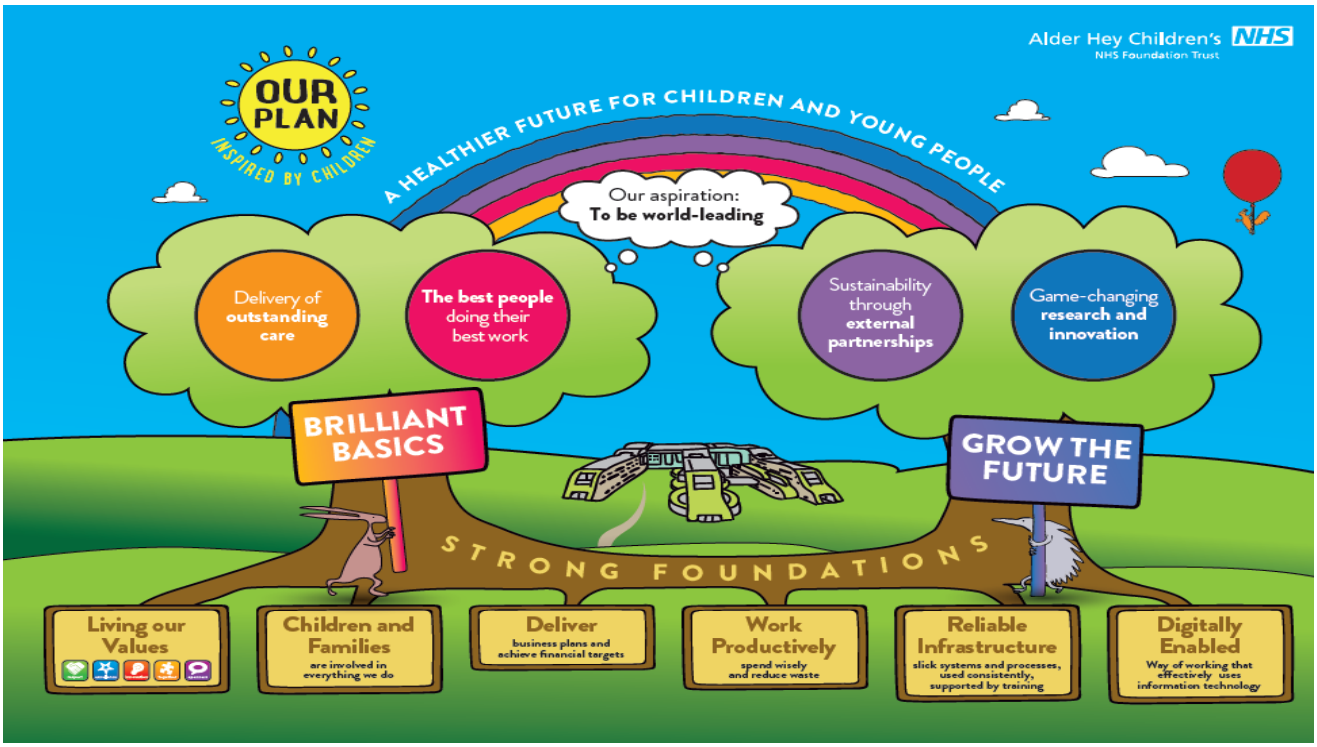
- Playing our part in ensuring Alder Hey does everything we can to have a **positive impact on our environment and communities.**

'**Our Plan**' sets out our response to these challenges and the steps we intend to take over the next four years to build on our strong platform and to realise our shared ambition to build the **healthier future for children and young people** that they deserve.

Dame Jo Williams
Chair

Louise Shepherd CBE
Chief Executive

Section 1: Our Vision, Aims and Objectives & Values



My Alder Hey. My Values.

respect — We show that we value every individual for who they are and their contribution

excellence — We pride ourselves on the quality of our care, going the extra mile to make Alder Hey a safe and special place for children and their families

innovation — We are committed to continually improving for the benefit of our patients

together — We work across the Alder Hey community in teams that are built on friendship, dedication, care and reassurance

openness — We are open and honest and engage everyone we meet with a smile

L.O.V.E.D.
Living Our Values Every Day

Section 2: Who We Are

Welcome to 'Our Plan'. At Alder Hey, our people are as vibrant as the children and young people we are here for, and the city we work in. Our big vision is to **create a healthier future for children and young people**. 'Our Plan' will outline how we will get there over the next 4 years and beyond.

What We Do

Our **3,800 staff**, plus 1,000 medical, nursing and allied health professional students, care for over **330,000 children and young people** each year. We provide care across 60 specialties from a range of settings, including our world-leading "**Alder Hey in the Park**" campus, our widespread and **diverse community sites** across Liverpool and North Mersey, and reaching out even further into Wales, Cumbria, Shropshire and the Isle of Man. **We are both a highly specialist and tertiary hospital with a global reach, and a local community and hospital provider for children and young people.**

We have more children and young people participating in clinical **research** studies than anywhere else in the UK, and are very fortunate to have both a purpose-built **research institute** and the UK's only NHS **Innovation Hub** to help us ensure children and young people are able to benefit from the very latest in research and innovation.

We host many **centres of excellence in specialist medicine and care**, and we are the **specialist leader for a number of key children's health issues**; many examples of this excellence can be seen in Appendix 1.

Our care and services are **clinically-led**, with four **clinical 'divisions'** - **Surgery**, **Medicine**, **Community and Mental Health** and the **Clinical Research** Division (see Appendix 3 for details).

Our Clinical Divisions' focus is **supported by professional departments**, Corporate and Support Services that deliver (for example) leadership on Our People, an ambitious digital infrastructure, financial rigour and an overarching communications and engagement plan.

Section 3: OUR ROLE IN A HEALTHIER FUTURE FOR CHILDREN AND YOUNG PEOPLE

At Alder Hey, we recognise and act on **our role as an advocate for the wellbeing and health of children and young people.** It is our ambition to **positively impact social value and lead others to do so**, in order to **enhance the wellbeing and life chances of children and young people**, and make a **positive contribution to our local economy and community.**

Over the next 4 years and beyond we will continue to;

- Listen to the **voices of children and young people** in all that we do, and as committed partners in **UNICEF Child Friendly City**
- Work in close **partnership with families and partner agencies** to provide truly **integrated** services and helping to build **resilient communities** supporting children and young people across our region;
- **Share our expertise** as a **regional specialist tertiary centre** with our partners, and learn from others – this means driving up **standards** and **advocating** for children and young people's services, and utilising the unique perspective we have from treating the sharp end of childhood illnesses and diseases to **identify underlying causes and drive for improved preventative solutions**
- Being a **strong advocate for children and young people's health and well-being**, actively supporting programmes and system plans that will enable all children to have the best possible start in life and manage their own health and well-being positively as they grow and develop
- Remaining at the **forefront of the positive technological and medical revolution** that is transforming healthcare and with it, the potential life chances of every child and young person
- Playing our part in ensuring Alder Hey does everything we can to **have a positive impact on our environment and communities** – by;
    - Contributing to the city's **Public Health**, **wellbeing** and **economic prosperity**, as partners in our community
    - Using our **buildings and spaces to support our community**, through Alder Hey in the Park

- **Recruiting** from our local community, and **attracting** people into Liverpool
- **Procuring local goods and services** wherever possible
- **Widening access** to quality work, for example through **volunteer career pathways**
- Prioritising action on **Climate Change** and the **Green** agenda for children and young people of the future.

Our Green Plan

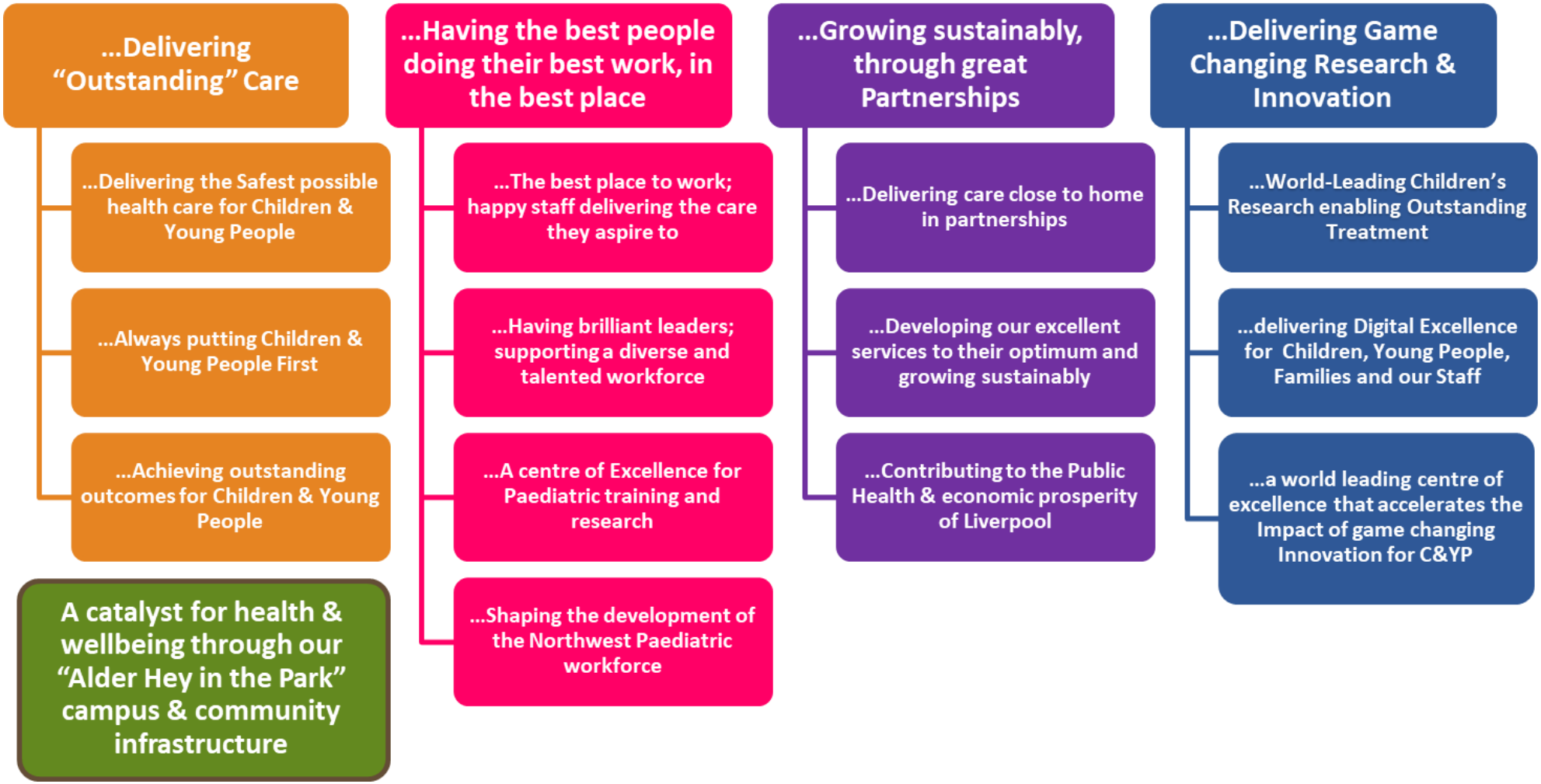
Alder Hey will continue to develop 'Alder Hey in the Park' and our community infrastructure as a **catalyst for improving the health and wellbeing** of our children and young people, families, staff and surrounding communities. Over the next 4 years, we will make being **'green'** part of our brilliant basics. We will deliver a Green Plan for Alder Hey that helps us play our part in **tackling climate change.** We will implement plans to, amongst other things: reduce our overall carbon footprint, enable more green travel options, and reduce waste.

During 2019/20, we will **create a cadre of advocates** for the Green Plan, setting the 'strong foundations' and challenging our current thinking and views. From 2020/21 to 2021/22, we will produce a Board-governed programme of action against climate change which is underpinned by a carbon-footprint reduction goal and a clinical focus on quality of life, such as air pollution.

> *"Children have the right to good quality health care – the best health care possible – to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. Rich countries should help poorer countries achieve this"*
>
> **UN Convention on the Rights of the Child**

Section 4: OUR 2024 AMBITIONS

By 2024, it is our ambition for Alder Hey to be known as…



Section 5: THE NATIONAL AND LOCAL CONTEXT

The NHS Long Term Plan[1] (LTP) launched by the Prime Minister at Alder Hey in January 2019 places a focus on moving to a new model in which patients get **more joined-up care, closer to home**. The LTP emphasizes the need to strengthen the NHS contribution to **prevention** and **reduce health inequalities,** improve **mental health** services**, reduce pressure on the emergency treatment system, personalize** care, and make the most of **digital opportunities, innovation and research** to truly transform care, for example in **outpatients**. The LTP also sets out a clear objective for all local systems to become **'Integrated Care Systems'** (ICS) by 2021.

For Alder Hey this means working in **partnership with our children, young people and families, involving them even more in all that we do**. It also means **working in partnership in our community** to support children and families in a more joined up way and closer to home or school.

The LTP focuses on a **strong start in life** for children, young people and families. Objectives are set in relation to **maternity**, **neonatal** care, **clinical networks**, **children and young people with cancer** (including access to genomic testing and tailored medicines, and increase in early diagnosis), **mental health**, **learning disability and autism**.

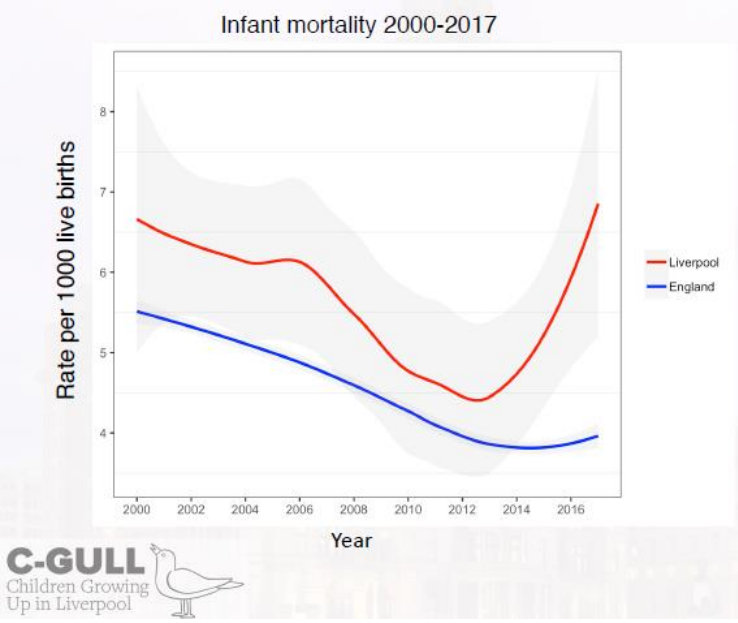
At Alder Hey, we welcomed the LTP and fully support the prioritisation of children and young people in the NHS's future plans. This is particularly important because, in Liverpool alone, the pressure on children, young people and families' health, as well as on NHS, local authority and other care services continues to increase year on year;

- 30% of children in Liverpool are born in poverty
- By age five, 35% of our children have poor development
- By age ten, 40% of our children are obese or overweight
- 10% of 5 – 16 year olds experience mental ill-health.

[1] https://www.longtermplan.nhs.uk/

Poverty is a key reason for poor health in children and young people[2]. People living in more deprived areas have a greater likelihood of experiencing poorer health. Over a **quarter of children and young people in Liverpool (26%) live in low income families**; significantly more than the England average (17%). In addition to this, the number of children and young people who use our services are growing;

- The number of **4 to 15 year old's** in Liverpool is projected to **increase by 18.5%** between 2016-26[3]
- In 2017, there were **5,906** live births in Liverpool[4]- **311** more births to Liverpool mothers than a decade ago
- Liverpool has a **high rate of A&E attendances** for children aged **0-4** years, **62% higher** than England as a whole.



"Starting Well"

To make a positive change to these outcomes and inequalities, we must enable children and young people to 'start well'. This means working together with partners to ensure children and young people have opportunities, life chances and the potential to lead safe and happy lives, irrespective of where they live or where they were born.

[2] Taylor-Robinson, D; BMJ 2019;364:l963
[3] Office for National Statistics - 2016-Based Sub-National Population Projections, June 2018
[4] Office for National Statistics, 2018

One organisation cannot change these outcomes alone. It is by working in partnership that we will make the difference. We have a real opportunity to achieve improvements by working together systematically;

- We will ensure that **all system partners provide the same pathways to access support** for mothers and families in the early years, no matter what organisation they come into contact with
- We will methodically **identify any pre-school developmental needs** a child may have, no matter which services they come into contact with; this will enable us to pick up challenges early and act on them in a joined up way
- Through our committed membership of 'Liverpool Health Partners', we will align our research strategies and ensure a we **maximise the impact of research for children and young people**, for example through the **'Starting Well'** collaborative (p32).

The future shape of Specialist, Tertiary and Quaternary services

As a specialist, tertiary and quaternary trust with a global reach, we are already **driving the future shape of many specialist services**; our remarkable people are continually creating innovations which push the boundaries of care, and undertaking research which evolves the evidence base nationally and globally.

NHS England specialist commissioners indicate a strategy for services provided in the North of England which follows the **national move towards a model of more consolidated specialist services**. Over the next four years, changes may be seen at a health economy, sub-regional, regional or national level. For Alder Hey, this means some services are sustainable in their current form, some may consolidate and some opportunities may arise in terms of new services.

'Our Plan' is to continue to grow our specialist, tertiary and quaternary services where this meets the needs of the children and young people we serve, as well as our wider system. This may mean growing certain services whilst changing how or where other services are delivered.

We will aim to increase the number of **nationally designated services** provided for children and young people in the North. We will work with **partner universities** to support

senior academics (Chairs) to lead services where possible. We will review opportunities to '**grow the future**' regionally and nationally (identified through divisional priorities and Clinical Service Plans p50). We will work in **partnership** where that makes us stronger.

'One Liverpool' (Our 'PLACE')

Alder Hey is based in the Liverpool system (our 'PLACE'), which is a diverse and complex health and care system, with eight NHS provider trusts (2 large adult acute hospitals, our own children's acute trust, a women's acute trust and four specialist trusts, located in the city but serving the wider region), one City Council, 96 General Practices, organised into 11 Primary Care Networks (PCNs), and a wealth of third, voluntary, social and faith sector providers. The '**One Liverpool**' plan has a **good start in life** for children and young people at its heart, and connects directly to '**Our Plan**', putting a focus on;

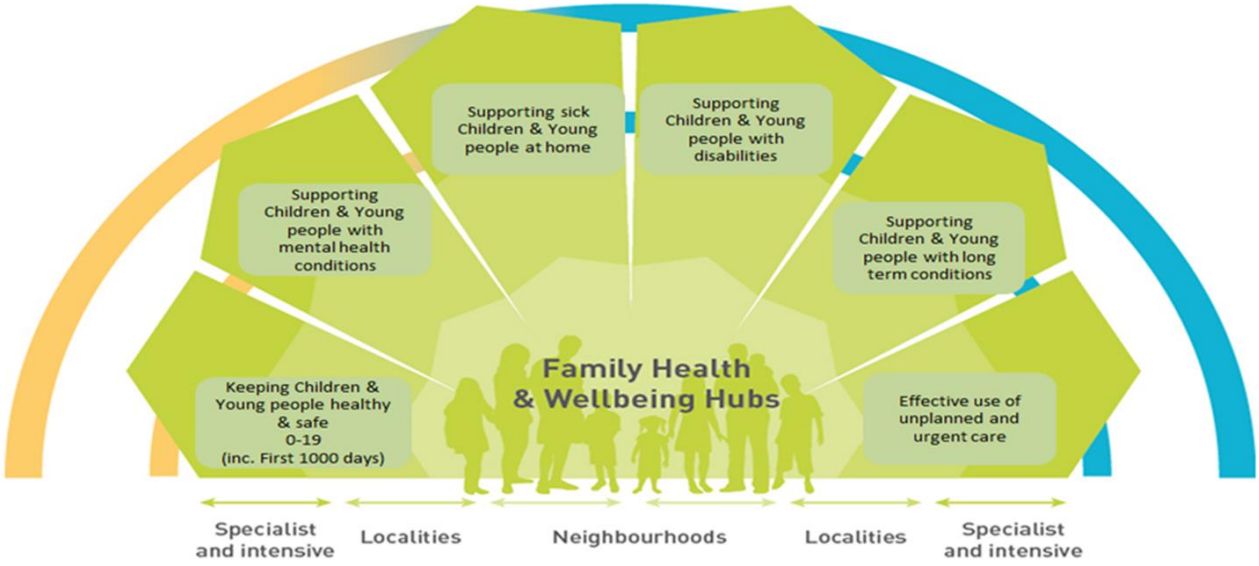
- Improving **Infant Mortality**
- Improving **School Readiness -** readiness to learn, and therefore earn
- Developing a **new model of integrated community care** – for Alder Hey this means delivery of our Children's Transformation plans (p15), **growing the future** through our community offer and providing more specialist services in local settings, face to face or via primary care teams and digital links.
- **Transforming Outpatient care** – through digital innovation
- Addressing **Childhood Obesity**
- Contributing to the city's **Public Health**, ensuring our children, young people, families and staff can make healthy choices.

"Morbid obesity in childhood is life limiting. It can cause comorbidities like diabetes, fatty liver disease, sleep apnoea, hypertension, and have a serious psychological impact on children and young people. We will further develop our multi-disciplinary Obesity services, designed around the child and family. Our tailored services will support them to make healthier life choices, address the complications of comorbidities medically or surgically as needed, and proactively address mental health issues, building resilience and self-esteem".

Urmi Das, Consultant Paediatric Endocrinologist (Alder Hey) and Honorary Senior Clinical Lecturer (University of Liverpool)

Children's Transformation

In **Liverpool, Sefton and Knowsley** (our three local 'PLACES') Alder Hey will continue to play an active role in the development of new models of care for children and young people. We will continue to drive and mature Children's Transformation plans in all three areas with a common focus on **improving services and care for children and young people**, as reflected in the following model;



Over the next four years we will continue to develop our **Community, Mental Health and general paediatric** services to work in increasing partnership with primary and community care, education, early help and the voluntary sector. We will **contribute to the LTP's prevention challenge** and the public health of Liverpool through developing our internal approach to **public health**, our commitment to the Liverpool Health Partners' **'Starting Well'** programme, and our **system-wide response to prevention** through the 'One Liverpool' Plan.

"Responsive community support enables early identification and management of issues relating to long term conditions. This is what I call 'community surveillance' as health professionals know what the foreseeable risks are to monitor for and prevent from occurring. Managing issues early, when they are small, prevents escalation to needing hospital attendances or tertiary care, but most importantly, it helps to normalise a long term condition as it's dealt with within the normal day of someone's life."

Leanne Turner – Clinical Specialist Physiotherapist, Alder Hey

The Cheshire and Merseyside Health and Care Partnership (C&M HCP)

The C&M HCP Vision is to improve the health and wellbeing of the region's 2.6 million population through creating a strong, safe and sustainable health and care system that is fit for the future, through delivering care more efficiently, improving the quality of care and improving the health and care of the population. This vision is being taken forward by Alder Hey in a number of ways;

- **We will continue to drive improvements to care for Women and Children regionally**, through collaborative working – for example developing a networked model of paediatric service delivery and workforce, which will ensure that women, their babies, children and young people would have access to services of the same high standard across Cheshire and Merseyside.

- **We will work in partnership across the system to deliver the very best mental health care** for children and young people, at the right time to meet their needs.

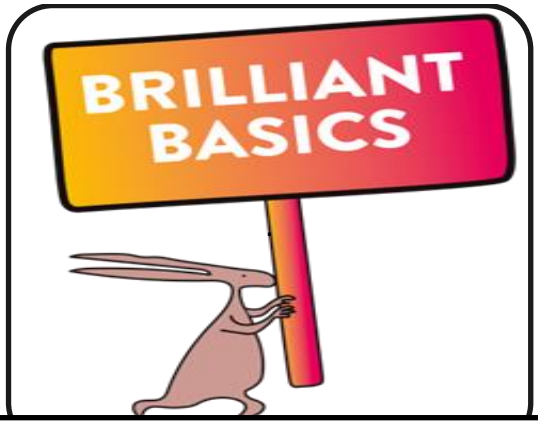
- **We will maintain our drive towards a local system which empowers staff and patients through digital technologies**, through continuing our leading role in the 'Digital Revolution' of Cheshire and Merseyside.

- **We will develop collaborative approaches for shared resources and services** where this benefits children and young people and enables sustainability of services for the future; our focus will be on building local collaboratives for **diagnostics (radiology and pathology**), **corporate services** and **estates and facilities**.

Section 6: 'OUR PLAN'

6.1 Our Strategic Aims

We have two **strategic aims** – to do the **basics brilliantly**, and to **grow the future**. These aims are interdependent; they are woven into each of our strategic objectives, and throughout all of the underpinning plans, programmes and projects.



Brilliant basics are the foundation on which high quality services are built

Growing the Future means we will make the most of our many opportunities at Alder Hey

2 strategic objectives
-Delivering **'Outstanding' Care**
-Best **People** doing their best work

2 strategic objectives
-Sustainability through **Partnerships**
-Game-changing **research and innovation**

We must have **brilliant basics** in order to **grow our future**

We must **grow the future** in order to sustain our **brilliant basics**

6.2 **OBJECTIVE 1: DELIVERY OF OUTSTANDING CARE**

Delivery of **outstanding** care	**Our 2024(+) ambitions are to;** • Deliver the **safest** possible healthcare for children and young people • Always **put children and young people first** • Achieve **outstanding outcomes** for children and young people 

To deliver these ambitions, we will prioritise focus on the following **clinical and patient outcomes** (as developed through Inspiring Quality – see p19);

Delivering the **safest** possible healthcare for children and young people	• Zero clinical incidents resulting in moderate, severe or catastrophic harm • Zero never events • Zero medication errors resulting in harm • Zero pressure ulcers • All septic children receive their antibiotics within 60 minutes • Zero children deteriorate unexpectedly • Zero readmissions to PICU within 48 hours • Zero hospital acquired infections
Always **putting children and young people first**	• Over 95% of children and young people report that we put them first • Over 98% of children, young people and their families would recommend the Trust.
Achieving **outstanding outcomes** for children and young people.	• Over 95% of children, young people and families report meeting the care goals they set • All children and families received information enabling them to make choices about their care

Inspiring Quality

Our Inspiring Quality approach across Alder Hey will set our culture of quality improvement, making it the core of who we are and how we work, and enabling us to deliver outstanding care. Inspiring Quality is the method by which we will **grow our future** position as a highly reliable and learning organisation.

We have developed Inspiring Quality with significant input from children and young people, our staff, patients/carers and our partners. The plan will be implemented by 2022/23, and will change how we work in four ways;

1. We will build a **culture of continuous quality improvement** that **empowers** individuals and teams to take a **systematic approach to daily improvement**, including launching an **Inspiring Quality hub** to support and develop staff
2. We will **always do everything with children, young people and families**; to design their care with them and to put them at the **centre of decision making**. This will include children and young people **setting their own goals** and ensuring that when they tell us something we hear it and act upon it
3. We will use **digital technology to transform patient care** by adoption of evidence-based digital pathways and a focus on how digital technologies can be used to capture patient reported outcomes
4. We will use **real-time data analysis to continually improve outcomes** including those that are meaningful to children and young people. We will invest in people and time to improve our care and services by embedding Quality Improvement in our everyday work.

Key Deliverables

Programmes / Projects	When
Inspiring Quality ▪ Training to all staff on the science of quality improvement ▪ Realising the benefit of embedded improvement science in the Trust	 19/20 19/20-22/23
Sepsis - 90% of patient have antibiotics within 60min as 'business as	19/20

usual’	
DETECT Study - digital monitoring of vital signs and reduction in use of critical care beds	20/21
Best in Outpatient Care – patient portals, digital consultations, online booking and scheduling, paper free outpatients	22/23
SAFER (Patient Flow tool) – fully implemented	20/21
Best in Mental Health Care - 24/7 crisis care line, access to 12 tier 4 beds, Dewi Jones onsite with Alder Hey	21/22
Best in Acute Care – new High Dependency Unit model of care, improved Emergency Decision Unit, new Paediatric Assessment Unit	21/22

6.3 **OBJECTIVE 2: THE BEST PEOPLE DOING THEIR BEST WORK**

	**Our 2024(+) ambitions are to;** • Be the **best place to work**; with **happy staff** delivering the care they aspire to • Have **brilliant leaders**; supporting a **diverse** and **talented** workforce • Be a **Centre of Excellence** for paediatric **training** and **research** • Shape the development of the **North West Paediatric workforce**

Every single person who works at Alder Hey is critical to the care of every single child who needs our services, and every single person matters. Our vision at Alder Hey is to **create a healthier future for children and young people**. **Our People Plan** outlines how we will support all of our people and the wider paediatric workforce to deliver this vision over the next 4 years and beyond.

Our People Plan has been developed in response to two things:

1. What our people are telling us about what it is like to work at Alder Hey, what they would like to see change, and how they would want to be involved

2. The impact of national and local workforce challenges, such as system working and collaboration, national workforce shortages, using technology to deliver 21st century care, improving diversity and inclusion and making the NHS a great place to work.

'**Our Plan**' takes on board the recommendations of the recently published NHS Interim People Plan (June 2016), which recognises that **we will need different people in different professions, working in different ways** in order to deliver the NHS Long Term Plan ambitions. It requires us to **promote positive cultures**, build **compassionate and engaging leaders** and make the NHS an agile and inclusive modern employer to **attract and retain** the best people.

The NHS Interim People Plan is specific about transforming the way our entire workforce works together – this includes doctors, nurses, allied health professionals (AHPs), pharmacists, scientists, dentists, non-clinical professions, social workers, commissioners, non-executives and volunteers (not exhaustive).

In developing our ambitions, we have considered both our **internal** role in supporting our own people, and our **external** role in supporting the paediatric education and workforce in our system.

Our People Plan for the next four years is built on the strong foundations already laid in place by our values, developed by our own staff. These values underpin every act and every interaction within Alder Hey and beyond and especially in every relationship that we build with the children, young people and families that we care for.

Our People Plan is based around 5 strategic pillars, all of which are fundamental to the development of a healthy, psychologically safe, improvement-focused, compassionate, inclusive and learning culture for our staff and for the children and young people we care for:

a) **Leadership development and talent management** – We will implement our new leadership strategy (linked with the 'Inspiring Quality' programme) which will support leaders at all levels to develop their management and leadership capability, including developing coaching skills as a critical element of their roles. We will recognise, support and **grow** increasing numbers of talented, compassionate leaders through delivery of key programmes, including "Strong Foundations" and "Mary Seacole".

b) **Wellbeing** – We will prioritise the **health and wellbeing** of our staff. We will deliver **'Time to Change'**, a national initiative focused on ending mental health discrimination and developing an enhanced staff support system to provide advice, guidance and support on a range of domestic and work related issues. We

> *"I just wanted to say thank you. You'll never know how much you impact every person that walks through your door. People in pain and feeling alone, and you give them hope. But you never get to see and appreciate the result of your labour"*
>
> **Young Person, CAMHS**

will focus on **eliminating bullying and harassment** and test novel approaches to resolution working in close collaboration with Trade Unions.

c) **Future workforce development** – We will continue to **'grow the future'** of children and young people's specialists. We will grow our capacity to offer training opportunities to the **wider North West work force**, and support local hospitals and primary care teams through education and outreach. We will **further develop new roles such as nurse associates, advanced clinical practitioners, physicians associates and new roles in pharmacy, specialist nursing and Allied Health Professionals (AHPs)** utilising the Apprenticeship Levy to support these developments where possible. This will **create new career pathways** and enable effective care to be delivered to children and young people from a wider staff base. We will work with our multiple academic partners to develop and support sustainable **clinical academic training pathways** across a range of clinical professions.

d) **Equality, diversity and inclusion** – We will support our **excellent staff networks**; the **BAME** (Black, Asian and Minority Ethnic) network, the **Disability** network and the most recently established **LGBTQI+** Network, who are helping to develop plans for improving staff experience and to improve staff diversity and inclusion. We will work with local experts in **community engagement** to improve links and provide better access to **employment opportunities** for the local community. We will continue to build on our success of **increasing opportunities to enter the workforce** through supported pre-employment programmes, apprenticeships, work experience and voluntary roles. We will continue to utilise the **Apprenticeship Levy**, and build on our success as an employer provider, with the aim of delivering a minimum of **50 apprenticeship starts every year** for the next four years.

e) **The Alder Hey Academy** – We will develop **learning and access to opportunities** at all levels, from schools to high level speciality teaching. We will continue to develop our **international networks**, working with the Liverpool City region to maximise opportunities for international placements and learning opportunities, such as our China partnerships. Working with our **Higher Education Institutions**, we will develop new and innovative opportunities for learning, utilising new technologies and digital platforms. We will continue to **'grow the future' of children and young people's specialists**. We will grow our capacity to offer training opportunities to the wider North

West work force, and support local hospitals and primary care teams through education and outreach.

Key Deliverables

Programmes / Projects	When
Implementation of the Leadership Strategy	19/20-23/24
Develop a Trust wide approach to Talent Management and Succession Planning	20/21
Development and set up of a new Staff Advice and Liaison Service (SALS) bringing together staff support, advice and guidance into one service and one place	19/20
Launch 'Time To Change', with over 100 mental health champions trained and deployed across the organisation	20/21
Continue to deliver 50 apprenticeship starts per year	20/21-23/24
Implementation of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) actions plans to improve diversity, inclusion and staff experience	20/21-23/24
Through the Academy, further develop new roles such as Physicians' Associates, Nurse Associates and develop clinical academic training pathways	20/21-23/24
Implement robust workforce planning processes are in place to support service development such as The Liverpool Neonatal Partnership	20/21
E-Roster – efficient rostering and improved job planning for the whole trust (Nursing 19/20, Consultants 20/21)	21/22

6.4 OBJECTIVE 3: SUSTAINABILITY THROUGH EXTERNAL PARTNERSHIPS

	**Our 2024(+) ambitions are 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

The future of health and care will be predicated on successful partnership working. We want Alder Hey to be known as a brilliant partner. We are both a highly specialist tertiary and quaternary hospital with a global reach, and a local community and hospital provider for children and young people; these differing care settings mean we will work in varied partnerships over the next 4 years and beyond.

Local Partnerships

We will work towards our ambitions to provide **care close to home**, **'grow the future' of our services** sustainably and ensure **children and young people are at the heart of everything we do**. Over the next 4 years we will do this by;

- Improving outcomes and reducing inequalities for children, young people and families through an **integrated, community focused model of care and support**. This will be delivered via the **Children's Transformation** Programme and the **'One Liverpool'** plan. These integrated community teams will be based on populations of 30-50,000 across Liverpool (similar plans are currently developing in Sefton and Knowsley). This work will contribute to the health of children and young people across a continuum – from improving the public health of Liverpool, through to ensuring effective use of unplanned and urgent care. The community model will be delivered through Children's community hubs and in local settings.

- Working with **Primary Care Networks** (PCNs) to seek new ways of providing enhanced children and young people's services in local environments, to enable digital alternatives to Outpatient care, and to raise paediatric standards locally. We will begin this work in 2019/20 by supporting children, young people, families and primary care teams to improve the management of **severe paediatric asthma**.

- Sustaining our commitment to Liverpool's efforts to become a **UNICEF Child Friendly City**; an early indication from children and young people's focus groups is that health and wellbeing is a significant theme in this work.

Bringing Women's and Children's, and Specialist Services together

We are **committed to joining up care** over the next 4 years. To do this, we will continue to build on several key local partnerships.

The Liverpool Neonatal Partnership

Excellent joint working with Liverpool Women's NHS Foundation Trust (LWH) will continue, in development of **The Liverpool Neonatal Partnership; one service, two trusts**.

To meet the neonatal standards, a **new Neonatal Intensive Care Unit (NICU)** will be built at Alder Hey by 2020/21, by expanding capacity to full provision of 24 cots (including 8 NICU) from April 2021. The new service will be provided by a **single leadership team working across both sites**, and will be designed to have the **same look and feel** to ensure a seamless experience for mothers, babies and families. The single leadership team is now in place, and the wider team will be fully recruited by 2021.

Bringing Specialist Trusts together for Liverpool (Local)

Alder Hey will continue to work locally with specialist trust colleagues in Liverpool to pool our knowledge, expertise and resource and work together to drive the **delivery of truly world-leading specialist services, research, education and innovation and to support our workforce more effectively**. We are collectively a huge asset and we will collaborate to enable the future development of life sciences and investment into the City Region.

Child and Adolescent Mental Health Services (CAMHS) (Local & C&M HCP)

The future for specialist mental health services is a 'lead provider' model. Alder Hey already provides a strong and diverse mental health service that despite challenges is well thought of by commissioners and families who use it. There are significant opportunities to embed services in the community by increasing integration with partners whilst creating a specialist centre on the Alder Hey site, and to enhance our work across our divisions and neurodevelopmental paediatrics.

Our ambition is to provide high quality, evidenced based mental health services, delivered by a highly skilled, innovative and motivated multi-disciplinary workforce. We are well placed to be a lead provider for Children and Young People's Mental Health for 0-25 year olds across Liverpool and Sefton. We will also play a partnership role in the CAMHS collaboratives across the wider Cheshire & Mersey footprint.

"CAMHS has really helped me to understand my difficulties and has provided a safe space for myself and many other young people. The participation group has given me the opportunity to help improve the stigma associated with mental health and give service users an opportunity to shape the service."

Young Person, Age 18

We will develop new relationships with **higher education institutions** (HEIs) with new roles and training opportunities and community services to respond to changing needs across the system, and we will ensure that children and young people can receive their care more locally through improvements in pathways with primary care and transformed community services.

Specialist, Tertiary and Quaternary services

We will develop our **excellent services to their optimum** over the next 4 years by seeking to **sustain** and **grow** the range of specialist services provided for children and young people of the North. We plan to;

- **Grow** service developments such as: **Cochlear Implants** in **ENT**, **Neurosurgery, Audiology**, **Optical** services, **Cardiac surgery** and **cardiology**, **Laser** and **Chronic Pain** services, **Paediatric Clinical Pharmacology**, **Neonatal** care, **Palliative care**, **Cancer** and **Genomics** (not exhaustive - see p46).

- Participate in the **'Getting it Right First Time'** (GIRFT) programme to identify and address unwarranted variation in care across paediatric specialties
- **Where we are stronger working together, we will seek to work in partnership**, for example across the North West.

Joining up Specialist, Tertiary and Quaternary care in the North

It is our vision to develop the North West as a 'powerhouse' of specialist, tertiary and quaternary services, ensuring that **children, young people and families from our region do not have to travel unnecessarily to receive the very best care**.

By working together with Royal Manchester Children's Hospital (RMCH – part of Manchester Foundation Trust) we will **improve the equity and quality of specialist services for children and young people and their families in the North**.

> *'We aim to have a truly networked service that optimizes the strength of each unit; through staff and facilities available; providing treatment and support for children, young people and families across the whole of the North West and beyond….so that all patients have access to identical facilities regardless of site"*
>
> **The NW Neurosciences Network Strategy (2019)**

We will build on the joint services we already provide over the next 2-4 years, focusing on;

- **Neurosciences** – we will deliver world-class neurology and neurosurgery care for children and young people across the North West network and beyond.
- **Cardiology** – we will deliver the future vision for joint partnership working within paediatric cardiology services across our two sites.
- **Operational Delivery Networks (ODNs)** – we will work together to develop our co-hosted ODNs, developing a common operating model to ensure the most effective neonatal critical care, paediatric neurosciences, cardiac, cleft lip and palate, intensive care, long term ventilation, HIV and major trauma services for children and young people in the North West.

International Child Health

Our International Child Health (ICH) department is already working towards the vision that '**Alder Hey will be contributing to improving the health of the world's children**, have an established, **international paediatric brand** with a **reputation for excellence**, be a

proven partner with a track record of international delivery and have a balanced portfolio of income generating and **mutually beneficial activities** in all areas of paediatric health delivery. Our comprehensive ICH strategy incorporates six key themes;

- **International health partnership (particularly with low-income countries)** – building on our established, mutually beneficial, partnerships, including our longstanding relationships in Malawi and our 21 year association with Kanti Children's Hospital, Kathmandu
- **Humanitarian 'mission' operations** – our people will be supported to continue the significant work they already undertake, for example, delivering cardiac surgery health camps in India, working with charities in Nepal or through humanitarian links with India
- **Commercial / business development** – We will build upon initial progress be made towards developing commercial activities overseas, for example our relationship with Al Jalila Hospital in Dubai and with partners in China, through development of our commercial business plan
- **Education and training** – we will continue to build Alder Hey's global reputation, staff benefits and income generation through our international education and training offer
- **Research** – We will continue to support Alder Hey's international research; this includes, (but is not limited to) internationally-based and world-leading research in oncology, child and maternal health, infectious disease, child development and disability, encephalitis, nutrition, Ebola and more (See 'ICH strategy' for leads and details)
- **Innovation** – we will continue, through our innovation plan (see p33) to develop and deliver world-class innovations on a global stage.

"Established in 2018, the Department of International Child Health is the first department in a paediatric hospital dedicated to coordinating humanitarian work and health partnerships with low and middle income countries. The department works in collaboration with the Alder Hey Academy and the research and innovation departments to likewise improve the care of children in poorly resourced countries"

Professor Barry L Pizer,
Consultant Paediatric Oncologist, Alder Hey
Honorary Professor, Institute of Translational Medicine, University of Liverpool

We will utilise our many strengths in each of these areas to deliver '**a healthier future for children and young people' on a global footprint** over the next four years and beyond.

'Alder Hey with…'

Alder Hey has a **strong brand name**, trusted by children, young people, families and partners alike. We **attract and retain** many leading paediatricians and clinicians. We see our role as both **working in partnership with local services to drive up paediatric standards**, and **working with partners to provide core services in non-specialist settings**. Both of these roles will help enable clinical sustainability as the NHS moves towards a model of more consolidated specialist services.

As we **'grow the future'** we will offer an **'Alder Hey with…' partnership model**, through which we will develop shared standards and governance for children and young people's services with local and wider partners. This could range from working locally with General Practice to 'accredit' practices, helping assure families that they will get the same level of care as they would if they came into Alder Hey, to offering services remotely with district general hospitals, where this benefits both the local population and the improvement of paediatric services across the region.

Key Deliverables

Programmes / Projects	When
Liverpool's Neonatal Partnership (single service with Liverpool Women's)	21/22
All-age CHD new network implemented (hosted at Alder Hey)	19/20
North West Partnership – Implementation of the neurosciences network strategy across the two sites (Alder Hey and RMCH)	22/23
Paying Patient unit established and fully operational	20/21
Develop a system partnership model for Aseptics (following successful licencing of Alder Hey unit)	22/23
International Child Health – Strategic delivery plan implemented	21/22
Establish and grow 'Alder Hey with…' partnership model(s) to support children and young people's care closer to home	23/24+
Partnerships developed with Primary Care Networks to improve paediatric pathways and raise standards (e.g. severe paediatric asthma)	20/21
Delivery of Community children's hubs (Children's Transformation - North Mersey/ system partnership)	22/23

6.5 **OBJECTIVE 4: GAME-CHANGING RESEARCH AND INNOVATION**

Game-changing research and innovation	**Our 2024(+) ambitions are to be known as;** • A **World-leading Children's research centre** enabling 'Outstanding' treatment • Delivering **Digital Excellence** for children, young people, families and our staff (see 'Digital Futures' p35) • A world-leading **centre of excellence** that accelerates the impact of **game-changing innovation** for children and young people

GAME-CHANGING RESEARCH

Alder Hey is already a leading light in children's research, recruiting more children and young people to research than any of our peers. We want to continue our journey to being a **world-leader in children's research**, by enabling children and young people to benefit from 'Outstanding' treatment, advanced medicines and cutting edge therapies and technologies.

We will do this because it leads to **better patient outcomes,** attracts **dynamic and motivated staff,** enables **long-term partnerships**, enhances our **international standing** and achieves **reinvestment** into Alder Hey.

"Research not only leads to the continued development of clinical practice, but also those NHS Trusts which deliver clinical research at scale are associated with better patient outcomes and improved CQC ratings. Therefore our mission is to offer all children and young people the opportunity to participate in clinical research"

Professor Matthew Peak, Director of Research, Alder Hey

We will build our portfolio to play on our **areas of strength** – there are **many excellent people doing research across the trust in diverse fields**. These include, but are not limited to;

- Complex experimental and early phase studies in children and young people
- Respiratory
- Rheumatological disorders
- Ear, Nose and Throat (ENT)
- Neurosciences

- Infectious diseases
- Paediatric Clinical pharmacology
- Medicines formulation research
- Paediatric surgeries

In addition, we will target **future research priorities** in neonatal, cardiovascular, Public Health, Mental Health and more.

Over the next 4 years we deliver our mission through;

- An **engagement and education** programme, with 'research clinics', expert workshops and systematic communication
- **Business model** development – a new financial model for research, offering opportunity for reinvestment and growth
- **Infrastructure** – recruitment into research, integration into divisions and clinical services and improving informatics.
- Development of further **clinical academic posts** with university partners across professional groupings.

Liverpool Health Partners & 'Starting Well'

We are a committed partner in, and of Liverpool Health Partners' (LHP). There is clear alignment between the LHP research strategy and '**Our Plan**' – particularly through the LHP **'Starting Well'** programme. 'Starting Well' is a **collaborative clinical research community** that connects NHS and Higher Education organisations, **maximises research opportunities** for our staff and the city of Liverpool, and ensures we are all **working to shared priorities** so we can make **maximum impact to improve the health of children and young people.**

Key Deliverables

Programmes / Projects	When
Research engagement and education programme implemented	20/21
New Business model for research implemented	19/20
Research infrastructure recruited and Divisional integration working effectively	20/21

INNOVATION

We have incredible innovation resources at Alder Hey, both in our fabulous clinicians and patients, and at our one-of-a-kind 'Innovation Hub'. Our mission is to become a **world leading hub, accelerating the impact of game-changing innovation for the next generation.**

Our vision is to build a healthier future for children and young people using digital and MedTech (medical technologies) Innovation as a key enabler. We will utilise our 1000 square metre dedicated Innovation Hub at the heart of the Alder Hey campus to solve real world health care challenges with cutting edge technology and as a centre of excellence.

We take a unique 'needs-led' approach which enables us to identify the right partners in the innovation ecosystem to create solutions which have a positive impact on children and young people. The industry standard 'technology readiness levels' give the timescale from identification of need, through to triage, pitching to investors and development of prototypes for clinical trials and evaluation as approximately 3-10 years, and on average 7 years. Our strategic goals for Innovation are to;

- **Unleash our innovation culture** – meaning all staff are empowered to create innovative solutions to any needs they identify, and become founders and entrepreneurs supported by the innovation service
- **Create the world's first 'Living Trust'** – creating improved patient experience, outcomes and safety, by building a portfolio of new technologies such as sensors, artificial intelligence (AI), and visualisation.
- **Have a sustainable and profitable business model** – to allow innovation services at Alder Hey to grow and generate income streams.

"Immersive Technology is helping us to produce advanced visualisation of the human body. This is leading to the development of better diagnostics and improved treatments. This includes the use of immersive technology for distraction therapy and mental health support at Alder Hey…Virtual and Augmented Reality is helping to enhance how we share our expertise through education, locally and globally."

Rafael Guerrero, Consultant Cardiac Surgeon, Clinical Director of Cardiac Services, Co-Director of Innovation

From 19/20 and beyond, Alder Hey's **Clinical Innovation leads** will work with healthcare professionals, patients, academia and industry to improve outcomes for patients, families, carers, staff and society.

We have implemented an innovation business plan aligned to our strategic objectives that enables us to develop our world-leading centre of excellence, continue our work as a **global thought leader**, take an '**accelerator**' approach to new products, and be a **test bed** for innovations and by unleashing an **innovation culture** across the trust.

Key Deliverables

Programmes / Projects	When
Innovation Business Plan – implemented	19/20
Board approved Innovation Strategy	19/20
Implementation of the strategy through the new Innovation Committee	20/21
At least one or more products move to "spin out" (commercial structure for a technology start up business)	20/21
Acceleration of 10 identified "needs" through the innovation triage process, with ensuing pitch to investors	22/23
Target of 50% of validated "needs" reach prototype; 10% go to Clinical Trials	23/24+

6.6 **STRONG FOUNDATIONS**

All of our strategic objectives are underpinned by vital 'strong foundations'. These are the infrastructures without which we cannot work, but that also drive many of our future ambitions, approaches and opportunities.

DIGITAL FUTURES

Our vision is to create an ethos of '**Outstanding Digital Excellence'**. At the heart of this vision is our 'north star' focus on **creating the best experience and outcomes for children, young people, families and staff**.

Through our **'Digital Futures'** strategy we will strive to;

- Provide the **best possible digital and technology services** to support, enable and drive clinical excellence, digital quality improvement, outcomes and patient safety
- **Deliver Information Technology (IT) basics brilliantly**, championing a 'Digital First' approach across Alder Hey, supported by excellent, proactive, customer focused services

- **Unleash innovation and research** to **grow the future**, harnessing digital technology in order to create opportunities to adopt and evaluate digital innovations throughout the world's first 'Living Trust'
- **Maximise local, national and international partnerships** to bring in expertise and new advances in pursuit of a shared **vision**

"Becoming part of the Alder Hey family has been a fantastic journey for me. It has been lovely to see Alder Hey's commitment to expanding their services based in the community, to ensure the patient is supported in the most appropriate environment. Alder Hey supports clinicians to be involved in IT development, to ensure that the patient's clinical journey is at the centre of innovation."

Victoria Furfie, Speech and Language Therapist /Divisional CCIO – Community

"Technology for us as young people is a large part of our everyday life. Living in this day and age the ability to use the newest technology is necessary for almost all jobs and therefore would be very useful for us to be a part of."

"Hospitals can be a very fearful place – especially for children – and we should use digital technology like virtual reality to reduce this."

Tom Age 17

Success is defined by outstanding digital excellence becoming central to delivery of improved outcomes and experience of health and social care for our Children, Young People, Families and our Staff, and that we act as an exemplar and implementation partner to other NHS organisations. The experience of technology application for staff and patients in our Trust should be better than their home experience.

Quality, safety and experience will be improved through moving to a world-class digital environment by ensuring the right information to the right staff at the right time. Through co-design with staff, children, young people and families, our **'Living Trust'** will support delivery of excellent care, provide intuitive and innovative ways of working. **Augmented digital assistants** will help ensure that children and young people can get the very best care. **We will use artificial intelligence (AI) and augmented technologies to eradicate the role of the clinician as a data entry technician.**

We will continue to be **at the forefront of a global healthcare system** as a **recognised leader in digitally-enabled healthcare and innovation**, creating a pipeline of new products and therapies in partnership with children and young people.

Key Deliverables

Programmes / Projects (see 'Digital Futures' strategy for details)	**When**
Digital Children, Young People and Families – digital front door, digital communications, digital services including digital and online communications	21/22
Digital Quality Improvement – digital hospital/community, Inspiring Quality, intelligence led care, digitally enabled staff, system wide developments	21/22
Unleashing Innovation and Research – Living Trust, Innovation Hub, Research and Evaluation	21/22
Technology Roadmap – Interoperability, service improvement plan, security and resilience	20/21

ALDER HEY IN THE PARK AND THE BEST COMMUNITY ENVIRONMENTS

Alder Hey has an amazing track record in building world-leading environments, as evidenced by our incredible **Alder Hey in the Park** hospital, **designed by children and young people**. Over the next four years we will continue with our ambitious plans to develop our **Health Campus**; this includes building **new bespoke specialist facilities for community and mental health services**, which will enable us to deliver the very best multi-disciplinary neurodevelopmental assessments all in one tailor-made place. We will relocate our **inpatient 'tier 4' CAMHS** services to a purpose-built specialist environment within the Alder Hey grounds.

Our **objectives** are to develop a whole health campus that;

- Supports Alder Hey's ambition to grow as a world class children and young people's healthcare organisation;
- Furthers Liverpool's drive to become a UNICEF Child Friendly City
- Provides significant community benefits to the local area including the return of a high quality park to the neighbourhood.

Key **enablers** for the health campus are:

- The creation of a fantastic new park
- The expansion of Alder Hey services on the campus including the community cluster and the neonates expansion
- The incorporation of neighbouring sites to facilitate the expansion of the hospital in the long term
- The creation and exploitation of a complementary 6 acre plot in the North East of the campus to further the objectives of Alder Hey and the City.

The development of the campus facilitates a number of connected **opportunities**, including;

- **Health and Wellbeing, including Mental Health** – we plan to use the Park to bring a focus and opportunity for developing programmes that support the city wide campaign to become a child friendly city and improve the health and wellbeing of children.

- **Science and Knowledge** – we will build on the development of the Innovation Hub, the Alder Hey Academy and Research to create a world class science offering based around Alder Hey;

- **Regeneration and community building** - looking at opportunities for involving the local community in building the campus, participating in events and programmes and generating a positive impact on the local area.

Key Deliverables

Programmes / Projects	When
Complete new Family Bereavement Centre (The Alder Centre)	20/21
Build specialist facilities for Community and Mental Health services, including Child and Adolescent inpatient (Tier 4) Mental Health facility (Dewi Jones unit)	20/21
Springfield Park – completed reinstatement and development plan	19/20
New Neonatal Intensive Care Unit (NICU)	22/23
Utility Infrastructure District Heating scheme (linking Institute and Community buildings with an energy efficient and cost effective ground source heat network)	20/21
Infrastructure Landscape – comprehensive landscaping for the access and connection to and between the new campus buildings	20/21

OUR FINANCIAL FUTURE

We have a clear financial strategy for Alder Hey to drive forward with the ambitions set out in 'Our Plan' which will underpin the required long term investment in our services and assets.

Alder Hey has been very successful in recent years in delivering financial balance and at the same time overachieving against our financial plans through one off commercial agreements. This achievement has also allowed us to attract central NHS incentive funds, which put the Trust in a strong position to be able to invest approximately £100m in our Estate, IT and Medical Equipment over the four year duration of 'Our Plan'. Going forward, the financial stability of the wider NHS sets a challenging context for the delivery of 'Our Plan', particularly as our system comes together in a way not previously seen.

Financially, this is likely to mean that we operate across one or more Integrated Care System(s) (ICS) with significant devolution of commissioning budgets. It will also likely mean a move away from what has been a heavily tariff based system, and one in which system financial targets outweigh the performance of individual organisations.

We can only achieve 'Our Plan' by embracing this changing environment; however we need to also recognise that some strategies of the past may not be fit for purpose in the future. We will be agile in our thinking, understanding the changing commissioning landscape and working with our partners to ensure we can continue to evolve and improve.

To meet our long term re-investment in our services and our people, and to ensure we can meet our long term financial obligations, we will move to an underlying £5m surplus (currently a £1.6m deficit). This is a significant challenge and will require us to be more radical in some of our approaches over the four years of 'Our Plan'.

We have outlined below the **key principles** that will underpin our financial strategy:

- **Reduce Waste** – we will continue to ensure our services are as efficient as possible, cutting waste that will play to our wider role in ensuring we minimise our consumption and support the environment and will also save money.

- **Innovate** – through our culture of innovation we will look for transformative solutions to the challenges we face. We will be at the forefront of ensuring our approach to innovation is embedded in how we change our front line services.

- **"Digital Futures"** – '**Our Plan**' is underpinned by technological advancement that will mean we can deliver care and services in a very different way in the future, Moving away from a focus on 'bricks and mortar' to delivering services in a way our next generation expect and more efficiently. An early example of this will be the transformation of how we deliver outpatient services.

- **Brilliant Basics & Inspiring Quality** – In the long term our programme to ensure we further improve safety and outcomes will make us more efficient. We will work with our specialties on a programme similar to Getting it Right First Time (GIRFT) to reduce clinical variation. Our aim to reduce safety incidents will not only improve the quality of our care but also will mean we continue to reduce waste.

- **Grow** – we will continue to grow our services where Alder Hey can offer the very best of care to our children and young people, be that independently or in partnership, and where this meets the needs of the wider system we serve.

- **In our 'PLACE'** – through our work on our clinical strategies we will deliver care in the most appropriate setting. We will have a dual aim - reducing the need for services to be delivered from hospital wherever possible, and at the same time ensuring we have the right capacity to look after children where they can benefit from our highly specialised services.

- **Inward investment** – We will attract investment into Alder Hey and the wider system within which we operate. Many of our supporting strategies, such as research, innovation and education, focus on this investment for us to make a stepped move in our offer. We will ensure services highlighted in the NHS Long Term Plan are well placed to meet the needs of our children.

- **Partnership** – our partnerships will help ensure that the collective whole is more resilient, is able to offer a higher quality of service and can be more efficient. Our initial work with the Specialist Trusts in Liverpool has highlighted this potential. Our early focus will be on our corporate services however we will look for further synergies wherever we can.

- **Non NHS** – Alder Hey is already a global brand and as we continue to develop we will look to help and support children and young people from across the World. The Trust Board are clear this will include us doing all we can to support countries less developed than our own, and growing our capacity for private international patients.

It is our belief that this financial strategy will work in the changing environment that we face, and as such, these principles underpin '**Our Plan**' throughout.

6.7 **OUR CLINICAL AND SERVICE STRATEGY**

In addition to the shared objectives described, our Clinical Divisions and individual services have identified key priorities over the next 4 years.

