Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 2nd July 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	Preparation
APPRENTICE STORY (1000 – 1015)						
Children and Young People Forum Presentation (1015 – 1030)						
1.	**19/20/95**	**10:30**	**Apologies.**	Chair	To note apologies: Hilda Gwilliams	For noting
2.	**19/20/96**	**10:31**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
3.	**19/20/97**	**10:32**	**Minutes of the Previous Meeting.**	Chair	To consider and approve the minutes of the meeting held on: **Tuesday 28th May 2019.**	Read Minutes
4.	**19/20/98**	**10:35**	**Matters Arising and Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Verbal
5.	**19/20/99**	**10:40**	**Key Issues/Reflections.**	All	Board to reflect on key issues.	Verbal
Strategy						
6.	**19/20/100**	**10:50**	**Output from Strategy Session on 25th June 2019.**	D Jones	To provide feedback from the event.	Verbal
Delivery of Outstanding Care						
7.	**19/20/101**	**11:00**	**Serious Incidents Report.**	P Brown	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report
8.	**19/20/102**	**11:10**	**Nurse Staffing report 2019/20.**	P Brown	To provide assurance on safe staffing levels.	Read report
9.	**19/20/103**	**11:20**	**Infection Control Annual Report.**	V Weston	To present the annual report.	Read report
10.	**19/20/104**	**11:30**	**Neurodevelopmental Improvement update.**	L Cooper	To share findings and outcome.	Read report
11.	**19/20/105**	**11:40**	**Update on transferred services from Liverpool Community**	L Cooper	To provide an update on the current position.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Health NHS Foundation Trust.			
12.	**19/20/106**	**11:50**	**Seven Day Service.**	N Murdock	To discuss and approve.	Read report
13.	**19/20/107**	**12:00**	**Mortality Report Quarter 4.**	N Murdock	To present the findings from the last quarter.	Read report
14.	**19/20/108**	**12:10**	**Digital update and Cyber Security:** - **Digital Strategy.**	K Warriner	To update the Board on the programme and present the Digital Strategy.	Read report
15.	**19/20/109**	**12:20**	**Alder Hey in the Park Site Development update.**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
16.	**19/20/110**	**12:25**	**Clinical Quality Assurance Committee: Chair's report:** - **Chair's verbal update from the meeting on 12.06.19.** - **Minutes from the meeting held on 15.05.19.**	A Marsland	To receive a verbal report of key issues from the June meeting and the approved minutes from May 2019.	Read minutes
Lunch (12:30 – 13:00)						
17.	**19/20/111**	**13:00**	**Integrated Governance Committee:** - **Chair's verbal update from the meeting held on the 22.6.19.** - **Annual Report.** - **Minutes from the meeting held on the 13.3.19.** - **Minutes from the meeting held on the 8.4.19.**	K Byrne	To note the Committee's annual report. To receive a verbal report of key issues from the June meeting and the approved minutes from the 13.3.19 and the 8.4.19.	Read report Read minutes
The Best People Doing Their Best Work						
18.	**19/20/112**	**13:10**	**People Strategy:** - **Workforce and Organisational**	M Swindell C Dove	To provide an update. To present the current position to the Board. To receive a verbal report of key issues from the	Read report Read report Read minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Development Committee: Chair's Report: **Chair's verbal update from the meeting on 26.06.19.** - **Minutes from the meeting held on 03.05.19.**		June meeting and the approved minutes from May 2019.	
19.	**19/20/113**	**13:25**	**NHSI Chair Letter and Self-Assessment.**	M Swindell	To present findings from the self-assessment.	Read report
20.	**19/20/114**	**13:30**	**Freedom to Speak up Report.**	K Turner	To provide an update on the current position.	Read report
Strong Foundations						
21.	**19/20/115**	**13:45**	**Proposal on future management of Board business.**	E Saunders J Grinnell	For discussion.	Presentation
22.	**19/20/116**	**13:55**	**Tariff and Contract Risks.**	J Grinnell	To highlight current and future risks.	Presentation
23.	**19/20/117**	**14:05**	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	N Deakin	To receive an update on programme assurance.	Read report
24.	**19/20/118**	**14:20**	**Resources & Business Development Committee Report:** - **Chair's verbal update from the meeting held on 27.06.19.**	I Quinlan	To receive a verbal report of key issues from the meeting held on the 27th June 2019.	Verbal
25.	**19/20/119**	**14:25**	**Corporate Report.**	J Grinnell	To receive the monthly report.	Presentations
26.	**19/20/120**	**14:40**	**Board Assurance Framework.**	Executive leads	To receive an update.	Read report
Sustainability Through External Partnerships						

27.	**19/20/121**	**14:50**	**Update on Specialist Trust Group and system governance.**	L Shepherd/ J Grinnell	To update the Board on the initiatives underway,	Verbal
28.	**19/20/122**	**14:55**	**Liverpool Integrated Care Partnership.**	L Shepherd	To provide the Board with an update on the Liverpool Integrated Partnership workshops/next steps.	Verbal
29.	**19/20/123**	**15:00**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital.**	A Bateman	To update the Board on progress towards the single service model.	Read report
30.	**19/20/124**	**15:10**	**Memorandum of Understanding with Manchester Children's Hospital.**	D Jones	To approve Memorandum of Understanding.	Read report
31.	**19/20/125**	**15:20**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time of Next Meeting: 3rd September 2019 at 10:00am, Tony Bell Board Room, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust Seal was not used in May/June 2019

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 28th May 2019 at 10:00am,**
Tony Bell Board Room, Institute in the Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Acting Chief Executive/Director of Finance	(JG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr N Murdock	Medical Director	(NM)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs M Swindell	Director of HR & OD	(MS)
In Attendance:	Ms L Cooper	Director of Community Services	(LC)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
	Mrs C Umbers	Associate Director of Nursing and Governance	
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs K Byrne	Non-Executive Director	(KB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs L Shepherd	Chief Executive	(LS)
	Mr D Powell	Development Director	(DP)
	Mr C Duncan	Director of Surgery	(ChrD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Prof L Kenny	Executive Pro Vice Chancellor	(PLK)
	Mrs K Warriner	Chief Information Officer	(KW)
Agenda item:	Mr H Rohimun	Executive Director, Ernst and Young	
	Mr J Cheung	Audit Manager, Ernst and Young	

Patient Story
The Board welcomed patient Olivia, with her mum, brother and aunt to the meeting.

Mum read out dad's experiences relating to when Olivia had suffered a cardiac arrest in 2018 resulting in her being unconscious for 30 minutes. Olivia had initially been taken to Ormskirk Hospital and was later transferred to Alder Hey. Thanks were given to staff at both trusts as well as the transport team.

Olivia is continuing to receive treatment on Ward 4B. The family said they were grateful for the care Olivia receives on the ward and the relationship staff and volunteers have built with Olivia.

On behalf of the Board the Chair thanked Olivia and her family for coming to the meeting and wished Olivia well for the future.

19/20/67 Declarations of Interest
There were none to declare.

19/20/68 Minutes of the previous meetings held on 7th May 2019
Resolved:
The Trust Board approved the minutes from the last meeting held on 7th May 2019.

19/20/69 Matters Arising and Action Log
Melissa Swindell noted that her action had been to report on the organisational change that had taken place in ED not apprenticeships has had been added to the action log. The organisational change had now been completed and the new rota was to commence from 1st June 2019.

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

19/20/70 Key Issues/Reflections
Royal Sussex County Hospital visit 20th May 2019 – Quality Improvement
Adam Bateman reported on an event held at the above hospital which had been rated as Outstanding by CQC. The event had focused on their approach to Quality Improvement including culture and employee engagement; the processes shared are currently being considered in relation to the *Inspiring Quality* programme at Alder Hey.

Five Digital Hubs across Liverpool
Liverpool City Council had announced funding for five digital healthcare hubs. Two applications have been submitted.

Summer Events
Mark Flannagan reported on the following two events:
21st June 2019 – Innovation Festival
19th July 2019 – Summer Festival

19/20/71 Liverpool Integrated Care Partnership (LICP)
Dani Jones noted the close of the 12 week System Capability Programme. The findings from the final session held last week are due to be received. Dani Jones agreed to circulate the report to the Board.
Action: DJ

19/20/72 Complaints report Quarter 4 report
Resolved:
As Anne Hyson had been unable to attend, the Board received the above report noting that it had previously been reviewed by CQAC.

19/20/73 Serious Incident Report
The Board received and noted the content of the Serious Incident report for April 2019. Cathy Umbers stated that during this reporting period there were no new Serious Incidents, two SI's had been closed. Of the three ongoing cases one was due to close this month.

Resolved:
The Board received the Serious Incident report for April 2019.

19/20/74 Digital Update
John Grinnell updated the Board noting:
- Digital Strategy was currently in draft form and would be presented at the July Trust Board.
- Progress continued to gain accreditation of Healthcare Information and Management Systems Society (HIMSS) Level 7 as part of the GDE programme ending in March 2020.

- The Meditech upgrade is to be scheduled for summer 2020.

Received:
The Board received the digital and GDE update.

19/20/75 Alder Hey in the Park Site Development Update
John Grinnell provided a verbal update to the Board with regard to the key components of the site as they currently stand. The report was currently under review and would be presented at the July Board.

Park and Land
Harry Dhaliwal from Step continues to support Alder Hey with submission of the planning application for the park and engaging with the community.

Alder Centre
The construction continues to make progress.

Community Cluster
The community cluster scheme as it currently stands is over budget. The Development team are reviewing plans to bring capital projects back into financial balance.

Jeannie France-Hayhurst asked if it would be possible to arrange a walkabout on the community cluster site for Non-Executive Directors to get a sense of the overall site plan. John Grinnell agreed to feed this back to the Development team for this to be arranged:
Action: DP

Resolved:
The Board received a verbal update on the Park Site Development.

19/20/76 Clinical Quality Assurance Committee
Anita Marsland gave a verbal update from the last CQAC meeting held on 15th May 2019 noting the continued focus on Sepsis. Nicki Murdock agreed for a Sepsis update to be presented at the September Board to provide an update on use of the DETECT Study.
Action: NM

Resolved:
The Board received and noted:
- The minutes from the joint Clinical Quality Assurance Committee and Clinical Quality Steering Group meeting held on 17th April 2019.

19/20/77 Draft Annual Report and Accounts
The Board received the draft Annual Report and Accounts for 2018/19 and discussed its content. The Chair congratulated all on the achievements described within the report and agreed to hold a thank you event for staff.
Action: MF

A discussion took place around the approval of the accounts that had been received by the Audit Committee on 23rd May 2019. John Grinnell informed the Board that the Trust has had positive opinions from both sets of auditors on the robustness of the control system over the last twelve months and recommended that the Board sign off the 2018/19 accounts.

Hassan Rohimun of Ernst &Young reported that residual actions raised at the last Audit Committee had now been completed.

John Grinnell reported on the limited assurance work completed on the Quality Account, with no recommendations for improvements in terms of the data audited.

The Chair thanked Erica Saunders and her team for their hard work in compiling the 2018/19 Annual Report, which paints a comprehensive and positive picture of a year of excellent performance by the Trust.

Resolved:
The Trust Board APPROVED the Annual Report and Accounts and the Quality Account for 2018/19.

19/20/78 Board Self–Certification of compliance with the Provider Licence

Erica Saunders reported on the annual self-assessment undertaken to assure the Board that the Trust continues to comply with the conditions of its NHS Provider Licence.

NHS Improvement will again this year undertake to audit a random sample of trusts' self-certification assurance; Alder Hey has not yet been selected for this process but the Board was asked to be mindful that this was a possibility.

Resolved:
The Board approved the annual Self-Certification and received the accompanying assurance report.

19/20/79 Register of Shareholder interests

The Board received the register of company shareholders and the shareholders' agreement for Digital Audiology and Hand Hygiene.

A workshop on the governance arrangements for the Acorn partnership is being on 25th June, all Board members are welcome to attend.

Resolved:
The Board received the register of company shareholders as at 30th April 2019.

19/20/80 Tariff and Contract Risks

John Grinnell reported on future reductions to the national children's services tariff. The Children's Hospital Alliance is working to resolve the issue with the centre. It was agreed a further update would be presented at the July Board.

Resolved:
The Board received the current position on Tariff contract risks.

19/20/81 Programme Assurance Update

The programme assurance report is currently being updated to focus on the benefits. The revised report will be presented at the July Board.

Resolved:
The Board received a verbal update on programme assurance.

19/20/82 Resources and Business Development Committee

Resolved:
The Board received and noted the approved minutes from the Resources and Business Development Committee held on 22nd May 2019.

19/20/83 Audit Committee
Resolved:
The Board received and noted the approved Audit Committee minutes from the meeting held on 18th April 2019.

19/20/84 Corporate report including Finance Month 1
Executive leads updated with highlights as follows:
Finance
John Grinnell reported the behind plan position for month 1 noting the focus on activity as well as other key areas going forward.

Performance
Adam Bateman highlighted that cancelled operations for non-clinical reasons had reduced by two thirds.

An update on the delay of medical records being available once scanned was received; support with this was to be outsourced. This risk was being closely monitored.

Quality domains
Cathy Umbers reported an overall increase in reporting.

Workforce
Sickness levels remain high at 5.3%. A programme of health and wellbeing support is underway.

First month of the annual PDR window shows compliance for end of April at 5%.

Resolved:
The Board received and noted the contents of the Corporate Report for month 1.

19/20/85 Board Assurance Framework (BAF)
Resolved:
The Board received and noted the content of the BAF noting the transitional phase into the new financial year.

19/20/86 People Strategy Update
The Board received and noted the contents of the People Strategy report for May 2019. The following points were highlighted and discussed:

- All divisional and departmental breakdowns of the staff survey results have been distributed to the relevant heads to support them with facilitating 'Big Conversations'.
- Good engagement has been received with the time to change action plan. This has been put in place to encourage staff to share their stories and challenge stigma in relation to mental health.

Resolved:
The Board received and noted:
- People Strategy report for May 2019.
- Approved Workforce and Organisational Development Committee minutes from the last meeting held on 1st March 2019.

19/20/87 Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital

Adam Bateman highlighted the three key reasons why a new model of care for neonatal babies in Liverpool is critical:

- The quality care of babies will be improved by strengthening the joint working between both organisations and ensuring babies will receive the right care in the right place
- Reducing the number of unnecessary transfers between hospitals sites by 50% will improve the clinical outcomes for babies as well as making the experience for families less stressful and upsetting. Impacting on mortality and morbidity
- To ensure babies at both site receive high quality as in line with national standards.

The Board noted progress made in the last 6 months. Jo Minford went through the benefits of having 7 day Advanced Nurse Practitioners now in place.

Whilst the Business Case for a single site Neonatal service was approved in February 2019 by Specialist Commissioners Alder Hey continues to negotiate the finalised finding agreement on behalf of both organisations.

Next steps over the next 6 months were received. Nurse recruitment was due to commence in August 2019.

The Board noted a date is to be agreed for the joint Board to Board.

Resolved:
The Board received an update on the Joint Neonatal Partnership.

19/20/88 Any Other Business

Jeannie France-Hayhurst

On behalf of the Board the Chair thanked Jeannie for her contribution over the last six years and wished her well in the future. Whilst Jeannie's term of office came to an end in June 2019 Jeannie would continue to be a trustee of the Charity.

Date and Time of next meeting: Tuesday 2nd July 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

Alder Hey Children's NHS
NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for May 2019							
07.05.19	19/20/50	Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital	To arrange an annual joint Neonatal Board to Board meeting	Julie Tsao	28.05.19		02.07.19: In process
Actions for July 2019							
05.03.19	18/19/328	Complaints Quarter 3 Report	To provide an update on the review of ADHD/ASD services	Lisa Cooper	02.07.19		02.07.19: Neurodevelopmental Improvement item is on the agenda
07.05.19	19/20/46	Digital Update	To present the Alder Hey Digital Strategy at the July Board	Kate Warriner	02.07.19		02.07.19: On Board agenda
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
07.05.19	19/20/49	People Strategy update	To look into a staff member sharing their experiences of the apprenticeship scheme	Melissa Swindell	28.05.19		02.07.19: On Board agenda
28.05.19	19/20/71	Liverpool Integrated Care Partnership (LICP)	To circulate the findings from the final session to the Board	Dani Jones	02.07.19		02.07.19: On Board agenda
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
Status							
Overdue							
On Track							
Closed							

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 2nd July 2019

Report of:	Chief Nurse
Paper Prepared by:	Chief Nurse and Trust Risk Manager
Subject/Title:	Duty of Candour and Incident Management, including all incident investigations of moderate harm or above and Never Events
Background Papers:	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.
Purpose of Paper:	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.
Action/Decision Required:	Note and approve current assurance position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• **Patient Safety Aim** – Patients will suffer no harm in our care. • **Patient Experience Aim** – Patients will have the best possible experience. • **Clinical Effectiveness** – Patients will receive the most effective evidence based care.
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 serious incidents reported. There were no safeguarding incidents reported and no never events.

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

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

Table 4 shows there was one closed SIRI during this reporting period.

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

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

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 2019/3163	07/02/2019	Surgery	**Unexpected death:** The patient was admitted from the Emergency Department (ED) on the 03 February 2019, following collapse at home.	Kelly Black, Surgical Matron	Final report submitted to CCG 07/06/2019.	Yes – An extension was granted for submission to CCG and CQC 07/06/2019.	Completed.

			Gastro-jej tube changed on the 01.02.19. Perforated bowel secondary to migration of Gastro-jej tube following the procedure on the 01 February 2019. Laparotomy and repair of bowel perforation performed on the 04 February 2019 (01.30), patient returned to PICU (03.00). Multiple inotropic support was provided; patient sadly went into multi organ failure. Extensive discussion with teams involved in the care. Decision to withdraw treatment; patient sadly died at 16:38.				
StEIS 2019/1718	22/01/2019	Medicine	**Unexpected death:** Four month old baby was admitted to Alder Hey via Emergency Department (ED) on 15th January 2019, with a bronchiolitis type illness, admitted to Ward 4C. The patient was managed with Airvo and nasal cannula oxygen plus a mixture of bottle and NGT feeds. Respiratory PCR positive for coronavirus, human metapneumovirus and rhino/enterovirus. The baby previously had multiple attendances to the Trust.	**Nursing lead:** Amanda Turton, Head of Acute Care **Medical lead:** Theo Anbu, Consultant	Final draft report in quality check stage.	Yes - Report due for submission to CCG and CQC 28/06/2019.	Completed.

			Just over 12 hour's pre acute collapse, the baby became tachycardic (fast pulse) and had episodes of fever, for which she was given paracetamol and ibuprofen on the ward. At 12:00 on 19 January 2019, a cardiac arrest call was issued because the baby had been found moribund and peri-arrest on the ward by her mother. The cardiac arrest team resuscitated her with assisted ventilation, dextrose and fluid boluses, IM and IV antibiotics. The baby was intubated on the ward, a high dose adrenaline infusion started and quickly transferred to PICU. Shortly after arriving in PICU, she went into PEA and CPR was commenced at 12:55hrs. Sadly, the baby did not respond to resuscitation and this was discontinued; baby sadly died at 13:20 hours.				

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**
StEIS 2019/3312	08/02/2019	Medicine	**Unexpected death:** The patient was admitted to Paediatric Intensive Care Unit from Emergency Department (ED) with septic shock on 4th January 2019. Full intensive Care support provided, but patient deteriorated, (multiple	**Investigation lead:** Amanda Turton, Head of Acute Care	Final report sent to CCG and family.	Yes	Completed.

			organ failure), and sadly died at 12.17 hours on 6th January 2019 Post Mortem finding: Influenza A positive (H1N1).				

END

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD OF DIRECTORS

Tuesday 2nd July 2019

Report of:	Chief Nurse
Paper Prepared By:	Director of Nursing
Subject/Title:	Nursing Workforce Report
Background Papers:	• Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals: National Quality Board, November 2017 • Safe, Sustainable and Productive Staffing: An improvement resource for neonatal care: National Quality Board, November 2017 • How to Ensure the Right People, with the Right Skills, are in the Right Place at the Right Time: National Quality Board, November 2013 • Hard Truths: The Journey to Putting Patients First: Department of Health, 2013 • Defining staffing levels for children and young people's services: RCN standards for clinical professionals and service managers: Royal College of Nursing, 2013 • Quality Standards for the Care of Critically Ill Children: Paediatric Intensive Care Society, December 2015 • Categories of Care: British Association for Perinatal Medicine 2011 • Safe staffing for nursing in adult inpatient wards in acute hospitals: National Institute for Clinical Excellence July 2014 • Safer Staffing: A Guide to Care Contact Time: NHS England 2014 • Single Oversight Framework: NHS Improvement September 2016 • Unwarranted variation: A review of operational productivity and performance in English NHS acute hospitals: Department of Health and Social Care, February 2016 • Standards of Proficiency for Registered Nurses: Nursing and Midwifery Council, May 2018
Purpose of Paper:	This paper provides the required assurance that Alder Hey Children's Hospital has safe nurse staffing levels across all in-patient and day case wards and appropriate systems in place to manage the demand for nursing staff To inform the Trust Board of proposed workforce improvements in 2019/20
Action/Decision Required:	The Trust Board is asked to note: • The content of the report and assurance that appropriate information

	is being provided to meet national and local requirements • The information on safe staffing and the impact on quality of care
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Provider of 1st choice • Deliver clinical excellence
Resource Impact:	

CONTENTS

1. EXECUTIVE SUMMARY

The aim of this paper is to provide assurance to the Trust Board of Directors that safe nurse staffing levels are being maintained across all in-patient and day case wards and appropriate systems are in place to manage the demand for nursing staff.

Since the previous annual Nurse Staffing Board report for 2017/18, the senior nursing leadership team have continued to work on the recommendations that were agreed. This report contains an updated position with regard to the nursing workforce and makes further recommendations for continued improvement.

Through effective implementation of the recruitment action plan, safe staffing levels have been sustained. Alder Hey has demonstrated significant success in this highly competitive regional and national market. In the last financial year of 2018/19, 92.6 WTE Band 5 Registered Nurses have been recruited as a result of local and national campaigns. In addition, the Trust has successfully externally recruited to key senior nursing leadership posts: Head of Critical care (Surgical Division), Head of Complex Care (Community Division), and Matron for Cancer Care (Medical Division) achieving a full senior nursing structure.

There are 8.4 WTE Band 5 front line staff vacancies at February 2019 across the wards. This is due in the main to the positive impact of increased funded establishments on Wards 1C Cardiac, Ward 3A and Ward 4B. Of note, the senior nursing team have supported the opening of an additional 11 beds as part of the Winter Plan through the Staff Nurse Rotation Programme (nursing pool), and these have been opened sustainably over winter.

There are currently 554.6 WTE front line Band 5 staff employed against a funded establishment of 544.6 WTE. Due to the increased establishments, the opening of additional beds, and with continuing high levels of maternity leave and sickness, there is no additional resilience in the nursing pool, however 25 WTE Band 5 nurses were successfully recruited in January 2019 and are due to commence in post in May 2019. This demonstrates sustained resilience in that the variance is linked to staff availability to work and not vacancies. 2018/19 has seen a reduction in the average number of front line staff leaving the organisation, with a reduction from 6.5 WTE to 5.7 WTE.

Successful recruitment and increased resilience has made an impact and overall positive change in the use of temporary nurse staffing. The use of front-line nurse agency staff has been zero in 2018/19, and Alder Hey is reported to have the lowest use of agency staff in England.

Of note, there have been no in-patient beds closed due to staffing issues. To assist with winter pressures and ensure bed availability for sick children admitted through the Emergency Department, 4 additional beds have been open on Ward 3C, 4 additional beds on Ward 4B, and 3 additional beds in EDU from October 2018 in line with the Winter Plan.

An audit against the RCN standards has been repeated in March 2019 which demonstrates a further improvement since 2018, with 14 standards now fully compliant and 2 standards partially compliant, compared to 13 compliant and 3 partially compliant in the previous year.

The Trust's mandated monthly submission of staffing levels to NHS website presented was consistently higher than 94% throughout the year against the nationally accepted level of 90%.

In 2018, a review of the process for newly qualified nurses to join the Trust was undertaken in collaboration with the universities and student nurses which resulted in the development of the Staff Nurse Rotation Programme: a standardised approach to staff working and gaining experience in different areas of the Trust, developing their knowledge and skills, and helping to retain our valued nursing workforce.

2. NATIONAL CONTEXT AND REGULATION

There are a number of tools available to determine safe staffing levels. The tools currently used at Alder Hey are Royal College of Nursing standards, nurse to patient ratio, skill mix review, patient acuity, Safer Nursing Care Tool, professional judgement and triangulation with nurse sensitive indicators.

Specific guidance for safe staffing levels in neonatal and paediatric settings is set in the main by the Royal College of Nursing (2013). An audit of the Trust's compliance against the 16 core standards conducted in March 2019 can be found in section 4.3, with the Trust fully compliant with 14 standards and partially compliant with 2 standards. This constitutes and improved position since the last annual Trust Board nurse staffing report.

Additional specialised guidance for staffing in paediatric intensive care and high dependency settings is set out by the Paediatric Intensive Care Society (PICS 2015). The British Association for Perinatal Medicine lay out standards for care of neonates (BAPM, 2011).

In November 2017, the National Quality Board (NQB) published improvement tools specifically for the care of children and neonates: Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals / neonatal care. The improvement resources are based on the NQB's expectations of safe, effective, caring responsive and well led care, on a sustainable basis, that ensures the right staff with the right skills are in place the right place at the right time. The Trust undertook an annual review of all ward establishments in line with this new guidance during Q1 to Q2 of 2018/19 and this will be repeated again in 2019/20. The results of the 2018/19 review are detailed in section 4.1 and 4.3.

In line with Department of Health Hard Truths Commitments (2013), all Trusts are required to submit monthly staffing data. The Trust is compliant with submitting data to the public through NHS website (previously NHS Choices) and on the Alder Hey website (Section 4.2 and Appendix 1)

In 2000, the Department of Health proposed that every hospital should have Matrons who are accountable for a group of wards and are easily identifiable to patients, in order to improve the delivery of patient care and patient experience, and to provide strong clinical leadership and authority at ward and departmental level. Following the restructuring to the three larger Divisions in November 2016, the Trust has successfully appointed to the three Head of Nursing roles across the Medical, Surgical and Community Divisions, whose duties include deputising for the Divisional Associate Chief Nurse, and all Matron positions. An example of the structure can be found in section 4.5 iv.

The Nursing and Midwifery Council (NMC) implemented Nurse Revalidation from April 2016, which requires all registered nurses to revalidate every 3 years to maintain their professional registration. The purpose of revalidation is to improve public protection ensuring nurses remain fit to practise throughout their careers. To date, all registered nurses due to revalidate have done so successfully.

The RCN's Principles of Nursing Practice states that 'Nurses and nursing staff must have up to date knowledge and skills and use these with intelligence, insight and understanding in line with the needs of each individual in their care'. In May 2018, the Nursing and Midwifery Council (NMC) launched new standards for nurse training to begin to commence from 2019, with a clear focus on ensuring nurses clinical competence at the point of registration. The Standards of Proficiency for Registered Nurses represents the skills, knowledge and attributes all nurses must demonstrate. Practice Educators play an essential role in the development of a workforce that is able to deliver high quality, effective and safe care. The Trust had 2 WTE Practice Education Facilitators (PEF) to support pre-registration students, and Critical Care have an established Education Team to support post registration learning and development, however a need was identified to strengthen the

support to the post registration nursing workforce who in turn support students, new staff and the future workforce. A business case was devised, approved and implemented to introduce and successfully recruit a Head of Nurse Education to the Trust, supported by 6 WTE ward based Clinical Educators and an additional PEF, to facilitate the advancement of nurse education in the Trust.

In July 2017, the Cheshire and Mersey (CM) Director's of Nursing presented a paper entitled 'Maximising the Collective Impact of Nurse Directors and Nursing within Cheshire and Merseyside' to the Local Workforce Advisory Board to consider and support a proposed programme of work to address some critical nursing workforce issues within CM. The intention and scope of the programme is designed to mobilise and maximise nursing leadership across CM and provide a platform for action which should align and deliver outcomes which will help support the ambitions of the CM STP and directly impact on the attraction and retention of a talented nursing workforce and safeguard future supply. The original five areas of focus have been consolidated into two workstreams focusing on recruitment and retention, and education. The Chief Nurse, Director of Nursing and Deputy Director of Nursing are actively involved in this project and recently presented at a regional "sharing best practice workshop regarding the new Staff Nurse Rotation Programme (section 4.5 iii).

3. SUMMARY OF ACHIEVEMENTS

The overall impact of the success of the recruitment, reduction in vacancies and other developments to support safe nurse staffing is as follows:

3.1: Recruitment

i. 92.6 WTE front line nursing staff recruited in 2018/19.
ii. 2 WTE Nurse Associates appointed in the last 12 months following qualification of the second cohort.
iii. The development of a responsive recruitment culture with evidence of strong partnership between senior nurses and human resource staff, notably working together on successful national recruitment days and a comprehensive induction and preceptorship programme for new nursing staff.
iv. Development of a "one stop shop" recruitment day.
v. Additional nurse recruitment sustained to cover maternity leave, sickness and vacancies.
vi. Additional nurse recruitment to safely staff 11 additional beds to manage the increased number of admissions during the winter period.
vii. Revamp of the Nurse Induction Programme and protected induction period.
viii. Improved and standardised preceptorship.

3.2: Safe staffing levels

i. No beds closed to admissions due to nurse staffing levels.
ii. No cancelled operations for "staffing unavailable".
iii. 11 additional beds opened and staffed sustainably to support bed availability due to projected winter pressures.
iv. Increased ward based funded establishment for registered and unregistered nurses on two wards.
v. Additional 2 wards now have a supernumery shift co-ordinator on shift (section 4.3).
vi. Comprehensive review of nurse staffing on Tier 4 CAMHS ward.
vii. Increased fill rates via NHSP for both registered and unregistered staff.
viii. No use of front line nursing agency staff for commissioned beds.
ix. Staffing levels consistently higher than 94% throughout the year above the 90% national mandate.

3.3: Strong and effective leadership structure

i. External recruitment to the new Head of Critical Care role in the Surgical Division.
ii. External recruitment to the Head of Complex Care role which became vacant. The role has been reviewed and provides a deputy to the Associate Chief Nurse Community role in line with the same structure in the Medical and Surgical Divisions.
iii. Effective succession planning and internal promotion to three Ward Manager posts on the Burns Unit, the Surgical Day Case Unit, and Ward 3A General Surgical Ward following the retirement of the previous post holders.
iv. Comprehensive review of the nursing structure in the Research Division resulting in additional Band 7 posts which have been successfully recruited to internally.
v. Internal promotion to Band 6 Ward Sister / Charge Nurse positions.
vi. Demonstrable involvement of the Chief Nurse, Director of Nursing and Deputy Director of Nursing in the Cheshire and Merseyside collaborative work regarding the nursing workforce.

3.4: Educational developments

i. Working collaboratively with our HEI partner the Trust has developed an MSc programme in leadership enabling staff to gain the necessary skills and competencies to successfully fulfil senior nurse roles. Maintained and supported 3 senior nurses per year to participate.
ii. Internal recruitment to Head of Nurse Education to the Trust, 6 Clinical Educators and a Practice Education Facilitator.
iii. Development and implementation of the new Staff Nurse Rotation programme: Facilitates the development of a wider skill set; access to a wider experience in medical, surgical and specialist fields.
iv. Maintained and recruited to the increased number of places of trainee Advanced Nurse Practitioners to enhance nursing practice and assist in the reduction of Junior Doctors.
v. Increased the number of places of trainee Nurse Associates to 8 per year and successfully recruited to through the Apprenticeship scheme.

3.5: Quality metrics

i. Reviewed and enhanced monthly Safety Thermometer, which is a point of care survey designed to measure commonly occurring harms and support improvements in patient care and experience.
ii. Reviewed and enhanced Ward Accreditation scheme, a quality initiative where wards across the Trust are regularly inspected by an independent senior team of nurses and patient experience leads assessed against a range of measures based on the CQC KLOE's.
iii. Reviewed and enhanced Ward Dashboards to ensure all staff have access to relevant data to improve patient care

4. HOSPITAL NURSE STAFFING MODEL

4.1: Ward establishments

The staffing model is fundamentally based on achieving compliance with the national requirements as described in section 2. A review of all ward establishments was undertaken in Q1-Q2 2017/18 and will be repeated in 2019/20.

As a result of the review and in collaboration with the Divisions, a number of improvements have been made to ward establishments, most notably:

- Ward 3A: increase in funded establishment to provide same registered nurse to patient ratio on days and nights. Increase in funded establishment of unregistered nurses to provide additional support to registered nurses due to higher acuity
- Ward 4B: Increased in funded establishment to enable consistent registered supernumery shift co-ordinator during day shifts
- Ward 1C Cardiac: increase in funded establishment to enable consistent Band 6 supernumery shift co-ordinator during night shifts

An additional audit of compliance against the RCN paediatric staffing standards was undertaken in Q4. The findings of the audit are outlined in section 4.3.

4.2: Safer staffing levels

In line with Department of Health Hard Truths Commitments (2013), all Trusts are mandated to provide nurse staffing information on a monthly return via the National Reporting and Learning System and publish this data at ward level and make the information available to the public. The Trust is compliant with submitting data to the public through NHS website, the Alder Hey website, and at ward level. A monthly ward fill rate of 90% and over is considered acceptable nationally. Fill rates for 2018/19 demonstrated that the overall staffing level was consistently higher than 94% throughout the year. The staffing levels reported are the head count on each shift which does not analyse skill mix or the impact of temporary staff on a shift.

In September and October 2018 and March 2019, there were 4 occasions where the average fill rate for registered nurses was 88% or 89% fill rate, however the wards were supported by Matrons, Ward Managers, Clinical Educators, and additional Health Care Assistants. The bed occupancy during those months was between 77-81%, ensuring safe quality care and appropriate nurse to patient ratios. In addition, the Trust recruited more than fifty registered nurses who commenced in October 2018 and are not counted in this figure as they were working in a supernumery capacity as part of their induction and preceptorship, however they were providing care to patients alongside the established ward staff.

Where patients have required specialling due to higher acuity, the overall fill rates for Health Care Assistants will be higher than 100% (as per section 5.7).

Appendix 1 provides a full break down of staffing levels by ward for 2018/19.

4.3: Compliance with RCN guidelines

To continue to monitor and improve staffing levels, an audit against the RCN standards has been repeated in March 2019 involving the Ward Managers, Matrons and Associate Chief Nurses for all in patient and day case wards.

4.3.1: RCN Core Standards

The thermometer below demonstrates year on year improvements against the RCN core standards since the first audit was undertaken in 2014.

July 2014	2	4	6	7	8	10	11	15	16	1	3	5	9	12	13	14
Feb 2017	2	4	6	7	8	9	10	11	12	13	15	16	1	3	5	14
Feb 2018	2	3	4	6	7	8	9	10	11	12	13	15	16	1	5	14
Mar 2019	2	3	4	5↑	6	7	8	9	10	11	12	13	15	16	1↑	14↑

The audit last year demonstrated the Trust was Green (full compliance) with 13 standards and Amber (partial compliance) with 3 standards.

The recent audit has demonstrated a further improvement against the standards, with core standard 5 moving from Amber (partial compliance) to Green (full compliance). Core standard 5 states that "a 25% increase to the minimum establishment is required to cover annual leave, sickness and study leave". The wards at Alder Hey have a funded establishment which includes a 23% uplift. The remaining 2% uplift is supported through the funding of the additional 40 WTE rotational Band 5 nurses achieving the full uplift and as such increasing the availability, resilience and support to the front line nursing workforce.

Although 2 standards have remained at Amber (partially compliant), there have been significant improvements in both standards as detailed in Table 1. Appendix 3 demonstrates improved position across two Amber rated standards and five Green rated standards.