Clinical Division				
Community & Mental Health	• Deliver consistent, equitable **access to all community and Mental Health services** e.g. Diagnostic waiting times for **autism** and **ADHD** underpinned by voices of children and families • **Robust IT infrastructure** that supports reporting and demonstrates improvement in outcomes for children & young people	• Successfully address workforce challenges including **more new roles** e.g. Physicians Associates and **opportunities for young people** e.g. Volunteering	• Be the **lead provider of community and mental health services** (including Primary Care workforce) for 0-25yrs across Liverpool & Sefton • Technology enabled reduction in hospital based **Outpatient** attendances	• Use the **newest technologies to support excellence in out of hospital care** e.g. **digital or online therapy** resulting in approx. 20% children and young people accessing their care via this route

Clinical Division				
Medicine	• Shift from **reactive to planned** care wherever possible • **Urgent Care** (Urgent Treatment Centres) • **Inspiring Quality**- do everything with children & families • Identify a **Children's Lead** for each Care Group (representation: interviews, planning, meetings) • **Obesity** – development of a 'Level 3' obesity service	• Implementation of **Integrated Workforce**, **Models of Care**, **Acute Response Team** for deteriorating patients • Staff **health, wellbeing and recognition** • **Training and Development** • Building **positive partnerships with families** and addressing challenging behaviours.	• **Primary Care / Networks -** links to Acute services • Technology enabled reduction in hospital based **Outpatient** attendance • New **Networks**- Asthma, Epilepsy, Diabetes • **Neurosciences** – North West for e.g. epilepsy surgery (NorCESS) & babies with abnormally high insulin levels (NorCHI) • **Palliative Care** – partnership in the community	▪ **Genomics**- Cancer, Neurology ▪ **Predictive Prevention** (Urgent Care, Respiratory) ▪ **Digital Futures** ▪ **Artificial Intelligence** (AI) ▪ Innovative Approaches to **Workforce** (Roles & Responsibilities) ▪ **Grow the future** (Research, Innovation, Partnerships)

Clinical Division				
			• **Diagnostics** – system partnership	
Surgery	• Fully established **Post-Operative Cardiac Unit (POCU)** • New clinical model of care in **High Dependency Unit** (HDU) • Liverpool **Neonatal** Partnership - delivery • **Electronic Anaesthetic Record** • Technology enabled reduction in hospital based **Outpatient** attendances.	• **Redesigned (multi-disciplinary) workforce model** to provide consistent, safe, effective cover for current "Junior Doctor level" • Target 50% reduction in **absence related to Mental Health.** • Retain **Resilient Staffing Levels**: recruitment, retention and succession planning for specialist roles – including **Operating Department Practitioners (ODPs)** and	• **Leading tertiary Neonatal** services in the NW • **Lead all-age Congenital Heart Disease** (CHD) service across the NW • Partner with adult **Burns Centre** to comply with all quality standards • Further **strengthen networks** with Manchester and Stoke • Increase number of **nationally designated**	• Step change in embedding Research and Innovation across Division • Implement **new pathways / ways of working** (new "firsts") which are adopted by other NHS Trusts • Widespread use of **Alder Play App** to facilitate care • Digitally enabled (AI?) **Theatre Scheduling**

Clinical Division				
		Critical Care nurses.	**services**, for example Vein of Galen, Selective Dorsal Rhizotomy (SDR), Deep Brain Stimulation (DBS), Burns, Cochlear Implants • Develop "**hub and spoke" models** with DGH's • Improve **transition pathways** into adult care	

In addition to the service priorities highlighted above we will to undertake a systematic approach to developing **clinical service plans** for every service by the close of 2019/20. These will be developed in partnership with service teams, enabling everyone to know where they are headed, and to know how they contribute to and influence Alder Hey's future. Clinical service plans will be collated and developed into our Clinical Strategy through a series of clinical engagement events during 19/20-20/21. The Clinical Strategy will be produced as a supplementary document to accompany '**Our Plan**' in 20/21.

Section 7: HOW WE WILL DELIVER 'OUR PLAN'

We will deliver and monitor progress against '**Our Plan**' in the following ways;

- Systematised and **on-going communication with staff** to ensure all aspects of '**Our Plan**' are understood and recognised, and so that we can incorporate feedback from staff to ensure the message is being received as anticipated
- Strategic oversight of overall progress against '**Our Plan**' presented to **Trust Board** on a twice-yearly basis
- Strategic oversight of progress towards our strategic objectives through **Trust Board** and **Committees of the Board**
- Regular review of progress against '**Our Plan**' with **Board of Governors** (twice yearly)
- Key risks to delivery of '**Our Plan**' identified through our Board Assurance Framework (BAF); monthly assurance provided to Trust Board
- Devolved clinical leadership within **Divisions** who oversee implementation of '**Our Plan**'. This will include;

    - Oversight of progress in cross-divisional themes and objectives through the **Strategy and Operations Delivery Board** (monthly)
    - Review of progress against strategic objectives and key milestones within **Divisional Boards** (monthly)
    - **Divisional Performance reviews** (bi-monthly) where Divisions provide assurance of progress against all aspects of '**Our Plan**' and have access to executive scrutiny and challenge. These will develop so that equal emphasis is placed on '**brilliant basics**' and '**growing the future'**.

- Transformational Projects and Programmes will be managed and monitored via the **Change Programme; governed via Programme Board** (monthly), with assurance reported through each Board Committee and Trust Board.

Section 8: A DAY IN THE LIFE…

'The Child or Young Person's Perspective'

From a children, young people, families and carers perspective, delivery of '**Our Plan**' will mean:

- Children and young people will be able to access Alder Hey standards of care from a wider base; they can walk into their local health centre, rather than coming into the hospital, knowing they'll get the same level of trusted service
- They will be able to 'tell their story once' as partners in their care will be working together across communities
- Children, young people, families and carers will be able to interact digitally with professionals involved in their care – this means they don't have to miss school and work for as many appointments!
- Children, young people and families can expect joined up, safe care that is enabled through a co-ordinated approach across the whole region

'Our People'

Implementation of '**Our Plan**' will mean the following for our staff;

- Our people have access to everything they need to treat their children and young people effectively, wherever they need it
- Our people will have access to fantastic training and education opportunities to develop themselves
- The health and wellbeing of our people will be held in the highest regard, and they will be supported as such
- Our people have ever greater opportunities to pursue research that improves outcomes for the children and young people they look after
- They will experience fewer frustrations as care will be more joined up, with less duplication through readily available information, integration and automation
- They will be encouraged and supported to develop and implement their innovations and ideas
- Technology will work as well for staff in work as their technology at home does

Our Trust, Broader System and Region

For Alder Hey, the broader system and region, delivery of '**Our Plan**' means:

- Putting children and young people's services and 'starting well' at the heart of system plans
- A universal approach and delivery of children and young people's services, which increases the standard of paediatric care across the whole system
- Developing a single paediatric workforce approach, which enables flexibility and clinical sustainability for all
- Working in partnership across the whole system
- Introducing cross-organisational pathways and ensuring a child or young person's record data is shared, reducing time and improving quality of service delivery and care
- Electronic flagging of children and young people suitable for research leading to quicker identification of patients and associated trials
- Improvements in population-health monitoring and planning

APPENDICES

Appendix 1: **Our Journey so far; the excellence already being delivered by the Alder Hey team**

We are extremely proud of the many accomplishments of our staff at Alder Hey. Here are some of our most recent achievements;

	• We are rated by the Care Quality Commission (CQC) as **'Outstanding' for Caring** and **'Good' overall** • We have an **amazing new hospital** delivering outstanding care • We have significantly **grown our community services**, providing vital care closer to home • We have achieved a **25% reduction** in **hospital acquired MSSA** in 18/19 • We are in our **3rd year of zero grade 4 pressure ulcers** • In 2018/19 we had **no cancelled operations for 'staffing unavailable'** and a **69% reduction in children experiencing cancelled operations** • We have achieved an **18.6% reduction in medication incidents since 2014/15** • We have achieved **full delivery** of the **national** cancer, referral-to-treatment and diagnostic **standards** • Our **Emergency Department** was in the top 15 in the UK for **meeting the 4 hour standard** in 18/19 • We won our bid to become one of the first **Mental Health 'Trailblazers'** in the UK, and are now providing mental health support into schools
	• **60% of our staff responded** to the staff survey, our highest ever response rate, and we saw improvements across over 75% of questions; **72% of staff said they would recommend the Trust as a place to work** to their friends and family, an increase of 8% from 2017 • We have recruited a **Consultant Clinical Psychologist** to lead the **Organisational Development** (OD) agenda for the Trust • We implemented a **Vocational Adviser** role, supporting work

	experience, careers fairs, schools engagement and pre-employment programmes • We have **zero use of nurse agency** due to proactive nurse workforce planning • We have more **Advanced Clinical Practitioners** (ACPs) in post than any other NHS organisation • We supported **over 55 members** of staff to access an **apprenticeship pathway** • We achieved **Library Quality Assurance Framework accreditation** • We launched the **Leadership Strategy** and developed the **Strong Foundations** programme • We won the **Business Education Award** for our **North West China Partnership**.
	• We achieved **Tier 1 Congenital Heart Disease** (CHD) status (with the Liverpool partnership) for the North, performing **410** operations in 18/19, and successfully tripling the size of our all-age **CHD network** to support the highest standards of CHD care throughout the North. • We achieved approval to develop the **Neonatal Intensive Care Unit (NICU)** and build our **Liverpool Neonatal Partnership** with Liverpool Women's Hospital • We formalised our **partnership with Royal Manchester Children's Hospital** (RMCH), enabling us to provide the best joined up care for children and young people across the North West (for example in neurosciences and burns).
	• We recruit the **highest number of children and young people to research studies; over 44,000** since the inception of the National Institute for Health Research (NIHR) Clinical Research Network (CRN). • We have wide-ranging **core research strengths** including respiratory, rheumatology, neurosciences, infectious diseases, clinical pharmacology (paediatric), medicines formulation research and paediatric surgeries.

	• In partnership with the University of Liverpool, the NIHR Alder Hey **Clinical Research Facility for Experimental Medicine** offers children and young people the opportunity to take part in life-changing research trials**.** • We are the only trust in the country that has a 'Bat Cave', otherwise known as the **Innovation Hub**, pioneering leading innovations globally
STRONG FOUND-ATIONS	• We are one of sixteen trusts who were identified as part of the **Global Digital Exemplar** programme, enabling us to digitise clinical pathways, improve integration and spearhead regional interoperability development • We have begun building our **new Alder Centre** to give the best possible environment for those using our **bereavement services** • We have built an amazing dedicated research, education and innovation **Institute,** which we share with **four academic partners** (University of Liverpool, Edge Hill University, Liverpool John Moores University and University of Central Lancashire) • We have launched our **International Child Health Department,** which is **providing philanthropic care** to children and young people world-wide.

We host many **centres of excellence in specialist medicine and care**, and we are the **specialist leader for a number of key children's health issues**.

Examples of our **excellence** include;

- **Major trauma** – we are one of two paediatric major trauma centres for the North West, providing networked care for the North West, North Wales and the Isle of Man.
- **Burns –** we treat burn injured children with all levels of severity of injury and work in partnership across the North West to provide the most specialist levels of care.
- **ECMO** (Extracorporeal Membrane Oxygenation - which is a highly specialised way to provide prolonged support for the heart and lungs when a child or young person cannot do this on their own) – this enables us to do our excellent cardiac surgery

and helps children and young people with recovery from possibly fatal respiratory problems.

- **Epilepsy** – we are one of just 4 centres for paediatric surgery in the UK.
- **Congenital heart disease (CHD)** – we are the lead (Level 1) provider for all paediatric surgery in the North West and we host the all-age CHD network for the region.
- **Childhood lupus** – we are the UK's first and only Centre of Excellence for Childhood Lupus, and a Coordinating Centre for the UK's multi-disciplinary translational research study group (JSLE Study Group) investigating this disease.
- **Muscular dystrophy** - we have been awarded by Muscular Dystrophy UK the role centre of clinical excellence, meaning we are recognised as a centre of excellence, treating around **550** children and young people with this rare and complex condition
- **Craniofacial surgery** - we are one of just **4** centres for craniofacial surgery in the UK.
- **Oncology** – The oncology/ haematology department at Alder Hey is proud to deliver first class care for children and young people suffering from solid tumours and leukaemia. We have a world class reputation in paediatric brain and spinal cord tumours. We have a proud record of development of participation in clinical trials including our role as a designated early phase trials unit.
- **Orthopaedics –** we are a centre of excellence for spinal surgery and the use of magnetic growing rods, which mean children with early onset scoliosis can have fewer surgeries, as doctors control their implanted rods from an external remote control.
- **North West Movement Analysis Centre (NWMAC)** – we are accredited by CMAS (the Clinical Movement Analysis Society) as one of the largest clinical gait laboratories in the UK; this means we can provide the best movement testing for children and young people with conditions like Cerebral Palsy.
- **Orthotics** – we are a nationally recognised service of excellence - supporting our Spinal service with new technology in 3D scanning and brace design; this helps patients become more accepting of their brace, improving outcomes and reducing incidents of spinal surgery to correct scoliosis.
- **Tier 4 Child and Adolescent Mental Health Services (CAMHS)** - we provide the most specialist level of CAMHS services through our Dewi Jones unit.
- **Paediatric Surgery** – we see the greatest volume of elective paediatric admissions

in the UK, and the second greatest volume of non-elective admissions[5] - this gives us critical mass in a significant range of paediatric surgeries, meaning we have a high degree of surgical expertise.

- **Paediatric Clinical Pharmacology** – we are the only training centre in the UK.
- We are a National Institute for Health Research (NIHR) **Clinical Research Facility for Experimental Medicine.**
- We host an NHS led **Paediatric Medicines Research Unit** involving four university collaborative partnerships.

We are also **locally, regionally and nationally recognised** for our;

- Sexual Assault and Referral Unit ('The Rainbow Centre')
- Liverpool schools pilot in Mental Health ('Trailblazer')
- Eating Disorder Service
- Community Respiratory Physiotherapy service
- Community Nursing and Matrons

[5] 'Getting it right first time' (GIRFT) Paediatric Surgery Review, October 2018

Appendix 2: **How we got here – Engagement so far**

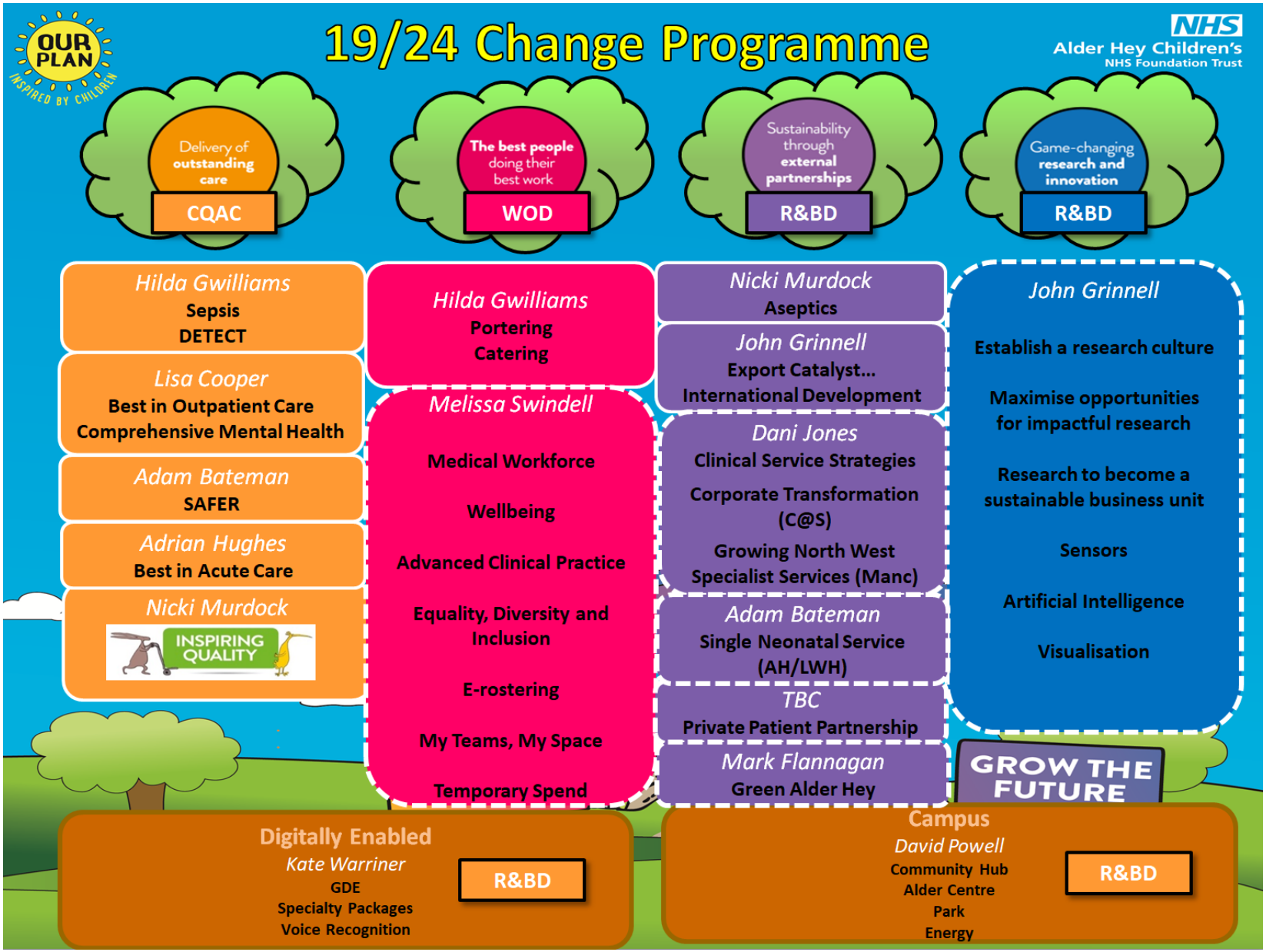
A strategy is only as good as the people who inform it and who will bring the future vision to life. The development of '**Our Plan**' has been, and continues to be, shaped through systematic communication and engagement with the following important groups;

Our People - Alder Hey staff	• Alder Hey Futures events – 17th September 19 • Alder Hey Futures weekly deep-dives – September 19 • 'Latest with Louise' updates – monthly • Inspiring Quality summit - 2018
Children, Young People & Families	• Inspiring Quality – throughout 2018 • Children & Young People's Forum – adoption of priorities including digital and climate change (ongoing engagement to be scheduled).
Clinical Divisions & Services	• 5 year Strategic Priorities – 24th January 19
Trust Board	• Strategy Development Session – 25th June 19 • Draft Strategy review – 3rd September 19 • Final Strategy approval – 1st October 19 • Designed Strategy document – 5th November 19
Council of Governors	• Strategy Development Session – 25th June 19 • Draft Strategy review – 16th September 19 • Final Strategy – 9th December 19
Specialist Commissioning	• Specialist Commissioning Local Strategy – 2018 • Executive to Executive meeting - 24th October 2019
Clinical Commissioning Groups & Local Authorities	• Liverpool 'System Capability Programme' and 'One Liverpool' Plan refresh – Summer 2019 • 'Shaping Sefton' – Summer 2019 • Knowsley 'Place' 5 year planning – Summer 2019
HCP Women's & Children's	• Women & Children's Roadshow – June 19

Appendix 3: **Clinical Divisions and Services**

Medicine	Surgery	Community	Clinical Research
- Emergency Department - General Paediatrics - Diabetes - Respiratory Medicine - Infectious Diseases - Immunology - Metabolic Diseases - Nephrology - Rheumatology - Gastroenterology - Dermatology - Endocrinology - Dietetics - Oncology - Haematology - Palliative Care - Bereavement Services - Radiology - Pathology - Pharmacy - Psychology - Therapies - Long Term Ventilation	- Cardiac Surgery and Cardiology - Paediatric Intensive Care - High Dependency Unit - Burns Unit - General Surgery - Urology - Gynaecology - Neonatal Surgery - Theatres - Anaesthesia and Chronic Pain - Ear, Nose and Throat and Audiology - Cleft Lip and Palate - Ophthalmology - Maxillofacial Surgery - Dentistry and Orthodontics - Neurosurgery and Neurology - Craniofacial Surgery - Orthopaedics - Plastic Surgery	- Children's Community Nursing Team - Homecare - Community Matrons - Community Therapies - Neurodevelopmental Paediatrics - Community Paediatrics - Safeguarding Services - Fostering and Adoption - Child and Adolescent Mental Health Services	- NIHR Clinical Research Facility for Experimental Medicine - Paediatric Medicines Research Unit - Children's Nursing Research Unit - Clinical Research Delivery multidisciplinary workforce - Research Safety, governance and quality team

Appendix 4: **The 2019-2024 Change Programme**



Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	**Change Programme Progress Report**
Report of:	Change Programme Progress
Paper Prepared by:	Natalie Deakin

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

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

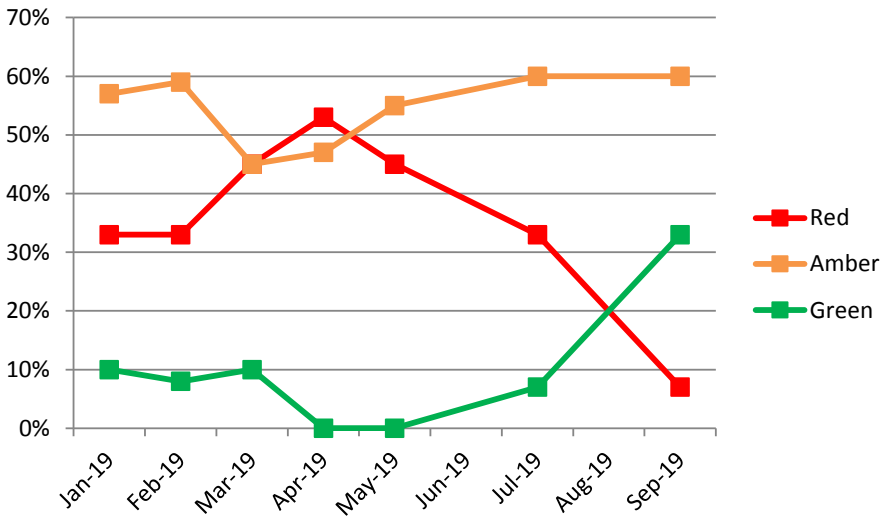
Change Programme

Programme Summary (to be completed by **Head of Programme Management**)

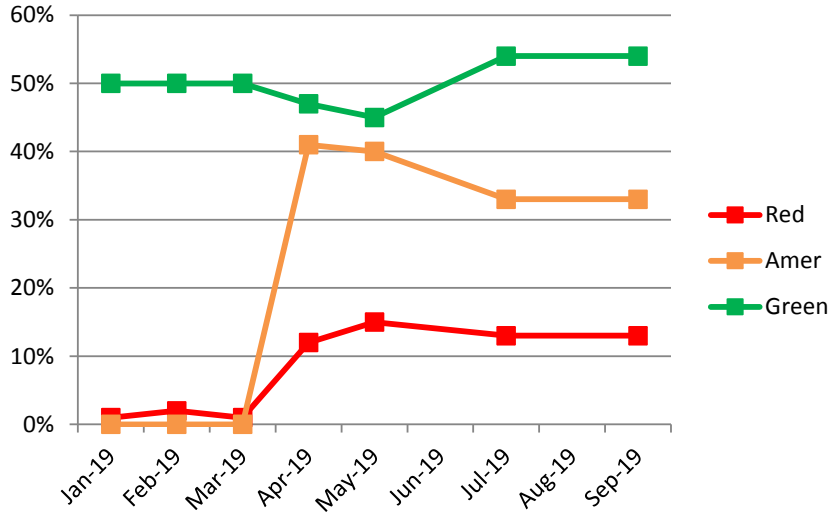
1. This Board report comprises of extracts from the assurance dashboard covering all 7 themes of the change programme as reporting to the Board sub-Committees: CQAC 18 September, WOD 19 September and RABD 25 September.
2. Slide 2 of this programme assurance report contains the current scope for the19/20 change programme.
3. Of the 15 projects rated in this report with regards to the **overall delivery** assessment: 7% of the projects are green rated with 60% amber and 33% red. These percentage summary assessments show improvement from the previous month.
4. The **overall governance** position is satisfactory with 54% of the projects green rated, 33% amber and 13% red. This has remained stagnant from the previous Trust Board report.

N Deakin, Head of Programme Management and Independent Programme Assurance 24 September 19

Delivery Ratings



Governance Ratings



19/24 Change Programme

OUR PLAN – INSPIRED BY CHILDREN

NHS Alder Hey Children's NHS Foundation Trust

Delivery of outstanding care – CQAC

Hilda Gwilliams
Sepsis
DETECT

Lisa Cooper
Best in Outpatient Care
Comprehensive Mental Health

Adam Bateman
SAFER

Adrian Hughes
Best in Acute Care

Nicki Murdock
INSPIRING QUALITY

The best people doing their best work – WOD

Hilda Gwilliams
Portering
Catering

Melissa Swindell
E-Rostering
Medical Workforce

Melissa Swindell
Wellbeing
Equality, Diversion and Inclusion
Advanced Clinical Practice
My Teams, My Space

Sustainability through external partnerships – R&BD

Nicki Murdock
Aseptics

John Grinnell
Export Catalyst…
International Development

Dani Jones
Clinical Service Strategies
Corporate Collaboration (C@S)
Growing North West Specialist Services

Adam Bateman
Liverpool Neonatal Partnership (AH/LWH)

TBC
Private Patient Partnership

Mark Flannagan
Green Alder Hey

Game-changing research and innovation – R&BD

John Grinnell

Establish a research culture

Maximise opportunities for impactful research

Research to become a sustainable business unit

Sensors

Artificial Intelligence

Visualisation

BRILLIANT BASICS

GROW THE FUTURE

Digitally Enabled – R&BD

Kate Warriner
GDE / HIMMS
Paper free
EPR Upgrade

Campus – R&BD

David Powell
Community Hub
Alder Centre
Park

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Delivering Outstanding Care

Work Stream Summary (completed by Independent Programme Assurance)

Overall, for the **Delivery of Outstanding Care** programme, governance and delivery ratings have remained fairly stagnant this month.

Year 2 PID for *Sepsis* was submitted to Programme Board but requires further development before sign off.

Focus should remain on completing any outstanding gaps in metrics particularly within the *Inspiring Quality* programme, *DETECT* study and *Best in Acute Care* project.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 11 Sep 19

CIP Status – as at 11th September 19

		In Year Forecast			
Division	Director	Target £000's	Forecast £000's	Gap £000's	% of target
Community	Lisa Cooper	534	470	-64	88%
Medicine	Adrian Hughes	2,269	1,427	-842	63%
Surgical Care	Christian Duncan	2,201	2,081	-120	95%
Subtotal: Clinical Divisions		**5,003**	**3,978**	**-1,025**	80%
Alder Hey in the Park	David Powell	199	78	-121	39%
Facilities	Hilda Gwilliams	194	55	-139	28%
Nursing & Quality	Hilda Gwilliams	87	0	-87	0%
Finance	John Grinnell	112	110	-2	99%
IM&T	Kate Warriner	94	239	145	254%
Human Resources	Melissa Swindell	92	25	-67	27%
Executive	Erica Saunders	101	8	-94	7%
Subtotal: Non-Clinical Divisions		**879**	**514**	**-365**	58%
Innovation		6	0	-6	0%
Academy		7	0	-7	0%
International		3	0	-3	0%
R&D		99	0	-99	0%
Grand Total		**5,997**	**4,492**	**-1,505**	75%

Independent Programme Assurance Report
Sepsis

Sep 19

Exec Sponsor: Hilda Gwilliams

To improve the awareness about sepsis throughout the hospital. Using a framework tool to support the early identification, escalation and timely response to treatment for patients with suspected/known sepsis.

Key Programme Metrics	Baseline (2017)	Current (July)	Target
Percentage of inpatients treated for sepsis with high risk criteria in <60 mins	N/A	79.3%	90%
Percentage of ED patients treated for sepsis with high risk criteria in <60 mins	N/A	80%	90%
Training in relation to sepsis management for Nurses	0	72% (using e-learning report)	90%
Training in relation to sepsis management for Clinicians	0	38% (using e-learning report)	90%

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	🟢	🔴	🟡	🟡	🟢	🟢		🔴	🔴	Sepsis Steering Group minutes are available up to 17 July 19. 'Year 2 PID' has not progressed since Programme Board on 22 Aug 19. Amended benefits / targets still need to be formally signed off at Programme Board and CQAC. Milestone Plan for 'year 2' is no longer available. There is a presentation which details the requested changes to benefits / metrics but no documentation regarding the outcome of this is available. An update presentation appears to show some of the metrics trending in the right direction although this is not reported formally on the benefits tracker.The communications plan 2018-20 gives a high level list of activities but they are not tracked for completion. Some risks are overdue their review date on the Ulysses system. EA/QIA complete. **Last updated 23 Aug 19.**

Independent Programme Assurance Report
DETECT

Sep 19

Exec Sponsor: Hilda Gwilliams

The project will:

- Standardise active monitoring of vital signs to determine the individual patient risk for deterioration using underpinning age-specific PEWS risk models.
- Improve the accuracy, availability and visibility of patients' vital signs and PEWS to the entire clinical team in real-time
- Use in-built escalation pathways, based on the recorded information, to prompt a timely review and appropriate treatment.
- Measure the clinical utility of VitalPAC Paediatric to detect deteriorating patients.
- Highlight patients displaying two or more components of the NICE sepsis pathway
- Further analysis of the cases of critical deterioration to understand individual risk factors for deterioration, the deteriorations which might be preventable and which processes would need to be affected to reduce deterioration across the hospital.
- Explore the experiences of patients and their families of being monitored using VitalPAC Paediatric and examine its clinical utility and acceptability to clinicians.

Key Programme Metrics	Baseline	Current	Target
Reduction in number of beds used for critical deterioration	7665 bed days used per annum	TBC	6.5% reduction in number f bed days
Reduction in length of hospital stay	TBC	TBC	TBC
Reduction in PICU costs	£11m (cost of stays in PICU associated with critical deterioration over a 12 month period)	TBC	TBC
Reduction in number of cardiac arrest calls	83 (Mar 18-Feb 19)	TBC	TBC

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	●	●	●	●	●	●		●	●	Evidence of project team meetings are in evidence up to 6 Aug 19. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed. Benefit metrics are outlined however not yet being tracked. A detailed workbook has now been uploaded which contains task logs and a comprehensive milestone plan although the plan does not appear to be tracked. There is a suite of stakeholder engagement however wider stakeholder engagement should now be considered as the implementation date approaches. Risks are on Ulysses and within review date. EA/QIA uploaded and signed. **Last updated 5 Aug 19.**

Independent Programme Assurance Report
Best in Outpatients

Sep 19

Exec Sponsor: Lisa Cooper

The Best in Outpatient Project will deliver an outstanding experience of Outpatients services for children, families and professionals, measured by increased patient, family and staff satisfaction, improvements to flow and waiting times, a safe increase in patient activity, enhanced methods of staff support and improved usability of clinical and administrative systems.

Key Programme Metrics	Baseline (Mar 19)	Current (July 19)	Target (Mar 20)
Increase % of visitors likely to recommend OPD	91% (Mar 19)	91%	95%
Increase Clinicians satisfaction with OPD (every 4m measure)	40% (Mar 18) 60% (Mar 19)	85%	80%
Reduce missing outcomes ePPF	1253 (Mar 19)	1097	626
Reduce cash up's completed after 48hours of appointment (ePPF)	11%	10%	5%
Reduction in Phlebotomy incidents	4	3	0

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	●	●	●	●	●	●		●	●	Evidence of Steering Group meetings available to 03 Sep 2019. A comprehensive 19/20 PID is available and has now been signed off at Programme Board. There is a comprehensive benefits tracker available albeit with a couple of minor omissions. A milestone plan for 19/20 is available and closely tracked. There is a planned approach to stakeholder engagement and a number of Outpatient departmental newsletters are in evidence. Monthly highlight reports which have been presented to Programme Board are available. Risks are managed via Ulysses and are all within review date. EA/QIA signed and uploaded. **Last updated 11 Sep 19.**

Independent Programme Assurance Report
SAFER

Sep 19

Exec Sponsor: Adam Bateman

The SAFER Bundle is a practical tool to reduce delays for patients in inpatient wards and works particularly well when it is used in conjunction with the 'Red and Green Days' approach. The SAFER Bundle blends five elements of best practice to achieve cumulative benefits namely; to reduce length of stay, increase turnover and improve patient experience.

Key Programme Metrics	Baseline	Current (July 19)	Target
A: 'Do you know your planned date of discharge?' (F&F test)	67%	87%	95%
E: Reduction in cancelled operations for non-clinical reasons	321 p.a. (27 per month)	38	240 p.a. (20 per month)
R: Reduction of in-patient delayed discharges with a LoS <21 days	16%	8.2%	12%

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	●	●	●	●	●	●		●	●	Evidence of SAFER Steering Group available up until 3 July 19. A comprehensive PID for 19/20 is available and has been signed off. There is a comprehensive benefits tracker which shows a number of primary metrics trending negatively over the past couple of months. There is a closely tracked and detailed milestone plan. There is evidence of stakeholder engagement evidenced and a comprehensive communication plan is available in the PID however a tracked communications plan would also be beneficial. Risks are within review date on Ulysses. An EA/QIA has been signed. **Last updated 6 Sep 19.**

Independent Programme Assurance Report
Best in Mental Health Care

Sep 19

Exec Sponsor: Lisa Cooper

Deliver a range of improvements in mental health services which will ensure that children and young people receive the right level of care, at the right time to meet their needs. This includes ensuring we have the right number of tier 4 beds, we deliver a comprehensive eating disorder service and our access to all CAMHS (including urgent care) is appropriate and timely.

Key Programme Metrics	Baseline	Current (July 19)	Target
Reduction in WNB rates	15.2%	11.7%	10%
Reduction in staff turnover	13.7%	11.2%	10%
Bed occupancy (DJU)	TBC	TBC	TBC

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	●	●	●	●	●	●		●	●	Evidence of project team meetings available until 09 Sep 19. There is a final PID which was signed off at Programme Board on 22 Aug 19. A number of the primary metrics are moving in a positive direction and all benefits are being tracked. A comprehensive milestone plan is evidenced and being tracked. A stakeholder analysis has been completed but further evidence required of wider stakeholder engagement. Risks are on Ulysses and are within their review period. A signed EA/QIA has been uploaded. **Last updated 10 Sep 19.**

Independent Programme Assurance Report
Best in Acute Care

Sep 19

Exec Sponsor: Adrian Hughes

The project is made up of five core workstreams to help dictate the most suited Model of Care for Alder Hey. Currently in the design phase of the scoping process focusing mainly on workstreams relating to HDU model, EDU model and out of hours cover to make an informed decision on how these areas will look and work and who will provide this cover in and out of hours. The workstream relating to Rapid Response team is being worked up with a separate team and fed back to wider group.

Key Programme Metrics	Baseline	Current	Target
Reduction in average LoS (HDU)	TBC	N/A	TBC
Reduction in the number of admissions to HDU	TBC	N/A	TBC
10% of patients to be discharged from HDU prior to 10am	4% (10 patients)	6.3% (May 19)	10% (71 patients)
Increase discharges before 12pm across all in-patient wards	20%	21.1% (May 19)	30%
Reduction in amount of re-admissions within 48 hours	TBC	N/A	TBC
Reduction in conversation rates from EDU to in-patient wards	TBC	N/A	TBC
95% of patients know who is in charge of their care (Family & Friends test)	90%	82.9% (May 19)	95%

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	●	●	●	●	●	●		●	●	Evidence of Models of Care meetings up to 9 Sep 19. A high level design process is available and the 19/20 PID has now been signed off. Various data packs are in evidence and the project now has clear measures for success including baselines but these now need tracking. A comprehensive milestone plan is available and is being tracked however there are now a number of missed milestones. There is evidence of stakeholder engagement including updates to Programme Board. Risks now available on Ulysses and are within review date. There is signed EA/QIA in evidence. **Last updated 6 Sep 19.**

Independent Programme Assurance Report
Inspiring Quality

Sep 19

Exec Sponsor: Nicki Murdock

The Trust's programme of work to embed systematic continuous quality improvement via a number of high impact changes and initiatives across the Trust which will contribute to the delivery of the following 3 aims: To put children first; To be the safest children's Trust in the NHS; To achieve outstanding outcomes for children.

Key Outputs	Baseline	Current	Target
Number of staff trained in Strong Foundations Leadership programme	0	20	85 by the end of year 2 (October 2021)
Number of staff trained in patient and family centered care	0	0	784 by the end of year 2 (October 2021)
No' of pathways being designed collaboratively with staff and patients / families	0	0	20 by the end of year 1 (October 2020)

Key Outcomes	Baseline	Current	Target
Children report that we 'put them first	TBC	N/A	95% of children report that we 'put them first
Children report meeting the care goals they set	TBC	N/A	95% of children report meeting the care goals they set
Specialties achieve outcomes that rank internationally	TBC	N/A	10 specialties achieve outcomes that rank in the top 10% internationally
Staff report feeling able to make improvements to care	TBC	N/A	80% of staff report feeling able to make improvements to care

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	🟢	🟢	🟢	🔴	🔴	🔴		🟡	🟡	Evidence of project meetings to 02 Sep 19. The Inspiring Quality Plan serves as a comprehensive PID. Benefits are clearly defined in the PID but no benefits tracker available as yet. Metrics would also benefit from baseline data. There is a complex project plan which is being tracked. A Phase 1 'Starting Change' paper is available which clearly maps out the next 6 months of the plan. There is evidence of wider stakeholder engagement in the form of a staff engagement sesion with pledges however this programme of work would benefit from a detailed communication plan. There are no risks on Ulysses and the EQ/QIA are yet to be completed. **Last updated 02 Sep 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

The Best People doing their Best Work

Work Stream Summary (completed by Independent Programme Assurance)

The *Improving Portering Services* project still requires a thorough review which should include charting the course of the project through this year and to its eventual closure as well as addressing issues with governance of the project.

The *Catering* project displays a very good standard of governance and initial trends for benefits/metrics appear positive with 3 out of the 5 metrics now trending positively.

The *Medical Workforce* and *E-Rostering* projects were initiated at August Programme Board and will be rated in the coming weeks.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 12 Sep 19

Programme Contribution to CIP Status – as at 12th September 19

		In Year Forecast			
Division	Director	Target £000's	Forecast £000's	Gap £000's	% of target
Community	Lisa Cooper	534	470	-64	88%
Medicine	Adrian Hughes	2,269	1,427	-842	63%
Surgical Care	Christian Duncan	2,201	2,081	-120	95%
Subtotal: Clinical Divisions		**5,003**	**3,978**	**-1,025**	80%
Alder Hey in the Park	David Powell	199	78	-121	39%
Facilities	Hilda Gwilliams	194	55	-139	28%
Nursing & Quality	Hilda Gwilliams	87	0	-87	0%
Finance	John Grinnell	112	110	-2	99%
IM&T	Kate Warriner	94	239	145	254%
Human Resources	Melissa Swindell	92	25	-67	27%
Executive	Erica Saunders	101	8	-94	7%
Subtotal: Non-Clinical Divisions		**879**	**514**	**-365**	58%
Innovation		6	0	-6	0%
Academy		7	0	-7	0%
International		3	0	-3	0%
R&D		99	0	-99	0%
Grand Total		**5,997**	**4,492**	**-1,505**	75%

Independent Programme Assurance Report
Catering

Sep 19

Exec Sponsor: Hilda Gwilliams

To implement the recommendations from the Independent Catering review to improve the overall food service delivery at Alder Hey whilst reducing the financial loss current operating within the Catering Department.

Key Programme Metrics	Baseline	Current (July 19)	Target
Increase in income	76,296 (June 18)	86,307	122,038 (July 19)
Reduction in expenditure	-105,052 (June 18)	-95,922	-134,971 (July 19)
Profit/loss	-28,756 (June 18)	-9,615	-12,933 (July 19)
Increase satisfaction with food served on the wards	98% (June 18)	Q removed- no data in July 19.	100% (July 19)
Reduce treetops waiting times and improve flow	Br'fast av. 2.54m Lunch av. 4.04s (Sept 18)	B=2.15 L=3.25	>20% (B=2.19m) (L=3.15m) (July 19)

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	●	●	●	●	●	●		●	●	Evidence is available for the project 'Steering Group' meetings up to 18 Sep 19.The extensive and detailed 'Review of Catering Services – Final Version' dated January 2018 is serving as a detailed PID. There is a detailed 'Catering Project Benefit Tracker 2019/20' with all benefits tracked a number of benefits showing positive trends albeit too early to ascertain whether trends will continue. May be useful to compare metrics with last year to allow for variation. There is a tracked plan up until Sep 19. Evidence of stakeholder engagement is available on SharePoint. All risks are within review date on Ulysses. **Last updated 10 Sep 19.**

Independent Programme Assurance Report
Portering

Sep 19

Exec Sponsor: Hilda Gwilliams

The aim of this project is to deliver an effective portering service which meets all KPIs agreed by the Trust relating to all portering tasks and to ensure that the department has the right resource at the right times throughout the working week thus reducing portering spend.

Key Programme Metrics	Baseline	Current	Target
Portering spend per month	£64,000 (per month)	£67,527 (July)	47,000 (per month)

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	🔴	🔴	🔴	🟢	🟢	🟢		🔴	🔴	Project team meeting notes available but no evidence of recent meetings. PID available but needs reviewing for 19/20. The Milestone Plan show significant slippage of all remaining milestones. No recent evidence of stakeholder engagement. All risks are within review date on Ulysses. EA/QIA complete. **Last updated 15 Jan 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

Work Stream Summary (completed by Independent Programme Assurance)

Sustainability through External Partnerships

The governance of the *Aseptics* project is maintained to a good standard however the overall delivery ratings still require improvement. The *Export Catalyst* is green rated for both governance and delivery however, the project life cycle appears to come to an end in September 19 with no milestones beyond this date. The Exec Sponsor is required to set the direction of the project for the coming months.

Global Digital Exemplar

The governance ratings of the GDE / HIMMS programme has improved this month and the delivery of speciality packages looks largely on track to meet the November target.

Park, Community Estate and Facilities

The governance and delivery ratings for the *Park, Community Estate and Facilities* programme have deteriorated significantly this month and the lack of SMART metrics now a major concern. There is very little evidence of engagement with key stakeholder and users of the buildings and services within this programme.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 20 September 19

Programme Contribution to CIP Status – 12th September 2019

		In Year Forecast			
Division	Director	Target £000's	Forecast £000's	Gap £000's	% of target
Community	Lisa Cooper	534	470	-64	88%
Medicine	Adrian Hughes	2,269	1,427	-842	63%
Surgical Care	Christian Duncan	2,201	2,081	-120	95%
Subtotal: Clinical Divisions		**5,003**	**3,978**	**-1,025**	80%
Alder Hey in the Park	David Powell	199	78	-121	39%
Facilities	Hilda Gwilliams	194	55	-139	28%
Nursing & Quality	Hilda Gwilliams	87	0	-87	0%
Finance	John Grinnell	112	110	-2	99%
IM&T	Kate Warriner	94	239	145	254%
Human Resources	Melissa Swindell	92	25	-67	27%
Executive	Erica Saunders	101	8	-94	7%
Subtotal: Non-Clinical Divisions		**879**	**514**	**-365**	58%
Innovation		6	0	-6	0%
Academy		7	0	-7	0%
International		3	0	-3	0%
R&D		99	0	-99	0%
Grand Total		5,997	4,492	-1,505	75%

Independent Programme Assurance Report
Aseptics

September 19

Exec Sponsor: Nicki Murdock

The Trust's long term aspiration is to establish and maintain a licensed Aseptic manufacturing unit to support internal demand, limit the need to outsource preparations, deliver the expanding research agenda, provide a commercial income generation opportunity for the organisation, whilst providing wider NHS resilience in line with STP principles.

Key Programme Metrics	Baseline (2019)	Current	Target
Increase the number of commercial research studies open to recruitment	3	3 (Aug 19)	6 (July 2020)
Reduction in medication errors in ASU (injectable therapy)	6	6 (Aug 19)	2 (July 2020)
Increase in number of ready to use products prepared in-house by ASU	66	66 (Aug 19)	230 (Jan 2020)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Aseptics											Minutes of the Quality Management Meeting of the Aseptics Services Department are available up to 20 Aug 19 and project team meetings up to 18 Jul 19. Scope is described by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' dated 16 March 2018' together with a 'Project Overview Document' dated 14 Jun 2018. A final business case dated 9th April 2019 is also evidenced. For the benefits which are being tracked, the metrics remain stagnant with no positive change seen as of yet. Some of the benefits now need to identify a sustainable way of measuring improvement. A 'Project Milestone Plan' is in place and being tracked and an exception report is in evidence dated 22.05.19 which resets some milestone deadlines. Project risk(s) now require review on Ulysses. EA/QIA signed off. **Last updated 13 Sep 19.**

Independent Programme Assurance Report
Export Catalyst

September 19

Exec Sponsor: John Grinnell

The purpose of the Export Catalyst Project is to:

- Produce an output of an overarching international strategy
- Prioritise and review the propositions across the business
- Supporting the creation of cost and business models per target market
- moving from reactivity to proactivity in market selection

Key Programme Metrics	Baseline	Current	Target
Sustainable Services	£200k contribution	£1m target contribution	Jan 2020 attain by Apr 2022
Strategy & Plans	NA	Final version of strategy document available	Sep 19
Pricing & Markets	NA	Documented and Agreed	Sep 19

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Export Catalyst					N/A	N/A	N/A				Evidence of meetings of project meetings up to 28 Jun 19 with an agenda for the debrief session on 23 Jul 19 available. Comprehensive initiation slides are available but no PID is necessary for this project given its relatively short project cycle. Evidence of stakeholder engagement. A detailed Gantt chart is available which is being tracked up to 26 Aug 19. The project life cycle as per the plan appears to come to a close at the end of Sep 19. Benefits are detailed but not tracked. Risks not applicable. No EA/QIA required. **Last updated 22 Aug 19.**

Independent Programme Assurance Report
GDE / HIMMS

September 19

Exec Sponsor: Kate Warriner

GDE - Create exemplars that can inspire others showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness.

Specialty Packages - The development of a digital bespoke clinical system will ultimately result in a paper lite system which enables improved patient safety, patient experience and staff experience. The review and sign off of agreed manual pathways and processes prior to digital development optimize clinical pathways and release time to care.

Key Programme Metrics	Baseline	Current	Target
Number of specialty packages complete	0	37 (Sep 19)	52 (Nov 19)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
GDE											GDE Programme Board meeting pack available up to 20 Aug 19 and GDE Delivery Group action log available up to 13 Aug 19. The GDE programme is RAG rated green on the CORA portal which is NHS Improvements digital platform and the Speciality Package project have self-rated themselves green for the upcoming November target in their highlight report. There is evidence of some stakeholder engagement. All risks are on Ulysses and within review date. **Last updated 20 Sep 19.**

Independent Programme Assurance Report
Alder Centre

September 19

Exec Sponsor: David Powell

This projects sets the plan to develop and construct the new Alder Centre with bereavement garden within the park setting once demolishment of the old site buildings has occurred and as the park landscape develops. The Alder Centre forms a key component of the overall Alder Hey and Springfield Park Master Plan, and of our new Children's Health Park Campus.

Key Programme Metrics	Baseline	Current	Target
Expansion of services on offer	Not available	Not available	10% increase in income (April 2020)
Increase the types of therapies delivered (To include arts, horticultural and pet therapy)	Not available	Not available	Not available

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Alder Centre											No minutes from project team meetings however evidence of meetings with contractors up to 29 Aug 19. Actions for this scheme captured as part of the weekly development meeting up to 17 Jul 19. Scope/approach defined in PID. Benefits defined in PID but no evidence of the tracking of benefits. Milestones are being tracked as part of the wider programme plan but this plan is being tracked up until June 19 and shows significant slippage. Limited evidence of Comms/ Engagement activities. Risks are on Ulysses but are not within review date. EA/QIA complete. **Last updated 3 Sep 2019.**

Independent Programme Assurance Report
Community Cluster

September 19

Exec Sponsor: David Powell

To build new facilities that will support the delivery of excellent clinical care for he following services:

- CAMHS
- Neurodevelopmental Assessment
- Psychological services
- Orthotics.

Key Programme Metrics	Baseline	Current	Target
Staff morale	Not available	Not available	Improvement of 10% (Sep 20)
Increase in efficiency of desks per staff members	Not available	Not available	15% improvement in staff to desk ratio (Sep 20)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Community Cluster											Draft PID uploaded 1 Feb 2018 with 'Initiation' Slides uploaded 27 Mar 2018. Actions recorded at the weekly development meeting up to 17 Jul 19. The 'Community Cluster board report April 19' details the winning design of the building. Plan for this scheme is available in the wider programme plan 'Development site 2018-2021' however this shows slippage on a number of key milestones and is tracked up until June 19. Evidence of stakeholder engagement however more recent evidence is now required. Risks on Ulysses are out of review date. EA/ QIA complete but not signed by Exec Sponsor. **Last updated 17 July 2019.**

Independent Programme Assurance Report
Park

September19

Exec Sponsor: David Powell

To redevelop Springfield Park in accordance with the land swap agreement with Liverpool City Council, entailing the demolition of the existing hospital site and creating an integrated site development encompassing Springfield Park, Alder Hey Children's Hospital, the Research and Education Building, future schemes and the developed surplus landsite. The project focuses on the physical reinstatement of Springfield Park, the exploration of the opportunity to create an enhanced park, models of park ownership and a schedule of events and activities.

Key Programme Metrics	Baseline	Current	Target
Generate income	£0	Not available	Not available
Increase community participation	Not available	Not available	Not available
Support environmental sustainability	Not available	Not available	100% increase in number of trees (2021)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Park											No Steering Group minutes / actions are available since 21 November 2018 however some actions with regards to the project were recorded at the weekly development meeting but minutes / actions for this meeting are up to 17 July. PID available on SharePoint but now needs updating. There is a comprehensive suite of benefits outlined in the PID however some benefits are not SMART and not tracked. Progress of benefits have not been tracked since Mar 19. Milestones are being tracked via a programme plan which was updated in Jun 19. There is no evidence of recent stakeholder engagement. Risks are on Ulysses but some are out of review date. EA/QIA complete. **Last updated 17 July 2019.**

Change Programme Progress Report

Natalie Deakin, Head of DMO

23.09.19

In August 2019, a paper was submitted to Trust Board which described the journey of the Change Programme and Delivery Management Office (DMO) in recent months. This was an unusual report for the Board to receive as it replaced the usual independent assurance report. However, this was a welcomed opportunity for me to report progress in my role as Head of DMO. I hope the Board found the report useful and I therefore propose that going forward a similar shorter progress report is submitted alongside the independent assurance report. The report would feature progress made regarding the enhancement of how we manage and deliver projects at Alder Hey and the steps we are taking as an organisation to become an exemplar in the management of projects within the NHS.

Enhancements to Independent Assurance Report

Over recent months, enhancements have been made to the current independent assurance report which includes the transparent reporting of project benefits. This has since brought about challenge at recent sub-committees regarding the number of TBCs featured in these reports. In my role as Head of DMO, this led to a thorough analysis of the reasons for the TBCs and although not applicable to all projects, the most common reason for these was related to the difference between outputs and outcomes. In project management, outputs tell the story of what is produced by the organisation's activities but does not address the value or impact on the service provided. Outcomes, on the other hand, describes the level of performance or achievement that occurred because of the activity or services provided by an organisation. In short, outputs lead us to ask the 'so what?' question and outcomes answer this question.

The analysis of the Change Programme benefits showed that a number of projects are using outcome measures prematurely and are therefore finding these difficult to measure or showing a lack of positive trends. An example of this is the Inspiring Quality programme. A two year plus programme, still in its 'preparing for change phase' as it creates capacity is currently reporting against outcomes which have not yet been impacted as the transformational changes proposed by the programme have not been implemented. For example, one such measure is '80% of staff feeling able to make improvements to care'. This measure will not be positively impacted until we have implemented the change or initiative linked to the measure. In this example the change/initiative would be the introduction of the Strong Foundations Leadership programme as well as the introduction of quality improvement training for staff. It is therefore proposed that outputs are also featured in the independent assurance report as shown in the example below:

Independent Programme Assurance Report
Inspiring Quality

Sep 19
Exec Sponsor: Nicki Murdock

The Trust's programme of work to embed systematic continuous quality improvement via a number of high impact changes and initiatives across the Trust which will contribute to the delivery of the following 3 aims: To put children first; To be the safest children's Trust in the NHS; To achieve outstanding outcomes for children.

Key Outputs	Baseline	Current	Target
Number of staff trained in Strong Foundations Leadership programme	0	20	85 by the end of year 2 (October 2021)
Number of staff trained in patient and family centered care	0	0	784 by the end of year 2 (October 2021)
No' of pathways being designed collaboratively with staff and patients / families	0	0	20 by the end of year 1 (October 2020)

Key Outcomes	Baseline	Current	Target
Children report that we 'put them first	TBC	N/A	95% of children report that we 'put them first
Children report meeting the care goals they set	TBC	N/A	95% of children report meeting the care goals they set
Specialties achieve outcomes that rank internationally	TBC	N/A	10 specialties achieve outcomes that rank in the top 10% internationally
Staff report feeling able to make improvements to care	TBC	N/A	80% of staff report feeling able to make improvements to care

OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
	●	●	●	●	●	●		●	●	Evidence of project meetings to 02 Sep 19. The Inspiring Quality Plan serves as a comprehensive PID. Benefits are clearly defined in the PID but no benefits tracker available as yet. Metrics would also benefit from baseline data. There is a complex project plan which is being tracked. A Phase 1 'Starting Change' paper is available which clearly maps out the next 6 months of the plan. There is evidence of wider stakeholder engagement in the form of a staff engagement sesion with pledges however this programme of work would benefit from a detailed communication plan. There are no risks on Ulysses and the EQ/QIA are yet to be completed. **Last updated 02 Sep 19.**

*Slide is an example only

This enhanced assurance report would allow the Board and sub-committees to receive assurance on the progress of both project outputs and outcomes as well as providing an indication as to why in some cases outcomes (benefits) are not being realised or are showing an adverse trend.

It is therefore recommended that the Board sign off this enhancement to the independent assurance report to allow greater insight into the progress reported against the projects featured on the Trust's Change Programme.

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report August 2019

How Did We Do?

Executive Summary **Month: August** **Year: 2019**

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Strong level of incident reporting reflective of a learning organisation, incidents reported relate to near miss or minor harm.
- Sepsis action plan in place with focus on support for ED

Highlight

- 100% of inpatients treated for sepsis with 60 minutes
- No moderate, severe or catastrophic incidents recorded in month.

Challenges

- 77% of CYP treated for sepsis treated within 60 minutes.

The Best People Doing their Best Work

Caring

- Emergency Department achieved 88% of families would recommend the Trust, their highest score for the year.
- Thematic analysis underway in relation to higher volumes of formal complaints over previous two months.

Highlight

- 94% of families whose child attended OPD would recommend the Trust.

Challenges

- Similar high number of formal complaints received as previous month.

Delivery of Outstanding Care

Effective

- There was an in-month improvement in waiting times to the Emergency Department to 94.7%, despite August seeing a 9% (n= 387). Nonetheless, we are concerned about underlying waiting times and we are delivering an improvement plan to increase workforce numbers and resilience, and pathways into primary care.
- High cancellation rate driven by consultant sickness and accommodating emergency operations. We have increased the proportion of theatre lists per week allocated to emergency and urgent operations.
- The scanning backlog will be outsourced by 27.09.19 and cleared by the end of October.

Highlight

- Patients re-booked to have their operation within 28 days

Challenges

- Emergency Department waiting times
- Scanning turnaround times
- Cancelled operations

Delivery of Outstanding Care

Responsive

- There was one patient who did not have an appointment within 2 weeks following a suspected cancer referral. This represents circumstances in arranging the appointment with the family, as opposed to an underlying issue with capacity. There is some local learning to update the standard operating procedure for arranging urgent appointments to reflect the need for telephone contact with families.

Highlight

- Achieved national referral-to-treatment & diagnostic standards
- The waiting list size is below target and no patient waited over 52 weeks for treatment
- % patients who know their planned date of discharge

Challenges

- Cancer 2 week wait from referral to date first seen

The Best People Doing their Best Work

Well Led

- In month 5 we delivered a £0.4k deficit which was £0.8k ahead of the plan which leaves us in line with our year to date plan.
- Activity levels improved in month overachieving in all POD's.
- Pay was underspent in the month bringing the cumulative position in line with plan. However non pay remains an area of concern and is overspent year to date by £1.7m.
- CIP performance also improved in month however there is still a material gap against our forecast versus target of £1.5m. A financial re-set is being taken through RABD to target key areas of improvement. Cash holdings are £80m which is significantly higher than plan driven by capital slippage and the receipt of the 2018/19 bonus PSF funding earlier than expected. Temporary staffing spend still remained high at £0.9m
- A concerted effort has meant we continue to achieve mandatory training levels again. It is key that this is sustained
- Completion of PDR's remain at just below the target of 90% and a concerted effort is required by all areas to improve this further. Sickness levels have reduced slightly but remain above target at 4.9%. A team are looking at specific actions that may support specific teams where sickness levels are high.

Highlight

- Year to date control total achieved
- Improved CIP
- Activity Levels
- Mandatory Training

Challenges

- Forecast year end Control Total
- Temporary staffing levels
- Sickness Levels

Game Changing Research and Innovation

Research and Development

Research Delivery Plan approved featuring:

- Establishment of a Research Culture
- Maximising opportunities for Impactful Research
- Becoming a sustainable business unit

Key progress includes:

- Recruitment of infrastructure and growth staff
- Working with Charity re future investment
- Improving divisional governance
- Engaging with staff
- Incentive model pilot under development

Highlight

- Progress on Research Delivery Plan providing strong foundations

Challenges

- Level of staffing to support and deliver research activity

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Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG			Comments Available
Clinical Incidents resulting in Near Miss	D	65	76	72	79	59	59	83	76	58	84	58	113	56		>=70	>=67	<67	✔
Clinical Incidents resulting in No Harm	D	312	288	316	285	218	284	251	279	300	294	297	316	285		>=316	>=301	<301	✔
Clinical Incidents resulting in minor, non permanent harm	D	69	86	90	95	67	78	84	105	94	108	76	71	69		<=86	N/A	>86	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	1	2	0	1	1	2	1	0	0	0	1	3	0		<=1	N/A	>1	✔
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	1	2	0	0	0	1	0	0		0	N/A	>0	✔
Medication errors resulting in harm	D	4	4	2	6	2	2	4	2	6	3	3	2	1		<=3	N/A	>3	✔
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	0	0	0	1	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	2	0	0	0	0	1	0	0	0	0	0	0	0		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis - A&E	D P	68.2%	54.5%	65.4%	57.6%	51.9%	77.4%	71.1%	79.4%	58.8%	71.1%	65.2%	79.3%	76.7%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	72.5%	78.2%	70.2%	76.2%	73.3%	70.2%	82.1%	73.3%	81.8%	71.4%	90.9%	80.0%	100.0%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	1	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	1	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	D	0	1	2	0	1	1	0	4	1	1	0	0	1		0	N/A	>0	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	D	88.2%	85.5%	80.0%	80.6%	90.1%	90.5%	80.3%	89.5%	78.8%	87.7%	80.4%	82.8%	88.1%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	100.0%	100.0%	93.2%	100.0%	100.0%	98.5%	100.0%	98.6%	88.4%	100.0%	93.8%	92.9%	92.9%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	97.0%	98.3%	98.2%	97.9%	98.2%	97.0%	96.2%	97.8%	97.3%	90.6%	90.1%	93.2%	92.5%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	89.9%	89.4%	84.7%	97.5%	100.0%	88.9%	76.9%	82.9%	80.8%	88.7%	100.0%	33.3%	78.8%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	89.7%	90.0%	90.3%	91.4%	91.7%	87.4%	89.1%	91.1%	92.7%	91.7%	93.5%	91.2%	94.4%		>=95 % >=90 % <90 %	✔
Complaints	W	13	12	13	5	7	7	9	16	7	9	6	15	13		No Threshold	✔
PALS	W	101	125	132	115	71	136	97	95	110	102	121	128	92		<=90 <=100 >100	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	0.0%	2.7%	1.0%	1.1%	2.4%	1.4%	1.8%	2.5%	2.7%	2.1%	1.3%	4.2%	4.1%		<=3 %	N/A	>3 %	✔
ED: 95% Treated within 4 Hours	D	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%	93.6%	91.3%	89.4%	91.8%	94.7%		>=95 %	N/A	<95 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	18	12	28	38	21	11	10	11	9	24	15	37	35		<=20	N/A	>20	✔
28 Day Breaches	W	7	1	0	6	6	4	1	1	0	0	1	2	0		0	N/A	>0	✔
Average Scanning Turnaround - Inpatient	D							44.00	49.00	49.00	50.00	55.00	55.00	65.00		<=7	N/A	>7	✔
Average Scanning Turnaround - Outpatient	D							26.00	23.00	24.00	21.00	23.00	23.00	31.50		<=5	N/A	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	94.7%	96.3%	96.4%	95.1%	96.7%	96.0%	94.9%	95.7%	98.3%	96.6%	97.5%	97.6%	95.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	99.6%	99.5%	99.6%	100.0%	99.6%	100.0%	99.3%	99.5%	99.3%	99.0%	98.1%	99.2%	97.5%		100 % >=95 % <95 %	✔
IP Survey: % Know their planned date of discharge	D P	60.6%	55.3%	60.2%	69.0%	59.4%	76.5%	82.8%	80.6%	88.8%	84.1%	87.9%	87.8%	87.1%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	91.6%	94.9%	92.2%	92.2%	92.5%	96.3%	94.3%	93.4%	99.3%	90.5%	96.3%	90.8%	98.0%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D											93.3%	94.5%	95.3%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D											70.9%	75.6%	72.1%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.0%	92.1%	92.1%	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.1%	92.1%	92.0%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	12,925	12,884	12,961	12,934	12,859	12,872	12,888	12,746	12,871	12,876	12,843	12,883	12,874		<=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	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	99.6%	99.5%	100.0%	99.8%	100.0%	99.8%	100.0%		>=99 % N/A <99 %	✔
PFI: PPM%		98.0%	100.0%	98.0%	99.0%	100.0%	100.0%	100.0%	98.0%	98.0%	98.0%	98.0%	100.0%	99.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG	Comments Available
CIP In Month Variance (£'000s)	W	-137	175	-174	-285	151	-199	-74	-75	-163	-54	-47	-26	176		>=-5% >=-20% <-20%	✔
Control Total In Month Variance (£'000s)	W	-396	359	-463	-48	564	-21	-433		-394	-165	596	-848	845		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	-129	2,907	-751	1,041	1,032	1,032	259	1,610	1,030	640	728	694	1,239		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	W	21,519	20,023	20,315	17,580	23,136	19,983	22,068	33,699	34,361	34,449	37,415	79,086	80,174		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	W	741	263	624	684	142	456	355	19,495	-612	21	846	-52	1,338		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	W	-311	51	-372	-74	-267	-510	-850	-495	183	-25	-130	-260	276		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	W	-825	45	-715	-659	689	34	63	-942	34	-161	-119	-537	-769		>=-5% >=-20% <-20%	✔
NHSI Use of Resources	W	3	2	2	1	1	1	1	1	1	3	3		3		<=3 N/A >3	✔
AvP: IP - Non-Elective	W									53	58	109	158	132		>=0 N/A <0	✔
AvP: IP Elective vs Plan	W									-45	-24	-41	-76	17		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	W									-53	-132	-241	-45	80		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	W									750	72	1,267	1,967	2,503		>=0 N/A <0	✔
PDR	W	82.3%	88.8%	90.1%	90.1%	90.1%	90.1%	92.2%	92.2%	4.8%	20.7%	47.3%	86.4%	89.3%		>=90 % >=85 % <85 %	✔
Medical Appraisal	W	6.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	98.4%	98.2%		>=95 % >=90 % <90 %	✔
Mandatory Training	W	88.6%	88.1%	89.7%	89.7%	89.0%	89.4%	88.8%	89.6%	90.0%	88.4%	90.5%	90.8%	91.9%		>=90 % >=80 % <80 %	✔
Sickness	D	5.2%	5.4%	5.6%	5.6%	6.1%	5.7%	5.7%	5.4%	5.2%	5.5%	5.2%	5.2%	4.9%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	D	1.3%	1.4%	1.6%	1.6%	1.6%	1.9%	1.7%	1.6%	1.5%	1.5%	1.4%	1.3%	1.0%		<=1 % N/A >1 %	✔
Long Term Sickness	D	4.0%	4.0%	4.0%	4.0%	4.4%	3.9%	3.9%	3.7%	3.7%	4.0%	3.8%	3.9%	4.0%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	D	1,082	820	998	971	883	937	1,046	1,357	1,114	1,061	899	1,058	992		<=800 <=960 >960	✔
Staff Turnover	D	10.5%	10.6%	10.4%	10.2%	9.6%	9.5%	9.5%	10.0%	9.8%	10.0%	9.9%	9.4%	10.1%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	W	93.9%	93.1%	93.2%	95.3%	94.2%	94.5%	92.8%	95.4%	95.3%	95.2%	92.6%	92.0%	93.5%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	W	85.0%	93.8%	60.0%	90.0%	90.0%	92.0%	95.0%	86.0%	81.5%	100.0%	81.2%	97.2%	92.5%		>=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

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	156	115	143	136	123	121	121	153	154	158	161	158	172		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	37	27	31	28	27	29	26	60	59	59	58	57	59		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	2	3	6	8	2	6	5	3	1	5	4	2	3		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	2	3	2	0	0	1	1	4	2	1	2	2	2		>=1	N/A	<1	✔
Number of patients recruited	W	249	238	195	296	158	238	211	314	234	221	350	431	165		>=200	>=171	<171	✔

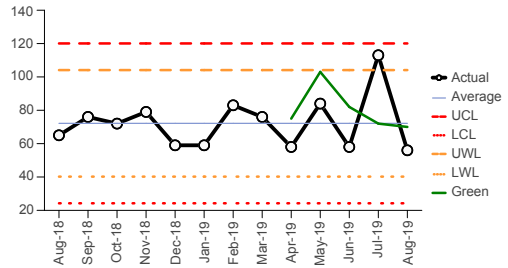
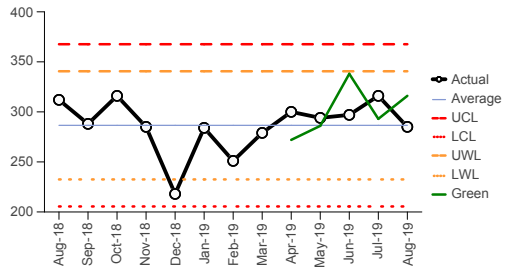
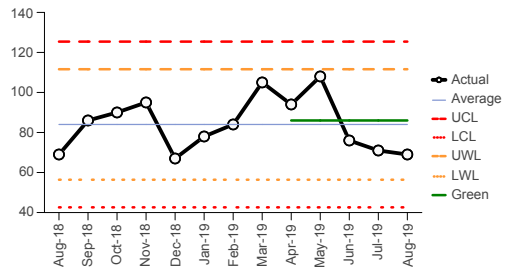
Delivery of Outstanding Care

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)
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 (897). 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 Murdoch **Committee:** CQAC	56	R <67 A >=67 G >=70		There were 411 clinical incidents reported in month, which is a decrease from 506 the previous month. Near miss and no harm incidents remain in line and consistent with the previous month's reporting figures, with 83.1% of the total number of incidents reported not resulting in harm to patients.
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 (3328). 19/20 aim is to see more than 5% reported than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	285	R <301 A >=301 G >=316		There were 411 clinical incidents reported in month, which is a decrease from 506 the previous month. Near miss and no harm incidents remain in line and consistent with the previous month's reporting figures, with 83.1% of the total number of incidents reported not resulting in harm to patients.
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 (1036). 19/20 aim is to see volume reported less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	69	R >86 A N/A G <=86		No Action Required

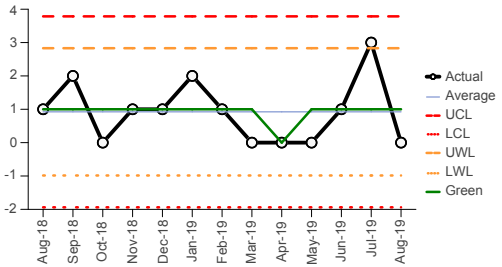
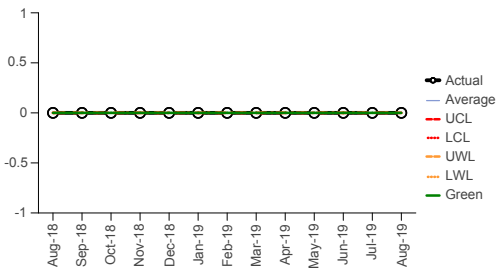
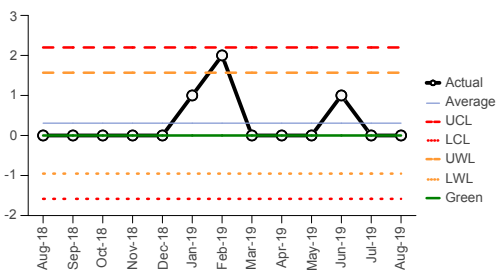
Delivery of Outstanding Care

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 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 (12). 19/20 aim is 11 or less, annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	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 Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
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 Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

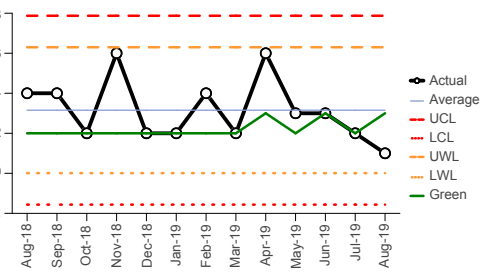
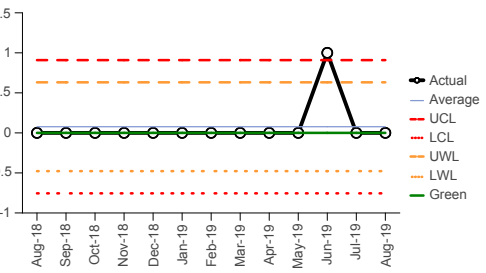
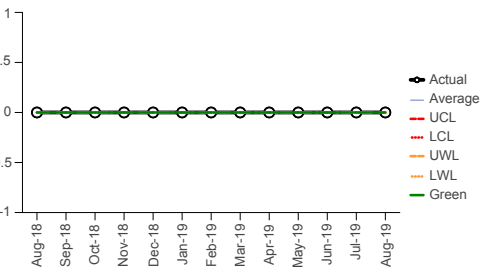
Delivery of Outstanding Care

7.3 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

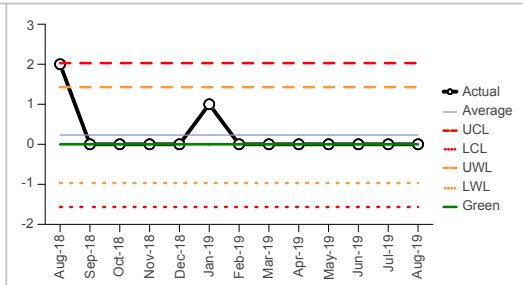
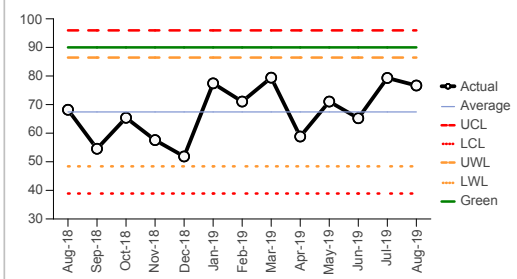
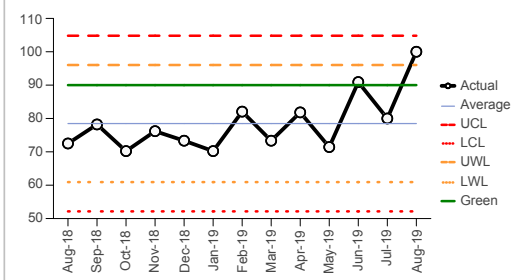
	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 18 - Mar 19 (42), 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 **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R >3 A N/A G <=3		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
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 Murdoch **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 Foundation Trust

D Drive W Watch P Programme

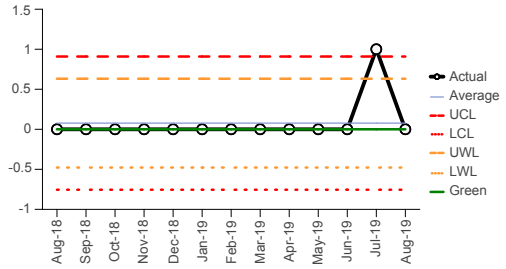
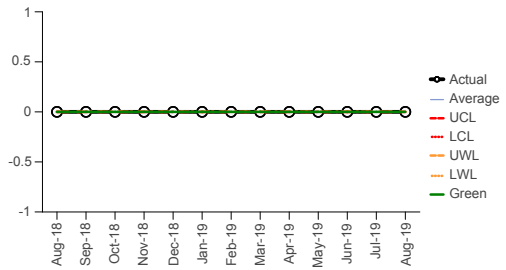
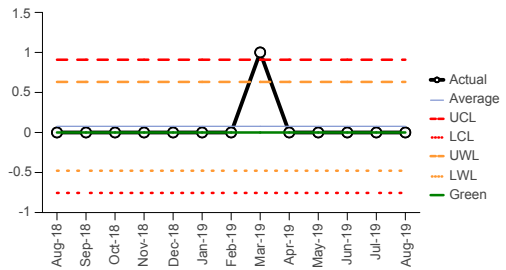
	Description	Performance	Threshold	Trend	Management Action (SMART)
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	76.67 %	R <90 % A N/A G >=90 %		Ongoing training, education and feedback to staff around sepsis. Discussions held at sepsis steering group and plans to push forward with improved electronic documentation following successful integration of sepsis staus in Inpatients. Work to be done with Meditech and IT for this to happen. All cases individually assessed by ED Sepsis Nurse and any concerns regarding inadequate sepsis management are escalated/incident reported.
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 Murdoch **Committee:** CQAC	100 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

7.5 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Mortality	**No of children that have suffered avoidable death - Internal** W Total number of children that have suffered avoidable death 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 Murdoch **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 Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
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 Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

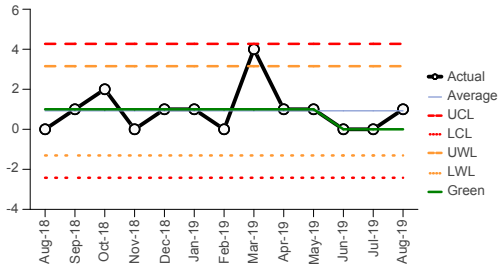
Delivery of Outstanding Care

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 - MSSA** D Hospital Acquired Organisms - MSSA . 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R >0 A N/A G 0		We continue to undertake RCAs on any hospital acquired bacteraemia to identify learning. We are currently still within the reduction target set for 2019/20.

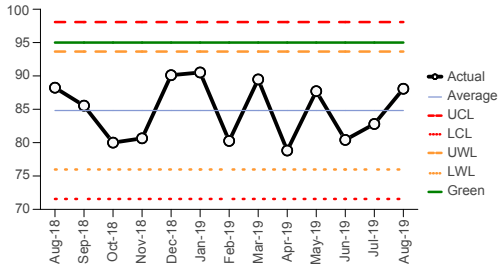
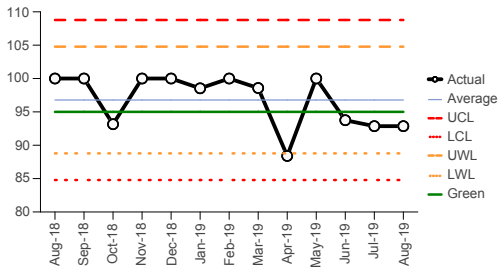
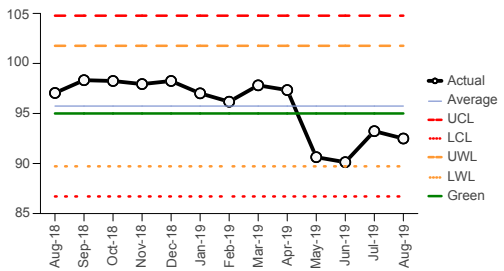
The Best People doing their best Work

8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
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 Murdoch **Committee:** CQAC	88.08 %	R <90 % A >=90 % G >=95 %		This is an increase of 6% since last month. The attitude off staff and lack of communication and shouting out names continues to be a theme during August. Negative comments that are triggered are sent straight to the department manager daily (in real time) where an action has been created. There have been a total of 380 responses which has doubled since July, 267 are extremely likely to recommend the Trust, 66 are likely, 14 neither likely nor unlikely, 14 unlikely, 11 extremely unlikely and 8 don't know. The total eligible to respond is approx. 5,000 C&YP
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 Murdoch **Committee:** CQAC	92.86 %	R <90 % A >=90 % G >=95 %		During August there has been no significant difference in would you recommend the Trust data? SMS responses have continued to increase since it was launched in July. July there was 1 response, during August there were 36 SMS responses. Staff training has been delivered to the Head of Quality for the use of the FFT system in order to act on the actions that have been generated. Total number of responses for August is 70 out of 1,197, 41 where extremely likely to recommend the Trust, 24 likely, 3 responses said neither, 0 unlikely, 1 extremely unlikely.
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 Murdoch **Committee:** CQAC	92.50 %	R <90 % A >=90 % G >=95 %		There is an increase of 3% of families saying they would recommend our Trust during August. There were 533 children/young people and families that completed the FFT feedback during August out of 1,809 that were eligible to respond. 402 said they are extremely likely to recommend, 90 said they would be likely, 17 neither likely nor unlikely, 4 unlikely, 5 extremely unlikely and 14 did not know. 231 responses were completed by tablet or kiosk and 303 by SMS. Data and themes are reported at CQSG and the findings disseminated by division leads. Feedback can be obtained in real time by all manager

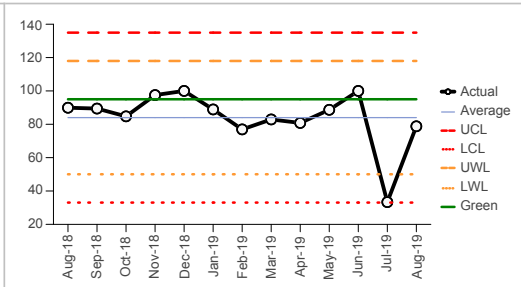
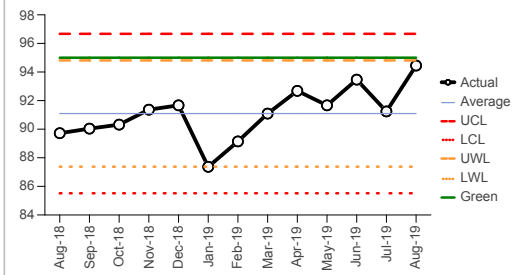
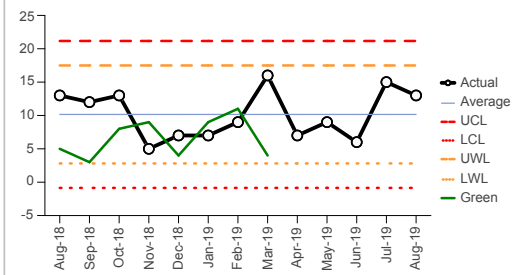
The Best People doing their best Work

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 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 Murdoch **Committee:** CQAC	78.79 %	R <90 % A >=90 % G >=95 %		A huge % increase for C&YP recommending our mental health services. The total response rate has increased from 3 in July to 66 out of and eligible total of 945 for August. 34 said they were extremely likely to recommend mental health, 18 would be likely, 6 neither likely nor unlikely, 1 unlikely, 2 extremely unlikely, 1 don't know. Method of collection: 46 tablet or paper, 20 SMS.
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 Murdoch **Committee:** CQAC	94.45 %	R <90 % A >=90 % G >=95 %		A 2.2% increases for August. The negative theme continues to be around the attitude of staff, a lack of communication to waiting times. This month there were 1187 responses this has doubled since July, out of an eligible total of 14,758. 997 said they are extremely likely to recommend the Trust, 126 likely, 13 neither likely nor unlikely, 146 unlikely, 6 extremely unlikely and 31 did not know. All negative triggers are sent to the outpatient service manager to disseminate to department leads to complete the generated action plan.
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	13	No Threshold		This is the second year that we have not seen the usual downward trend of formal complaints during the summer.

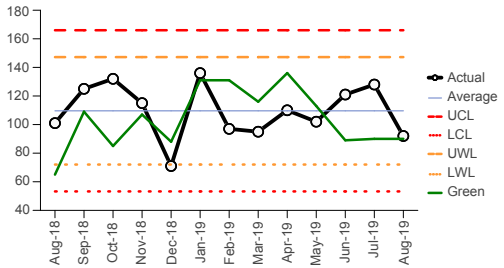
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

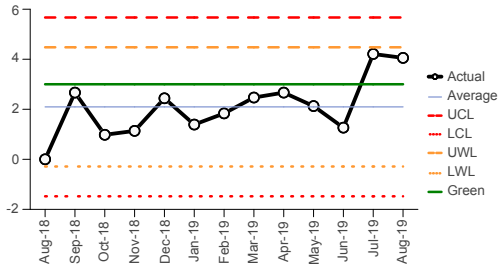
	Description	Performance	Threshold	Trend	Management Action (SMART)
PALS	**PALS** W Total number of PALS contacts. Threshold is based on a 10% Reduction on 18/19 (1347). 19/20 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	92	R >100 A <=100 G <=90		Slight reduction in infromal concerns during summer - this is the norm we expect

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

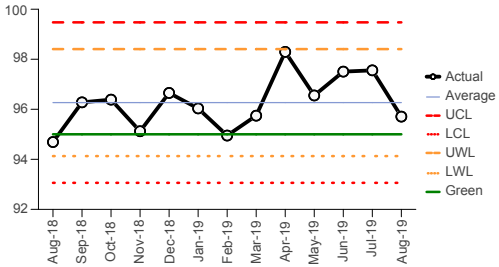
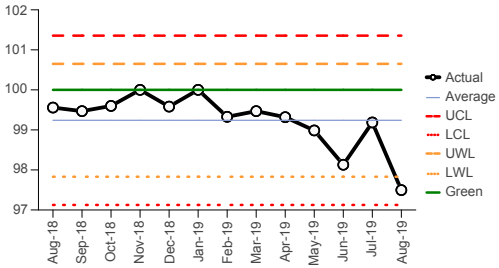
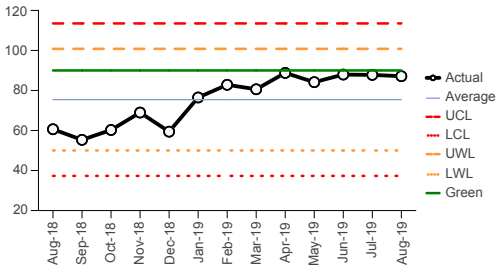
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally 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 Murdoch **Committee:** CQAC	4.05 %	R >3 % A N/A G <=3 %		This is a metric that is reported annually across the UK. There are accepted variations in the monthly incidence of PICU readmission within 48hrs across the year, but we note that the annual incidence 2.5% is within the reported threshold (below 3%) for readmission to PICU within 48hours of discharge. Review of the August cases suggest no potential for preventability.

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

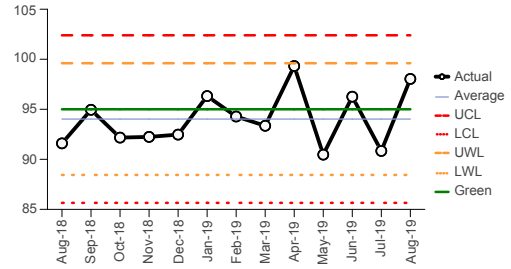
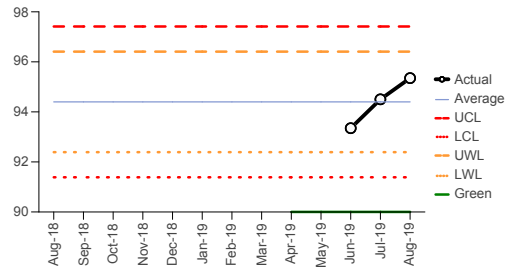
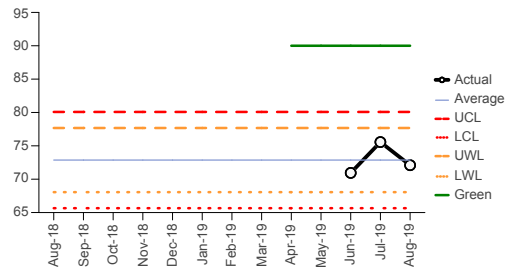
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	95.71 %	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 Murdoch **Committee:** CQAC	97.50 %	R <95 % A >=95 % G 100 %		During August there have been 552 responses for inpatients. Medicine received 192 responses 96.88% said they were treated with respect. Surgery 351 responses 98.01% said they were treated with respect 1 response from Dewi Jones 100% 8 where unknown. Actions have been generated and are managed by the ward managers. 1B burns scored 94.0%, 1C 95.89% these were the lowest for inpatient respect. 1B ICU, 1C and 4B all scored 100% for respect.
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 Murdoch **Committee:** CQAC	87.12 %	R <85 % A >=85 % G >=90 %		83.06% of families within medicine knew their discharge date. 88.89% within surgery knew their date of discharge. Data is available in real time for all managers to access to identify any issues or concerns within their department. Training and further engagement is ongoing.

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	98.03 %	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 Murdoch **Committee:** CQAC	95.35 %	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 Murdoch **Committee:** CQAC	72.09 %	R <85 % A >=85 % G >=90 %		The school is on holiday until September further interaction with the teachers is required, the play manager and patient experience/quality lead will liaise with the team to discuss further support going forward Medicine 54.81%, Surgery 41.99%

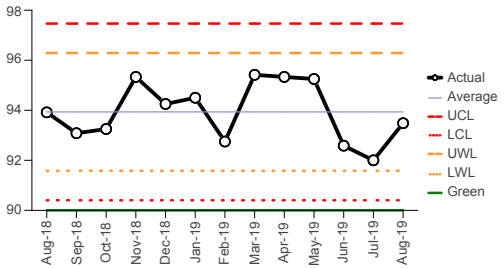
The Best People doing their best Work

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	93.48 %	R <90 % A N/A G >=90 %		No Action Required

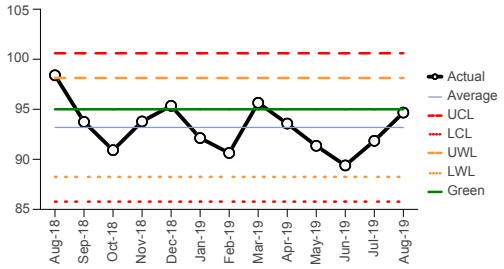
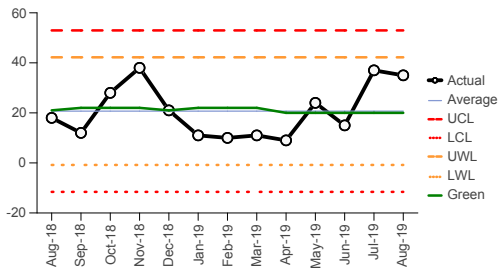
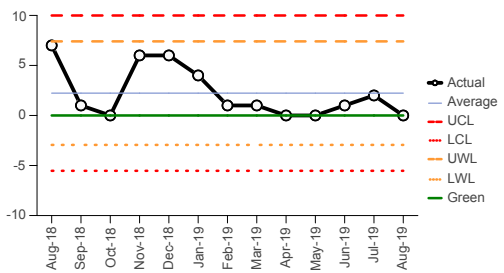
Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

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	94.67 %	R <95 % A N/A G >=95 %		Alder Hey 4 Hour Standard in August was 94.7% (98.4% August 2018/19). There has been a 9% increase in attendances in comparison to August 18/19, this equates to an additional 385 patients. Challenges being faced have been a reduction in Consultant cover due to sickness, an increase in the number of trauma cases and on 8 occasions there was no GP cover.
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 (284). This is inline with trajectory from Oct 18 - Mar 19 **Exec Lead:** Adam Bateman **Committee:** RABD	35	R >20 A N/A G <=20		Multiple cancellations due to a high demand in emergency capacity throughout the month. This will be supported by an additional general surgery list for urgent patients that is added to the theatre schedule from September. There wer also 7 unavoidable cancellations due to surgeon sickness.
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	0	R >0 A N/A G 0		No Action Required

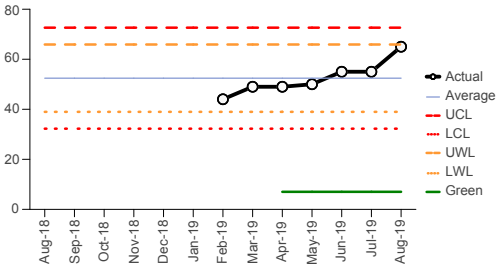
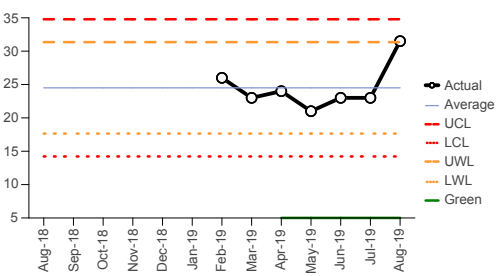
Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

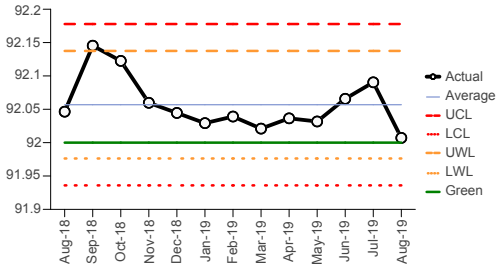
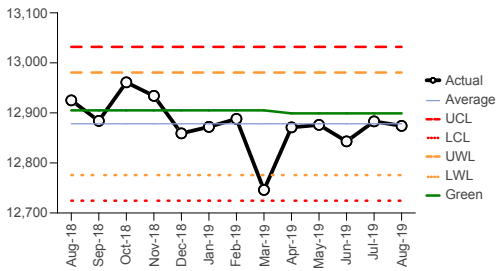
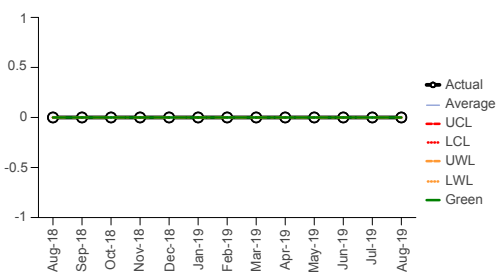
	Description	Performance	Threshold	Trend	Management Action (SMART)
Scanning	**Average Scanning Turnaround - Inpatient** D Days from being clinically coded following inpatient discharge to episode notes being scanned and uploaded on to the viewing system (Image Now). Average based on working days. **Exec Lead:** Adam Bateman **Committee:** RABD	65	R >7 A N/A G <=7		Unfortunately due to some down time and absences turn around time has increased. Work is continuing to progress with Outsourcing of backlog with an anticipated go live of end of Sept/October to commence. Additional ways of operating are also being reviewed and considered to assist in improving turnaround times.
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	31.50	R >5 A N/A G <=5		Unfortunately due to some down time and absences turn around time has increased. Work is continuing to progress with Outsourcing of backlog with an anticipated go live of end of Sept/October to commence. Additional ways of operating are also being reviewed and considered to assist in improving turnaround times.

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

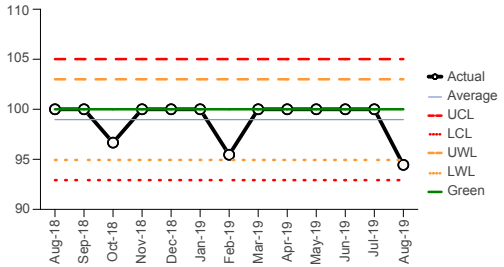
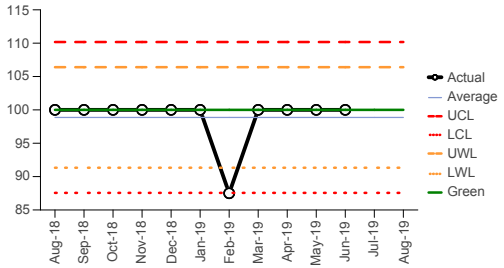
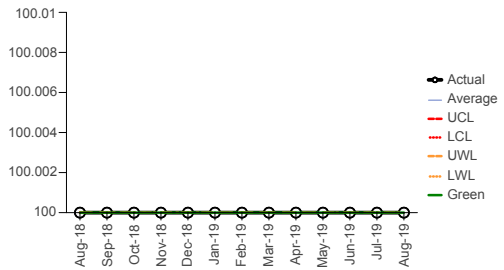
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.01 %	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	12874	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 Foundation Trust

D Drive W Watch P Programme

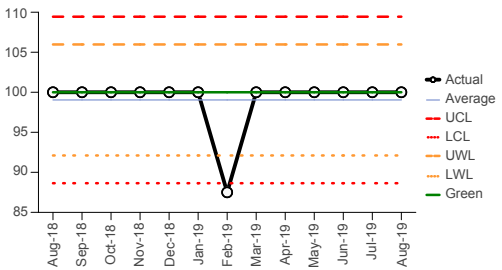
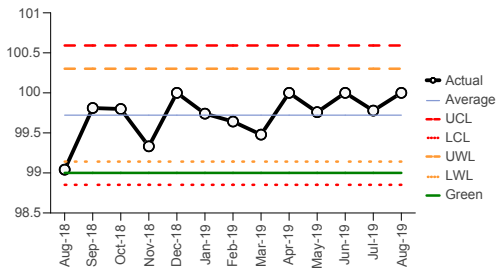
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	94.44 %	R <100 % A N/A G 100 %		Under performance against 2 week target is due to one patient breach being unable to attend first offered appointment due to being on holiday.
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

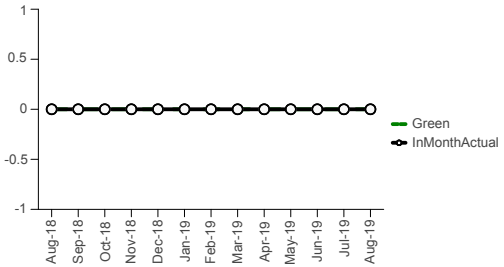
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** 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

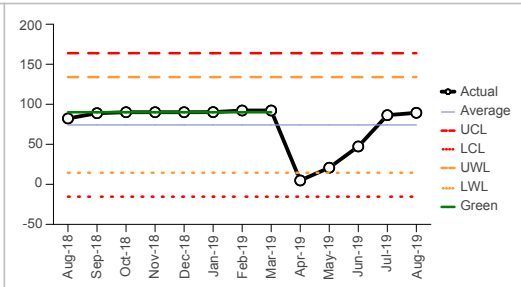
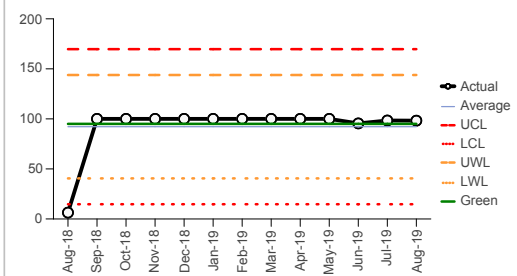
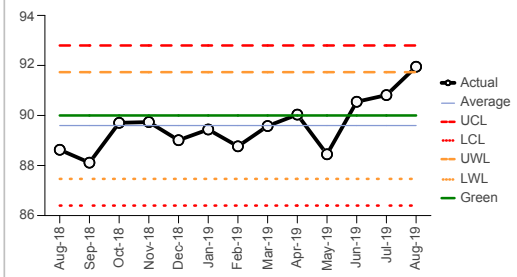
The Best People doing their best Work

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	89.32 %	R <85 % A >=85 % G >=90 %		The PDR compliance was 89% at the end of the window, the L&D team are continuing to chase up any outstanding appraisals in order reach 90%
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	98.22 %	R <90 % A >=90 % G >=95 %		No Action Required
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	91.95 %	R <80 % A >=80 % G >=90 %		No Action Required

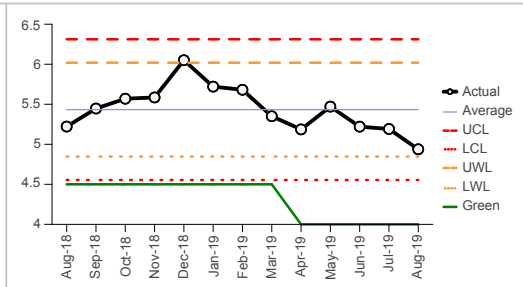
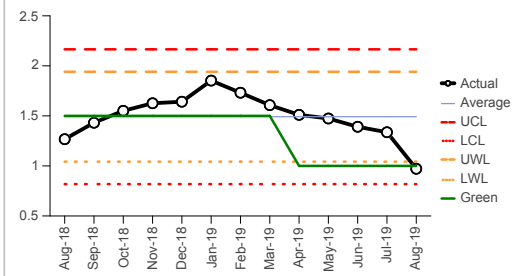
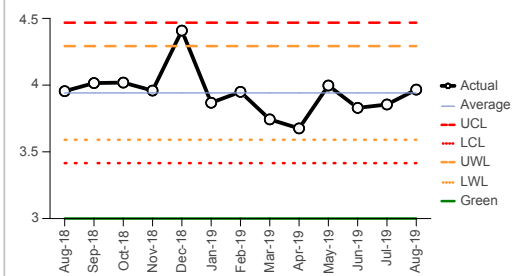
The Best People doing their best Work

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	4.94 %	R >4.5 % A <=4.5 % G <=4 %		Trust absence has reduced to less than 1% above target. The Trust top 3 reasons for absence continue to be Anxiety/Stress, Others Musculoskeletal and Gastrointestinal problems. Action plans are in place for areas with significant absence. In addition a full review of all absences is being undertaken with individual action plans in place.
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	0.97 %	R >1 % A N/A G <=1 %		See 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	3.97 %	R >3 % A N/A G <=3 %		See above

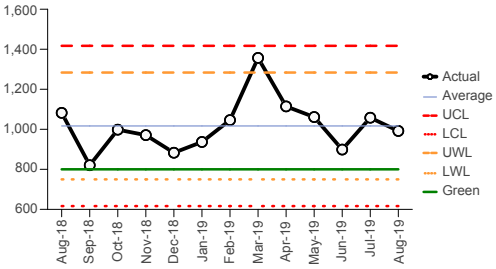
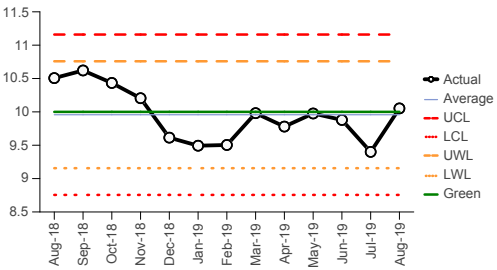
The Best People doing their best Work

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	991.60	R >960 A <=960 G <=800		Business Partners together with Finance Accountants and Ass 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	10.05 %	R >11 % A <=11 % G <=10 %		The Division of Medicine had the most leavers in August (12 staff/36%) 25% of Trust leavers were Nurses and 25% belong to the Additional Clinical Services staff group. Voluntary resignation was the main reason for leaving among staff (57%)

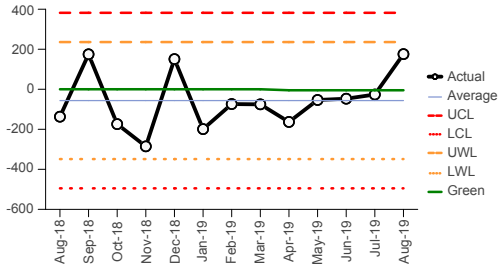
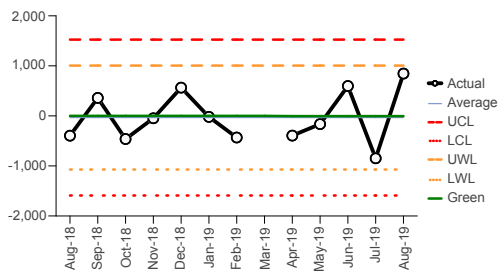
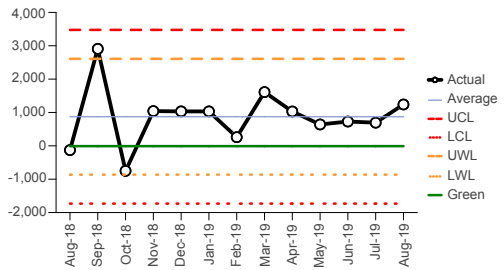
The Best People doing their best Work

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	176	R <-20% A >=-20% G >=-5%		No Action Required
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	845	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,239	R <-10% A >=-10% G >=-5%		No Action Required

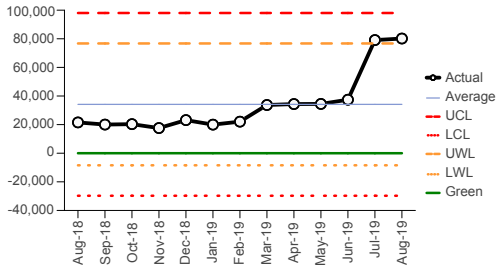
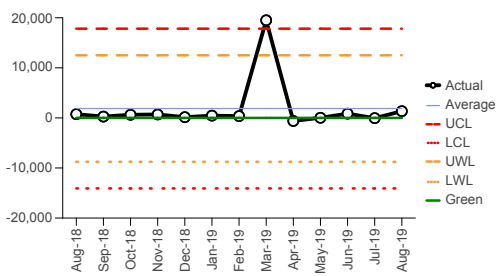
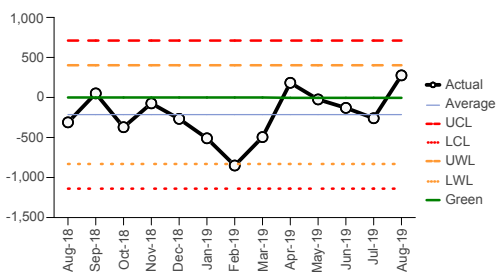
The Best People doing their best Work

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	80,174	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	1,338	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	276	R <-20% A >=-20% G >=-5%		No Action Required

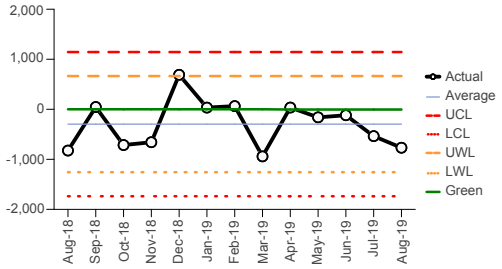
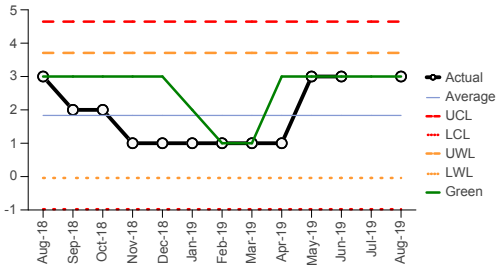
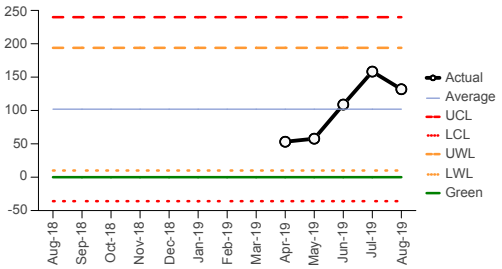
The Best People doing their best Work

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	-769	R <-20% A >=-20% G >=-5%		Non Pay was overspent in August due to the costs of electricity and gas supplies. The Trust is working with its partners to ensure we have secured the best prices for energy in order to reduce future overspends.
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 Forecast for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	131.82	R <0 A N/A G >=0		No Action Required

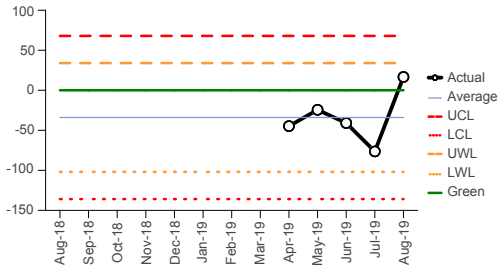
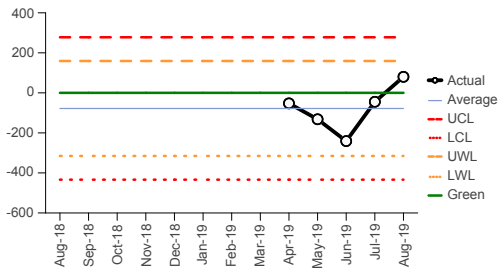
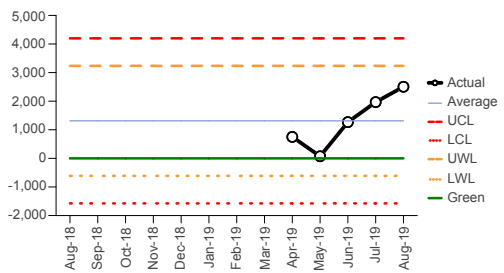
The Best People doing their best Work

16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP Elective vs Plan** W Actvity vs Forecast for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	16.60	R <0 A N/A G >=0		No Action Required
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Forecast for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	80.12	R <0 A N/A G >=0		No Action Required
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Forecast for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	2503.28	R <0 A N/A G >=0		No Action Required

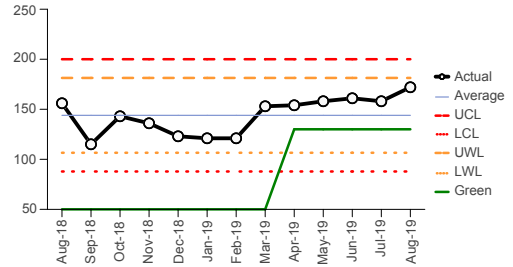
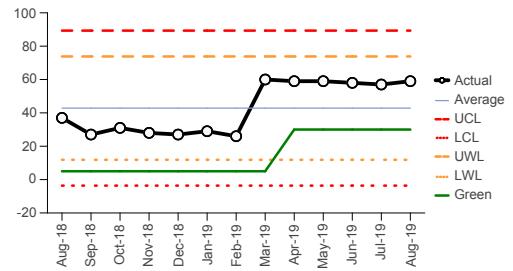
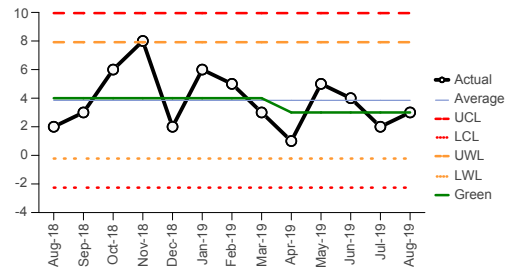
Game Changing Research & Innovation

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	172	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	59	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	3	R <2 A >=2 G >=3		No Action Required

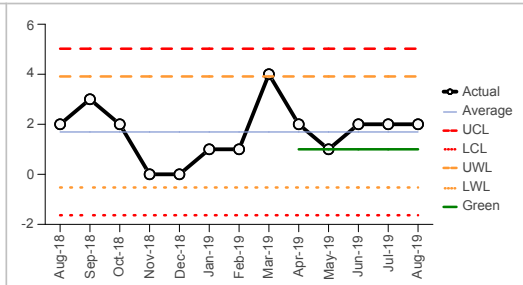
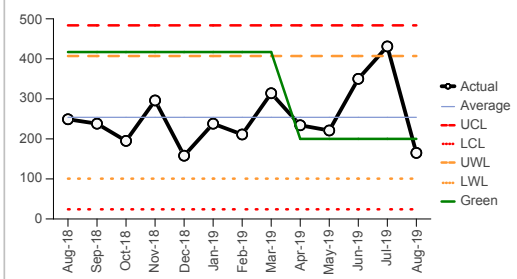
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

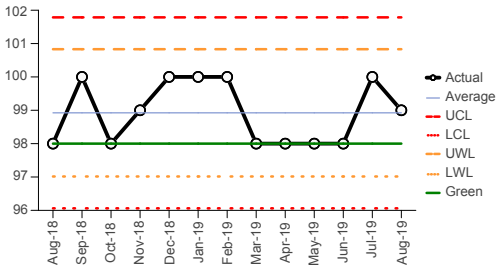
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	R <1 A N/A G >=1		No Action Required
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Matthew Peak **Committee:** REIC	165	R <171 A >=171 G >=200		Number of new studies opening (academic and commercial) being purposely stalled due to lack of capacity within the clinical research division. This will improve as key posts are recruited to in the coming weeks and months.