Table 1 below provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to improve compliance:

Table 1: Core standards to be applied in services providing health care for children and young people		
Standard		**Compliance**
1	The shift supervisor in each clinical area will be supernumerary to ensure effective management, training and supervision of staff	**Partial ↑**
	Improved position from 2017/18. PICU, HDU, Ward 1C Neonatal (days), Ward 1C Cardiac , Wards 3A, 4A, and 4B 9days) all have a supernumery shift co-ordinator The improvement in 2018/19 has seen a funded Band 6 night co-ordinator established on Ward 1C Cardiac, and a co-ordinator on Ward 4B for day shifts Gaps exist on Wards 3B, 3C, 4B (nights), Burns Unit, EDU and Medical Day Case. However, all Ward Managers are supernumery; all wards now benefit from presence of a supernumery Matron; and all wards now benefit from the presence of a Clinical Educator introduced in Q3 2018/19. A significant number of wards benefit from a supernumery Advanced Nurse Practitioner (ANP) and / or Trainee ANP (see core standard 2) and whilst ANP's should not be counted in the bedside establishment, they provide key clinical leadership, skill, experience and knowledge that benefit the ward teams All wards allocate a nurse to take charge and co-ordinate the shift. This model requires nurses on the shift to increase the number of patients they care for to facilitate a supernumery co-ordinator, or the co-ordinator cares for patients as well as taking charge of the ward	
2	Nurse specialists and advanced practitioners will not be included in the bedside establishment, except periodically where required to maintain skills, to teach and share expertise with ward and department-based staff	**Compliant**
	Fully compliant ANPs support the following wards: Ward 1C Cardiac: 2 trainee ANPs who will cover 6 days once qualified Ward 1C Neonatal: 1 ANP and rotational programme with LWH	

	Ward 3A: ANP and 2 Trainee ANPs Ward 3B: 2 ANPs 2 TANPs Ward 3C: ANP and a trainee ANP; Ward 4A: 1.5 WTE ANP and 1 trainee ANP Ward 4B: ANP Ward 4C 2 ANPs HDU: 4 ANPs MDC: ANP In addition, the following areas have ANPs who contribute to the medical rota: PICU ED	
3	At least one nurse per shift in each clinical area (ward/department) will be trained in APLS/EPLS depending on the service need	**Compliant**
	Comprehensive review of resuscitation training needs analysis conducted in 2017. Identified that the services that need APLS trained staff on each shift are PICU, HDU, ED, Ward 1C, Ward 4A and Patient Flow team All other wards / registered nurses required to undertake PLS. Plan in place to achieve 90% compliance by March 2019 in line with CQC action plan	
4	There will be a minimum of 70:30 per cent registered to unregistered staff	**Compliant**
	Fully compliant. Ward 4B has a ratio of 50: 50 however that is a deliberate workforce configuration as the support staff are trained to care for children requiring long term ventilation Increased est on 3A 18/19 based on acuity	
5	A 25 per cent increase to the minimum establishment is required to cover annual leave, sickness and study leave	**Compliant ↑**
	The wards at Alder Hey have a funded establishment which includes a 23% uplift. The remaining 2% uplift is supported through the funding of the additional 40 WTE rotational Band 5 nurses achieving the full uplift and as such increasing the availability, resilience and support to the front line nursing workforce. In addition, 6 WTE nurse Clinical Educator's have been appointed in August 2018	
6	There should be a minimum of two registered children's nurses at all times in all inpatient and day care areas	**Compliant**
	Fully compliant	
7	Nurses working with children and young people should be trained in children's nursing with additional training for specialist services or roles	**Compliant**
	Fully compliant	
8	Seventy per cent of nurses should have the specific training required for the speciality, for example, children's intensive care, children's oncology, children's neurosurgery	**Compliant**
	Fully compliant. Specialist wards have locally or regionally delivered programmes to support staff development and expertise in their field as identified in their local Training Needs Analysis	
9	Support roles should be used to ensure that registered nurses are used effectively. Support roles are defined in the standards as a minimum of the following:	**Compliant ↑**

	Supernumery Ward Manager: Fully compliant	
	Ward receptionist / ward clerk / admin support for ward staff: Fully compliant	
	Play Specialist: Fully compliant apart from PICU however they can make a referral to the Play Specialists as required which will then be reviewed and actioned appropriately. Improved position in 2018/19 as HDU now have a Play Assistant All areas have access to the significant Arts for Health programme which includes musicians attending the wards and departments	
	Housekeeper: Fully compliant. Burns Unit access PICU / HDU housekeeper	
10	Unregistered staff must have completed a course of training specific to the setting, and in the care of infants, children and young people and have undergone a period of competence assessment before carrying out care and delegated tasks	**Compliant ↑**
	All new Health Care Assistants signed up to NHSP undertake Advanced Clinical Skills training. All HCA's on wards have assessment of competency in assigned skills. Examples of this are: On Ward 1C Neonatal, all HCAs are scheduled to attend Northwest Neonatal Operational Delivery Network training specifically for unregistered staff working in a neonatal unit to commence September 2019 On Ward 3C all HCAs have completed training for Tracheostomy care, peripheral blood sampling, naso-pharyngeal suction, and feeding tubes	
11	The number of students on a shift should not exceed that agreed with the university for individual clinical areas	**Compliant**
	Fully compliant	
12	Patient dependency scoring should be used to provide an evidence base for daily adjustments in staffing levels	**Compliant**
	SCAMPS tool in place	
13	Quality indicators should be monitored to provide an evidence base for adjustments in staffing levels.	**Compliant ↑**
	Ward Managers / Divisional representative attend daily Bed Meetings to inform of ward level patient acuity and requirement for additional staff. Data collected on bed meeting Sitrep Monthly Safety Thermometer and Infection Control audit regularly conducted and ward dashboards completed. Ward Accreditation process embedded which incorporates all ward quality indicators. In line with Hard Truths Commitments daily staffing information displayed electronically to the public via screens	
14	Where services are provided to children there should be access to a senior children's nurse for advice at all times throughout the 24 hour period. The expectation is that this post would be at a minimum of band 8a dependent on the full scope and remit of the position in which case the post may be graded higher where the remit is greater. All post holders of matron positions in children's services must hold a registered	**Partial ↑**

	children's nursing qualification	
	Improved compliance to partial compliance in 2017/18 following recruitment to all Head of Nursing and Matron posts therefore compliant in hours Band 8A and above cover Further improved position to 2017/18 as the business case for Acute Care Team (ACT) to support staff 24 hours per day and respond to patients showing early signs of deterioration was approved at Operational Delivery Board in August 2018 and implementation phase now in progress. Lead in time approximately 12 months due to need to recruit and appropriately train staff	
15	All staff working with babies, children and young people must comply with the Safeguarding children and young people: roles and competences for health care staff (2010). All staff must be able to access a named or designated safeguarding professional for advice at all times 24 hours a day	**Compliant**
	Fully compliant. Nursing and Medical staff on call	
16	Children, young people and young adults must receive age appropriate care from an appropriately skilled workforce in dedicated environments that meet their specific needs	**Compliant ↑**
	Appropriately trained workforce and specially designed Children's Hospital Further improvement in 2018/19 as a business case was devised, approved and implemented to introduce and successfully recruit a Head of Nurse Education to the Trust, supported by 6 WTE ward based Clinical Educators and an additional PEF, to facilitate the advancement of nurse education in the Trust.	

4.3.2: RCN Specific Guidance

Analysis has taken place to audit front line staffing against the relevant specific staffing guidance sections of the RCN guidelines not captured within the core principles.

The audit conducted in March 2019 demonstrated that the Trust remains fully compliant with 2 standards and partially compliant with 2 standards. However there has been an improved position within both the Amber rated (partially compliant) standards due to the increased establishment on Ward 3A resulting in the same nurse to patient ratio on both day and night shifts and an increased number of HCA's as outlined in Table 2 below and Appendix 2.

The thermometer below demonstrates year on year improvements against the relevant RCN specific standards since the first audit was undertaken in 2017.

Feb 2017	5	6	7	8
Feb 2018	5	6	7	8
Mar 2019	5	6	7↑	8↑

Table 2 below provides analysis against the standards, identifies existing challenges to compliance, and identifies actions to mitigate and improve compliance:

Table 2: Staffing principles within "Defining staffing levels for children and young people's services"		
Section		**Compliance**
Section 5: Neonatal services	Bedside, deliverable hands-on care: Special care 1:4 nurse: infant High dependency care 1:2 nurse: infant Intensive care 1:1 nurse: infant	**Compliant**
	Fully compliant. Neonates requiring intensive care are nursed on PICU, surgical and cardiac neonates requiring high dependency care are nursed on Ward 1C. Neonates on other wards are nursed 1:3 in line with standards in Section 7 below A workstream to set out workforce requirements for the neonatal Single Service with LWH has been established	
Section 6: Designated children's intensive care and children's high dependency services	PICU 6.7-7.06 WTE per bed dependent upon maternity leave included in calculation Bedside, deliverable hands-on care: Level 1: HDU 1:2 nurse: child Level 2: PICU or HDU cubicle patient: 1:1 nurse: child Level 3: PICU: 1:1.5 nurse: patient Level 4: 2:1 PICU: nurse: patient (ECMO)	**Compliant**
	Current ratio now at 6.6 WTE per PICU bed compared to 6.4 WTE in 2016. HDU compliant with 4.4 WTE per bed Full nursing ECMO team established and recruited to for PICU All patients are nursed as per ratios set above unless not required for example a patient who is being transferred from PICU to a ward HDU care provided on general HDU, Ward 4A and Ward 1C Cardiac all provide 1:2 care	
Section 7: General children's wards	Bedside, deliverable hands-on care: Children < 2 years of age 1:3 registered nurse: child, day and night Children > 2 years of age 1:4 registered nurse: child, day and night	**Partial ↑**
	RCN standards no longer differentiate between the staffing ratio between day and night. Achieving compliance with this standard would require significant additional financial investment. The senior nurse leadership in conjunction with the ward managers and team leaders have agreed that there is reduction on "off ward" activity e.g. journeys to; radiology, theatre throughout the night and as such have proposed and agreed that the night staffing levels would be -1 to daytime Due to the economies of scale in the bigger new wards the night staffing level is increased from current levels but not the same as daytime levels. This staffing plan continues to be monitored and evaluated and all wards will have annual establishment review undertaken as per best practice guidelines. All wards compliant except Wards 3B, 4B, 4C and EDU on night duty however additional temporary staff are sourced where acuity is high and necessitates the need to increase the night nurse to patient ratio	

Section 8: Specialist children's wards	At least a third of patients on specialist wards (such as oncology, cardiac, neurosurgery) should be classed as requiring high dependency care, although in some ward areas this may be as high as 50 per cent. The relevant standards must be followed (1:2 registered nurse: child). The minimum standard for other children being 1:3 registered nurse: child	**Partial ↑**
	There is a case to say that almost all of the in-patient wards at Alder Hey are specialist in nature Wards with dedicated HDU beds (Ward 1C and Ward 4A) are established for 1:2 ratio for commissioned HDU beds, and in addition Ward 4A provides 1:2 ratio for orthopaedic patients requiring a higher intensity of care Ward 3C regularly has high acuity patients requiring a HCA 1:1 and this is always supported and facilitated through temporary staffing as required Wards are not established for 1:3 ratio for remainder of patients. Achieving compliance with this standard would require significant additional financial investment Funded establishments increased on Wards 4B and 1C Cardiac in 2018/19	

4.4: Recruitment and Resilience

The senior nursing team have continued to undertake recruitment activities throughout 2018/19 and have recruited 92.6 WTE front line registered nurses between, demonstrating consistent and successful local and national recruitment. The Trust has also trained and appointed 2 WTE Nurse Associates who are amongst the first waves of the new Nurse Associates programme nationally.

Table 3 shows actual number of starters per quarter in 2018/19 in comparison to the previous 2 financial years.

Table 3: Front line registered nurses recruited in WTE

Q1 2016/17			Q2 2016/17			Q3 2016/17			Q4 2016/17			Total
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
	25	5.8	6		65.6		2		5.45	12.22	2.8	124.87

Q1 2017/18			Q2 2017/18			Q3 2017/18			Q4 2017/18			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
2	22.35	2.61	2.51	1	49.67	10.15	3.92	0	5.96	3.46	1	104.63

Q1 2018/19			Q2 2018/19			Q3 2018/19			Q4 2018/19			
April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	
4	26.21	3	1.22	0.76	4	48.53	2.22	0	1.31	0	1.39	92.64

There has been a recognised reduction in the number of staff who have commenced employment in the Trust since 2016/17.

During 2018, the senior nurse leadership team undertook a listening event with the Universities, student nurses and newly qualified Staff Nurses in order to better understand their requirements

with the aim of recruiting and retaining nursing staff. The student nurses advised us that they were not comfortable with the term of "Nurse Pool" as they did not understand what the term meant, they did not feel the term conveyed the permanence of a substantive position, and the term did not foster a feeling of being part of a team. Newly recruited Staff Nurses staff fed back that there was inconsistent preceptorship across Trust. The senior nursing leadership team also recognised that we were unable to clearly articulate our "offer".

Therefore, as a result of the review, the senior nursing leadership team identified opportunities and implemented improvements in the recruitment of registered nurses through a formalised corporate process, including a "One Stop Shop" recruitment day, incorporating a clearly articulated offer to new staff, and the development of the Staff Nurse Rotation Programme (see section 4.5 iii and section 5.1).

There are 8.4 WTE Band 5 front line staff vacancies at February 2019 across the wards. This is due in the main to the positive impact of increased funded establishments on Wards 1C Cardiac, Ward 3A and Ward 4B.

Of note, the senior nursing team have supported the opening of an additional 11 beds as part of the Winter Plan through the Staff Nurse Rotation Programme, and these have been opened sustainably over winter.

There are currently 554.6 WTE front line Band 5 staff employed against a funded establishment of 544.6 WTE. Due to the increased establishments, the opening of additional beds, and with continuing high levels of maternity leave and sickness, there is no additional resilience in the Nurse Pool, however 25 WTE Band 5 nurses were successfully recruited in January 2019 and are due to commence in post in May 2019. This demonstrates sustained resilience in that the variance is linked to staff availability to work and not vacancies. Table 4 below demonstrates the overarching Trust position regarding funded, contracted, and actual front line registered nurses, and a full break down by ward is provided in Appendix 3.

Table 4: Funded, contracted and actual front line registered nurse establishments Feb 2019

	Funded	Contracted	Actual	Variance Funded to Contracted
Band 5	544.6	554.6	525	**+10.7**
	Funded	**Contracted**	**Actual**	**Variance Funded to Contracted**
Band 6	142.8	154.2	147.6	**+11.4**
	Funded	**Contracted**	**Actual**	**Variance Funded to Contracted**
Band 7	15.6	20.2	20	**+4.6**

The Chief Nurse, Director of Nursing and Deputy Director of Nursing are involved in the Cheshire and Mersey project working towards zero vacancies within the region.

Appendix 4 provides analysis of all new starters in 2017 by ward.

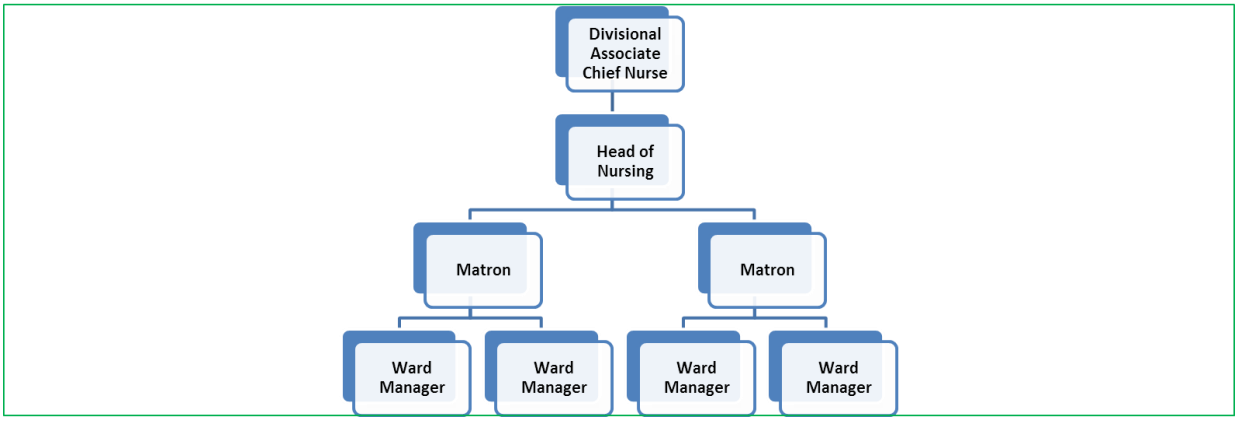
4.5: Workforce developments in 2018/19

i. **Acute Care Team (ACT):** A business case was devised and approved to establish an ACT team to support staff 24 hours per day in responding to patients showing early signs of deterioration. This is a significant and vital development in ensuring the safety of our patients 24 hours a day. The team will include an Advanced Nurse Practitioner on every shift, a support nurse for the Surgical Division and a support nurse for the Medical Division. The implementation phase is approximately 12 months due to need to recruit and appropriately train staff.

ii. **Clinical Educators:** In May 2018, the Nursing and Midwifery Council (NMC) launched new NMC standards for nurse training to begin to commence from 2019, with a clear focus on ensuring nurses clinical competence at the point of registration. A business case was devised, approved and implemented to introduce and successfully recruit a Head of Nurse Education to the Trust, supported by 6 WTE ward based Clinical Educators and an additional PEF, to facilitate the advancement of nurse education in the Trust. This will have a positive impact on our compliance with NMC and educational standards.

iii. **Staff Nurse Rotation Programme:** Developed in 2018 following a collaborative review involving local Higher Education Institutions, student nurses, and new Staff Nurses. The programme is a standardised approach to staff working and gaining a wider experience in different areas of the Trust, developing their knowledge and skills, and helping to retain our valued nursing workforce. During the first year of employment at Alder Hey, the nurse is allocated to a medical or surgical ward in line with their preference. In the second year, the nurse transfers to a specialist ward. All new nurses have a standardised and protected induction and preceptorship period. The programme also incorporates a formal standardised approach to staff movement within the Trust via a Transfer Window if the nurse is not happy on the allocated ward and considering leaving the Trust. The first cohort of the new Staff Nurse Rotation Programme commenced in October 2018 and has been positively evaluated thus far. The senior nursing leadership team will continue to monitor, evaluate and refine the programme based on feedback, results and audit.

iv. **Head of Nursing and Matron structure fully recruited to:** Following the restructuring to the three larger Divisions in November 2016, the Trust has successfully appointed to the three Head of Nursing roles across the Medical, Surgical and Community Divisions, whose duties include deputising for the Divisional Associate Chief Nurse, and all Matron positions. An example of the structure is as follows:



v. **Advanced Nurse Practitioner trainees:** Increased number of places to 6 per year available and recruited to enhance nursing practice and assist in the reduction of Junior Doctors

vi. **Nursing Associate role:** The nursing associate is a new health care role introduced by the Department of Health. The role is designed to bridge the gap between health care assistants and registered nurses by providing a route into nursing, enhancing the quality of hands-on care offered by the support workforce through defined and funded training and development, and strengthening the support available to nursing staff, releasing them to focus on higher level skills. Alder Hey has trained and employed two Nursing Associates and increased the number of training places at Alder Hey to 8 per year across 2 intakes per year.

4.6: Proposed workforce developments for 2019/20 to 2021/22

i. **"Proud to Care":** Devise a programme of "Proud to Care" across the wards and departments which underpins the Trust objectives, particularly 'Delivery of Outstanding Care' and 'Best People Doing Their Best Work', demonstrating safe, caring, effective, responsive care in wards and departments which are well led. It is anticipated that this programme will take 2-3 years to fully roll out and embed across the Trust.

ii. **Improvement Boards**: Implement as part of the Trust Inspiring Quality initiative. The boards are a visual quality improvement tool where staff identify opportunities to improve the quality of care, the patient experience and the experience of staff. The expected benefits are that staff have the means to solve problems and as a result feel a sense of ownership over solutions; enhanced patient experience, more value and less waste for patients; more engaged and developed staff and increased staff satisfaction; improved and more frequent communication between staff resulting in fewer problems; improved unit performance, decreased costs and increased efficiencies; and a streamlined approach to workforce organisation.

iii. **E-rostering:** A recommendation of the Carter Review is the implementation of e-rostering as a means of ensuring staff are deployed in the most productive way. The Trust is one of only 8 hospitals in England not to have a Trust wide e-rostering system. E-rostering is a pipeline project in the Trust Change Programme and a steering group has been established to manage the review. The Trust has identified 2 potential suppliers, however the Trust is also awaiting feedback from NHSI regarding a bid to work collaboratively with another Trust, and there is potential to apply to NHSI on a stand alone basis as a first time adopter.

iv. **Neonatal Single Service Workforce:** Continue to work in partnership with Liverpool Women's Hospital to plan, develop and recruit to the Single Neonatal Service in line with British Association of Perinatal Medicine (BAPM) standards.

v. **Nurse Associates and Pharmacy Technicians:** The long term plan is to train and recruit an appropriate number of Nurse Associates to support each shift on each ward. The benefits realisation from this change in workforce configuration would enable a Pharmacy Technician to be introduced on each ward to support the nurses with medicines administration. This follows the successful research project in 2017 which demonstrated the positive impact of the role on patient experience, medication safety, and releasing nursing time to care.

5. WORKFORCE CHALLENGES

5.1: Leavers

The average leaver rate per month in 2018/19 was 5.7 WTE per month compared to 6.5 WTE in 2017/18, therefore there is a small but significant average decrease in front line staff leaving the Trust. There was a shift in the pattern of leavers in 2018/19 with fewer staff leaving in Q1 and Q3 than previously.

Following an analysis of exit interviews, the senior nursing leadership team identified that there was no agreed process for staff to move wards if they were unhappy: the process was mostly reactive and often relied on senior nurses having to intervene to enable a nurse to transfer between wards and departments. This may have resulted in nurses leaving the Trust to gain a different experience at another organisation rather than retaining the nurse at Alder Hey.

Therefore, in line with the development of the Staff Nurse Rotation Programme, a proactive retention methodology has been introduced, incorporating a formal standardised approach to staff movement within the Trust via a Transfer Window where a nurse is not happy on their ward and considering leaving the Trust. The Transfer Window is open to all nursing staff, not only newly recruited staff. It is anticipated that this strategy will improve the retention of our valuable nursing workforce and the senior nursing leadership team will monitor the effect of this process on the leaver rate.

Appendix 5 provides analysis of all leavers in 2018/19 by ward. Table 5 shows actual leavers by Quarter demonstrating the improved position since 2016/17:

Table 5: Actual and average leavers in WTE per Quarter

	Q1		Q2		Q3		Q4		Total	
Year	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Actual**	**Mean per month**	**Total**	**Mean for year**
2016/17	**20.6**	(6.8)	**12.3**	(4.1)	**22.5**	(7.5)	**19.2**	(6.6)	**75.4**	(6.2)
2017/18	**20.5**	(6.8)	**14.5**	(4.8)	**24.7**	(8.2)	**18**	(6)	**78.4**	(6.5)
2018/19	**10.9**	(3.6)	**21**	(7)	**15**	(5)	**22.4**	(7.4)	**69.4**	(5.7)

5.2: Age profile of nursing staff

Age profiling and the potential for retirement is an integral part of effective workforce planning, thus enabling predicted future requirements to be identified and factored into the Trust's recruitment strategy.

Any registered nurse in the pre-1995 NHS pension scheme is eligible for full retirement at the age of 55 and actuarially reduced retirement from the age of 50. The nursing age profile in Table 6 identifies 41.6 WTE front line nursing staff aged 55 and over who could retire with immediate effect. This is a consistent with the position reported in March 2018 from 42 WTE. In 2018/19 5 (3.72) front line staff retired. In addition, a Matron and two Ward Managers also retired (senior nursing team not reflected in the table below). There are a further 50.6 WTE (aged 51-55) achieving retirement age in the next 5 years. Information relating to retirement intention is only available through staff sharing information voluntarily, therefore this poses a risk to the organisation. In order to impact assess and mitigate the risk of future gaps in the nursing workforce, work will continue to seek staff intentions over the coming years.

Table 6: Age profile of front line nursing staff in WTE

Age range	**21-25**	**26-30**	**31-35**	**36-40**	**41-45**	**46-50**	**51-55**	**56-60**	**61-65**	**66-70**
WTE 2017/19	150.4	149.6	130.5	93.2	47.8	58.4	57.6	25.3	14.9	1.9
WTE 2018/19	128.1	169.8	117.2	99.1	58	44.4	50.6	26.8	14.2	0.6

Effective succession planning is key, and there has been successful internal promotion to front line Band 6 and Band 7 nursing roles, including Ward Manager roles.

5.3: Maternity leave

Maternity leave cover is not currently included within the calculated ward establishments for any of the wards. In 2015/16 the Trust Board acknowledged the significant maternity leave issue and the challenges upon the nursing workforce and agreed to establish a nursing pool of 20 WTE registered nurses. In 2017/18, in recognition of the average maternity leave figure of 40 WTE, the Chief Nurse and Director of Finance agreed to increase the funded nursing pool to 40 WTE in order to further improve resilience and optimise bed occupancy.

It is clearly evidenced in Table 7 that an average number of around 40 WTE represents a "normal" level of maternity leave at any one time across the ward nursing teams. 60% of costs are recovered from central government across the duration of a period of maternity leave absence, the remaining 40% is the Trust's internal challenge, which is valued in the region of £480,000 per annum. Appendix 7 provides analysis of all maternity leave in 2018/19 by ward.

Table 7: Average maternity leave in WTE					
Year	**Q1**	**Q2**	**Q3**	**Q4**	**Average in year**
2016/17	42.6	41.6	44.3	45	43.3
2017/18	36.8	35	31	35.6	34.6
2018/19	36.4	36.6	39.6	38.4	37.7

5.4: Sickness

Long term sickness (LTS) has remained high in comparison to the last 2 years as shown in Table 8a below, with Q4 showing an increase to 32 WTE front line nursing staff. Ward Managers are supported by the HR team to ensure all staff on LTS are appropriately supported and managed.

Short term sickness has increased significantly over 2017/18. Ward Managers are working in collaboration with HR to manage sickness, and the senior nursing leadership team are engaged with the Trust Staff Wellbeing Committee to understand the top reasons for sickness absence and to support strategies to help staff stay well and in work.

Table 8a: Average LTS in WTE				
Year	**Q1**	**Q2**	**Q3**	**Q4**
2016/17	30.9	21	27	24.6
2017/18	15.7	14.7	24.4	29.4
2018/19	22.5	30.5	25	32

Table 8b: Average STS in WTE				
Year	**Q1**	**Q2**	**Q3**	**Q4**
2016/17	20.8	12.5	14.2	10.8
2017/18	6.8	8	13	15.7
2018/19	14	15	18.9	21.7

Staff health and wellbeing will continue to be an area of support and focus in 2019/20.

5.5: Attrition rates of recruited staff

The Trust continues to experience a 30-35% attrition rate amongst new recruits with appointed nurses subsequently taking up employment elsewhere. This attrition rate compares with a reported figure of 50% attrition as the national average. The intelligence demonstrates the need to recruit over and above the number of staff known to be required at any given time.

5.6: Increasing patient acuity

Specialling refers to patients' acuity requiring 1:1 nurse to patient ratio of care, which is over and above all acute inpatient ward normal rostered shift pattern and funded establishment (excluding PICU and HDU). The vast majority of special shifts are utilised on surgical wards (3A and 4A), and medical wards (3C and 4B). An example of a typical patient requiring "special" 1:1 care for a period of time would be a child requiring non invasive ventilation stepping down from HDU to Ward 4B.

5.7: Change to student nurse funding

In July 2016, the Government confirmed the decision to replace NHS bursaries for nursing with student loans, and student nurses were charged tuition fees from August 2017.

The full impact of this is still emerging however currently there has not been a reduction in the number of suitable applicants applying to train as a childrens nurse. There has however been a continued pressure in mental health and learning disability nurses.

This situation will continue to be monitored in collaboration with our HEI partners and the CM regional workstreams.

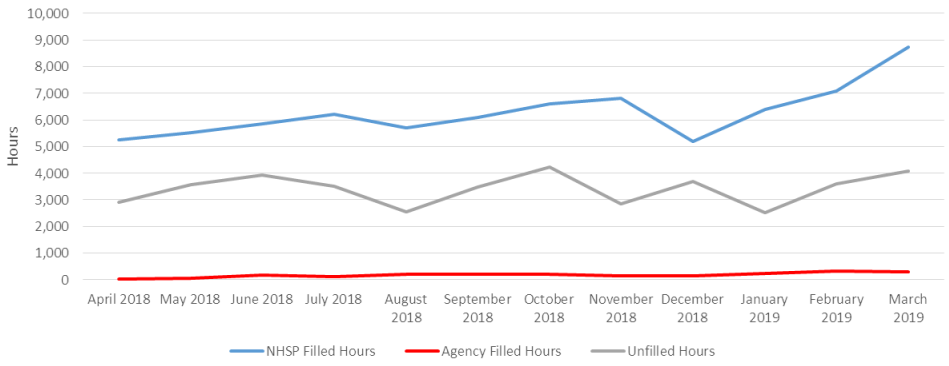
5.8: Temporary staffing: NHSP and agency

There has been a continued drive to reduce the use of bank and agency staff, which in addition to reducing expenditure, also provides safer nursing care with staff employed directly by the Trust.

Wards and departments continue to use NHSP predominantly to fill staffing gaps such as short term sickness. In 2018, the senior nursing leadership team undertook a piece of work to better predict the requirement for temporary staffing based on recruited staff, average leaver rate and the opening of additional winter beds.

The use of front-line nurse agency staff has been zero in 2018/19, with the only agency nurse usage required to support the specialist CAMHS team.

Alder Hey has the lowest use of agency staff in England as evidenced in the comparative data provided by NHSP temporary staffing providers.



6. RECOMMENDATIONS

A positive foundation has been built to support ongoing workforce management and further development. The senior nursing team will continue to implement planned developments, recruitment strategies, workforce reviews, and educational strategies. In addition, the team will respond to national and local developments and changes, and identify opportunities to transform and enable effective new ways of working.

The Trust Board of Directors is asked to support the following recommendations for further development:

a) Support the improvements and developments as detailed in section 4.6.

b) Continue to monitor and evaluate staffing levels and review safety and effectiveness, with specific emphasis on night staffing levels and staffing levels in specialist areas as outlined in section 4.2.

c) Continue to work with medical colleagues to identify the impact and plan to address reduction on junior medical staff numbers / changes to medical staff roles.

d) Continue to work in partnership with HEI's in the evaluation and further development of new nursing and support roles including through the apprenticeship route.

e) Continue to work with HEI's to promote nursing as a career choice with young people from all backgrounds and ethnic groups.

f) Continue recruitment activities to ensure that low levels of nursing vacancies are maintained.

Appendix 1: Staffing Availability Report 2018/19

Ward Safer Staffing 2018/19	Day registered	Day HCA	Night registered	Night HCA	Overall staffing	Overall Bed Occupancy
April	95%	102%	93%	123%	97%	85%
May	95%	102%	93%	113%	96%	82%
June	94%	96%	92%	99%	94%	83%
July	94%	101%	91%	108%	94%	80%
August	91%	106%	93%	93%	93%	75%
September	89%	108%	88%	111%	92%	77%
October	90%	105%	89%	106%	92%	81%
November	93%	103%	94%	96%	94%	83%
December	92%	105%	90%	106%	94%	74%
January	93%	104%	94%	97%	95%	74%
February	91%	98%	90%	112%	93%	81%
March	90%	110%	88%	115%	93%	79%

Appendix 2: RCN audit compliance by ward March 2019

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	Sec 5	Sec 6	Sec 7	Sec 8
1C Card	↑																			
1C Neo																				
3A																			↑	↑
3B																				
3C																				
4A																				
4B	↑																			
4C																				
PICU									↑											
HDU									↑											
Burns																				
EDU																				
MDC																				
SDC/ SAL																				
Renal																				
Trust overall RAG rating	↑	=	=	=	↑	=	=	=	↑	↑	=	=	↑	↑	=	↑	=	=	↑	↑

Key

Green:	Compliant	↑: Improved position compared to 2017/18
Amber:	Partial compliance	↓: Deteriorating position compared to 2017/18
Red:	Non compliant	=: Static position compared to 2017/18
Blue:	Trust agreed workforce requirement	
Grey:	Not applicable	

Appendix 3: Trust Front-line Nursing Workforce at February 2019

FRONT LINE REGISTERED NURSING WORKFORCE AT FEB 19																
	B5				B6				B7							
	Funded	Contracted	Actual	Variance F-C	Funded	Contracted	Actual	Variance F-C	Funded	Contracted	Actual	Variance F-C	Total Funded RN	Total Contracted RN	Total Actual	Variance F - A
1C cardiac	45.29	45.92	45.57	0.63	12.15	12.36	11.36	0.21					57.44	58.28	56.93	-0.51
1C Neo	18.65	19.34	19.98	0.69	5.33	5.33	5.33	0					23.98	24.67	25.31	1.33
3A	40.71	43.6	42.52	2.89	5.33	5.92	5.2	0.59					46.04	49.52	47.72	1.68
3B	28.47	28.07	25.56	-0.4	4.63	4.74	4.25	0.11					33.1	32.81	29.81	-3.29
3C	40.96	40.63	35.28	-0.33	7.99	6.24	5.24	-1.75					48.95	46.87	40.52	-8.43
4A	58.6	54.43	51.34	-4.17	10.65	11.46	11.5	0.81					69.25	65.89	62.84	-6.41
4B	26.95	27.53	26.71	0.58	7.1	7.2	6.38	0.1					34.04	34.73	33.09	-0.95
4C	41.86	45.81	43.45	3.95	5.33	5.13	4.21	-0.2					47.19	50.94	47.66	-0.47
BU	13.34	12.21	11.93	-1.13	2.86	2.7	2.74	-0.16					16.2	14.91	14.67	-1.53
PICU	105.06	105.18	102.17	0.12	41.68	48.9	47.95	7.22	9.43	14.52	14.2	5.09	156.17	168.6	164.32	8.15
HDU	56.55	61.06	50.69	5.05	13.52	15.65	15.35	2.13	2.66	3.49	3.55	0.83	72.73	80.2	69.59	-3.14
SDC	12.4	12.91	12.15	0.67	4	4.76	5.07	0.76					16.4	17.67	17.22	-0.82
MDC	3.44	3.27	3.27	-0.17	1.69	1.77	1.77	0.08					5.13	5.04	5.04	-0.09
DJU	8.6	8	8.37	-0.6	2	2	2	0					10.6	10	10.37	-0.23
OPD	11.17	8.96	9.06	-2.21	2.4	2.29	2.29	-0.11					13.57	11.25	11.35	-2.22
ED / EDU	32.61	37.74	37.02	5.13	16.19	17.8	16.98	1.61	3.55	2.27	2.27	-1.28	52.35	57.81	56.25	3.9
Total	**544.66**	**554.66**	**525.07**	**10.7**	**142.85**	**154.25**	**147.62**	**11.4**	**15.64**	**20.28**	**20.02**	**4.64**	**703.14**	**729.19**	**692.69**	**-13.03**
F = Funded																
C = Contracted																
A = Actual																

Appendix 4: New Band 5 staff commenced in post in 2018/19

Starters WTE 2018/19	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac		0.61				1	5						6.61
1C Neo							1						1
3A							5						5
3B							5					1.39	6.39
3C							2.92						2.92
4A							5	1.22					6.22
4B							5	1					6
4C							3.61						3.61
BU													0
PICU	3	2		0.46		3	8			0.31			16.77
HDU							5						5
SDC							1						1
MDC													0
DJU		1	1										2
OPD					0.76								0.76
ED	1		2				2			1			6
Pool		22.6		0.76									23.36
Total	**4**	**26.21**	**3**	**1.22**	**0.76**	**4**	**48.53**	**2.22**	**0**	**1.31**	**0**	**1.39**	92.64
Q total	**Q1: 33.21**			**Q2: 5.98**			**Q3: 50.75**			**Q4: 2.7**			

Appendix 5: Leavers in 2018/19

Leavers WTE 2018/19	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
1C cardiac				1		0.51						1	**2.51**
1C Neo												1	**1**
3A	0.4									2		0.81	**3.21**
3B		0.92				1			0.92	0.92		0.5	**4.26**
3C				1	1			0.8	1				**3.8**
4A				1.92		1		1					**3.92**
4B	0.92						3						**3.92**
4C	0.77			1	0.8	1			0.92		1	0.92	**6.41**
BU										0.61		1	**1.61**
PICU	1	1		2		1.17	1.8	1.61		0.31		3.84	**12.73**
HDU				1.61		1.37	1	0.92	1.07	1	2.61	0.92	**10.5**
SDC		1				0.83							**1.83**
MDC													
DJU	1	1											**2**
OPD				0.79									**0.79**
ED								1			1	3	**5**
Pool	2		0.92	2		1							**5.92**
Total	**6.09**	**3.92**	**0.92**	**11.32**	**1.8**	**7.88**	**5.8**	**5.33**	**3.91**	**4.84**	**4.61**	**12.99**	**69.41**
Q total	**Q1: 10.93**			**Q2: 21**			**Q3: 15.04**			**Q4: 22.44**			

Appendix 6: Maternity leave in 2018/19

ML 2018/19	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
1C cardiac	0	0.61	1.61	2.61	2.61	2.61	2.61	2.61	2.61	2.61	1	1
1C Neo	0	0	0	0	0	0	0	0	0	0	0	0.69
3A	3.45	3.53	2.53	3.81	1.92	1.92	1.92	1.92	0.92	0.92	0.92	0.92
3B	0.5	0.5	1.42	3.45	1.84	1.84	1.84	2.45	2.45	3.45	3.45	3.45
3C	0	0	1	2	2.92	2.92	2.92	3.84	5.56	5.56	5.56	5.56
4A	4.38	4.38	4.38	5.38	5.38	5.77	6.69	6.69	5.69	3.69	1.92	1.92
4B	2.92	3.92	3.92	3	3	3	2.61	2.92	3.84	1.92	1.92	1.92
4C	2.84	2.84	2.84	2.84	1.92	0.92	1.92	1.92	2.84	2.92	2.92	2.92
BU	1.73	1.73	0.92	0.92	0.92	0	0	0	0	0	0	0
PICU	8.08	14.91	7.61	5.46	5.06	6.14	5.22	5.22	6.62	5.61	5.61	4.99
HDU	3.98	3.98	3.37	3.81	6.37	6.37	8.37	7.37	7.37	8.37	9.29	9.29
SDC	1	1	1	0	0.76	0.76	1.76	1.76	1.76	0.76	0.76	0.76
MDC	0	0	0	0	0	0	0	0	0	0	0	0
DJU	0	0	0	0	0	0	0	0	0	0	0	0
OPD	0	0	0	0	0	0	0	0	0	0	0	0
ED / EDU	1	1	1	1	1	1	1	1	2	2	3	4.99
Pool	2.8	3.8	2.8	0.92	3.84	3.84	0.92	0.92	0.92	0.92	0.92	0.92
Total	**32.68**	**42.2**	**34.4**	**35.20**	**37.54**	**37.09**	**37.78**	**38.62**	**42.58**	**38.73**	**37.27**	**39.33**
Q average	**Q1: 36.4**			**Q2: 36.6**			**Q3: 39.66**			**Q4: 38.44**		

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Report of	The Director of Infection, Prevention & Control on behalf of the Trust's Infection Prevention & Control Committee
Paper prepared by	Nicki Murdock, Medical Director & DIPC Valya Weston ADIPC & IPC Service Lead Christopher Parry Infection Control Doctor Josephine Keward IPC Lead Nurse
Subject/Title	2018/19 Annual Report of the Infection Prevention & Control Committee
Background papers	Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance. 2009 (revised 2015)
Purpose of Paper	• To provide assurance in respect of all the elements contained in the assurance framework. • To highlight achievements • To highlight areas of non-compliance and provide areas for improvement in 2019-20. • To highlight current pressures
Action/Decision required	• That the Board receives and approves the Annual Report of the Infection Prevention & Control Committee
Link to:	IPS Work plan which is mapped to the IPC code and Trust objectives.
Resource Impact	Healthcare associated infections have a financial resource implication for all Trusts. Implementation of the 2019-20 IPS work plan and associated Trust wide action plans will have resource implications; however the aim of these projects is to have a direct impact on the reduction of Healthcare associated infections.

Alder Hey Children's NHS
NHS Foundation Trust

ANNUAL REPORT TO THE TRUST BOARD

PREPARED BY THE ASSOCIATE DIRECTOR OF INFECTION PREVENTION AND CONTROL ON BEHALF OF THE INFECTION PREVENTION & CONTROL COMMITTEE

April 1st 2018- March 31st 2019

Director of Infection Prevention and Control
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CONTENTS

EXECUTIVE SUMMARY

Work Plan Performance

The work plan for 2018-19 consisted of 14 objectives and a total of 118 deliverables. At the end of Q4 2018-19; ***78%*** (93/118) of the total of deliverables have been completed. ***17%*** (21/118) of the total deliverables were in progress (amber). ***0%*** were classified as red. 5% (6/118) were classified as grey as these are objectives that have not yet been progressed. Please see table 1 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green	Grey
Q1	14	118	0% (0)	25% (30)	59% (70)	16% (18)
Q2	14	118	0% (0)	21% (25)	72% (85)	7% (8)
Q3	14	118	0% (0)	19% (23)	75% (88)	6% (7)
Q4	14	118	0% (0)	17% (21)	78% (93)	5% (6)

Table 1: Deliverables RAG rating

Please click the link below for the full work plan.

IPC workplan 2018-19 Q4 Final.pdf

Achievements

Infection Prevention and Control and Vascular Access

- Plans drawn up and incorporated into the IPC work plan, to incorporate strategies to integrate Community staff, premises and education into the IPC audit and educational plan.
- Successful roll out of new hand hygiene audit tool throughout the Trust.
- Submission of a business case for three ultra violet machines for the enhancement of the deep cleaning and PPM processes throughout the Trust.
- Successful development and submission of a business case to purchase a new 'Cephaid' machine for rapid identification of carbapenamase producing organisms therefore freeing up isolation cubicles.
- Surgical Site Infection surveillance expanded to incorporate all inpatient surgical procedures.
- First launch of the annual "Love Bug Day" in February 2019 with the support of Industry Partners.
- Incorporated practical hand hygiene assessment in mandatory training.
- Successful integration of the Vessel Health and Preservation 2016 (VHP) framework into the Meditech system through the GDE project.
- Commencement of a PIR process for all MRSA, MSSA, E.Coli, Klebsiella and Pseudomonas which are then reported to divisional goveranance teams via a situation report.
- An increase in the percentage of staff compliance in Fit testing.

Tissue Viability

- The new Tissue Viability Service is now embedded into the awareness of Trust Staff.

- New classification system for pressure ulcers as directed by NHSI, now implemented into the Trust.
- 83% reduction in the number of grade/category 3 pressure ulcers reported in 2018-19.
- 2018-19 figures show the sustained rate of 0 in our grade/category 4 pressure ulcers.
- The increase in number of grade/category 2 pressure ulcers is reflective of a greater awareness and improved education across the Trust which has led to an increase in reporting.
- The introduction of an improved system of defining when grade/category 3 and 4 pressure ulcers are avoidable/lapse in care and the targeting specific steps to address these through undertaking Root Cause Analysis and sharing lessons learned.
- Link e-learning package with Electronic Staff Record (ESR). Work with community nursing team to support management of pressure ulcers in the community.
- A support structure for community staff with access to specialised tissue viability knowledge is now in place. Tissue viability link nurses are now established in the community and attend monthly Trust link nurse meetings and training sessions.
- Implementation of a new Tissue Viability Service ensuring continuity of the service seven days per week; consisting of a Tissue Viability Specialist Nurse, Tissue Viability Support Nurse and Tissue Viability Link Nurse System across the Trust.
- Implementation of an improved wound assessment tool on the Meditech System.
- Establishment of a rejuvenated Tissue Viability Link Nurse System with monthly meetings and educational sessions supported by industrial partners.
- Implementation of alternative intravenous dressings through the intravenous Access and Therapy Group to minimise the incidences of cannula acquired pressure ulcers across the Trust.
- Development of a Trust wide wound care formulary, offers rationalisation and evaluation of the wound care products across the Trust. This wound care formulary was launched for staff in November 2018.
- Implemented tissue viability competency assessment. Commenced with Link Nurses and will roll out to all qualified nursing staff.
- Implementation of tissue viability training compliance monitoring which is fed back to ward managers monthly.

1 Introduction

Alder Hey Children's NHS Foundation Trust recognises the obligation placed upon it by the Health Act 2008, (updated 2015) to comply with the Code of Practice for Health and Social care on the prevention and control of infections and related guidance.

The Trust supports the principle that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection are provided within the Trust.

1.1 Purpose

The Code of Practice (DH 2008) requires Trust boards to receive an annual report from the Director of Infection Prevention and Control and Associate DIPC. The purpose of the annual report is to inform the Trust Board of progress in delivering the Infection Prevention and Control Agenda and to provide assurance that appropriate measures are being taken to prevent and control healthcare associated infections.

1.2 Scope

This report is in relation to the provision of an effective Infection Prevention and Control (IPC) service for Alder Hey Children's NHS Foundation Trust.

2 Performance

2.1 Work Plan Performance

The work plan for 2018-19 consisted of 14 objectives and a total of 118 deliverables. At the end of Q4 2018-19; ***78%*** (93/118) of the total of deliverables have been completed. ***17%*** (21/118) of the total deliverables were in progress (amber). ***0%*** were classified as red. 5% (6/118) were classified as grey as these are objectives that have not yet been progressed. Please see table 2 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green	Grey
Q1	14	118	0% (0)	25% (30)	59% (70)	16% (18)
Q2	14	118	0% (0)	21% (25)	72% (85)	7% (8)
Q3	14	118	0% (0)	19% (23)	75% (88)	6% (7)
Q4	14	118	0% (0)	17% (21)	78% (93)	5% (6)

Table 2: Deliverables RAG rating

2.2 Hospital acquired Infections

The table below show the number of hospital acquired infections for 2017-18 compared to 2015-16 and 2016-17.

	2015-16	2016-17	2017-18	2018-19
MRSA BSI	***3***	***2***	***4***	***0***
MRSA (Non bloodstream)	***8***	***4***	***9***	***7***
Cdiff	***2***	***1***	***1***	***1***
MSSA	***6***	***13***	***14***	***10***
Gram Negative bacteraemia	***11***	***8***	***16****	***16***
RSV	***10***	***11***	***10***	***35***
Influenza	***8***	***5***	***8***	***6***
Rotavirus	***0***	***0***	***0***	***1***

Figure 3; Hospital acquired infections

The Trust reports mandatory infections caused by identified organisms: MRSA, MSSA, E Coli, Klebsiella and Pseudomonas bacteraemia and Clostridium *difficile* Infections (CDI).

In 2017-18 the Trust reported 27 hospital acquired infections due to mandatory reportable organisms. This is a rate of 0.40 per 1000 bed days. This compares to 35 hospital acquired infections reported in 2017-18 with a rate of 0.58 per 1000 bed days.

*The increase in the incidence of mandatory reportable HAI in 2017-18 was due largely to an increase of mandatory reportable organisms that we now have to report to PHE.

Figure 4 shows our internal target status for 2018-19.

Metric	Target 2018-19	Target Figure	Actual Figure	Current Status
HA - MRSA (BSI)	*Zero Tolerance*	***0***	***0***	
C.difficile	*Zero Tolerance*	***0***	***1***	
MSSA	*25% Reduction from 17-18*	***10***	***10***	
CLABSI (ICU Only)	*10% Reduction from 17-18*	***18***	***18***	
Gram-Negative BSI	*10% Reduction from 17-18*	***14***	***16***	

Figure 4, Internal HAI target

2.2.1 MRSA Bacteraemia

There has been **0** hospital acquired cases of MRSA bacteraemia during 2018/19 compared to 4 cases in 2017/2018.

2.2.2 CDIFF

There has been **1** hospital acquired case of Clostridium *difficile* during 2018/19 which is the same as last year.

A Post Infection Review (PIR) has been conducted of the case and we are awaiting a review date in the hope of appealing this case with Liverpool CCG, as the internal review did not identify any lapses in care.

2.2.3 MSSA

Data collected from 2016/17 and 17-18 demonstrated that there had been a 50% increase in the number of hospital acquired MSSA bacteraemia in the Trust from 2015-16. Therefore in 2018-19 we set an internal target of 25% reduction and developed a Trust wide Action plan to reduce the avoidable incidences of MSSA bacteraemia across the Trust. Please see link below for action plan.

MSSA Bacteraemia Action Plan 2017-18 (

We achieved the internal target at the end of 2018/19 and have completed the Action plan. Going forward the momentum will continue to reduce our MSSA bacteraemia (a further internal target reduction of 10% in 2019/20) and this will be monitored on a regular basis through a quarterly report through the IPCC.

2.2.4 Gram Negative Bacteraemia

At the start of April 2017 the mandatory surveillance for Public Health England (PHE) was expanded from just E Coli bacteraemia to include all Klebsiella and Pseudomonas bacteraemia. Post Infection Reviews (PIRs) have continued for all these identified Gram Negative bacteraemia and findings/ identified actions are reported via the Situation Reports through the Divisional Governance structures.

PIR themes have been discussed with NHSI and there are plans to implement a quality improvement process to address the most significant identified themes. Additionally these identified themes continue to be fed back to the North Mersey Gram Negative Blood Stream Infection Reduction Group as part of the whole Health economy strategy.

2.2.5 Respiratory Syncytial Virus (RSV)

RSV is a highly transmissible seasonal viral respiratory infection predominately seen in the paediatric population. Children require isolation whilst they are symptomatic and high numbers are seen during the winter period. RSV is monitored as part of the Trust local surveillance programme and is a key infection prevention marker for paediatric Trusts.

During 2018/2019 there were **35** cases of hospital acquired RSV compared to **10** in 2017/18. Therefore this will form an action plan for 2019-20. We have set an internal target of 25% reduction for 2019-20.

The table below shows a rate for RSV per 1000 bed days for the Trust, for the winter period 2018/2019. The Trust had a rate of 1.06 per 1000 bed days for hospital acquired RSV for 2018/2019. This has increased from last year when the Trust rate was 2.4 per 1000 bed days. The rate of 1.06 per 1000 bed days is outside limits published in literature but there are no national rates published to be able to benchmark against.

	Total RSV for season	Occupied beds for season	Rate per occupied bed days
14/15 Season	11	38,712	0.28
15/16 Season	10	33,090	0.30
16/17 Season	9	33,092	0.27
17/18 Season	8	33,955	0.24
18/19 Season	35	33,161	1.06

Figure 5; RSV breakdown by year

Internal target set for 2019-20 with a 25% reduction (35 cases 2018-19, aim for 26 cases 2019-20) in conjunction with a Trust wide action plan with specific objectives which will be monitored through IPCC.

2.2.6 Influenza

During 2018/2019 there have been **6** cases of hospital acquired Influenza compared to **8** in 2017/2018. The table below shows the Trust rate for hospital acquired influenza per 1000 bed days.

The rate for hospital acquired influenza for 2018/2019 was 0.15 per 1000 bed days. This has decreased from last year when the rate was 0.21.

	Total Influenza for season	Occupied beds for season	Rate per occupied bed days
14/15 Season	6	38,712	0.15
15/16 Season	8	33,090	0.24
16/17 Season	5	33,092	0.15
17/18 Season	7	33,955	0.21
18/19 Season	5	33,161	0.15

Figure 6; Objectives RAG rating Q4* Please note the table below shows 5 cases as 1 of the 6 cases for 2018/2019 fell outside the winter period.

Staff Influenza Vaccination

The campaign ended with the Trust achieving **75.3%** of all frontline staff vaccinated against influenza. These results are consistent with last year's compliance.

Group (baseline)	Baseline	Overall Uptake	Percentage Uptake 2018-19
1-Doctors (ESR)+ Rotational /Junior staff	517	388	75.0%
2- Nurses(ESR)	1219	984	80.7%
3- Support to Tech(ESR)	344	232	67.4%
4- Support to clinical(ESR)	341	220	64.5%
TOTAL FRONT LINE STAFF UPTAKE	**2431**	**1823**	75.29%

Compliance (Green) is indicated by a score >75%

Figure 7; Influenza uptake by staff group

What worked well 2018-19

- Communication campaign
- Launch day in the atrium
- Ward based vaccinators
- Walk rounds
- Staff nurse allocated to IPCT from October to March to assist with delivery of vaccine
- Updating of Staff Spreadsheet on a monthly basis

What needs to improve for 2019-2020

- Overall increase in uptake for clinical staff to be over 80% in order to achieve the CQUIN target.
- Engagement in achieving target by the divisions.
- Increase in numbers of quadrivalent vaccines purchased to ensure that no restriction in access to the vaccine during the campaign. During 2018-19 we had to limit the vaccine to clinical staff only during December to ensure that we reached out target.

- Purchase of trivalent vaccine with adjuvants for the over 65 years so all clinical staff have access to appropriate vaccine.
- A Budget needs to be allocated for the campaign. In 2018-19 the costs of the campaign was a cost pressure on the IPC budget for the 2nd year running. The budget is required for the purchase of consumables such as plasters, cotton wool, and alcohol gel and for incentives such as campaign pens and sweets.
- Medical staff uptake needs to improve in the following specialities; Neurology, Anaesthetics, Dental and oral max fac, Neurosurgery, Optical services, Orthopaedics, Surgical spec-ENT, Surgical Speciality –Ophthalmic, Surgical speciality plastics, community paediatricians
- Allied Healthcare professionals in the following groups need to improve uptake; Speech therapy, Appliances, Audiology, ECG, Perfusionists, Community OT
- Action plan required to increase uptake amongst nursing in the following groups, CAMHS, Home carers, CCNT.
- Areas with uptake below 75% develop an action plan to be developed in the divisions to increase uptake e.g. DJU, Theatres, Surgical day case, 4A and 4B and OPD,
- Action plan to be developed by Community division to improve uptake as below 50% of front line staff. Uptake could be increased if this becomes a role for the Community ICN if the business case is successful.
- Team prevent to improve liaison with Community teams and use all their allocated hours for vaccination.
- Attendance and input into End of season campaign review by MDT.

2.3 Outbreaks

There was **1** viral outbreak during 2018/2019 compared to 3 in 2017/2018. The outbreak was as follows:

- A laboratory confirmed Norovirus outbreak in February 2019 on Ward 3B, 1 patient and 18 staff affected. There were 0 bed days lost to this incident.

2.4 Central Line Associated Bacteraemia Infections (CLABSIs)

CLABSIs are one of the most significant hospital-acquired infections with **54 cases** in 2018/2019 compared to **50 cases** in 2017/2018 (These numbers are not validated as currently we are only able to validate PICU cases due to the difficulty with capturing data per 1000 catheter days). The table below shows hospital-acquired lab confirmed CLABSIs during 2018-19 compared to 2017-18, 2016-17 and 2015-16.

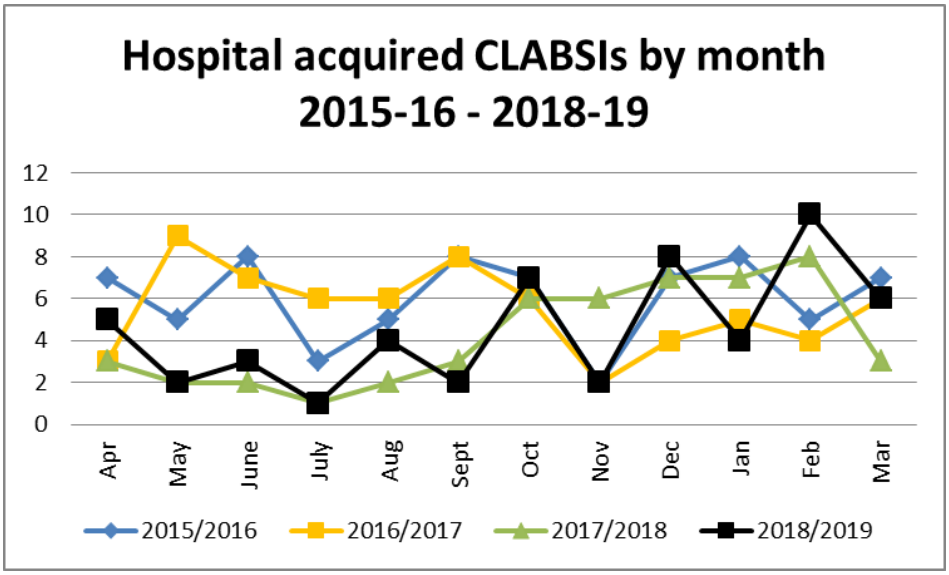


Figure 8; Hospital acquired CLABSI

The graph below shows the PICU CLABSI rate by month.

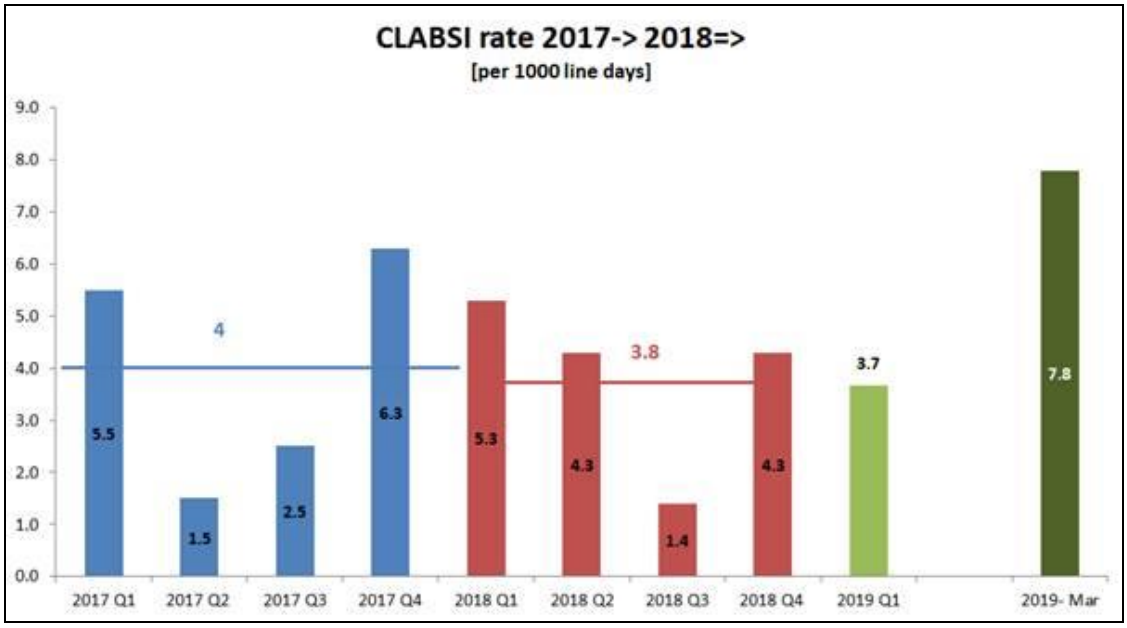


Figure 9; Hospital acquired CLABSI for PICU

Key issues

The validated CLABSI rate per 1000 catheter days for PICU has decreased from 4 per 1000 line days to 3.8 per 1000 line days. This rate remains high compared to paediatric published data, however the acuity of the patients treated at the Trust needs to be taken into account when considering these figures.

Currently the Trust is unable to report validated accurately Trust wide CLABSI rates in 1000 line days due to difficulty capturing the data across the Trust. However there is a work being undertaken to

try and capture this data and progress this work through the GDE project team to develop a programme in the Meditech system to capture more robust vascular access data.

During 2018-19 collaborative working across the Trust has commenced in the prevention of CLABSI, through the Intravenous Access and Therapy group and the commencement of the CLABSI initiative to heighten the awareness of CLABSI both on the PICU department and across the Trust.

2.3 Multi Drug Resistant (MDR) Organisms

Multi-drug resistant organisms pose a significant clinical risk due to the limited range of therapeutic antibiotics that may be available to treat a patient's infection. There continues to be the emergence of extended spectrum β-lactamases (ESBLs) and Carbapenemase Producing Enterobacteriaceae (CPEs) both regionally, nationally and internationally. The main focus for the reduction of ESBLs and CPEs continues to be effective antibiotic stewardship, patient surveillance by rectal screening and implementation of basic infection prevention and control practices.

NHS Trusts across the North West continue to encounter significant cases of CPE. The number of organisms remains low at Alder Hey. However ongoing surveillance for these organisms is extremely important in view of inter hospital transfers.

Delay in the laboratory confirmation of presumptive CPE results by the reference laboratory was having a significant impact on the period of isolation for suspected cases. A business case was developed and agreed in 2018-19 to introduce rapid testing for CPE detection into the Trust. We are currently working on the SOP in order to roll this system out across the Trust.

2.3.1 MRSA Admission Screening

MRSA admission screening is undertaken to detect colonisation (carrying the bacteria without any infection). In certain individuals, colonisation may predispose to infection and colonised patients have the potential to transmit the bacteria to another patient. An internal tolerance for compliance has been set at 95% following the removal of mandatory reporting to the DH.

The graph below shows the compliance by month for MRSA screening for 2018-19 compared to previous years.

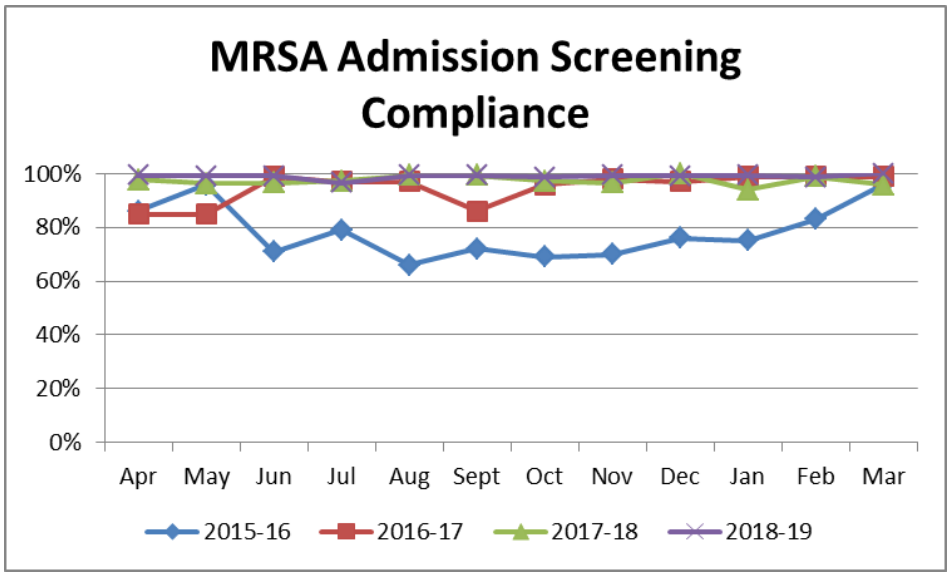


Figure 10; MRSA Admission screening compliance

2.3.4 CPE Screening

The graph below shows CPE screening compliance by month for 2018-19 compared to previous years.

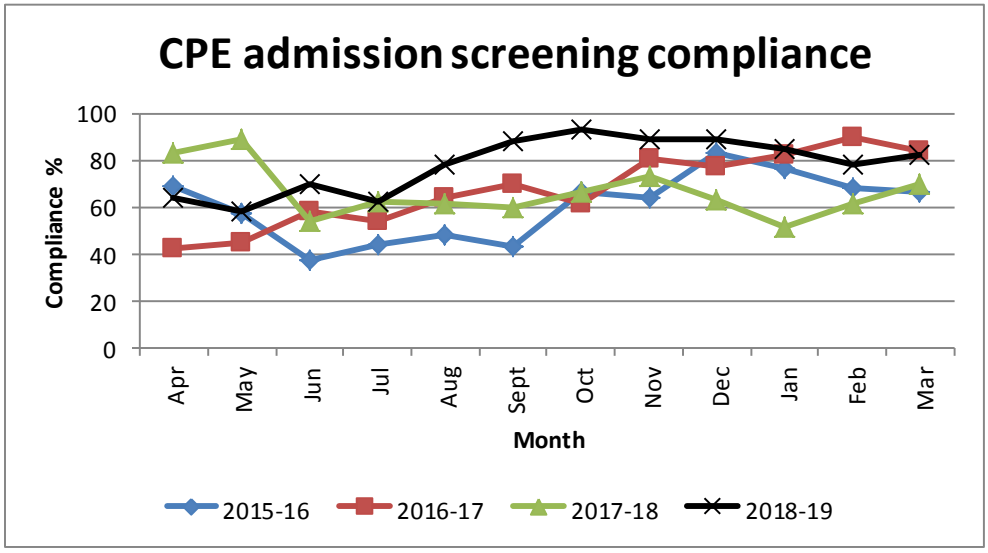


Figure 11; CPE Admission screening compliance

Key Issues

Compliance for CPE admission screening was 78% in 2018-19 compared to 66% in 2017-18. This remains a concerning trend that needs to be reversed due to the increase in cases of CPE especially in the North West region.

A Trust wide action plan was created in 2018/19 to address the issues surrounding the compliance in CPE screening. To date all actions have been completed except for putting a prompt for all eligible

patients on the Meditech system, this however is being progresses. The success of these actions is reflected in the graph above.

2.3.5 Antibiotic Stewardship

In 2018/19 we were set 1 national CQUIN which was split into 3 parts:

- Decrease total consumption of antibiotics per 1000 admissions by 2%
- Decrease total consumption of carbapenems per 1000 admissions by 2%
- Increase the proportion of antibiotic usage within Access group of the AWaRe category by 3%

The baseline data for all of the above targets was financial year 2016/17.

Unfortunately we were unable to achieve either of these targets. We saw our total consumption increase by 15%, our carbapenem consumption increased by 22% and we were only able to increase our proportion of the Access antibiotics by 0.45%.

We continue to try and understand the impact of the sepsis pathway on the consumption of antibiotics. We have reviewed the consumption of the antibiotics we used commonly for community acquired sepsis and hospital acquired sepsis and we have observed a marked increase in their use, eg, ciprofloxacin use has increased by 74%.

We have seen a large number of extended courses of carbapenems which is almost directly related to the bad flu season we had last winter. After looking into carbapenems prescribed on Meditech (excludes PICU) we identified the average course length was 5 days (compared to 3 days the year before) and the range had increase from 1-12 to 1-21. We were also able to demonstrate the consumption of carbapenems on PICU had markedly increased when compared to the previous two years.

We continue to audit IV antibiotic prescriptions on AMS ward rounds. In the previous year we reviewed 4536 prescriptions (+25% from 2017/18) and noted a 95% appropriateness score. Note: this does not include Critical care, Oncology, CF patients or ED/Outpatient prescriptions.

We have identified a need for a radical change in the approach of the AMS team as well as engagement from clinicians and we have commenced the development of a 5-year plan which we plan to work with the executive team.

Actions

- Develop and publish 5-year AMS plan
- Continue an Antimicrobial Stewardship ward-round Monday to Friday – consultant-led 3 times a week – for 2019/20 this will also include antifungal stewardship
- Establish a governance/quality process to divisional boards

2.3.6 Sepsis

Sepsis Pathway

The sepsis pathway has been fully integrated in to the electronic patient documentation/pathway. In our first year we implemented a mandatory sepsis concern question every time a set of clinical observations were inputted. This was to prompt the nurse to think about any deviation in clinical observations and provided the nurse with a prompt if any risk criteria had been identified.

In year two we have expanded this scope to now include clinicians. Every time a clinician reviews a child and documents in the electronic ward review document, they too have a mandatory question asking if the review was due to a sepsis concern if they had any concerns regarding sepsis. As well as this we have introduced a sepsis status which is able to provide a visual prompt and hospital wide clinical overview for all those patients where there are sepsis concerns and/or if being treated for sepsis. This is an ongoing evolving piece of work but provides a level of assurance that nurses and clinicians are being prompted to think about sepsis and not having to rely on a paper screening tool.

The status's are monitored by the sepsis nurse and also provide the trigger points for continued data collection. The aim is now to look at electronic data collection which can provide the trust with an overview in the form of a dashboard in relation to compliance against targets and monitoring of cases rather than this work being done manually.

A recent audit by MIAA – Review of Sepsis Process Final Report 2018/19 concluded -

"There is an adequate system of internal control, however, in some areas weaknesses in design and inconsistent application of controls puts the achievement of some aspects of the system objectives at risk.

Moderate Assurance

This assurance rating is in relation to several areas of the overarching sepsis framework and processes, including training. It is not directly related to patient care.

It was evident that substantial progress in Sepsis care and promotion had been undertaken by the specialist Sepsis Leads."

CQUIN Performance for Inpatients

	Q1	Q2	Q3	Q4
2a) Sepsis screening	100%	100%	100%	100%
2b) Timely treatment of sepsis with IV antibiotics	76%	73%	73%	75%
2c) Antibiotic Review	96%	97%	95%	100%

Figure 12; CQUIN performance for inpatients 2017-18

CQUIN Performance for ED

	Q1	Q2	Q3	Q4
2a) Sepsis screening	100%	100%	100%	100%
2b) Timely treatment of sepsis with IV antibiotics	62%	67%	60%	76%

Figure 13; CQUIN performance for ED

Training and Education

E-learning is now live for both hospital and community staff to access on ESR. Be-spoke presentations are delivered at request throughout the hospital and also at community locations to continue to provide education and support to staff.

Using the sepsis status, daily ward rounds have begun to discuss the identified patients with nurses and look at the care they are receiving.

A comprehensive training needs analysis is taking place to map out the trusts diverse workforce and to look at how we best train and educate so that we are not solely reliant on e-learning.

Actions

- Continued development of the sepsis status to aid in electronic data capture
- Continued monitoring of identified patients and data collection to provide quality assurance in relation to sepsis care management
- Review of the sepsis bundle of care rather than just administration of IVAB in relation to those cases with a 'treat as sepsis' status identified as high risk.
- Networking and collaboration across other paediatric hospitals to help influence paediatric sepsis care.

2.3.7 Surgical Site Infections

Current Trust SSI (surgical site infection) rates are:

- Cardiac PHE Rate for quarter 4 was **0.9%.**
- Orthopaedic spinal surgery PHE rate for quarter 1, 2, 3 & 4 was **0%.**
- Neurosurgery PHE rate for quarter 1, 2, 3 & 4 is **0%**.

Data for Q4 has been submitted but rates are not available currently.

SSI rates remain low across all specialities. All specialities are now monitored, followed up and reported through internal measures.

Actions

- CVC files now able to be pulled from SSIS database to upload straight into PHE

- Text messages are now sent to every patient 30 days post operatively.

- OneTogether working group established and baseline assessment undertaken. 64.5% of elements compliant and work has commenced on addressing non-compliant elements.

3 Environment

3.1 IPC Spot Audits

This year the IPCT have established a new spot audit which is conducted monthly on each ward area. The audits encompass ward environment, linen/waste/sharps/spillages, patient equipment and clinical practice. The table below shows overall results by month by ward/department for 2018-19.

	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Yearly Average
AED	69	95	78	74	86	76	77	83	77	83	77	75	79
EDU	76	85	86	86	89	80	80	86	83	91	82	91	85
1B PICU	83	69	79	79	80	77	79	68	81	87	82	98	80
1B HDU	73	84	80	78	82	85	83	90	82	79	88	93	83
1B Burns	87	96	89	89	78		86	95	86		89	92	89
1C	70	71	80	68	87	83	74	83	80	87	82	60	77
3A	62	81	87	98	90	79	90	90	88	83	92		85
3B	73	85	85	89	80	85	88	85	90	87	88	88	85
3C	82	80	85	90	80	88	90	90	85	93	88	90	87
4A	71	68	69	86	76	74	80	88	73	78	90	60	76
4B	61	80	82	89	77	93	88	64	83	83	83	88	81
4C	78	73	85	95	83	80	83	90	68	72	85	73	80
Dialysis	92	81	90	93	97	97	93	87	93	97	96	97	93
CRF	81	82	81	88	94	96	90	92	93	100	100	97	91
OPD GF		45	65	65	89	81	81	91	97	91	85	94	80
OPD 1st		85	84	85	85	97	93	97	97	91	97	90	91
OPD 2nd	81	68	82	85	88	93	88	71	88	84	91	88	84
Theatres				95	97	98		98	98		95	98	97
Therapies	47	62	46	71	79	95	76	70	69	70	88	77	71
Medical Daycase	87	71	74	70	85	88	92	82	88	84	84	84	82
Radiology			79	75	91	91	91	79	91	87	94	94	87
Rainbow Centre						76	91			96	100	96	92
Dewi Jones Unit			76						78				77
Total	73	77	79	83	85	86	85	85	85	86	89	86	83

Figure 14; IPC Sport audit compliance by month and department.

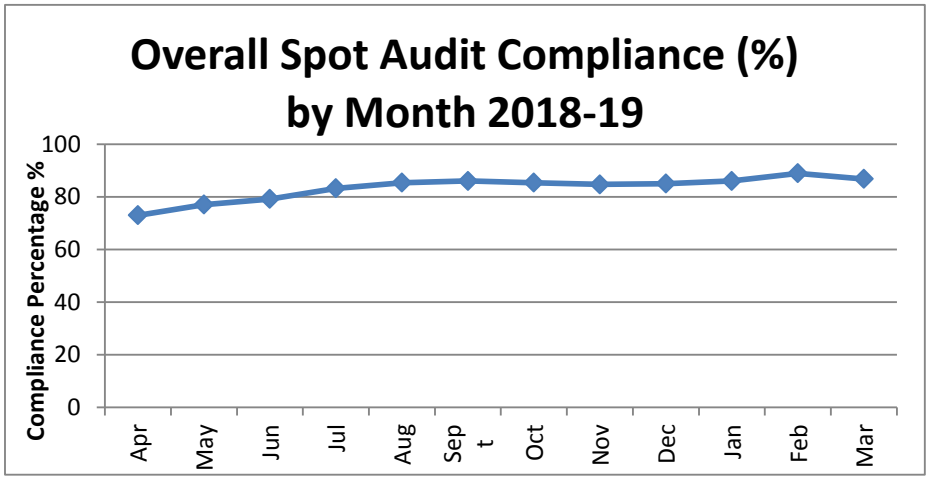


Figure 15: Spot Audit Compliance graph

3.2 Water quality

The Trust has a system and people for governing water safety in the organisation. Oversight for water safety management is provided through the Trust Water Safety Group which is chaired by the Chief Operating Officer.

The highlights from our work programme this year includes:

- Fixes to our water system infrastructure to deliver better water temperatures and better flow
- An independent assessment of our water safety management practices with a corresponding action plan to implement recommendations
- Improving the hot water temperatures to deliver compliance with regulatory standards. There are still challenges in this area and we continue on our programme to enhance the water system.

We manage water safety though the following controls:

- Sampling for pseudomonas and legionella
- Use of filters on taps to mitigate risk of infection
- Water temperature surveillance
- Robust cleaning processes
- Training and suitably appointing personnel
- Regular independent operational and governance auditing of systems and practices

3.3 Air quality

The Trust continues to undertake monthly surveillance for aspergillus in critical care and on the Oncology unit whilst the demolition and building work continues. Currently aspergillus air levels remain very low.

Air quality in theatres, particularly in the ultra-clean theatres is compliant with HTM guidance for ventilation. This is monitored by the Trusts Theatre Manager and the authorised engineer (AE) in Ventilation.