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

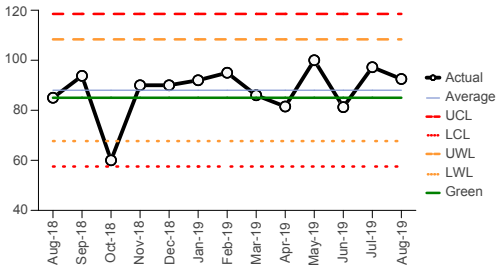
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	92.50 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG
Clinical Incidents resulting in Near Miss	D	5	14	33	No Threshold
Clinical Incidents resulting in No Harm	D	29	72	137	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	1	11	49	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0 / N/A / >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0 / N/A / >0
Medication errors resulting in harm	D	0	0	1	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0 / N/A / >0
Never Events	W	0	0	0	0 / N/A / >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		100.0%	100.0%	>=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	1	0	0 / N/A / >0

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	2	3	1	No Threshold
PALS	W	21	28	10	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
ED: 95% Treated within 4 Hours	D		94.7%		>=95 % / N/A / <95 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	5	30	No Threshold
28 Day Breaches	W	0	0	0	0 / N/A / >0

All Divisions

D Drive W Watch P Programme

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		95.4%	95.9%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		97.0%	97.8%	100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge	D P		83.8%	89.0%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		97.0%	98.6%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		94.4%	95.9%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		75.1%	70.4%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	71.6%	93.5%	94.1%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,107	3,501	8,266	No Threshold		
Waiting Greater than 52 weeks	W	0	0	0	0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W		100.0%	100.0%	>=99 %	N/A	<99 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG		
Control Total In Month Variance (£'000s)	W	17	949	455	No Threshold		
Income In Month Variance (£'000s)	W	57	667	775	No Threshold		
Pay In Month Variance (£'000s)	W	-4	294	-117	No Threshold		
Non Pay In Month Variance (£'000s)	W	-36	-12	-203	No Threshold		
AvP: IP - Non-Elective	W		65	67	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	-1	17	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		100	-22	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	90	232	1,244	>=0	N/A	<0
PDR	W	90.1%	87.8%	93.3%	>=90 %	>=80 %	<85 %
Medical Appraisal	W	99.7%	96.2%	95.2%	>=95 %	>=90 %	<90 %
Mandatory Training	W	93.2%	91.9%	90.3%	>=90 %	>=80 %	<80 %

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
Sickness	D	4.2%	4.7%	5.7%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	0.8%	1.2%	1.0%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.4%	3.5%	4.7%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	122	282	513	No Threshold		
Staff Turnover	D	10.2%	10.3%	10.6%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	87.3%	98.8%	92.5%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	A continued good month in relation to 'SAFE' care, in particular our first month where we had a 100% of our inpatients with sepsis treated within 60mins. We saw a decrease in our incidents resulting in minor or moderate harm and continued performance of 0 children with severe harm. We did however have our first MSSA bacterium this financial year,	**Highlight** • 100% IP with Sepsis treated within 60mins • Clinical incidents resulting in in moderate, semi-permanent harm • 0 Pressure ulcers **Challenges** • MSSA Acquired Organism
CARING	August saw a reduction in the number of PALS from the previous 2 months, but an increase in the number of complaints and the highest number this financial year.	**Highlight** • Reduced number of PALS **Challenges** • 3 complaints for the month
EFFECTIVE	We continued to see a challenge around managing our ED target in line with the 95% standard, but it did improve to 94.7% compared to the previous 2 months. We see continued increases in the number of attendances through ED. We had a higher number of on the day cancellations but no breaches of the 28 target to get our patients back in quickly.	**Highlight** • 0 28 Day Breaches **Challenges** • 94.7% ED target • 5 patients cancelled on the day.
RESPONSIVE	We continue to perform well with patients receiving the diagnostics within 6 weeks despite capacity challenges within a number of our services. Patients advise that they know is in charge of their care and have information to inform choice, however we are not hitting 90% of our patients knowing about their planned date of discharge. As part of the SAFER work stream there will be focus on improvements in this area.	**Highlight** • 100% diagnostics within 6 weeks • 97% know who is in charge of their care • 95.4% received information enabling choices about their care. • 0 patients waiting 52 weeks **Challenges** • 83.8% patients know their planned date of discharge • 75.1% Patients involved in learning.
WELL LED	We had a good month financially, with a financial over performance, activity over performance. We had a good month for HR metrics with improvements on our PDR and our Mandatory Training. However, we continue to struggle with our sickness targets for both long term and short term sickness. We are working closely with our HR colleagues to manage in line with policies and procedures and to work closely around the health and wellbeing strategy to enable longer term improvements for our staff.	**Highlight** • £949k over performance against the control target • 87.8% PDR • Mandatory Training 91.9% **Challenges** • Sickness 4.7% • Short term sickness 1.2% • Turnover 10.3^

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Medication Errors (Incidents)	23	30	45	45	27	29	32	35	46	40	23	32	32		No Threshold
Cleanliness Scores	96.2%	97.6%	96.3%	95.7%	95.6%	96.8%	96.8%	98.3%	97.7%	97.8%	91.8%	96.5%	98.4%		>=90 % >=80 % <80 %
Clinical Incidents resulting in Near Miss (D)	22	30	31	25	19	17	31	29	17	27	20	32	14		No Threshold
Clinical Incidents resulting in No Harm (D)	83	76	110	92	57	79	82	74	94	84	75	102	72		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	23	27	15	22	14	27	15	30	31	28	23	23	11		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	1	2	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	1	1	0	0	0	1	0	0		0 N/A >0
Medication errors resulting in harm (D)	0	2	1	3	0	0	2	1	4	3	0	1	0		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	3	2	4	6	3	3	3	2	2	3	3	4	4		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)	81.8%	83.3%	80.0%	100.0%	83.3%	77.8%		60.0%	100.0%	33.3%	100.0%	80.0%	100.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	1	1	2	0	2	2	6	1	0	0	2	1	1		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	0	0	0	0	0	0	1	0	0	0	0	1		0 N/A >0
Pharmacy - Dispensing for Out Patients - Routine	53.4%	50.0%	58.0%	55.0%	41.0%	50.0%	63.0%	62.0%	63.0%	54.0%	63.0%	52.5%	52.5%		>=90 % >=80 % <90 %
Pharmacy - Dispensing for Out Patients - Complex	78.8%	86.0%	86.0%	94.0%	89.0%	91.0%	67.0%	95.0%	60.0%	75.0%	100.0%	87.5%	87.5%		>=90 % >=80 % <90 %

CARING

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Complaints (W)	3	6	6	1	4	3	2	3	2	1	2	3	3		No Threshold
PALS (W)	23	21	34	19	21	41	33	20	25	26	37	37	28		No Threshold

EFFECTIVE

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Referrals Received (Total)	1,569	1,680	2,087	1,985	1,755	2,037	1,934	2,181	2,019	2,109	1,952	2,172	1,670		No Threshold
ED: 95% Treated within 4 Hours (D)	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%	93.6%	91.3%	89.4%	91.8%	94.7%		>=95 % N/A <95 %
Theatre Utilisation - % of Session Utilised (W)	77.8%	84.8%	80.4%	80.9%	86.7%	84.5%	83.8%	82.4%	81.8%	83.3%	82.4%	85.5%	84.4%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	4	0	2	4	0	4	2	0	1	1	1	2	5		No Threshold
28 Day Breaches (W)	2	0	0	1	0	0	1	0	0	0	0	0	0		0 N/A >0
Clinic Session Utilisation (D P)	82.0%	84.2%	83.6%	85.7%	81.8%	81.8%	87.5%	87.4%	85.9%	84.9%	84.6%	86.3%	81.5%		>=90 % >=80 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	33	27	37	36	29	29	58	32	64	62	62	40	43		No Threshold
OP Appointments Cancelled by Hospital %	16.5%	14.6%	15.2%	15.0%	16.3%	16.0%	16.1%	14.3%	18.4%	19.4%	17.5%	15.9%	17.7%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	14.8%	13.2%	13.3%	11.9%	14.2%	12.6%	12.9%	10.5%	12.2%	12.2%	11.6%	13.2%	14.4%		<=12 % <=14 % >14 %

Medicine

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG		
Was Not Brought Rate (New Appts)	W	17.8%	16.0%	14.4%	13.7%	16.8%	14.5%	14.1%	11.0%	14.2%	14.4%	10.5%	13.9%	15.4%		<=10 %	<=12 %	>12 %
Was Not Brought Rate (Followup Appts)	W	13.7%	12.2%	12.9%	11.3%	13.3%	12.0%	12.5%	10.3%	11.5%	11.4%	12.0%	12.9%	14.0%		<=14 %	<=16 %	>16 %
Coding average comorbidities		3.49	3.48	3.56	3.50	3.75	3.75	4.00	3.92	4.38	4.37	4.38	4.46	4.52		No Threshold		

RESPONSIVE

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG		
Convenience and Choice: Slot Availability		96.5%	100.0%	99.4%	92.1%	91.4%	91.5%	87.5%	78.0%	63.1%	66.8%	64.5%	64.7%	72.9%		>=96 %	N/A	<96 %
IP Survey: % Received information enabling choices about their care	W	92.4%	93.1%	95.1%	94.1%	94.1%	93.3%	89.7%	94.2%	98.6%	94.8%	97.9%	97.4%	95.4%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	99.4%	99.2%	99.5%	100.0%	100.0%	100.0%	100.0%	99.4%	99.3%	98.6%	97.9%	99.5%	97.0%		100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge	D P	54.8%	45.4%	56.7%	60.8%	55.9%	68.7%	75.0%	76.0%	85.0%	82.1%	82.8%	84.1%	83.8%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	91.7%	94.6%	91.6%	88.2%	91.2%	98.5%	92.2%	92.9%	98.6%	91.5%	95.8%	88.4%	97.0%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D											92.7%	94.7%	94.4%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D											69.4%	86.2%	75.1%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	90.2%	91.1%	89.9%	91.5%	92.7%	92.9%	92.5%	93.9%	94.6%	94.3%	94.7%	94.3%	93.5%		>=92 %	>=90 %	<90 %
Waiting List Size	W	3,402	3,210	3,199	3,365	3,295	3,686	3,398	3,355	3,434	3,771	3,565	3,762	3,501		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		35	18	15	6	13	18	22	15	7	5	5	7	11		No Threshold		
Diagnostics: % Completed Within 6 Weeks	W	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	100.0%	99.6%	100.0%	100.0%	100.0%	99.8%	100.0%		>=99 %	N/A	<99 %
Pathology - % Turnaround times for urgent requests < 1 hr		92.3%	92.0%	90.3%	89.3%	89.5%	89.9%	89.4%	90.8%	92.4%	91.0%	92.7%	93.4%	90.8%		>=90 %	>=85 %	<90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs		100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	99.9%	100.0%	99.9%		>=90 %	>=85 %	<90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs		99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	100.0%		>=95 %	>=90 %	<95 %
Imaging - % Reporting Turnaround Times - ED		89.0%	85.0%	94.0%	78.0%	83.0%	93.0%	88.0%	92.0%	75.0%	83.0%	94.0%	86.0%	96.0%		>=90 %	>=85 %	<90 %
Imaging - % Reporting Turnaround Times - Inpatients		87.0%	91.0%	87.0%	75.0%	80.0%	88.0%	82.0%	86.0%	84.0%	84.0%	88.0%	92.0%	82.0%		>=90 %	>=85 %	<90 %
Imaging - % Reporting Turnaround Times - Outpatients		98.0%	95.0%	98.0%	85.0%	87.0%	82.0%	92.0%	85.0%	88.0%	86.0%	96.0%	92.0%	93.0%		>=85 %	N/A	<85 %
Imaging - Waiting Times - MRI % under 6 weeks		72.0%	66.0%	77.0%	66.0%	71.0%	69.0%	78.0%	66.0%	67.0%	64.0%	63.0%	73.0%	78.0%		>=95 %	>=90 %	<95 %
Imaging - Waiting Times - CT % under 1 week		87.0%	85.0%	85.0%	89.0%	73.0%	89.0%	82.0%	89.0%	81.0%	82.0%	85.0%	87.0%	88.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Plain Film % under 24 hours		93.0%	93.0%	91.0%	91.0%	91.0%	92.0%	91.0%	92.0%	91.0%	92.0%	92.0%	92.0%	91.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Ultrasound % under 2 weeks		92.0%	87.0%	82.0%	90.0%	88.0%	84.0%	86.0%	81.0%	85.0%	78.0%	90.0%	86.0%	89.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks		100.0%	100.0%	88.0%	100.0%	100.0%	92.0%	88.0%	81.0%	100.0%	60.0%	78.0%	68.0%	68.0%		>=95 %	>=90 %	<95 %

WELL LED

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	87	205	-120	20	71	-436	-245		-147	-298	-219	-310	949		No Threshold		
Income In Month Variance (£'000s)	W	533	545	116	581	25	50	418	416	-225	-298	86	79	667		No Threshold		
Pay In Month Variance (£'000s)	W	-67	-54	-89	-37	-126	-212	-219	-247	-53	100	37	-79	294		No Threshold		
AvP: IP - Non-Elective	W									17	20	89	111	65		>=0	N/A	<0
AvP: IP Elective vs Plan	W									-30	-26	-30	-56	-1		>=0	N/A	<0
AvP: OP New										95.61	-99.66	98.67	143.21	284.45		>=0	N/A	<0
AvP: OP FollowUp										-283.82	-484.12	-337.98	-202.73	-52.19		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W									-6	-119	-154	-65	100		>=0	N/A	<0

Medicine

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG		
AvP: Outpatient Activity vs Plan	W									-188	-584	-239	-60	232		>=0	N/A	<0
PDR	W	85.5%	88.6%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	2.8%	14.1%	37.4%	83.8%	87.8%		>=90 %	>=85 %	<85 %
Medical Appraisal	W										100.0%	95.5%	98.4%	96.2%		>=95 %	>=90 %	<90 %
Mandatory Training	W	87.9%	87.6%	89.4%	90.4%	90.0%	91.0%	90.1%	90.7%	90.7%	89.7%	92.0%	91.2%	91.9%		>=90 %	>=85 %	<80 %
Sickness	D	4.3%	4.6%	4.6%	4.7%	5.1%	4.7%	4.5%	4.9%	4.4%	4.6%	4.4%	5.1%	4.7%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.3%	1.7%	1.7%	1.8%	1.7%	1.9%	1.9%	2.0%	1.6%	1.4%	1.1%	1.6%	1.2%		<=1 %	N/A	>1 %
Long Term Sickness	D	3.0%	2.8%	2.8%	3.0%	3.4%	2.8%	2.6%	2.9%	2.8%	3.1%	3.3%	3.5%	3.5%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	229	201	189	242	175	219	297	326	270	271	263	247	282		No Threshold		
Staff Turnover	D	10.7%	10.4%	10.0%	9.5%	8.4%	8.3%	8.1%	8.8%	8.6%	9.1%	9.5%	9.5%	10.3%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	99.0%	98.0%	95.5%	97.5%	97.2%	96.0%	97.0%	103.2%	100.2%	101.0%	97.5%	97.8%	98.8%		>=90 %	>=85 %	<90 %

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Medication Errors (Incidents)	46	49	38	43	35	39	38	42	42	56	48	32	43		No Threshold
Cleanliness Scores	93.6%	94.9%	82.4%	95.2%	98.0%	97.3%	97.2%	98.0%	98.2%	97.7%		97.0%	96.8%		>=90 % >=80 % <80 %
Clinical Incidents resulting in Near Miss (D)	34	34	33	42	30	31	38	35	29	32	26	62	33		No Threshold
Clinical Incidents resulting in No Harm (D)	154	151	129	135	101	141	102	141	143	138	170	136	137		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	36	47	61	57	43	40	49	57	47	70	40	37	49		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	0	0	2	1	0	0	0	1	2	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	1	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	3	2	0	3	2	2	2	1	2	0	3	1	1		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	66.7%	71.4%	68.0%	63.6%	66.7%	62.5%		90.9%	75.0%	75.0%	100.0%	75.0%	100.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	1	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	1	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA (D)	0	1	2	0	1	1	0	3	1	1	0	0	0		0 N/A >0

CARING

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Complaints (W)	3	1	1	1	0	1	2	3	0	0	1	6	1		No Threshold
PALS (W)	22	27	27	27	16	27	17	16	23	21	17	22	10		No Threshold

EFFECTIVE

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Readmissions to PICU within 48 hrs (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Referrals Received (Total)	3,380	3,242	3,680	3,808	2,844	3,668	3,776	4,001	3,701	4,056	3,735	4,114	3,246		No Threshold
Theatre Utilisation - % of Session Utilised (W)	88.7%	86.9%	87.4%	88.2%	85.6%	89.4%	89.5%	90.6%	90.0%	90.0%	88.6%	90.1%	90.9%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	14	12	26	34	21	7	8	11	8	23	14	35	30		No Threshold
28 Day Breaches (W)	5	1	0	5	6	4	0	1	0	0	1	2	0		0 N/A >0
Clinic Session Utilisation (D P)	83.3%	83.3%	82.3%	83.8%	82.0%	84.0%	85.5%	88.9%	87.8%	87.2%	86.8%	88.8%	86.8%		>=90 % >=80 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	41	44	34	37	48	55	74	58	53	41	40	43	37		No Threshold
OP Appointments Cancelled by Hospital %	12.7%	14.5%	13.7%	12.9%	13.5%	14.3%	14.6%	14.0%	13.8%	13.3%	13.2%	12.3%	12.5%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	13.0%	10.7%	11.9%	11.4%	13.4%	13.0%	12.0%	10.8%	12.1%	11.4%	9.5%	9.8%	10.7%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	14.8%	12.4%	11.8%	12.3%	15.4%	12.7%	12.1%	11.2%	11.7%	11.2%	10.8%	10.5%	12.0%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	12.2%	10.0%	11.9%	11.0%	12.5%	13.2%	11.9%	10.6%	12.2%	11.4%	9.0%	9.4%	10.2%		<=14 % <=16 % >16 %
Coding average comorbidities	3.70	3.75	3.70	3.56	3.99	3.96	4.12	3.92	4.08	4.24	4.15	4.12	4.15		No Threshold
CCAD Cases	35	33	38	30	31	33	39	42	30	36	31	43	35		No Threshold

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Convenience and Choice: Slot Availability		96.6%	93.6%	86.3%	88.3%	80.4%	82.6%	90.6%	87.0%	80.0%	76.5%	90.0%	89.7%	82.0%		>=96 % N/A <96 %
IP Survey: % Received information enabling choices about their care	W	95.9%	98.0%	97.3%	95.6%	98.5%	97.7%	98.3%	96.8%	98.0%	97.9%	97.2%	97.7%	95.9%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	W	99.7%	99.6%	99.7%	100.0%	99.3%	100.0%	98.9%	99.5%	99.3%	99.3%	98.3%	99.0%	97.8%		100 % >=95 % <95 %
IP Survey: % Know their planned date of discharge	D P	63.7%	60.6%	62.7%	73.2%	62.0%	81.3%	87.8%	83.8%	92.4%	85.6%	91.3%	90.1%	89.0%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	W	91.5%	95.1%	92.5%	94.3%	93.4%	95.0%	95.6%	93.7%	100.0%	89.7%	96.5%	92.4%	98.6%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	D											93.8%	94.4%	95.9%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	D											72.1%	68.9%	70.4%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.7%	93.1%	93.6%	94.1%	93.7%	93.1%	94.0%	94.0%	93.6%	94.0%	94.0%	93.8%	94.1%		>=92 % >=90 % <90 %
Waiting List Size	W	8,549	8,704	8,650	8,400	8,320	7,923	8,221	8,129	8,165	7,712	7,939	7,765	8,266		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	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.5%	92.3%	100.0%	91.7%	100.0%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-45	-320	-25	-209	-253	-240	-470		-405	-63	282	-525	455		No Threshold
Income In Month Variance (£'000s)	W	294	-285	449	131	47	-56	208	364	-372	159	370	53	775		No Threshold
Pay In Month Variance (£'000s)	W	-44	-69	-209	57	-2	-30	-407	-274	23	-7	-34	-165	-117		No Threshold
AvP: IP - Non-Elective	W									36	37	20	48	67		>=0 N/A <0
AvP: IP Elective vs Plan	W									-15	2	-10	-22	17		>=0 N/A <0
AvP: OP New										-66.91	-239.93	-281.00	-121.28	183.93		>=0 N/A <0
AvP: OP FollowUp										434.69	139.90	758.71	754.55	1,060.07		>=0 N/A <0
AvP: Daycase Activity vs Plan	W									-46	-14	-87	17	-22		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W									368	-100	478	633	1,244		>=0 N/A <0
PDR	W	83.6%	90.7%	90.0%	90.0%	90.0%	90.0%	96.6%	96.6%	11.6%	42.7%	74.4%	93.8%	93.3%		>=90 % >=85 % <85 %
Medical Appraisal	W										100.0%	95.5%	98.4%	95.2%		>=95 % >=90 % <90 %
Mandatory Training	W	87.2%	87.8%	88.6%	87.8%	88.0%	90.0%	88.4%	89.4%	88.8%	87.3%	88.6%	89.3%	90.3%		>=90 % >=85 % <80 %
Sickness	D	5.6%	6.0%	6.5%	6.0%	6.4%	6.2%	6.4%	5.2%	5.2%	6.2%	6.6%	6.4%	5.7%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.4%	1.3%	1.7%	1.6%	1.9%	2.1%	2.0%	1.6%	1.5%	1.7%	1.6%	1.6%	1.0%		<=1 % N/A >1 %
Long Term Sickness	D	4.2%	4.7%	4.8%	4.4%	4.5%	4.1%	4.4%	3.6%	3.7%	4.5%	5.0%	4.8%	4.7%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	509	374	529	485	484	474	564	591	515	505	461	527	513		No Threshold
Staff Turnover	D	10.3%	10.8%	10.7%	10.6%	9.8%	9.7%	9.9%	10.3%	10.5%	11.0%	11.4%	10.0%	10.6%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	90.1%	88.6%	91.3%	93.6%	91.9%	93.3%	89.3%	89.4%	91.9%	91.0%	89.1%	89.4%	92.5%		>=90 % >=85 % <90 %

Community & Mental Health Division (August 2019)

SAFE	Incident reporting across the division remains high. New assurance process in Division rolled out with full day risk and governance presentations planned for September.	**Highlight** • Zero Never Events reported • Zero pressure ulcers reported • Agreed investment to support Infection, Prevention and control across division • Improvements in medication errors reported **Challenges** • Backlog of scanning clinical records requires action (linked to corporate risk)
CARING	Development of divisional participation post to support engagement with children, young people and families across the division.	**Highlight** • Over 90% responses in FFT for Community and Outpatients would recommend services • Continued reduction in the number of PALS related to communication and appointments (Community Paediatrics) **Challenges** • Capturing of feedback from wide range of services. Division is exploring additional ways to capture the views of children, young people & families e.g. telephone calls, additional Meridian terminal
EFFECTIVE	Improvement programme in Community Paediatrics commenced with the aim of delivering on a range of improvements for children, young people, families and staff working in the service. This work will support a planned reduction and improvement in waiting times for ASD and ADHD.	**Highlight** • Complex Care team have led and supported improvements in the process of recording information for children and young people with complex needs which will ensure any future admissions to hospital are supported. **Challenges** • Whilst there is a reduction in "Was not brought" rate this remains a challenge in Community Paediatrics and will form part of the improvement plan.
RESPONSIVE	The Division has been focussed on ensuring greater visibility of waiting times as part of corporate report and August report includes data for a number of services for the first time.	**Highlight** • Continued reduction in the number of children who have waited over 40 weeks to access Community Speech and Language therapy in Sefton • Reduction in number of hospital initiated cancelled clinics • Reduction in overall waiting list size in Community Paediatrics

		Challenges • Continued waiting times for ASD and ADHD.
WELL LED	Mandatory training and PDR rates across the division remain above 90%. The Division was ahead of financial plan by £27k in month and £9k year to date.	**Highlight** • Division has sustained improvements in sickness absence across a range of teams (4.2%). • Divisional reward and recognition approach in development. **Challenges** • Staff turnover is higher than the Trust average and work is ongoing to explore this.

Community

D Drive W Watch P Programme

SAFE

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Medication Errors (Incidents)	8	7	8	5	4	10	9	5	10	6	3	5	4		No Threshold
Cleanliness Scores	100.0%	94.0%	98.0%			100.0%					99.5%				No Threshold
Clinical Incidents resulting in Near Miss (D)	5	4	4	5	5	3	3	4	4	9	6	4	5		No Threshold
Clinical Incidents resulting in No Harm (D)	41	38	40	27	27	35	30	33	27	31	21	32	29		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	2	4	1	1	2	1	2	4	1	0	3	4	1		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
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
CCNS: Advanced Care Plan for children with life limiting condition	0											8			No Threshold
CCNS: Supported early discharges from hospital care	0														No Threshold
CCNS: Prescriptions	0														No Threshold

CARING

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Complaints (W)	4	3	2	2	1	1	4	5	4	4	1	3	2		No Threshold
PALS (W)	27	43	36	40	11	35	27	31	30	30	34	31	21		No Threshold

EFFECTIVE

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Referrals Received (Total)	666	694	981	1,067	769	905	970	1,082	893	1,016	897	974	582		No Threshold
Clinic Session Utilisation (D P)	80.7%	80.5%	82.7%	81.1%	77.9%	79.0%	81.0%	87.2%	83.4%	83.3%	83.3%	82.1%	81.4%		>=90 % >=85 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	15	39	42	21	8	8	18	16	20	14	14	8	7		No Threshold
OP Appointments Cancelled by Hospital %	25.0%	24.4%	19.0%	24.2%	25.6%	20.0%	23.5%	24.8%	22.2%	18.6%	21.3%	18.5%	12.8%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts) (W)	17.4%	12.8%	13.5%	12.9%	13.9%	17.6%	13.6%	12.5%	14.3%	15.8%	12.8%	14.9%	12.6%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	25.4%	21.4%	17.7%	22.0%	22.4%	20.8%	18.5%	16.6%	20.0%	18.8%	18.2%	18.8%	20.5%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	27.7%	18.6%	18.1%	17.7%	17.5%	21.8%	18.6%	17.1%	16.5%	21.3%	15.8%	19.7%	14.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	10.3%	12.3%	10.1%	14.6%	13.0%	13.4%	12.0%	7.9%	14.4%	11.7%	12.0%	10.6%	11.8%		<=14 % <=16 % >16 %
CAMHS: % CHOICE Was Not Brought Rate															No Threshold
CAMHS: % All Other Was Not Brought Rate															No Threshold
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	85.7%	99.0%	93.5%	104.3%	100.0%	95.9%	88.8%	118.9%	115.7%	100.0%	91.4%	98.2%	86.2%		No Threshold
CAMHS: Tier 4 DJU Bed Days	186	207	203	220	217	207	173	237	212	202	161	182	155		No Threshold
Coding average comorbidities	8.00	4.00	2.00	2.67		2.00	1.50	6.00	4.00	2.50	3.00	3.00	5.50		No Threshold
CCNS: Number of commissioned packages	0														No Threshold

RESPONSIVE

	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU	2	1	2	2			2	2			2	1			No Threshold

Community

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
CAMHS: Referrals Received		193	262	370	410	297	332	351	402	325	344	309	326	184		No Threshold
CAMHS: Referrals Accepted By The Service		120	165	242	267	183	203	210	232	190	217	172	175	124		No Threshold
CAMHS: % Referrals Accepted By The Service		62.2%	63.0%	65.4%	65.1%	61.6%	61.1%	59.8%	57.7%	58.5%	63.1%	55.7%	53.7%	67.4%		No Threshold
Community Therapies Waiting Times - Maximum Weeks Waiting																No Threshold
Community Therapies Waiting Times - 92nd Percentile																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%		>=96 % N/A <96 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.7%	87.3%	87.1%	78.8%	78.3%	82.7%	78.3%	74.2%	75.2%	74.9%	73.9%	76.4%	71.6%		>=92 % >=90 % <90 %
Waiting List Size	W	974	970	1,112	1,169	1,162	1,263	1,269	1,262	1,272	1,393	1,339	1,356	1,107		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: 2 Appointments within 6 weeks		0	0	0	0	0										No Threshold
CAMHS: Crisis / Duty Call Activity		165	274	393	445	277	325	343	424	343	337	343	315	266		No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)-Liverpool Specialist		16.00	16.00	16.00	15.00	16.00	16.00	14.00	14.00	16.00	16.00	17.00	0.00	0.00		No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)-Sefton Specialist		31.00	9.00	24.00	30.00	18.00	35.00	28.00	24.00	17.00	20.00	0.00	0.00	0.00		No Threshold
ASD: Completed Pathways		80	70	59	40	22	50	56	65	60	52	81	37	67		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)		60.0%	62.9%	67.8%	65.0%	40.9%	36.0%	35.7%	55.4%	63.3%	21.2%	23.5%	13.5%	26.9%		No Threshold
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %)	P	100.0%		100.0%	80.0%	100.0%	100.0%	100.0%	90.0%	100.0%	75.0%	75.0%	57.1%	71.4%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %)	P			100.0%			100.0%			100.0%	0.0%		66.7%			No Threshold
CAMHS: URGENT Choice 2wk Completed Wait within 92%					0.0%	0.0%	0.0%	44.4%	63.6%	18.8%	0.0%	36.4%	81.2%	0.0%		No Threshold
CAMHS: URGENT First Partnership 4wk Completed Wait within 92%							50.0%	52.6%	7.1%	33.3%	9.5%	35.0%	36.4%	28.6%		No Threshold
CAMHS: ROUTINE Choice 6wk Completed Wait within 92%		29.3%	20.5%	32.7%	21.9%	28.6%	5.6%	8.0%	9.4%	10.7%	14.3%	13.0%	13.6%	6.1%		No Threshold
CAMHS: ROUTINE First Partnership 12wks Completed Wait within 92%							0.0%	5.9%	5.0%	22.2%	4.8%	5.3%	9.5%	2.9%		No Threshold

WELL LED

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-156	59	60	-65	115	-32	16		-59	71	-8	-11	17		No Threshold
Income In Month Variance (£'000s)	W	-67	53	43	21	265	87	61	336	-111	177	36	-47	57		No Threshold
Pay In Month Variance (£'000s)	W	-29	69	19	-15	-2	-151	-56	-304	183	-71	-64	2	-4		No Threshold
AvP: OP New										-1.48	-7.08	-1.63	33.14	-0.08		>=0 N/A <0
AvP: OP FollowUp										-10.87	56.99	323.17	244.03	90.10		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W									-12	50	322	277	90		>=0 N/A <0
PDR	W	78.7%	87.9%	93.0%	93.0%	93.0%	93.7%	93.7%	93.7%	1.4%	10.8%	48.6%	87.1%	90.1%		>=90 % >=85 % <85 %
Medical Appraisal	W										100.0%	95.5%		99.7%		>=95 % >=90 % <90 %
Mandatory Training	W	92.7%	91.2%	92.5%	91.4%	90.9%	88.3%	89.2%	90.3%	92.2%	89.2%	90.2%	92.0%	93.2%		>=90 % >=85 % <80 %
Sickness	D	5.3%	5.7%	5.4%	6.6%	7.6%	7.9%	7.5%	7.4%	6.7%	6.4%	4.9%	4.3%	4.2%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	0.8%	1.5%	1.3%	1.8%	1.6%	1.7%	1.5%	1.8%	1.5%	1.6%	1.2%	0.9%	0.8%		<=1 % N/A >1 %
Long Term Sickness	D	4.5%	4.2%	4.1%	4.8%	6.0%	6.2%	6.0%	5.6%	5.3%	4.8%	3.7%	3.4%	3.4%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	186	135	159	169	144	179	106	367	198	226	96	158	122		No Threshold

Community

D Drive W Watch P Programme

		Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Last 12 Months	RAG
Staff Turnover	D	12.2%	12.5%	12.5%	12.8%	12.9%	12.2%	11.9%	12.8%	11.8%	11.7%	9.9%	10.2%	10.2%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	100.0%	105.0%	98.0%	99.0%	99.0%	97.0%	100.0%	106.0%	100.0%	102.0%	97.0%	87.0%	87.3%		>=90 % >=85 % <90 %

NHS
Alder Hey Children's
NHS Foundation Trust

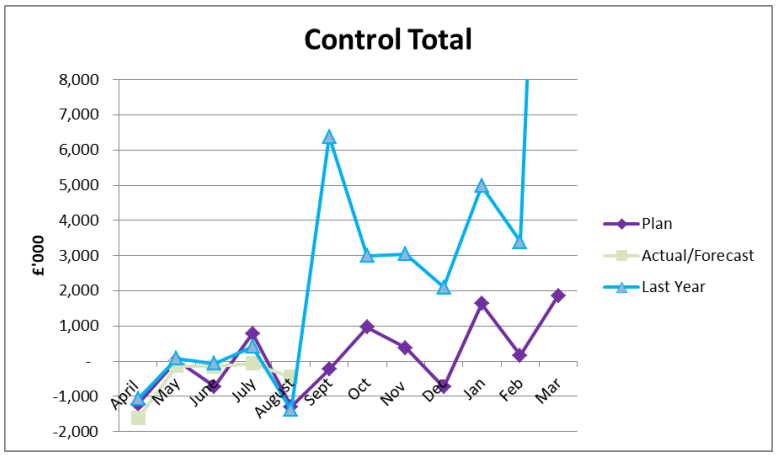
Financial Dashboard -M5 2019/20

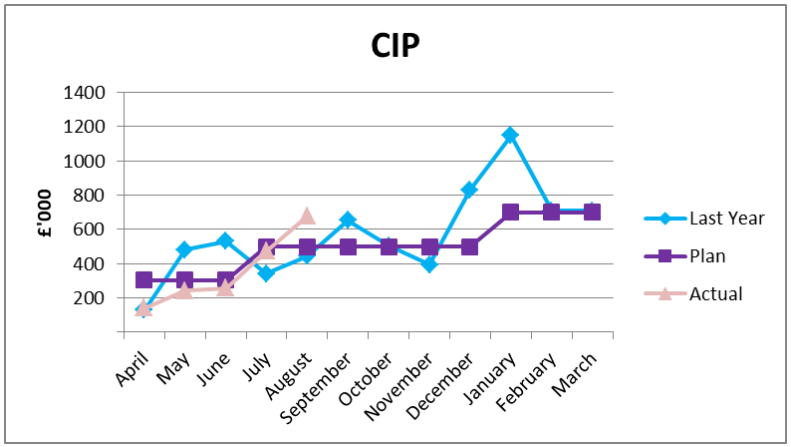
How Did We Do?

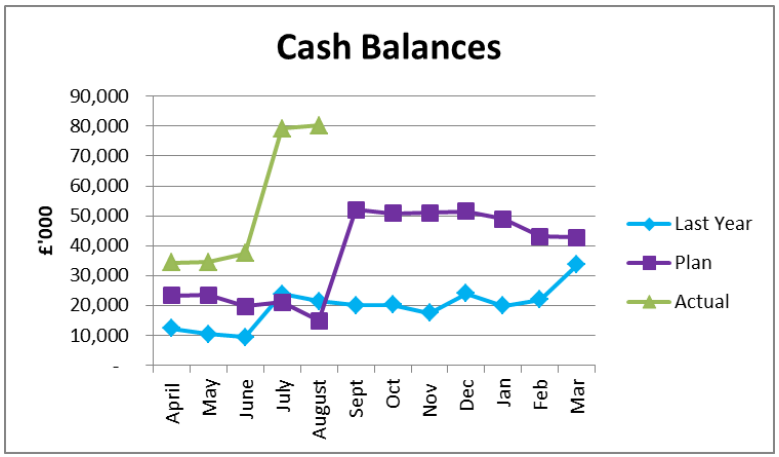
Executive Summary **Month: 5** **Year: 2019**

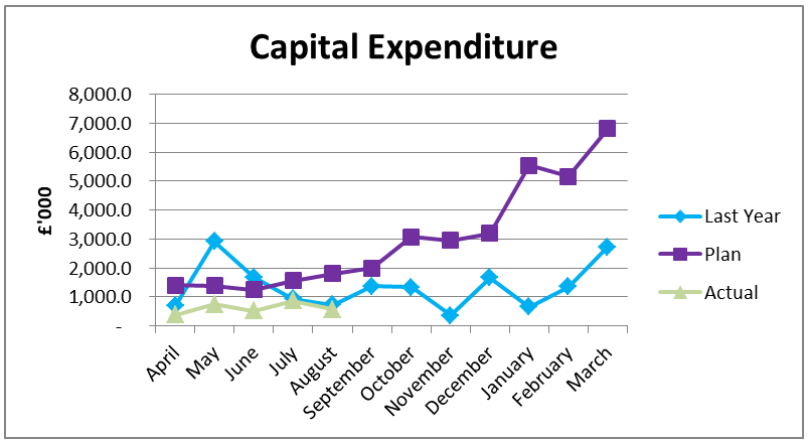
Alder Hey Children's NHS

Control Total in month	CIP Forecast for year	Use of Resources	Control Total Forecast
(£0.4m)	£4.5m	3	(£1.8m)
Achieved	Not Achieved	On Plan	Not Achieved

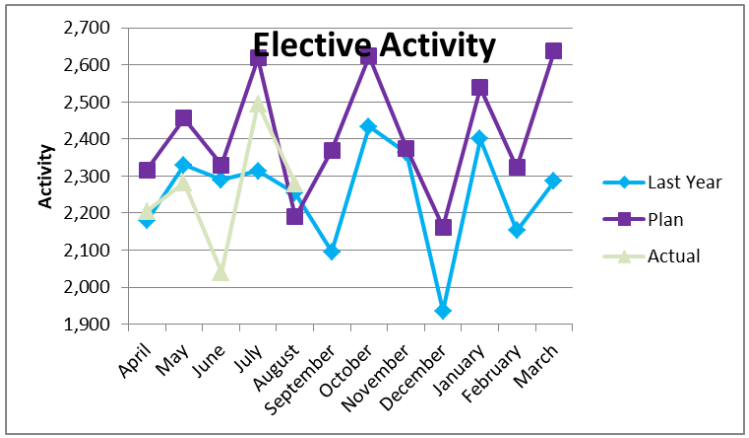


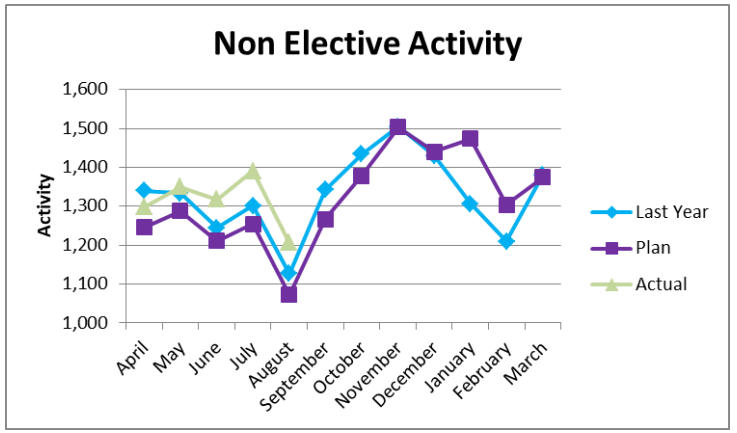


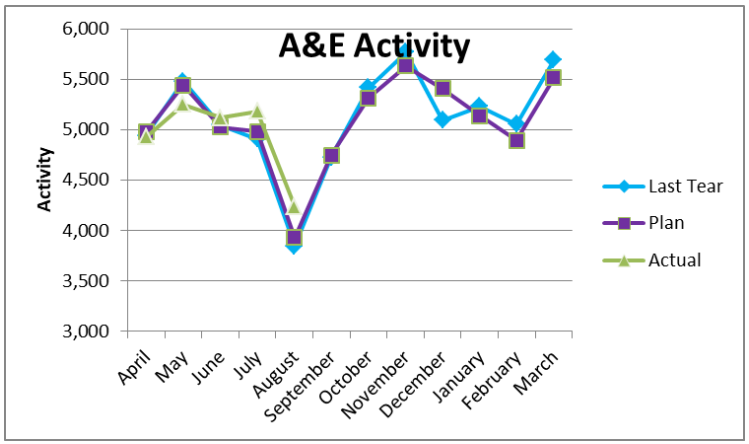


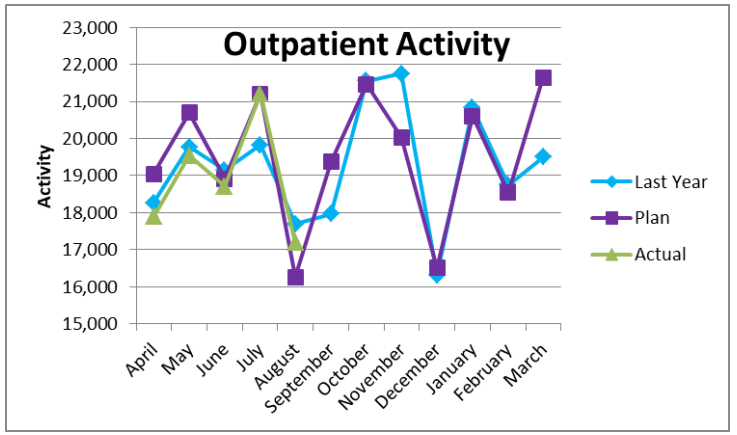


Elective Activity in Month	Non Elective Activity in Month	Outpatient Activity in Month	A&E Activity In Month
2,279	1,206	17,182	4,239
Over Achieved	Over Achieved	Over Achieved	Over Achieved









Surgery Division		
SAFE	• No SUI • No Never Events • No HAI • No grade 3 Pressure ulcers	**Highlight** • 100% sepsis response compliance (up from a difficult July) **Challenges** • Cardiac death on WL • Estate and Environment (Theatre and Crit Care) – water and insects
CARING	Friends and family reports under development	**Highlight** • Perfect Ward family feedback **Challenges** •20 PALS in August and 7 complaints
EFFECTIVE	Mandatory Training remains above 90%	**Highlight** • Recruitment into multiple teams – anaesthetics, orthopaedics, orthodontics and nursing • PDR Completion in excess of 90% • Mandatory Training 90% in August • POCU review and progress **Challenges** • IG remains a challenge • Medical workforce poor on some MT Metrics • Workforce for junior doctors

RESPONSIVE	18 week RTT =94%(92) Clinic Utilisation =87% (^) Junior doctors workforce planning in advance of Feb rotation	**Highlight** • Theatre utilisation 90.9% **Challenges** • 30 Patients cancelled on the day (emergency activity, surgeon availability or over run. Not lack of beds)
WELL LED	86% incidents reported within 24 hrs Progression of development of governance infrastructure following loss of HoQ Neonatal Partnership Neonatal Leadership appointed	**Highlight** • Financial Performance (600K ahead) • Risks 97% within review date • CLABSI and liner working groups initiated • VOGM bid submitted **Challenges** • Financial Performance • Sickness Levels • 6 risks >=15

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	**Clinical Quality Assurance Committee Assurance Report**
Date of meeting:	18th September 2019 – Summary 17th July 2019 – Approved Minutes
Report of:	Anita Marsland, Committee Chair
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 17 July 2019 along with the approved minutes from the 12 June 2019 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)	Transition of non ventilated tracheostomy patients to adult services – risk number 1597.

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)

- Programme Assurance Update
- Update on Clinical Cabinet
- CQC Roadmap update
- CQC Inspection Report Tier 4 Service
- Nutrition Update
- Board Assurance Framework
- Transition update
- Position Statement regarding completed actions from complaints made
- Mandatory Training Reporting Process for Junior Doctors on rotation
- Corporate Report – Quality metrics
- Complex Children update
- After Action Review Procedure – approved
- Research Annual Report
- CQSG Key issues Report

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

Transition of C&YP to Adult services remains a risk, Medical Director & Chief Nurse meeting with Aintree in mid November 2019, in order to agree way forward.

4. Positive highlights of note

Junior Doctor Mandatory training data now available and showed improved position.

5. Issues for other committees

N/A

6. Recommendations

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

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 17th July 2019
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Denise Boyle	Associate Chief Nurse - Surgical Division
	Lisa Cooper	Divisional Director for Community Division
	Rose Douglas	Associate Chief Nurse, Community Division
	Christian Duncan	Divisional Director, Surgical Division
	Mark Flannagan	Director of Communications and Marketing
	Hilda Gwilliams	Chief Nurse
	John Grinnell	Director of Finance/Deputy Chief Executive
	Anne Hyson	Head of Quality – Corporate Services
	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
	Cathy Wardell	Associate Chief Nurse – Medicine Division

In Attendance:

	Jill Preece	Governance Manager
	Julie Creevy	Executive Assistant (Minutes)
	Jason P Taylor	Innovation Manager
Agenda item:		
19/20/61	Natalie Deakin	Change Programme Manager
19/20/62	Lachlan Stark	Head of Planning & Performance
19/20/63	Jason P Taylor	Innovation Manager
19/20/66	Valya Weston	
19/20/69	Pete Arrowsmith	Head of Resuscitation
19/20/74	Phil O'Connor	Director of Nursing

19/20/44 Apologies:

Adam Bateman	Chief Operating Officer
Pauline Brown	Director of Nursing
Adrian Hughes	Divisional Director, Medicine Division
Dani Jones	Director of Strategy
Matthew Peak	Director of Research
Rachel Greer	Associate Chief of Operations, Community
Will Weston	Associate Chief of Operations, Medicine
Sarah Stephenson	Head of Quality – Community Division Division

19/20/66 Declarations of Interest
None declared.

19/20/67 Minutes of the previous meeting held on 12th June 2019
Resolved:
CQAC approved the minutes of the previous meeting held on 12th June 2019.

19/20/68 Matters Arising and Action Log
Action Log

19.20.05 – Sepsis Update – this item to be removed from action log, as this item is on the agenda for discussion.
Mandatory training juniors - position statement paper is on the agenda - item to be removed from action log.
19.20.10 – Corporate Report Quality Metrics – 'CQAC to receive analysis of minor harm incidents' – this item to be removed from action log as this is on the agenda for discussion.
P Brown took prompt action, AM raised at Board, now closed.

19.20.14 – Nutrition Steering Group – 'Lack of Medical representation/ToR for Nutritional Steering'. LC stated that previously the Nutrition Steering Group had struggled with the lack of any medical representation at Nutritional Steering Group, the Nutrition Steering Group had since met again, and an update is due to be provided at CQSG in August 2019. Nutritional Steering Group are focussing on a wider strategy, focussing on healthy pledge.

HG stated that with regards to Medical engagement – the Nutritional policy was problematic in terms of ratification, and that further thought is required regarding the policy, with appropriate feedback to be received to HG & NM. NM stated that she had recently met with Gastroenterologist on 24th June 2019, and that she is currently building up a relationship with Gastroenterology colleagues.

HG referred to a family who had presented at Board of Directors meeting on 6th November 2018, who are parents of a child who has cerebral palsy and had requested that the Trust try an alternative option of blending food, via the childs feeding tube. LC advised that the Trust now have a new Head of Dietetics in post, who would lead on enteral feeding. CQAC noted that the Nutrition Policy is out of date. LC re-emphasised that the plan is to have a strategy which would be in place, and queried whether there would be a need for nutritional policy. HG stated that there is a need for policies and procedures to be in place.

CQAC noted that a Sub Group had been set up regarding TPN and enteral feeding, with the Nutritional Steering Group reviewing wider activity.
CQAC agreed it would be beneficial to receive a Nutritional Steering Group update at September meeting, which would focus on Public Health.

Action: **J Preece to share National Nutritional standards – baseline assessment with Lisa Cooper.**

Action: CQAC to receive Nutrition update at September 2019 meeting.

LC stated that discussion at Executive Team meeting is planned on 18th July 2019 regarding healthy weight. LC stated that the team are currently establishing an audit with regards to weighing & measuring of young people, in terms of standards, equipment, trainining, how often checks are taking place and minimum standards. LC stated that there is an issue regarding equipment.

19.20.47 – Patient Information Leaflets – AM confirmed that this item had been escalated to Board of Directors as appropriate and this item could be removed from action log.

19.20.60 – 'Update regarding establishment of Clinical Cabinet' – NM sought clarification as to whether there is a requirement to present a briefing paper to Board of Directors. CQAC confirmed that discussion should take place initially at Executive Team meeting, followed by presentation to Board of Directors at 3rd September Board of Directors meeting.

Action: NM to provide briefing paper to Executive Team, followed by presentation to Board of Directors at 3rd September 2019 meeting.

19.20.68 - Action: 'CQAC to receive Sepsis update'. HG referred to concern regarding documentation, HG stated that numerous meetings had taken place, and suspected that evidence is not being fully captured and uploaded as appropriate. HG stated that a meeting with G Smith would take place, with regards to addressing any documentation issues. HG stated that there is a need for the project administration to be reviewed.

HG had drafted proposed escalation process, for cases which required escalating to Exec level, to be shared with N Murdock/James Ashton & David Porter. Both HG & NM would be inviting teams to meet with Chief Nurse & MD regarding any required support, in order to rescue a deteriorating child**.**

Action: Sepsis Update to be received by CQAC in September 2019.

CQAC noted that AM & HG had discussed the issue regarding escalation, with ongoing discussion taking place regarding the process. NM stated that she does not attend Sepsis Steering Group. NM stated that she would aim to periodically attend the Sepsis Steering Group meetings going forward, as and when possible.

HG stated that there had been changes at local level, which had resulted in inpatients receiving 100% antibiotics within 1 hour, and that providing that this trend continued, that this would be an extremely robust position going forward. HG stated that A&E continued to be challenging.

CQAC noted that D Porter & Sepsis Team are due to attend Trust Board on 3rd September 2019 meeting to provide Sepsis update.

19.20.68 **-** JG referred to 'Inspiring Quality', and that there appeared to be numerous KPI's stating "as to be confirmed", and whether there needed to be further detailed discussion during September CQAC meeting.

CQAC agreed that they should receive an Insipriing Quality update at September 2019 meeting.

Action: CQAC to receive Inspiring Quality update at September 2019 mtg.

Discussion took place with regards to whether there is a need to extend September CQAC meeting longer.

Action: HG & JC to review workplan and draft agenda to review items for discussion.

19/20/69 Programme Assurance Update

ND provided Programme Assurance update, key issues as follows:-
ND stated that the Sepsis Project had stagnanted with regards to the lack of evidence included on sharepoint.
Best in Outstanding Care – continued to improve.
CQAC received and noted Programme Assurance update.

19/20/70 Outpatient and Brilliant booking update

L Stark provided an Outpatient & Brilliant booking update, which included details of Exec leads, brilliant booking project plan milestones, room utilisation, Digital transformational, update & DNC roll out hybrid booking & progress to date, key issues as follows:-

- CQAC noted that the Digital Outpatient Transformational project is slightly behind plan, with Iain Gilbertson establishing a Digital group.

Key improvements:-

- No child unaccounted had been launched.
- Looking at tolerance on documentation
- Play and distraction – John Lennon Airport had commited to funrdaise £100,000 and are working with the Youth Forum to establish ideas.
- Looking at NHS Plan to reduce follow ups by 30%
- Summary of EPPF form, significant amount of work had taken place to complete pathway form to inform colleagues of the outcome, and ensure no child leaves the Trust unaccounted for – zero target.

HG asked whether the Trust had an escalation process in place with regards to 'no child unaccounted for' – L Stark confirmed that there is a programme of work in place, and individuals could be identified at individual level. L Stark confirmed that the team would liaise with Divisional Directors as appropriate for support and action when required.
HG stated that she had previously had discussion with Simon Bowers, with regards to Transformational Community Setting, business as usual, with an exchange of information in phlebotomy, gathering data. Currently scoping out primary care networks, focussing on phlebotomy. Regarding collective bodies.

L Shepherd referred to the Trust's offer to create a faculty of primary care for children, strategically with next move, link with public health. Enhancing Digital to ensure it is ransformational, with patients book appointments online.

L Shepherd emphasied the importance of making progress with regards to Clinical Prioritisation Booking in order to further improve the patient experience, improving Telehealth – with the need for a proposal with commissioners. L Shepherd stated that the Specialists Trusts could do really well in this regard. JG alluded to contractual arrangements – JG referred to different to technology in order to reduce outpatient attendances, needs to be done with clinical team. JG asked whether the team are being forensic with patients, in order to access services promptly, and recognised the need for effort required to be transformational.

Discussion took place regarding the value of a child returning for a 12 month review, and whether there was a clear clinical need for child to be seen by a medic, or whether the child could be seen by a specialist nurse, of via telehealth appointment, whilst noting any potential safeguarding issues. CD stated that a commissioner discussion would be welcomed, as there are clear

instances when a child is being followed up from habit, rather than clinical necessity. CD queried why particular patients are not transferred back to the care of the GP, who could then refer child back to Alder Hey when appropriate.

AM acknoweded positive progress to date. L Shepherd alluded to the challenge regarding level of ambition, and not continuing to incrementally continue, L Shepherd was supportive, with the need to link in with primary care discussions.

Discussion took place regarding the most appropriate forum, JG confirmed that this would be within the change programme.

19/20/71 **Research Annual Report**

Jason Taylor, General Manager, Innovation Team presented Research Annual Report, on behalf of M Peak, key issues as follows:-

- Recruited 3,500 patients over the year into NIHR clinical research studies at Alder Hey in 2018/19. Whilst this is a reduction in recruitment numbers compared to previous years, this is due to closure of some very high recruiting studies.
- A multi-professional workshop was held in January 2019, led by Matthew Peak and Adam Bateman in response to research being incorporated within well led category. This had brought challenges. Strategy had been to Executive Team, detailing what investment is required within research and wider environment, CQAC noted that an Action plan is in place. Team will be recruiting staff, JT stated that he envisaged that this would result in positive changes in the future.
- JT stated that there are clear processes in place with regards to Safety for studies locally and nationally, with training supplied to staff and the wider Trust.
- Ongoing discussions taking place regarding DETECT study. Requirement for new staff and broader engagement. Action plan had been agreed. With a further update in due course.

JT stated that it had been a good year, but he would expect to see an improved position next year. AM stated that she had recently attended Quality Assurance Round for Research Division on 3rd July 2019, which had been positive.

JG requested clarity regarding the purpose of the Research Annual Report, and queried whether it was to detail whether the division is safe, or whether the report is detailing activity. JT stated that he would need to obtain clarity from Matthew Peak, as he was relatively new to this position, in order to ensure clarity regarding the purpose of updating the committee. JG stated that the content of the report did not currently articulate key achievements and key issues.

JG stated that there is a need to obtain the purpose of the Research Annual update and provide further clarity. AM stated that she was hoping for an offline discussion regarding this issue, as colleagues are unsure regarding the amount of information to be included.

Action: NM & JT to undertake an offline discussion, followed by feedback to JG, with CQAC receiving an update at September 2019 meeting.

ES stated that grant, studies and activities should be included within the report. CU stated that she was unable to attend the Research Division Quality Assurance Round, but had noted that this was an extremely positive Quality Assurance round for all involved.

19/20/72 CQC Action plan & monitoring

ES presented CQC Acton plan update, key issues as follows:-
ES stated that this would be the last time that the committee would review the CQC Action plan. CQAC noted that no CQC notes following the CQC engagement meeting had been received to date. CQC Inspector had since left, and the Trust was currently awaiting further detail regarding replacement inspector.

- ES confirmed that the Trust Wide Action Plan remained green – exec governance mapping item was now complete. ES would be suggesting to M Swindell that the DBS issue become closed on the Action log, as there is a rolling programme to address this issue.
- CQAC would receive updates as appropriate regarding Transition item.
- Radiology item now closed.
- OPD item closed.
- Issues regarding End of Life would be tracked as appropriate.
- Material issue regarding net inspection, the Trust have a project plan developed to take forward in future.

AM thanked all contributors with regards to progress made to date regarding CQC Action Plan. AM queried whether there was any shared learning. CQAC noted the importance of ensuring supporting evidence is in place, that actions are SMART and are fully completed in a timely manner. Considering Trust responses and ensuring actions match and are apportionate.

AM asked the committee whether they are content with managing current situation. HG highlighted the importance of ensuring escalation takes place when there is a complex issue at divisional level which required escalation. L Shepherd strongly supported this approach.

L Shepherd stated that there is a need to regroup regarding this issue, in order to review this, in terms of medical issues.

Action: HG/NM/AH & CW to regroup to address medical issues.

AM expressed thanks from Medicine Division.

19/20/73 End of Life/Palliative Care Exception Report

CW, Associate Chief Nurse for Medicine presented End of Life/Palliative Care Exception report, key issues as follows:-

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CW stated that since the last meeting she had met with AH/AB/service manager, positive discussion had taken place regarding potential options, a working group had been established, invite would be shared with palliative care representatives within hospice. Decisions reached to go out to advert for locum and substantive palliative care consultant, in order to explore

further. Division are looking at potential nurse consultant post, who would be included on rota. CW is currently drafting up Job Description. CW stated that the nurses had gone through organisational change process, resulting in identified leaders, with interest received from Manchester Children's and strong candidates. CW highlighted the importance of ensuring strong nurse leadership, with the division looking at an integrated approach, working with Claire House to work together with community in order to develp a plan for integrated workfore. C Wardell was meeting with Claire House on the afternoon of 17th July 2019 for further discussion, to review how the Trust could work together and explore further options.

HG queried whether identified risk were included on the Risk Register and reviewed by AH & CW.

Action: Offline discussion with HG/NM & AH to relook at risk and discuss service and support required.

L Shepherd stated that there is a need to promptly reconnect with Claire House.

AM thanked CW and Medicine Division for continued effords with regards to Palliative Care during this difficult position. CQAC noted that there is a need to ensure that this is kept on the strategic agenda.

19/20/74 Quarter 1 DIPC Report

V Weston, presented Quarter 1 DIPC report, key issues as follows:-

- The work plan for 2019-20 consisted of 17 objectives and a total of 215 deliverables. *63%* (135/215) of the total of deliverables had been completed. *15%* (33/215) of the total deliverables are in progress (amber). *1% (1/215)* are classified as red. *21%* (46/215) are classified as grey, as these are new objectives that have not yet been progressed.
- Grand negative bacteraemia had six last months clabsi, pseudomonosis, ecoli, if mixture in organisms in blood culture have to count twice, 3 cases, had been reviewed, 3 cases reviewed in July. One related to a long stay patient on 3C, patient has a stoma, vascular assess device, gastrostomy, couldn't put bag on colostomy. IPC team are currently looking at tucki vests to take vascular away from problem areas. Rather than getting colostomy deteriorated, bringing back tissue viability nurse to be involved earlier and be proactive.
- MSSA bactaraemia had an increased number in March, looked into cases, majority are patients transferred into our Trust, don't screen for MSSA in majority of cases, discussions with labs had taken place, looking to start screening in September – HG queried what group this reported into – VW confirmed that have IV access and therapy group.
- Workbook regarding community, and delivering infection control to community, case went to IRG yesterday, further work to do regarding this Business Case. HG quantifiable quality improvements need reviewing. Further work to do in terms of Business Case regarding quality section robustness, which required further evidence

Action: Offline discussion with HG & VW.

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HG – referered to the mandated report – in terms of the national indicators, when they don't fit our cohort, HG stated that there is a need for process to support this – some challenge into steering group.
LC stated that assurance is required regarding support for staff in the Community Division. It is a corporate risk, which had been ongoing for a period of time, requires prompt progress. VW stated that the Tissue viability nurse feels vulnerable.
CQAC noted that there is a significant amount of information contained within the IPC report. AM requested that a deep dive takes place, in order for the committee to have a comprehensive understanding of the key issues raised.

Action HG will link with NM. AM referred to escalation assurance process and will be advised by NM & HG

19/20/75 Quarter 1 Complaints Report

A Hyson, Head of Quality, presented Quarter 1 Complaints report, key issues as follows:-

- 23 formal complaints, compared to 32 last year. First section deep dive a number of complaints related to waiting times. 4 MP complaints, continuing themes. 3 day target, all acknowledged 62% acknowledged on same day, 25 working days. Sticking point just miss. Had 1 complaint withdrawn this quarter as complaint was appropriately addressed,
- PHSO – AH had been contacted by Ombudsman on 16th July 2019, Ombudsman had been reviewing a case for 12 months, involving a number of staff. CD is meeting with staff members in person to brief staff. Ombudsman are planning to come into the Trust and undertake face to face interviews with staff, with a significant amount of questions which had been received by Ombudsman. CD confirmed that 4 people would be interviewed from the Surgery Division. Ombudsman had requested a response by 30th July 2019. This complaint related to a number of organisations. Questions are clinically driven, CD stated that he is confident that the team would be able to provide answers. Ombudsmen going to look at falsification of notes. Case had been involved in a police investigation, with no case to answer.
  AM queried that the division is assured that staff would be supported during PHSO investigation. HG stated that she didn't envisage any over concern.

  CQAC noted that there is a need to ensure appropriate support is provided to individuals during the PHSO process. CD confirmed he would inform staff by 26th July 2019 via a face to face update. HG requested that correct colleagues are involved in the meeting with regards to Human Resources support for staff etc.

- PALS – consistent theme regarding Community paeds, waiting times for appointments, community paeds, ENT and Audiology, although not large numbers. In Quarter 1 2019-20 PALS contacted received total 338, in comprarison to the same quarter in 2019, this is a decrease of 45.
- Compliments had been received regarding concierge desk.
  LC stated that review of compliments are welcomed within the report, and stated it would be helpful to include number relating to each division.
  Discussion took place regarding how divisions review lessons learnt, themes, and how the divisions encourage young people's voices are heard.
  MF stated that it is good to involve forum, MF would speak to Becky Murphy in Comms for any appropriate action. MF stated that the Green plan on dashboard, would be presented to Board in October 2019 to outline

programme.
NM stated the importance of ensuring clear evidence is provided, NM queried regarding the complaint
regarding recycling and asked what the Trust is doing to address issues raised within the complaint.
Action: CQAC to receive a position statement/report for September 2019 with regards to Deep dive re actions completed regarding complaints.

MF stated that the Green Plan would be shared at Board in October 2019.

JG alluded to phlebotomy service and queried the current route of information flow when any key issues arise, in order to ensure appropriate colleagues are updated, given issue approximately 18 months ago regarding staffing issues. HG questioned whether a recovery plan is in place for that service. CW confirmed that every complaint has an action plan in place.

19/20/76 Corporate Report – Quality Metrics

H Gwilliams, Chief Nurse presented Corporate Report – Quality Metrics, key issues as follows:-

Safety

- Medication errors above target, resulted in minor harms are being reviewed. within Medication Safety Group. Sepsis – com cell heard changes at local level from inpatient resulting in 100% compliance. Drafted escalation SOP NM to sign off and then share with divisions. Looking at how NM and HG can provide support.