3.4 Environmental Cleanliness

The IPC team have collaborated with Domestic services , Health & safety, Ward managers, Housekeepers and Ward managers to progress actions to improve environmental cleanliness including;

- The introduction and implementation of a new cleaning policy

- Development of Standard Operating procedures (SOPS) for the validation of cubicle cleaning and deep clean process using ATP Luminometer

- Introduction of regular meetings with the Housekeepers to address IPC issues

- Commencement of task and finish group for waste management to address issues identified in Waste audit and trial a new waste management process bag to bed system

- Structural modifications of the Bed wash area to ensure safe flow from dirty to clean

3.6 Decontamination

Interpreting Final Rinse Water Results

Automatic endoscope re-processor (AER) weekly water for total viable count (TVC) is now collected in-house by trained endoscopy decontamination staff. The weekly water testing for TVC's is now carried out by 20/30 laboratory with improved comprehensive results

Environmental Mycobacteria testing in Endoscopy

Water Test	Satisfactory Results	Frequency
Total organic carbon	Less than 1 mg/L	Yearly
Appearance	Clear bright and colourless	Yearly
PH	5.5 - 8.0	Yearly
Electrical conductivity	Less than 40 µs/cm at 25°C	Weekly
Hardness	Less than 50 mg/L CaCO3	Weekly if appropriate
Total Viable Count	Less than 10 cfu m/L acceptable	Weekly
Environmental Mycobacteria	Non detected in 100 m/L samples	Quarterly
Pseudomonas aeruginosa	Non detected in 100 m/L samples	Quarterly

Figure 16; Environmental Mycobacteria testing in Endoscopy

Achievements within 2018-2019:

- Re-appointment of Authorised Engineer for Decontamination AE(D)
- Theatres became CJD compliant 1st October 2018 with new instruments and processes, some service issued still to be addressed
- Dental have new improved transportation of surgical instrument process and striving to be consistent with theatres for all processes
- Hydrotherapy have a new arrangement in place with IFM for decontamination of the pool ducts and channels
- Schedule of Decontamination Audits with date to present action plans are presented to Decontamination Committee (as below)
- New equipment procured and implemented in the Mortuary for autopsy instrument

Annual and Quarterly Validation

All quarterly and annual maintenance has been performed though difficulties in obtaining the validation reports continued throughout 2018 and resolved June 2019.

MODEL	COMMISSION DATE	APR 2018	MAY 2018	JUN 2018	JUL 2018	AUG 2018	SEP 2018	OCT 2018	NOV 2018	DEC 2018	JAN 2019	FEB 2019	MAR 2019
STEELCO 6/ IE 9965 AUTOCLAVE	11/08/2015												
	13/01/2016												
MIELE PG8825/ 126460043 BED WASHER – NOT YET IN USE													
STEELCO 15066002 AER				15/06/2018			20/09/2019			25/01/2019			24/04/2019
STEELCO 15066003 AER				16/06/2018			20/09/2019			25/01/2019			24/04/2019
STEELCO 15066001 AER				15/06/2018			20/09/2019			17/01/2019			24/04/2019
STEELCO STORAGE CAB 009	21/05/2015			17/05/2019			09/08/2018			12/11/2018			11/02/2019
STEELCO STORAGE CAB 008	26/05/2015			17/05/2018			09/08/2018			12/11/2018			11/02/2019
STEELCO STORAGE CAB 010	21/05/2015			17/05/2018			09/08/2018			12/11/2018			11/02/2019
STEELCO SPECIAL FEEDS 1506010CK025 WASH/DISIN	14/07/2015			04/07/2019			31/10/2018			03/01/2019			22/03/19

Figure 17

Decontamination Audit and Committee Schedule 2019

Trust Decontamination Audit and Committee Schedule 2019		
JANUARY No Audits winter pressures	**FEBRUARY** No Audits winter pressures	**MARCH** w/c 1 Endoscopy w/c 1 Bed Wash area
		Present to Decontamination Committee 18th April
APRIL w/c 1 Dental	**MAY** w/c 31 Special Feeds	**JUNE - Decontamination Annual Report due** w/c 3 Hydrotherapy w/c 10 Theatres
Present to Decontamination Committee 18th April	Present to Decontamination Committee 18th July	Present to Decontamination Committee 18th July
JULY w/c 1 Radiology w/c 8 Ophthalmology w/c Communities	**AUGUST** w/c 5 All Wards Echo/Cardiac/ECG Wards 3a 3b 3c 4a 4b 4c audit	**SEPTEMBER** w/c 2 Accident Emergency Department w/c 9 ENT
Present to Decontamination Committee 24h October	Present to Decontamination Committee 24th October	Present to Decontamination Committee 24h October
OCTOBER w/c 7 Endoscopy (6 Monthly) w/c 14 Dental	**NOVEMBER** w/c 4 Pathology - Autoclave w/c 11 OPD w/c 18 Mortuary	**DECEMBER** w/c 9 Hydrotherapy
Present to Decontamination Committee 16th January 2020	Present to Decontamination Committee 16th January 2020	Present to Decontamination Committee 16th January 2020
All DEPARTMENTS must COMPLETE their own audit and devise their departmental action plan and return to DECONTAMINATION within 2 weeks of audit date		
NOTE: All Departments to Complete a Departmental Audit Template, to update the Committee whether in attendance or sending apologies		

Figure 18

3.7 Building Services

The Building Services Team, (BST) is responsible for the monitoring of the Private Finance Initiative, (PFI), contract including the monitoring of the Hard FM provider Interserve to ensure Planned and Preventative Maintenance, (PPM) is compliant and that routine call logs for various issues is resolved in line with the contractual obligation. The BST are also responsible for working alongside department requests for works outside of the contract, these are known as ad hoc works, small

works and Trust Variation Requirements, (TVE's). The category of job is based on the actual cost of the works.

Over the past year the BST have worked in partnership with the Infection & Prevention Control team, (IPC), on several key issues.

These include, but not limited to:

- Potential changes to the ventilation specification within several areas of the ED & ICU department to ensure highly infectious patients can be accommodated without risk to other patients
- Water Safety Group collaboration in regards to hot and cold water issues
- Checks and changes to room not meeting the contractual air changes specification
- General cleanliness of the environment and improving with weekly walkabouts
- Removal of all portable fans within the new build

The BST will continue to grow the relationship with IPC and support the department in any way which contributes to the overall objective of ensuring a safe environment for patients and staff.

4 Infection Prevention and Control Activity

4.1 Hand Hygiene Trust Compliance

Hand Hygiene Compliance-self reporting by clinical areas

During 2018-19 we introduced a new hand hygiene app to ease the recording of hand hygiene opportunities for staff on the wards. This has eliminated the use of paper audits and allows staff to record opportunities at any time.

Compliance with hand hygiene is demonstrated by scoring above 95%. Overall hand hygiene Compliance for 2018-19 was **86%**. Compliance varied by staff group and opportunity. The chart below shows the compliance by staff group for 2018-19.

Job Role	Wash	Rub	None	Total	Wash %	Rub %	Total %
Facilities/maintenance worker	1	0	3	4	25%	0%	25%
Domestic	8	16	36	60	13%	27%	40%
Visitor	10	24	24	58	17%	41%	59%
Scrub practitioner	39	12	33	84	46%	14%	61%
Porter	30	29	26	85	35%	34%	69%
Registrar	71	51	44	166	43%	31%	73%
Teacher	1	12	4	17	6%	71%	76%
Volunteer	5	14	6	25	20%	56%	76%
Administration	1	7	2	10	10%	70%	80%
Play specialist	9	17	5	31	29%	55%	84%
Clinical nurse consultant	8	12	3	23	35%	52%	87%
Junior Doctor	118	169	44	331	36%	51%	87%
Medical student	20	52	11	83	24%	63%	87%
ECG technician	4	3	1	8	50%	38%	88%
Nurse manager	1	6	1	8	13%	75%	88%
Student nurse	135	132	35	302	45%	44%	88%

Job Role	Wash	Rub	None	Total	Wash %	Rub %	Total %
Consultant	270	196	56	522	52%	38%	89%
Healthcare assistant	200	224	50	474	42%	47%	89%
Nursing assistant	35	37	8	80	44%	46%	90%
Pharmacist	1	18	2	21	5%	86%	90%
Clinical nurse specialist	15	18	3	36	42%	50%	92%
ODP	242	59	22	323	75%	18%	93%
Staff nurse band 5	819	811	117	1747	47%	46%	93%
Radiologist/Radiographer	52	71	8	131	40%	54%	94%
Advanced Nurse Specialist	58	44	5	107	54%	41%	95%
Sister band 6	376	324	33	733	51%	44%	95%
Physiotherapist	74	90	5	169	44%	53%	97%
Band 7 Nurse	65	62	3	130	50%	48%	98%
Dietician	8	39	1	48	17%	81%	98%
Matron	6	10	0	16	38%	63%	100%
Occupational therapist	5	0	0	5	100%	0%	100%
Perfusionist	1	2	0	3	33%	67%	100%
Pharmacy technician	0	3	0	3	0%	100%	100%
Phlebotomist	30	3	0	33	91%	9%	100%

Figure 19; Staff groups hand hygiene compliance 2018-19

The chart below shows overall hand hygiene (self-reporting by clinical areas) compliance by month for 2018-19 compared to previous years.

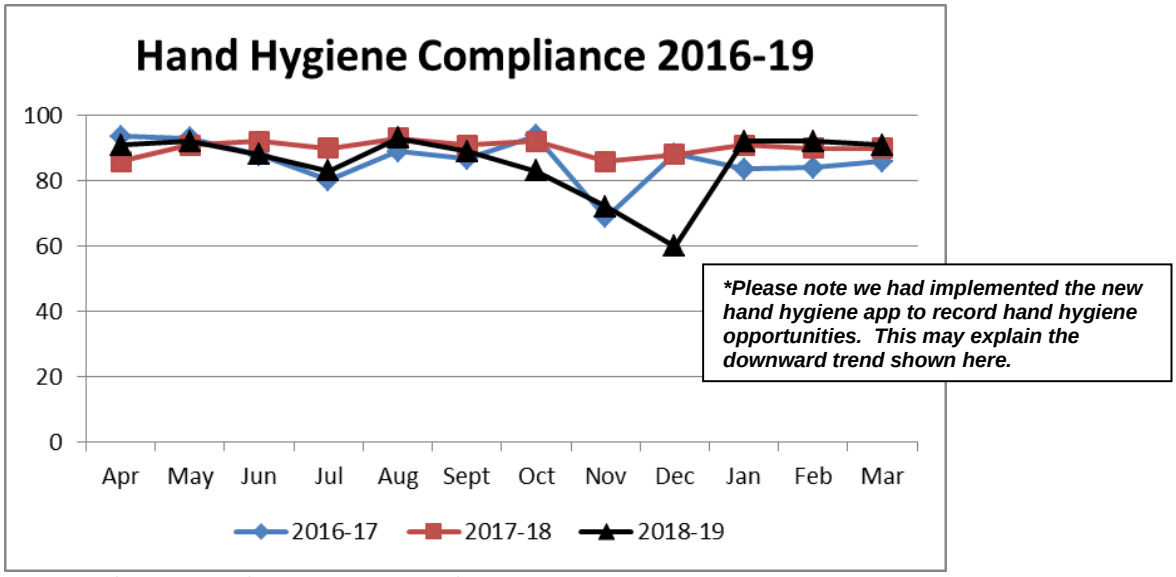


Figure 20; Hand Hygiene compliance score 2016-17 and 2017-18

4.2 Infection Prevention and Control Mandatory Training

IPC training is delivered in stand up sessions at Induction and during mandatory training study days and via online work books. Additional training is provided for IPC Link personnel at monthly education sessions and bespoke sessions are provided for Critical care, Bank staff, Medical and Nursing students and Hotel services staff. Further ad hoc sessions are provided as required and requested.

This year we have introduced a practical hand hygiene assessment at induction and mandatory training to monitor the quality of how effectively staff wash their hands.

The table below shows compliance for IPC training at the end of 2018-19.

Infection Prevention and Control – Level 1 – 3 Years (Non-Clinical)	Infection Prevention and Control – Level 2 – 2 Years (Clinical)
91.60%	81.99%

Figure 22; Mandatory Training compliance Trust wide 2017-18

Key issues

- Compliance <90% for front line staff.

4.3 Policies and Procedures

The following policies/guidelines have been written/reviewed/updated in 2018/2019:

Title
Policies
Sharp Management Policy
Blood Borne Virus Policy
Measles Policy
Infection Prevention & Control in the Operating Department
Cleaning Policy
IPC Policy
Pertussis Policy
Cystic Fibrosis Policy
Notifiable Diseases Policy
Guidelines
IV Cannulation & Fixation Guidelines
Management of IV Therapy and Vascular Access Care
IV Set Change Guideline
Pressure Ulcer Guidelines
Guideline for Insertion of a long line
Guideline for the Insertion of a Peripherally Inserted Central Catheter (PICC) in Ward Area
Taking Blood Cultures Guidelines
Guidance for the Nursing Care of an Umbilical Venous Catheter (UVC)
Guidelines for Extravasation and Infiltration injuries

5 Intravenous Therapy Service

Training and Education

The vascular access service continues to provide training and education in intravenous therapy, cannulation and venepuncture and ANTT across the trust to all members of the multidisciplinary team. 2018-2019 details as below:

- Intravenous therapy training: Total of 78 staff attended the training
- Cannulation and venepuncture: Total of 49 staff attended training
- ANTT Key Trainer training: Total 37 staff attended training

The team also has a 3 hour timeslot on induction for rotational clinicians in which they cover ANTT, venepuncture and cannulation in a paediatric setting.

The intravenous therapy training provision is currently under review and a new format for delivery, including practical work stations, will be implemented in 2019-2020.

Aseptic Non Touch Technique(ANTT)

The team has implemented an annual ANTT assessment for all staff across the trust. Compliance for this is currently reported through the IPC dashboard. The team are working with Learning and Development to record this within ESR for year 2019-2020. Compliance audits for ANTT practice are being submitted electronically and wards are receiving their audit compliance reports via email and also ANTT practice compliance is being report through the IPC dashboard.

Equipment

Reviews have been undertaken on a number of pieces of IV related equipment as part of the MSSA action plan for 2018-2019. With the following actions being undertaken:

1. Successful implementation of Posiflush 0.9% NaCL syringes: Prefilled syringes helping to reduce risk of key part contamination and hence reducing risk of infection to patients from vascular access devices and reducing risk of needle stick injury to staff.
2. New peripheral vascular access securement dressings have been introduced: helping to reduce risk of pressure ulcer formation from vascular access devices and improving infection control practices around securement of peripheral vascular access devices
3. A table top exercise to shortlist safety cannula and butterfly needles for trial by the trust in 2019-2020, with a view to possible implementation on 2019-2020 depending on outcome of trial periods and staff feedback.
4. In 2019-2020 a review of central vascular access device securement and dressings will be undertaken.

Vascular Access Clinical Service

In October a new team member was recruited to the service, with significant vascular access insertion experience within the adult setting, since this appointment the team has been able to consider extending their skill set for vascular access device insertions.

The vascular access clinical service now has an ultrasound machine, purchased with monies received from a charitable donation. There are now 2 team members who are competent to insert PICC lines, although capacity for this is severely restricted at this time. A business case is being submitted in 2019-2020 to address this capacity issue and also to provide clinical support and clinical auditing of vascular access care and maintenance practice to all clinical areas. There is also ongoing work with surgery to develop an advanced vascular access service with a single point of access for all vascular access device insertions.

An electronic referral system to the vascular access team has been introduced, through the GDE project, to utilise evidence based practice in the practice of Paediatric Vessel Health and Preservation (VHP). It also incorporates the care and maintenance of vascular access devices: the VHP has been developed and integrated into Meditech, the referral mechanism is now being used across the trust and the team are hoping to expand its use further in data collection and auditing purposes. There will be a further review in 2019-2020 following implementation to make any additions or changes, as necessary to fine tune this process.

6 Tissue Viability Service

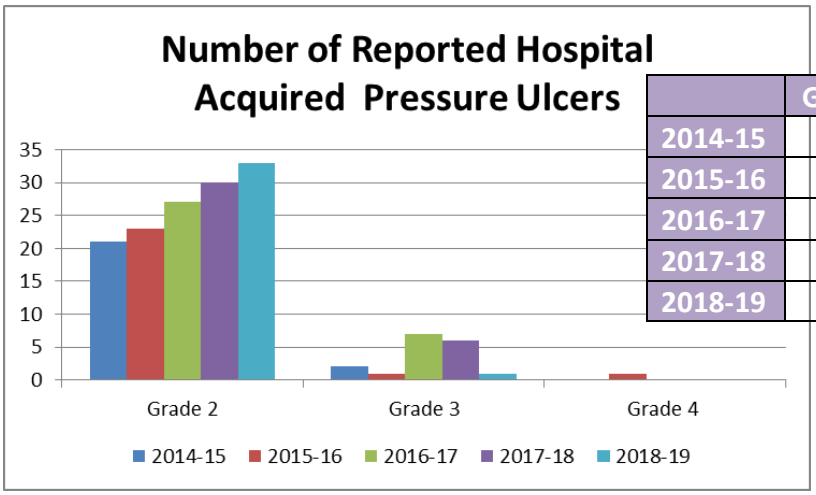
The new Tissue Viability Service has now been embedded into the awareness of Trust Staff with the establishment of a rejuvenated Tissue Viability Link Nurse System with monthly meetings and educational sessions supported by industrial partners. A new classification system for pressure ulcers (as directed by NHSI) has now been implemented and the development of a Trust wide wound care formulary which was launched for staff in November 2018.

The service has introduced an improved system of defining when grade/category 3 and 4 pressure ulcers are avoidable or there has been an identified lapse in care and then targeting specific steps to address these through undertaking Root Cause Analysis (RCA) and sharing lessons learned.

The service has developed a tissue viability competency assessment which has commenced with Link Nurses and will be rolled out to all qualified nursing staff. The service has also started compliance monitoring training which will be fed back to ward managers on a monthly basis.

The service has begun work with community nursing teams to support the prevention and management of pressure ulcers in the community. A support structure for community staff with access to specialised tissue viability knowledge is now in place. Tissue viability link nurses are now established in the community and attend monthly Trust link nurse meetings and training sessions.

The table below shows hospital acquired pressure ulcers by grade and year. There has been a significant reduction in the number of grade/category 3 pressure ulcers reported in 2018-19 (1 grade/category 3 in 2018-19 which equates to a decrease of 83%). The 2018-19 figures show the sustained rate of 0 in our grade/category 4 pressure ulcers. The increase in the number of grade/category 2 pressure ulcers is reflective of a greater awareness and improved education across the Trust which has led to an increase in reporting.



	Grade 2	Grade 3	Grade 4	Total
2014-15	21	2	0	23
2015-16	23	1	1	25
2016-17	27	7	0	34
2017-18	30	6	0	36
2018-19	33	1	0	34

Figure 21

Future Plans

- Replacement/adaptation of the Braden Q assessment tool with a more suitable to the requirements of Alder Hey.
- Commencement of a working relationship with Southampton University into exploring innovative solutions in the prevention of medical device related pressure ulcers.
- Tissue Viability Specialist Nurse to undertake a Level 7 master course in Tissue Debridement at Bradford University.
- To establish and embed a comprehensive Trust wide mattress service, for both static and dynamic mattresses.
- In collaboration with the Alder Hey events team the Tissue Viability service plan to develop a regional Tissue Viability Conference to support and update staff not only within the Trust but in the North West Region.
- To hold two annual Tissue Viability Study Days for all clinical practitioners with the Trust.
- Development of a business case to expand the Tissue Viability team in order to support staff in the community to deliver safe and effective care to children and young people and families in community settings.

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
1. Staffing								
IPC Code: 1,3,4,8,9 **Trust Values:** Excellence Togetherness	Director of Infection Prevention and Control – Medical Director	Nicki Murdoch (NM)						
	IPC Doctor Role: Consultant Microbiologist Consultant Infectious Diseases	Dr Chris Parry (CP) Dr Beatrix Larru (BL)						
	Associate DIPC	Val Weston (VW)						
	Lead Nurse IPC	Jo Keward (JK)						
	IPC Specialist Nurse (Band 7)	Claire Oliver (CO)						
	Community IPC Specialist Nurse (Band 7)							
	0.4 Surgical Site Specialist nurse(Band 7)	Lisa Moore (LM)						
	0.2 Seconded IPC Associate Nurse (Band 6) – initially for 1 year	Alan Bridge (AB)						
	0.6 IPC Data Analyst (Band 5)	Carly Quirk (CQ)						

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Clinical assistant (Band 4)	Vickie Lam (VL)						
	PA/Admin assistant - shared with the Sepsis Team(Band 4)	Lucy Whitfield (LW)						
	Lead Nurse Tissue Viability	Jansy Williams (JW)						
	Tissue Viability Associate Nurse	Hannah Dunderdale(HD)						
	IV Lead Nurse	Sara Melville (SM)						
	Associate Nurse Specialist IV	Zara Burns (ZB)						
	IV Nurse Specialist	Roy Ventura (RV)						
	OPAT/AMS Nurse Specialist	Ruth Cantwell (RC)						
	Associate Nurse OPAT	Claire Crouch (CC)						
	Associate Nurse Specialist IV	Anne MacDonald (AM)						
	Infection Prevention & Control Committee (IPCC) The IPC reports to the Board via the IPCC. The IPCC meets 6 times	DIPC and Associate DIPC						

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	per year and is chaired by the DIPC. The Terms of Reference were reviewed and amended in February 2018.							
2. *Surveillance*								
IPC Code: 1,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together	**Alert organisms** To maintain and alert staff to any potential risks from pathogenic organisms	Microbiology and IPC Team	To provide IPC advice and support in order to minimise the risks to patients, staff and visitors.					
	Mandatory Reporting It is mandatory requirement for the Trust to report a variety of pathogenic organisms/ infections to PHE for monitoring purposes							
	MRSA/ MSSA/VRE/E.coli/Klebsiella/ Pseudomonas Bacteraemia	DIPC/ Associate DIPC/ IPC Doctor(BL), IPC Team and a review panel	To identify, communicate and instigate investigations by the clinical teams for all Trust apportioned cases. All cases to be reviewed under the Post Infection Review (PIR) and Root					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			Cause Analysis (RCA) processes, through a Review Panel and to disseminate lessons learned from the process and actions required and monitored.					
	Clostridium difficile	Microbiology/ IPC Team and Antimicrobial Pharmacist (AT)	To identify, communicate and instigate investigations by the clinical teams for all cases. All cases to be reviewed under the Post Infect Review (PIR) and Root Cause Analysis (RCA) processes, through a Review Panel and to disseminate lessons learned for the process and actions required and monitored.					
			To instigate an incident meeting with clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
	CPE	Microbiology and IPC Team	To instigate an incident meeting with clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
			Revise Surveillance Policy to					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			incorporate the new PCR testing process.					
			Training of new PCR testing process.					
			Implementation of CPE PCR testing in the Trust					
	Surgical Site Infection (SSI) for Orthopaedics (spinal, elective implants and k wires), Cardiac Surgery, Neurosurgery and plastics.		To ensure data required by PHE is inputted in a timely manner.					
			To ensure data required by PHE is inputted in a timely manner.					
			Development of monthly PIR process of significant SSI. Memberships to include IPC Dr, Leads for SSI, ADIPC, relevant Consultant Surgeon, Tissue Viability.					
	Viruses	Microbiology & IPC Team	To provide data on HAI Influenza & RSV rates per 1000 bed days.					
			To support investigations into HAI Influenza and RSV cases and investigations into outbreaks with other respiratory viruses.					
			To provide predictions and provide commentary during the winter season on Respiratory viruses (in collaboration with the PHE) to assist in planning elective activity and patient flow.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			Due to the increase in hospital acquired RSV cases 2018-19 a review will be undertaken.					
			RSV review to be presented at IPCC during Q2 2019-20.					
			A review of hospital acquired Influenza 2018-19.					
			Influenza review to be presented at IPCC during Q2 2019-20.					
	Expert Virology provision and expertise	Medicine General Manager Glenna Smith (GS) and Microbiology.	To secure expert Virology provision and expertise.					
3. Hand Decontamination								
IPC Code: 1,2,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Children's Hand Hygiene Initiative – in conjunction with Industry Partner	IPC Team and Industry Partner	Present proposed pilot study to Patient Forum and Parents Forum					
			Introduce the pilot scheme into the identified areas. Pilot study to run over 2 months.					
			Present finding of the pilot study to the Trust.					
			Write up study for publication.					
			If pilot successful – to introduce scheme across the Trust.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	To scope and implement new and innovative hand hygiene signage across the Trust.	IPC Team	To explore the feasibility of introducing new and innovative hand hygiene signage across the Trust.					
	To ensure that the non-compliance with hand hygiene proforma is utilised throughout the Trust.	DIPC, Associate DIPC and IPC Team	IPC team to scope how non-compliance can be reported across the Trust.					
			IPC team to communicate the process via the Link Nurse/Representatives and the governance structures					
	To ensure that hand hygiene technique assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC and Learning and Development.	To explore the feasibility of putting hand hygiene compliance on the ESR system for all clinical staff on an annual basis.					
			Once hand hygiene assessments are recorded on ESR. To develop a monitoring system across the Trust.					
			Include compliance in IPC Dashboards to provide assurance.					
	Hand Hygiene Heroes	Clinical Assistant/IPC Admin	Development of the Hand Hygiene Hero (HHH) Team & Production of HHH Database.					
			Develop a TOR for HHH.					
			Provide half day training with					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			industry partners/Team Prevent/IPCT.					
	Hand Hygiene Reporting to Trust Board	IPC Data Analyst/ADIPC	To include quality control Hand hygiene compliance data in Trust Board Report.					
	Hand Hygiene Summit	Lead IPC Nurse & Assistant Practitioner	To organise 6 monthly hand hygiene summits for Trust Staff					
			To provide a report 6 monthly to IPCC of hand hygiene Heroes and hand hygiene activity.					
4. Policies								
IPC code 1,2,3,4,5,6,7,8,9 & 10 **Trust Values** Respect Excellence Innovation Togetherness Openness	Review and update IPC policies as required.	IPC Team	Monitored reviewed and updated as part of the IPCT meetings on a monthly basis.					
	To provide advice and support on IPC policies.	IPC Team						
	Participation in updating where IPC is an integral component of relevant policies.	EW	Provide an update of policy review dates					
	Review and update Tissue Viability Policies	Tissue Viability Specialist Nurse	To develop in collaboration with Regional colleagues a regional policy for pressure ulcer prevention and management policy					
			To ensure all local guidelines are kept up to date					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
5. ANTT								
	To ensure that ANTT assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC, ANTT Specialist and Learning and Development	To explore the feasibility of putting ANTT annual assessments on the ESR system as a mandatory field for all clinical staff.					
	Liaise with St Helens and Knowsley Trust regarding standardising ANTT rotational staff assessments	Associate DIPC/SM	To develop a SOP to standardise ANTT assessments for rotational staff recognising from other Trusts within the last 12 months.					
	Plan to expand this process to cover other Trusts in the North West	Associate DIPC/SM	To progress the work started with Whiston and other North West Trusts in the region through the North West IV Forum.					
	Liaise with ANTT experts to review and refine existing processes.	Associate DIPC/SM	Attend annual ANTT conference and to attend North West IV Forum meetings.					
	Ensure that ANTT data is communicated to divisional leads, matrons and ward/department	Data Analysts and ANNT team	Ensure ANTT assessments data is reflected on the monthly IPC Dashboard. Ensure ANTT audit data is reflected					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	managers.		on the monthly IPC dashboard. Ensure that dashboards are distributed to relevant teams in a timely manner.					
6. Vascular Access								
IPC Code: **Trust Values:**	To progress the plan for the Vascular access team to insert more advance vascular access lines, so freeing up theatre, surgeon and anaesthetist time and ensuring that the correct vascular access is placed at the right time.	ADIPC/Vascular Access Lead Nurse/ Identified Leads from the surgical Division	To initiate meetings with relevant personnel (including leads from the surgical division) to develop the plan going forward.					
			To progress the meetings to map out how the new service will be implemented and utilised.					
			To monitor and report on the progress of the service through the IPCC and Surgical divisional structure.					
			To develop a project plan to be monitored and reviewed through IPCC and Surgical governance structure.					
	To expand the Vascular Access team to ensure that team has the capacity to deliver the advanced vascular	ADIPC/ Vascular Access Lead Nurse.	To develop a business case for identified additional staff.					
			Submit business case to IRG.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	access service.		To develop job descriptions for new roles.					
			To recruit staff to the new positions.					
	Widen accessibility of teaching and training for MDT	IV Team and Learning and Development	To develop an easy access E-Learning package for all Staff.					
			To run a Bi-Annual IV study day for all staff to book onto					
	Review of Sharps safety and vascular access	IV Team ADIPC	Review of butterfly needles and clinical trials.					
			Implementation of preferred butterfly needles into the Trust.					
			Review of cannula (including winged cannula) and clinical trials.					
			Implementation of preferred cannula option.					
	To explore the implementation of central line vascular access dressings to assist in the work to reduce CLABSI levels across the Trust.	IV Access and Therapy group	Explore central line dressing options including the use of CHG.					
			To identify suitable areas to trial the new dressings.					
			Evaluate the trial of the dressings through the IV Access and therapy group.					
			Decision to be made by the IV Access and therapy group on whether to					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			implement the new dressings.					
			To monitor CLABSI rates if new dressings are implemented to evaluate their impact on CLABSI rates.					
	Pilot evaluation of the National IV Passport	ADIPC and Vascular Access Lead Nurse	To identify areas for trialling of the IV Passport.					
			To introduce the IV passport to the relevant areas via training and question and answer sessions.					
			Undertake pilot study.					
			Feedback findings to IV Access and Therapy Group and to the national group.					
	To explore initiatives with relevant staff to reduce the rates of CLABSI in the Trust.	ADIPC/Vascular Access team/ relevant Trust personnel (IV Access and Therapy group).	To initiate meetings to look at CLABSI rates in PICU and HDU.					
			To explore how reliable CLABSI rates can be captured across the Trust.					
			Explore how this data can be communicated across the Trust.					
			Instigate targeted initiatives across the Trust to help reduce the rates of CLABSI.					
			Communicate progress through the					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			IPCC and divisional governance structures.					
7. Training & Education								
Infection Prevention & Control								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	To ensure that IPC staff are kept updated with IPC evidence based practice.	Lead IPC Nurse	To ensure that a member IPC Team attends the North West Infection Prevention Society (IPS) meetings at least once per year and feeds back to the team.					
		Associate DIPC	To regularly attend local HCAI whole health economy meetings.					
		Associate DIPC/Lead IPC Nurse	To attend local and national IPC/relevant conferences as the service will allow					
		Lead IPC Nurse	To attend Vaccinator training or undertake on line update					
	To ensure that Trust staff are kept updated with IPC evidence based Practice, please see plan below:							
	Induction	Lead Nurse IPC/CO	At least once per month					
	Mandatory	IPC Team	For all clinical staff yearly (monthly sessions) & work book.					
			To develop a new E-Learning package to replace monthly sessions and workbook for clinical staff.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			Non-clinical 3 yearly – work book					
			To develop a new E- Learning package to replace the work book. Following the same principles developed from the Clinical E-Learning package.					
	Volunteer IPC Training	CO/VL	Quarterly					
	Hotels Services IPC training	VL	At least once per quarter					
	IPC Link Personnel	IPCT	Monthly					
	Fit Testing Key Trainers	CO	Training is updated Bi-annually – records of staff training reported through IPC Dashboards on a monthly basis					
	Flu vaccinator Training	Lead Nurse IPC	Annual (4 sessions per year)					
	Ad hoc training	IPCT	As required					
Tissue Viability								
	Tissue Viability Link Personnel	TV Team	Monthly					
	Tissue Viability study day/conference for Clinical Staff	TV Team	Twice yearly					
	To ensure that Tissue Viability staff are kept updated with tissue	Tissue Viability Specialist Nurse	Attend TVS/Wounds Conference UK on an annual basis.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Viability evidence based practice.							
IV Therapy								
	ANTT Key Trainers	ANTT Specialist Nurse	Bimonthly					
	To ensure that Vascular Access staff are kept updated with Vascular Access evidence based practice.	Vascular Access Lead Nurse	Attend annual ANTT conference.					
			Attend North West IV forum meetings on a regular basis.					
Education Events								
	Infection Prevention & Control	IPCT	Love Bug Day - Annually					
			Infection Control Week - Annually					
			IPC Study Day – Annually					
	Tissue Viability	TVN	Tissue Viability Conference Sept 2019					
			Pressure Ulcer Hero Day – Annually					
	IV Therapy	IV Lead Nurse	Bi-annual IV master class study days in intravenous therapy practice accessible for PDN's and ANTT key trainers and staff					
8. Audit								
Infection Prevention & Control								

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
IPC Code: 1,2,3,4,5,6,7,8,9 **Trust Values:** Excellence Openness Respect Together Innovation	To provide assurance to the Board and relevant committees of adherence to high quality IPC practices	Lead IPC Nurse/IPC Specialist Nurse/IPC Clinical Assistant	Revise audit programme for 2019-20.					
			Communicate all findings to the relevant clinical staff and report via IPC dashboards and discussed at divisional governance meetings and IPCC.					
			All lessons learned are disseminated to relevant staff and other agencies as appropriate in a timely manner.					
Tissue Viability								
	To provide assurance to the Board and relevant committees of adherence to high quality tissue viability practices	TV Nurse Specialist	To develop a point prevalence audit					
			Undertake point prevalence audit on a 6 monthly basis					
			To report findings of the audit to IPCC and Divisional Governance Meetings.					
Intravenous Therapy								
	To provide assurance to the Board and relevant committees of adherence to high quality vascular access practices	Vascular Lead Nurse	To report ANTT competency and assessments figures to data analyst for dissemination through IP Dashboards.					
			To report audit findings through IV					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			newsletter, IPCC and divisional governance meetings.					
9. Antimicrobial Prescribing								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	Antimicrobial Stewardship (MS) Ward Rounds	Antimicrobial Pharmacist	AMS Ward Rounds (x3/week)					
	AMS Committee Meetings	Antimicrobial Pharmacist	AMS Committee (at least quarterly)					
	Introduction of AMS training to all clinical staff in the Trust	Antimicrobial Pharmacist/ Sepsis Nurse Specialist/ OPAT Nurse Specialist	AMS training to be introduced across the Trust (currently delivered to junior doctors on induction but not to nurses).					
			To introduce AMS training into Induction training					
			To introduce AMS training into mandatory training					
10. Communication								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10	5 Year IPC Strategy	DIPC/ADIPC/ IPC Dr	Develop a 5 year IPC strategy to be presented to Trust Board and external bodies.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Trust Values: Excellence Openness Respect Together Innovation	Yearly IPS Work Plan	Infection Prevention Services Team	Develop a yearly IPS Workplan to be presented to Trust Board and external bodies.					
	IPC bi-monthly report	Lead Nurse IPC	IPC bi-monthly report reported through the IPCC.					
	IPC Dashboard	IPC Data Analyst	Monthly dashboard distributed Trust wide reported through Divisional Governance meetings and IPCC.					
	Communication with the Whole Health Economy	ADIPC	To attend HCAI/IPC meetings across the local area.					
	Communication with other Trusts and agencies such as Public Health England (PHE) and NHS England	IPCT	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.					
	To keep Infection Prevention and Control Intranet page up to date with relevant information	IPC Administrator	Ensure that the IPC intranet pages are kept up to date on a monthly basis or as necessary.					
	To ensure that Paediatric Infection Prevention and Control remains high on the agenda at a national	Associate DIPC	Associate DIPC to communicate specific paediatric needs to Infection Prevention Society (IPS) through representation on the IPS Board.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	level.							
	Communication with other Paediatric Trusts and other hospitals/healthcare facilities caring for paediatric patients.	Associate DIPC/CO	Commencement of the national IPS Paediatric Forum to share best evidence based practice, benchmarking and innovative projects. To include meetings face to face and virtual and a national annual conference.					
	Infection Prevention Control Services & Sepsis Newsletter	IPST & Sepsis Nurse	Bi-Monthly newsletter.					
11. Information Technology								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Innovation Together	To continue to enhance the use of Meditech to assist the IPC team in monitoring HCAI	IPC Team, IT team and Pathology IT Manager.	Set up quarterly and ad hoc meetings to explore how the Meditech system can assist IPC.					***Q1*** *- Meeting to be arranged*
		IPC Team, IT team and Meditech Lead	Set up meeting with Martin Levine to explore Meditech information required.					
	Explore other surveillance systems to provide more comprehensive data for the Trust.	ADIPC/IPC Dr/Microbiologist	Organise a visit to Whiston to scope out feasibility of obtaining ICNet at Alder Hey.					
			Organise a meeting with ICNet					
	To develop	Consultant	To instigate a working group to					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	opportunities to enhance epidemiological surveillance systems and monitoring opportunities within the Trust	Infectious Diseases/ADIPC/ Data Analyst	explore possibilities to enhance the surveillance systems and reporting across the Trust.					
			To develop a business case to develop the enhanced surveillance system agreed.					
	To ensure the IPC intranet page remains relevant for staff at Alder Hey and is kept up to date with best practices and new developments both internally and externally.	IPC Admin	Review and update Intranet Page on a regular basis.					
		Pathway Co-ordinator	To ensure all new policies and procedures are uploaded onto the Intranet.					
		IPC Admin	To ensure that relevant communications are uploaded onto the Intranet					
	To ensure the Tissue Viability intranet page remains relevant for staff at Alder Hey and is kept up to date with best practices and new developments both internally and externally.		Review and update Intranet Page on a regular basis.					
		Pathway Co-ordinator	To ensure all new policies and procedures are uploaded onto the Intranet.					
		IPC Admin	To ensure that relevant communications are uploaded onto the Intranet					
	To ensure the IV	IV Nurse Lead	Review and update Intranet Page on					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	intranet page remains relevant for staff at Alder Hey and is kept up to date with best practices and new developments both internally and externally.		a regular basis.					
		Pathway Co-ordinator	To ensure all new policies and procedures are uploaded onto the Intranet.					
		IV Nurse Lead	To ensure that relevant communications are uploaded onto the Intranet					
12. Interface with relevant groups								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC to attend and provide expert opinion for topics related to IPC.		As required					
	Escalate issues to DIPC as necessary.	Associate DIPC	Regular meetings with DIPC					
	Infection Prevention Strategy Meetings	DIPC/ADIPC/IPC Dr/ Building Services & Other relevant invited parties	Monthly					
	To review new equipment /environmental utilisation	IPCT	Ad hoc meetings as required.					
	Decontamination	ADIPC	To attend scheduled meetings. To provide expert advice and support as required.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Water Safety	Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Hotel services	Lead Nurse IPC Associate DIPC to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Ward managers/matrons	Lead Nurse IPC Associate DIPC or IPCT to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Health and Safety	Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Integrated Governance Committee	DIPC/Associate DIPC/ Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Medical Devices Committee	IPC Lead Nurse	To attend scheduled meetings. To provide expert advice and support as required.					
	Trust Quality meetings • ***CQAC*** • ***CQSG*** • ***CQPG***	Associate DIPC Lead Nurse IPC to deputise. IPCT to attend ad hoc for training purposes.	To attend scheduled meetings. To provide expert advice and support as required.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Divisional Integrated Governance Meetings	Medical Division – Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					
		Surgical Division – IPC Nurse Specialist	To attend scheduled meetings. To provide expert advice and support as required.					
		Community Division – ADIPC until Community IPCN appointed	To attend scheduled meetings. To provide expert advice and support as required.					
	Trust Board	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
13. Gram Negative Bacteraemia								
IPC Code: 1,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Innovation Respect Together Openness	Adherence with regards to Gram Negative Blood Stream Infections (GNBSIs) targets	DIPC/ Associate DIPC	To organise meetings with other paediatric Trusts and NHSi to develop a specific paediatric action plan for gram negative bacteraemia reduction.					
		IPC Data Analyst	Ecoli, Klebsella spp, Pseudomonas aeruginosa bacteraemia data to be recorded on the MESS system.					
		DIPC/ Associate DIPC	PIR reviews to be undertaken for all hospital acquired gram negative bacteraemia.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		ADIPC/IPC Data Analyst	Trust wide situation reports to be disseminated. Lessons learned and Trust wide actions to be addressed through Divisional Governance Structure.					
		ADIPC/IPC Data Analyst	Themes from PIR reviews to be monitored and reviewed via IPCC.					
		Associate DIPC	PIR reviews to be shared across the whole health economy and NHSI.					
14. Community								
IPC Code 1, 2, 3, 4, 5, 6, 8, 9. 10 **Trust Values** Respect Excellence Innovation Together Openness	To ensure that a high quality Infection Prevention Service (IPC, Tissue Viability and IV services) is delivered to Community Services	Sarah Stephenson (SS) – Quality Lead for Community, Associate DIPC, Lisa Cooper (LC) Director of Children & Young People Community & Mental Health Division	To scope out the provision and requirements for Infection Prevention Services for Community Services. To include an audit programme, specific training – mandatory and ad hoc, advisory services and Link personnel updates and requirements.					
			Further deliverables will be added once IPC provision in the Community has been established.					
15. High Consequence Infectious Diseases								
IPC Code 1, 2, 3, 4, 5, 6,	To ensure that Alder Hey is able to care for	In conjunction with Infectious	Attend National HCID Network meeting.					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
8, 9. 10 **Trust Values** Respect Excellence Innovation Together Openness	patients with HCID both internally and externally.	Diseases and Critical Care we will develop a team of In conjunction with Infectious Diseases and Critical Care we will develop a team of professionals able to care for and manage a patient with a high consequence infectious disease and manage a patient with a high consequence infectious disease.	Collaborative working with the Royal University Hospital Liverpool & Evelina Hospital.					
			Assign HCID Team					
			Develop guidance for the identification and management of HCID patients in conjunction with Emergency Planning					
			Training for HCID Team (6 monthly updates following sign off).					
			Purchasing of HCID equipment					
			Identify areas for storage of equipment.					
			Identify area with appropriate isolation and ventilation facilities to Nurse patients prior to transfer to the Royal on confirmation of HCID.					
			Develop training Strategy for Domestic Staff for decontamination of environment.					
			Develop strategy for disposal of HCID waste and Linen.					
			Develop a communications strategy for suspected HCID patients.					
16. Tissue Viability								

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
IPC Code 1, 2, 3, 4, 5, 6, 8, 9. 10 **Trust Values** Respect Excellence Innovation Together Openness	To implement measures to reduce the incidence of hospital acquired pressure ulcers	Tissue Viability Specialist Nurse/Tissue Viability team	Regular clinical updates for all clinical staff					
			Collection of pressure ulcer data					
			Reporting hospital acquired pressure ulcers via IPC dashboards monthly					
			Update report to IPCC bi monthly showing any trends.					
			Reporting via safety temperature system.					
	To empower staff in the Trust to develop skills in dealing with minor skin integrity issues before escalating to the Tissue Viability team.	Tissue Viability Specialist Nurse/ Tissue Viability team	Implementation of wound flow chart for staff to take action.					
			Implementation of TV red folder on each ward					
			Monitor number of referrals to TV and report to IPCC.					
	To implement measures to ensure that Moisture related skin damage is managed throughout the Trust	Tissue Viability Specialist Nurse/ Tissue Viability team	Implementation of MASD flow chart for staff to take action.					
			Implementation of TV red folder on each ward					
			Monitor number of referrals to TV and report to IPCC.					
			2 day MASD campaign					
17.	***OneTogether Programme***							
IPC Code 1, 2, 3, 4, 5, 6, 8, 9. 10	Integration of the OneTogether Programme	***Lisa Moore*** ***Alan Bridge*** ***Kelly Black***	Quarterly Reports to IPCC benchmarking our progress with all elements of the OneTogether					

IPC Code & Trust Values	Plan & Priority Activities 2019-20	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Trust Values Respect Excellence Innovation Together Openness		***Shelley Cobley***	Programme					
			Commencement of bi-monthly key stakeholder meetings with regarding to OneTogether Programme.					
			Produce TOR for OneTogether Group.					
			Key members of the OneTogether Group to attend OneTogether Conference for update.					
		Alan Bridge ***Lisa Moore***	To produce bi-monthly reports to be cascaded to all surgeons and through surgical governance structure.					
	SSI Leaflets	Shelley Cobley, Pre op CNS	Review pre-op information given to patients and their families.					
		Kelly Black, Surgical Matron	Review post-op information given to patients and their families and audit of current post-op information.					

Alder Hey Children's NHS
NHS Foundation Trust

Trust Wide Infection Prevention and Control Action Plans

Drawing from the evidence presented in the IPC Annual Report 2018/19, key themes were identified to target for 2019/20. Trust wide Action Plans have been developed with other key stakeholders from the Trust to implement and progress these actions.

Key Themes	Infection Prevention and Control or identified Lead	Other Specialists from the Service
Surgical Site Infections (SSI)	Lisa Moore	Alan Bridge (IPC Associate Practitioner)
Environmental Cleanliness	Jo Keward	Vickie Lam (IPC Clinical assistant)
Isolation	Claire Oliver	Jo Keward (Lead Nurse IPC)
RSV	Jo Keward	Claire Oliver (IPC Nurse Specialist)
Medical Device related Pressure Ulcers	Jansy Williams	Hannah Dunderdale

These Actions Plans will be reviewed and monitored via the IPCC and the governance structures in each relevant division and progress communicated to the Trust Board.

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 02 July 2019

Report of:	Director Community & Mental Health Services
Paper Prepared by:	Lisa Cooper Director Community & Mental Health Division
Subject/Title:	Neurodevelopmental Paediatrics Update & Improvement Plan
Background Papers:	
Purpose of Paper:	The purpose of this report is to provide a current position paper and proposed improvement plan in relation to Neurodevelopmental paediatric services commissioned via NHS South Sefton; NHS Southport and Formby; NHS Liverpool and NHS Knowsley CCGs.
Action/Decision Required:	Alder Hey Trust Board are asked to note this paper and identified improvements as an agreed way forward for Alder Hey to deliver a safe, effective and evidence based Neurodevelopmental service which meets the needs of children, young people and families.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Delivery of outstanding care • The best people doing their best work • Sustainability through external partnerships • Strong Foundations
Resource Impact:	Staff and financial resource identified

1. Introduction

Alder Hey currently delivers neurodevelopmental paediatric services across a number of CCG footprints with varying levels of commissioned activity and capacity. Currently, each local CCG area commissions a different level of service from Alder Hey. The services are based within the Community and Mental Health Division at Alder Hey.

The current assessment processes for neurodevelopmental conditions are managed within the Community Paediatric Service, which also provides generic and specialist community based paediatrics to children, young people and families across the Liverpool, Sefton and Knowsley footprints.

For the purpose of this paper the improvement plan refers to:

- Autism Spectrum Disorder/Condition (ASD/C)
- Attention Deficit and Hyperactivity Disorder (ADHD)
- Service wide improvements across all commissioned pathways

Since 2016, Alder Hey has worked in partnership with relevant CCGs and Local Authorities with some success in developing and implementing a range of improvements to pathways for the assessment of children and young people with neurodevelopmental conditions.

However, following a CQC inspection of services in 2017 and SEND inspections in 2018/19 (Liverpool and Sefton), the Community and Mental Health Division at Alder Hey have identified that further priority improvements are required within the neurodevelopmental paediatric services so as to ensure the provision of safe, effective and evidenced based neurodevelopmental services to children, young people and families.

This paper addresses the need for additional improvements and investment in the neurodevelopmental paediatric services provided within the Community and Mental Health Division at Alder Hey.

2. Current Commissioned Service Provision

Alder Hey's Community Paediatric Service currently delivers general neurodevelopmental paediatric services for Liverpool, Sefton and Knowsley as well as specialist services e.g. Tuberous Sclerosis and an assessment and diagnosis service for children and young people referred for ASD or ADHD diagnosis.

The process of assessment and diagnosis of ASD and ADHD is underpinned by NICE guidance (CG128) (NG87) which clearly articulate the recommended pathway and quality standards CCGs and NHS commissioned services should attain when commissioning and providing these services.

Below is a summary of the current level of services commissioned by CCG footprint:

CCG	ASD	ADHD
Liverpool	Commissioned capacity for ASD diagnostic pathway (as per NICE guidance) for 960 assessments per year	Capacity for ADHD assessments commissioned as part of generic community service. No specific volume agreement.
Sefton	Commissioned capacity for ASD diagnostic pathway (as per NICE guidance) for 500 assessments per year. Commissioned during 2018/19 with staged implementation during 2019/20 as recruit into posts.	Capacity for ADHD assessments commissioned as part of generic community service. No specific volume agreement
Knowsley	Capacity for ASD assessments commissioned as part of generic community service. No specific volume agreement	Capacity for ADHD assessments commissioned as part of generic community service. No specific volume agreement

3. Identified Improvement Areas

Following a divisional internal review of service provision and recent SEND inspections the following specific areas for improvement have been identified:

3.1 ASD

- Waiting times to start pathway (Liverpool) approx. 12 months
- Lack of a commissioned pathway (Sefton)
- Provide only Community Paediatrician element of pathway in Knowsley
- Increasing demand
- Commissioned capacity does not meet demand
- Significant backlog of referrals when services transferred
- Waiting times Speech & Language Therapy (Sefton > 40 weeks)
- Limited investment in services (Sefton)
- Inability to recruit sufficient high quality clinical staff
- Appointment booking system
- Poor IT infrastructure and support (paper reliant)
- Not compliant with NICE guidance

3.2 ADHD

- Referrals managed within the generic clinic capacity
- Waiting times
- Increasing demand
- Commissioned capacity does not meet demand
- Inability to report on accurate waiting times (manual process)
- Inability to recruit sufficient high quality clinical staff
- Appointment booking system
- Poor IT infrastructure and support (paper reliant)
- Transition to adult services
- Provide only Community Paediatrician element of pathway in Knowsley

4. Proposed Improvement Plan

The actions set out in this proposed improvement plan are designed to deliver safe, effective and evidence based neurodevelopmental paediatric services which deliver a maximum 18 week wait to treatment for all children and young people referred to the services.

All options included have been developed using the current data available to the Community & Mental Health Division.

To deliver the improvements required, a number of key assumptions have been made:

- Referrals remain static
- Staff maintain clinical caseloads within the level recommended by the Clinical Director
- Improvements in IT to enable more agile working/remote access to clinical systems including printing and scanning

Below is a summary of high level improvement actions which are supported by a detailed and robust divisional project plan. Performance against this project plan is monitored on a monthly basis via the divisional business meeting and Alder Hey SEND Group.

Action	Resource	Completion Date
Develop comprehensive service improvement plan	N/A	May 2019 (Completed)
Review of service and divisional risk registers to ensure all risks identified and recorded	N/A	June 2019 (Completed)
Engage external provider to support ASD assessments (backlog)	Approx. estimate £300k (non-recurrent investment via CCGs)	January 2020

Implement new pathway for ADHD diagnosis for Liverpool and Sefton	Within current resource	Liverpool pathway in place Sefton TBC
Short term additional capacity to address ADHD backlog to reduce the number of children and young people waiting for MDT & joint assessment	Additional MDT & joint assessment appointments over 12 months (TBC via CCGs)	Liverpool in place Sefton TBC
Delivery of IT improvements across Community	As part of capital project	December 2019
Recruit to project manager for 12 months to support delivery of service wide improvements	£45,000 (Divisional funding)	July 2019
Explore potential of divisional finance lead being released to support review of core offer, services specification and funding arrangements	TBC	July 2019

In addition, to the above identified improvements the Director of Community & Mental Health Division is leading the following:

- In partnership with CCGs the agreement of robust service specifications which include agreed performance indicators and activity
- Redefine Core Offer (linked to service specifications)
- Continue to develop and improve relationships with Parent Carer Forums and voluntary sector organisations

4. Recommendations

Alder Hey Trust Board are asked to note this paper and identified improvements as an agreed way forward for Alder Hey to deliver safe, effective and evidence based neurodevelopmental paediatric services which meets the needs of children, young people and families.

BOARD OF DIRECTORS

Tuesday 02 July 2019

Report of:	Director Community & Mental Health Services
Paper Prepared by:	Lisa Cooper Director Community & Mental Health Division
Subject/Title:	Update regarding transferred services from Liverpool Community Health NHS Foundation Trust.
Background Papers:	
Purpose of Paper:	The purpose of this paper is to provide an update on the staff survey results and NHS Improvement review (March 2019) in relation to services which transferred in 2017 to Alder Hey NHS Foundation Trust from Liverpool Community Health NHS Foundation Trust.
Action/Decision Required:	Alder Hey Trust Board is asked to note the contents of this report and to be assured that identified improvement actions are being implemented within the Community and Mental Health Division in relation to services transferred from Liverpool Community Health NHS Foundation Trust.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Delivery of outstanding care • The best people doing their best work • Strong Foundations
Resource Impact:	No additional resource required

1. Introduction

In April 2017, the provision of a number of children's community based services transferred from Liverpool Community Health NHS Foundation Trust to Alder Hey NHS Foundation Trust. The transfer of these services was following the Berwick Review (2018) which identified significant and serious failings in the provision of these services by Liverpool Community Health NHS Foundation Trust.

In total, 150 clinical and non-clinical staff within 11 services transferred to Alder Hey as listed in the table below:

Service	WTE Staff	CCG
Speech and Language Therapy (Liverpool)	41.15 wte	Liverpool
Community Dietetics (Liverpool)	1.0 wte	Liverpool
Community Matrons (Liverpool)	3.0 wte	Liverpool
Speech and Language Therapy (Sefton)	21.18 wte	Sefton
Occupational Therapy (Sefton)	12.39 wte	Sefton
Physiotherapy (Sefton)	6.68 wte	Sefton
Community Dietetics (Sefton)	2.3 wte	Sefton
Complex needs (Sefton)	6.07 wte	Sefton
ADHD/ASD nursing team (Sefton)	3.46 wte	Sefton
Continence Services (Sefton)	1.0 wte	Sefton
Service Manager (Sefton)	1.0 wte	Sefton
Hearing Impairment Network (Cheshire & Merseyside)	6.02 wte	Cheshire & Merseyside CCGs Lead: Liverpool CCG

Since the transfer of the above services to Alder Hey in April 2017, Alder Hey has implemented the following to ensure the provision of safe, effective and evidenced based services to children and young people:

- All services located within Community & Mental Health Division with new leadership team and structure
- Revised governance and risk management structure
- Service and divisional development days
- Therapy leads management infrastructure to ensure that all services have clear operational and clinical management support
- Baseline quality review with all teams to highlight priority areas for support and development
- Co-located therapy services within localities to deliver improvements in IT, communication and teamwork
- Undertook capacity and demand reviews across all services
- Development of investment proposals to support service development

2. Staff Survey Results 2018

The full results of the 2018 staff survey for the staff transferred to Alder Hey from Liverpool Community Health can be found in **Appendix 1**. Key positive highlights from the report are shown below:

Area	Transferred LCH Services (%)	Trust (%)
Response rate	81%	60%
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age?	99%	86%
How satisfied are you with the opportunities for flexible working patterns?	86%	60%
I receive the respect I deserve from my colleagues at work	88%	73%
My work is valued by my organisation	80%	77%
In the last 12 months how many times have you personally experienced harassment, bullying or abuse at work from managers?*	97%*	91%*
In the last 12 months how many times have you personally experienced physical violence at work from patients / service users, their relatives or other members of the public? *	99%*	91%*

When errors, near misses or incidents are reported, my organisation takes action to ensure that they do not happen again	80%	73%
I would recommend my organisation as a place to work	84%	72%

Please note: * Scores are positive where higher is better

The following areas for improvement within the staff survey have been identified for this collective group of staff:

- Management of health and well being at work e.g. stress, time pressures
- Access to mandatory training
- Own pressure to come to work

Actions taken as a result of the above include:

- Mandatory training sessions now held within community locations and services
- Development of Community & Mental Health Division wide staff reward and recognition group
- Health and wellbeing sessions to be held in community locations and services

3. NHS Improvement clinical service review visit (March 2019)

A recommendation of the Kirkup review for all Trusts who received services from Liverpool Community Health was that all services should be reviewed 1-year post transfer, to ensure that they were safe and effective.

As part of Alder Hey's commitment to improvement, it was agreed that NHS Improvement (NHSI) would lead a review with Alder Hey staff and external partners, to help identify areas of good practice and areas for improvement. It was agreed that the findings from the review would then to be used to support Alder Hey's ongoing quality improvement work.

The review was undertaken in March 2019 and consisted of external reviewers including staff from agencies such as NHS Improvement, NHS England and CCGs. Each reviewer had access to key lines of enquiry which were intended as a guide to help inform the type of questions to ask of staff, patients and carers. Following reviews of clinical areas each team was asked to identify notable good practice and areas for improvement.

The findings of the review are shown in **Appendix 2**. Key highlights of the review included:

- Staff felt valued and supported by senior managers and wider organisation
- Visible and supportive senior divisional leadership team

- Staff were able to report concerns, incidents and risks in a supportive culture
- Investment in services
- Training and development more accessible
- Passionate and enthusiastic staff

The following areas for improvement were identified as part of the review:

- Resuscitation equipment at the Sefton site and understanding of staff to their responsibilities
- DNAR forms in the community matrons service
- Branding and logos
- Electronic access for all clinicians
- Increasing assessment resources and toys for OT/Speech therapy in Southport
- Provide feedback to the staff involved with this review
- Build regular dialogue between corporate and community services
- Health and wellbeing sessions to be held out in the community

A robust action plan has been developed **(Appendix 3)** to ensure all identified improvements are implemented within the services. This action plan is monitored on a monthly basis via the Community and Mental Health Divisional Governance meeting.

4. Recommendations

Alder Hey Trust Board is asked to note the contents of this report and to be assured that identified improvement actions are being implemented within the Community and Mental Health Division in relation to services transferred from Liverpool Community Health NHS Foundation Trust.

Appendix 1: Staff Survey results 2018

LCH transferred staff survey 2018.do

Appendix 2: NHS Improvement Visit March 2018

Alder Hey FT Clinical Service Review Marcl

Appendix 3: Action Plan for Transferred Services

NHSI action plan transferred LCH servi

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 2nd July 2019

Report of:	Medical Director
Paper Prepared by:	Liz Edwards, Head of Clinical Audit and NICE Guidance.
Subject/Title:	Seven Day Hospital Services.
Background Papers:	7 Day Hospital Services Self-Assessment – Autumn/Winter 2019/20.
Purpose of Paper:	To illustrate the Trust's position in terms of meeting the required compliance (90%) for the priority standards.
Action/Decision Required:	The Trust Board is asked to: • Note the content of the report.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	To deliver outstanding care.
Resource Impact:	

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Seven Day Hospital Services (7DS) – 12 June 2019

1. Introduction

In February 2019 the Trust provided its first board assurance report to demonstrate progress against the Seven Day Hospital Services (7DS) standards.

The 7 day service board assessment framework illustrates the Trust's position in terms of meeting the required compliance (90%) for the priority standards. The framework facilitates a narrative to demonstrate work in progress to meet compliance to all 10 standards.

The audit was undertaken by the clinical audit team, who reviewed a cohort of patients admitted as an emergency during week commencing 04 March 2019, whose length of stay exceeded 14 hours.

2. Audit findings

Standard 2 Time to initial consultant review & first consultant review within 14 hours - the data indicates an improvement in compliance, achieving 67% during weekdays and 50% at weekend (previously 52% during weekdays and 44% at weekend)

Full compliance was maintained for standards 5 and 6

The data for standard 8 cannot be verified as a cohort of patients admitted to 4A high dependency ward were not accounted for at this time. This element of the audit will be repeated before the end of June 2019 and the framework amended to reflect accurate findings.

The implementation of electronic 'Standard Documentation' has had a positive effect on the data collection for the audit. Additional changes to mandatory fields within Meditech will provide further clarification and subsequently further improve data quality. Examples are clarification regarding frequency of review, most senior person on ward review. This has been discussed with IM&T team with a view to amendments being completed prior to the next 7DS audit in the autumn.

Progress against standards 1,3,4,7,9 and 10 are provided in the narrative within the framework.

3. Further actions to be taken to facilitate the delivery of 7DS assessment

- A working group is to meet before the end of July 2019 to agree the process for continuous monitoring of 7DS compliance, with a view to developing a programme for 7DS assessment within the Medical, Surgical Divisions.
- Review of the process for reporting the updated framework within Divisional Integrated Governance Committees.
- Review the additional fields required within meditech to improve data quality

7 Day Hospital Services Self-Assessment

Organisation	**Alder Hey**
Year	**2019/20**
Period	**Autumn/Winter**

Alder Hey: 7 Day Hospital Services Self-Assessment - Autumn/Winter 2019/20

Priority 7DS Clinical Standards

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 2: All emergency admissions must be seen and have a thorough clinical assessment by a suitable consultant as soon as possible but at the latest within 14 hours from the time of admission to hospital.	Achieved 52% during weekdays and 44% at weekend when audited in April 2018 The Trust's 'Future Models of Care' project is due to be completed by the end of March 2019 - current data suggests that this piece of work will identify the need for consultant general paeds presence until 10pm . This will be implemented by the end 2020 through consultant recruitment and targeted job planning. Majority of current medical speciality job plans do not include routine weekend programmed activity, this will also be addressed following completion of 'Future Models of Care' project Future 7DS audits will take into account patients who have been assessed as no longer requiring HDU and are awaiting transfer to general ward areas (stepping down). In such circumstances, further consultant review in HDU is no longer required. Review of required length of stay for patients receving care from plastics team is under review - on occasions patients remain in HDU area but their progress is such that a consultant review is not deemed necessary before step down. The NHS guidance for 7 day service advises that patients admitted who are following a Trust approved pathway can be excluded from the audit if the pathway has been approved by the commissioners. This has not been taken into account during previous audits and may significantly affect compliance for this standard. Management of patients following a clinical pathway to be discussed with commissioners and NHSI team to establish whether this cohort will be excluded from future 7DS audits	No, the standard is not met for over 90% of patients admitted in an emergency	No, the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 5: Hospital inpatients must have scheduled seven-day access to diagnostic services, typically ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, and microbiology. Consultant-directed diagnostic tests and completed reporting will be available seven days a week: • Within 1 hour for critical patients • Within 12 hour for urgent patients • Within 24 hour for non-urgent patients	Q: Are the following diagnostic tests and reporting always or usually available on site or off site by formal network arrangements for patients admitted as an emergency with critical and urgent clinical needs, in the appropriate timescales?	Microbiology	Yes available on site	Yes available on site	Standard Met
		Computerised Tomography (CT)	Yes available on site	Yes available on site	
		Ultrasound	Yes available on site	Yes available on site	
	Fully compliant with all diagnostic tests for standard 5	Echocardiography	Yes available on site	Yes available on site	
		Magnetic Resonance Imaging (MRI)	Yes available on site	Yes available on site	
		Upper GI endoscopy	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance		Weekday	Weekend	Overall Score
Clinical Standard 6: Hospital inpatients must have timely 24 hour access, seven days a week, to key consultant-directed interventions that meet the relevant specialty guidelines, either on-site or through formally agreed networked arrangements with clear written protocols.	Q: Do inpatients have 24-hour access to the following consultant directed interventions 7 days a week, either on site or via formal network arrangements?	Critical Care	Yes available on site	Yes available on site	Standard Met
		Interventional Radiology	Yes available on site	Yes available on site	
		Interventional Endoscopy	Yes available on site	Yes available on site	
		Emergency Surgery	Yes available on site	Yes available on site	
	Fully compliant with all diagnostic tests for standard 6	Emergency Renal Replacement Therapy	Yes available on site	Yes available on site	
		Urgent Radiotherapy	Yes available on site	Yes available on site	
		Stroke thrombolysis	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Percutaneous Coronary Intervention	Not applicable to patients in this trust	Not applicable to patients in this trust	
		Cardiac Pacing	Yes available on site	Yes available on site	

Clinical standard	Self-Assessment of Performance	Weekday	Weekend	Overall Score
Clinical Standard 8: All patients with high dependency needs should be seen and reviewed by a consultant TWICE DAILY (including all acutely ill patients directly transferred and others who deteriorate). Once a clear pathway of care has been established, patients should be reviewed by a consultant at least ONCE EVERY 24 HOURS, seven days a week, unless it has been determined that this would not affect the patient's care pathway.	The criteria for frequency of assessment will be disseminated to medical and nursing staff - this will be discussed as part of the ongoing implementation of standard documentation to prompt staff. 'Future Models of Care' project will address frequency of review as described within 7 day service standards. Additionally this project will include plans to develop a bespoke 7 day service HDU team. Implementation will begin in 2019 with an aim to complete this work (including consultant recruitment) over a 3 year period.	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Once Daily: No the standard is not met for over 90% of patients admitted in an emergency	Standard Not Met
		Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	Twice Daily: No the standard is not met for over 90% of patients admitted in an emergency	

7DS Clinical Standards for Continuous Improvement

Self-Assessment of Performance against Clinical Standards 1, 3, 4, 7, 9 and 10
Standard 1 -Standard met Patient and family feedback is continuously collected and reported on a monthly basis. The questionnaires include sections regarding, privacy & dignity, decision making, Information available and choice regarding care. The implementation of Meridian was recently acheived and dicsussions are ongoing regarding the review of dtat collected collected during weekday and weekend periods specifically. Standard 3 -Partially compliant: The Trust currently adopts an MDT approach to the management of patients with complex needs in liaison with the lead Specialist Consultant for each period of hospital admission. This is supported by the use of health passports and the complex care team. The 'Future Models of Care' project involves review of children with complex needs and their management during an acute admission with a view to appointing a consultant lead for complex care by end of 2020. Standard 4 - A process for formal handover between consultants and between junior doctors is under review. This will include training needs analysis for doctors at all levels. Standard documentation will facilitate a tool for documenting handover, however this will be delayed for 1 year following implementation of SD. This work will be further supported by the job planning review and Future Models of Care project. Standard 7 - Partially compliant: CAHMS Crisis Care Team available 7 days, but not 24hrs each day. On call psychiatry available at all times. Crisi Team will respond wiithin 1 hour during working hours, and will provide assesssment within 4 hours of admission during working hours. 7 Day Services Working Group will work with Communiity Division to develop action plan for full compliance by end 2020. Standard 9 - Non compliant : It is difficult to assess the Trust's position currently, however this will be addressed by the 7 day service working group. Standard 10 - Partially compliant: The Trust has a comprehensive Clinical Audit plan supported by Divisional audit plans to demonstrate staff involvement in patient outcomes. The development of the Trust's strategy entitled Inspiring

7DS and Urgent Network Clinical Services

	Hyperacute Stroke	Paediatric Intensive Care	STEMI Heart Attack	Major Trauma Centres	Emergency Vascular Services
Clinical Standard 2	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust
Clinical Standard 5	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust
Clinical Standard 6	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust
Clinical Standard 8	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust	Yes, the standard is met for over 90% of patients admitted in an emergency	N/A - service not provided by this trust

Assessment of Urgent Network Clinical Services 7DS performance (OPTIONAL)
Fully compliant for Urgent Network Clinical Services appropriate to Children's services

Template completion notes

Trusts should complete this template by filling in all the yellow boxes with either a free text assessment of their performance as advised or by choosing one of the options from the drop down menus.

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

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

Section two is the Quarter 4 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. 2018 – Dec. 2018)	55
Number of deaths reviewed	49
Departmental/Service Group mortality reviews within 2 months (standard)	47/55 (85%)
HMRG Primary Reviews within 4 months (standard)	29/55 (53%)
HMRG Primary Reviews within 6 months	39/43(91%)

The HMRG performance target of reviews within 4 months has dropped this quarter to 53% but 91% have been completed within 6 months. An increased number of cases have been very complex requiring discussion at multiple meetings resulting in less reviews being covered within 4 months. The group is of the opinion that it is important to have all relevant information to achieve a complete and effective review and to discuss it fully. Therefore, it is appropriate to take the necessary time, and it unlikely that we will ever achieve 100%. The standard of 4 month is useful so reviews are done in a timely manner and if there is a concerning trend it will be identified in a reasonable time period.

We are still undertaking a number of changes in our mortality process to improve and meet the National Guidelines released at the end of last year.

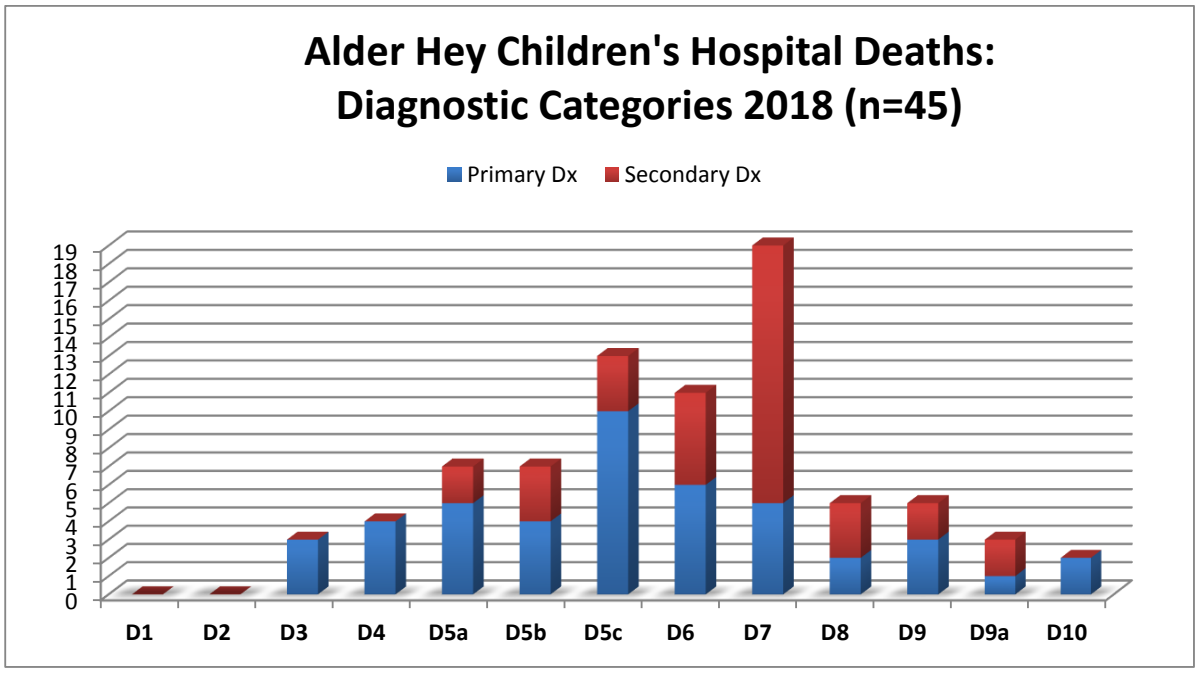
Outputs of the mortality review process for hospital deaths for 2018:

Month (2018)	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	7	7	5	4	7	3		1		1
Feb	1	1	1	1	1	0				
March	6	6	6	6	6	0				1
April	6	6	6	4	4	4		1		1
May	4	4	4	4	4	0				
June	4	4	3	2	4	3				2
July	4	4	3	1	2	2			2 (both 72 hour reviews)	1
August	5	5	3	1	5	3		1		1
Sept	3	3	3	1	3	1				1
Oct	3	3	3	1	3	1				
Nov	7	3	6	1		1				
Dec	5	3	4	3		2		1	1	1

Potentially Modifiable factors and Actions

Over this period, there has been 1 potentially avoidable death identified by the HMRG process. This was a child that was unfortunately involved in a house fire so the death would have potentially been avoidable looking at external factors.

Primary Diagnostic Categories



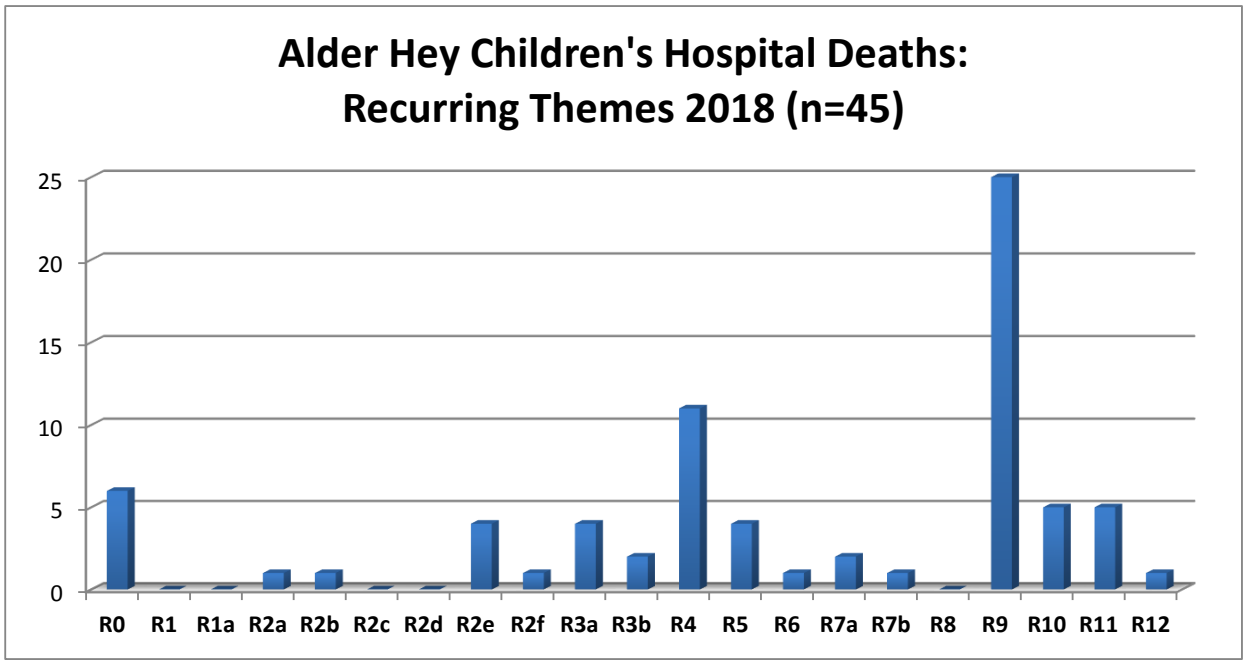
Diagnostic/Disease Categories (based on CEMACH categories - ref. *Arch Dis Child* 2011;96:922-6 + 927-31)

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 primary diagnostic category is cardiac 22%, which is not surprising since Alder Hey is a major cardiac unit. A number of children are transferred for assessment and unfortunately have very significant lesions which are inoperable or palliative. The next highest category is chronic medical conditions -13% closely followed by congenital 11%. A considerable number of the children who die in the hospital have complex medical conditions resulting from congenital conditions so these figures correspond with the hospital caseload.

There is only one hospital acquired infection recorded which has the primary cause of death and 2 as a secondary cause. The child with the hospital acquired infection had a number of reviews and the infection was unfortunate rather than due to lack of care. The others were children who were immunocompromised or had a prolonged PICU stay.