Caring

- Caring - 5 A&E remained challenging.

Patient Experience

- Families recommending the Trust had shown a slight improvement in May, had recovery action plan in AED.
  Most feedback from children related to play, and issues regarding out of hours drinks and food, distraction, TVs and waiting times. Had 3 months improved percentage, with the need to continue improvements. Large piece of work regarding scoping in terms of play.

  HG – referred to the process of collecting feedback from families and stated that the booths to collect feedback are located in the wrong position and are bland, Mark/comms team are looking at how to position booths in improved locations. Jess Robinson, had also discussed with Children's Forum regarding children's comments.
- Issues regarding Waiting times, and the environment, with two very busy clinics, looking at how these can separate in order to ensure waiting rooms are not so congested. Further work to do to enable continued improvements. CD stated that there is a need to use clinic facilities in different way.
  L Shepherd referred to Mental Health – small numbers and whether there was any possibility to have more machines, given that the team only currently have 1.
  Therapy teams looking at piloting in a different
  way – text message. Community nurse adult work – leave form and then someone rings, part of review of how we get feedback. Quality good, but numbers small.

AM queried whether committee were content with update received, all confirmed they were content with the update.

19/20/77 Resus Huddle Presentation

P Arrowsmith presented Resus Huddle Presentation, key issues as follows:-
PA provided background detail regarding support required regarding improving services during an arrest.National guidance from NHSE had been received. PA advised that he is looking to ensure that 5 minutes prior to the beginning of a shift the huddle would ensure key actions are made, whilst identify any training needs, equipment, this would aid situations when the Trust have locums in place, to ensure new starter familiarisation. During the huddle team leaders would be established, together with a second lead for simultaneous calls. Delegation of roles within the team would be discussed, frequent flyers would be discussed to ensure the team are aware of critical risk patients. Plan would be to include a booklet at huddle, and stored on IPad. ICU & Anaesthetics 9.00 am huddle would be able to send a member of staff to huddle, who would be person carrying bleep – with roles allocated, and any issues regarding training would be addressed.

PA stated that the bleeps are tested every day, and stated that the escalation process is not being sufficient captured at present. Based on incident reports/debriefs. PA, or Head of Resus would review each call to ascertain whether organised team is helpful. Patient safety discussion has taken place. Anaesthesia first on to call cardiac calls, they may not be at first huddle but would be at second one. CQSG discussion had previously took place.
There is a need to streamline 50 bleep holders, as they are not all required, Tabards are available to fully identify team leader. 9.00 am and 9.00 pm will need to link in with anaesthetists.

CD stated that he fully supported the resus huddle, together with a simplified process.

CQAC fully support the proposed safety huddle, and noted that training for wider organisations, is addressed in Trust Policy.

HG queried whether any amendments would be required within policy, PA stated that he would review this. HG queried whether any other support was required. PE stated that a review from Birmingham had previously taken place and the findings from report are awaited.
PA referred to an issue regarding the team not knowing who is responding to Bleeps.

Communication would be provided to teams through the divisions.
Plan for paper initially, with electronic process thereafter.
HG queried, whether there are still issues regarding bleeps, PA stated that that the bleeps are tested at 10.00 am for 3 groups, with Standard Operating Procedures. PA stated that he is unsure regarding management of Bleeps with regards to governance, and associated risk. CU confirmed that this Issue is on the risk register.
Action Offline discussion with KW

19/20/78 Board Assurance Framework

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

Control measures had been reviewed, there is a requirement for a greater focus in the coming year focussing on Exec Leads. The associate BAF risks for CQAC is Risk 1.1.

19/20/78 Mandatory Training figures position statement

MS presented the Mandatory Training figures position statement, key issues as follows:-

There had been some significant changes to Mandatory Training reporting in recent months regarding reporting. In April 2019 Resuscitation training topics were re-added to the 'Overall Mandatory Training' compliance figure.

Training in mandatory compliance was doing well overall with 86% compliance in resus.

Previously used to report on two different figures, now have 1 overall figures showing compliance currently at 90%. National decision made, CQC would now accept figures from data set from ESR.

As of 5th July 2019, the Trust's Overall Mandatory Training compliance is at 90%, against a target of 90%, level 3 for safeguarding 93%. With focus being place on the need to increase compliance across Estates and Facilities & Medical Workforce, which are not yet above 90%.

MS thanked divisions for prompting staff.

Action: MS to resend updated spreadsheet document to Committee members

CQAC noted that overall training figures are moving in the right direction, with good progress made. HG queried whether the divisions are drilled down into reports for workforce groups – MS confirmed that reports are received by individual doctors, with some further refinement of reports required.

HG referred to the issue of juniors, lead employer Whiston and data coming to our system. Whiston updated piece of work regarding shared training centre system, all Trusts can access training system, Trusts asked to sign upto an MOU, MS stated that H Blackburn would be bringing an update to September 2019 and would ensures an accurate picture. If dataset not right would look like a decrease, given the new intake of Junior Doctors. However MS stated that the Junior Doctors are not included on records, with exception of clinical fellows with a separate report for juniors.

LS stated that shouldn't we know this information anyway, we didn't previously have access. Darren Shaw is working closely with St Helens. AM stated that she felt more assured, however ongoing focus should continue.

Need assurance on how to link off sign off of appraisal to compliance of mandatory training, have no mechanism for doing this.

Action: NM to follow up with Urmi Das re key requirements of employment regarding mandatory training.

NM queried whether there are times of year when clinics are reduced i.e. Christmas, or any specific campaign. Safeguarding level 3 should be multi agency and how it will look in future.

AM congratulated HR team on improvements to date.

19/20/79 Minor Harm Analysis Report

CU presented Minor Harm Analysis Report, which detailed themes, status of incidents, lessons learnt, key findings & actions for improvement key issues as follows:-

Report covered period 1st April 2018 – 31st May 2019 and detailed 970 minor harm incidents, reported detailed Corporate report had consistently

shown the level of 'low harm incident'
Reported range between - 76 to 96 upward trend**.**

- Top themes within the Division of Surgery were pressure ulcers, treatment/procedure/skin damage & IV Therapy issues.
- Top themes within the Division of Medicine related to Sample issues, Transfusion, Documentation.
- Top these for Community Division related to slips, trips and falls, with the majority had a high number of manager review, however there are some incidents with no manager review.

Information showed that there is a high proportion of incidents that have had a managers review completed, however there was a significant number where a manager review had not taken place. Information showed a significant number of incidents across the three divisions where no lessons learned have been identified on the Ulysses incident reporting system. The risk with both these issues is that there is increased likelihood of a repeat of the same or similar incidents recurring, and potential for more severe consequences.

CQAC noted that work is ongoing regarding actions for improvement. With Divisions requested to look back at lessons learnt. Divisions had been supported, weekly incident report by harm are shared and by area, weekly reports regarding outstanding manager reviews are circulated. Weeky reports are circulated on areas, highlighting how many reports originate from each area. Seen a consistent increase in number of incidents reported.

AM & JG thanked CU for this update and queried whether there is a more core understanding of recording of what harm is, or whether they are near misses or incidents. 95% sample incidents - is this a harm? – and queried whether there is consistency of approach – CU confirmed that the definition is very clear, and confirmed that all staff are aware. Categorisation, level of awareness, whole process required a wider scrutiny. CU confirmed they are categorised correctly.

NM stated that now Hilda had returned, there would be a need for a clinical summit with regards to clinical incidents with reports from 3 at the top, regarding assurance – with a need to review over next 12 months. With the aim to diarise half day in the first instance.
Discussion to take place regarding harm level.

RD – stated that within the Community division that they had introduced quarterly resource report to offer opportunity to challenge.

CQAC agreed that the Clinical Summit is the correct way to focus on**.**
Action: HG & NM to arrange Clinical Summit with each Division.

19/20/80 CQAC Terms of Reference

HG Presented CQAC Terms of Reference.
ES stated that Dame Jo had asked for ToR to ensure committees are dovetailed, fine and fit for purpose. JG queried how to make conversations more divisionally focussed, and queried whether Divisional Directors would be committee members or attendees. ES confirmed that she would update Dame Jo on this point.

Any further queries regarding the ToR to be shared with HG and ES.

19/20/81 CQSG Key issues report

PoC presented CQSG Key issues report, key issues as follows:-

- Annual consent audit which forms part of CCG quality contract, 40 surgical consent forms across 8 services, comprehensive of forms flagged, concern highlighted regarding evidence of immediate actions highlighted within report, and lack of action plan. Have fed back as appropriate. Come out of internal audit process. CU queried whether this audit needed to be redone to ensure it covers all divisions. Audit was undertaken by specialty originally.

Action: HG & NM would need to review and agree. HG to meet with Liz & Nicki and will send out update thereafter.

Julie Grice mortality update - POC refered to ownership of process, within divisions and shared learning regarding mortality. Julie Grice, requested support from Divisional Directors. CD stated that he is surprised by this, can ensure Julies report shared with Divisional Directors, to feedback to Julie directly. Some cross divisional issues.

- CQSG had received a positive presentation from Joann Kiernan with regards to the Trust being compliant with disability standards, this was a great joint appointment with HEI which is working well.
- CU stated that Medical attendance at CQSG remained problematic, – CQSG - NM to review.

Action: NM to review/address lack of Medical representation at CQSG meetings.

- Late amendments to CQSG minutes of this meeting flagged incident management.

HG thanked value of CQSG members, HG stated that she would review both CQAC & CQSG work plans.

Action: HG review CQAC & CQSG work plans.

19/20/82 Any Other Business

None

18/19/83 Date and Time of Next meeting

10.00 am – Wednesday 18th September 2019, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	Duty of Candour and Incident Management, including all incident investigations of moderate harm or above and Never Events
Report of:	Chief Nurse
Paper Prepared by:	Trust Risk Manager
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. Incident Investigation 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:	n/a

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1. Background:

NHS England published a revised 'Serious Incident Framework' in 2015, and an updated 'Never Events Policy and Framework' and updated 'Never Event' list in January 2018. The NHS England Serious Incident Framework (2015) defines the fundamental purpose of patient safety investigation, i.e. to learn from incidents, not to apportion blame (except in specific defined circumstances such as criminal activity, repeated same/similar errors) whilst identifying a system-based method for conducting investigations (root cause analysis).

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, set specific requirements for registered organisations such as Alder Hey NHS Foundation Trust, about the incidents that must be reported to the CQC. The Trust has a responsibility to report to the CQC serious incidents and 'Never Events' that relate to patient safety/patient harm. In addition, the Trust has a statutory duty to apply Duty of candour for all moderate and above harm incidents, and Never Events.

In November 2014 a statutory Duty of Candour was introduced for all Secondary care providers registered with CQC in England as set out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory Duty of Candour be introduced for health and care providers. This is further to the contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. In April 2015 this became law for all providers and the CQC guidance requires Trusts to achieve a verbal Duty of Candour for moderate harm and above incidents within 10 working days. This should be followed up with a written Duty of Candour in a suitable timeframe.

There are three levels of investigation identified within the NHS, where regulation 20 applies, as follows:

- Level 1 (60 working days to complete) – This is a concise Internal Investigation, suitable for less complex incidents usually at moderate harm level (meaning short term harm), and managed by individuals or a small group.

- Level 2 (60 working days to complete) – This level of investigation is conducted for all severe or catastrophic/death harm incidents. This is a comprehensive Internal Investigation, requiring management by a multidisciplinary team, involving experts and reportable to the Strategic Executive Information System (StEIS), which is accessible to the CCG, CQC and Department of Health.

- Level 3 (6 months to complete) – This is an independent investigation, externally conducted, where the integrity of the organisation has the potential to be challenged.

Current position

Table 1 shows the Trust's 2019/20 performance for serious incidents requiring investigation (SIRI). All SIRI investigations are monitored via the monthly investigation 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, a bi -monthly report of progress with actions, from SIRI investigations is presented to the Clinical Quality Steering Group, with exceptions reported to Clinical Quality Assurance Committee.

During this reporting period, there were no new serious incidents reported. There were no safeguarding incidents reported and no never events.

Table 2 shows the cumulative position; there are four open serious incident investigations.

Table 3 shows the Trust had no moderate harm incidents during this reporting period.

Table 4 shows there were no closed SIRIs during this reporting period.

Table 1 Serious Incidents requiring investigation (SIRI) performance data:

	SIRI (General)												
	2018/19	2019/20											
Month	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
New	1	0	0	0	1	2	2	0	0	0	2	2	0
Open	2	4	3	0	0	3	5	5	3	2	0	4	4
Closed	1	1	1	3	0	0	0	0	2	1	2	0	0
	Safeguarding												
Month	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
New	0	0	0	0	0	0	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
	Never Events												
Month	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
New	2	0	0	0	0	1	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	1	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
	Cumulative Position												
	4												

Table 2 Ongoing serious incidents requiring investigation (cumulative):

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2019/16286	24/07/2019	Community	**Category 3 Pressure Ulcer:** Pressure ulcer to the bottom of the patient's spine; the patient is in a wheelchair and has spina bifida and a prominent lower end of spine. Tissue Viability Nurse Specialist reviewed the patient and confirmed the pressure ulcer as a granulating Category 3 pressure damage.	**Nursing lead:** James Ashton, Sepsis Nurse Specialist **Medical lead:** Jane Ratcliffe, Consultant	The RCA panel meeting was held on the 18/09/2019, the report is being written.	Yes – Report due for submission to CCG and CQC 17/10/2019.	Completed.
StEIS 2019/15130	09/07/2019	Surgery	**Category 3 Pressure Ulcer:** The patient recently underwent orthopaedic surgery and was discharged home with a splint in situ. The patient's parents contacted the Trust concerned with a black area on the foot; local advice was sought and the parents were advised to attend Alder Hey.	Kelly Black, Surgical Matron	The first panel meeting has been held; a further panel meeting is scheduled for the 26/09/2019. An extension was required, as further information was requested from colleagues in Wales.	Yes – Extension granted. Report due for submission to CCG and CQC 18/10/2019.	Completed.

			The patient was reviewed by the Tissue Viability Nurse Specialist; the wound was debrided and the wound was classified as a granulating category 3.				
StEIS 2019/13792	21/06/2019	Surgery	**Infection Control incident:** In June 2015, a Medicines and Healthcare products Regulatory Agency (MHRA) medical device alert was released relating to the potential of M.chimaera within heater cooler units. On the 25th January 2019, a test confirmed a positive result for environment Mycobacteria. Public Health England and MHRA were informed. On 28th January 2019, 2 new heater coolers were brought into the Trust and the contaminated theatre heater coolers taken out of service. Final confirmation of M.Chimera received on the 12th June 2019.	**Nursing lead:** Valya Weston, Associate Director, Infection, Prevention and Control **Medical lead:** Christian Duncan, Director for the Surgical Division	The final draft of the RCA report has been received; the report is in the final quality check stage.	Extension requested on report to the 04/10/2019 (originally due for submission 16/09/2019).	Working with NHS England to finalise Duty of Candour letters.
StEIS 2019/12707	07/06/2019	Medicine	**Unexpected death:** First attendance: The patient attended the Emergency Department	**Nursing lead:** Nicola Evans, ED Manager **Medical lead:** Charlotte	Final amendments are to be made to the RCA report, prior to submission to the CCG and CQC.	Yes – An extension was granted to the 20/09/2019.	Completed.

			(ED) on the 04/06/2019 at 22:09 hours. All patients have an initial eyeball by the triage nurse prior to booking in; to establish if they require urgent treatment. History of Temperature that evening. The patient was bright and alert on arrival; as documented by the Triage Nurse. Observations were recorded; no pre-existing risk factors for sepsis identified. Documented as alert and responding to smiles. The Paediatric Early Warning (PEW) score was 2 due to a slightly elevated heart rate. No nurse or parental concerns identified. Triage category green – non-urgent (standard to be seen within 4 hours). The parents decided to leave following triage and are documented as leaving the department at 22:59 hours. <u>Second attendance</u>: The patient and family re-attended ED the following day, 05/06/2019. The patient's father found him febrile and more unwell, the patient had vomited some bile and a rash was	Durand, ED Consultant			

			noticed on his tummy. He became more vacant on the way into ED; the family ran in with him unresponsive. 08:19 hours - Attended ED, brought in by parents, taken straight to Resus as unwell. 09:46 - Cardiac arrest 10:31 - patient sadly died.				

Table 3 Moderate harm incidents:

	Duty of Candour (excluding SIRIs)							
Reference Number	**Date investigation started**	**Type of investigation**	**Division**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
Nil								

Table 4 Closed SIRIs:

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
Nil							

END

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	**Mortality Assessment At Alder Hey**
Report of:	**Nicki Murdock, Medical Director**
Paper Prepared by:	Dr Julie Grice, Hospital Mortality Review Group

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

MORTALITY ASSESSMENT AT ALDER HEY -
Medical Director's Report

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

Section two is the Quarter 1 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)

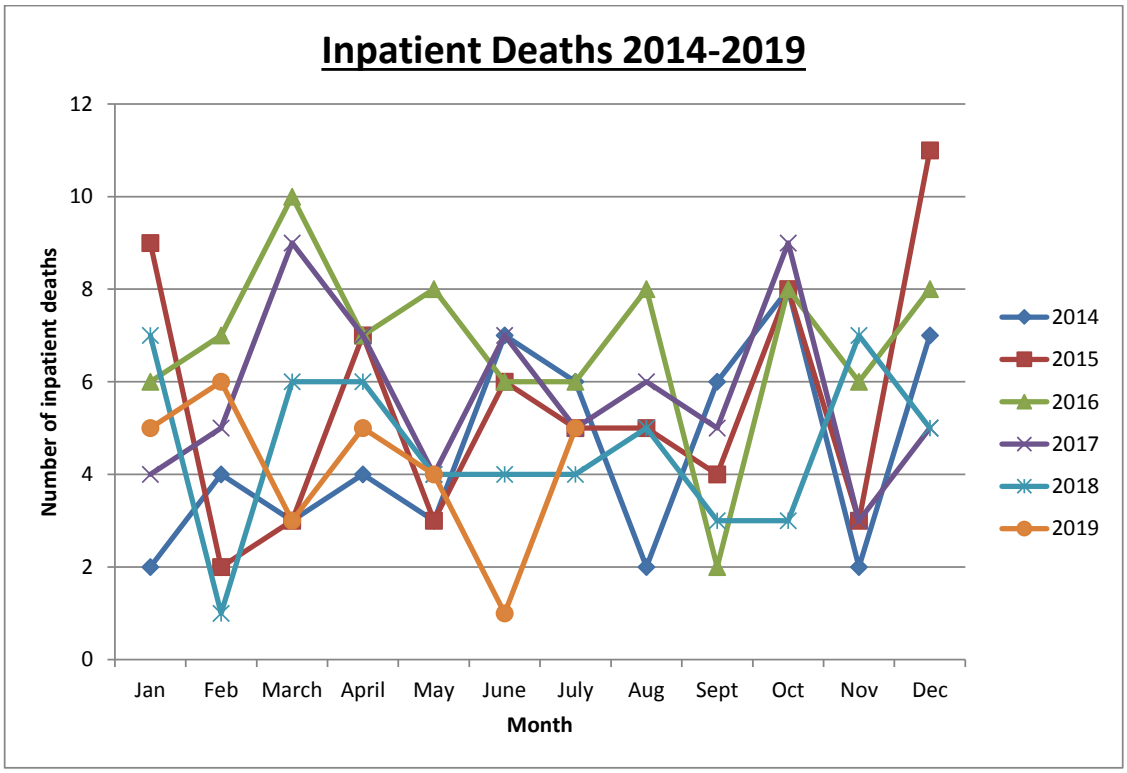
Number of deaths (Jan. 2019 – Dec. 2019)	35
Number of deaths reviewed	17
Departmental/Service Group mortality reviews within 2 months (standard)	26/30 (87%)
HMRG Primary Reviews within 4 months (standard)	7/19 (37%)
HMRG Primary Reviews within 6 months	9/11 (82%)

The HMRG performance target of review within 4 months has dropped from the last report to 37%, which is disappointing, but we have changed our reporting process to meet the new national requirements. This was due to commence at the beginning of April, so we changed our forms accordingly, and it was then delayed until September. Therefore, we have a backlog which, with hindsight, could have been avoided but since we had started the new process, it seemed wiser to continue it.

The 6-month figure still remains very good with only 2 cases preventing completion. The aim is to catch up over the next few months, although there is still a very limited pool of reviewers, which puts pressure on the target. However, the meetings are well attended and time available is maximised to ensure thorough discussion. Some of the cases have been extremely complex and challenging, requiring multiple discussions and in some cases more information. Over this period, the last of the 2018 cases have been completed.

The standard of the 4-month target is useful to support reviews being done in a timely manner and if there is a concerning trend it will be identified in a reasonable period.

Looking at the last 5 years of mortality figures according to the time of the year, there are no concerning spikes or trends.



Outputs of the mortality review process for hospital deaths for 2019

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		
Jan	5	5	5	1	5	2	1		1	
Feb	6	3	6	2	4	1		1	3	1
March	3	1	3	1						1
April	5		3	3						
May	4		3						1	2
June	2*		1							
July	5		5							
August	5									
Sept										
Oct										
Nov										
Dec										

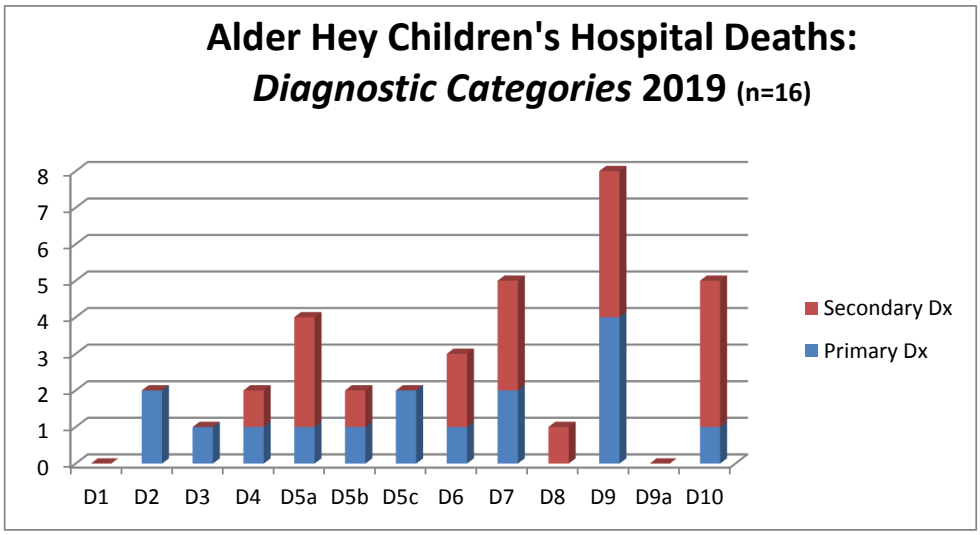
*death in Emergency Department

Potentially Modifiable factors and Actions

Over this period there have been 2 deaths with potentially avoidable factors; one with internal avoidable factors and the other external. The external avoidable one was deemed preventable, as the case concerned a suicide by hanging so considered to be avoidable.

The other case was one in which the child died of sepsis after being admitted with a viral illness. Sepsis was considered when the child deteriorated but discounted when they subsequently improved; unfortunately there was then a rapid deterioration and despite best attempts they died. No organism had grown prior to death indicating sepsis A full RCA was undertaken and a number of recommendations made including the importance of printing out overnight monitoring data as otherwise it deletes after 72 hours; the bronchiolitis pathway to be updated and some limitations with the PEWS score that need to be recognised.

Primary Diagnostic Categories

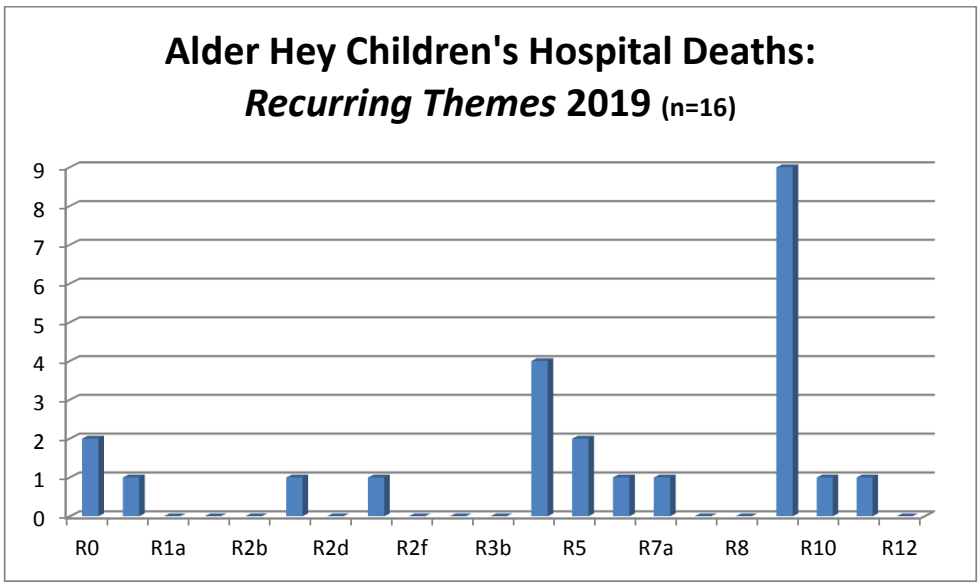


Diagnostic/Disease Categories (based on CEMACH categories - ref. *Arch Dis Child* 2011;96:922-6 + 927-31)

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*

The most common diagnostic category is infection at 25% but with no hospital acquired infections recorded. There are then 3 at 12.5% - self-inflicted, cardiac and congenital.

The main secondary category is 25% of cases caused by sudden unexplained death, followed by medical and congenital causes. These will probably change over the year since currently this only covers 16 deaths, a relatively small figure so is easily skewed.



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

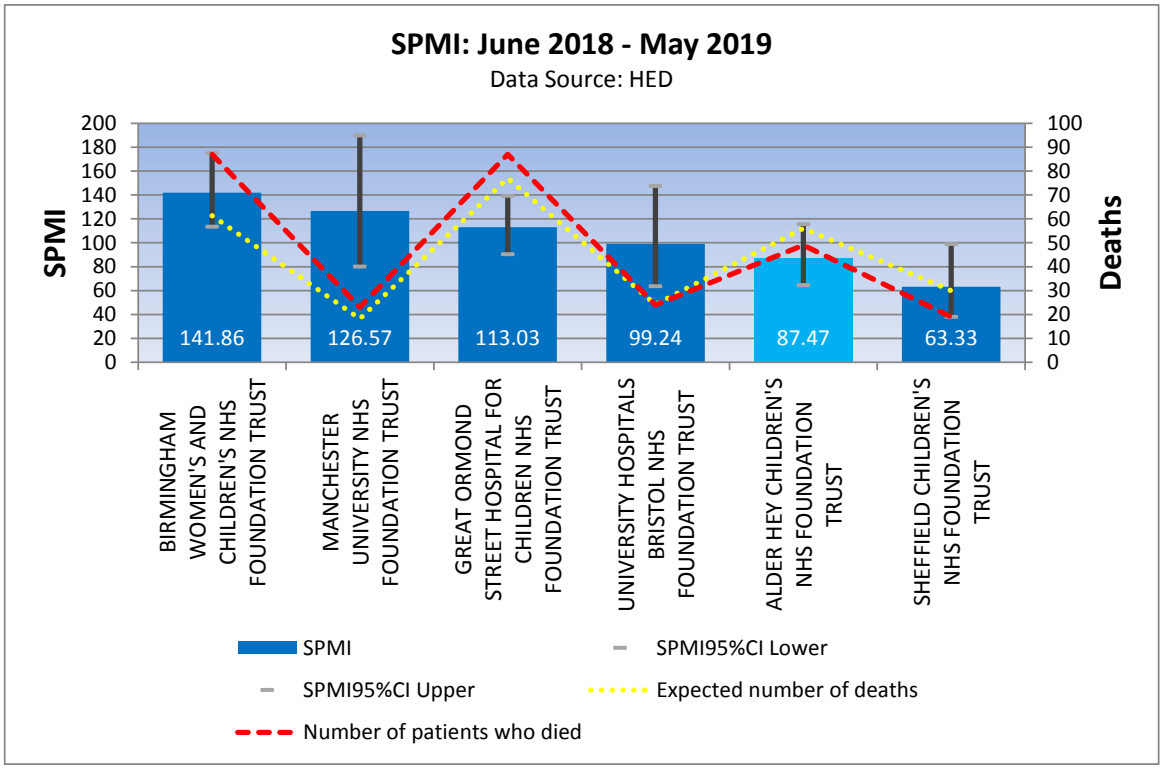
The commonest theme is clearly the withdrawal of care in 56% of cases, which shows that the intensive care team are providing the best possible care until they feel all treatment options are futile, then with the full agreement of the family withdrawing intensive care, whilst ensuring the child is comfortable.
The next commonest is that death is inevitable prior to admission, this occurred in 25% of cases. This is where even when the Alder Hey teams provide optimal care, there is nothing than can be done to prevent death. This may not be apparent prior to transfer and may require investigations to be taken in the Trust to complete a full assessment and then discuss all treatment options or lack of. There are no worrying recurrent themes that are becoming apparent and the 2 main recurrent themes are consistent in the figures.

Section 2: Quarter 1 Mortality Report: April 2019 – June 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 June 2018 to 31st May 2019.

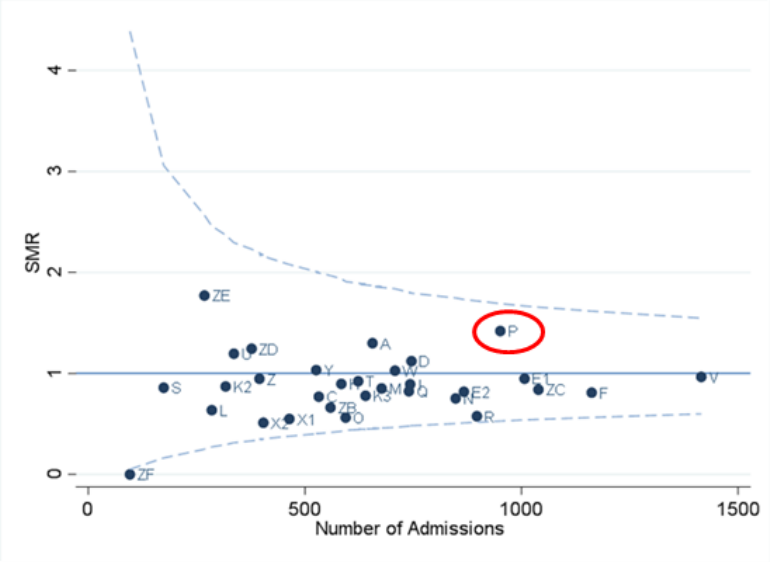


The chart shows that Alder Hey has a lower mortality level than the average NHS performance with 49 deaths against 56 expected deaths.

PICU

It is important to recognise that 85-90% of our deaths occur in PICU as is the case in other children's trusts. In the most recent PICANet report (2018 Annual Report of the Paediatric Intensive Care Audit Network January 2015-December 2017), 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.

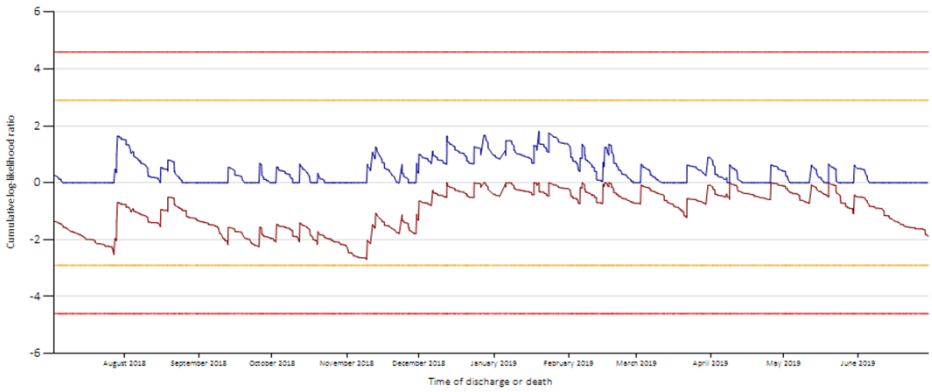


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

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.

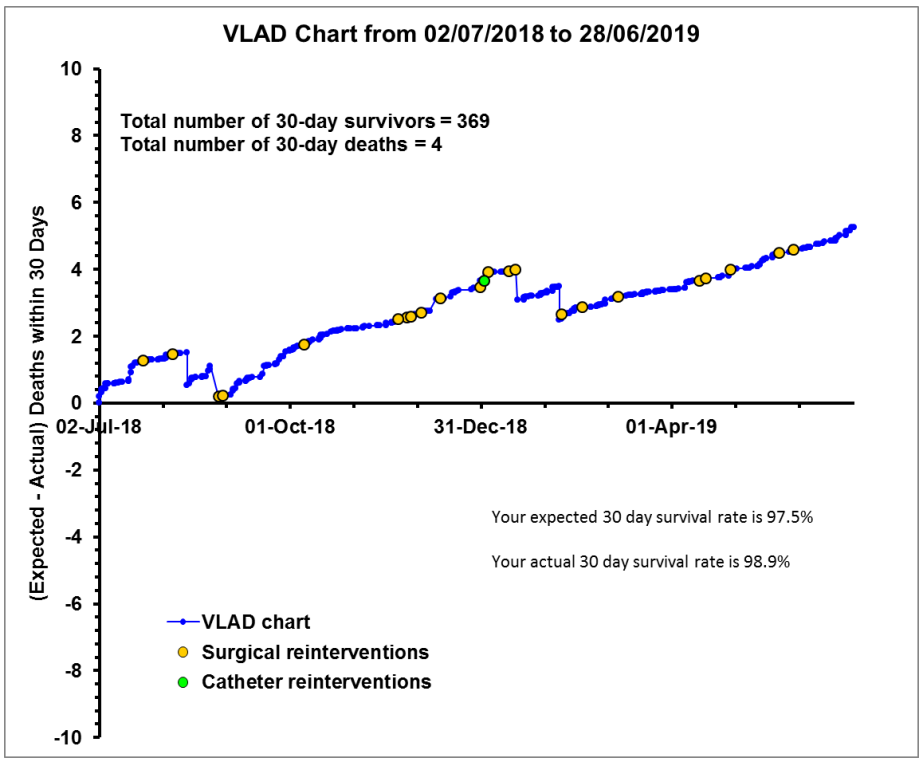
This data is nationally validated because it is generated by PICANet.

The above RSPRT chart indicates that we have been in the "Safe Zone" between August 2018 and June 2019. 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.

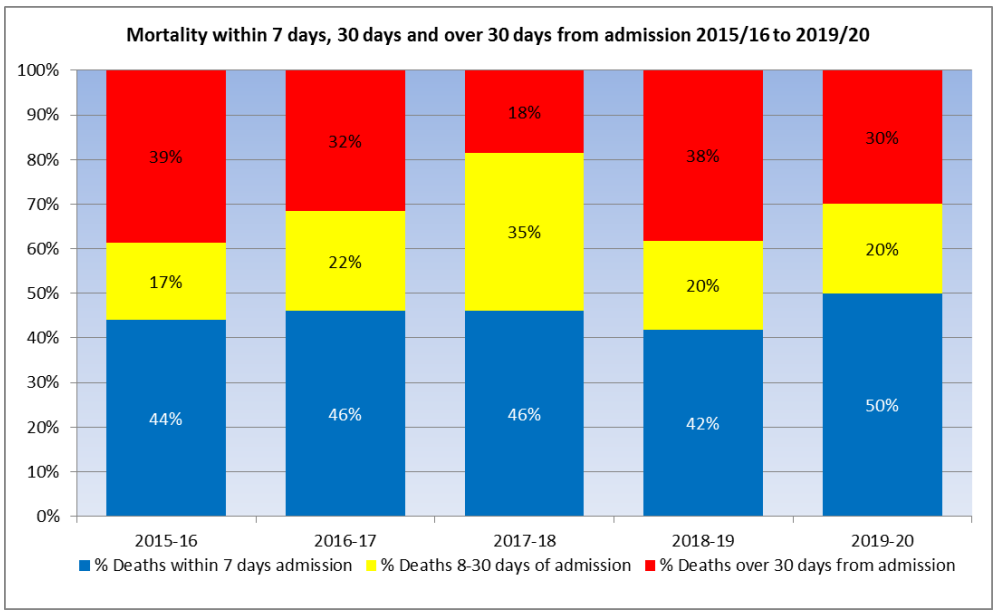


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from July 2018 to June 2019. The survival rate at 30 days was 98.9% against an expected rate of 97.5%.

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 – June) 50% occurred within 7 days of admission, 20% occurred within 8-30 days from admission, and 30% deaths occurred over 30 days from admission.

Conclusion

The HMRG is functioning well although there have been a number of challenging cases resulting in less cases being reviewed within the 4 months. The process continues to adapt according to the national guidelines and there will need to be a number of changes over the next few months to ensure we meet the national requirements. Our process is robust but needs to provide the data required to input into the national database. We need to strive to engage clinicians both internally and externally and the links with the CDOP process will change following the guidelines. We continue to review every in-patient death in HMRG and the majority of deaths have at least one departmental group review in addition.

There is clearly considerable amount of work to be done 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.

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 6**

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 7**

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 7**

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 9**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	**Research Delivery Plan Update**
Report of:	**Clinical Research Division**
Paper Prepared by:	Jason Taylor, General Manager (Research)

Purpose of Paper:	Decision ☐ Assurance ☐ Information **X** Regulation ☐
Background Papers and/or supporting information:	Appendix 1 ResearchPillar_ExecsMeeting_200619
Action/Decision Required:	To note **X** To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** **X**
Resource Impact:	

1. Introduction

The purpose of this paper is to provide the Trust Board with an update on the Research Delivery Plan.

2. Background

The core requirements for the Research Delivery Plan were agreed at a multi-disciplinary workshop in January 2019, this then evolved into a series of iterations culminating in a strategy and outline delivery plan being presented and approved in June 2019 (see Appendix 1) and supporting financial plan in July 2019.

In summary:

Research Vision

To be a World-Leader in Children's Research by Enabling Children and Young People to Benefit from Advanced Medicines and Cutting Edge Therapies & Technologies

Strategic Objectives

- Establish a Research Culture
- Maximise Opportunities for Impactful Research
- Become a Sustainable Business Unit

3. Progress Update

The Clinical Research Division has worked at pace to fulfill the Research Delivery Plan. Key activities to date are detailed below.

3.1 Staffing for Infrastructure

A pre-requisite for the successful execution of the Delivery Plan is the establishment of stable operational leadership, delivery team management and key support functions.

General Manager	Appointed, in place from Sep 2019
Senior Nurse	Appointed, start date to be agreed
Finance Assistant	Appointed, in place from Aug 2019
Pathway Co-ordinator	Interviews scheduled for Sep 2019
Contracts & Finance Manager	Role banding underway

3.2 Staffing for Growth

To further embed research culture throughout the Trust, a new post of Associate Divisional Research Director (Clinical) has been developed. The three post-holders (one per Division) will further develop their Division's

research portfolio, support new and existing researchers and engage with commercial and academic partners.

Associate Divisional Research Directors	Currently being advertised.

In addition, the Deputy Director of Research will have additional PAs manage to support the Division in achieving its strategic and operational goals.

3.3 Charity Investment

The Clinical Research Division has been awarded £340K investment from Alder Hey Charity to support the growth of clinical research capacity at Alder Hey over the next two years with the potential for an additional year contingent on progress. This is exclusively directed towards NHS clinical professionals and not investment in academic capacity. Some of the Charity funding is for University of Liverpool Honorary Professors/Associate Clinical Professor, supporting partnership working. This will enable the Division to fund dedicated time for the Trust's clinical researchers to conduct impactful research (see Next Steps section).

3.4 Governance

To improve the governance of research with the Trust, the Clinical Research Division has established a Research Management Board (Terms of Reference approved by Trust Board) whose aims are to:

- Support implementation of the research strategy within the Trust
- Support integration of research into divisional and corporate operations
- Monitor research strategy effectiveness through key performance measures

The Research Management Board will meet quarterly beginning in October 2019.

3.5 Staff Engagement

The Division has developed a new forum to engage staff new to research and to support those already research active. A programme of monthly 'Research Clinics' is now underway and provides opportunities for staff to hear about live research activity, to meet prospective collaborators in other specialities and to learn more about the processes that underpin high quality, impactful clinical research.

3.6 Incentive Model

An income distribution model has been agreed to ensure that clinical researchers, their departments and Divisions are better incentivized to support research activity.

Principles of the model are:

- Income targets for research to be apportioned to clinical divisions based on current portfolio

- Costs of delivering research and supporting activity to be reimbursed
- Distribution of any overachievement of target in lines with NIHR model:
  - Reimburse actual cost
  - Create a research capacity funding pot
  - Deliver a contribution to the Trust

4. Next Steps

Significant progress has been made with plan delivery. Next steps include:

4.1 Research Futures

The £340K investment from Alder Hey Charity will enable a significant development of the Trust's research capacity and capability.

1) The Trust's Honorary Chairs will each be provided with additional dedicated time to further conduct their research.

2) An internal research fund will be created to which clinical researchers from all Divisions will be able apply to apply. Successful applicants will be provided with dedicated time to conduct their research, support from their Associate Divisional Research Director and the Clinical Research Division.

In both cases, clinical researchers will periodically report progress to the Charity to communicate the benefits of this investment and to provide an evidence base for future investment.

4.2 Incentive Model Pilot

An initiative known as the 'Newcastle Plan' has seen national charities, clinicians, representatives from industry and from the NHS and the National Institute of Health Research, gathered together to address the lack of capacity at centres of excellence and other neuromuscular centres in the UK to invest in key infrastructure posts required to conduct Duchene Muscular Dystrophy (DMD) commercial research studies. To date, the Clinical Research Division, Dept. of Finance and Neuromuscular Team have conducted an empirical exercise to quantify the impact of the charitable investment on: number of additional clinical trials opened; number of patients recruited; study delivery costs; overall income and profit; areas of additional investment needed to further increase capacity.

The funding provided through posts enabled by the Newcastle Plan, research track record to date and the scale of the future opportunity for impact makes this portfolio the best fit for piloting the Incentive Model in 19/20.

A plan is under development for inclusion in the change programme.

4.3 Partnership

The Trust's role as a partner with Liverpool Health Partners (LHP) will require integration and alignment of the research processes of the Clinical Research

Division with its equivalent within the other LHP partners. The expectation is that this is in place by March 2020.

To ensure alignment the Division will engage with LHP's co-design of the system approach to research and in parallel ensure change management processes are managed effectively.

4.4 Strategy Development

A key component of the Delivery Plan is the development of a 5 year Research Business Plan to provide a roadmap for the future within the Our Plan Strategy.

Appendix 1 – Research Pillar

ResearchPillar_Execs Meeting_200619.PPTX

Jason Taylor
General Manager (Research)

Alder Hey Children's NHS
NHS Foundation Trust

Game-changing **research and innovation**

Progress Update: Research Delivery Plan

OUR PLAN
INSPIRED BY CHILDREN

Alder Hey Children's NHS
NHS Foundation Trust

Plan Summary

Alder Hey Children's NHS
NHS Foundation Trust

Research Vision

To be a World-Leader in Children's Research by Enabling Children and Young People to Benefit from Advanced Medicines and Cutting Edge Therapies & Technologies

Alder Hey Children's NHS
NHS Foundation Trust

Strategic Objectives

Establish a Research Culture

Organisational Development

Maximise Opportunities for Impactful Research

Partnerships with Industry, Academia, NHS & Charities

Become a Sustainable Business Unit

Business Model, Market Share, Revenue Generation & Contribution

Alder Hey Children's NHS Foundation Trust

Progress Update

Alder Hey Children's NHS
NHS Foundation Trust

Staffing – Infrastructure

General Manager, Senior Nurse, Contracts Manager, Finance Assistant, Pathway Co-ordinator

Staffing – Growth

Associate Divisional Research Director x 3

Charity Investment

Successful £340K bid to improve research capability

Governance

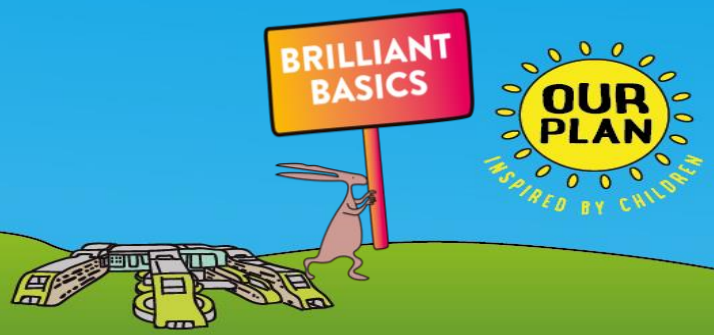
Research Management Board established

Staff Engagement

Research Forum established

Incentive Model

Improved ownership, transparency & benefits for Research



Alder Hey Children's NHS
NHS Foundation Trust

Next Steps

Alder Hey Children's NHS
NHS Foundation Trust

Research Futures

Charity funded Clinical Research Roles

Incentive Model Pilot

Duchene Muscular Dystrophy (DMD) Pilot 19/20

LHP SPARK Alignment

Integration with LHP Partners structures & processes

Strategy Development

5 Year Research Business Plan

Alder Hey Children's NHS
NHS Foundation Trust

Game-changing **research and innovation**

Progress Update: Research Delivery Plan

OUR PLAN
INSPIRED BY CHILDREN

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	**People Plan**
Report of:	**Director of HR & OD**
Paper Prepared by:	Director of HR & OD

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	NHS Interim People Plan
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:	TBC

Alder Hey Children's NHS
NHS Foundation Trust

Alder Hey People Plan

2019-2024

'The best people doing their best work, in the best place….'

Strategic Vision

By 2024 we will be known as…

…the **best** place to work, with **happy** staff delivering the **care** they **aspire** to

….having **brilliant** leaders who support our **diverse** and **talented** workforce

….a **Centre of Excellence** for Paediatric **training and research**

….having a key role in shaping the development of the **Northwest Paediatric** workforce

Welcome to our **People Plan**.

Every single person who works at Alder Hey is critical to the care of every single child who needs our services, and every single person matters. Our vision at Alder Hey is to create a healthier future for children and young people. Our People Plan outlines how we will support all of our people and the wider paediatric workforce to deliver this vision over the next 4 years and beyond.

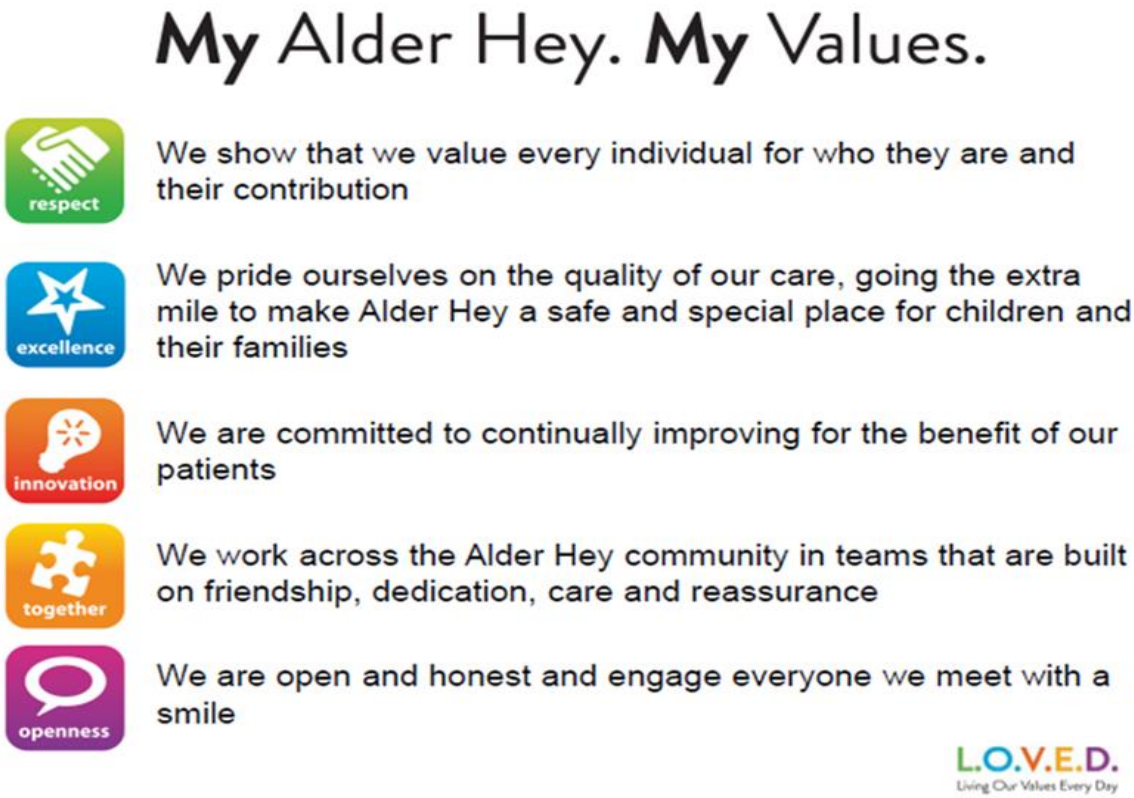
Our Plan has been developed in response to two things:

1. what our people are telling us about what it is like to work at Alder Hey, what they would like to see change and improve, and how they would like to be involved in these changes, and

2. the impact of national and local workforce challenges such as; the impact of system working and collaboration, national workforce shortages, using technology to deliver 21st century care, improving diversity and inclusion and making the NHS a great place to work

Our People Plan takes on board the recommendations of the recently published NHS Interim People Plan (June 2016)[1], which recognises that we will need different people in different professions, working in different ways across different services in order to deliver the NHS Long Term Plan ambitions. It requires us to promote positive cultures, develop and support compassionate and engaging leaders and make the NHS an agile and inclusive modern employer to attract and retain the best people.

[1] https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf



Our People Plan for the next four years is built on the strong foundations already laid in place by our values, developed by our own staff. These values underpin every act and every interaction within Alder Hey and beyond and especially in every relationship that we build with the children, young people and families that we care for.

The Plan is based around 5 strategic pillars, all of which are fundamental to the development of a healthy, psychologically safe, improvement -focused, compassionate, inclusive and learning culture for our staff and for the children and young people we care for:

Health & Wellbeing

By 2024 we will…

…have developed an environment that encourages and enables staff to lead healthy lives and make choices that support positive wellbeing; everyone will feel able to thrive at work and deliver the care they aspire to.

How will we achieve this?

- We will prioritise the physical, mental, social and financial health and wellbeing of our staff.

- We will develop psychological safety in our teams, so that our staff trust and respect each other and feel able to be open with each other and with the children and families in their care

- We will develop a working environment that encourages all staff to 'speak up' and 'listen up' and continue to support the work of our Freedom to Speak Up Guardian and Champions.

- We will focus on eliminating bullying and harassment from this organisation, building a restorative culture and testing novel approaches to resolution working in close collaboration with Trade Unions.

- We will develop an enhanced staff support system to provide advice, guidance and support on a range of domestic and work related issues.
- We will deliver 'Time to Change', a national initiative focused on ending mental health discrimination

- We will further develop our reward and recognition strategies, engaging with staff to ensure these are meaningful and relevant

Leadership Development and Talent Management

By 2024 we will…

…*have compassionate and inclusive leadership at all levels and across all services creating a safe and trusting working environment in which people can grow, learn, make changes, and feel free to speak up and challenge with both courage and kindness.*

How will we achieve this?

- We will implement our new leadership strategy (linked with the 'Inspiring Quality' programme) which will support leaders at all levels to develop their management and leadership capability, including developing coaching skills as a critical element of their roles.

- We will recognise, support and **grow** increasing numbers of talented, compassionate leaders through delivery of key programmes, including 'Strong Foundations', Mary Seacole and through Apprenticeship pathways.

- We will develop a strategy for identifying and nurturing talent, creating capacity for development and success and supporting career progression and building capability for the future.

- We will create the conditions for good system leadership; supporting our leaders to develop the leadership qualities required to effectively work across boundaries with diverse groups of people, patients, service users and staff.

Future Workforce Development

By 2024 we will…

…have embedded strategies and processes that attract and retain the highest calibre of staff and which facilitate greater diversity across all staff groups. We will maximise our expertise to support the development of the North West paediatric workforce through collaboration, partnerships and integration.

How will we achieve this?

- We will have an established workforce planning process, with identified pipelines for all levels of professionals who work at Alder Hey and beyond.

- We will further develop new roles such as nurse associates, advanced clinical practitioners, physicians associates and new roles in pharmacy, specialist nursing and Allied Health Professionals (AHPs) utilising the Apprenticeship Levy to support these developments where possible. This will create new career pathways, and less linear career pathways, to enable effective care to be delivered to children and young people from a wider staff base.

- We will work with our multiple academic partners to develop and support sustainable clinical academic training pathways across a range of clinical professions.

- We will optimise digital technologies that can enable our people to work to their full potential as routine tasks are automated.

Equality, Diversity and Inclusion

By 2024 we will…

…have a diverse and inclusive workforce which truly represents the local population, and will be a place where all staff feel their contribution as an individual is recognised and valued, and the care we provide reflects this.

How will we achieve this?

- We will support our excellent staff networks; the BAME (Black, Asian and Minority Ethnic) network, the Disability network and the most recently established LGBTQI+ Network, who are helping to develop plans for improving staff experience and to improve staff diversity and inclusion.

- We will work with local and national experts in inclusion and community engagement to improve links and provide better access to employment opportunities for the local community.

- We will develop and support inclusive leadership across the organisation to support our diverse staff to access the workplace, feel safe here and know that their differences are acknowledged, understood and respected. This will include a commitment to continuing with the reciprocal mentoring programme.

The Academy

By 2024 we will…

…be a recognised national and international centre of excellence for paediatric healthcare education and training, supporting skills and knowledge development at every level; from school children to specialist.

How will we achieve this?

- We will continue to develop our international networks, working with the Liverpool City region to maximise opportunities for international placements and learning opportunities, such as our China partnerships. Working with our Higher Education Institutions, we will develop new and innovative opportunities for learning, utilising new technologies and digital platforms.

- We will continue to 'grow the future' of children and young people's specialists. We will grow our capacity to offer training opportunities to the wider North West work force, and support local hospitals and primary care teams through education and outreach.

- We will continue to build on our success of increasing opportunities to enter the workforce through supported pre-employment programmes, apprenticeships, work experience and voluntary roles. We will continue to utilise the Apprenticeship Levy, and build on our success as an employer provider, with the aim of delivering a minimum of 50 apprenticeship starts every year for the next four years.

Making our People Plan a Reality

Making this vision a reality is everybody's responsibility. We will measure our success in achieving the Plan in a number of ways:

- What our staff tell us it's like working here
- What our children, patients and families tell us it's like being cared for by us
- What our students tell us it's like learning with us
- What our partners tell us it's like working with us
- Using specific measures, such as the NHS Staff Survey, to assess the delivery and effectiveness of changes we make.

We will provide regular feedback on progress to everyone in the organisation through enhanced and improved internal communications.

The objectives set out within this Plan, alongside key actions, risks and dependencies, anticipated timescales and key outputs are incorporated within the HR and OD Operational Plan. This will be formally reviewed by the Workforce and Organisational Development Committee on an annual basis.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	**Workforce & OD Committee Assurance Report**
Date of meeting:	19th September 2019 – Summary 26th June 2019 – Approved Minutes
Report of:	Claire Dove, Committee Chair
Paper Prepared by:	Jackie Friday, WOD Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Workforce & OD Committee Assurance Committee meeting 19th September 2019 along with the approved minutes from the 26th June 2019 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ■ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐
Resource Impact:	None
Associated risk (s)	BAF 1.1 – Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations – current risk IxL: 3x3 BAF 2.1 – Workforce Sustainability – current risk IxL: 3x3

	BAF 2.2 - Staff Engagement – current risk IxL: 3x3 BAF 2.3 - Workforce Equality, Diversity & Inclusion – current risk IxL: 3x4

1. Introduction

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

Under its terms of reference, the Committee is responsible for providing strategic direction and board assurance in relation to all workforce matters including monitoring progress against workforce indicators and supporting the organisation in delivering a positive patient centred culture.