Primary Recurrent Themes



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 withdrawal of care in 55 % 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 common theme is death -inevitable prior to admission, this occurred in 25 % of cases. This is when even with optimum care there is nothing that the teams in AHCH can do to prevent death. This may not be apparent prior to transfer and may require investigations to be undertaken in AHCH to complete a full assessment and discuss all treatment options or lack of.

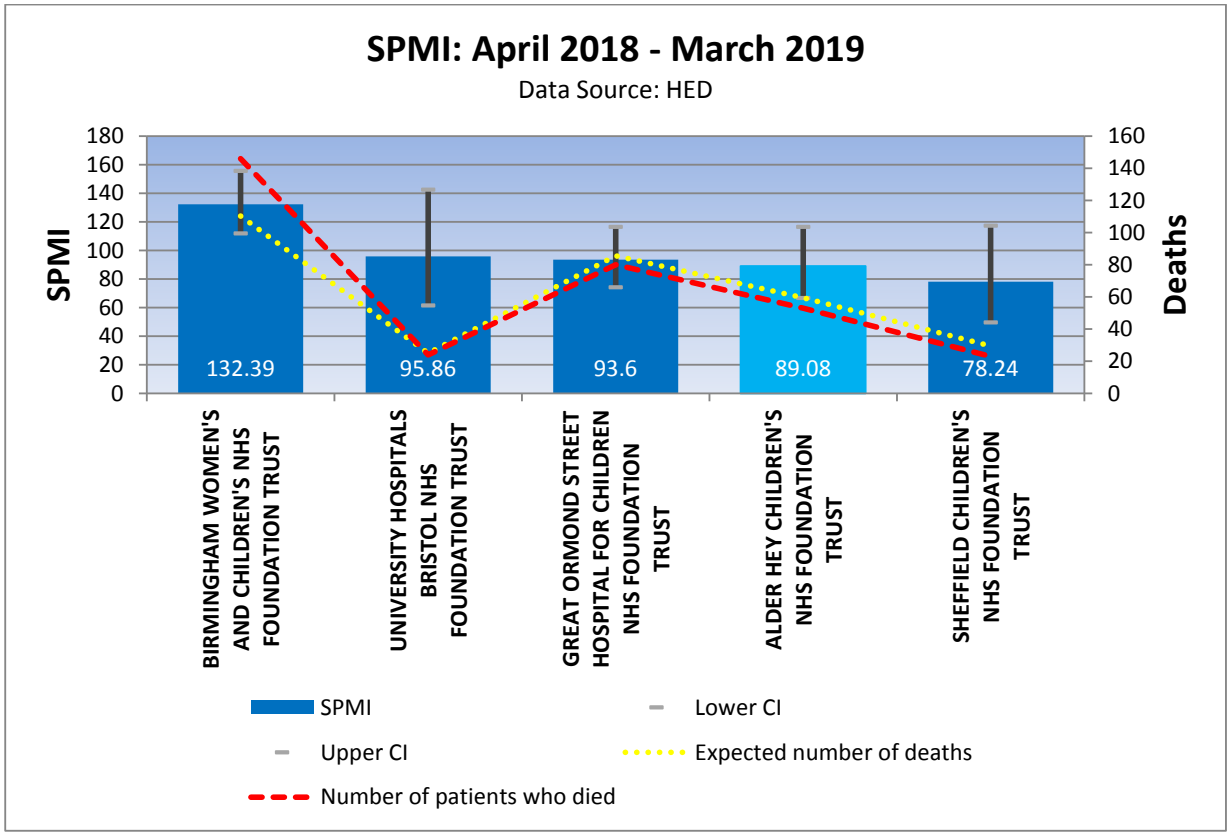
There are no worrying recurrent themes that are becoming apparent during the case reviews.

Section 2: Quarter 4 Mortality Report: January 2019 – March 2019

External Benchmarking

-Standardised Paediatric Mortality Index (SPMI); – HED

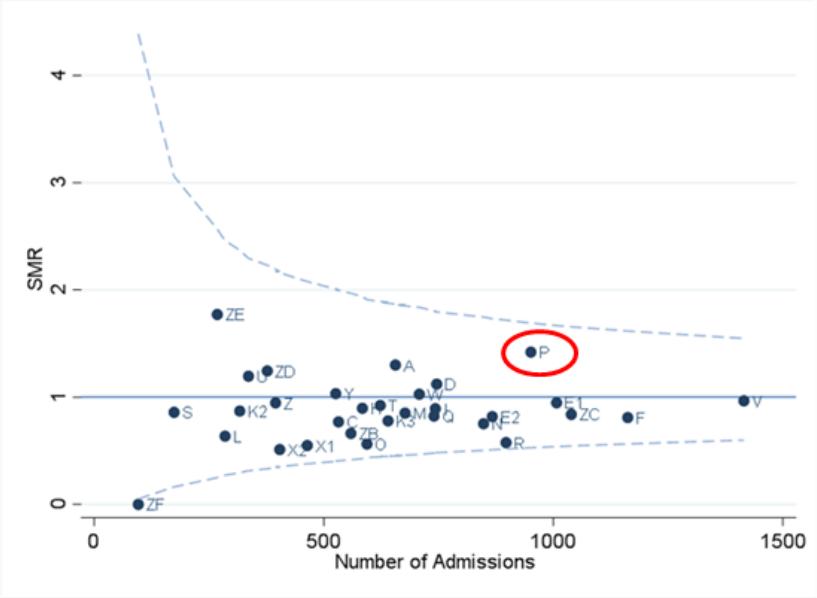
HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. The most recent data available is for the period 1st April 2018 to 31st March 2019.



The chart shows that Alder Hey has a lower mortality level than the average NHS performance with 53 deaths against 59.5 expected deaths. However Alder Hey's SPMI is similar to the hospital's with similar work load – Great Ormond Street and Bristol.

-PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other children's trusts. In the most recent PICANet report (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.

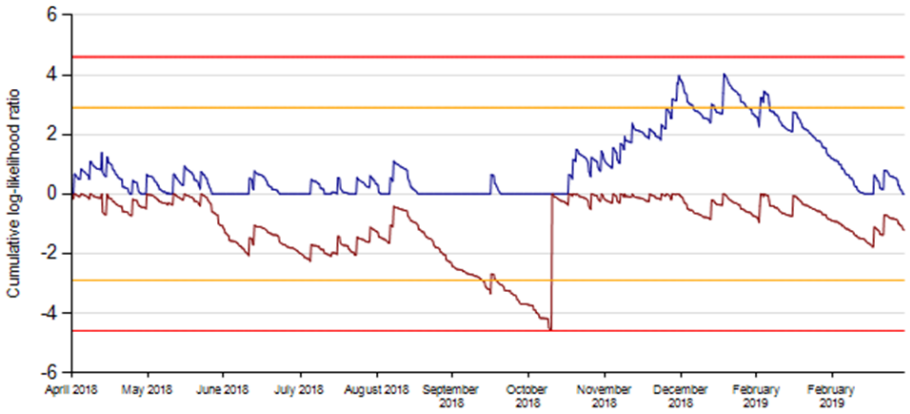


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

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.

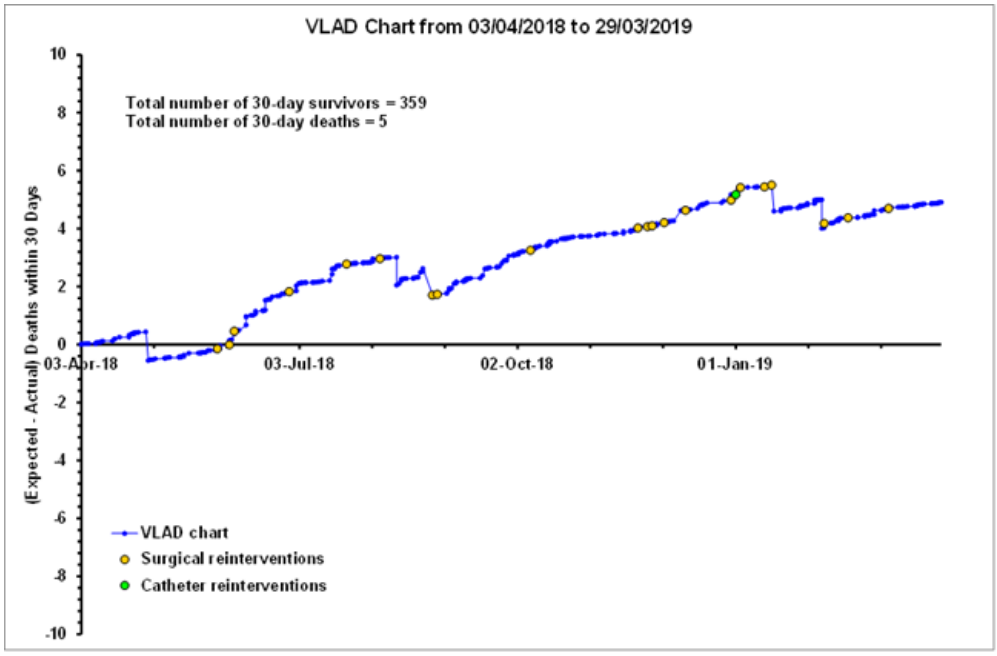
This data is nationally validated because it is generated by PICANet.

We had a total of 48 deaths in 2018. The above RSPRT chart indicates that we have been in "Safe Zone" except for the period between November 2018 and February 2019. Between November 2018 and December 2018 we had 14 deaths, 12 of them belonged to the "Death inevitable on PICU admission" group in retrospect. Of the 2 unexpected deaths, one patient died after acute lung injury and brain injury following inhalational burns in a house fire and the other was a neonate post-complex cardiac surgery. All PICU deaths + RSPRT trends are discussed in the following month and monitored regularly.

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

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

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

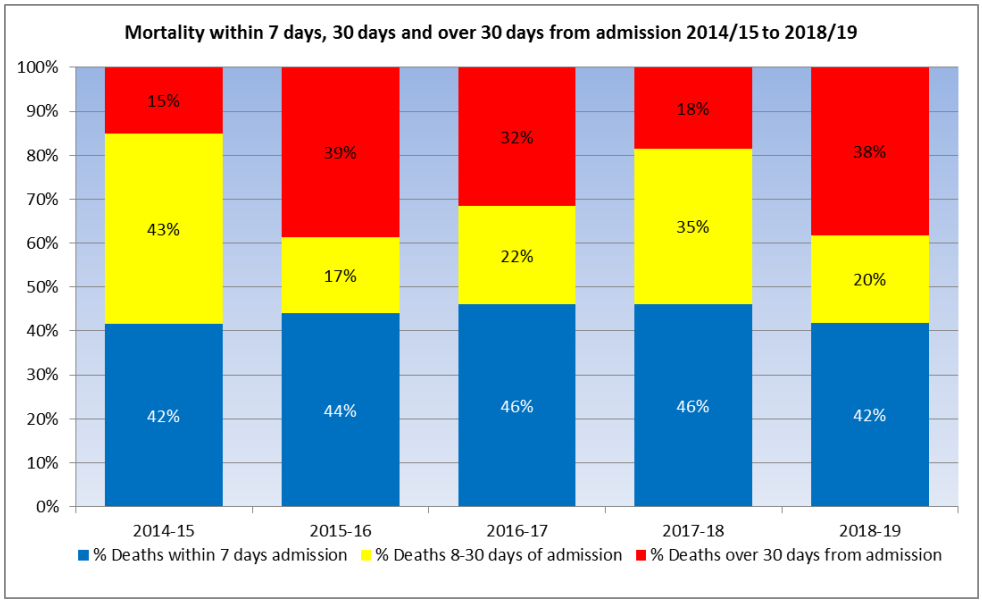


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from April 2018 to March 2019. The survival rate at 30 days was 98.6% against an expected rate of 97.3%.

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 year (Apr – Mar) 42% occurred within 7 days of admission, 20% occurred within 8-30 days from admission, and 38% deaths occurred over 30 days from admission.

Conclusions

The HMRG is functioning well although there have been a number of challenging cases resulting in less cases 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 5**

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 6**

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 6**

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 8**

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
2nd July 2019

Subject/Title	Digital Strategy Digital and Information Technology Update
Paper prepared by	Kate Warriner, Chief Digital and Information Officer
Action/Decision required	The Trust Board is asked to: • Approve the Trust Digital Strategy • Note progress with GDE change control • Note overall progress to date with Digital and Information Technology developments
Background papers	Draft Digital Strategy (attached as Appendix)
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Inspiring Quality, Strong Foundations Significant contribution to the strategic objectives for: - Brilliant Basics - Digitally Enabled Care - Outstanding Care - Game Changing Innovation - Positive patient experience - Improving financial strength

Digital Strategy, Digital and Information Technology Update

1.0 Purpose of Paper

The purpose of this paper is to provide Trust Board with a draft of the Trust's digital strategy, report on progress with digital transformation programmes and developments with regards to Operational Information Technology.

2.0 Digital Strategy

2.1 Strategy Summary

Named by the Children and Young People's Forum, 'Digital Futures', the draft digital strategy for Alder Hey is attached as an appendix to this report. Digital Futures has been developed over the past three months with vast clinical input from staff across the Trust. It has been developed in partnership with our digital team, divisions, innovation and research teams and Children and Young People's Forum.

The ambition for Digital Futures is to create an ethos of 'Outstanding Digital Excellence' within Alder Hey. At the heart of this vision is our 'north star' focus on creating the best experience and outcomes for Children, Young People and Families, and Staff.

Through this we will strive to:

- Deliver the best possible digital and technology services to support, enable and drive clinical excellence for Children, Young People and their Families
- Deliver Information Technology basics well, championing a 'Digital First' approach across Alder Hey, supported by excellent, proactive, customer focussed services
- Provide the very best digital services, technologies and advancements for Staff, with a focus on digital quality improvement, outcomes and patient safety
- Unleash innovation and research to harness 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

2.2 Delivery of the Strategy

It is proposed that Digital Futures will focus on three key themes:

1. Digital Children, Young People and Families
2. Digital Quality Improvement
3. Unleashing Innovation and Research

Our Digital Children, Young People and Families theme is driven by our organisational approach of putting Children first. Through this theme we will deliver a range of capabilities to enable Children, Young People and Families to interact through a digital front door with Alder Hey.

We will deliver this theme through 3 workstreams:

- Digital Front Door
- Digital Communications
- Digital Services

Our Digital Quality Improvement theme builds on much work delivered to date and underpins our Brilliant Basics ethos. It will enable our aspirations in terms of Inspiring Quality, and support our staff to do their best work in delivering outstanding care to children and young people.

This theme focusses on 5 themes:

- Digital Hospital
- Digital Community
- Inspiring Quality – Continuous Quality Improvement
- Intelligence Led Care
- Digitally Enabled Staff

The Unleashing Innovation and Research theme supports our strategy in terms of growing the future.

This theme focusses on 4 key workstreams:

- Living Trust
- Innovation Hub
- Research and Evaluation
- System Wide Developments

These themes will be supported by cross cutting foundations of Partnerships, Design Principles, Culture and Values; underpinned by a clear technology roadmap.

2.3 Governance

In terms of governance, it is proposed that a Digital Oversight Collaborative is established. This group will replace the GDE programme board. This group will act as a steering group to oversee delivery of digital programmes and operational IT delivery. It is proposed that the group will report into the Resources and Business Development Committee (RABD) and Trust Board via RABD.

Due to many of the factors of the strategy supporting / serving key clinical programmes, there will be a close relationship and lead officer identified with regards to clinical programmes including Inspiring Quality and Best in Outpatient Care.

Major change programmes will be operationally managed through the Digital Oversight Collaborative and associated sub groups, but will report formally to the Trust programme board.

A Digital Design Authority will be established to support and underpin a range of programme areas, taking a view on clinical prioritisation. This group will be clinically led

and report to the Digital Oversight Collaborative. A range of groups will be established as necessary throughout the lifetime of the strategy to oversee key programmes of work.

An Operational IT group will be established with divisional leads to support day to day operational delivery.

A quarterly forum will be established to bring together areas of overlap between digital, innovation and research functions.

2.4 Investment

It is clear that to deliver Digital Futures, a significant level of investment is required. External sources of investment will be identified and proactively progressed. Internally, the trusts capital plans support a level of investment in IT business as usual, resilience and digital advancements over the next 5 years. Additionally, from a sustainability perspective, revenue budgets are in place to support our ambitions which include a level of efficiency across the organisation.

2.5 Digital Futures Summary

The alignment of key strands of work will ensure we maximise the sum of many parts. It will both liberate and disrupt our ways of working to improve the care we give to Children and Young People. It will put us at further at the forefront of global digital leadership. We believe that our relationships, support, leadership and talents of our staff will enable us to deliver our aspirations.

3.0 Digital Transformation

As agreed at May RABD and Trust Board, the digital major change priorities for 19/20 are:

- Global Digital Exemplar and HIMSS Level 7 Accreditation
- Electronic Patient Record Upgrade Planning
- Paperfree

3.1 GDE and HIMSS Level 7

In terms of Global Digital Exemplar (GDE) & HIMSS Level 7 Accreditation, work has been ongoing to review milestones and delivery. There are two milestones remaining within the programme with c.£1.6M attached. Due to an assessment against the final milestone, a change control notice has been developed with NHS Digital. This was approved by GDE Programme Board in June and is under review with NHS Digital.

The Change Control Notice recommends amendment of some content including removal of EPR upgrade from March 2019, and addition of further ambitious digital projects including artificial intelligence, virtual reality and a digital paediatric intensive care unit.

A gap analysis has been undertaken with regards to HIMSS accreditation, the key risk is with regards to implementation of closed loop medications. A group has been established, led with digital and pharmacy colleagues to develop a weekly delivery plan.

3.2 Electronic Patient Record Upgrade Planning

Plans have been developing with regards to the EPR upgrade. Work is underway with clinical teams to ensure there is a review of functionality requirements to ensure inclusion in contract. Demonstrations are in place for W/C 24th June 2019.

In parallel, work is underway to review the infrastructure and disaster recovery plans to ensure we have the level of resilience we require to operate safe services.

3.3 Paperfree

A range of activities have commenced with regards to paperfree. These include an external review and a range of options being developed to address short term scanning issues and a longer term programme and plan with regards to scanning and paperfree.

4.0 Operational Information Technology Delivery

There has been a significant focus on Operational Information Technology Delivery in the last quarter. An independent review was undertaken in April 2019, following which interim leadership arrangements were put in place. Key areas of focus include:

- Technology Roadmap
- IT Service Improvement Plan
- Community IT Service Improvement Plan
- Key Performance Indicators Reporting
- Infrastructure and Resilience
- Cyber Security

4.1 IT Service Improvement Plan

Following feedback from staff, an IT Service Improvement Plan has been developed. This is operational in focus but aligned to delivering brilliant basics as part of our Trust and Digital Futures strategy.

4.2 Community IT Service Improvement Plan

It is widely reported and recognised that Community teams have a substandard IT experience. A specific improvement plan has been developed for community including:

- Improved network connectivity
- Device strategy
- Improved support with migration to Alder Hey systems
- New IT service support model
- Windows 10 implementation

Dedicated resources are in the process of being established to deliver against a plan to conclude in December 2019.

4.3 Key Performance Indicators Dashboard

A key performance indicators dashboard is in development. It is proposed that this is presented to operational delivery board and up through committee structures to Trust Board. In addition, any major operational IT issues and a cyber dashboard will be reported routinely.

4.4 Infrastructure and Resilience

Following identification of risks with regards to disaster recovery and resilience, a review of the IT Operating Model continues including a plan emerging for the infrastructure strategy and options for disaster recovery and resilience.

4.5 Cyber Security

Trust Board had an engaging Board Cyber Training session, delivered externally in partnership with NHS Digital in June 2019. Plans are in place through both GDE and the new digital strategy with regards to a roadmap to achieving Cyber Essentials +. An external assessment was undertaken in March 2019, following which an action plan has been developed.

Performance via key KPIs will be included in the IT operational dashboard noted above.

5.0 Risks

There are a number of risks to delivery of both the transformation and operational areas of Digital and Information Technology including:

- HIMSS accreditation: Closed Loop Medications complexity - impact to GDE and HIMSS accreditation. Weekly task and finish to be established
- Clinical risk of dual paper and digital records compounded by scanning delays – to be mitigated via proposed paperfree programme, proposals in development
- Service and Information Technology resilience – lack of secondary data centre / disaster recovery infrastructure for either the EPR or core infrastructure, options appraisal commissioned
- Investment post 19/20 – quantified as part of the digital strategy and immediate risks in terms of resilience and service delivery
- External reputation and GDE accreditation – CCN developed, approved by GDE programme board, in dialogue for approval with NHS Digital
- Microsoft support – requirement to move to Office 365 by the end of December 2019 due to lack of support nationally post this date which would result in a cyber security risk

6.0 Summary and Recommendations

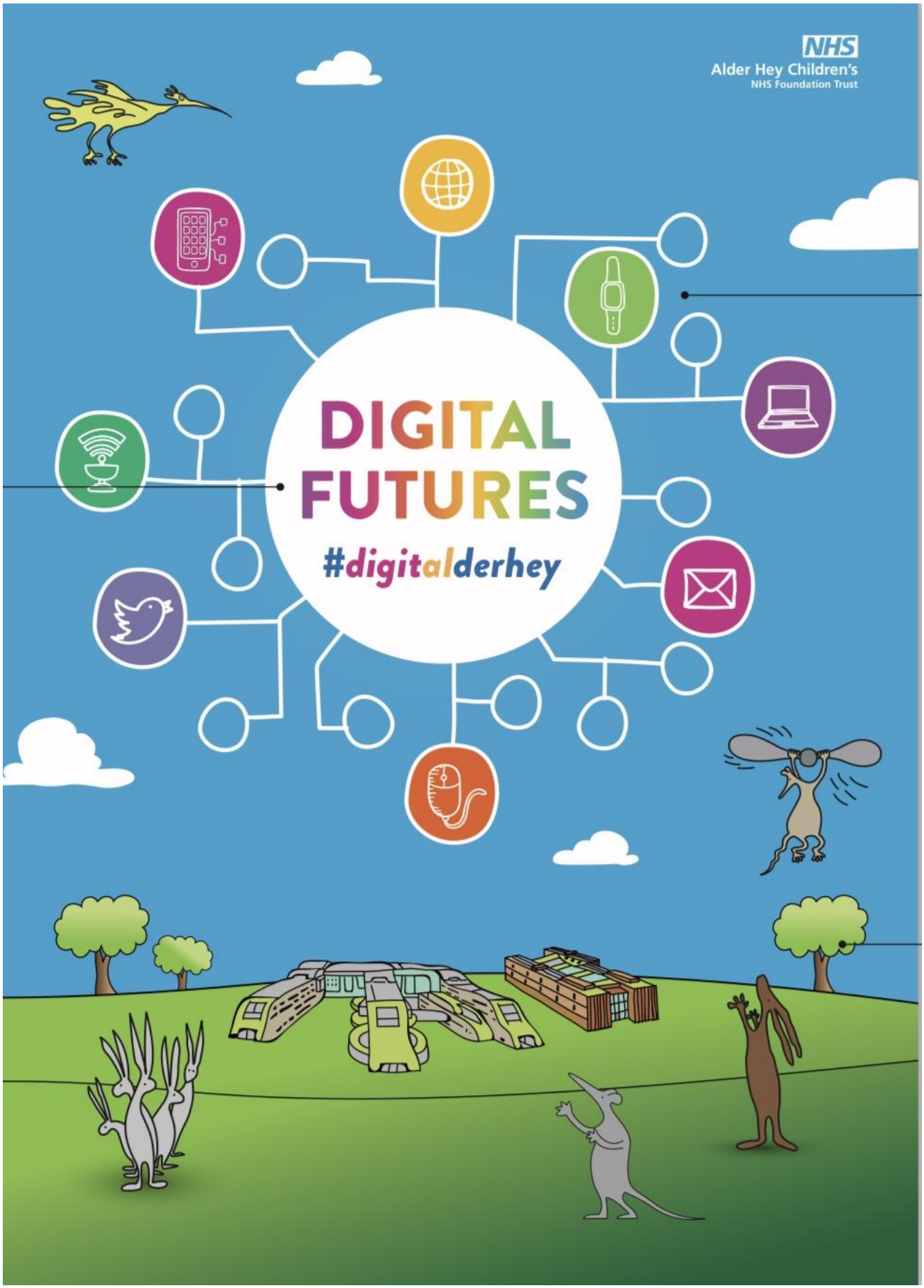
In summary, progress has been excellent in a short space of time. The Digital Futures strategy will help to set a clear strategic direction for digital in Alder Hey and the focus on Operational IT will provide transparency on performance, successes and risks. The technology roadmap and service improvement plan are essential to increase resilience and comply with national regulatory requirements.

Trust Board is asked to :

- Approve the Trust Digital Strategy
- Note progress with GDE change control
- Note overall progress to date with Digital and Information Technology developments

Kate Warriner
Chief Digital and Information Officer

Appendix 1 – Draft Alder Hey Digital Strategy



Contents

Foreword

Everything we do, almost every part of our day is determined by digital technology. This technology has led to life changing inventions and has linked individuals across the world, with potential for collaboration and game-changing learning. In our NHS we are trying to mirror the difference that digital makes everywhere else.

At Alder Hey we are determined to be a leader in the NHS, creating a digital future by working with our children and young people to give them the best possible care, supported by unleashing the power of digital technology in every part of what we do. We want the experience of everyone we are in touch with to be enhanced through digital, from their first contact to their last.

We pledge to use digital to ensure that we are safer and that we deliver the best possible care at every step. For our staff we pledge that their working day will be made better by delivery of a digital infrastructure that is based around their day to day needs. Using this Digital Strategy Alder Hey has the opportunity to transform the way we work and the way we deliver care.

Section 1: Our Digital Promise - Outstanding Digital Excellence

A very warm welcome to 'Digital Futures': #digitalderhey. Digital Futures sets out the digital ambitions and strategy for Alder Hey NHS Foundation Trust over the next five years.

Our ambition 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 and Families, and Staff.

Through this we will strive to:

- Deliver the best possible digital and technology services to support, enable and drive clinical excellence for Children, Young People and their Families
- Deliver Information Technology basics well, championing a 'Digital First' approach across Alder Hey, supported by excellent, proactive, customer focussed services
- Provide the very best digital services, technologies and advancements for Staff, with a focus on digital quality improvement, outcomes and patient safety
- Unleash innovation and research to harness 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

We believe that achieving Outstanding Digital Excellence, having an ethos of creating the best digital experience and delivering the best clinical outcomes should 'be our norm' and cut through everything we do internally, locally, regionally, nationally and internationally. We will not always get it right but we will focus our efforts to try and get it right, every time.

The opportunity of digital is immense for health and care services. It is here to stay and further expand and will both enable and drive both current and future developments.

We will focus delivery on three key transformation themes:

4. Digital Children, Young People and Families
5. Digital Quality Improvement
6. Unleashing Innovation and Research

These themes will be supported by cross cutting foundations of Partnerships, Design Principles, Culture and Values; underpinned by a robust technology roadmap.

Section 2: Framing the Digital Strategy

'Digitally Enabled' is identified as a strong foundation in Alder Hey's 'Our Plan'. It is a core tenet of the Trust's five year strategy. It is important to note that this cuts through our whole strategy from Brilliant Basics and Outstanding Care, supporting our people to do their best work, through to growing the future with game changing research and innovation. Improving Care through Technology is a key plank of our Inspiring Quality strategy and delivering best in outpatient care. The translation of innovative digital developments into enablers of improved patient care and experience will be supported by a robust framework of evaluation.

We expect and get a 'digital experience' every day and it isn't unusual, or even "digital". It just is what we do and get - from waking up to our phone alarm, to listening to music, to using 'sat nav' on way to work, online shopping, messaging family and friends on WhatsApp etc.

In health and care services, the use and development of digital and technology are critical factors prevalent in much of what we do, but has way more potential and opportunity to truly support and transform the way in which we provide, plan and deliver care.

Alder Hey NHS Foundation Trust

Alder Hey enjoys a world-leading reputation in many disciplines and is recognised as a leader in healthcare innovation and technology. With Alder Hey in the Park we have an infrastructure, clinical entrepreneurs, and active engagement with industry, academia and the local community that has created an exemplar of the power of public and private collaboration and partnerships for accelerating innovation into healthcare.

Crucially, the aspiration to transform care for children, young people and their families through digital technology is one of the key aims of the Inspiring Quality programme, with an aspiration to have excellent digital pathways and a clinical intelligence portal supporting high quality care.

Cheshire and Merseyside Health and Care Partnership

Regionally, delivery of a 'digital revolution' is one of the key enabling workstreams of the Cheshire and Merseyside Health and Care Partnership. The regional Digit@LL Strategy was published in July 2018. Digit@LL sets out a vision for the local system of empowering staff and patients through digital technologies. The strategy outlines a vision of integration of digital information and records and presents an innovation ambition to make Cheshire and Merseyside the place innovators come to learn and see digital excellence.

Digit@LL is centered around six thematic headings of:

- Empower – delivery of person held records and assistive technology empowering and activating citizens to utilise digital technologies to manage their own care, take control and work in partnership in relation to their health and wellbeing
- Enhance - improving quality, safety, patient experience & outcomes through significantly reducing paper processes and records that cause inefficiency and delays in care
- Connect – delivery of the North West Coast Local Health and Care Record Exemplar Programme, Share2Care, connecting and supporting the integration of our local health and care organisations. ensuring that information is available to the right people, in the right place, at the right time to deliver and drive service delivery, integration and transformation
- Innovate - creating a culture of constant 'innovation' and improvement with our approach to technology enabled health and care services
- Secure - supporting all local health and care organisations to ensure that our local system operates and functions safely through a robust approach to Cyber Security.
- Collaborate – working collaboratively with partners across Cheshire and Merseyside

Alder Hey has contributed vastly to the development of the C&M digital leadership and strategy over the past 2 years. We are the host provider for a number of system wide schemes and have made significant progress to date.

For our staff, these regional capabilities mean that they will have access to information held in other organisations for the children and young people they are caring for. It will support us to use data and intelligence to manage our proactively and give our local citizens a seamless service across health and care.

Through the Share2Care programme, we will have access to a shared record called 'e-Xchange' which will allow the exchange of key information across health and social care. Both professionals and patients will be able to access and interact with this information.

We will share best practice and expertise through collaboration. We will work together in partnership with other health and care organisations, sharing scarce expertise and specialist skills.

NHS, Academia and Industry Partnerships

Partnerships between NHS, Academia and Industry are key. Through these partnerships, we envisage the creation of a single integrated, secure governance framework, allowing researchers and clinicians to safely and securely use data to develop new scientific knowledge and novel therapies and technologies.

This will help to increase the profile and impact of Liverpool's world-class life sciences ecosystem (including but not limited to Liverpool Health Partners), increase our understanding of disease, enhance our health services and improve the prevention, detection, and diagnosis of diseases in children including inflammatory diseases such as asthma, infection and cancer.

National Priorities

Nationally, digital technology has been seen as a key priority for several years. This focus has seen investment in a number of organisational and regional digital schemes including the Global Digital Exemplar and Local Health and Care Record Exemplar Programmes both of which, Alder Hey is part of.

There are a range of guiding principles and priorities set out in the technology vision for the National Health Service. These include a focus on user need, privacy and security, interoperability and openness and digital inclusion. Priorities for the NHS set nationally include infrastructure and standards, including cloud first, digital services designed to meet the needs of users, enablement of innovation so that cutting edge technologies can be easily implemented and the right skills and culture to drive the best outcomes for patients.

The formation of NHSX is a major development for digital advancements in the NHS, demonstrating a continued commitment to driving up a digital NHS fit for the current and future.

Section 3: The Journey So Far

Alder Hey is in a great place in terms of developments, investments and vision that have been in place for many years.

Feedback from people who visit Alder Hey includes what a fantastic place it is, the wonderful services provided to children and young people and the care and compassion given to often worried and anxious families.

The warm, kind and vibrant vibe in Alder Hey is infectious to those receiving care there, and those that visit for direct care, education or professional purposes.

Digital Futures is the next chapter in our history of delivering digital advancements. Some of our key achievements to this point, and things which make us unique are:

- We are a specialist paediatric Trust which attracts THE best staff in their field of expertise delivering incredible outcomes and care for our Children and Young People
- We have an amazing new hospital, delivering outstanding care
- We have wonderful community services providing fabulous care closer to home
- Alder Hey is the only Trust in the country that has a Bat Cave. The Bat Cave, otherwise referred to as the Innovation Hub, pioneering leading innovations
- Alder Hey is one of sixteen Trusts who were identified as part of the Global Digital Exemplar Programme in 2016. This has enabled us to digitise clinical pathways, improve integration and spear head regional interoperability developments
- There are core building blocks including an integrated Electronic Patient Record and an Electronic Document Management System. These systems are the foundations which are allowing us to digitise customised clinical pathways to fit the workflows and pathways in place at Alder Hey with individual clinical teams thus enabling improvements to quality, patient safety and efficiency
- Our incredible Paediatric Intensive Care Unit has its medical devices integrated with the ICU EPR enabling safe care for our children and young people
- Our Community teams have extensive use of a community EPR, integrated with other community services and General Practice
- We have an integrated approach to clinical imaging with many ‘Other Ologies integrated into our PACS system

- Our Orthopaedic surgeons are a global exemplar of good practice as the first to run nationwide clinical research studies completely online
- *Our Cystic Fibrosis 'CF START'* is using an innovative approach employing national registry data to collect key outcome measures. This is the first global paediatric registry-based study of a medicine and is highlighting the potential to conduct large comparative effectiveness studies with minimal cost to the health service and to the families involved
- Alder Hey continues our proud legacy of pioneering research into children's health and wellbeing. We are the centre which enrols the most children and young people into important clinical research studies, ranging from discovery science to trials of important new medicines for children. The assembly of integrated child health data from different domains enables improvement in outcomes through analysis of 'big data' and application of emergent artificial intelligence methods

As a local health and care system, the Cheshire and Merseyside Health and Care Partnership has made significant progress over the last three years. This includes the launch of our region wide Digit@LL strategy, significant collaboration, securing national funding to support regional priorities. On a practical level, progress includes the delivery of the first phase of a regional shared record, a specialist group supporting cyber security and resilience and a patient held record in development.

Alder Hey has played a significant role in these developments. Through our GDE programme, we provided senior and technical leadership and pump primed the early work to connect up our local system with a shared record. We provided leadership and expertise to the regional work on digital diagnostics and our Chief Executive Officer is the Senior Responsible Officer for the Cheshire and Merseyside Digital Revolution workstream.

Section 4: The Difference is Digital - A Model Alder Hey

Our ultimate Digital Futures ambition for Alder Hey 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 Our Children, Young People and their Families, and Our Staff.

We will deliver this vision to:

- Improve outcomes for Children, Young People and Families through the use of digital technology
- Use digital technology in every clinical pathway design and clinical interaction
- Use digital technology to provide our staff with high quality decision support to ensure patient centric care
- Exploit digital innovation with private partners and academia delivering game changing innovations
- Elevate the opportunity of technology and innovation in the development of the health park and children's Knowledge Quarter
- Accelerate the research offer and increase research participation and safety through the use of intelligent digital tools
- Maximise our investment in our core systems and applications

What do we mean by Outstanding Digital Excellence?

The term 'digital' means different things to different people. At its simplest definition, the term digital is about showing information in the form of an electronic image and using that information in a different way. A good example is to demonstrate the difference between analogue and digital in a watch or telephone.

For the purpose of Digital Futures, the term 'digital' builds on its definition above. In a health context, it is about using digital systems and information to engage, deliver and transform services through technology, supporting both current and future ways of working. This may be through the delivery of core equipment that works for great care

delivery, advancement of electronic patient record systems through to the opportunity of artificial intelligence, machine learning and information to support research.

Through the term outstanding digital excellence, we mean:

- Digitally empowered staff - a great staff experience with 'invisible IT' that 'just works
- Minimal clicks to get where you need to – championed through a 'save a click' campaign to improvement
- Digitally active Children Young People and Families - we will do now what Children and Young people need next with Digital Innovation and Med Tech at the Centre of Quality Improvement
- A 'no wrong device' ethos, enabling an 'any time, any place, anywhere' approach to delivery
- A world leading centre of excellence that accelerates the impact of game changing Innovation for Children & Young People
- Europe's most digitally mature children's Trust, as rated by staff and patients, validated by international accreditation
- A Digital First approach focussed on Inspiring Quality Aims and Outcomes
- An integrated customer service approach
- Systems that work and talk to each other, giving back the gift of time to clinicians
- Mobilising health data for science and innovation - improving children's health through better data science, improves the health of future generations
- Using routinely collected data to improve public health, diagnostics and treatment
- Integrated digital systems make patient entry into clinical trials easier, and patients in clinical trials do better
- Integrated digital systems which facilitate collection of meaningful patient outcomes, which allows robust evaluation of interventions, processes and policy
- Allowing access to unique data assets across the Trust by the research community in a safe, secure and ethical framework. This will lead to new diagnostics, treatments and insights which will transform outcomes for patients
- Dynamic partnerships between the NHS, academia and industry through an integrated digital strategy is critical to create the necessary environment for Alder Hey to maintain its status as a world leader in children's health

- Use of artificial intelligence to model patient data and predict outcomes of treatment strategies. Use artificial intelligence to reliably predict critical deterioration using vital signs trends and patient history, which will allow interventions to be introduced to prevent such catastrophic events

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 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.