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

People Strategy;
WRES / WDES
Staff Survey Action Plan
Pay Report

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

E&D
Mandatory training compliance

4. Positive highlights of note

Approved WRES / WDES action plan;
Approved People Strategy

New standing items:

- Mandatory Training &
- CQC preparedness

5. Issues for other committees

- RABD – Sickness levels
- CQAC – CQC preparedness
- CQAC – HEE inspection

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
26TH June 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	(PB)
	Mr N Davies	HR Business Partner	(ND)
	Mrs K Turner	Trust LiA Lead	(KT)
	Mr A Bateman	Chief Operating Officer (Part Attendance)	(AB)
	Mrs G Thomas	Apprenticeship Delivery Manager	(GT)
	Mr P OConnor	Deputy Director of Nursing	(POC)
	Mrs S Owen	Deputy Director of HR&OD	(SO)
	Mrs N Murdock	Medical Director	(NM)
	Mrs J Potier	Consultant Clinical Psychologist / Ass.Dir. of OD	(JP)
	Ms N Deakin	Change Programme Manager	(ND)
	Mr R Woodhouse	Trainee Clinical Psychologist – (Part Attendance – Observer)	
	Ms E White	Care Pathways, Policies & Guidance	(EW)
Apologies:	Mrs D Brannigan	Patient Governor (Parent & Carer)	(DB)
	Mr T Johnson	Staff Side Chair	(TJ)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr A Hughes	Director of Medical Division	(AJ)
	Ms L Cooper	Director of Children & Young People - CAMHS	(LC)
	Ms R Greer	Associate COO, Community Division	(RG)
	Ms K Bayley	HR Medical Staffing Manager	(KB)
	Mrs H Ainsworth	Equality & Diversity Manager	(HA)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr I Quinlan	Non-Executive Director	(IQ)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/49 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 3rd May 2019 and they were approved as an accurate record. Introductions were made to the Committee.			
19/50 **Matters Arising, Actions**	**The Committee considered the following under matters arising:** **17/21 – Programme Assurance**			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	MKS confirmed there is a review of the workforce projects within the programme.			
	19/35 – Apprenticeship *Produce a plan to develop how we move forward with apprenticeship/workforce* – MKS advised that following the closure report presented at WOD Committee in May the above plan will be deferred to September. Two further staff have recently been appointed to the Apprenticeship Team.			
	19/04 - Education Governance *Postgraduate Education Monitoring Visit Action Plan – share actions to divisional leads, divisional boards and HRBPs to inform response to HEE.*- MKS advised that the Action Plan has been shared with Divisions/Board. Still awaiting feedback from HEE re Pastoral/Structural/On-call. HEE visiting again in October. **Action 19/04 is noted as complete.**			
	18/49 – Wellbeing *NHSI Health & Wellbeing Improvement Programme Update - Pick up with Sarah Smith sickness data availability for Comcell.* – MKS advised this can be closed as this information does not get presented to CommCell. **Action 18/49 is noted as closed.**			
19/51	**Modern Slavery** The Director of HR&OD gave a brief verbal update regarding our obligations and regulatory practices at the Trust. MKS advised that she had spoken with the Director of Corporate Affairs and in accordance with NHS guidelines, Alder Hey does not meet the required criteria of responsibility to report on modern slavery. MKS added this doesn't necessarily mean we do not have an obligation to ensure we take action regarding modern slavery. MKS alluded to work that had taken place at the Royal Liverpool relating to modern slavery and procurement processes. CD described the work she is involved in relation to 'social values' to support modern slavery and advised that we as a Trust need to be socially responsible to people, particularly in relation to ethical Procurement processes. PB advised that child exploitation issues sits within the Nursing Strategy. CD advised that she has spoken to the Trust Chair and has agreed to liaise with the Head of Procurement to progress this ethical piece of work and ensure the correct processes are in place. The Committee agreed it was the right to do. The Committee **agreed** next steps to progress modern slavery project	Progress Modern Slavery procurement processes.	CD	TBC

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/52 **Programme Assurance 'The Best People Doing Their Best Work'**	**Programme Assurance Framework – June 2019** The Committee received a regular summary prepared by the External Programme Assessor and Assurance Team. The purpose of this assurance framework is to ensure the monitoring of robust processes for progression. All papers supporting Programme Assurance for the work stream 'The Best People Doing Their Best Work' is recorded as read prior to the meeting. The Change Programme Manager advised that the new Trust Board Assurance Proforma is still a work in progress with decisions relating to what projects are to be included under the work stream 'The Best People Doing Their Best Work' still under discussion. ND gave a brief summary of the current dashboard. The 'Improving Portering Services' project still requires a thorough review which should include charting the course of the project through this year and to its eventual closure as well as addressing issues with governance of the project. The 'Catering' project displays a very good standard of governance and initial trends for benefits/metrics appear positive with 3 out of the 5 metrics now trending positively. The Director of HR&OD shared with the Committee that all Executives are rethinking how we manage projects going forward with a refocus on large scale projects, meaning that not all projects listed on the dashboard will be 'initiated' (see projects under the dotted line). MKS confirmed that the People Strategy presented next will inform the projects going forward such as Health & Wellbeing and supporting the medical workforce. The Committee discussed E-rostering and its benefits. CO/POC advised there is a requirement to have dedicated support in place to progress this project along with financial support as a fundamental requirement. E-rostering needs to be in place for nurses by 2020 and doctors by 2021. The Committee acknowledged traction had been lost with E-rostering due to unexpected delays around a bid for finance for this project. CD advised that a cost analysis will be required and we should align ourselves with the best providers. The Committee **noted** the comments made.	Put in place project support and financial support for E-rostering	MKS/SO/ POC	
19/53 Progress against the People Strategy	**Interim NHS People Plan** The Committee received a copy of the Interim People Plan, this reports sets out the vision for people who work for the NHS to enable them to deliver the NHS Long Term Plan, with a focus on the immediate actions we need to take. The report is noted as read. The Committee **noted** the content.			
19/54	**People Strategy** The Committee received a presentation delivered by the Director of HR&OD. The			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	purpose of the presentation is to update the Committee on the latest developments to support the strategic pillars for The Best People Doing Their Best Work work stream. The presentation, issued to the Committee is noted as read. As outlined in the presentation, MKS went on to detail the priorities/objectives of the Interim People Plan to get a sense of what we need to focus on now. Further conversations have taken place to support the development/ambitions of the following: **Leadership Development and Talent Management** Indepth discussion commenced with particular attention brought to defining the pillar for 'Leadership Development and Talent Management'. The ambition is by 2024 to have compassionate and inclusive leadership at all levels and across all services creating a safe and trusting workforce environment in which people can grow, learn, make changes and feel free to speak up and challenge with both courage and kindness. This ambition will be supported by a number of projects: clinical leadership; strong foundations; talent and succession; leadership faculty and coaching for improvement. MKS advised that a letter has been issued to our leaders inviting them to take part in the Strong Foundations Programme. The new leadership framework will help equip and support leaders in their role and the NHS Long Term Plan acknowledges that this is critical to its success as it evolves over the next 10 years. **Employee Wellbeing** The Committee reflected on Employee Wellbeing, the ambition is by 2024 we will have developed an environment that encourages and enables staff to lead healthy lives and make choices that support positive wellbeing; everyone will feel able to thrive at work and deliver the care they aspire to. This ambition will be supported by a number of projects: Time to Change; Health & Wellbeing Plan; SALS; Occupational Health; Reward and Recognition. CD advised that MIND has been endorsed and the plan is for it to be launched September/October. The Committee noted that this is a big commitment and the Trust will be looking for about 100 staff to be champions. MKS advised that the SALS project will be developed by JP and KT and will offer a triage of help to support staff i.e. financial help. **Future Shape of the Workforce** The Committee received an update outlining the ambition to be reached by 2024 of an established workforce planning process, with identified pipelines for all levels of professionals who work at Alder Hey and beyond. Maximising the Trusts expertise to support the development of the North West Paediatric workforce through collaboration, partnerships and integration. This ambition will be supported by a number of projects: workforce planning process (nursing) incl e-rostering; advance clinical practice; medical workforce programme; partnerships with RMCH/LWH and digital processes. MKS advised there is a lot of work to do to support this, building			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	good partnerships with other organisations is key for the best interests of the children we care for. **Equality, Diversity and Inclusion** The Committee received a brief update outlining the ambition to be reached in that we will have a truly diverse and inclusive workforce which represents the local population, where all staff feel their contribution and diversity is recognised and valued, and the care we provide reflects this. MKS acknowledged that EDI has some standardised processes to adhere to and we have met compliance, but further development will be achieved with projects to support the following: community engagement; WRES/WDES; develop staff networks; positive action in recruitment and apprenticeships. **Culture and Engagement** The Committee received a brief outline of the ambitions and objectives to be reached in that the Trust will have made significant progress towards building a healthy, improvement focussed, compassionate and inclusive culture for our staff and the children and young people we care for. **Academy** The Committee reflected on the work to develop the whole Academy leadership and acknowledged there was more to do on education governance and apprenticeships to achieve 2024 ambitions. MKS confirmed the Committee will receive further development updates in October. The Committee **noted** the content of the presentation.			
19/55	**Marketing & Communications Activity Report** The Committee received the Marketing & Communications Activity report prepared by the Director of Marketing & Communications. The purpose of the report is to provide the Committee with an update on progress against the Marketing and Communications Operational Plan. MF advised that work to define the Trust message and brand has commenced and the implementation for a more planned approach for events/projects at the Trust is being developed. The Committee discussed past/future events and acknowledged the requirement of a core message framework to support events. The Committee **noted** the progress made.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/56	**Staff Survey Update** The Committee received a report prepared by the Learning & Development Manager. The Trust Action Plan was developed from the findings of the 2018 Staff Survey. The purpose of the report is to update the Committee on some of the key themes from the Trust Action Plan and to outline 'next steps/other actions'. The report was noted as read. The Committee noted that the Staff Temperature Checks have been revitalised and now mirror the engagement questions from the national survey to help the Trust understand how we are doing throughout the year as well as focusing on how staff feel about psychological safety. The Committee discussed how best to support staff in relation to staff raising concerns. CD suggested linking both the SALS project and the temperature check to make more tangible. A discussion took place about doctor support and NM advised that there is a national programme available to doctors. The Committee **noted** the progress made.			
19/57	**Mandatory Training Update** The Committee received a report prepared by the Learning & Development Manager. Since the last update there have been some key changes to how Mandatory Training is reported. To improve transparency of training compliance it was decided to no longer report Core Mandatory Training separate from Overall Mandatory Training. Also all Resuscitation training topics are now included within the overall mandatory training compliance. The purpose of the report is to update the Committee on compliance targets reached, areas of focus and actions taken to support improved compliance. The report is noted as read. The report confirmed that as of 14th June 2019, Mandatory Training compliance is at 89%. MKS confirmed that the target is set at 90% and advised that Mandatory Training is designed to keep people safe and the compliance performance is referred to by the Care Quality Commission to monitor this. The Committee discussed various ways Mandatory Training can be accessed i.e. e-learning via ESR Portal. NM & PB to deliberate outside of this Committee ideas/concepts around possible methods that can be put in place to support Mandatory Training compliance of doctor and nursing staff. CD asked what further plans are in place to see improved processes for Mandatory Training. MKS advised that the first objective of the Learning & Development Manager was to review the reporting processes and ensure e-learning systems was up and running. The second objective is for the Learning & Development Manager to work with subject matter experts to improve the quality of training.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **noted** the progress made.			
19/58	**Education Governance Update** The Committee received a report prepared by the Medical Education & Revalidation Manager. The purpose of the report is to update the Committee on progress made to the recommendations raised following HEE NW visit in May. The report is noted as read. The Committee **noted** the progress made.			
19/59	**Health & Wellbeing Update (Sickness Absence)** The Committee received a presentation prepared by the Deputy Director of HR&OD. The purpose of the presentation is to update the Committee on a review of sickness absence trends for short and long term illness over the last year and contains a breakdown of the top 10 reasons for absence. SO alluded to the presentation and summarised that sickness for May 2018-May 2019 was 5.44%; rolling 12 month – 5.54%; long term sickness – 3.4% and short term sickness – 1.9%. SO pointed out that the Trust always monitors the 'stretch' targets and added that the Corporate Division now have an HR Manager in place to support services. In response to questions raised by CD and NM, SO confirmed that the sickness absence review includes all staff bar junior doctors, whose sickness is recorded by St Helens & Knowsley as the Lead Employer for junior doctors. SO and MKS confirmed that the national sickness absence rate is 4%, but acknowledged in comparison to north and south, the north west has higher sickness rates. It was recognised that a lot of hospitals outsource ancillary work, so this can have positive impact on those hospitals' sickness statistics. SO outlined the operational support available to support sickness absence going forward: • In depth review of all long term sickness cases. • Support plans developed for all complex cases. • Review of sickness policy and process – moving towards prevention in partnership with managers and staff side. • Dedicated HR support for all areas to provide guidance and advise on sickness management. • Analyse of absence reasons to provide targeted support. • Bespoke sickness training sessions being provided to areas of high sickness. • Team Prevent pilot management helpline.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale

	The Committee considered the processes to support staff under stress and discussed the underlying causes that can bring on stress within the workforce, be it in the work place or outside of work (i.e. financial/working patterns/junior doctor staff shortages/office space limitations). The Committee acknowledged the importance of ensuring the correct support is in place for patients and that the wellbeing of our staff is important too. A number additional ideas were discussed to support staff (i.e. financial wellbeing/dependence leave)
	
	SO went on to outline organisational enablers and health interventions overseen at the Health & Wellbeing Steering Group, particular attention was brought to support for mental health at work and stress. In relation to ending mental health discrimination, SO advised that the Trust had signed up for the 'Time to Change Pledge', to empower everyone to challenge stigma and speak openly about their own mental health experiences. SO outlined what is already available and what the Trust is doing to support staff:
	
	• Introducing 100+ Mental Health Wellbeing Champions across the organisation.
	• Providing Mental Health in the Workplace training in conjunction with MIND to managers and service leads.
	• Training additional Mental Health First Aiders/
	• Developing suite of toolkits and guidance for supporting Health and Wellbeing in the Workplace.
	• Task and finish groups to focus on:
	  ○ Menopause in the workplace
	  ○ Reasonable adjustments and support
	  ○ Communications and resources
	
	SO emphasised that following really good discussions at the Health & Wellbeing Steering Group the Trust is starting to see the benefits for the wellbeing of our staff, although it may take a bit of time to fully embed. CD advised that it would be beneficial to link up with the Universities pastoral teams. At the suggestion of CD, NM will arrange a focus group with Junior Doctors to support issues.
	
	The Committee **noted** the progress made.			

19/60 **Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks**	**Board Assurance Framework – (May 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. MKS advised that plans are on track to address risks. The Committee **noted** the content of the report.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/61	**Key Workforce Risks KPIs – May 2019** The Committee received a regular report prepared by the Deputy Director of HR concerning the key risks relating to workforce monitoring for May 2019. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. The report is noted as read. Key headlines are: SO outlined the detail in the report. NM highlighted that some of the narrative does not match the statistics in the report. SO to pick up anomalies around narrative. Pay accuracy – SO advised that the same errors are being seen (i.e. late or non-receipt of Change or Leavers form) resulting with overpayments to staff. The Committee acknowledged that the errors occurring are because managers are not completing Change or Leavers forms in a timely manner. The Committee discussed the robust processes in place to reclaim overpayments and considered the security breach implications of a delay in deactivation processes due to late receipt of Leaver notification forms. MKS concluded that it would be worth revisiting this issue, with the production of a clear flowchart to advise/remind managers of processes for leavers. The Committee **noted** the content of the report.	Update narrative on Key Workforce Risks Produce an updated leavers flowchart	SO SO/MKS	September 2019 September 2019
19/62 Sub Committee Minutes	The Committee received the minutes for the following for information. • JCNC – 26.02.2019 & 25.04.2019 • Health & Safety – 14.02.2019 • Education Governance – 14.03.2019 The Committee **noted** the content of the minutes.			
19/63 **Legislation, terms & conditions, employment policie4s/EIAs – review & ratification/approval.**	The Committee received the following policies and Equality Assessments for formal ratification/approval. **Medical Staff Covering Absent Colleagues & Vacancies, Including Stepping Down Arrangements Policy and EA** **Consultant and SAS Doctor Job Planning Policy & EA** The Committee deliberated over the implementation/delivery of the above polies. NM advised that work has commenced to support this. MKS advised that both	Virtual ratification of policies	CD/IQ	

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	policies had been approved at LNC after considerable discussion. The Committee approved both policies/EA's subject to virtual ratification by CD and Non-Exec IQ. CD agreed to review with IQ and report back to the Committee.			
19/64 AOB	None.			
Date of Next Meeting	**Rescheduled to Thursday 19th September 2019, 1.30pm-3.30pm – Tony Bell Boardroom, Institute in the Park (Originally due to be held - 28th August 2019)**			

Action List

Minute Reference	Action	Who	When	Status
Meeting Protocol				
	Modern Slavery			
19/51	Liaise with Head of Procurement to progress processes.	**CD**	**TBC**	
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Update on identified resource for Projects AHP, Temporary Staffing and E-Rostering. Noted on 23/10/2018 – Rob Griffiths has been identified as resource for AHP. Temp staffing has seen a recent spike and it was advised that MKS will lead a group to get under the E-rostering issues. Noted on 26/06/2019 – MKS advised that a re-think about the overall programme has commenced.	ND MKS		Ongoing Ongoing
19/35	Apprenticeships – Produce a plan to develop how we move forward with apprenticeship/workforce. Noted on 26/06/2019 this item deferred until September 2019.	MKS/GT	September 2019	
19/52	E-Rostering – Put in place project support and financial support.	MKS/SO/POC	September 2019	
People Strategy Overview & Progress Against Strategic Aims				
	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/CL	Ongoing	Ongoing
	Equality & Diversity			
17/13	• 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	HA HA/SM	1/4ly Update 6 monthly Review	Ongoing Ongoing
	Education Governance Update			
18/38	• To be a regular item on the Committee Agenda.	HB	May 2019	Ongoing
19/04	Postgraduate Education Monitoring Visit Action Plan – share actions to divisional leads, divisional boards and HRBPs to inform response to HEE. Noted on 26/06/2019 – plans shared, noted as complete.	RG/AMc	ASAP	Complete
	Wellbeing			
18/49	NHSI Health & Wellbeing Improvement Programme Update • Pick up with Sarah Smith sickness data availability for ComCell. Noted	MKS	ASAP	Complete

	on 26/06/2019 – this action is not now relevant. ComCell takes place on a Monday morning so latest stats not available. Sickness is recorded on ESR.			
Key Workforce Risks				
	May 2019			
19/61	• Update the narrative on key workforce risks • Produce an updated leavers flowchart	SO SO/MKS	September 2019 September 2019	
Legislation, terms & conditions, employment policies/EA's review & ratification/approval				
19/63	Virtual ratification/approval of policies & EA • Medical staff covering absent colleagues and vacancies, including stepping down arrangements policy & EA • Consultant and SAS doctor job planning policy & EA	CD/IQ	September 2019	

CHILD FRIENDLY CITIES AND COMMUNITIES – AN INTRODUCTION

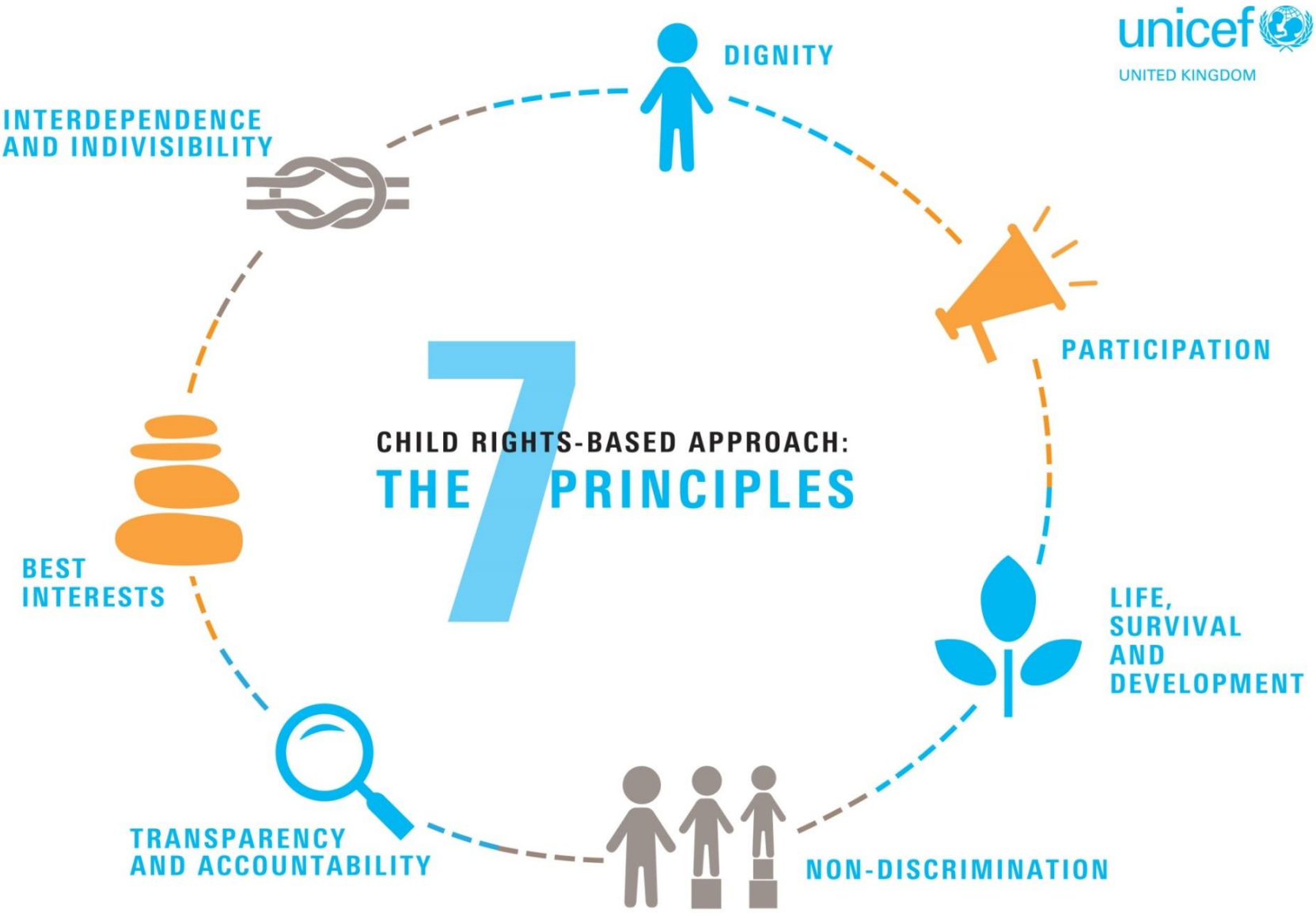
CHILD FRIENDLY CITIES & COMMUNITIES

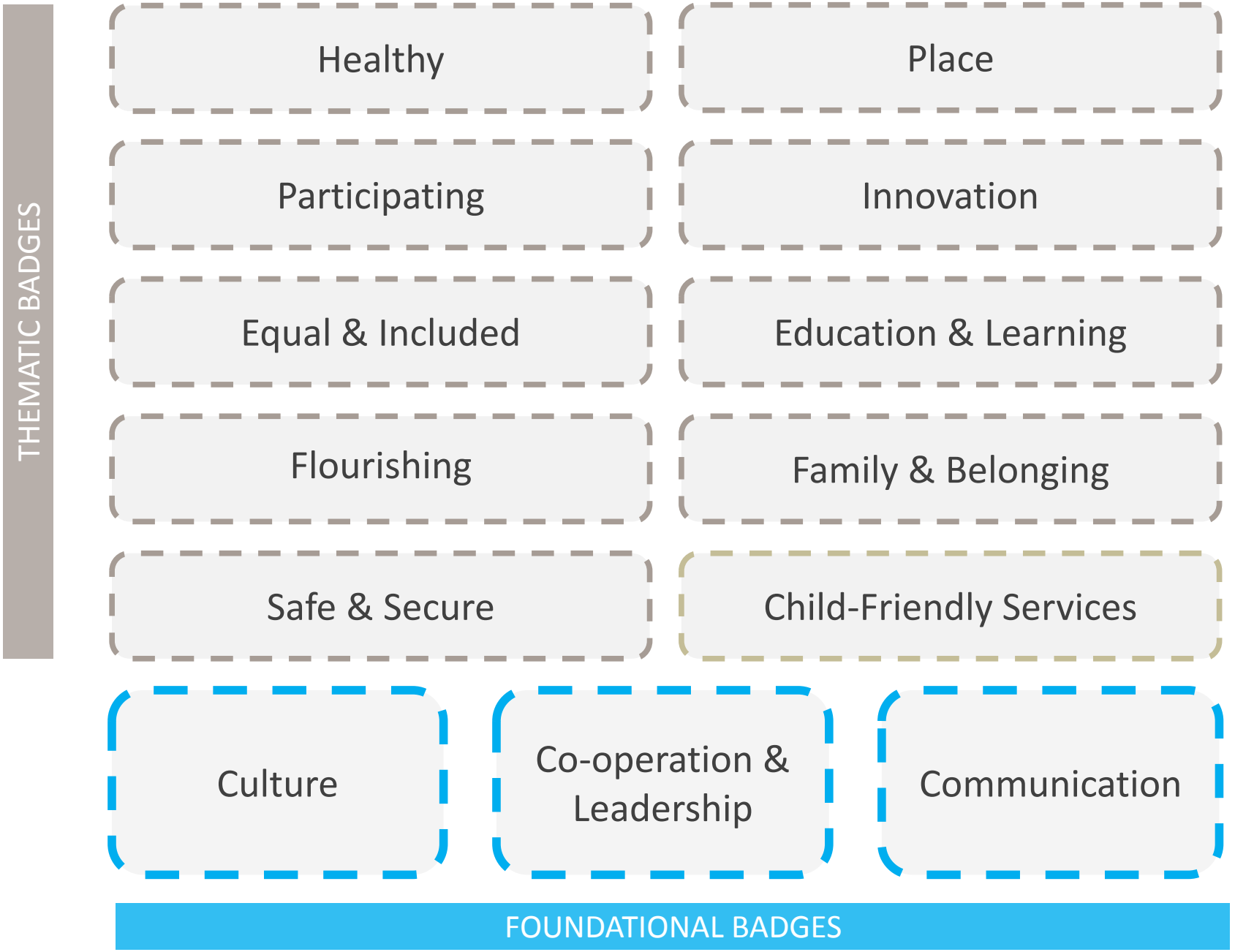
unicef UNITED KINGDOM

WHAT IS A CHILD FRIENDLY CITY/COMMUNITY?

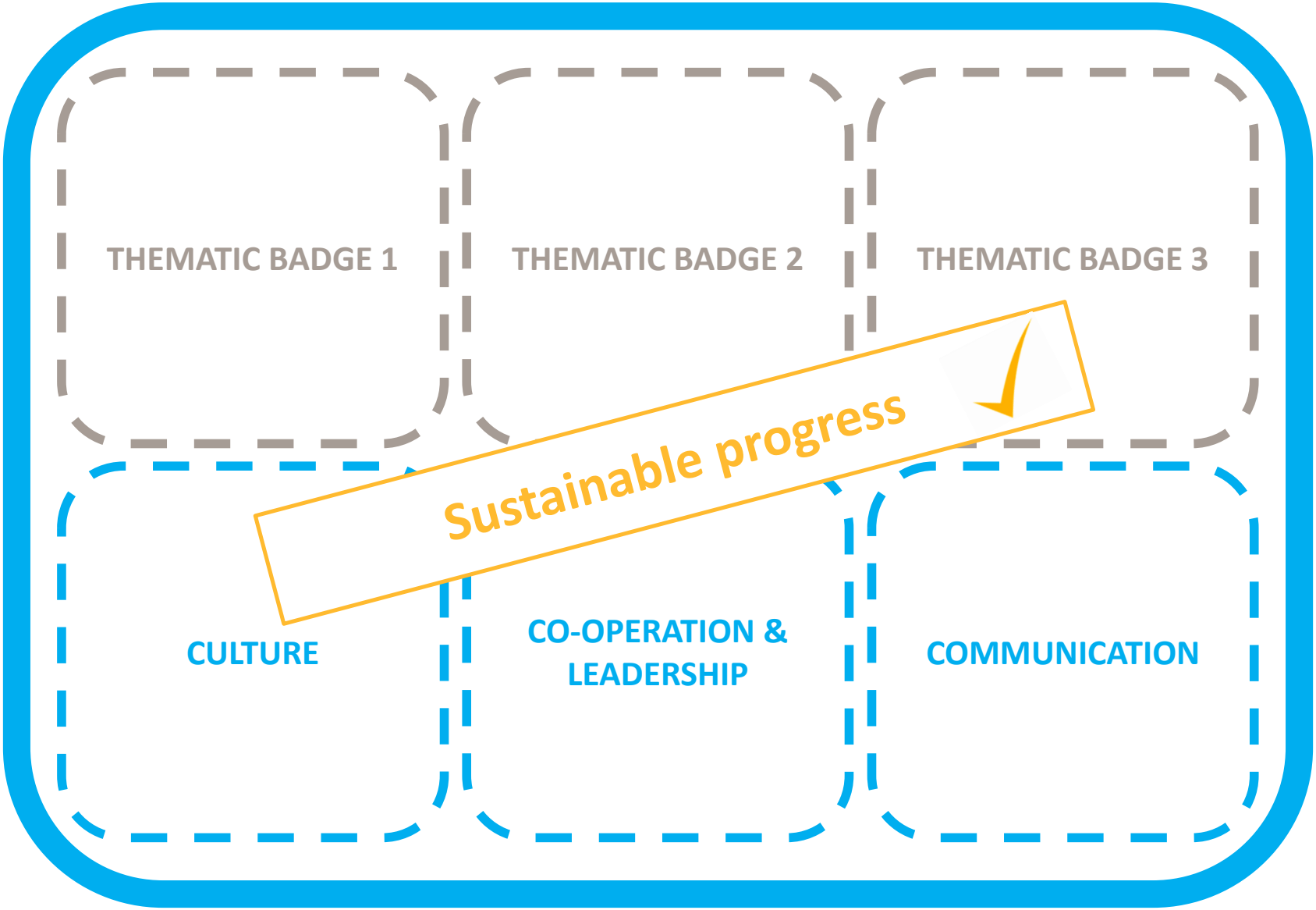
Child Friendly Cities & Communities is a Unicef UK programme that works with councils to put children's rights into practice.

The programme aims to create cities and communities in the UK where all children – whether they are living in care, using a children's centre, or simply visiting their local library – have a say in the local decisions, services and spaces that shape their lives.




THEMATIC BADGES
Healthy
Place
Participating
Innovation
Equal & Included
Education & Learning
Flourishing
Family & Belonging
Safe & Secure
Child-Friendly Services
Culture
Co-operation & Leadership
Communication
FOUNDATIONAL BADGES

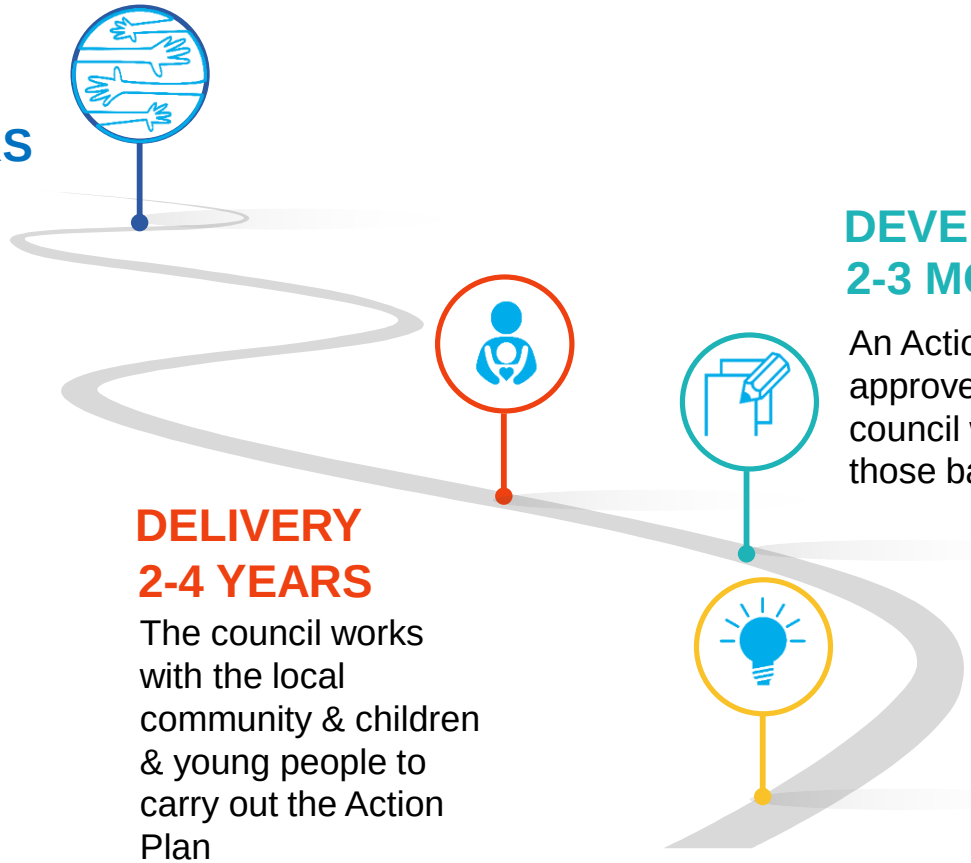
RECOGNITION



THE JOURNEY

RECOGNITION LASTS FOR 3 YEARS

An independent panel of experts assesses the council's progress & decides whether to recognise the city/community as child-friendly



DISCOVERY 6 MONTHS

The council, community & children & young people come together to agree their priorities – six 'badges'

DEVELOPMENT 2-3 MONTHS

An Action Plan is drafted & approved showing how the council will achieve progress in those badges

DELIVERY 2-4 YEARS

The council works with the local community & children & young people to carry out the Action Plan

DISCOVERY – 6 MONTHS

SLA in place

Robust and clear **Safeguarding** arrangements are in place:

- Review CFC's safeguarding guidance and share with relevant staff
- Nominate Designated Safeguarding Persons
- Complete and return the CFC safeguarding checklist
- Host a Unicef UK-facilitated breakfast briefing

The partnership with Unicef UK has been announced and a **Communications** plan is in place to increase local knowledge of the programme:

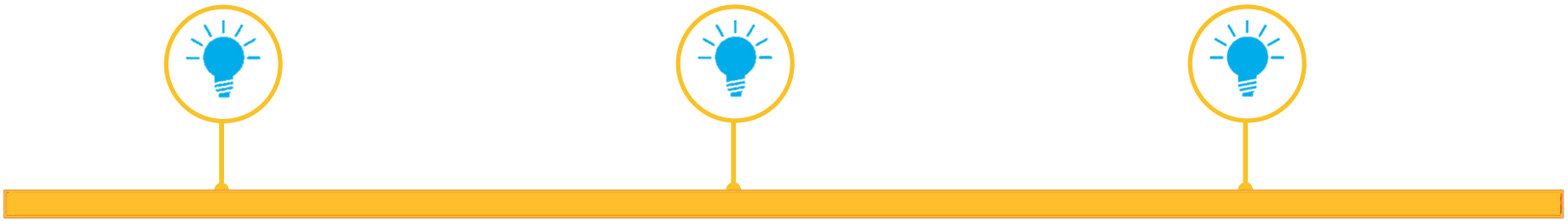
- Draft and submit a CFC communications plan
- Publically launch the programme
- Include CFC in the LA's annual communication plan
- Offer opportunities for communications staff to join Unicef UK-facilitated training sessions

Local **Youth Participation & Engagement** teams understand the programme and opportunities are in place for children and young people to influence its development:

- Host Unicef-UK facilitated training sessions
- Map existing local participation structures and explore alternative models of youth participation
- Support a group/structure of children and young people to influence the programme and decision-making

DISCOVERY CONTINUED

Consensus on **six badges**



A **Governance & Decision-Making** structure is in place, including CFC Champions, and those involved feel able to promote the programme:

- Review the governance and coordination structure submitted at the Expression of Interest stage
- Host a Unicef UK-facilitated breakfast briefing
- Host Unicef UK-facilitated training sessions

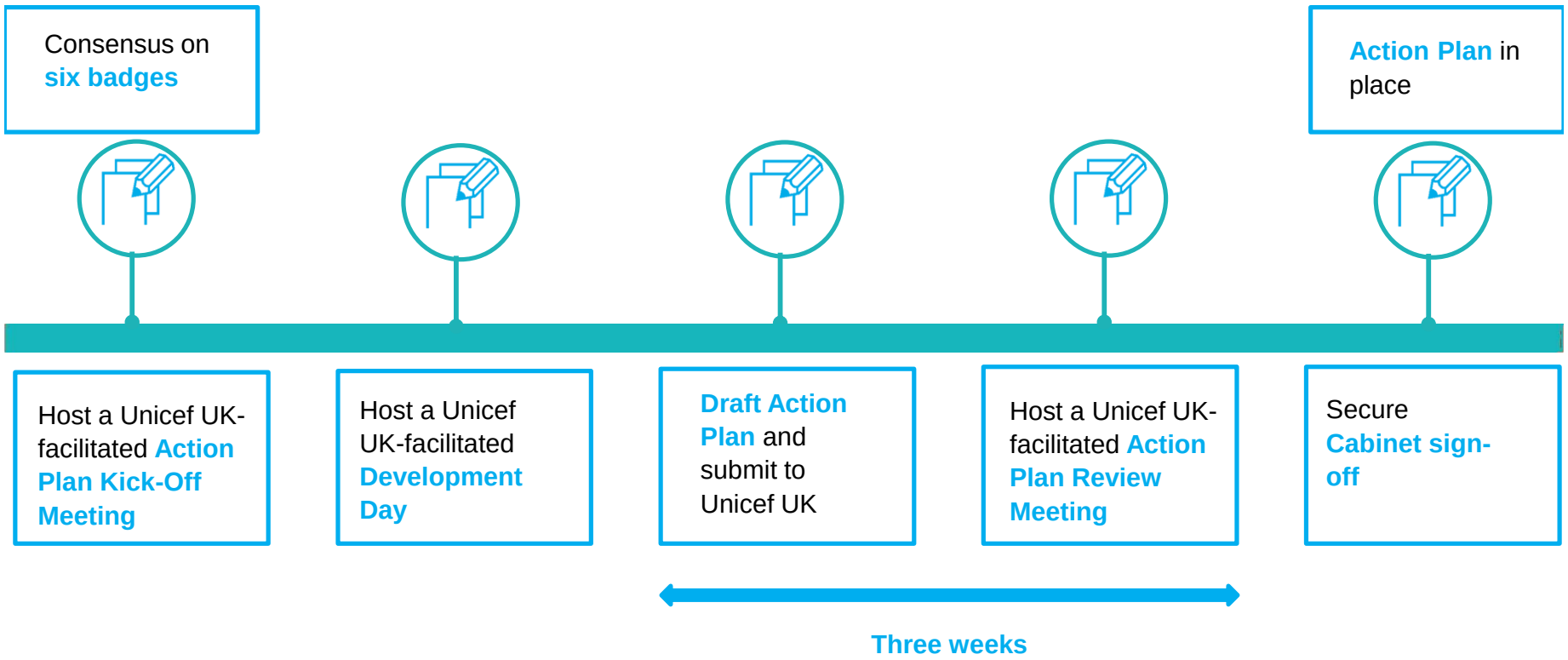
There is a clear, evidence-based understanding of the existing situation for children and their priorities, and agreement on which three thematic **Badges** to focus on during the programme:

- Review existing local data
- Host Unicef UK-facilitated Youth Discovery and Community Discovery Days
- Consult more widely to close any gaps
- Draft and submit a badge rationale report

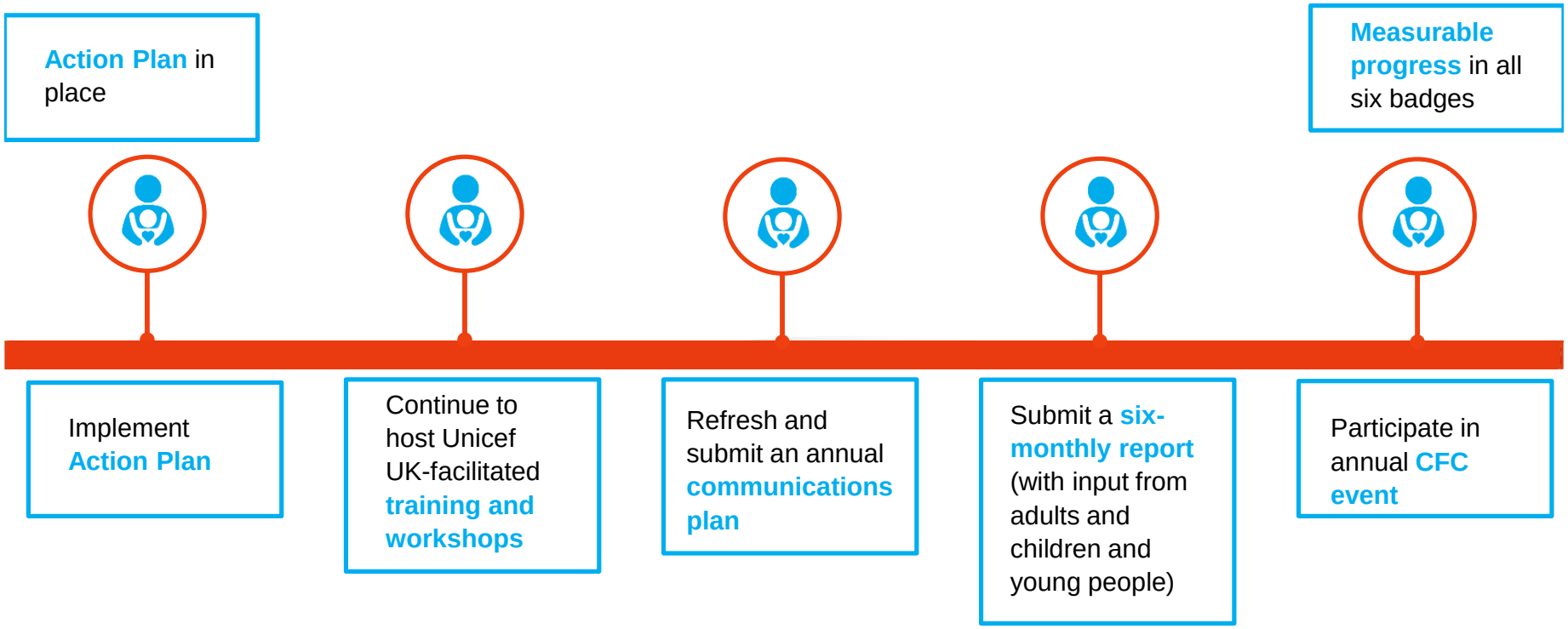
A **Baseline Study** is completed:

- Disseminate survey to children and young people, and professionals
- Host focus groups

DEVELOPMENT – 2-3 MONTHS



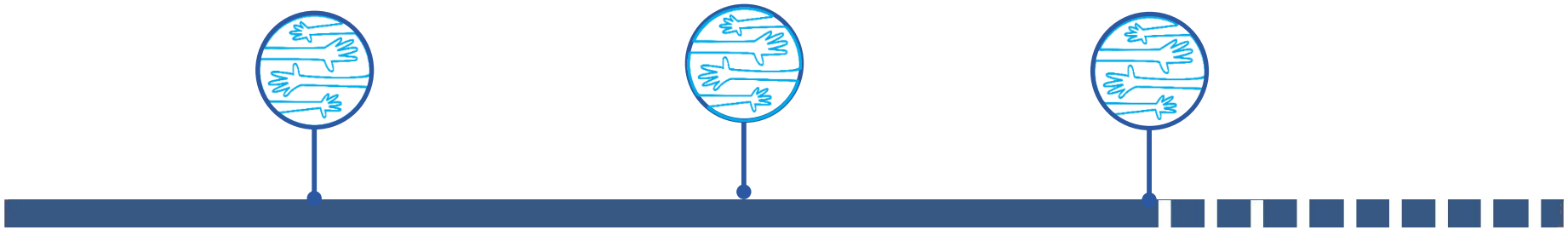
DELIVERY – 2-4 YEARS



RECOGNITION – LASTS FOR 3 YEARS

Measurable progress in all six badges

Child Friendly City or Community



Submit evidence backed up with testimony from children and young people

Commit to **self-regulate** and alert Unicef UK of any significant changes

Submit **Three-Year Plan** and evidence sustained progress for renewed recognition

THANK YOU

W: unicef.org.uk/child-friendly-cities

E: cfc@unicef.org.uk

CHILD FRIENDLY CITIES & COMMUNITIES

unicef UNITED KINGDOM

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	19/20 Financial Recovery
Report of:	John Grinnell, Director of Finance/ Deputy CEO
Paper Prepared by:	Alison Chew, Associate FD Operational Finance Claire Liddy, Director of Operational Finance

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

1.0 Introduction

The purpose of this paper is to provide an update to the Trust Board on the following:

- 2019/20 current forecast gap against control total
- 2019/20 Recovery Approach
- Further risks which could impact on the position

2.0 2019/20 Forecast – Month 5 position

At the end of August 2019 the divisions submitted financial forecasts which did not deliver against the £1.6m control total and resulted in a year end gap, after mitigation, of £3.4m. This is an improvement since month 4 of £0.9m. The following table provides details of this gap by division:

Division	Control Total £'000	Month 5 FY Forecast £'000	Month 5 FY Variance £'000
COMMUNITY	1,467	1,173	-294
MEDICINE	9,269	8,315	-954
SURGICAL CARE	39,125	38,485	-640
ALDER HEY IN THE PARK	(7,231)	(8,580)	-1348
EXECUTIVE	(3,600)	(3,691)	-91
FACILITIES	(4,688)	(5,452)	-764
FINANCE	(4,096)	(4,075)	21
HUMAN RESOURCES	(2,996)	(3,174)	-178
IM&T	(3,482)	(3,497)	-15
NURSING & QUALITY	(3,052)	(3,527)	-475
ACADEMY	149	(32)	-180
INNOVATION	(362)	(369)	-7
INTERNATIONAL	7	(171)	-178
RESEARCH & DEVELOPMENT	617	161	-456
Divisional Total	**21,125**	**15,566**	**(5,559)**
OTHER/MITIGATION	(19,497)	(17,391)	2106
Control Total:	**1,628**	**(1,825)**	**(3,453)**

The implications of the Trust not delivering the control total are the loss of PSF funding of up to £3.4m which would impact on the cash available to the Trust to invest in the capital programme.

3.0 2019/20 Recovery Approach

The Executive Team have agreed a recovery approach. 5 individual work-streams have been initiated each led by an Executive with the support of a Project Manager, Accountants and the appropriate specialist staff in that area. It is estimated that the 5 work-streams will achieve £2.9m of the required recovery with the remaining gap to be recovered through Divisional improvements. There is currently £0.3m included in the month 5 forecast relating to the recovery projects.

The Sustainability Delivery Group on the 6th October is dedicated to reviewing the progress of schemes against the gap and will identify mitigating actions to close any gap remaining at that point.

Details of the recovery work-streams are in the following table:

Workstream	Executive Lead	Target £'000	Included in the Month 5 Forecst £'000
IMPROVING ACCESS TO CARE	John Grinnell/Kate Warriner/Adam Bateman	1,407	230
PAY	Melissa Swindell	1,000	100
ENERGY	John Grinnell	250	
PRINTING/POSTAGE	Kate Warriner	100	9
MEDS ON DISCHARGE/WASTE	Hilda Gwilliams/Nicki Murdock/Adrian Hughes	134	
TOTAL		**2,891**	**339**

The Sustainability Delivery Group (SDG) as a governance structure will continue on a weekly basis and will monitor the progress of the recovery reporting weekly back to the Executive Team.

4.0 Further Risks

The forecast submitted at month 5 is a deficit of (£1.8m) which is £3.4m behind the plan. There is a risk that this could deteriorate further in coming months. The issues that could have a negative impact on the forecast financial performance are:

- Impact of Brexit
- Winter pressures over and above those planned for by the Divisions
- CIP slippage or delay
- Activity run rate issues
- Unforeseen cost pressures

In the event of a further deterioration of the forecast the recovery plan actions would need to be expanded and accelerated.

5.0 Finance Communication Plan

In order to support the financial recovery process a communication plan is being developed to engage with staff to create a shared understanding how financial control supports delivery of Outstanding Care. Key elements of the communication plan are:

- **Financial awareness**:
  - Branding of the financial approach – focussed on quality of care as end result, synced with wider Alder Hey 'Futures' strategy
  - Workshops for whole trust on Alder Hey Finance
  - Monthly info graphic to be shared on trust financial position
  - Walk around by finance department to all areas
- **Building capability and capacity for staff:**

- Financial training
- Understanding money flows
- Focus on productivity and efficiency

6.0 Recommendation

The Trust Board is requested to note the actions being taken to recover the financial position and the progress made to date to ensure the Trust achieves its Control Total surplus and qualifies for PSF funding.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1 October 2019

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

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

Board Assurance Framework 2019/20

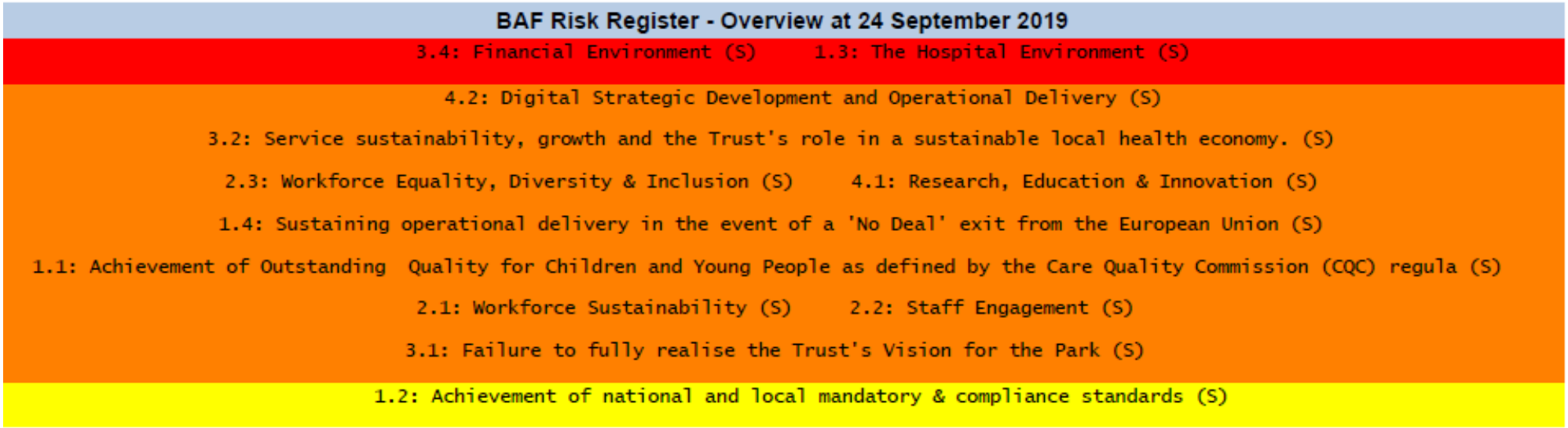
1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's operational plan are being proactively managed.

2. Review of the BAF

The diagram below gives a high level heliview of the current version, followed by a summary and a brief on the changes since the last Board meeting. The full document is included as Appendix A.

BAF Risk Register - Overview at 24 September 2019



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

3. Summary of BAF - at 24 September 2019

The diagram below shows that all risks remained static 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	**Achievement of outstanding quality for children and young people**	3-3	2-2	STATIC	STATIC
1.2 ES	**Achievement of national and local mandatory & compliance standards**	3-2	3-2	STATIC	STATIC
1.3 JG	**The Hospital Environment**	4-4	4-2	STATIC	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**	3-3	3-3	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work					
2.1 MS	**Workforce Sustainability**	3-3	3-2	STATIC	STATIC
2.2 MS	**Staff Engagement**	3-3	3-1	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	3-4	3-1	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships					
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**	3-3	3-2	STATIC	STATIC
3.2 DJ	**Service Sustainability & Growth**	4-3	4-2	STATIC	STATIC
3.4 JG	**Financial Environment**	4-4	4-3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation					
4.1 CL	**Research, Education & Innovation**	3-3	3-2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Operational Delivery**	4-3	3-2	STATIC	STATIC

8. Changes since 3 September 2019 Board meeting

External risks

- ***Service Sustainability and Growth (DJ)***
  Risk reviewed: updated to include our future and role in the wider system, 'Our Plan', staff sessions and One Liverpool plan. No change to risk level in month.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Risk Reviewed, all actions remain on track, no change in risk score

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***
  Risk reviewed no change to score. Actions updated to reflect latest position. Weekly group in place with full oversight.

Internal risks:

- ***Achievement of National and Local Mandatory & Compliance Standards (ES)***
  Risk reviewed - no change to score in month. All actions remain on track. Challenges remain within ED due to record attendances over the summer months.

- ***Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations (HG)***
  No change to score in-month. Action updated to reflect actions implemented following receipt of RPIR on 13/9.

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

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Risk reviewed post completion of Phase 1 park tender.

- ***Digital Strategic Development and Operational Delivery (KW)***
  Good progress with mobilisation of digital futures strategy and actions to mitigate key resilience risks.

- ***Workforce Sustainability (MS)***
  Risk reviewed, all actions remain on track, risk score remains the same.

- ***Staff Engagement (MS)***
  Risk Reviewed, actions remain on track and risk rating remains the same.

- ***The Hospital Environment (JG)***
  Agreement reached with Project Co. to jointly commission an independent survey of the fabric of the roof. Awaiting outcome of non-destructive pipe testing validation meeting with Project Co. directors and members of the Board being convened to oversee.

- ***Research, Education & Innovation (CL)***
  Updated actions and owners. risk score static.

Erica Saunders
Director of Corporate Affairs
1 October 2019

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations.		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Hilda Gwilliams	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Risk Description

Not having sufficiently robust, clear governance systems and processes and people in place supported by the expected culture and values that underpin learning for improvement

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

Gaps in Controls / Assurance

CQC regulation ratings.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implement a bespoke trust wide programme of work in relation to CQC organisational readiness	16/12/2019	Trust RPIR received (13/9) which signals an inspection within six months. Data requests disseminated with QC process in place to meet three week deadline. Programme approach implemented across all KLOEs. A focus on well-led domain in relation to risk is underway.

Executive Leads Assessment

September 2019 - Hilda Gwilliams No change to score in-month. Action updated to reflect actions implemented following receipt of RPIR on 13/9.
August 2019 - Hilda Gwilliams Risk reviewed. No change to score in-month.
June 2019 - Philip O'Connor Staffing Paper remains on schedule for presentation at Trust Board 2nd July 2019. Recruitment event held on 15th June; secured 57 new starters.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Achievement of national and local mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective			Link to Corporate risk/s: No Risks Linked		
Exec Lead: Erica Saunders	Type: Internal, Known		Current IxL: 3x2	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)
Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.	- NHSI quality concern rating - CQC rating - Compliance assessment against NHSI Provider License to Board - NHSI quarterly review meeting
Compliance tracked through the corporate report and Divisional Dashboards.	Refresh of Corporate Report undertaken for 2018/19. Monthly reporting to the Board via the Corporate Report
Risks to delivery addressed through Operational Board, RBD, CQAC, WOD, IGC & CQSG and then through to Board	Regular reporting of delivery against compliance targets through assurance committees and board
Early Warning indicators now in place	Business Intelligence Portal (Infofox) & daily monitoring report used as a source of intelligence and to highlight performance concerns
Operational Delivery Board taking action to resolve performance issues as they emerge	Ops Board Meetings continue on the last Thursday of every month - any issue fully minuted
Emergency Preparedness meetings continue to take place every 2 months which reports into IGC	Emergency Preparedness meetings continue to take place every 2 months which reports into IGC. EP Reports to IGC
Divisional Executive Review Meetings taking place monthly with 'three at the top'	Divisional/Executive performance reviews
Weekly performance meetings in place to track progress	
6 weekly meetings with commissioners (CQPG)	Meetings continue into 2019/20. ToRs attached
Divisional leadership structure to implement and embed clinically led services	Devolved governance structure model
Weekly Exec Comm Cell overseeing key operational issues and blockages.	Planned to continue during 2019/20 (held every Monday AM)

Gaps in Controls / Assurance

1. Critical Care bed capacity due to building issues in the run up to winter
2. ED 4 hour target - difficult to maintain consistently due to high demand
3. Assurance required to underpin Divisional reporting on CQC standards
4. Work with CCG to manage demand & develop / fully utilise existing capacity across PC
5. Proactive management of patient flow making better use of trend analysis data

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Undertake capacity & demand modelling for the surgical wards	31/03/2020	Modelling completed for the winter period. Best in Operative Care Steering Group now progressing annual plan based on bed occupancy
2. In order to sustain high performance a task & finish group established for designing the optimal assessment unit models, and appointment based consultations for non-urgent patients.	30/09/2019	ED Action Plan being monitored by the divisional leadership team and through Ops. Board including a comprehensive workforce plan. COO has requested key areas are expedited at pace
3. Programme of work to be developed 'from Good to outstanding' - Road map to understanding presentation to be prepared for executives - Present road map to executives for approval of direction of travel - Identify project leads and arrange schedule of meetings - Development Project plan. - Briefing CQC readiness presentation to be developed for Divisions . - Arrange presentation to Divisions multidisciplinary teams - Present CQC readiness presentation. - Development CQC evidence template for Divisions. - Approval of evidence template from executives - Guidance document for evidence to be developed. - Approval of guidance document - Circulate template and guidance to Triumvirate to - Commence evidence gathering	31/10/2019	Programme approach implemented with support from DMO and signed off at CQAC

- Monitor evidence submission - Evidence Quality check. - Present outcome of evidence profile - Trust readiness Present readiness profile.		
5. Continue to monitor theatre schedule, discharge planning and capacity & demand modelling through: SAFER Project Group Best in Operative Care Steering Group Clinical Utilisation Review Best in Acute Care Programme	31/03/2020	Programme Assurance continues to be monitored monthly through Clinical Quality Assurance Committee
Executive Leads Assessment		
September 2019 - Erica Saunders Risk reviewed - no change to score in month. All actions remain on track. Challenges remain within ED due to record attendances over the summer months		
August 2019 - Erica Saunders Risk reviewed - no change to score. All actions remain on track. Challenges remain within ED, an improvement plan is being implemented along with changes to some clinical pathways. We are actively recruiting nursing and medical staff to increase resilience in readiness for Winter.		
July 2019 - Cathy Umbers Action 7628 reviewed and revised to reflect the sequence of actions required to prevent the risk in terms of preparedness for CQC inspection		

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care		Risk Title: The Hospital Environment		
Related CQC Themes: Safe			Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell	Type: Internal, New		Current IxL: 4x4	Target IxL: 4x2	Trend: STATIC

Risk Description

A number of building concerns remain unresolved in particular pipe-work corrosion, water ingress, risk of falls and water temperatures.

Existing Control Measures	Assurance Evidence (attach on system)
Monthly issue meetings	Maintenance of issues list and issues review meeting
Monthly liaison meetings	Liaison minutes reported to Trust Board monthly
Regular reports to IGC	IGC Agendas, Reports and Minutes
Building Management Services Risk Register	Risk Register held on Ulysses - reported to IGC
NED / ED / Project Co senior group overseeing management of pipework risk	Letter of agreed actions. Minutes from meeting.
Water Safety Group meets monthly	Minutes

Gaps in Controls / Assurance

Pipes - awaiting non-destructive testing outcome to assess levels of degradation across the whole site
Water Ingress - awaiting long term resolution from Project-Co

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Plan for management of pipework to be agreed	31/10/2019	Meeting planned early Sept to receive firm plans from Project Co
Prepare recommendation to Board on proposed pipework replacement strategy	31/10/2019	Paper being prepared for October 2019 Board
Agree a Strategy for ensuring roofing structure is water-tight	31/12/2019	Remedial works underway to ensure roof is water-tight. works planned to be completed by end of Q3

Executive Leads Assessment

September 2019 - John Grinnell
Agreement reached with Project Co. to jointly commission an independent survey of the fabric of the roof. Awaiting outcome of non-destructive pipe testing validation meeting with Project Co. directors and members of the Board being convened to oversee.

August 2019 - John Grinnell
Risk reviewed - no change to score in-month. Key focus on pipework actions -overall rating unlikely to change until actions complete October 2019.
Focus on water ingress in ICU - business continuity being led by COO

June 2019 - David Powell
Risk reviewed, no change to score in-month. Key focus on pipework actions - overall rating unlikely to change until actions complete October 2019

Board Assurance Framework 2019-20

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: 3x3	Target IxL: 3x3	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.

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 weekly; work stream leads identified; risk assessments undertaken.
Internal command team structure focusing on eight key areas each week to assess level of risk and update plans based on national information. Group responds to national guidance as it is published.	Weekly report to Executive team to address deficits and escalate as required

Gaps in Controls / Assurance

There may be supply issues in the event of a No deal Brexit. Our assurance is that we are in a position to respond to this and have alternatives in place for the identified high risk areas which we do.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Continuing to refine oversight arrangements and associated resources ahead of 31st October 2019 deadline	17/10/2019	Update report going to Board on 1 October to provide assurance in relation to business continuity plans
Continue to engage and lobby NHSE colleagues to ensure centrally managed mitigations are understood and adequate	31/10/2019	Areas of concern are being flagged through national central Brexit team. Plans still rely on central mitigations being adequate to ensure key supplier routes.

Executive Leads Assessment

September 2019 - John Grinnell
Risk reviewed, no change to score. Actions updated to reflect latest position. Weekly group in place with full oversight

August 2019 - John Grinnell
Risk reviewed, current score remains. Business continuity plans continue to evolve as required

June 2019 - John Grinnell
Risk reviewed - current score adequate. Further review of arrangements to take place post election when we expect to receive further national guidance.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability		
Related CQC Themes: Safe, Effective, Responsive, Well Led, Well Led, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to deliver consistent, high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place, at the right time.

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
Mandatory training fully reviewed in 2017, with a new system of reporting linked to competencies on ESR; enabling better quality reporting.	- 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	Large-scale nurse recruitment event 4 times per year
HR Workforce Policies developed in partnership with staff side	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 Strategy	People Strategy report monthly to Board

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	31/03/2020	good work progresses - over 90% mandatory training across the trust with some hotspot areas still in development.
2. Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. Target is 4% absence rates across the organisation.	31/03/2020	
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	30/09/2019	Progress delayed. Looking to have in place for September 2019.

Executive Leads Assessment

September 2019 - Melissa Swindell
Risk reviewed, all actions remain on track, risk score remains the same

August 2019 - Sharon Owen
Risk reviewed, all actions remain on track, risk score remains the same.

July 2019 - Melissa Swindell
Risk reviewed. No change in risk score. Action regarding workforce planning requires further focus and progression.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 2.2	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x1	Trend: STATIC

Risk Description
Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims.

Existing Control Measures	Assurance Evidence (attach on system)
People Strategy	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.
People Strategy Reports to Board (monthly)	Board reports and minutes
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 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
BME and Disability 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

Gaps in Controls / Assurance
Internal Communications Strategy and Plan

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Brand paper taken to March Ops Board and detailed implementation now under way	31/03/2020	

Executive Leads Assessment
September 2019 - Melissa Swindell Risk Reviewed, actions remain on track, risk rating remains the same
August 2019 - Sharon Owen Risk reviewed, actions remain on track, risk rating remains the same.
July 2019 - Melissa Swindell Risk reviewed. Actions on track.

Board Assurance Framework 2019-20

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: 3x1	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)
Wellbeing Strategy	monitored through WOD
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
Staff Survey results analysed by protected characteristics and actions taken by E&D Lead.	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
LGBTQ+ Network established	Taking forward actions for LiA - enabling achievement of a more inclusive culture. Monthly network meetings established.
Time to Change Plan	Time to Change Plan

Gaps in Controls / Assurance

1. Workforce not representative of the local community
2. BME and disabled staff reporting lower levels of satisfaction in the Staff Survey than non-BME other staff

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.	30/09/2019	Time to Change Plan agreed - implementation planned for Sept 2019
1. Work with Community Engagement expert to develop actions to work with local community	30/09/2019	On track for September 19

Executive Leads Assessment

September 2019 - Melissa Swindell
Risk Reviewed, all actions remain on track, no change in risk score

August 2019 - Melissa Swindell
Risk reviewed. All actions remain on track; no change in risk score

June 2019 - Melissa Swindell
Risk reviewed. All actions remain on track; no change in risk score.

Board Assurance Framework 2019-20

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: 3x3	Target IxL: 3x2	Trend: STATIC

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	
Redevelopment Steering Group	Reports into Programme 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	

Gaps in Controls / Assurance

Fully reconciled budget with Plan.
Risk quantification around the development projects.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Complete cost assessment and scheme rationalisation	22/10/2019	
Secure approval for plans to increase Park footprint	12/11/2019	Planning for Park extension submitted 31/07/2018
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	31/12/2019	On hold-Dependent upon residential scheme (revised target date no April 2018)
Complete cost plan for final park works	12/11/2019	
assessment of status including risk of all development projects	31/10/2019	
Secure planning	31/10/2019	

Executive Leads Assessment

September 2019 - David Powell
Risk reviewed post completion of Phase 1 park tender

August 2019 - David Powell
Monthly review prior to Campus Steering Group

June 2019 - David Powell
Risk reviewed, no change to score in-month. Risk profile to be reassessed on completion of cost plan work.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 3.2	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Service sustainability, growth and the Trust's role in a sustainable local health economy.		
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 to service sustainability development/growth:
A) risk of failure to deliver business as usual and maximise growth opportunities due to NHS financial environment and constraints on internal infrastructure
B) Risk of failure to develop external opportunities for partnership and to proactively establish the Trust's role in the development of a sustainable local health economy
C) Risk of failing to play our part in reducing unwarranted variation in Children & Young People's services across the City and beyond.

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)
Accreditations confirmed through national review processes	Alder Hey partake in routine Quality Systems Team (QST) Peer Reviews for range of services - e.g. CHD peer review scheduled for July 19 (evidence to follow)
Five year plan agreed by Board and Governors in 2014	Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report
Compliance with All Age ACHD Standard	ACHD Level 1 service now up and running; developing wider all-age network to support - agreement reached to host at Alder Hey.
Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off (March 18, September 18)	Strategic Plan 2018-21 approved by AH Trust Board November 2018 - inclusive of international growth & development
Capacity Plan identifies beds and theatres required to deliver BD plan	Daily activity tracker and forecast monitoring performance for all activity.
Growth and sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board	Growth through Partnerships included in Strategic Business planning - both annual operational plan and the developing long term / strategic plan Monitored at Programme Board and via Strategy & Ops Delivery Board
Gap / risk analysis against all 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.
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	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly)
'Our Plan' - Draft - 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' draft 1v4 - attachment to be added following October Trust Board approval
'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. Attachment to be added following November's Trust Board

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
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.
Completion and publication of the Trust's strategic plan to 2024: 'Our Plan'	08/11/2019	Draft 'Our Plan' to Trust Board for comments - September 19 Draft 'Our Plan' to Council of Governors for comments - September 19 'Alder Hey Futures' staff events to set out 'Our Plan' and hear from staff - September 19

Executive Leads Assessment

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

September 2019 - Dani Jones Risk reviewed: updated to include our future and role in the wider system, 'Our Plan', staff sessions and One Liverpool plan. No change to risk level in month.
August 2019 - Dani Jones Reviewed the risk, considered the score. Added assurance evidence to several control measures.
June 2019 - Dani Jones Reviewed the risk. Considered the score. Updated historical control measure actions. Removed 2 x historical/outdated control measures (trauma business case, 7 day working project)

Board Assurance Framework 2019-20

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: 4x4	Target IxL: 4x3	Trend: STATIC

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

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

Gaps in Controls / Assurance

1. Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan.
2. 'Grip' on CIP
3. Affordability of Capital Plans

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Five Year capital plan	04/11/2019	5 year plan development continuing and funding gap reduced but not yet fully closed. Progress to be reported to November Board and 5 year plan to be submitted to NHSI end of Nov.
1. Tracking actions from Sustainability Delivery Group	31/03/2020	on target
2. Develop fully worked up CIP programme - £1.5m gap	31/03/2020	CIP continues to be managed weekly at SDG. Links with financial recovery and 6 workstreams which will also improve CIP position

Executive Leads Assessment

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

August 2019 - Alison Chew
Risk reviewed. This remains high risk. Divisional recovery plan implemented and managed weekly at SDG and Execs. Capital affordability still a challenge but progress being made.

June 2019 - John Grinnell
Risk reviewed. Given current divisional forecast and capital affordability challenges this remains a high risk, therefore no change in score.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 4.1	Strategic Objective: Game-Changing Research And Innovation	Risk Title: Research, Education & 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 exploit new opportunities in research, innovation & education due to incomplete management systems.

Existing Control Measures	Assurance Evidence (attach on system)
Establishment of RIE Board Sub-committee	Research, Education and Innovation Committee established
Steering Board reporting through to Trust Board	Research Strategy Committee set up as a new Board Assurance Committee
RABD review of contractual arrangements	Reports to RABD and associated minutes
Programme assurance via regular Programme Board scrutiny	Reports to Programme Board and associated minutes
Digital Exemplar budget completed and reconciled	
Innovation Co budget in place	Secured ERDF funding for Innovation Team Innovation Board established
Establishment of Research Management Board	Research Management Board established.
Establish Innovation Board Committee	Committee oversight of Innovation strategy with NED expertise

Gaps in Controls / Assurance

Sporadic meetings of RIE committee
Governance structure for Innovation Board to be agreed
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
Develop a robust Academy Vision and Operating Model	01/12/2019	Framework refresh
Agree incentivisation framework for staff and teams: for research time & innovation time	01/12/2019	
Complete collaboration contract with University of Liverpool	19/12/2019	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.
Complete review and implement new structures and framework for research, innovation & education	01/10/2019	New governance structure agreed with Chair for action in Quarter 3-4 2019/20

Executive Leads Assessment

September 2019 - Claire Liddy
Updated actions and owners. risk score static

August 2019 - Jason Taylor
New Clinical Research Division delivery plan agreed 04.07.19

June 2019 - David Powell
Risk reviewed, no change to score in-month

Board Assurance Framework 2019-20

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: No Risks Linked		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x3	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
Monthly update to Trust Board on digital developments	Board agendas, reports and minutes
GDE Programme Board in place & fully resourced - Chaired by Medical Director	GDE Programme Board tracking delivery
Clinical and Divisional Engagement in Digital Strategy	Implementation of fortnightly huddle with divisions from April 2019. Divisional CCIOs in the process of being recruited. Community Division - commenced in post June 2019. Surgery TBC Sept 2019. Medicine in progress. Divisional IT Leads confirmed Sept 2019.
NHSE & NHS Digital external oversight of GDE programme	NHSD tracking of GDE 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
Options appraisal for Disaster Recovery approach	Options in development, capital identified in capital plan, issue presented to RABD and included in Trust Board in September.
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

1. IT operating model assessment underway
2. Lack of secondary data centre / disaster recovery - approach agreed and progressed
3. Cyber security investment for additional controls approved - dashboards in place

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Cyber security investment for additional controls approved	01/10/2019	Investment approved, dashboards proof of concept in place, additional resources in the process of being recruited
2. Lack of secondary data centre / disaster recovery	31/12/2019	Approach agreed and progressed, actions for strengthened resilience to be completed by the end of 2019
1. IT operating model assessment underway	02/12/2019	Service Improvement Plan in place

Executive Leads Assessment

September 2019 - Kate Warriner
Good progress with mobilisation of digital futures strategy and actions to mitigate key resilience risks.

August 2019 - Kate Warriner
Strategy approved by Trust Board July 2019. Mobilisation plans in development. New governance arrangements to be established from September. Programmes redefined on Trust Change programme to reflect strategy developments. Options appraisal for IT resilience commenced, interim disaster recovery arrangements scoped. Service development in progress.

July 2019 - Kate Warriner
Strategy approved by Trust Board July 2019. Mobilisation plans in development. Options appraisal for IT resilience commenced.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 01/10/2019

Paper Title:	Corporate Risk Register Report
Report of:	John Grinnell, Deputy Chief Executive/Director of Finance
Paper Prepared by:	Cathy Umbers, Associated Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Integrated Governance Committee minutes and associated papers
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:	Resources identified to support management of risks as required.

1. Introduction

This paper provides the Board with the opportunity to scrutinise the current Corporate Risk Register (CRR) and review the changes to the register between 1st April 2019 and 28th September 2019, as discussed at the Integrated Governance Committee (IGC) at its bi-monthly meeting.

2. Corporate Risk Register

The CRR has been updated to highlight the current position, following review by the IGC on 11th September 2019, the Executive Management Team on the 12th September and senior management team on the 26th September 2019. The summary of the CRR is included as Appendix 1 of this report.

There are currently **28** high risks on the CRR. The report shows one extreme risk at a score of 25, one very high risk at score of 20, sixteen high risks at score of 16 and ten at score of 15.

The summary report highlights the trend for each individual active current high risk, in addition to the current controls and actions to mitigate the risks to support achievement of the identified target score. Furthermore, the risks are aligned to the strategic objectives and the Care Quality Commission Key Lines of Enquiry, domains.

The high risks as shown at **Table 1**, accounts for 9.93 % of all risks, currently on the Trust Risk Register.

Table 1. Trust Risk Profile (407 risks)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk				No risk rating
1	2	3	4	5	6	8	9	10	12	15	16	20	25	
2	**4**	**5**	**19**	**8**	**72**	**47**	**102**	**27**	**81**	**10**	**16**	**1**	**1**	**12**
11 (2.7%)			**99 (24.32%)**			**257 (55.50%)**				**28 (9.93%)**				

3. Corporate risks closed and reduced

There were four high risks closed during this reporting period and ten high risk scores reduced. The summary of the closed and reduced scoring risks is included as Appendix 2 of this report.

Appendix 1 Corporate Risk Register (CRR)

Master Corporate Risk Register (CRR) 2

Appendix 2.

High Risks reduced/closed 1st April 2019 -28th September 2019				
Ref	**Risk description**	**Current Risk Score**	**Target Risk Score**	**Agreed Mitigation/Action**
1883 1884 (duplicate)	Risk of injury to a person(s) or car/material item from fin caps falling. **Closed**	**4**	**4**	Fin caps have now been mechanically fixed so unlikely to come loose again
1872	Lack of security surveillance **Closed**	**4**	**4**	Reception is manned in the building from the opening at 7am until 6pm, in an event reception staff will inform the security desk in the main hospital and request immediate help.
1808	Fire Risk in Institute due to lack of equipment storage **Closed**	**6**	**6**	**Closed** - An interim solution has been found on the 1st floor of the institute
1887	Unsafe patient area due to roof leak **Closed**	**NA**	**NA**	Revised risk opened reference 1958 9refer to current high-risk register report)
1909	Information for parents, children and young people may not be clinically updated and reviewed and therefore providing incorrect information	**12**	**4**	**Controls:** Patient Information Standards Policy. Trust Lead for PILs advises Divisional Triumvirate of their position regarding their own Divisional PILs status monthly. Monitored via Clinical Quality Assurance Committee **Actions:** Comprehensive action plan in place
1935	Workload for existing nursing staff exceeds national average recommendation. Unable to ensure required patient contact is maintained. (Diabetes) – (Linked to 1937 & 1938 & 1941)	**12**	**2**	**Controls:** Prioritising outpatient clinics to provide MDT support for patients. Medical on call in and out of hours. Diabetes specialist nurse on call **Actions**: Recruitment of additional two B6 nurses
1937	Risk to organisational reputation as Alder Hey is one of the largest Children and Young Person's Diabetes service's in England (linked to 1935 & 1938 & 1941))	**12**	**6**	**Controls:** Prioritising patient safety to deliver safe, effective care. **Actions:** Recruitment of additional two B6 nurses Ongoing monitoring of staffing requirements and recruitment including international recruitment underway.
1938	Risk Of non-compliance with commissioning of diabetes. (linked to 1935 & 1937 & 1941)	**12**	**4**	**Controls:** Prioritising patient safety to deliver best practice care. **Actions:** Recruitment of additional two B6 nurses Ongoing monitoring of staffing requirements and recruitment including international recruitment underway.

1941 (1973 duplicate)	Capacity to extend diabetic nursing role as non- medical prescribers. Linked to 1935, 1937, 1938)	**8**	**4**	**Controls:** Medical support in and out of hours to support dosing. Experienced diabetes nurses prescribing, who are up to date with current guidelines and protocols. **Actions:** Identify and secure a place for nursing staff to undertake non medical prescribing course on each cohort at Edge Hill University. Recruitment of additional two B6 nurses
1967	Loss of this facility will stop the team being able to start insulin pump therapy for children with type 1 diabetes. Potentially leading to unstable diabetes and associated long term complications.(linked to 1968)	**8**	**4**	**Controls:** Diabetes training is provided in the Catkin building in a dedicated room. Additional room available in ED **Actions:** To identify a suitable alternative clinical location for the diabetes training room to be relocated. This should be a clinical area with hand wash facilities, large enough to accommodate an examination couch and large table for insulin pump setup. Plan to be developed and implemented with support of senior management team.
1968	Risk of loss of training room could result in the cessation of new pump starts for diabetic patients. (linked to 1967)	**12**	**4**	**Controls:** Providing training for insulin pump therapy within the catkin building, with additional facility in ED department. **Actions:** To identify a suitable alternative clinical location for the diabetes training room to be relocated. This should be a clinical area with hand wash facilities, large enough to accommodate an examination couch and large table for insulin pump setup. Plan to be developed and implemented with support of senior management team.
1979	Due to the age of the pumps x 14, there is a risk of fluid ingress.	**12**	**2**	**Action** Pumps purchased, now in Trust, progressing manufacturing software configuration
1980	Ability to fill rotas of Junior doctors (middle grades) cover between the hours of 09:00 and 16:00. 9General Paediatrics Medical Division0	**12**	**8**	**Controls:** Currently 3.6 wte middle grade support to General Paediatricians Advanced Nurse Practitioners support in place on wards First on call medical registrar bleep to provide emergency support. **Actions:** Undertaking a review of available funding and review of on call rota vacancies. Active recruitment plan
1887	Unsafe patient area due to roof leak	**NA**	**NA**	**Closed** - Now managed via risk 1958

Appendix 1 Corporate Risk Register Report (CRR) 28/09/2019

Ref	Risk Description	Controls/Mitigations	Action(s)	Risk Score	Target	Trend	Link to Strategic Objective	Link to CQC domain
1715	Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease.	Repeat scans.	Agreed business case to purchase software.	25	2	↑	Delivery of Outstanding Care	Safe, Well-Led
1169	Ability to staff non-malignant Haematology medical staff rota.	Locum consultant oncologist, Junior doctors acting up via Royal College, Consultant Haematologists undertaking high intensity on call, 1/2.	Job planning for Haematology medical workforce. ANP training programme (2 staff on course).	20	5	⇔	The Best People Doing their Best Work	Well-Led, Safe
947	Meditech Infrastructure does not have hot fail over site (Disaster Recovery Platform).	Downtime Recovery software in place which takes regular snapshots of MEDITECH data and is accessible from a dedicated PC in each ward / department. Nightly backups of the live system to ensure a stable recovery point in the event of primary failure. Agreement with partner with infrastructure to restore back ups should there be a catastrophic failure.	Meditech 6 resilience implemented by the end of 2019. Meditech Expanse resilience in partnership with CCC implemented in line with go live of system in 2020. Options appraisal of solutions available to performing function to be developed and to go via the appropriate route for approval.	16	4	⇔	The Best People doing their Best Work	Well-Led, Safe
654	Staff acquiring airborne hospital acquired Infections whilst delivering patient care.	Isolation policy, IPC Team fit testing programme. Staff trained on wards to fit test, Staff vaccination policies.	Staff influenza vaccination campaign. Purchase portacount machine to enable quicker testing. Awareness campaign. Development of Divisional plans	16	4	⇔	The Best People Doing their Best Work	Well-Led, Safe
799	Failure to control contractors on site (CHP) & retained estate.	Control of Contractors Policy. Incident reporting. H&S risk assessments. Training on Sky systems	MIAA audit.	16	4	⇔	The Best People Doing their Best Work	Safe, Well-Led
1866	Risk that outdated Clinical Guidelines may have an impact on the quality of patient care and treatment (150+)	A central database of guidelines on intranet available.	Create action plan with implementation timescales.	16	2	⇔	Delivery of Outstanding Care	Well-Led, Safe
1306	Ability to recruit junior doctors to fill gaps in rotas in the Division of Surgery.	Recruiting every 6 months, and advertising regularly, to ensure significant cover as far as possible. Locums allocated within current establishment. Current members of the team are picking up ad-hoc shifts.	Development of long term strategy.	16	6	⇔	Delivery of Outstanding Care	Well-Led, Safe
884	Failure of RO Plant supporting Haemodialysis.	Review of water quality reviewed by team daily to ensure appropriate levels to deliver appropriate care. Operational Plan weekly review with executive lead. Business continuity plan reviewed and updated. Current plans are supported by Broadgreen for additional RO and also Manchester.	Plan for New RO plan N+1 system.	16	4	⇔	Delivery of Outstanding Care	Safe, Well-Led
1958	Risk of reduction in critical care capacity and significant disruption to the care of children require intensive or high dependency care, associated with the unplanned closure of critical care beds.	Contingency plans - Use of beds within PICU to house PICU patients only. Roof has been protected while canopies are put up & area in POD 1 has been sealed.	Scope/remit agreed. Action with Project Co to contract a suitable surveyor to undertake an inspection of the building fabric and provide details to both parties on suitability, performance and integrity.	16	4	⇔	Delivery of Outstanding Care	Well-Led, Safe
902	Ability of clinical staff to view patient information electronically between systems i.e. EMIS and Meditech. (connectivity issues)	Paper notes provided to clinicians working in community. Roll out of mobile devices for staff in CAMHS and Community. Incident reporting. High level meetings weekly to monitor progress with IM&T plan.	IMersey to undertake review and provide feedback on options, to support connectivity and data migration. IM&T plan in place to improve network connectivity, provide appropriate devices, Migrate iMersey connected staff to AH network.	16	4	↓	The Best People Doing their Best Work	Well-Led, Safe
1241	Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council.	Options appraisal, regular capital planning meetings.	Phased approach plan.	16	6	⇔	Sustainability through external partnerships	Well-Led, Responsive
1388	Risk of pipe burst due to corrosion.	Rapid response team in place. Shielding of electrical items in areas of pipe-work. Risk assessments completed.	External consultant appointed to produce a plan for testing pipes, replacing requirements and advise executives accordingly. Monthly meeting with executives, non-executive and partners to monitor progress.	16	6	↓	Sustainability through external partnerships	Well-Led, Safe
1270	Delays in diagnosis of ADHD and ASD (in relation to ADHD, delays in commencement of possible drug regimes).	Weekly waiting times review meeting, monthly reports structure agreed with CCG, to support on-going monitoring. Control of waiting times available via Meditec, additional financial investment, additional staffing including dedicated Pharmacist.	Secure project management resource to lead system and process review. Working group to review and revised pathway, commence a prescription audit, measuring against ADHD recommended medication regimes. Undertake procurement process to identify a third party provider who may be able to support the service.	16	8	⇔	Delivery of Outstanding Care	Safe, Well-Led
1524	Risk of staff practising outside sphere of competency due to reduced capacity to transition patients (ADHD) to adult services.	Quarterly project progress reports to divisional board meeting (Liverpool). Commissioning leads identified with each of the serving CCGs. Formal contract withdrawal notice on the care provision to adults receiving ADHD specific medications and care ceasing from 1 April 2019. CCG made arrangements of adult service provision by Merseycare. Liverpool cohort project team in place.	To meet with transition leads to discuss this risk and consider how the Transition Policy should be inclusive of a process when adult services are not in a position to either accept referrals as no service exists, or where an adult service exists and significant waits are evident, i.e. 3 years.	16	8	⇔	Delivery of Outstanding Care	Safe, Well. Led
1187	Server infrastructure no longer replicated to a secondary site.	Support and maintenance contracts on remaining hardware, Alerts configured to notify IM&T staff if there are any problems on the infrastructure. I- Weekly health check reports by expert 3rd party to advise on any weaknesses or vulnerabilities as well as capacity etc. Procurement of replacement primary infrastructure complete. Agreement with partner with infrastructure to restore back ups should there be a catastrophic failure. Daily Back Ups in place of all key IT systems.	Procure and Implement new resilience equipment.	16	4	⇔	Delivery of Outstanding Care	Safe, Well-Led

1904	Ability to fill nursing rotas effectively on Ward 4A.	Effective rota planning for staff, including use of NHS Professionals staff as required. Three times daily huddles with senior manager and patient flow meeting to monitor and manage staffing. Matron and ward manager meetings to forward plan.	International recruitment to be undertaken in November, plan in place. Authorisation given from division to place independent national advert to recruit experienced orthopaedic and neurosurgical nursing staff.	16	2	↑	The Best People Doing their Best Work	Well- Led, Safety
1921	Potential risk of failing to respond to the Trust bleep system process.	Stand Operating procedure, daily tests at 100.00 hours, Quarterly reports re compliance to Resus Committee from Facilities	Non Identified	15	4	⇔	Delivery of Outstanding Care	Safe, Well-Led
1919	Failure to reach 80% compliance with front line Staff influenza vaccination in 2019-20.	Annual staff influenza Campaign, Staff influenza vaccination compliance on IPC dashboard from October to 2019-March 2020, Staff Vaccination policy.	Divisions to create an action plan on how they will ensure that 80% of their front line staff are vaccinated against influenza.	15	10	⇔	The Best People Doing their Best Work	Safe, Well-Led
964	Risk of elective list errors due to planning and scheduling processes.	Process: Theatre coordinator checking operating lists to ensure adequate detail. Theatre coordinator liaising with radiographers to coordinate resource. Safety alert sent out re: operating lists. Work stream is reviewed via the best in operative care project. NatSSIPs document produced which outlines standard for booking and scheduling process. WHO checklist and safety huddles before each operation, Monday review of Theatre list utilisation three weeks in advance. Weekly incident meeting and shared learning. New booking rules in place.	Operational team to consider process for booking and scheduling to theatre for those patients who do not attend clinic at Alder Hey . Review pilot, consider whether sufficient to reduce risk.	15	4	⇔	Delivery of Outstanding Care	Well-Led, Safe
825	Risk of potential deliberate jumping from height from internal balconies.	Risk assessment completed, staff training completed.	Trust working with project co to develop solution. Regular Executive review and update reports.	15	5	⇔	The Best People Doing their Best Work	Safe, Well-Led
1668	Potential failing to respond to the results of diagnostic tests.	RM54 - Diagnostic Tests and Screening Procedures Policy . Royal College / professional standards requiring clinicians who order tests to take responsibility for following up results and acting appropriately.	Rheumatology Team leading a notices pilot . Establish results functionality in Expanse and work with clinical group as part of Expanse deployment, to establish how best to use the new functionality - Due end March 2020. Service/Operational managers departmental leads to correctly assign consultants to clinical groups on Meditech 6 (including on call cover groups). IT team to implement changes to clinical groups and new clinical group functionality in Meditech Live	15	5	⇔	Delivery of Outstanding Care	Safe, Well-Led
1588	Inadequate ventilation system on Critical care Manusa cubicle.	Plan agreed for interim management of children at risk of infection in Critical care. When If clinically appropriate, utilise Manusa cubicle on another ward and relocate specialist staff / equipment to this area (care around the child), Option to empty the rest of the POD, providing critical care to other children in the other PODs and isolating the patient with infection.	To explore options to upgrade/change the ventilation system.	15	5	↓	Strong Foundations	Safe, Well-Led
1961	Risk to Patient Care and operational delivery caused by cyber security issues.	Cyber baseline assessment conducted by MIAA, Annual penetration testing / vulnerability scanning conducted by 3rd parties as part of CE and CE+ audits, Fully managed network parameter security - proactively monitored by third party, Sophos Central Antivirus Solution. Information Security Policy, Information Security Policy, Information Governance Training including Cyber Security for all end users - target 95% of staff undergoing training. Annual submission and audit against the Data Security & Protection Toolkit (DSPTK).	Board Approval in September to proceed with funding to enhance the trusts cyber defence tools. Product evaluation ongoing and further Cyber/Security Audits in train for Sep/Oct. Produce monthly dashboards demonstrating progression against all critical and high actions.	15	5	⇔	Delivery of Outstanding Care	Well-Led, Safe
1787	Error in the prescribing, preparation, administration and monitoring of Parenteral Nutrition.	Alaris GP pumps have had profiles added to allow "TPN - Pharmacy Solution", "TPN - Lipid" or "TPN - Mixed bag" to appear on the screen of the pump so helping to prevent mix-up of rates. TPN tutorial is provided for Junior Doctors following induction. Latest session was held on 8th April 2019. Parenteral Nutrition Policy is available, Standard "all-in-one" Parenteral Nutrition products are commercially available which would prevent the risk of administration of lipid and aqueous phases at the wrong rates, Template prescriptions contain information to guide prescribers in prescribing of Parenteral Nutrition, TPN is prescribed for each individual patient - both specific contents and the rates of administration, TPN preparation uses a computerised system called Abacus.	Non-medical prescribers (dieticians and pharmacists) to be appointed to support prescribing and the development of a Trust Nutrition Team. Prescribing of TPN through the meditech system will be pursued, Different coloured light protective bags to be introduced for TPN within the Trust. Protocols and new prescriptions for standard bags for neonates and older children will be produced, Criteria for initiation of TPN will be agreed with all relevant teams, Video demonstrating appropriate set-up for TPN required on the intranet.	15	5	⇔	Delivery of Outstanding Care	Safe, Well Led
1965	Risk of patients lost to follow up, following discharge.	Currently when the interim ward clerk is on leave, the critical care ward clerks will provide cover from the critical care desk. Staff access reports via Meditech, which gives details of all ward discharges and also the follow up appointment requests. This enables us to monitor the reports to ensure follow up requests are not missed.	Remedial action: determine leadership and management of this group of staff . Redeploy staff/ temporary staff to be sought via NHS professionals .Gap analysis for all clinical areas to determine when additional ward clerks required, how many currently in place, what is the deficit, Development of Business Case.	15	4	⇔	Delivering outstanding care	Safe, Well-Led
1984	Delays in children being able access Cardiac treatment (delayed stepdown from critical care meaning that this capacity is not available for other patients).	1C (cardiology) patient flow group review capacity issues and identify any children who can be safety nursed in other areas of the trust . daily review on the ward round all the children who need a bed on the cardiac unit and make informed decisions of priority . Daily huddle to review bed availability and prioritise any emergency cases. Weekly list planning meeting - to look ahead to the next week and anticipate any issues and manage case mix of cases as appropriate.	Cap on Cath Lab lists to 3 patients (not 4) to reduce peak of admissions on to the ward. Request Pectus Cases go to SAL pre-operatively, complete audit on Ward Round SOP, to identify any inconsistencies and improve discharge planning, timing of decision making and flow.	15	4	⇔	Delivering outstanding care	Effective, Well-Led

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	Digital and Information Technology Update
Report of:	This report is to provide Trust Board with an update on Alder Hey Digital Futures mobilisation, operational IT, progress and digital transformation programmes progress
Paper Prepared by:	Kate Warriner, Chief Digital and Information Officer

Purpose of Paper:	Decision ☐ **Assurance** ✓ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Digital Futures Strategy
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:	Resources linked to capital plan

Trust Board
Digital and Information Technology Update

1. Introduction

The purpose of this paper is to provide Trust Board with an update on Alder Hey Digital Futures mobilisation, operational IT, progress and digital transformation programmes progress.

2. Context

Throughout the summer months, work has been ongoing to mobilise the Trust's Digital Futures strategy with a number of key activities in terms of governance, investment planning and programme mobilisation. In addition, work has been undertaken to address and mitigate a number of infrastructure risks, particularly in relation to operational Information Technology resilience and cyber security.

3. Digital Futures Mobilisation

From a governance perspective, work is ongoing to mobilise new arrangements with the establishment of a Digital Oversight Collaborative (DOC) from October 2019. The DOC will have oversight of the digital strategy mobilisation, operational IT delivery and major digital programme developments.

There will be a number of groups reporting into the DOC which will be established from October 2019. These include:

- Digital Clinical Design Authority
- Operational IT Group
- Programme Delivery Group
- Digital, Innovation and Research forum

The Digital Clinical Design Authority will be chaired by a clinical lead from the Inspiring Quality Programme to ensure appropriate alignment and priority of digital developments to support clinical and quality outcomes.

Work has been ongoing to develop a support model for divisional teams including the identification of a named digital lead for each division and the appointment of Divisional Chief Clinical Information Officers.

In terms of informatics skills development, Alder Hey has recently achieved the North West Informatic, Skills and Development network Excellence in Informatics Level 1 Award. This externally accreditation signals an important step in the development and investment in both digital, clinical and wider Trust staff skills and development.

4. Alder Hey Technology Roadmap - Operational IT Key Performance Indicators / Service Improvement Plan

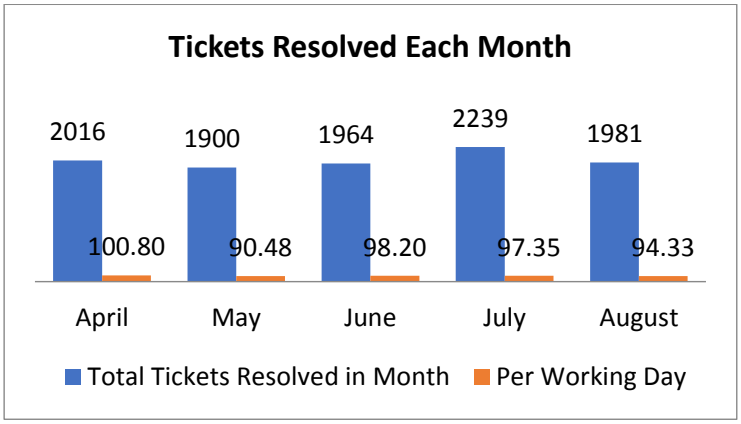
Work has been ongoing from an operational IT perspective to develop a proactive, staff focussed delivery model. Included in this is work with regards to operational IT performance. This work will be developed and iterated over time with divisions.

For this reporting period, KPIs are split into key areas:

1. Activity
2. Team SLA Performance
3. Critical / Core Systems Availability

4.1 Activity

With regards to activity, the overall average number of IT incidents resolved on a monthly basis is on average 2000 incidents. The chart below demonstrates activity for year to date and the number resolved per working day by operational IT teams.

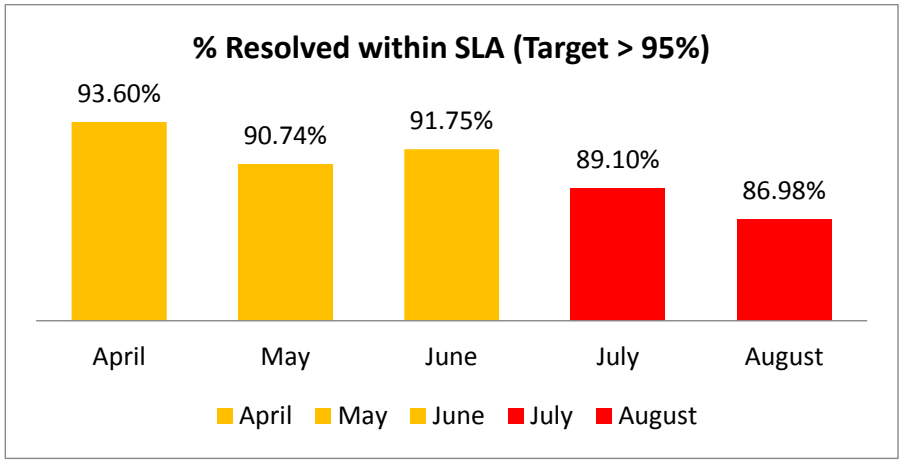


Through a range of service improvements, plans are in place to reduce the number of incidents by 10-20% by April 2020. This reduction then supports a move to a more proactive model of service to front line teams. These service improvements include the implementation of self-service password reset, new starters account automation process and other initiatives to reduce activity. Work is ongoing with divisions to design and test these processes with services.

4.2 Team SLA Performance

From an SLA performance perspective, there are a range of priority levels of incident category from priority level 1 to priority level 5. Priority level 1 are for major issues requiring immediate attention, where as priority 5 are more for day to day and general planning.

A target for team has been developed with an ambition to resolve incidents within a 95% target against SLA time.



Work is ongoing with regards to the data quality of incident classification. This is a new way of working for the service, however introducing this type of performance driven discipline is in line with IT service best practice and will ultimately help to monitor performance, quality, delivery and identify areas for improvement.

There were notable issues in July and August due to higher than normal sickness issues departmentally. The transparency of data is assisting with more accurate resource planning and delivery.

4.3 Critical/Core System Availability

In terms of critical and core systems availability, performance data for August demonstrates no unplanned issues impacting any of the Trust critical systems. Planned patching is scheduled on a monthly basis and is a requirement to ensure the Trust is compliant and safe from a cyber security perspective.

	Hours Offline (Planned)	Hours Offline (Unplanned)	Overall % System Available	
Network	0	0	100%	
Meditech	4	0	99.46%	Planned Meditech Patching
JAC (Pharmacy)	0	0	100%	
Exchange / Email	0	0	100%	
Intranet / Internet	0	0	100%	
Shared / Home Drives	0	0	100%	
Haemonetics/Bloodtrack	0	0	100%	
BadgerNet	0	0	100%	
ImageNow	0	0	100%	
PACS	0	0	100%	
CRIS	0	0	100%	

4.4 Technology Roadmap Service Improvement Plan

Progress is positive with regards to the technology roadmap service improvement plan with key updates summarised below:

Project	Summary
Replacement Computers	• Replacement project formally moved into deployment phase on 2nd September, prioritising clinical areas agreed with service leads for wards, theatres, outpatients and ED before moving onto corporate services • Project on track to complete the refresh of 1100 devices by the end of the year and ensure that these devices support Windows 10
Windows 10	• 3100 devices to upgrade to Windows 10 by Jan 2020 • Project formally started on 2nd September and on track to upgrade the PCs by the end of the calendar year

Office 365	• Migration of Trust email and office systems to a hosted email environment by the end of 2019 • Additional functionality available through Office 365 • Infrastructure and network readiness is in test • Communication plan is being developed with communications team. Service champions are being identified to act as super users and receiving training and support in key functionality • Proof of concept planned for September, full migration scheduled for November 2019
Community Service Improvement Plan	• Community Staff Migration: migration of users scheduled over the weekend of 10th September, due for completion by 19th October • New devices for community teams are being delivered as part of migrations and PC refresh/Windows 10 programmes • Work ongoing to improve the connectivity, wi-fi and network performance at all community sites, and for this to be completed by the end of December • Service Delivery: Plans to consolidate community IT support through Informatics Merseyside due to fragmentation of current arrangements and poor staff experience
Critical Area Floorwalking	• Process started and evolving for technicians to undertake proactive visits each day in Theatres, ED, Wards and Outpatients, checking in with service leads for any priority issues to resolve, auditing kit and undertaking device health checks

5. Alder Hey Technology Roadmap – Data Centre Strategy and Resilience

Significant work has been undertaken with regards to Alder Hey's data centre strategy and resilience.

Investment has been identified through the Trust capital programme to put in place systems to increase the level of resilience in Alder Hey's IT infrastructure. Progress has been excellent with actions in place for completion by the end of 2019.

Strategically, plans are agreed to work in partnership with the Clatterbridge Cancer Centre on infrastructure and resilience. This partnership will enable cross working, joined up vendor management, sharing of skills and ultimately a high quality, high standard infrastructure to support front line clinical teams.

6. Digital Transformation Programmes

6.1 GDE/HIMSS

Intense work continues with regards to the ongoing implementation of the GDE programme. As we head into the last 8 months of the programme, areas of focussed attention move to the GDE and HIMSS Level 6/7 accreditation activities.

Dates have been agreed with HIMSS to undertake the Level 6 assessment at Alder Hey in November. Work continues with addressing gaps to achieve HIMSS Level 6 accreditation with specific focus on electronic notes and closed loop technologies. Work on completion of specialty packages continues at pace as does the implementation of the regional Share2Care programme which was supported through Alder Hey's GDE Programme.

Profile of the GDE programme and Alder Hey Digital Futures is high with excellent feedback from NHS England, NHS Digital and NHSX. A team presented at the NHS Expo event with excellent responses to the progress that has been made. Alder Hey GDE blueprints are available and accessible to the rest of the NHS including specialty packages, share2care and paperless PICU.

6.2 Meditech Expanse

The next generation EPR for Alder Hey has formally commenced with the programme of work being initiated. This work will see the implementation of Meditech Expanse as a next generation web based EPR for Alder Hey staff.

A programme lead has been appointed, and contracts signed with the supplier. Key next steps are mobilising governance, identifying a programme and engagement approach with staff, preparing the hardware infrastructure with a view for software to be available for our staff to start to design and work with from November/December 2019.

Go live dates have been identified as September 2020. This will be a major delivery programme for the Trust in 2020 and will be the first Expanse implementation within the NHS.

7. Key Risks

There are a number of key risks being managed in terms of strategy mobilisation including:

- Capacity across organisation to mobilise complex and high volume programmes of work
- Scale of work in 2019 – mitigated with plans and dedicated delivery resources
- Internal skills – strengthened with recent recruitment
- IT resilience – mitigated through plans in place
- HIMSS Accreditation – challenges with closed loop technologies being managed with dedicated nursing capacity and ward level engagement / plans

8. Summary and Recommendations

Rapid progress against a number of major areas has been made following the approval of the Digital Futures strategy in July 2019.

Whilst there is a significant amount of challenging work in train, plans are developed and clearly understood against priority and nationally directed programmes.

Trust Board is asked to:

- Note the progress with the mobilisation of the digital futures strategy
- Note Operational IT key performance indicators
- Support progress with resilience plans
- Note progress and agreed timeframes for next Generation EPR programme

Kate Warriner
Chief Digital and Information Officer
September 2019

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 01.10.2019

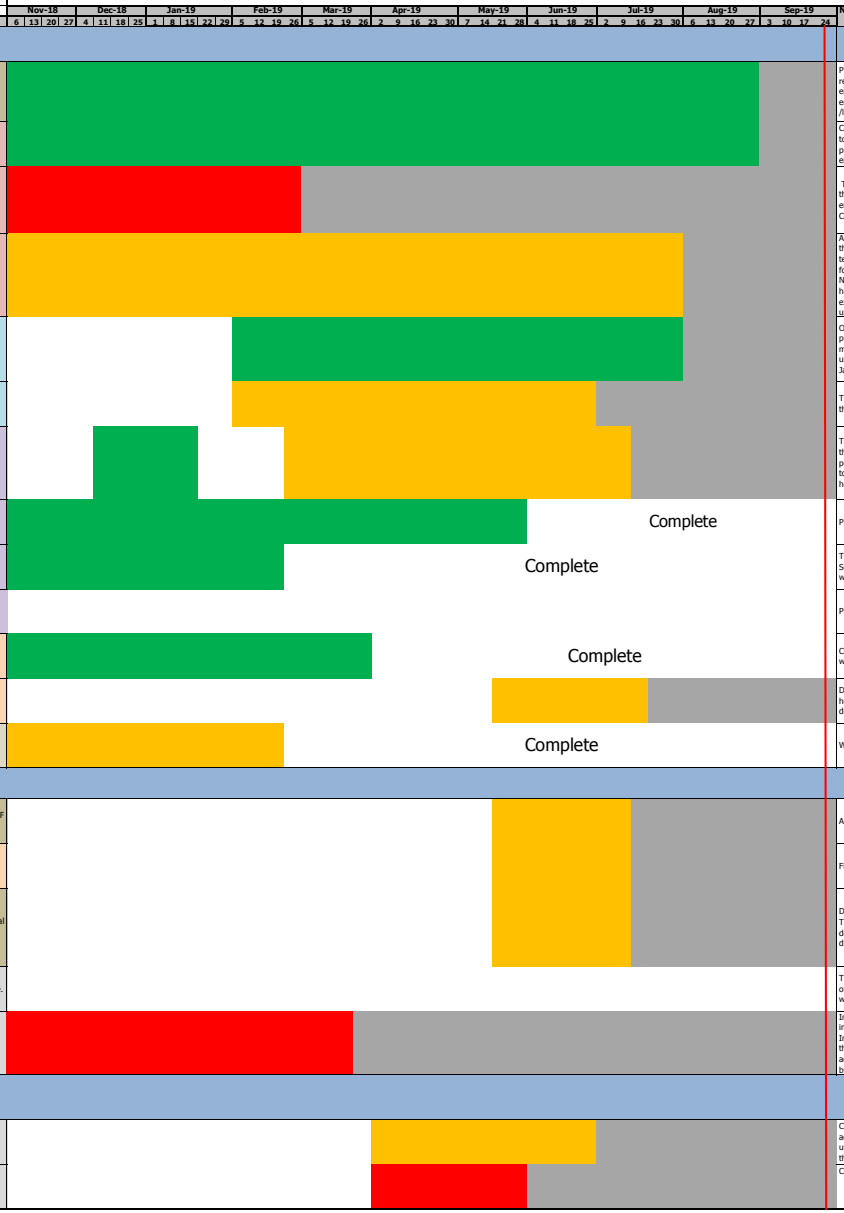
Paper Title:	**Alder Hey in the Park Site Development Update**
Report of:	**David Powell**
Paper Prepared by:	Sue Brown

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

Trust Board. **HIGHLIGHT REPORT Site & Park Development September 2019**

SRO: David Powell
Author: Sue Brown

Key
- Planned project timeline
- On track
- up to 3 months delay
- Over 3 months delay



Week Commencing	Narrative
Creation of campus	
Park Creation	Planning application has been resubmitted, going to planning committee in October for approval of the full reinstatement of the park and masterplan.. We are still planning to commence work on phase one towards the end of the year and the design team have met with a bidder following a tender exercise which completed at the end of August. A decision on the preferred bidder will occur during September with the construction /landscaping works commencing late this year into the first 2 months of 2020.
New Schemes: The Alder Centre	Construction of the Alder centre is well underway, Building is taking form on site, the topping out ceremony took place on the 11th of September and was a successful event. Construction is on plan and in line with the project delivery programme. Funding discussion with the charity continue in relation to the overall financial envelope and their contribution.
New Schemes: Community Cluster	The (Pre-contract service agreement (PCSA) has been agreed with Galliford Try, sign off at executive level of the contract is due to occur in September with a delay of one week, this process extends for 12 weeks , ending in November 2019 . Construction budget has now been set at £13M following a reduction to the GIFA . Construction is due to commence in January 2020 .
New Schemes: Neonatal Unit	A number of options have been examined over recent months and it is more likely that to deliver as close to the HBN guidance and the user requirements a new build/extension to the CHP will be required. The Project team are currently working with all the relevant professions to develop a full brief that can go out to the market for design/construction in November following Board approval on the basis that this s achieved at the November Board . Enquires in relation to a feasibility study via the PFI process and any interest they would have in delivering the development is ongoing as planned date for feedback has been delayed and is now is expected in circa 3 weeks, however an option appraisal on the procurement route for the development is under consideration and will require executive approval.
Support Scheme: Infrastructure	Ongoing review and scoping of future infrastructure requirements in relation to additional new builds are being pulled together with specification in line with the planned programme for the new builds and the overall masterplan for the site developments. Exploration of a number of grants and subsequent applications is underway. the programme plans for all information to be presented and approved by the trust board in January 2020
Support Scheme: District Heating	This opportunity is under assessment but has some delay due to issues on the core schemes detailed above, this is still under consideration..
Site Clearance: Demolition & decommission Phase 2	There has been a two month delay to the decommissioning and demolition plan due to the delay in signing the lease on the police station and some IM&T main cables & services disconnection The delay has led to a £2k per week cost which could impact slightly on the budget. The project team are currently looking at an option to release a number of buildings earlier than planned in the next phase (Oncology, Mgt Block, Genetics, Boiler house and CBU management/estates block), which if successful will release buildings from June/July 2020.
Site Clearance: Relocation of on-site services/corporate teams	Planned relocation have been completed
Site Clearance: Temporary car park	Temporary car park work and move completed. Some further work to assist with footpaths and the main road may be required and funding is being sought within the Trust to assist with this at a cost of C. £90k
Site Clearance: Housing residual teams e.g. medical records	Planning work to commence in September
North East Plot: Land sale	Completed at the end of March 2019. Work with the developer will continue to ensure the development fits in with the larger campus plans and local residents.
NE Plot-Staff amenity spec	Discussions commenced with regard to what the opportunities are there for services such as a crèche/gym, hospital staff accommodation. A staff survey provided favourable results in pursuing these types of development.
Community Services: Kilby house	Works completed, lease agreed and signed and all moves completed
Exploitation of Campus	
Health and wellbeing: linkage to UNICEF CFC	Alder Hey to approach LCC for initial discussions on out of area placements/service needs.
Science & Knowledge	First Step involved in discussions with the trust and KQ team on the opportunities for the future.
Regeneration/community building: local ownership model etc.	Discussions on community ownership mode have now commenced with Capacity Lab who are supporting the Trust in developing the brief for this work and also in bringing interested partners into discussions on the park development. A substantial partner has expressed interest in supporting the current phase development and discussion with them will continue throughout September and October
Exploring linkages with Broadgreen site.	This project still at the exploratory stage, however an initial discussion with Broadgreen re potential for sharing of some accommodation for offcies has been explored and ruled out as the space was on along lease and would need complete renovation and refurbishment.
Securing Neighbourhood sites (police etc.)	In relation to the eaten road area, this activity is delayed due to focus on the short term issues above. The immediate targets are the police site, the DoE building and the vets practice. Initial offers have been made on two buildings (the Knotty Ash Care Home which is adjacent to Alder Hey on the other side of the Loop line and a building on Prescot Road, both of which could be considered for office accommodation) The Structural survey has been completed on 410 Prescot road and is currently under review by the trust advisors..
Other	
Space Utilisation review	Currently reviewing external organisations that can assist in this process, with particular attention to office accommodation and utilisation across are participating in a selection process and quoting for work to be undertaken. Three organisations are participating and the process should concluded with a recommendation to the executive team early October.
Post occupancy evaluation:AHP	Currently reviewing literature and developing options for this assessment.

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Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 01/10/2019

Paper Title:	Integrated Governance Committee (IGC)
Report of:	Kerry Byrne, Non- Executive Director, Chairperson Integrated Governance Committee
Paper Prepared by:	Cathy Umbers, Associated Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Integrated Governance Committee minutes and associated papers
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 identified

1. Introduction

The purpose of this paper is to provide the Board with assurance that the Integrated Governance Committee (IGC) is compliant with its terms of reference.

2. Background

The Divisions and Corporate Services presented their Risk Management Reports to the committee, focusing on high risks, and others that required committee input. The Corporate Risk report was also presented and discussed, including evidence of improvements, areas where further work was required to ensure the risks are mitigated to tolerable level. The committee was advised that there are currently 25 high risks identified in the Trust, 7 new high risks were identified since the last reporting period and 2 high risks were closed. The Board Assurance Framework (BAF) was also presented and it was noted that it has been restructured enabling more effective clarity around the controls to mitigate risks. In addition, the BAF policy was reviewed and ratified. The Committee noted the current compliance against the NHS England Core Standards for EPRR and its statutory responsibility under the Civil Contingencies Act 2004 and the training and exercising programme for 2019/20.

3. Conclusion

While it was acknowledged that good progress has been achieved in managing risk, it was agreed that further focused work is required to enable the committee be assured that risks are being managed effectively in all Divisions and Corporate Services. Therefore it was agreed that going forward the Corporate Risk Register Report, BAF and the BAF deep dive will be moved to the top of the agenda. The Division leads were also advised to focus on risk management in their services and review effectiveness of assurance processes. This will support the work of the Integrated Governance Committee going forward.

4. Recommendations

The Board is asked to note the content of the Integrated Governance Committee minutes and assurance progress.