Our aspiration is that our digital advancements will enable a true level playing field for all of our patients and families. Augmented digital assistants could help ensure that children and young people can get the very best care. These would include digital assistants who can identify sub optimal attendance and uptake of resource.

We need to use artificial intelligence and augmented technologies to eradicate the role of the clinician as a data entry technician. This kills the primary purpose of what clinicians are there to do - which is to care for patients.

Through our focus on experience, we will have an increased appreciation for the human denizens of Alder Hey to be viewed as part of a grand system that is our organisation. This is key as it will support optimising clinical interfaces with information in the same way as we would optimise a machine. We will look to efficiency measure this in some way to help guide the development of our technologies.

People like to be with people and anything we can do to free time up to allow this presence is truly golden. A change approach with empathy is absolutely key, and in tune with the culture of Alder Hey. We will strive to get better and developing technologies that allow us to be better at empathy and more importantly have more time to practice it. This will be ceded to Artificial Intelligence in the future whereby a member of clinical staff can bring AI to a care process.

We will have a measure for success that incorporates the softer aspects of care and the holistic care of the staff as part of the wider system. By using the improvement of this measure as a way to mould and guide our technological development, we can transform into a truly 21st century caring organisation. This will allow us to move to the forefront of a global healthcare system.

A Day in the Life……

Digital services for the future will feel different for our Children, Young People and their Families and for our professionals. In order to deliver a modern health and care service, technology and digital innovations will feature in everything we do.

'The Child or Young Person's Perspective'

From children, young people, families and carers perspective, delivery will mean:

- Children and young people will only need to tell their story once
- Technology will be used for individuals to self-care and self-monitor proactively
- Children, young people, families and carers will be able to interact digitally with professionals involved in their care
- Joined up, integrated, safe care is enabled through a co-ordinated approach across the whole region

'Our Staff'

For our staff, this will mean:

- Staff have access to everything they need to treat their children and young people effectively, wherever they need it
- Care is more joined up and with less duplication through readily available information, integration and automation
- Ownership of the system will enable how staff will work in the future creating a supportive and engaging environment for staff
- Technology in work will work as well for staff as their technology at home does

Our Trust, Broader System and Region

For the Trust, Broader System and Region, delivery of this strategy means:

- Working in partnership across the whole system
- Universal approach and delivery
- Cross organisational pathways are introduced and facilitated and the child or young person's record data shared, reducing time and improving quality of service delivery and care
- 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, and high quality risk stratification

The vignettes below demonstrate 'A Day in the Life' for a range of roles and settings across Alder Hey.

Community Speech and Language Therapist

"Working in community means starting your day in a variety of settings including: the child's home, a community clinic, the child's school or nursery setting. Therefore, I have IT systems which 'just work' in a variety of settings. I can access the child or young person's paperless record via the use of remote working devices including laptops and tethering devices. This means time efficiencies can be made so we have more time to deliver direct therapy and support to the child & young person. By having this flexibility it means that I can ensure the child receives the best care in the most appropriate environment.

Whilst working with the child or young person we will be able to view electronic care plans of our own service and also the most proximal services working with the child. This ensures that we are working collaboratively for the child or young person to achieve the best outcomes in line with the child or young person's care aims.

Access for children or parents to a digital record is vital and they will be able to see information that is important to them such as: appointment dates, recent reports & care plans. Particularly for children with complex needs, it is important that they and their parents can access this information as co-ordinating all of their care can be a momentous task. This allows them to be empowered about their own health & care.

Specific to Speech & Language Therapy, we will be aware of the most up to date technology available to support our children & young people with their communication. This can include

apps/devices for alternative and augmentative communication and using technology to support therapy intervention such as skype sessions to deliver therapy."

Outpatient Services

"There will be a vast reduction in children and young people physically attending outpatient clinics. Children and Young People will physically attend where they need to, maximising digital consultations and communications.

Clinical systems will not only allow clinician's a clear overview of the entire patient journey, they will also be able to talk to each other to facilitate data to be collected using one system but then recorded and viewed on another. This enables the clinician to have a clear paperless digital record, where they are able to see all the information they require in one place, reducing duplication and increasing clarity & quality.

Children and young people will be able to digitally 'check in' for appointments and this will link to an electronic clinician's board showing real time data. This will allow clinicians to know which patients have arrived, which patients are being seen currently and will also allow for clinician's to see any potential delays with clinic times.

We will put the child & young person's needs at the forefront of our care by utilising technology to ensure the child's patient journey is as supportive of their individual needs as possible. Examples of this include: using Virtual Reality technology to provide a distraction to the child which will hopefully reduce anxiety during procedures such as taking blood; providing children & young people who find waiting in busy environments difficult, with devices that will bleep when they are ready to be seen – allowing them to wait in open outdoor area more suitable to their needs."

Inpatient Ward Staff

"To deliver effective inpatient care and ward rounds, good information systems for staff are crucial. The systems we have work well to support quicker and easier access to relevant background information which supports us as clinicians to identify important trends that indicate whether children are at risk of deterioration.

During ward rounds we use digital systems to ensure that care plans are recorded in a timely manner and these care plans are easily accessible to a variety of appropriate professionals to ensure holistic care of the patient. We no longer use paper records; all of our information is captured in intuitive digital systems.

To work most effectively, these digital systems are quick and easy to use and the quality of care is improved by having this appropriate technology to support patient care on the wards."

Theatre Staff

"Technology can be used to preserve the extensive knowledge that a surgeon acquires over their career. Technology allows us to train large decision capable distributed computing networks which allow one system to achieve the experience of a lifetime, in a short space of time, whilst preserving the ability for an eternity.

Surgery and AI is an area of constant development and in the near to mid future these technologies will be utilised with the goal of maximising the outcomes for patients and improving the efficiencies of the surgeon.

Technology will work with the surgeons to create a distributed decision making framework with human intelligence at its core."

Clinical Researchers

"The delivery of and participation in clinical research improves health outcomes for individuals and across a healthcare institution. Therefore, it is important that clinical research opportunities for patients and support for staff are made easy and efficient. By automating elements of patient selection, the electronic patient record is able to easily identify eligible patients for clinical trials.

Consent for research is administered and recorded digitally as part of the electronic patient record. This will ensure transparency and completeness of consent and also ensure that this information is clearly accessible within the patient record for regulatory purposes.
As well as supporting efficiencies by streamlining assessment of eligibility of children for studies, we can clearly identify children who are currently involved in a research study so that all clinicians working with this child are aware of this thereby improving safety. We can also use data collected to support risk prediction.

We utilise a variety of technology to gather information for research data capture episodes, including using SMS alerts to patients involved in research studies. Speciality packages will include key clinical variables which support the population of cohort and registry datasets from routine care episodes. Core outcome sets are part of the child's electronic patient record, allowing

us to clearly evaluate and capture outcomes, not only to contribute to research studies but also to inform individual, speciality and organisational health outcomes. This supports our agenda of clinical research working for patients as it clearly identifies clinical outcomes for the individual patient.

Alder Hey will also be part of network based technologies, to allow access to electronic records remotely for our partner Higher Education Institutes.

The World's First Living Trust

It is widely reported that Digital Innovation, particularly artificial intelligence is set to bring a paradigm shift to healthcare, and there are already many applications in personal health, screening and diagnosis, decision making, treatment, research, and training for example. Alder Hey Innovation is looking to bring all these technologies together in to a true Living Organisation.

Through a focus on visualisation, feeling and sensing, our living organisation will support advancements in immersive technologies, sensors and artificial intelligence. We will do now what Children and Young people need next with Digital Innovation at the Centre of Quality Improvement.

The unique combination of clinical innovators and entrepreneurs, academic experts in cutting edge engineering and bio-science, technicians and the highly skilled innovation support crew, represents a powerful engine for exploration and transformational change. This combined with the children that daily inspire us all, makes for a genuinely unique and magical environment in which to innovate.

What Outcomes do we want to Achieve?

We know that with improved data, we can improve outcomes for children, young people, families, carers, staff and society as a whole. We have seen great examples of this in a number of clinical areas. We are passionate about adopting pioneering new approaches to care. We will build upon our longstanding local relationships across different settings to transform care for patients.

In terms of specifics, we will support the enablement of the following clinical and patient outcomes as set out in delivery of outstanding care and inspiring quality:

The safest Children's trust in the NHS:

- 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

Put Children and Young People First in everything we do

- Over 95% of children report that we put them first
- Over 98% of children, young people and their families would recommend the Trust
- Under 5 complaints are received each month
- Under 80 PALS are received each month

Achieving outstanding outcomes for Children & Young People

- Over 95% of children report meeting the care goals they set
- All children and families received information enabling them to make choices about their care

External Accreditation

We will become Europe's most digitally mature children's Trust, as rated by staff and children, validated by an international digital maturity accreditation.

Based on the Healthcare Information and Management Systems Society (HIMSS) Europe Electronic Medical Record Adoption Model (EMRAM), an internationally recognised best in class maturity model will be utilised to measure and assess our levels of digital maturity. HIMSS is a global, cause-based, not for profit organisation focussed on better health through information and technology. HIMSS leads efforts to optimise health engagements and care outcomes using information technology.

The HIMSS Levels are from level 0 to level 7 with level 7 being the most digitally mature organisations. The content of the levels are:

STAGE	HIMSS Analytics EMRAM EMR Adoption Model Cumulative Capabilities
7	Complete EMR: external HIE, data analytics, governance, disaster recovery, privacy and security
6	Technology enabled medication, blood products, and human milk administration; risk reporting
5	Physician documentation using structured templates; full CDS; intrusion/device protection
4	CPOE; CDS (clinical protocols); Nursing and allied health documentation; basic business continuity
3	Nursing and allied health documentation; eMAR; role-based security
2	CDR; Internal interoperability; basic security
1	Ancillaries - Lab, Rad, Pharmacy, PACS for DICOM & Non-DICOM - All Installed
0	All Three Ancillaries Not Installed

Delivering HIMSS level 7 will give us complete universal coverage across In Patient areas. Clinically this will give us the ability to deliver three important functions which have an evidenced based improvement in patient care and reduced costs.

1. The ability to deliver genuine clinical decision support delivers the ability to reliably integrate lab and demographic data which support the management of our patients. Not only does this shorten the time to diagnosis and alerting but it does so in a reliable manner. Integrated risk scores allow the use of order sets tailored to individuals
2. Medication administration is entirely digitised allowing for closed loop administration. This allows continuous stock control, eliminates wrong drugs being administered to patients and improves patient safety through alerting on critical medication omission and allergies. This technology also brings similar benefits for blood transfusion, pathology samples and implants. This improves efficiency but also improves patient safety
3. Patient pathways involve multiple handoffs between departments and providers. NHS England document 10,000 harms annually due to failures of hand offs.

We will adopt the same standards and work with HIMSS with regards to outpatient and community care.

More locally, we will ensure we meet standards in terms of professionalism and staff development. We will work with the informatics skills and development network to achieve the excellence in informatics accreditation.

Section 5: The Nuts and Bolts of Delivery - Making IT Work

We will deliver Digital Futures through a set of interrelated themes, a portfolio of programmes, underpinning foundations and technology roadmap.

We will have an integrated delivery model with key teams and divisions and a proactive approach to engagement, co-design, delivery and support.

Our core themes are:

- Digital Children, Young People and Families
- Digital Quality Improvement
- Unleashing Innovation and Research

Our underpinning foundations are based on a set of design principles and a digital first approach set through the ethos of the Trust values.

We will deliver to an agreed plan and governance model.

Theme 1: Digital Children, Young People and Families - Putting Children First

Our Digital Children, Young People and Families theme is driven by our organisational approach of putting Children first. Through this theme we will deliver a range of capabilities to enable Children, Young People and Families to interact through a digital front door with Alder Hey.

We will work in partnership with the Children's and Young People's Forum to ensure that deliverables are in line with the way in which our Children and Young People wish to interact with us.

We will deliver this theme through 3 workstreams:

- Digital Front Door
- Digital Communications
- Digital Services

The digital front door will include development of our web presence and the Alder Play app including access to key information. We will develop our augmented assistant and integrate key regional and national patient facing services with it.

We will implement digital communications with families and professionals, minimising the paper we send out. We will enhance our texting services to support best in outpatient care and brilliant booking.

We will develop a range of digital services including online consultations, telehealth and remote monitoring.

Workstream	**Deliverables / Projects**	**When**
Digital Front Door	Website	19/20
	Alder Play	19/20 – 20/21
	Patient Portal / NHS App	19/20 – 20/21
	Augmented Assistant	19/20 – 20/21
Digital Communications	No more letters other than by exception	19/20 – 20/21
	Email / Txt contact	19/20 – 20/21
	Online booking and scheduling of appointments	19/20 – 20/21
Digital Services	Digital Consultations	20/21 – 21/22
	Telehealth/Care including remote monitoring	20/21 – 21/22
	Digital Outpatients	19/20 – 20/21
	Paediatric App Library	20/21 – 21/22

Theme 2: Digital Quality Improvement

Our Digital Quality Improvement theme builds on much work delivered to date and underpins our Brilliant Basics ethos. It will enable our aspirations in terms of Inspiring Quality, and support our staff to do their best work in delivering outstanding care to children and young people.

This theme focusses on 5 themes:

- Digital Hospital
- Digital Community
- Inspiring Quality – Continuous Quality Improvement
- Intelligence Led Care

- Digitally Enabled Staff

Our digital hospital and digital community themes will deliver a range of capabilities to support our vision of outstanding digital excellence. These will accelerate where we are now and increase our capability to significantly develop further.

Our intrinsic link to support and enable inspiring quality is essential to underpin this change in culture across Alder Hey.

Our workstream in terms of digitally enabled staff is critical to the success of the whole digital strategy. Without core basics in place in terms of technology and processes, we will not achieve our aspirations. A continuous approach to service improvement is a major component of this work.

Workstream	**Deliverables / Projects**	**When**
Digital Hospital	Paperfree	19/20 – 20/21
	GDE Accreditation	19/20
	HIMSS Level 7 Accreditation	19/20
	EPR Upgrade	19/20 – 20/21
	Electronic Anaesthetics Charts	19/20 – 20/21
	Integrated observations	19/20 – 20/21
Digital Community	Paperfree	20/21
	Maximise EMIS	19/20 – 20/21
	Community service improvement plan	19/20
	Digital Outpatients	19/20 – 20/21
	Tele clinics	20/21 – 21/22
Inspiring Quality - Continuous Quality Improvement	Ongoing development of clinical pathways	19/20 – 21/22
	Service improvement plans linked to divisional operational priorities	19/20
	Remove Faxes and Pagers	19/20 – 20/21
	Digital Huddle Boards	19/20
	Online Collaboration Tool	19/20
Intelligence Led Care	Clinical Intelligence Portal	19/20
	Ward to Board Intelligence	19/20 – 20/21
	Outcomes at our fingertips	19/20 – 20/21
Digitally Enabled Staff	Digitally enabled staff – give them the right tools, empowering staff to continually improve care	19/20
	Hardware Right	
	Processes right	19/20

	Tailored training	19/20
	Continuous Service Improvement	19/20
	ESR Maximisation	19/20 – 21/22
	NHS Jobs/Recruitment Tool	19/20 – 20/21
	Extranet	20/21
		19/20 – 20/21

Theme 3: Unleashing Innovation and Research

The Unleashing Innovation and Research theme supports our strategy in terms of growing the future.

Based in our dedicated innovation lab at the heart of the Alder Hey campus, we aspire to be an innovation factory capable of taking the problems and challenges that we face on the ground on a daily basis and solving those with cutting edge technology and innovation. We look to create rapid proofs of concept and operational prototypes that are market ready much more swiftly than is traditionally the case. With a partnership with the innovation and research teams, we look to trial innovations on-site as part of our full cycle innovation development and evaluation process.

This theme focusses on 4 key workstreams:

- Living Trust
- Innovation Hub
- Research and Evaluation
- System Wide Developments

Workstream	**Deliverables / Projects**	**When**
Living Trust	Sensors	19/20 – 21/22
	Artificial Intelligence	19/20 – 21/22
	Immersive Technology	19/20 – 21/22
Innovation Hub	Maximise the opportunity of the Bat Cave	19/20 – 21/22
	Evaluation & Clinical utility Test bed	19/20 – 21/22
	Linkage with research methodologies	19/20 – 21/22
	Global Innovation Thought Leaders	19/20 – 21/22
	Accelerator of New Product/Solution	19/20 – 21/22

	Development	
Research & Evaluation	Studies led by Alder Hey clinical academics to be online wherever possible Create an Artificial Intelligence hub with local universities to improve the diagnosis and management of paediatric illness Development of an evaluation principles framework Development of on evaluation regulatory framework	19/20 – 21/22 19/20 – 21/22 19/20 – 21/22 19/20 – 21/22
System Wide Developments	Rapid deployment of clinical prediction models between Trustworthy Research Environments (TRE) and clinical workflow systems. Deployment of Share2Care Programme Improved Diagnostics Sharing across Cheshire and Merseyside	19/20 – 21/22 19/20 – 20/21 19/20 – 21/22

Technology Roadmap

From a technology perspective, Digital Futures will be underpinned by a robust technology roadmap.

Alder Hey will undertake a review of its current data centre operating model and how this should be refreshed when it comes to end of life. Cloud technologies will be reviewed and where appropriate will form part of the overall data centre strategy. We will look where possible to maximise opportunities in partnership with other local NHS organisations.

With regards to Cyber Security, significant investment has already been made to improve the level of cyber defence. We will look to achieve Cyber Essentials +.

Desktop/Device Strategy: We will develop a no wrong device ethos. This will be supported through a device strategy to ensure staff always have a fit for purpose device that is refreshed at appropriate stage.

We will ensure full move to Windows 10 and move to Office 365, maximising the opportunities of functionality for staff.

Workstream	Deliverables / Projects	When
Interoperability	Open standards, interoperability and data access	19/20-20/22
Service Improvement Plan	Microsoft Product Refresh Remote Access Standardisation Self-Service Password Reset Automated Account Requests and Share Drive Access PC/Device strategy and refresh Office 365 Core and Clinical Infrastructure strategy	19/20 19/20 19/20 19/20 19/20 19/20 19/20 – 20/21
Security and Resilience	Disaster Recovery enhancements Cyber Essentials Cyber Essentials +	19/20 19/20 19/20 – 20/21

Design Principles, Values & Culture

Our design principles, values and culture importantly set out how we will achieve our ambitions.

We will adopt the values pledge set out through the Digit@LL strategy and champion a collaborative leadership approach where our shared values are at the heart of how we deliver, develop and behave.

We also include some specific principles and behaviours pertinent to delivery in Alder Hey.

The totality of these principles are highlighted below, linked to our core Trust values of **Excellence, Innovation, Respect, Together, Openness.**

Trust Value	Design Principle / Values Pledge
Excellence	**Simplify** – we will create a great experience for staff and our population by keeping things simple and not unnecessarily overcomplicating our approaches or duplicating effort **Work with Empathy** **Customer focussed** service model with feedback loop and confidence in resolution
Innovation	**Unleashing Innovation Culture** – create mind set shift as part of Trust OD

	strategy **Licence to Succeed, Permission to Fail** – we will create an environment and culture where we encourage innovation and learning and accept that with innovation there can be projects **It's ok to be a geek or a nerd – unleash the inner nerd!**
Respect	**No 'Badges on Speedos'** – we will not use our credentials or level of hierarchy to undermine the views of others, we will be respectful of all opinions and input, and work together for our population **We are digitally responsible –** for the Children and Young People we are here to serve, we will operate a digitally responsible environment
Together	**One Team Ethos** – we will work together as 'one team' with our divisions in order to provide a joined up service to staff. We will work together, not in silos **Do With not To –** our service needs should drive the system **Co-Design and Co-Produce with the Person at the Centre** – We will work with our population and staff to ensure that the services we develop are designed around people not organisations **Work in Partnership** – we will work together as a collaboration, build and lead our digital programmes together. Digital leaders will 'walk the walk' with their clinical colleagues and vice versa, to ensure a deep level of understanding of the impact of their work **Pool efforts and assets** – working together to leverage best value, drive economies of scale, avoid duplication and unnecessary competition
Openness	**Share our Learning** – We will share our work openly and transparently with one another and with external colleagues, creating learning from best practice approach. We will contribute to blueprints locally and nationally. Where appropriate, we will share, co-commission or jointly procure systems **Open Standards** –our approach is based on open standards and being vendor agnostic, with principles of working together to implement through this approach, including agreed standards for collaboration

Partnerships

We will work proactively and collaboratively with external partners to achieve Digital Futures.

We will encourage a world leading health IT industry in England with a supportive environment for software developers and innovators.

Partners will be from a range of organisations and will include:

- The Children and Young People's Forum
- Local Health and Social Care Organisations
- Liverpool Health Partners
- Cheshire and Merseyside Health and Care Partnership
- Academia
- National Regulators
- NHSX
- NHS Digital
- Industry Partners
- SMEs
- Connectors

Service Model, Partnership and Customer Service

Integration

Our service model and approach will have a relentless focus on integration, partnerships and customer service. This will include a principle of operating in 'one team' without silos.

We will work in an integrated way with divisions with identified digital leads for each division.

There will be intrinsically close working between digital, innovation and research teams.

Core Clinical Team

We will have a core clinical digital team with a range of expertise. Roles within this team will include the Chief Clinical Information Officer, Divisional Chief Clinical Information Officers, Chief Nursing Information Officers and individuals working in Trust programmes with digital leadership or activities identified as part of job planning or objectives

This team will work together supporting day to day activities across the Trust in terms of operations and advice on more strategic developments.

Digital Clinical Experts

The core clinical team will be enhanced by a range of digital clinical experts and those with an interest in digital across the Trust. This group may include, but not be limited to, nurses, allied health professionals, trainees, individuals working on key digital systems and practice education facilitators.

It is critical that this group is recognised as a group of experts to support the ongoing work of digital within Alder Hey.

Digital Genius Bar

It is critical that we aim to get the experience of digital brilliant for staff. In order to do this, we need a different approach to support and engagement. We will look to move from a reactive to proactive approach to supporting staff, through a digital genius bar type ethos. This includes proactive approaches to problem solving and training, tailoring needs to individuals.

We will proactively work with services, wards and departments to ensure that day to day services shift to a proactive service model ensuring we give the best service possible. We WILL deliver brilliant basics for clinical teams and strive to get it right first time, ensuring timely and proactive support.

We will look to provide a personal service. In order to do this we will automate a number of tasks and empower staff to have the ability for issues to be resolved in a more streamlined way, like they can when interacting with technologies at home.

We will ensure assurance that our staff are part of a continuing programme to update/refresh their knowledge profile of our clinical digital systems. This will be achieved through the publication of events and sessions and on-line teaching through a digital portal. Available through a desktop icon or extranet staff will be able to apply for, book, receive training and complete quizzes allowing the DigITal Clinical Systems Training team to support staff training proactively.

Governance

In order to govern delivery, a Digital Oversight Collaborative will be established. This group will act as a steering group to oversee delivery of digital programmes and operational IT delivery.

The group will report into the Resources and Business Development Committee (RABD) and Trust Board via RABD.

Due to many of the factors of the strategy supporting / serving key clinical programmes, there will be a close relationship and lead officer identified with regards to clinical programmes including Inspiring Quality and Best in Outpatient Care.

Major change programmes will be operationally managed through the Digital Oversight Collaborative and associated sub groups, but will report formally to the Trust Programme Board.

A Digital Design Authority will be established to support and underpin a range of programme areas, taking a view on clinical prioritisation. This group will be clinically led and report to the Digital Oversight Collaborative. A range of groups will be established as necessary throughout the lifetime of the strategy to oversee key programmes of work.

An Operational IT group will be established with divisional leads to support day to day operational delivery.

A quarterly forum will be established to bring together areas of overlap between digital, innovation and research functions.

Investment

It is clear that to deliver Digital Futures, a significant level of investment is required. External sources of investment will be identified and proactively progressed. Internally, the trusts capital plans support a level of investment in IT business as usual, resilience and digital advancements over the next 5 years. Additionally, from a sustainability perspective, revenue budgets are in place to support our ambitions which include a level of efficiency across the organisation.

Digital Futures will allow bold investments into digital that will differentiate Alder Hey as a global leader. It will support radical changes that will improve quality and productivity that will drive

efficiencies to reinvest in services. A robust approach to benefits realisation will be in place, reported through the Trust's programme governance arrangements.

All major cases will undergo business case and approvals, linked to the corporate processes and structures in place across Alder Hey.

Section 6: Digital Futures

Alder Hey is a wonderful place. We deliver world class services to our Children and Young People. Building on our digital and technology developments and investments, it is a pivotal time for our next stage of delivery through Digital Futures.

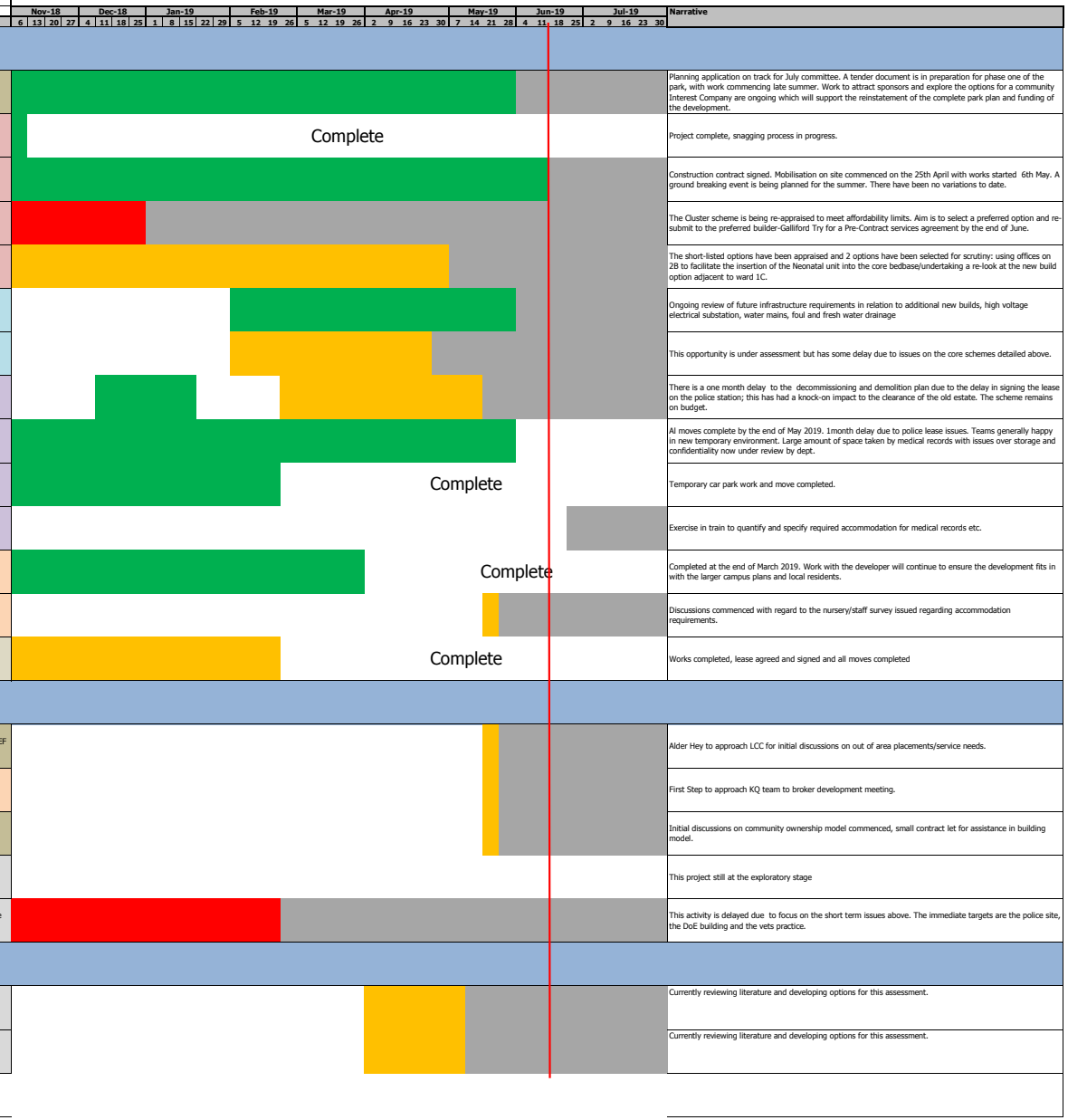
The alignment of key strands of work will ensure we maximise the sum of many parts. It will both liberate and disrupt our ways of working to improve the care we give to Children and Young People. It will put us at further at the forefront of global digital leadership. We believe that our relationships, support, leadership and talents of our staff will enable us to deliver our aspirations.

We will create an amazing experience and deliver fantastic outcomes with outstanding digital excellence at the heart.

HIGHLIGHT REPORT Site & Park Development June 2019

SRO: David Powell
Author: Sue Brown

Key
Planned project timeline
On track
up to 3 months delay
Over 3 months delay



	Narrative
Creation of campus	
Park Creation	Planning application on track for July committee. A tender document is in preparation for phase one of the park, with work commencing late summer. Work to attract sponsors and explore the options for a community Interest Company are ongoing which will support the reinstatement of the complete park plan and funding of the development.
New Schemes: Institute Phase II	Project complete, snagging process in progress.
New Schemes: The Alder Centre	Construction contract signed. Mobilisation on site commenced on the 25th April with works started 6th May. A ground breaking event is being planned for the summer. There have been no variations to date.
New Schemes: Community Cluster	The Cluster scheme is being re-appraised to meet affordability limits. Aim is to select a preferred option and re-submit to the preferred builder Gallifford Try for a Pre-Contract services agreement by the end of June.
New Schemes: Neonatal Unit	The short-listed options have been appraised and 2 options have been selected for scrutiny: using offices on 2B to facilitate the insertion of the Neonatal unit into the core bedbase/undertaking a re-look at the new build option adjacent to ward 1C.
Support Scheme: Infrastructure	Ongoing review of future infrastructure requirements in relation to additional new builds, high voltage electrical substation, water mains, foul and fresh water drainage
Support Scheme: District Heating	This opportunity is under assessment but has some delay due to issues on the core schemes detailed above.
Site Clearance: Demolition & decommission Phase 2	There is a one month delay to the decommissioning and demolition plan due to the delay in signing the lease on the police station; this has had a knock-on impact to the clearance of the old estate. The scheme remains on budget.
Site Clearance: Relocation of on-site services/corporate teams	Al moves complete by the end of May 2019. 1month delay due to police lease issues. Teams generally happy in new temporary environment. Large amount of space taken by medical records with issues over storage and confidentiality now under review by dept.
Site Clearance: Temporary car park	Temporary car park work and move completed.
Site Clearance: Housing residual teams e.g. medical records	Exercise in train to quantify and specify required accommodation for medical records etc.
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 the nursery/staff survey issued regarding accommodation requirements.
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 to approach KQ team to broker development meeting.
Regeneration/community building:local ownership model etc.	Initial discussions on community ownership model commenced, small contract let for assistance in building model.
Exploring linkages with Broadgreen site.	This project still at the exploratory stage
Securing Neighbourhood sites (police etc.)	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.
Other	
Space Utilisation review	Currently reviewing literature and developing options for this assessment.
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

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 15th May 2019
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Adam Bateman	Chief Operating Officer
	Denise Boyle	Associate Chief Nurse - Surgical Division
	Lisa Cooper	Director of Children & Young People Community & Mental Health
	Christian Duncan	Divisional Director, Surgical Division
	John Grinnell	Deputy Chief Executive/Director of Finance
	Hilda Gwilliams	Chief Nurse
	Jeannie France-Hayhurst	Non-Executive Director
	Adrian Hughes	Divisional Director, Medicine Division
	Anne Hyson	Head of Quality – Corporate Services
	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
	Stefan Verstraelen	Head of Quality – Surgery
	Cath Wardell	Associate Chief Nurse – Medicine Division
In Attendance:		
	Sandra Cudlip	Associate, Mersey Internal Audit Agency (MIAA) *Observing*
	Jill Preece	Governance Manager
	Julie Creevy	Executive Assistant (Minutes)
	Simon Hooker	Governor
Agenda Item:		
19/20/23	Lucy Howell	Project Manager, SAFER Bundle
19/20/31	Andy Darybshire	Chair, Clinical Ethics Committee
19/20/39	Phil O'Connor	Deputy Director of Nursing

19/20/21 Apologies:

	Pauline Brown	Director of Nursing
	Mark Flannagan	Director of Communications and Marketing
	Dani Jones	Director of Strategy
	Jo McPartland	Clinical Director/SGL for Cancer Services & Laboratory Medicine
	Nicki Murdock	Medical Director
	Matthew Peak	Director of Research
	Sarah Stephenson	Head of Quality – Community
	Julie Williams	Appointed Governor

19/20/22 Declarations of Interest
None declared

AM welcomed Sandra Cudlip from Mersey Internal Audit Agency. Sandra was supporting the Trust in mapping out committee structures to review whether there were any opportunities to reduce the burden of the Trust Committees. Sandra was attending the committee meeting in order to observe the flow of information within the committee.

AM welcomed Simon Hooker, Governor who periodically attends CQAC meetings.

19/20/23 Minutes of the previous Joint CQAC & CQSG meeting held on 17th April 2019

Resolved:

CQAC approved the minutes of the previous Joint Clinical Quality Assurance Committee/Clinical Quality Steering Group meeting meeting held on 17th April 2019.

19/20/24 Matters Arising and Action Log

Action Log

18/19/137 - Transition Update – LC confirmed that Jacqui Rogers had attended the Divisional meeting on 26th March 2019. A standard template had been agreed and a further meeting is scheduled for 21st May 2019. LC confirmed that the Community Division had close oversight on transition issues. Committee agreed that this item would be closed and removed from the action log, with a scheduled position statement/update report being shared at July 2019 CQAC meeting.

18/19/152 – Sepsis Update – 'NM to be invited to the next Sepsis Steering Group meeting, together with Resus colleagues to enable offline discussion regarding Intra Osseous' – HG stated that this had been diarised in NM's diary and could be removed from action log.

19/20/05 – 'Overall position statement regarding mandatory training figures to be shared at future Executive team meeting with CQAC receiving an update in July 2019' - HG confirmed that MS had presented a Mandatory Training update at Executive meeting on 9th May 2019, showing current compliance. MS stated that a focus on low compliance areas is now required from all; the HR team are providing support to Divisions. Mandatory training compliance would be updated through Executive Team on a monthly basis going forward to ensure full compliance by May/June 2019.

19/20/08 – 'Programme Assurance Update – Project leads to address lack of progress regarding 'Delivery of Outstanding Care, Sepsis Project and Comprehensive Mental Health Projects' - HG stated that the Project Team had devised a new template in order to present progress/benefits and to highlight any blockages. HG stated that a programme is in place for the Executive Team to receive weekly updates for each of the pillars within the change programme.

'CQC Action log – IT Action plan/migrating services/ - exploring bringing forward transition date from 30th August 2019' – HG stated that discussions with Kate Warriner, CIO had taken place and that this item is on plan, and could be removed from the action log. LC stated that the plan for community connectivity would be monitored via the Executive Team on a monthly basis and through the Community Divisional Board meetings. All agreed that the final plan should be shared at CQAC meeting, once monitoring and timeframes had been agreed.

19/20/10 'Corporate Report Quality Metrics – CQAC to receive analysis of minor harm incidents at July 2019 CQAC' – Committee noted that the

Divisions are also due to include actions for improvement which would also be included at July 2019 CQAC meeting.

19/20/11 – 'CQAC Annual Report – ES to amend committee priorities' – ES confirmed that this item had been completed, and would be shared at Audit Committee on 23rd May 2019 and Trust Board on 28th May 2019. This item to be closed and removed from the action log.

19/20/14 – 'Nutritional Steering Group update – offline discussion required with HG & NM regarding medical representation/ToR for Nutritional Steering Group' – HG stated that she had a booked discussion with NM on 16th May 2019 to discuss the requirement for medical engagement and representation ideally via the Gastroenterology service.

19/20/17 – 'Divisional Governance Reports – Offline discussion to take place with HG & JG regarding support for Community Division' – HG stated that a Business Case had been produced, but had not gone through the full sign off process. JG stated that there are a number of requests for monies which have elements of quality/safety and strategic issues; further discussion and clarity is require between JG & HG to address this issue.

Safer Bundle Update

LH presented an update of the work undertaken by the team to progress the SAFER project, describing each of the key elements in turn. Greater focus would be required in the next phase on including integration of Best in Acute Care and SAFER to ensure consistent ward rounds within all medical wards. Next Steps would include improving flow from Critical Care to inpatient wards. HG stated that it was great to see progress and improvements regarding children being discharged. HG queried whether there were any themes which required any actions for those cohort of children who don't get timely discharged. LC confirmed that the team are still working with Medical Ward staff on 3C to ascertain whether there are any emerging themes, with further targeted work still required. J Grinnell queried next steps with regards to stretch targets. LH confirmed that there is further work to do with regards to flow and projects working in parallel, with further work to do in order to join up. Further work to do with regards to weekends and the need to drive forward the next phase. J Grinnell stated the importance of having a clear refreshed plan for the year ahead to be shared at Programme Board with CQAC receiving a detailed update for the next quarter.