Alder Hey Children's NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE
10th July 2019
Time: 10:00-12:00
Venue: Institute in the Park, Large Meeting Room

Present:

Mrs K Byrne	Non-Executive Director **(Chair)**	(KB)
Mr J Grinnell	Director of Finance	(JG)
Mrs E Saunders	Director of Corporate Affairs	(ES)
Mr P O'Connor	Deputy Director of Nursing	(PO)
Mrs M Swindell	Director of HR & OD	(MS)
Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mrs R Greer	Assoc. Chief of Op (Community)	(RG)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)

In Attendance Other:

Mrs J Keward	Infection Control Nurse	(JK)
Mrs J Hutfield	Compliance, Risk & Contracts Manager	(JH)
Ms Lesley Calder	Minute Taker	(LC)
Ms Glenna Smith	General Manager, Medicine	(GS)

In Attendance:

Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mrs C Fox	Programme Director for Digital	(CF)
Mrs S Brown	Senior Project Manager	(SB)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mr J Taylor	General Manager – Innovation	(JT)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Mrs J Fitzpatrick	Information Governance Manager	(JF)
Mrs A Kinsella	Health & Safety Manager	(AK)
Ms L Fearnehough	Head of Technical Services	(LF)
Mrs S Brown	Senior Project Manager	(SB)
Mr S Atkinson	Interim Associate Director of Estates	(SA)

Apologies:

Mrs C Barker	Chief Pharmacist	(CB)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mrs N Murdock	Medical Director	(NM)
Mrs L Robinson	Quality Assur & Compliance Manager	(LR)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mrs L Cooper	Divisional Director of Community	(LC)
Mr D Powell	Director of Development Directorate	(DP)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mrs V Weston	Assoc. Dir. of Infection Prevention	(VW)
Mrs P Brown	Director of Nursing	(PB)
Mrs J Preece	Governance Manager	(JP)
Mr A Bateman	Chief of Operations	(AB)
Mr M Flannagan	Director of Communications	(MF)
Mr A Hughes	Director of Medicine	(AH)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
	2.	**Chair's introduction**	KB thanked the committee for getting the papers in on time. KB advised there is no BAF Deep Dive Report being presented on the agenda today, however this will resume at the meeting in Sept 19. KB advised that there is currently inconsistency in the way that the Divisions are reporting their project related risks to IGC. KB advised that she has asked John Grinnell to look at how the project risks are reported to both Programme Board and IGC and suggest the best approach for reporting project risks to IGC. KB requested that going forward we will move the Corporate Risk Register, BAF and the BAF Deep Dive to the top of the agenda. KB advised that at a recent Quality Assurance Round (QAR) the team presented only 2 risks for their service. One of these risks had been closed as it had reached its target and the other was rated low risk. There were a number of items presented during the (QAR) that had risks associated with them. Staff acknowledged that although they were aware of the risks, they had not considered adding these to their risk register giving various rationales for this, although they recognised they were risks that could impact on patient and/or staff safety. In view of this KB asked the Division leads present to consider "How do they assure themselves that their teams are actively raising and managing risk across the different services or are they just taking it on trust? KB suggested that she would like to attend a Divisional Integrated Governance Meeting in each division to gain a better understanding of how this is managed and assurance provided. KB requested a schedule of meeting from each	Divisional Governance Leads to provide dates	AM / RG / CW	Immediate

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Division to enable her arrange attendance.	of their DIGC meetings for the rest of the calendar year.		
19/20/33	**2.1**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 22nd May 2019. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	The Committee reviewed each of the outstanding actions and updates have been included in the Actions Log at the end of the minutes.			
	2.4	**IGC Review of Terms of Reference**	**Resolved** that: the TOR was ratified subject to no changes requested from the committee in the next 5 working days.			
	2.5	**IGC Annual Report**	**Resolved** that: the Annual Report was ratified subject to no changes requested by the committee in the next 5 days.			
	3.	**Risk Register Management Reviews**				
Item no	**Item**	**Key Point Discussions**		**Action**	**Owner**	**Time Scale**
19/20/36	**3.0**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. • Total number of risks = 61 • Number of new risks identified since the last reporting period = 6 (1904, 1905, 1906, 1907, 1908, 1914) • Number of risks closed and removed from the risk register = 3 (1563, 1824, 1842)			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		• Number of risks with an overdue review date = 1 (AM advised this has been reviewed since production of this report) • Number of risks with no agreed action plan = 11 • Number of high/extreme risks escalated to the Executive Team = 4 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **High risks with a score of 15+** **Risk no 1588 (risk rating 20):** "**Ventilation System on Critical Care."** AM advised this risk has been on for some time and it has increased in score from 10-20. The Trust had originally decided to accept this risk but it has since been reassessed. The Trust has had a Measles outbreak which Infection Prevention and Control are leading on and this is the reason for the increased risk score. However, it is expected this will be reduced soon. **Risk no 1887 (risk rating 20): "Unsafe patient area; roof leaking into bed spaces 45 & 46 orange pod (HDU)".** Temporary measures have been introduced and the beds re-opened **Risk no 1306 (risk rating16):** "**Concerns around junior doctor shortages in surgery."** AM advised this risk is due to gaps in the junior doctor's rotations and there are concerns around the Feb rotations which the Medical Director has been involved in addressing. KB asked is there a timescale for this plan? AM advised there are proposals within the division but need to have further discussion with the Medical Director. **Risk no 964 (risk rating15): "The process for planning and**			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		scheduling of elective lists in not robust enough to prevent errors occurring." AM advised that there is a pilot electronic template which has been agreed and will go live from July 19 and then rolled out. KB asked will the pilot reduce this risk to an acceptable level? AM advised that a consistent electronic system will ensure the risk is mitigated. **<u>Risks scores increased</u>** **Risk no 1588 (see above)** **<u>Risks scores decreased</u>** **Risk no 1870 (from 15 to 10): "A patient attending the ward could deteriorate clinically and this may not be recognised due to lack of monitoring of their condition."** There is no suitable clinical area within the ward environment to monitor these patients and there is limited nursing staff available to monitor their condition and escalate if there is any deterioration. Key actions were agreed at a meeting held on 29.04.19 with Neurosurgical Consultants, Advance Nurse Practitioners and Junior Dr's. Matron and ward manager also present. This included "an agreement that if no bed is available on 4A in which to review a patient attending the ward with an acute neurosurgical issue, then the patient will attend AED and be reviewed in that department by the neurosurgical team". **Risk no 544 (from 9 to 6): "Cancelled cardiac operations**." Risk reviewed, and current controls have enabled sustained reduction in cancellations over recent months. **Risk no 1731 (from 8 to 4): "CPE management on 4A."**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Retractable screens in place in the HDU bay (orange pod, beds 1-4). This risk is now at target i.e.4 **Risk no 1351 (from 4 to 2): "Lack of nurses trained in using varying types of ventilation for neurosurgical, craniofacial and orthopaedic pre and post-operative patients."** Training programme has commenced and will continue to be monitored via ward manager and practice education team. Once assured that the correct level of staff have had initial training, this will be monitored through ward TNA and risk closed/reduced as appropriate. Risk at target on the register AM advised that clinical risks are the biggest category of risks on the register. The division of surgery has interrelationships with other services/depts. and these risks are looked at, at the divisional risk register workshops. 98% of risks are in review date. CU asked if the division are up to 98% risks reviewed what is being reviewed if you are already providing this assurance. AM advised the reviews to take place are on status or risk score. There is a bit of housekeeping to do to look at whole assessment to actively review all risks. CU advised that at a recent Division of Surgery risk revalidation meeting **Risk no 1881 (risk rating 12)** was discussed and concerns were raised about lack of progress to resolve **"** If there is no reception staff, parents will attempt to gain access by either tailgating or using the door release button under the desk". This risk had been raised at PICU quality assurance round on 24th April 2019 at which time escalated to Chief Nurse who actioned immediately, meeting			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			with ward manager and actions were agreed to mitigate it. AM advised the risk remains at risk rating of 12. There is an agreed action plan after discussions with the Chief Nurse. There is frustration around the pace of implementing the plan in the agreed timescale. JG advised this needs to be addressed quickly as there is a risk to patients and staff as families are tailgating access to ICU when they don't need to be there. MD advised that every pod has CCTV as does the link corridor. JG advised the risk is still showing as a risk rating of 12 and needs to be addressed asap. AM to provide a progress update to the next IGC Meeting. AM advised that reviewing risks on the risk register within the timeline is much stronger for the Surgical Division; however there are still a number of actions outside of the review date and this is being addressed. **Resolved** that: the Committee NOTED the contents of the paper	Risk no 1881 AM to provide an update to next IGC Meeting	AM	11th Sept 19
19/20/37	**3.1**	**Medicine Division**	Glenna Smith (GS) presented the risk management report for Medicine. • Total number of risks = 86 • Number of new risks identified since the last reporting period = 6 (1889, 1891, 1901, 1902, 1910, 1913) • Number of risks closed and removed from the risk register = 12 (1502, 1749, 1764, 1793, 1831, 1821, 1826, 1830, 1834, 231, 863, 935) • Number of risks with an overdue review date = 24 • Number of risks with no agreed action plan = 6			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			(884, 941, 1901, 1344, 581, 1605) • Number of risks with changed risk scores = 20 • Number of high/extreme risks escalated to the Executive Team = 6 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 GS advised that she has spoken to AH regarding the overdue risks and those with no action plan and there is a commitment to update these asap and so there should be an improvement for the next IGC meeting. **New risks** **Risk no 1889 (risk rating 4) "Access to 3 treatment rooms that house the CDs cupboard, Medicine storage facility, sharp instrumentation storage and waste sharps bins during 08:00 - 18:00 are not locked because they are constantly in use which could result in unauthorised access to these items."** Swipe access is to be put in place. This was identified by an environmental risk assessment completed March 2019. CU advised this risk score is low for this risk, considering the current gaps in controls and the fact that swipe access is not yet in place. GS advised she will pick this up with the risk owner. **Risk no 1891 (risk rating 6) Metabolic Service: Safety issues (maintaining patient safety, inpatient and outpatient)**. Manchester Dietetics team supportive of maintaining service and delivering care at Alder Hey, therefore risk reduced. **Risk no 1901 (risk rating 4) "Infection risk to patients and staff."**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Hydro pool water checked weekly. No recent incidents reported. **Risk no 1902 (risk rating 6) "Inability to deliver a safe clinical service for ED and Major Trauma or provide leadership to the ED for service development and improvements. Inability to deliver core departmental activity such as undergraduate and postgraduate training".** Interviewed and appointed 1.6 WTE due to commence in post in November. Currently covering gaps with locum posts. Speaking to Consultants in the region who have covered Locum consultant's shifts to see if a regular shift is more appropriate. Daily monitoring to ensure safe service. **Risk no 1910 (risk rating 9) "Lack of interventional radiology capacity".** GS advised that a consultant has been employed to provide cover. Further actions to mitigate are progressing. **Risk no 1913 (risk rating 12) "Inappropriate resuscitation Practice"** The cause of this risk is identified as "Failure to comply with C26 'Children's Advanced Care Plan Policy. Not all inpatient resuscitation plans are documented on Meditech. Report is not run regularly. No system for chasing up resuscitation plans that have not been reviewed. Handover does not always include detail of resuscitation plans." Controls include: Resuscitation policy, Meditech report identifying patients with inpatient resuscitation plans and mouse mats introduced in clinical areas detailing how to access advanced care plans and resuscitation plans. Actions being taken include: Task and finish group convened to review issues, identify options and make recommendations.			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Closed risks (1502, 1749, 1764, 1793, 1813, 1821, 1826, 1830, 1834, 231, 863, 935) **High risks** **Risk no 884 risk rating 16 "Failure of RO Plant supporting Haemodialysis"** Current controls: Internal workarounds and testing of water quality by clinical team, weekly checks from IFM and meetings with Interserve and Renal Team to provide assurance regarding delivery of operational plan. GS advised that due to the leaks they are working with Manchester and the Royal to provide services. **Risk no 1726 risk rating 12 "Significant delay in scanning turnaround times".** Current controls: Scanning turnaround times being monitored as part of weekly 'ComCell' meeting and is being monitored via the corporate report on a monthly basis. Actions being taken: IM&T to work on establishing Cold Feed into Image Now/Stratus to eliminate scanning. Task & Finish Group established to identify actions to mitigate risk, fortnightly meetings commenced. Risk reviewed and remains as is. Actions from Task & Finish Group continue to be undertaken however turn around remains at 21 and 51 days. **Risk no 1169 risk rating 20 "Fragile Medical Workforce within the Haematology Service".** Current controls: 2 x Advanced Nurse Practitioner (ANPs) in place to support ANP gaps. Recruitment of 2 Locum Consultants. Actions being taken: ANP training programme in place - 2 staff on the course and job planning for Haematology. Haematology Briefing paper written and discussed with Medical			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Director and the Chief Operating Officer on 31/05/2019. Paper contained an update on the current status of the service, plus a range of options we are working through to cover the on call service. Further meeting with Medical Director and Head of Haematology on the 7th June 2019 to discuss progress. Meeting arranged for 12th June with Head of Haematology and Consultant Haematologist from the Royal Liverpool to progress. These actions are being monitored on a daily basis. Confirmation that Locum Consultant will be re-joining the service on the 1st August 2019. GS advised there is a plan in place to cover on-calls till November 19 and that the Division of Medicine are working with the Haematology Service at the Royal to provide the service after that time. The Division of Medicine are doing all they can to mitigate this risk, however the risk score remains the same. **Risk no 1251 risk rating 16 "Lack of Consultant cover for Palliative Care".** Controls include Consultant Paediatric Nephrologist to provide cross cover and meetings arranged between Medicine and Community Division management teams on a 2-3 week basis. Actions being taken include: working with Commissioners to develop a transformative model of care for Alder Hey and the region. Solution of recruiting an additional Consultant from Chester has not evolved, meeting held with Divisional Director, Divisional Associate Chief Nurse and Service Manager to discuss the plans regarding possible solutions. The Trust's Chief Operating Officer is meeting with the senior leadership team within the Division to discuss and monitor progression of the work plan. GS advised that the Palliative Care Consultant is looking at the plan of joint working across Medicine and Community to ensure a service is ongoing. There are not many Palliative Care Consultants to recruit to the service. GS advised there is considerable work to complete to get this up to date.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1730" Risk rating 15 IT design of the Neurophysiology Department" "Current design of the neurophysiology department with standalone network for EEG explorations and standalone machines for EMG, intra-operative monitoring and invasive EEG related imaging is vulnerable to failure. Recent incidents have been recorded in relation to this risk." Controls include functioning PC in place with access to all systems were required and additional PCs are now available within the nursing area of the department and Trust laptop available for use. Action plan in place; awaiting further contact from the department to follow up issues being tracked as part of the issue log. LF advised IT are working with the department to integrate the Neurophysiology network transfer to Alder Hey. KB asked can this reduce the risk once the integration has taken place. LF advised yes it will mitigate the risk. **Risk no 1787 Risk rating 15 "Error in the prescribing, preparation, administration and monitoring of Parental Nutrition (PN)"** Controls include the PN Policy, Alaris GP pumps have had profiles added to help prevent mix up of rates, template prescriptions contain information to guide prescribers in the prescribing of PN. Actions being taken include: Non-medical prescribers (dieticians and pharmacists) to be appointed to support prescribing and the development of a Trust Nutrition Team, different coloured light protective bags to be introduced for PN within the Trust, prescribing of PN through the Meditech system will be pursued. Risk reviewed and actions updated following meeting 14/06/19. No change in risk score yet.)			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			GS advised that the Medicine Division are reducing their risks even though there is not a significant reduction at this time. There is still a lot of work to complete, however she is confident the Division is showing assurance of effective management of risk. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/38	**3.2**	**Community Division**	Rachel Greer (RG) presented the risk management report for Community. • Total number of risks = 52 • Number of new risks identified since the last reporting period =4 (1890, 1900, 1915, 1918) • Number of risks closed and removed from the risk register = 4 (1779, 1782, 1783, 1791) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 4 (reduced to 1 since production of this report) • Number of risks with changed risk scores = 6 • Number of high/extreme risks escalated to the Executive Team = 3 (1524, 902, 1270) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **New risks** **Risk no 1890 risk rating 9 – "Risk of children, families and staff exposed to verbal confrontation and unpredictable behaviour in Outpatient G2 reception/waiting area (current risk score: 9)"** Risk of confrontation in G2 area caused by unpredictable behaviour			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			from public. Controls in place include: introduction of nursing comfort rounds. Violence and Aggression Policy in place. Actions "Complete violence and aggression risk assessment on all floors of Outpatients, including nursing and reception areas." Further additional actions to be added. **Risk no1900 risk rating 9 – "Risk of breach of confidentiality and impact on privacy and dignity due to the design and size of the fracture bay environment"** Fracture bays in ground floor Outpatients are unfit for purpose; small and confined area of outpatients. Controls in place are that only patients ready to be seen are called forward; curtains are in place for privacy and dignity and Privacy and Dignity Policy in place. Further action is to install screen filters to all computers in the fracture bays once received. **Risk no 1915 risk rating 9 – "Data quality errors with multiple ways to book / cancel and re-book appointments."** This is a Trust-wide issue as over 270 staff have access to book appointments. Controls include, user guides and training in place for PCOs and reception staff and waiting lists reviewed at the Weekly Performance Meeting with errors picked up. Further action is for BI to develop monitoring reports. **Risk no1918 risk rating 9 – "Post GDE Community Physio EPR not fit for purpose; incomplete clinical records**" Lack of GDE developer time allocation has meant that changes required following the 3 month post go-live (22nd Jan 2019) test period have not been implemented and the new electronic patient record is not fit for purpose. Gap in control identified is lack of developer time and capacity to address the issues. Further action is to report ongoing issues to GDE developer and monitor progress.			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Increased risks **Risk no 902 - risk rating 16 (increased from 12) "Inadequate connectivity in community sites and outreach venues for clinicians to view patient records electronically."** Risk score increased following escalation at Divisional Board in May 2019. Incidents relating to access to Citrix and L Drive continue to be reported. Staff not reporting any improvement in connectivity, therefore escalated risk due to length of time risk has been on risk register and potential for realisation. One of the main gaps in controls is staff's lack of influence on some of the providers who need to contribute to solutions as well as lack of consistent Wi-Fi in community settings. RG advised there is a delayed action plan in relation to the connectivity in the community and there have been more issues with this recently. This represents an increase in risk and Community are working with the Chief Digital Officer to mitigate. **Risk no 1270 – 16 (increased from 12) "Waiting time for ASD and ADHD assessment".** Lack of capacity to deliver the assessment due to increased demand. Misunderstanding that families believe there is lack of support available without a diagnosis. Risk score increased following escalation at Divisional Board in June 2019. Current controls have not managed to reduce risk and backlog of children and young people waiting for assessment has increased therefore risk score has increased. Retention of current staff and ability to recruit to vacant posts is a gap in the controls while demand for the service is increasing. RG advised the plan went to Exec Meeting and Trust Board. There are actions in place to agree the improvements and support mitigation of risk. **High risks score 15+** **Risk no 1524 risk rating 16 – "Risk of harm due to inappropriate**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			care or advice provided to patients by paediatricians and specialist nurses with lack of clinical knowledge about this age group and their presentations." There is lack of capacity in adult ADHD service to transition patients. Adult ADHD service has in excess of a 3 year waiting list. RG advised that transitioning over to adult services has been delayed. Actions in place to manage but dependant on adult services **Risk no 1270 (see above)** **Risk no 902 risk rating 16 (see above) – "Inadequate connectivity in community sites and outreach venues for clinicians to view patient records electronically."** RG advised there has been an increase in the number of risks caused by the transfer of risks from the Outpatients Department to Community and that some of the new risks are related to Outpatients. RG advised the committee that the Division are confident they are effectively managing the risks for Community, while recognising there is ongoing work required. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/39	**3.15**	**Research Division**	Jason Taylor (JT) presented the risk management report for the Research Division. • Total number of risks = 5 • Number of new risks identified since the last reporting period = 1			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 1 (1751) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risks with a score of 15+</u>** **Risk no 1751 risk rating 15 – "Unsustainable business model for clinical research and the research strategy."** This risk was first identified on 24th October 2018. The research finance model does not enable both research growth and a contribution to the overall Trust's financial solvency. Research income contributes to some of the funding however there is insufficient funding to allow growth of the team and only supports the research delivery staff and no additional support. JT advised the division are trying to resolve the business research model and will provide an update at the next IGC Meeting. (Existing action 18/19/38 in relation to this). JG advised that the business model has been now been approved. JT advised clinical research is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/40	**3.3**	**Infection Control**	Jo Keward (JK) presented the risk management report for Infection			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
		Service	Prevention and Control. • Total number of risks = 10 • Number of new risks identified since the last reporting period = 2 (1919, 1374) • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 1 (795) • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 2 (1593, 654) • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 2 (654, 1919) **New risks** **Risk no 1919 risk rating 15 "Failure to reach 80% compliance with front line staff influenza vaccination in 2019-20."** JK advised this risk relates to failure of meeting CQUINN target requirements. There are concerns with staff engagement. The IPC team have been scanning the potential for increased cases of influenza, noting Australia has seen 3 times more cases. Current controls include plan for Flu campaign, Staff Vaccination Policy, monitoring compliance via IPC compliance dashboard, shared across the Trust. There are actions in place to mitigate risk. This risk is interrelated to risk 654 (see below)			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1374 risk rating 4 - "Increasing prevalence of HCAI MSSA Bacteraemia within the Trust" **<u>Increased risks</u>** **Risk no 654 risk rating 16 (increased from 12) "Staff acquiring airborne hospital acquired infections whilst delivering patient care".** The issue causing this risk is "Failure to ensure an adequate seal whilst wearing the respirator could lead to staff being exposed to infectious particles". Fit testing for FFP3 respirators ensures that there is an adequate seal and that the most appropriate mask is used. All staff undertaking aerosol generating procedures or caring for patients under airborne isolation must be fitted tested. This risk has been increased due to the high risk of a more widespread flu in 2019/20 and poor uptake of training. There are difficulties in getting a FIT Tester in each area or providing the capacity to enable this. KB asked if training was mandatory. JK confirmed the training is mandatory. JK advised that there is a comprehensive plan in place to ensure actions are being performed in areas and is being monitored centrally by IPC and Divisions have been asked to provide a training plan to ensure all necessary staff have been trained. CU asked what is being asked for in the plan. IPC have asked for assurances of training completed over a 1 month period. CU advised that the IPC team should arrange a meeting with Triumvirate in the three divisions to ensure the expectations are clear and the plans are consistent across the Trust. JG agreed with this suggestion.	Risk 654 VW/JK to arrange meeting with 3 divisions to clarify expectations and ensure consistency of plans across the Trust.	VW/JK	11 Sept 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			MS advised that a number of the IPC risks have MS as the owner. MS to speak to VW as if MS not the right owner who will they assigned these risks to? CU advised that before putting a lead on any risk the lead should be made aware. KB advised the lack of completion of FIT testing should be referred to CQAC for a deep dive to be completed and reviewed. KB to contact Chair of CQAC **<u>Decreased risks</u>** **Risk no 1593 – risk rating 8 (reduced from 12) "A patient can acquire a HCAI due to inadequate deep cleaning process".** Agreed at IRG June 2019 the Trust will hire 3 UV machines with a view to purchase. Discussions are currently taking place with the company to organise this. New cubicle validation process with ATP swabs has now commenced. **<u>Overdue risks</u>** **Risk no 795 risk rating 12 – "Risk of infection to patients, staff and public from possible contamination in the water system."** Water temperatures are not in line with Health Technical Memoranda (HTM) regulations. IPC have been unable to review this risk as the IPCT are not able to action and mitigate it, therefore Building Services has been requested to review it. JK advised IPC are satisfied with management of risks on the register. **Resolved** that: the Committee NOTED the contents of the paper	MS to speak to VW about risk leads for IPC risks	MS	11 Sep 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/41	**3.4**	**Facilities**	Mark Devereaux (MD) presented the risk management report for Facilities. • Total number of risks = 10 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 (1456) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk score = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **Closed risks** **Risk no 1456 risk rating 3 – "Reduced CCTV Coverage on Retained Estate."** MD advised all risks are within review date and Facilities are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/42	**3.5**	**IM&T**	Leanne Fearnehough (LF) presented the risk management report for IM&T. • Total number of risks = 16			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 3 • Number of risks with an overdue review date = 1 • Number of risks with no agreed action plan = 1 • Number of risks with changed risk score = 1 • Number of high/extreme risks escalated to the Executive Team = 3 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risk with a score of 15+</u>** **Risk no 947 risk rating 16 – "Meditech Infrastructure does not have hot fail over site (Disaster Recovery Platform)."** Risk reported on the BAF. CDIO to include costs as part of the overall strategy for IM&T to go to Board for approval July 19. **Risk no 1187 risk rating 16 – "Server infrastructure no longer replicated to a secondary site."** Risk reported on the BAF. A proposal has been presented by Dell Technology to address the lack of resiliency within the existing infrastructure on 09/0719. This provided the Trust with 3 solutions, associated costs and benefits/ risks. This will be going to Executives for approval. **Risk no 1701 risk rating 16 – "Loss of access to patient data/ records held in MD Analyze"** Support in finding adequate support for existing solution and resources to instate a support contract. LF advised there was a			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Data Centre Workshop held yesterday and it is going to the Executive meeting for discussions. KB asked LF to complete the risk details on the financial implications on the IM&T report. CU advised LF to update the assurance statement in the report, as 6.25% is incorrect and once amended send through to LC. LF advised that IM&T have improved greatly and have had a thorough review of the risk register and are comfortable with their current position. **Resolved** that: the Committee NOTED the contents of the paper	LF to complete details on the financial risks on the IM&T report. LF to update the assurance statement and send through to LC	LF LF	11th Sept 19 24th July 19
19/20/43	**3.6**	**Human Resources**	Melissa Swindell (MS) presented the risk management report for Human Resources. • Total number of risks = 8 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 (1736) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 1 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention IGC = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Closed risks **Risk no 1736 risk rating 6 "Lack of available local union representatives."** Actions in place to help mitigate. MS advised that Human Resources have had a thorough review of the risk register and comfortable that all risks have been reviewed with action plans in place. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/44	**3.7**	**Finance**	John Grinnell (JG) presented the risk management report for Finance. • Total number of risks = 5 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 JG advised the committee that the Finance department have no overdue and no risks without agreed action plans and are 100% compliant and are satisfied at this point with the risks on the register. **Resolved** that: the Committee NOTED the contents of the paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/45		**Building Services & Estates**	Graeme Dixon (GD) presented the risk management report for Building Services. • Total number of risks = 10 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 2 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 2 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risks with a score of 15+</u>** **Risk no 1388 risk rating 20 – "Pipe corrosion"** Meeting held with Execs/Non Execs on current status. Monthly meeting to be planned with the SPV (landlords) in order to track actions and progress. GD advised that Building Services is waiting an update from SPV regarding the pipework as there are 35 areas to date that need replacing. The work will be completed once we have a pipework specialist to complete, as this work has gone out to tender. GD advised that the pipework is being monitored rather than replaced by SPV at this time. The thermal imaging that is being used determines category 3- 4 corrosion. There are reports available of where all the category 3-4 corrosion points are and this is being acted on accordingly. JG advised going forward GD needs to have input into all the Corrosive Pipework Meetings with SPV and			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			therefore is to attend meetings. The next meeting is scheduled for 17th Sept 19. **Risk no 825 risk rating 15 – "Internal balconies".** Feasibility study undertaken by contractors on the 26th April 19. GD advised that the 'Feasibility Study Report' has been completed and submitted there are 2 options to address the risk. GD advised he will send the report to the Executives for decision. Stuart Atkinson (SA), Interim Associate Director of Estates advised he has concerns of what is in place in the CHP building at present in terms of risk. Full length glass is a solution, however very expensive. Any changes will not happen quickly as the landlords need to agree any decisions the Trust makes. GD advised the current design of the balconies is standard which is included in other Paediatric Trusts however the balconies are not in the same position within the building in other Trusts. JG advised the Trust needs to find a route to a conclusion as we need to mitigate this risk. SA will provide an update at the next IGC Meeting. GD advised all risks are within review date and Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	Risk 825 SA to provide an update at the next IGC Meeting	SA	11th Sept 19
19/20/45a		**Development Directorate**	Sue Brown (SB) presented the risk management report Development Directorate. • Total number of risks = 12 • Number of new risks identified since the last reporting period = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of risks closed and removed from the risk register = 4 (1259, 1880, 1817, 1872) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 3 (1 increased 2 decreased) • Number of high/extreme risks escalated to the Executive Team = 1 (1241) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 SB advised there is an error in the changed risk scores and she will send an amended report through. **<u>Risks with Financial Implications</u>** **Risk no1241 risk rating was 16 – "Lack of Capital Funding for the Park."** Gaps in Controls: The original capital allocated was based on delivery of the Park in 2017. We are now planning to hand back the park to LCC in 2022 with inflation currently running between 30% & 40%. SB advised Development Directorate are currently looking at alternative designs to meet budget. **Risk no 1412 risk rating 9 "Contracts with Universities to support RE phase 11 are not yet signed."** SB advised that discussions and negotiation of space and building facilities has taken longer than anticipated to reach an agreement. There has been a change in contracts which has now been drawn	SB to send through an amended risk management report through to LC Risk 1412 SB to provide an update at next IGC	SB SB	18th July 19 11th Sept 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			up and letters went out to the Universities this week. SB to provide an update at the next IGC Meeting SB advised that the Development Directorate risks continue to reduce as progress is made, risks have been reduced within this reporting period, and the Directorate are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/46	**3.9**	**Health & Safety**	Amanda Kinsella (AK) presented the risk management report for Health & Safety. • Total number of risks = 9 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **Risk no 1836 risk rating 9 – "Lift Entrapment – arrangements for out of hours (Institute in the Park)".** H&S transferred this risk to the Estates Department as the risk refers to lift entrapment in the Institute in the Park specifically. AK advised the training of shift engineers has now been completed but there is	Risk 1836 AK to provide an update at next	AK	11th Sept 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			still the issue of what is in place to minimise risk out of hours. AK to provide an update at the next IGC meeting. **Risk no 1386 risk rating 12 – "Lift Entrapment – CHP"** Near miss incident (patient entrapment) – Design of lift car hatch to roof makes it extremely difficult to pass vital medical equipment into the lift in the event of entrapment. Following extensive reviews of the design with the lift company, they have presented a design and costings to modify each bed lift, making the hatch accessible, but also ensuring the lift is aesthetically pleasing. Decision required to proceed. If agreed to proceed to modify bed lifts, decision will be required if modification should be roll out to public lifts also. AK advised the report has been submitted to CPG and the Executives for financial approval and Building Services are waiting to start completion of the work. **Risk no 799 risk rating 12 – "Failure to control contractors on site (CHP) & Retained Estate"**. MS advised that H&S are still waiting on the report from MIAA. Once there is a solution this risk can either be closed or decrease the risk score. MS to provide an update at the next IGC Meeting. AK advised the committee that Health & Safety are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	IGC Meeting. Risk 799 MS to provide an update at next IGC Meeting.	MS	11th Sept 19
19/20/47	**3.10**	**Business Preparedness & Emergency Planning**	Elaine Menarry (EM) presented the risk management report for Business Preparedness & Emergency Planning.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Total number of risks = 13 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 (1469) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **Closed risks** **Risk no 1469 – risk rating 6"Emergency Preparedness Mandatory Training attendance below trust 90% target level".** Actions: 91% compliance has now been achieved. " EM advised the training attendance will continue to be monitored at the Emergency Preparedness Group Meetings. EM advised all risks are within review date and Business Preparedness & Emergency Planning are satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/48	**3.11**	**Information Governance**	Jo Fitzpatrick (JF) presented the risk management report for Information Governance. • Total number of risks = 8			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of new risks identified since the last reporting period = 1 (1903) • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = The new risk included is to acknowledge that the SPINE – PDS (Patient Demographic Service) is not always accurate which can potentially lead to a data breach at the Trust. **<u>New risks</u>** **Risk no 1903 current risk rating 9 – "PDS (Patient Demographic Service) is not always accurate and staff could contact the wrong person or send a letter to the wrong address."** JF advised that the SPINE (National patient demographic database) is not always accurate and that the PDS integration will help mitigate this risk as the screen will be in real time and discrepancies will be picked up. JF also advised that staff training is on-going this week. JF advised the Committee good progress has been made with managing the IG risks and IG and are satisfied with progress made to date. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/49	**3.12**	**Medicines Management &**	CU presented the risk management report for Medicines			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
		Pharmacy	Management & Pharmacy. • Total number of risks = 15 (15 active, 0 residual) • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 2 (1415, 1787) • Number of risks with no agreed action plan = 1 • Number of risks with changed risk scores = 1 • Number of high/extreme risks escalated to the Executive Team = 1 (1787) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **Risks closed** **Risk no 231 – Risk rating 3 "Electronic Prescribing for Chemotherapy".** **Overdue risks** **Risk no 1415 risk rating 12 – "Unsupported medicines databases".** **Risk no 1787 risk rating 15 – "Error in the prescribing, preparing and administration of parenteral nutrition."** Reviewed 21st – 24th June 2019. There is an improvement of 50% compared with the last reporting period. **Risks with no agreed action plan** **Risks no 1787 risk rating 15 – "Error in the prescribing, preparing and administration of parenteral nutrition."** CU advised there has been considerable work ongoing around this high			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			risk. MDT meeting monthly. Meeting notes embedded into risk on Ulysses after each meeting. **Risk 1344 risk rating 8 – "Pharmacy and ASU cold store."** GD advised the ASU cold store work has been completed and this risk will now close. CU advised the Committee, Medicines Management & Pharmacy recognise that while ongoing work is required, good progress made to date. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/50	**3.14**	**Global Digital Excellence**	Cathy Fox (CF) presented the Global Digital Excellence risk management report to the committee. • Total number of risks = 9 • Number of new risks identified since the last reporting period = 1 • Number of risks closed and removed from the risk register = 4 • Number of risks with an overdue review date = 1 (1625) • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 1 (1625) • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>Increased risks</u>** **Risk no 1625 "Risk rating increased from 4 to 9. "Legacy data**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			held on historic systems." Plan to address issue being developed as part of update. CF advised that we need to retain the data for legal reasons. There is a piece of work being completed by Nick Barnes, Consultant Radiologist to collate the data in one place. KB advised she hears Nick Barnes referred to frequently in the IGC Meetings and asked if he should attend the meetings. **<u>Closed risks</u>** **Risk no 1894 "**Consent for blood transfusion." This was added to GDE in error and has now been removed. **Risk no 1484** "Information Governance patient portal." This is a project risk as system not yet implemented. **Risk no 1780 "**Server infrastructure for Stratus (ImageNow replacement)." This is now in place. **Risk no 1623"** Availability of clinical notes during Meditech downtime." The process is now in place and has been tested. **<u>High risks</u>** **Risk no 1668 risk rating 15 "Test results not picked up when clinicians are away from the office."** Action: There is a pilot underway with Rheumatology and the outcome is due in 2 months, with plans to spread across the Trust. CF advised the Committee that GDE are satisfied with progress made to date. **Resolved** that: the Committee NOTED the contents of the p paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/51	**3.16**	**Marketing & Communications**	Cathy Umbers (CU) presented the risk management report for Marketing & Communications. • Total number of risks = 3 (806, 807, 808) • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 3 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 CU advised she met and completed risk validation and teaching with the Marketing & Communications team and there will be a comprehensive report submitted to the next IGC Meeting. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/52	**3.17**	**Innovation**	Jason Taylor (JT) presented the risk management report for Innovation Dept • Total number of risks = 4 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 (1700) • Number of risks with an overdue review date = 1 (1400)			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of risks with no agreed action plan = 1 (1400) • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **Closed risks** **Risk no 1700 – "failure to achieve the benefits from the CAMHS NHS Test Bed Project.**" **Overdue review and no agreed action plan** **Risk no 1400 risk rating 4 – "Acorn: Governance for Acorn Partnership not in place".** JT advised this outstanding risk is with external partnerships to action and he will provide an update to the next IGC Meeting. JT advised Innovation is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper	Risk 1400 JT to provide an update to the next IGC Meeting.	JT	11th Sept 19
19/20/53	**4.**	**Corporate Risk Register Review Report**	Cathy Umbers (CU) presented the Corporate Risk Register (High Risks) **Summary** This report is inclusive of all high risks on the register from 1st May 2019 – 30th June 2019. There are currently **25** high risks on the register. The report shows that the required assurance is not in			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			place for all risks on the register **<u>Risks overdue review</u>** **1169 risk score 20 ""**"Fragile medical workforce within haematology service". **1251 risk score 16** "Lack of Consultant cover for palliative care team" **1787 risk score 15** "Error in the prescribing, preparation, administration and monitoring of Parenteral Nutrition". **1866 risk score 16** "Guidelines out of date on intranet (150**)** **1312 risk score 15** "Tendering for Subcontracted provision" **<u>Actions overdue completion</u>** **1251 risk score 16** – actions references 3149 & 3150 **1668 risk score 15** - actions references: 6986, 7652, 6989, 6991, 6992, 5136, 6990, and 6988. **1701 risk score 16** – actions references 7485, 5031 **1787 risk score 15** – action reference 6146 **1866 risk score 16** – action reference 6931 **1909 risk score 15** – action reference 7537 **1887 risk score 20** – actions references 7234, 7235 **799 risk score 16** – actions reference 1720,1721 **825 risk score 16** – action reference 6838 **884 – risk score 16** – no actions identified			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			<u>New high risks identified</u> = 7 **Risk no 1909 Current risk rating 15** (Business Support Unit) "Information leaflets for parents, children and young people may not be clinically updated and reviewed and therefore providing incorrect information." CU advised there needs to be more detail on this risk. It is currently not clear the % of leaflets that are out of date. The plan to address the deficits needs to be added to the risk assessment and associated actions. This risk is clearly associated with informed consent and this needs to be clarified in the risk assessment. In addition, a further risk is required to be assessed and uploaded onto the risk register in respect of child friendly information leaflets, this was highlighted at the last CQC inspection **Risk no 1241 risk rating 16** (increased from 12) – "Lack of capital funding." **Risk no 1270 risk rating 16** (increased from 12) (Community) "Waiting time for ASD and ADHD assessment." Discussed in division of community report **Risk no 1588 risk rating 20** (increased from 10) Current risk rating increased from 10 to 20 "Ventilation system on Critical Care." Discussed in Division of surgery report **Risk no 884 risk rating 16 (**increased from 4) – "Failure of RO plant supporting Haemodialysis." Discussed in Medical Division report **Risk no 902 risk rating 16** (increased from 12) – "Inadequate connectivity in community sites." Discussed in community division	Risk 1909 risk assessment plan to address Deficits and associated actions informed consent. A further risk is required to be assessed and uploaded on to the risk register in respect of child friendly leaflets	PB/AH	11th Sept 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			report **Risk no 825 risk rating 16** (increased from 10) – "Risk of potential deliberate jumping from height from internal balconies." Discussed in Business Services report **Risks reduced/closed** **1884 (closed)** – **"**Caps falling off wooden fins" was 16 at last reporting period. This risk was reviewed and closed as it was a duplicate on the register. **1872 (closed)** – Current risk rating 4 (was 15) 'Lack of security surveillance'. System upgrade complete and commissioned. **Note;** 18 of 25 high risks **remain static** since last reporting period. CU advised that while there is evidence of progress with mitigating some of the high risks, this appears limited from the available evidence on the register. It is very concerning that risks are not being reviewed at least within defined timescales as this provides no assurance these are being managed. In addition, there are a considerable number of actions for improvement to mitigate risks which are past their expected date of completion and there is limited/no progress update to explain why that is, despite many of the risks showing reviews of the risks have taken place. CU asked the question "if the risks have been reviewed and there are associated actions past expected date of completion, what are the reviewers reviewing?". This needs to be considered and addressed by the risk managers and owners going forward. Clearly monitoring progress with actions is central to managing the risk effectively.	Progress with actions to be checked at each risk review and a progress update to be entered onto the risk into the action section of each risk.	All	11th Sept 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			KB advised risk titles and descriptions need to be articulated clearly to enable understanding about what is being said. This is particularly important where risks from various registers will be combined into summary reports so individual risks need to be understandable outside of the context of their original risk register. This information will be going to Board. All risk owners and managers need to question whether if anyone looked at the risks on their register would they know what the risk assessments are telling them and why risks are scored at the level identified. KB advised things are getting better but more work needs completing outside of meeting to bring up to date. KB wants to be at a place where if she is asked at Trust Board about the position of the Corporate Report, she can provide assurance that high risks are being actively managed; not only for internal assurance of effective risk management, but this will be a key focus for the CQC particularly in the well-led and safety domains. At present, she would not be able to provide that assurance. **Resolved** that: the Committee NOTED the contents of the paper	All divisions and departments to review the wording of their risks, controls and actions to ensure that they are understandable in a standalone context, given that summary reports on risks of 15+ will now be reported to Board	All	11 Sep 19
19/20/54	**5.**	**Board Assurance Framework (BAF)**	Erica Saunders (ES) presented the Board Assurance Framework. ES advised there has been a significant amount of work completed by JP on restructuring the BAF and it is much easier to read now and you can see where the controls are. ES advised that an overview of the report will be going to Trust	.		

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Board which shows examples of additional support, accreditation visits and the usual points about "ward to board" to strengthen the governance overall. KB asked should there be a BAF risk relating to the NHS Pensions & Tax to show the level of risk around capacity. It would be helpful to do a sustainability piece on the Deep Dive covering this topic. MS has asked NHSI for data concerns and will bring an update to the next IGC Meeting. **Resolved** that: the Committee NOTED the contents of the paper	Pensions & Tax MS to provide an update to next IGC Meeting	MS	11th Sept 19
19/20/55 -	**8.**	**Emergency Preparedness Annual Report & Executive Summary**	Elaine Menarry (EM) asked the committee to note the current compliance against the NHS England Core Standards for EPRR and its statutory responsibility under the Civil Contingencies Act 2004 and to also note the training and exercising programme for 2019/20. KB advised that reading the annual report has been a learning experience for her about the breadth of what is involved in Emergency Preparedness. **Resolved** that: the Committee RATIFIED the contents of the papers.			
19/20/56		**BAF Policy**	Erica Saunders (ES) presented the Board Assurance Framework. Policy. ES advised there have been minor updates to the BAF Policy. **Resolved** that: the Committee RATIFIED the contents of the papers.			
		Meeting	The Committee was asked to consider if any of the risk matters			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
		Effectiveness Review	discussed today should be referred to any other assurance committees. It was re-confirmed that KB will refer to CQAC the issue of insufficient FIT testing for a deep dive review. MS also reflected that there were numerous workforce risks that had been discussed throughout the meeting and these were across a number of departments. MS asked that the high risks relating to workforce be extracted and provided to her for presentation to WOD.	High risk workforce risks to be extracted and provided to MS for presentation to WOD	CU	31 Aug 19

INTEGRATED GOVERNANCE COMMITTEE

COMPLETED ACTION LIST – MAY 2019

No	Item	Owner	When	Status
18/19/83	Risk no 1746 - Fire risk within the Institute in the Park. Insufficient systems and processes in the Institute in the	S Brown	~~22nd May 19~~ 10th July 19	Update 31.08.19 a part-time security staff member now in post out of hours in the Institute. The staff member

No	Item	Owner	When	Status
	Park to manage a fire evacuation out of office hours			has been trained in processes for lift and fire procedures/evacuation. Risk score has decreased to risk 8. Action completed
18/19/102	Staff to monitor & update overdue risks & make arrangements for when designated person/s are unavailable to review.	All	On-going action	Update 22.05.19 KB advised the review date has now been changed to monthly (from weekly) and adherence to reviewing risks on this basis will be monitored by the Governance Team. This action will be removed as timeliness of review of risks is considered at each IGC Meeting. Completed
18/19/114a	Risk 1344 – Pharmacy and ASU cold store. All been agreed awaiting installation	A Kinsella/G Dixon	~~22nd May 19~~ 10th July 19	Update 10.07.19 GD advised we can now close this action as the work is being commissioned today. Completed.
18/19/126	Risk no's 1796, 1797 Change to food ordering process & lack of financial back of house system. JG advised this is not an operational day to day risk and Catering need to look at an Improve Programme going forward. CU advised the risk assessment needs reviewing and to look at a Change Management Programme and where this reports into.	M Devereaux	~~1 week~~ 10th July 19	Update 10.07.19 MD advised the new food ordering system is in place and this action/risk can now be closed. Completed
18/19/109	Assurance reports for Risk No 1709 - Ceiling Tiles, Risk no 825 - Internal Balconies	G Dixon	10th July 19	Update 10.07.19 GD advised due to the ongoing monitoring and work completed with the ceiling tiles (risk 1709). We have achieved good results (far fewer issues with tiles) and this action can now be closed. Risk 825 is being reported at each IGC meeting. Completed
18/19/138	Risk no 1751 – Unsustainable business model for clinical research and the research strategy is the only high risk. The need is to reach an agreement on the finance model that supports growth of the clinical research division. There is ongoing work between senior CRD and Director of Finance to co-produce a workable research finance model. JG advised that work is in progress and will update at next IGC meeting.	J Grinnell	~~22nd May 19~~ 10th July 19	Update 22.05.19 JG advised the Clinical Research will have a medium term plan the first week in June 19. It is a significant model which has come back through Board. There is a way forward and a business strategy however until a broader strategy is determined we cannot resolve the financial implications. JG to update IGC July 19. Update 10.07.19 JG advised that the business model has been approved. Completed

No	Item	Owner	When	Status
18/19/143	Junior Doctors Experience include on the BAF	M Swindell	10th July 19	Update 10.07.19 MS advised this has now been completed and is included on the BAF. Completed.
18/19/143	BAF 2.3 Apprenticeships to be included in existing control measures and gaps in controls of. this risk	M Swindell	10th July 19	Update 10.07.19 MS advised this has now been completed and is included on the BAF. Completed.
18/19/143	Exec training on BAF Masterclass on using Ulysses	J Gwilliams	10th July 19	Update 10.07.19 ES advised JP has almost completed all training for Execs. Completed.
18/19/145	Corroded Pipework Meeting	L Calder	1 week	Update 10.07.19 KB advised the initial meeting took place. There were 5 representatives from SPV in attendance and it was agreed for this meeting to commence on a monthly basis until we have assurance the issue is being managed. GD is to be present at the monthly meetings going forward. Due to Summer holidays the next meeting is to take place in September 19. Action completed.
18/19//145a	Control of Contractors update	M Swindell	22nd May 19	MS to provide an update at next IGC in May 19. Completed.
18/19/145b	Fire Risk Institute in the Park update	M Swindell	22nd May 19	MS to provide an update at next IGC in May 19. Completed
19/20/02	Risk 1887 **-** Unsafe patient area; roof leaking into bed spaces 45 & 46 orange pod (HDU) **-** update to be provides at next IGC	A McColl	10th July 19	Update 10.07.19 AM advised there should have been a level of assurance completed by May 19 which didn't happen. June 19 there were more floods and we closed orange pod for a period of 1 week. There is work that needs completing around the skylights which is expected to start in July and will be finished Aug 19. GD advised Building Services completed water tests on this area and it's only when there is a heavy downpour it shows the leaks. GD advised there is a plan in place and will forward to AM. Action completed (and ongoing updates will be provided to IGC as needed).
19/20//05	Risk 1374 **-** Increasing prevalence of HCAI MSSA Bacteraemia within the Trust – risk to be reopened and a cluster review to be completed.	V Weston	10th July 19	Update 10.07.19 JK advised that the risk has been reopened and 4 out of 5 cases have been looked at with one outstanding but in progress. Action

No	Item	Owner	When	Status
				completed.
19/20/13	Risk 1893 – Information Asset Management Tool. The Trust needs to decide who is responsible and if we have a data breach. JF to speak to ES outside of IGC Meeting.	Jo Fitzpatrick	10th July 19	Update 10.07.19 JF advised she is in the process of reviewing the Asset register. Update 10.09.19 Before any tasks can be performed for Information Asset Management - a review of what we have and who is responsible along with who is the Information Asset Owner needs to be identified." I have contacted all Information Asset Owners and now have an updated list of information assets, so this particular action against the risk can be closed. Action completed.
19/20/16	Risk no 1751 – Unsustainable business model for clinical research and the research strategy. Risk was first identified on 24th Oct 19 and there have been no changes to the risk profile.	J Taylor	10th July 19	JT to provide an update at the next IGC Meeting. Update 10.07.19 this was discussed on action item 18/19/138 and will be tracked there. Action removed.
19/20/17	Marketing & Communications - arrange meeting with CU to review risks.	L Calder	5th June 19	LC to arrange a meeting with Marketing & Communication and Cathy Umbers. Action completed.
18/19/142	Review the CRR to see if the high risks have been brought up to date. If so. move to monthly reporting	C Umbers	~~10th July 19~~ 11th Sept 19	Update 10.07.19 KB advised the risks will be monitored on an ongoing basis and if there is a decline in report management this timescale will be reviewed. Action completed

Alder Hey Children's NHS
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INTEGRATED GOVERNANCE COMMITTEE

ACTION LIST – JULY 2019

No	Item	Owner	When	Status
19/20/10a	Risk 1756 – Multi-storey car park fire alert. GD is awaiting feedback on a business case approval from the Execs.	G Dixon	10th July 19	GD to chase up with the Execs and report back to next IGC meeting. Update 10.07.19 Stuart Atkinson, Interim Director of Estates advised that the car park is fully compliant however external company asked about a sprinkler system. Estates needs to formalise the rationale before an agreement is decided as sprinkler system would cost £1 million and the car park is compliant as it is.
18/19/86	Risk no 799 – Failure to control contractors	M Swindell/A Kinsella	~~10th July 19~~ 11th Sept 19	Update 10.05.19 MS advised H&S are awaiting to see the final version of the report with agreed actions from MIAA before an update can be provide. MS to provide an update of progress at next IGC Meeting.
18/19/101	Risk no 1668 score 15 – Test results not picked up when clinicians away from the office	J Grinnell/A Hughes	~~22nd May 19~~ 10th July 19	Update 10.07.19 AM advised there is a pilot system which is in progress and teams are in the process of agreeing who are covering for one another. Once agreed can commence with the process.
18/19/109	Risk no 825 - Internal Balconies	G Dixon	~~10th July 19~~ 11th Sept 19	Update 10.05.19 Risk 825 GD advised we cannot remove this from the actions. GD advised there is a meeting on 12.07.19 to discuss the outcome of the internal balconies feasibility study and the options for the Trust to mitigate the risk. GD to provide an update at the next IGC Meeting.
18/19/114a	Risk no 1787 current score 15 – Potential errors associated with prescribing, preparing and administration of parenteral nutrition	C Barker	~~10th July 19~~ 17th July 10	Update 10.07.19 Glenna Smith (GS) will speak with CB and provide an update to the Chair in 1 week.
18/19/123	Risk no 1831 **-** As part of an audit of IT / clinical systems conducted in January 2018 it was identified that a file share related to the Natus System which is used within the Neurophysiology can be accessed by all users. Unsuccessful capture of data. LF advised this is an unsuccessful capture of data and is being worked	L Fearnehough/J Fitzpatrick	~~10th July 19~~ 11th Sept 19	Update 10.05.19 JF advised we need advice from managers who require access to the Natus System? LF advised the issue should be resolved over the next few weeks. Update to be provided at next IGC Meeting.

No	Item	Owner	When	Status
	through. KB asked has this been brought to the attention of Information Governance. LF to speak to JF outside of the meeting.			
18/19/124	Risk no 1131 - Process for scanning and archiving clinical notes within Community Division.	A Bateman	~~22nd May 19~~ ~~10th July 19~~ 11th Sept 19	Update 10.07.19 RG advised a Task & Finish Group has been set up and there is a piece of work in progress to look at outsourcing some of the scanning. JG advised this is also being addressed at Com Cell Meetings. AB to provide an update to the next IGC Meeting.
18/19/125	Risk no 1593 – A patient can acquire a HCAI due to inadequate deep cleaning process Business case was reviewed at IRG and the funding for new UV machines now with Medical and Surgical COOs. KB advised for this to be taken outside of IGC to discuss the funding.	V Weston/J Keward	~~12th June~~ 11th Sept 19	Update 10.07.9 JK advised the lease company has agreed to lease the Trust 3 new UV machines and the Infection Control team can also keep the original machine. This risk has now been reduced and will be closed once the UV machines are in place. VW to provide progress at the next IGC Meeting.
18/19/127	Risk no 1832 - Signing of electronic documents. The way users sign electronic documents impacts on the visibility of that document to other users. LF advised she will pick this up with M Levine, Head of Clinical Systems.	L Fearnehough	~~22nd May 2019~~ 10th July 2019	Update 10.07.19 LF advised this meeting has not taken place yet. LF to provide an update at the next IGC Meeting.
18/19/127	Risk no 1701 - MD Analyse is a legacy application used within both Neuro and Orthopaedics in order to document clinical outcomes. LF advised this is an historical system which is old and unsupported and the supplier no longer exists. IT is working with the clinical teams to look at companies to support them. JG advised he will raise this issue with the Exec team.	~~J Grinnell~~ C Fox	~~10th July 19~~ 11th Sept 19	Update 10.07.19 Cathy Fox (CF) advised there has not been much movement with this. IT is working on this with the support from the Neurosurgeons. There are still a few gaps to deal with and IT are looking at how we can maintain the system. Update to be provided at next IGC Meeting.
Item 2	Divisional Governance Meetings schedule of calendars for the year.	Divisional Leads	11th Sept 19	Leads to provide dates of their DIGC meetings for the rest of the calendar year for the Chair to attend. Update 03.09.19 LC emailed leads to provide information.
19/20//03	Risk 1882 - risk of additional admissions to hospital including PICU and delays to discharge - update to be provided at next IGC	C Wardell	~~10th July 19~~ 17th July 19	Update 10.07.19 GS advised there are now no delays to discharge. CCG have funded chairs but this issue is not having them on site. KB advised for the risk to be

No	Item	Owner	When	Status
				looked at as the title of risk does not reflect what the risk is. GS to update the risk. Update 04.09.19 H Cibinda has updated the title of the risk. Completed
19/20/10b	Risk 1858 – Security and fire risk controls. SB advised this risk requires to be broken down into individual risks.	S Brown	~~10th July 19~~ 11th Sept	SB to feedback progress to next IGC Meeting. Update 10.07.19 SB advised that there are a number of risks that are tied together with the Institute risk 1858, risk 1746. The Development team are putting a task & finish group together to work on breaking down the risks as we need to follow up if any of the problems were part of the cost of the institute and clarity is needed on what the risks are. KB advised clarity around the actions is also needed. SB to provide an update at the next IGC Meeting.
19/20/11	Risk 1840 – Regularly delivering COSHH compliance training. All generic risk assessments have been completed and waiting for Communications to upload to the intranet page.	A Kinsella	~~10th July 19~~ 17th July 19	Update 10.07.19 AK advised that this will be completed by the end of the week. AK to provide an update once complete.
19/20/36	Risk no 1881(risk rating 12) If there is no reception staff, parents will attempt to gain access by either tailgating or using the door release button under the desk.	A McColl	11th Sept 19	AM to provide an update to next IGC Meeting
19/20/40	Risk no 1919 risk rating 15 Failure to reach to risk 80% compliance with front line Staff influenza vaccination in 2019-20. **Risk no 654 risk rating 16 (increased from 12) "Staff acquiring airborne hospital acquired infections whilst delivering patient care".** JK advised there is a comprehensive plan in place to ensure actions are being performed in areas and is being monitored centrally by IPC and Divisions have been asked to provide a training plan to ensure all necessary staff have been trained. IPC have asked for assurances of training completed over a 1 month period. CU advised that the IPC team should arrange a meeting with Triumvirate in the three divisions	V Weston/J Keward M Swindell	24th July 19 11th Sept 19	VW/JK to speak to all divisions to ensure plan is in place. VW/JK to arrange meeting with 3 divisions to clarify expectations and ensure consistency of plans across the Trust.

No	Item	Owner	When	Status
	to ensure the expectations are clear and the plans are consistent across the Trust. JG agreed with this suggestion. Owners of IPC risks. If MS not the right owner of risks who will they assigned these risks to?			MS to speak to VW in relation to right owner of IPC risks.
19/20/42	Financial Implications of the risks of the IMT report to be included. Update the assurance statement within the IMT report as 6.25% is incorrect.	L Fearnehough L Fearnehough	11th Sept 19 24th July 19	LF to complete details on the financial risks on the IM&T report. LF to update the assurance statement and send through to LC
19/20/45	Risk no 825 risk rating 15 – Internal balconies	S Atkinson	11th Sept 19	SA to provide an update at the next IGC Meeting
19/20/45a	Directorate Risk Management Report to update an error in the changed risk scores. Risk no 1412 risk rating 9 Contracts with Universities to support RE phase 11 are not yet signed.	S Brown S Brown	24th July 19 11th Sept 19	SB to update and send copy through to LC. Completed SB to provide an update at next IGC Meeting.
19/20/46	Risk no 1836 risk rating 9 – Lift Entrapment – arrangements for out of hours (Institute in the Park). Risk no 799 risk rating 12 – Failure to control contractors on site (CHP) & Retained Estate	A Kinsella M Swindell	11th Sept 19 11th Sept 19	AK to provide an update at next IGC Meeting. MS to provide an update at next IGC Meeting.
19/20/52	Risk no 1400 risk rating 4 – Acorn: Governance for Acorn Partnership not in place		11th Sept 19	JT to provide an update to the next IGC Meeting.
19/20/53	**Risk no 1909 "Current risk rating 15** (Business Support Unit) Information leaflets for parents, children and young people may not be clinically updated and reviewed and therefore providing incorrect information. There needs to be more detail on this risk. It is currently not clear the % of leaflets that are out of date. The plan to address the	P Brown / A Hyson	11th Sept 19	There needs to be more detail on this risk as it's not clear percentage of leaflets that are out of date. The plan to address the deficits needs to be added to the risk assessment and associated actions. Also clarify the informed consent in the risk assessment.

No	Item	Owner	When	Status
	deficits needs to be added to the risk assessment and associated actions. This risk is clearly associated with informed consent and this needs to be clarified in the risk assessment. In addition, a further risk is required to be assessed and uploaded onto the risk register in respect of child friendly information leaflets which was highlighted at the last CQC inspection. Risk titles and descriptions need to be articulated clearly to enable understanding what is being said.	All	11th Sept 19	A further risk is required to be assessed and uploaded to the risk register in respect of child friendly leaflets. This is particularly important where risks from various registers will be combined into summary reports so individual risks need understandable outside of th context of their original risk register.
19/20/54	Should there be a BAF Report on Pensions & Tax? MS to provide an update to next IGC Meeting	M Swindell	11th Sept 19	MS to provide an update to next IGC Meeting
Meeting Effectiveness Review	MS also reflected that there were numerous workforce risks that had been discussed throughout the meeting and these were across a number of departments. MS asked that the high risks relating to workforce be extracted and provided to her for presentation to WOD	CU	30th Aug 10	High risk workforce risks to be extracted and provided to MS for presentation to WOD.

Alder Hey Children's NHS
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BOARD OF DIRECTORS

Tuesday 1st October 2019

Paper Title:	**Resource and Business Development Committee Assurance Report**
Date of meeting:	25 September 2019 – Summary 24 July 2019 – 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 September 2019 along with the approved minutes from the 24 July 2019 meeting. No meeting was held in August 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:	None
Associated risk (s)	Include risk(s) reference, title of risk, and current risk score.

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)**

LTP draft submission and submission timetable
Update on Financial Recovery Plan & key actions to close gap
PFI key risks update
Update on Campus Development and next phase of development
Update on next steps digital futures
Focus on marketing & comms activities

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

Risks around LTP:	System control & total requirements Tariff uncertainty Significant revenue costs associated with capex investment Commissioners QIPP assumptions Our 5 year transformation plan
Finance report:	Financial forecast still showing a gap - recovery plan underway
PFI:	Board to Board meeting to be held 8th October 2019 to escalate concerns around roof leakages; water temperatures; and pipe degradation.

4. **Positive highlights of note**

Energy usage improved

Progressing Digital Plan:	Infrastructure Collaboration with Clatterbridge Rolling out new equipment Signed Meditech expansion contract

High August activity & performance
Reduced sickness level for August

5. **Issues for other committees**

None

6. **Recommendations**

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