19/20/25 Best in Acute Care update

AB & AH presented the Best in Acute Care update which detailed the Project workstreams including HDU model, EDU+model, Out of hours cover (General Paediatrics), Pathways and Thresholds and Acute Care Team (ACT). Particular focus from the team to date had been on HDU Model, Out of hours cover (General Paediatrics) and Pathways and Thresholds, in order to ensure that the Trust provides safe and effective care. NM/AH & AB continue to meet with clinical colleagues on a weekly basis in order to progress the programme.

Key issues were as follows:-

- Committee noted what the team are trying to achieve, whilst being mindful of the need to create fulfilling jobs, when there may be changes in working practices.

- Committee noted the Pathways and thresholds required to determine which patients should be admitted under a particular speciality and which should be referred for advice. The approach would also reduce delays caused by divergent views on which specialty a patient should be admitted under and also would provide nursing staff and non-consultant medical staff with improved information on referral and advice actions.
- Completed pathway and thresholds guidelines for all eleven specialties in scope had been delivered and a Pathways and a Thresholds Panel had been held in order to mediate and subsequently ratify the guidelines.
- There is a plan to issue guidelines for inpatients admitted under a specialty and for requesting advice to wards and staff, together with all new doctors in training.
- HDU Model – to be delived by general paediatricians via a plan to recruit a talented cadre of individuals on the specialist registrar who had undertaken specialist interest training (SPIN) in High Dependency Care. This would create a separate HDU medical team, which would also benefit the PICU, enabling the intensivists to further develop ECMO, whilst ensuring resilience and robust cover. It would also ehance doctor-to-patient ratios and provide a more resilient on-call system. The first consultant post is to be advertised late May with the aspiration of a HDU model and team to be operational by 2020.
- Out of hours - a workshop had been held to collectively diagnose the issues and identify solutions; the process had used qualitative (junior doctor survey) and quantitative (capacity & demand analysis) evidence to inform the new model of care. It was intended to pilot extended Consultant General Paediatrician cover until 21:00.

CQAC received and noted the workstream position statement regarding EDU+ model and ACT team. CW stated that the ACT team is currently on plan.

AM stated that it was positive to see the progress made to date. JG asked about the implications of the programme as a whole and suggested that it would be helpful for the committee to see the full position; ES commented that the programme links into some of the 7 day standards so it would be appropriate to link the two when the next 7DS report is due.
AM thanked both AH & AB for update.

19/20/26 **Programme Assurance Update**

ND presented the new Change Programme update which had been developed.
Key issues were as follows:

- Overall, for the Delivery of Outstanding Care programme, both governance and delivery ratings had improved this month.
- DETECT, Inspiring Quality and Best in Acute Care, baselines should be now established and targets agreed.
- The lack of positive trends on metrics for the Comprehensive Mental Health project should be addressed by the Executive Sponsor.
- Year 2 PID for Sepsis still required sign off.

HG queried whether an effective Project Team is in place for Best in Mental Health Care. LC stated that a meeting is scheduled for 21st May 2019 in order to review the required evidence so that it can be uploaded. AM queried

whether this is still being refined. LC stated that CQAC are due to receive a update at the June meeting, which will detail the current position.

ND stated that there is currently a lack of positive trends and that a further detailed update would be provided at the June CQAC meeting.

CQAC agreed that the newly developed Programme Assurance template was a positive step and allows attention to be drawn to salient issues and key information.

AM thanked ND for update.

19/20/28 **Quarter 4 update: Children with Medical Complexities**

LC presented Quarter 4 update to the Committee.
Key issues were as follows:

- Complex Discharge team which was fully implemented in February 2019, consisting of Nursing, Medical, Social Care and Therapy Staff.
- Its aim is to be accessible for both familes and staff, ensuring a single point of contact via email or phone, with web page also available with supporting information. Ward rounds are in place to support ward teams with links to SAFER and CUR.
- Weekly detailed escalation reports highlight delayed discharges together with reasons for delays. There are embedded pathways, with built in reviews using feedback from parents internal and external staff and for team development.
- As at April 2019 Long Stay Discharges over 30 days as follows:-
  400 day discharges = 2
  200-399 day discharges = 0
  90-199 day discharges = 4
  30-89 day discharges = 28
- Reasons for delayed discharges ranged from Housing (25%), Care Package (20%) Legal (14%), Safeguarding (11%) and other issues which related to equipment, repatriation, parental engagement, carer training and rehabilitation.

Plans for 2019/20:

- Meditech template in development, incorporating trigger factors to aid early identification of children and young people with complex needs.
- Involvement in training/induction of clinical staff
- Attend ward/department manager meetings to discuss themes identified regarding complex discharge.
- Review metric formulas used with Service Improvement & Costing Team & Performance teams.
- Data analysis of ‘frequent flyers’ to identify avoidable hospital admission
- Lead work stream within Children’s Transformation Plan
- Development of Carers Skills passport and Well Child Nurse post
- CQAC noted that compliments were now included within the update, which was welcomed by committee.

LC stated that it was extremely welcoming to have the early help social worker in place which had resulted in a positive impact within the team.

JFH highlighted the importance of prompt timely support with colleagues from the local authority, when early support is required. LC stated that both

HG and LC are the Executive contacts to liaise with when issue requires escalation, should the team experience delays and blockages with regard to local authority processes.
AM thanked LC for update.

19/20/29 **Quality Account 2018/19**

TR presented the Quality Account for 2018/19 and requested formal approval of the report. CQAC noted that the Quality Account had been circulated to external stakeholders for comment. The Quality Account would form part of the Annual Report and would be submitted to NHS Improvement at the end of May and published on 30th June 2019.

Part 1 of the Quality Account detailed the Statement on Quality by Louise Shepherd. Part 2 Detailed the priorities for improvement and statements of assurance from the Board. Part 3 detailed other information regarding Quality Performance in 2018/19. CQAC noted that this year's account included statements regarding Freedom to Speak Up, 7 Day services and Junior Doctor gaps. CQAC noted that the Quality Account was the final draft, pending receipt of comments from Commissioners, Overview and Scrutiny Committees, Healthwatch and Governors.

Next steps – Ernst & Young are due to issue their opinion on the limited assurance work prior to the Annual Report being presented at Audit Committee on 23rd May 2019, followed by presenting to the Board of Directors on 28th May 2019.

LC queried whether there is an opportunity to create a brief summary, ensuring it was young person friendly. LC stated that it would be helpful if the Children & Young People Forum could provide a formal statement of support. ES stated that similar summaries had been produced in previous years and agreed to follow this request up via Rebecca Murphy within the Communications team who had undertaken this in the past.

Action: ES to liaise with RM in order to draft a child friendly 2 page summary, together with a formal statement of support for C&YP Forum.

TR stated the importance of recognising the significant achievements that had taken place to date, throughout the Trust and that he felt privileged to be involved in the creation of the Quality Account for 2018/19.

CQAC received and noted the the contents within the repoert and approved the Quality Acount for 2018/19.

AM raised a question from Dame Jo Williams with regard to the audits and actions and asked who co-ordinates actions and follow ups. TR stated that actions would be tracked and followed up by Divisions through local governance process.
AM thanked TR and colleagues for the commendable Quality Account.

19/20/30 **Annual Clinical Audit Programme & Update which included update regding Confidential enquiries/national guidance assurance report**

LE provided the Annual Clinical Audit Programme for 2018/19 and management if NICE guidelines.

Key issues were as follows:-

- The Trust Clinical Audit plan was formally published in July 2018 and illustrated activity around mandatory National Audits, Confidential enquiries and Trust wide audits undertaken to fulfil requirements of the CCG Quality contract and NHS England.
  All audits had been completed and data submitted as required.
  The Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) policy audit had not been undertaken as planned, due to staff shortages within the Palliative care team. This audit was required as part of the CCG Quality contract. The Division of Medicine care team had informed the commissioners of mitigiation issues, and there is a plan in place to ensure completion of this policy audit.

Updates on actions previously identified:-

- Quarterly updates of local and Trust Clinical Audit plans to Divisional Integrated Governance Committees – LE stated that the Clinical audit team had provided updates to the Divisional Integrated Governance Committees and that the details of a cross divisional schedule and process for attending meetings is currently being awaited.
- Review of lonstanding local audits which remain incomplete to be undertaken by Divisional Triumvirate and Head of Clinical Audit including the development of an action plan to ensure a robust process for completion and prevention of further non-compliance.
- The Divisional Triumvirate for Surgery had been asked to make a decision regarding the significance of continuing with 16 audits, which to date had not yet commenced or an update had not been received by the clinical audit team. Currently 16 (14% previously 16%) of the audits within the local plan required an update, with some audits dating back to 2017. The Divisional Director had been asked to assist with identifying whether outstanding audits are cancelled or incorporated into the local audit plan for 2019/20.

Local Audit Plans

- Ongoing work progressing in order for the Clinical Audit team to support Divisional Triumvirate and Heads of Quality in developing Clinical Audits plans for 2019/20.
- Clinical Audit team to support Divisional Triumvirate and Heads of Quality in managing clinical audit activity registered, but not included in the Trust and Divisional plans.
- RCA action plan audits – each division will include audits of actions taken as a result of incidents, complaints and litigation within their Local Clinical Audit plans for 2019/020. Local audits plans are currently in development.
- Dissemination of clinical audit findings – arrangements are in progress to include clinical audit presentations within the Grand Round schedule. On completion of the audit, the lead is invited to present to a Trust wide audience, in addition to specialty meetings. Additionally the Clinical Audit intranet page and pending Extranet page would include a section where staff can access clinical audit reports and presentations as additional means of learning from audit findings.

NICE guidance

Since the previous reporting period four NICE clinical guidelines had been published (to the end of April 2019). Therefore at present, there are 89 relevent paediatric guidelines, of which, 16 require a baseline assessment, 8 of which are within date for completion and return and 8 remain outstanding.

20 guidelines require further information regarding and action plan development/completion. Significant progress had been made in terms of completing baseline assessment of new guidance. This is predominantly due to increased engagement between NICE co-ordinator who meets with clinical leads in order to complete the assessment. It is anticipated that this would also improve compliance regarding completion of action plans and management of clinical audit requirements related to national guidance.

Clinicans had reported concern regarding NICE guidance not followed by Alder Hey, usually as a result of local audit findings. As such a process for reporting back to NICE directly will be agreed with the Medical Director.

HG welcomed comments from divisions with regards to local audits. DB stated that C Duncan /A Bateman and D Boyle had agreed the process for monitoring within Surgery via two performance meetings per team, per year. CD stated that the process of reappointing Clinical Directors was approaching and that this would be a good opportunity to include local audits within these posts, in order to ensure all appointed CD's have departmental and divisional audit role.

LE stated the importance of having a named person within each Division in order to ensure owernship for those audits allocated for each of the divisions.

JG queried the role of the Committee in terms of Clinical Audit and this report. LE commented that any learning would be addressed through each of the Divisions and that CQAC monitored due process to ensure that Divisions are adhering to policy and responding to guidance as appropriate.

AM stated that the role of CQAC is to provide assurance to the Board of Directors and that it is important for CQAC to have sight of the whole position. HG stated that there is a requirement for annual plan/sign off process to ensure learning from audits, and queried whether this could be captured via a cumulative action log. CU stated that another possibility could be to include an update section at the Divisional monthly reporting through CQSG, in order to provide a monthly position statement.

CQAC agreed that a small group would be convened to address this issue.

Action: HG to convene a small group and report back to CQAC. Confirmation required from Divisions regarding named Audit Leads. CQAC to receive a further update at a future meeting.
AM thanked LE for update.

19/20/31 **Quarter 4 DIPC Report**

VW presented the Quarter 4 DIPC report. Key issues were as follows:

- The work plan for 2018/19 consists of 14 objectives and a total of 118 deliverables. Highlights include:
  - ✓ The Trust had reached 25% reduction in MRSA cases.
  - ✓ The Trust had reached a 10% reduction in CLABSI.
  - ✓ Team are working closely with NHSI with regards to increase in gram negative.
  - ✓ 1 Cdiff case last year was upheld, with no lapses of care.
- VW stated that there had been an increase in Cdiff, given the annual

annual target of 0, with the Trust having 1 Cdiff case in March.

- Workplan is aiming to set target rate re RSVs.
- Relaunching Isolation policy with an education programme-aim to establish by end of June 2019.
- Tissue viability service is now established, team had been working with Southampton and GoSH to ascertain whether any practices could be adopted.

AM thanked VW for update.

19/20/32 Quarter 4 Complaints Report (January 2019 – March 2019)

AH presented the Quarter 4 Complaints report. Key issues were as follows:-

- The Trust had received 30 formal complaints during this period. One complaint from this quarter was subsequently withdrawn. As a comparison in 2017/18 Q4 the Trust received 30 formal complaints. Categories of complaints as follows:-
  - Consent, Community, Confidentiality – 9
  - Treatement/Procedure – 8
  - Access, admission, transfer, discharge – 8
  - Medication – 2
  - Data Protection – 1
  - Clinical assessments (Diagnostics, Scans, tests) – 1
  - Documentation (records, identification, IT system) – 1

  A deep dive had been undertaken into the highest category, which concluded that there were no duplicate areas, and 9 cases covered 9 different areas.
- Report against three day acknowledgement; in Quarter 4, 30 out of 30 complaints were acknowledged within 3 days.
- The Trust's internal timeframe for responding to complaints is 25 days, however if the complaint is complex this can be discussed with the complainant and negotiate and extended timeframe for a response. CQAC noted the timeframes for the 9 complaints still open together with the supporting comments.
- Complaint outcome – 13 complaints were not upheld within this quarter and 7 complaints were upheld. 9 complaints are still ongoing and one was withdrawn as detailed above.
  All complainants are fully updated regarding any delays in response timeframes.
- Referrals to Parliamentary & Health Service Ombudsman – two cases from earlier in the year are still being assessed by the Ombudsman, with a view as to whether they will go ahead and investigate or not.

PALS summary

- In Quarter 4 2018/19 PALS contacts received total 336, in comparison to the same quarter in 2017/18 this is a very slight increase of 12.
- PALS concerns are received in a variety of methods, phone call, email, written and face to face. Phone calls and face to face account for 68% of the contacts, whilst the written concerns account for 32%.
- The main issues identified within Quarter 4 relate to appointments management – waiting times.

CQAC received and noted the Complaints and PALS Quarter 4 report for 2018/19.

Action: AH agreed to send an amended version (clear copy minus the draft watermark to JC for circulation to committee).

AH commended the work of the PALS team, this was echoed by the committee. AM thanked AH for update.

19/20/33 Clinical Ethics Support Group Annual Report

AD presented the Clinical Ethics Support Group Annual Report. Key issues werer as follows:

AD updated CQAC regarding the three main principles/functions of the Clinical Ethics Support Group. He reported on changes to membership of the group during the year.

The Clinical Ethics Support Group had been established in 2011, under the leadership of Dr. Paul Baines. The group is scheduled to hold a monthly meeting to discuss any cases on the 1st Wednesday, however activity is very variable and during the last 12 months there had been 5 meetings, with a range of clinical cases discussed including:

- Ethical Concerns regarding prescribing 'non medicinal medicines' to children undergoing treatment.
- Ethical guidance and moral concerns regarding the guidance on management of Spinal Muscular Atrophy Type .
- Moral and ethical aspects of a request for a non therapeutic circumcision for an infant male with a complex family background.
- Ethical issues when novel therapy is unavailable in one country in the UK, but available in adjoining part of the UK.

The Clinical Ethics Support Group received support from Julie Creevy during the year who had been instrumental in ensuring discussion were recorded and the group robustly administered. AD thanked Julie Creevy for her invaluable assistance.

AD outlined a range of other activities and plans for the coming year, including training opportunities that had been supported by the Trust, links established with other paediatric organisations and the need for a higher profile for the work of the group plus new members.

Preliminary discussion had taken place with Medical Director regarding establishing a legal ethical forum to meet quarterly to discuss medico-legal aspects of the Trusts activity.
AM thanked AD for update.

19/20/34 CQC Action plan update

ES presented the CQC Action plan. Key exception issues as follows:

- MS stated that agreement had been reached with the Trade Unions with regards to DBS issue and that there is a planned roll out for 1st June 2019. With case by case basis.
- Radiology actions had progressed such that the ratings on the remaining items could be updated as on track.
- Outpatients – a significant amount of work had taken place to address the issue regarding up to date, child friendly information leaflets. HG stated that there is a requirement for a working group to be established in order to ensure all leaflets are available in a child friendly format. HG stated that she had previously undertaken discussion with Pauline Brown with regard

to the potential for various roles to support this agenda and provide support – ie whether it could be a potential function for specialist nurses.

CQAC Agreed that a task and finish group be created to address this issue.

Action: Anne Hyson to provide brief summary position statement at June 2019 CQAC meeting.

CW queried whether this item should remain on the CQC outpatient action plan. HG confirmed that this is a Trust wide issue and an ongoing piece of work.

End of Life – CW stated that the delays were due to a consultant being off on sick leave and that the team are going through a period or organisational change. Following the organisational change process, this would result in a leader in Palliative care. CW stated that the Medicine Division are starting to address this issue. CW stated that she would envisage progress being made over the next couple of months. Weekly meetings with key personnel are being held to address challenges of single handed consultant. The team are currently working with consultant colleages in Chester, in order to ascertain whether any support could be provided to Alder Hey.

Action: CQAC agreed to receive an execption report at the June 2019 CQAC meeting.

CQAC agreed that a 'deep dive' would be beneficial and that AB would link in with CW to address issues.

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19/20/35 Corporate Report – Quality Metrics

Caring – 'Friends and Family test who would recommend Alder Hey as a place for treatment' – responses are averaging around 80% or just above, the Trust had seen a 10% improvement during March, there is a requirement to see a continued improvement going forward.

Issues relating to 'feedback regarding play'– CQAC noted that during periods when ED was extremely busy it was difficult to support play given demand placed upon ED waiting areas. In addition, CQAC noted difficulty in cleaning ED when it is full to capacity, however revised measures had been implemented and HG stated that she hoped to see sustained improvements going forward.

Safe – Clinical incidents resulting in minor harm and above – from March 2018 equated to 93.

Effective – HG stated that both she and NM had agreed an escalation process when individual Sepsis cases are not met.

Action: HG requested findings from an IPC cluster review meeting update for next meeting.

AM thanked HG for update.

19/20/36 Board Assurance Framework

ES stated that there is a Board strategy Session scheduled for 25th June 2019, when the BAF risks will be reset.

The updates in month included independnet assurance received via the CCG annual review of the Trust's process to assess if CIP's are impacting on quality, with positive feedback received.

Nurse staffing had been extremely successful with an update due to be presented at the Board of Directors meeting on 2nd July 2019.
AM thanked ES for update.

19/20/37 Clinical Claims Report

HG stated that the Clinical Claims Report had been deferred due to capacity issues within the Clinical Claims team; CQAC noted that they would receive a detailed Clinical Claims Report at the June meeting.

19/20/38 External Visits/Accreditation report

ES presented the External Visit/Accreditation Report for 2018/19 which detailed external visits, inspections and accreditations undertaken throughout the year, together with nominated lead, visit dates and date report and action plan had been presented to relevant committees. LC stated that there was an extremely robust process for recording of visits within the Community Division and offered to share this with Medicine and Surgery.

Action: LC to request Rose Douglas, Associate Chief Nurse, Community Division to circulate visit template in order that all Divisions are consistenly using the same template.

CQAC received and noted the contents of the External visit register.
AM thanked ES/JP for update.

19/20/39 CQSG Annual report

PoC presented the CQSG Annual report, which detailed CQSG membership, and key achievements during the year.

POC reported that key areas had been reviewed within CQSG ToR and CQSG workplan to ensure they are upto date and represent a balanced and appropriate workload with the right people involved. A Policy Ratification Group had been created to ratify a number of policies with 90% of policies ratified through this group.

The challenge remained regarding the lack of Medical representation at CQSG; HG stated that NM is aware of this issue and is currently in the process of addressing this issue.

Action: NM to provide update at June CQAC with regards to lack of Medical representation at CQSG meetings.

AM, on behalf of CQAC members paid tribute to CQSG members and the signficiant support which CQSG had provided to date to CQAC.

AM sought comments from committee members with regards to the previous joint CQAC/CQSG meeting held on 17th April and whether CQAC members

found this meeting beneficial, committee agreed that the joint meeting was extremely posititive and worked well due to the inter dependencies of both CQAC/CQSG.

CQAC received and noted the CQSG Annual report and workplan which was shared for information.

19/20/40 CQAC Annual workplan

AM presented the CQAC Annual workplan which was noted and accepted by the Committee.

19/20/41 Interpreting Translation and Accessible Information Policy

AH presented the Intepreting Translation and Accessible Information Policy. The policy had been rewritten and had been through appropriate consultation. AH stated that the Policy had not yet formally been reviewed and approved by the Policy Review Group and that this was due to be reviewed at the Policy Review Group on 21st May 2019. CQAC were satisfied with the content of the policy and were happy to support ratification, prior to this being discussed/approved at Policy Review Group on 21st May 2019.

18/19/42 Any Other Business

None.

18/19/43 Date and Time of Next meeting

10.00 am – Wednesday 12th June 2019, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

Integrated Governance Committee - Annual Report 2019/20

The Integrated Governance Committee

The purpose of the Integrated Governance Committee is to:

- Ensure processes, structures and responsibilities are in place for identifying and managing risks at all levels of the organisation from wards and departments to Board Committees.
- Ensure the maintenance of a comprehensive Corporate Risk Register, with risks prioritised with appropriate action plans in place and managed.
- Develop a culture of risk awareness across the Trust.
- Ensure the Trust maintains a Board Assurance Framework (BAF) that is reviewed by the Committee, and presented to the Trust Board at each of their meetings.
- Ensure each Division, Corporate Function and The Change Programme maintain an up-to-date risk register, and are actively managing the identified risks.
- All Divisions, Corporate Departments are subject to review and challenge of their progress in embedding risk management, in line with the Committees work programme.
- Ensure the Trust has an up-to-date Risk Management Strategy, BAF Policy and associated policies that comply with relevant regulatory, legal and code of conduct requirements.
- Approve relevant policies and procedures required for effective Governance including Risk Management and practice.
- Support the ongoing embedding of good Governance, including effective Risk Management across the Trust by initiating and overseeing training and awareness initiatives across the Trust.
- Advise on mandatory training requirements for Governance including Risk Management.
- Ensure any learning from the identification of risks, and associated action to mitigate is communicated throughout the Trust.

Constitution

The Membership comprises one Non-Executive Director, who currently chairs the committee, Executive Directors, and attendees including Associate Director of Nursing and Governance, Associate Chiefs of Operations x3, Associate Chief Nurses x3, Head of Building Services, Head of Interim Estates and Capital Planning, Head of Soft Services (Facilities), Division Heads of Quality x 3, Deputy Director of Risk & Governance, Information Governance Manager, Business Continuity Manager, Chief Pharmacist, Health and Safety Manager.

IGC meets bi-monthly and the schedule of attendance for 2018-19 is shown in Appendix A, There was one additional meeting held this year in April.

The Board is provided with assurance following each meeting about progress with the committee workplan. The minutes from each IGC meeting is provided to the proceeding Board showing the key issues and outcomes from the Committee meeting. In addition the Board Assurance Framework (BAF) is provided to the Board at each meeting.

Achievements in 2018/19

- The Trust has continued risk validation meetings monthly with the four Divisions and Corporate Functions including Infection Control, Facilities (soft services), IM&T, Human Resources, Finance, Estates & Building Services, Development, Health and Safety, Business Preparedness & Emergency Planning, Information Governance & Records Management, Medicines Management & Pharmacy, GDE Project, Marketing & Communications, Innovation and ensuring support is provided, challenge where required, and management of risks from 'Ward to Board' is consistent. Moreover, there is an emphasis on assurance, that each and every risk is being managed effectively, i.e. risks clearly identified from assessment, risk rating reflects assessment of controls, gaps in controls which are expected to be reflected in the actions for improvement and progress with the identified actions are discussed including any additional actions to mitigate the risk. In addition, assessing that reviews are completed in line with timeframes identified on risk assessment, and appropriate escalation completed in a timely manner.
- Ongoing development and implementation of risk management reporting template for IGC risk management reports, to ensure consistency of risk reporting and enable IGC to be assured of consistent progress with the management of risk.
- Development and implementation of practice 'Risk Management Guide' to support Risk Management Strategy.
- Each Division and Corporate Service present their risk register reports for scrutiny at each IGC, focusing on high risks, and other lower level risks that may impact on the achievement of Corporate Objectives.
- The Corporate risk register is presented for scrutiny at each IGC meeting and include all high risks, which are clearly linked to Corporate Objectives.
- The BAF is updated and presented for scrutiny at each IGC meeting.
- Clear lines of accountability and responsibility for the ownership and management of risk identified and appropriately challenged.
- Risks elevated to 15 or above transferred to relevant executive, until mitigated to at least a high moderate (meaning risk score = 12), and at that point transfer back to local risk owner. Management of the risk locally, remains with the identified risk manager/function where risk originated as identified on the register.

- Annual schedule of Risk Management training including training on the risk register provided to groups and individuals, available for all staff.
- Ongoing developments of the Governance and Quality Assurance web page on the Trust intranet, to support staff in the effective management of risk.
- The risk register risk assessment on Ulysses has been considerably modified following staff feedback. Ongoing regular training sessions have been provided to staff groups across the Trust on the requirements to assess and manage risk effectively, which have received favourable feedback from staff.
- Additional staff support has been provided through further development of risk management 'step by step guides', including action guide, communication guide, guide to completing risk assessments on the risk register and the risk matrix assessment guide. All guides available on the governance and quality assurance web page on the intranet, in addition to being available on the front page of Ulysses (electronic risk management system).
- Significant reduction in high risks achieved across the Trust with recognition that further concentrated work is required to reduce the ongoing high risks.
- The Committee approved and monitored its annual work programme and the effectiveness of each meeting is assessed by the Chair and Director of Corporate Affairs. The meeting is subject to scrutiny by Internal Audit as part of their annual audit plan and ongoing review of the risk management systems and processes.
- Introduction of a "deep dive" on a saple of BAF risks by an executive at each meeting.
- Introduction of a policy sub-group to review policies in detail and propose to IGC their approval.

Assurance Statement

Based on the information provided, the Committee members can confirm that the assurance framework is fit for purpose and that the control environment is operating at a satisfactory level with areas to improve on highlighted below. IGC also agrees to the declaration reported to the Board in respect of the Annual Governance Statement.

Committee Priorities for 2019/20

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2019/20-:

- The Committee will continue to hold Directors and others to account for the effective management of governance and risk through support and challenge, to provide assurance to the Trust Board that all necessary actions to support the achievement of the corporate objectives is being applied effectively.
- Further concentrated work to reduce the high risks on the risk register with the ongoing support from the executive team.
- Introduce a regular review of the CRR by the Executive Team and the Board.

- Provide other Board Committees with the CRR risks relevant to their remit for review and challenge.
- Continue the 'deep dive' of strategic risks on Board Assurance Framework and linking this to the Corporate Risk Register.
- Continue to monitor the effectiveness of the devolved governance model, through assurance reporting that risk management is owned and managed locally and that this is providing an effective Ward to Board system of governance.
- Support the ongoing enhancement and functionality of the Ulysses risk management module as well as further development as required.
- The Committee will ensure a coherent and integrated approach to governance including risk management through the Risk Management Strategy and associated policies.
- Divisions to develop local risk management training plans and schedule of training to support staff understanding of the principles of risk management, responsibilities and expected standards of best practice.

Kerry Byrne
Committee Chair
24 May 2018

IGC - RECORD OF ATTENDANCE 2018/19 **APPENDIX A**

Quorum: Chair or nominated deputy, two Executive Directors (one of whom is a clinical lead)
(if the Medical Director cannot attend then, one of the Clinical Directors should deputise for them)*

Members

	May 2018	Jul 2018	Sept 2018	Nov 2018	Jan 2019	Mar 2019	TOTAL %
Ms Kerry Byrne **(Non-Executive Director)**	N/A	N/A	N/A	✓ (Chair)	✓ (Chair)	✓ (Chair)	100%
Mr S Igoe **(Non-Executive Director)**	✓ (Chair)	✓ (Chair)	✓ (Chair)	N/A (Chair)	N/A (Chair)	N/A (Chair)	100%
Mr S Ryan **(Medical Director)**	✓	✓	✓	✓	Dep	N/A	83%
Ms Nicki Murdock **(Medical Director)**	N/A	N/A	N/A	N/A	N/A	Dep	17%
Mrs P Brown (represents Chief Nurse) **(Director of Nursing)**	✓	Dep	✓	✓	✓	✓	100%
Mags Barnaby **(Interim Chief Operating Officer)**	X	X	X	X	X	X	0%
Adam Bateman **(Chief of Operations)**	✓	X	X	✓	X	X	33%
Mrs M Swindell **(Interim Director of HR)**	Dep	✓	✓	✓	✓	✓	100%
Miss E Saunders **(Director of Corporate Affairs)**	✓	Dep	✓	✓	✓	✓	100%
Mr J Grinnell **(Deputy Chief Executive, Director of Finance)**	✓	✓	✓	X	✓	✓	83%
Mr D Powell **(Development Director)**	✓	Dep	Dep	Dep	X	Dep	83%

Attendees

	24 May 2018	11 Jul 2018	12 Sept 2018	20 Nov 2018	15 Jan 2019	13 Mar 2019
Cathy Umbers – Associated Director of Nursing & Governance	✓	✓	✓	Dep	✓	✓
Adrian Hughes – Director of Division of Medicine	Dep	X	✓	Dep	✓	✓
Andy McColl - Associate Chief of Operations (Surgery)	✓	X	✓	✓	✓	✓
Denise Boyle – Associated Chief Nurse (Surgery)	X	✓	X	X	X	X
Will Weston – Associate Chief of Operations (Medicine)	✓	X	X	X	X	X
Cathy Wardell – Associated Chief Nurse (Medicine)	Dep	X	✓	✓	✓	✓
Andrew Williams – Director of CAMHS	X	X	X	X	X	X
Rachel Greer – Associated Chief of Operations	✓	X	X	X	✓	✓
Catrin Barker – Chief Pharmacist	✓	✓	✓	✓	✓	✓
Charlie Orton – Associated Chief Operating Officer (Research)	X	✓	X	X	X	✓
Valya Weston – Associate Director of Infection Prevention and Control	Dep	X	✓	✓	X	Dep
Stefan Verstraelen – Divisional Head of Quality (Surgery)	✓	✓	X	X	✓	✓
Claire Liddy – Deputy Director of Finance	X	X	X	X	X	✓
John Williams - Assistant Director of Estates	Dep	X	Dep	Dep	Dep	Dep
Sue Brown – Associate Director (Development)	X	Dep	Dep	✓	X	✓
Mark Deveraux - Head of Soft Services	✓	✓	✓	✓	✓	✓
Tony Rigby – Deputy Director of Risk & Governance	✓	✓	✓	✓	✓	X
Graeme Dixon –Operational Lead (Building Services)	✓	✓	✓	✓	✓	✓
Sarah Stephenson - Head of Quality (Community)	✓	✓	✓	✓	✓	✓
Jacquie Ruddick - Head of Quality (Medicine)	N/A	✓	X	✓	X	N/A
Lesley Robinson – Quality Assurance & Compliance (Medicine)	✓	X	X	✓	✓	X
Elaine Menarry – EP & Business Continuity Manager	✓	X	X	✓	✓	✓
Amanda Kinsella – Health & Safety Manager	✓	X	✓	✓	✓	✓

Liz Baker – Information Governance Manager	**Dep**	X	X	X	**N/A**	**N/A**
Jo Fitzpatrick – Information Governance Manager	**N/A**	**N/A**	**N/A**	**N/A**	✓	✓
Kerry Morgan – Deputy Head of Information	✓	✓	**Dep**	✓	**Dep**	**Dep**
Cathy Fox – Head of Informatics	✓	X	✓	**Dep**	**Dep**	✓
Jill Preece – Governance Manager	✓	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**

INTEGRATED GOVERNANCE COMMITTEE
13th March 2019
Time: 10:00-12:00
Venue: Institute in the Park, Large Meeting Room

Present:

Mrs K Byrne	Non-Executive Director **(Chair)**	(KB)	Ms L Calder	Minute Taker	(LC)
Mrs M Swindell	Director of HR & OD	(MS)	Mr J Taylor	General Manager - Innovation	(JT)
Mrs E Saunders	Director of Corporate Affairs	(ES)			
Mrs P Brown	Director of Nursing	(PB)			
Mr A Bateman	Chief of Operations	(AB)			

Apologies:

In Attendance:

Mrs C Barker	Chief Pharmacist	(CB)	Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mrs S Brown	Senior Project Manager	(SB)	Mr C Duncan	Director of Division of Surgery	(CD)
Mr G Dixon	Operational Lead (Building Services)	(GD)	Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Ms S Stephenson	Head of Quality (Community)	(SS)	Mrs C Liddy	Deputy Dir. of Finance & Bus. Dev	(CL)
Mrs L Cooper	Research Governance & Quality Lead	(LC)	Mrs C Fox	Programme Director for Digital	(CF)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)	Mr M Flannagan	Director of Communications	(MF)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)	Mrs N Murdock	Medical Director	(NM)
Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)	Mrs C Orton	Assoc. Chief Operating Officer (Research)	(CO)
Mrs J Keward	Lead Nurse Infection Prevention & Con	(JK)	Mrs R Douglas	Assoc. Chief Nurse (Community)	(RD)
Mr J Williams	Head of Estates and Capital Planning	(JW)	Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mrs E Menarry	EP and Business Continuity Manager	(EM)	Mrs L Robinson	Quality Assur & Compliance Manager	(LR)
Mrs J Fitzpatrick	Information Governance Manager	(JF)	Mrs V Weston	Assoc. Dir. of Infection Prevention & Con	(VW)
Mrs A Kinsella	Health & Safety Manager	(AK)	Mrs H Gwilliams	Chief Nurse	(HG)
Mrs H Thompson	GDE IM&T Project Manager	(HT)	Mr J Grinnell	Director of Finance	(JG)
Ms L Fearnehough	Head of Technical Services	(LF)	Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mr A Hughes	Director of Medicine Division	(AH)	Miss J Gwilliams	Trust Risk Manager	(JG)
Mrs R Greer	Assoc. Chief of Operations (Community)	(RG)	Mrs L Cooper	Divisional Director of Community	(LC)
Mr S Verstraelen	Head of Quality (Surgery)	(SV)	Ms K Morgan	Deputy Head of Information	(KM)
Mrs J Hutfield	Compliance, Risk & Contracts Manager	(JH)	Mr A Williams	Director of CAMHS	(AW)
Ms L Brown	GDE Project Manager	(LB)	Mr D Powell	Director of Development Directorate	(DP)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
18/19/121	**2.**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 15th January 2019. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 15th January 2019.			
	2.3	**Chair's introduction**	KB commented on the size of the agenda for this meeting, and particularly the inclusion of a number of very long and detailed policies and procedures for review. KB advised that it has been agreed in the pre-meeting to set up an IGC Policy Sub-Group to review policies in detail before presentation to IGC for ratification. This will require a senior representative from each division. This can be grade 8a or above. KB referred to her recent email regarding some enhancements to the risk management process to ensure the IGC meetings are used most effectively. She asked attendees, when presenting their reports, to focus on new risks, risks with changed scores and those overdue and with overdue actions so that we can have a Trust-wide discussion on these where appropriate. She advised that in future meetings we will also include risks removed from risk registers.	C Umbers, IGC Policy Sub Group Chair	CU	1 week
	3.	**Risk Register Management Reviews**				

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/122	**3.1**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. AM focused on the high risks from the Surgical Division for this reporting period. Risks from the Surgical Divisions report were highlighted as follows: • Total number of risks = 57 • Number of new risks identified since the last reporting period = 9 1795, 1801, 1815, 1816, 1818, 1824, 1841, 1842, 1845 • Number of risks closed and removed from the risk register = 10 - 1274, 1285, 1309, 1403, 1517, 1634, 1697, 1741, 1754, 1760 • Number of risks with an overdue review date = 1 (as per 28.2.2019) • Number of risks with no agreed action plan = 7 (as per 28.2.2019) • Number of high/extreme risks escalated to the Executive Team = 2 - 1306, 964 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 1 decreased in movement: **Risks with changed score** **Risk no 1304 risk rating 12: – Lack of visibility as pre-operative clinical information not visible on Meditech.** Risk reduced from 9 to 6 as all documentation is live in Meditech and is visible. Training session took place with anaesthetists on 15 January 2019, to show them where documentation is kept. Further rollout required, as all patients should have their triage form recorded on Meditech, but this is currently not possible due to outpatient room capacity.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			<u>New risks (with a score of 12+)</u> **Risk no 1795 risk rating 12: - Lack of ventilation in the decontamination room.** There are insufficient controls to mitigate this risk. Actions: Redesign ventilation system. There has been an internal inspection and the Division are taking actions forward. The next step is to identify a timescale. **Risk no 1815 risk rating 12: - Risk to patient safety from lack of pre-operative assessment.** There are insufficient controls to mitigate this risk. Actions: Outpatient leadership team have reviewed an available outpatient room to support capacity for pre-op service and the division are actively chasing to have a sink installed to turn into a clinic room, for which currently there is a 12 week wait. **Risk no 1818 risk rating 12: - Visual /Audible warning that the Cath suite and IR are running on power supplied by the UPS to the radiographer/clinician.** There are no adequate controls in place however conversations are happening with an external provider to look at a software change to alert the operator of the UPS activation. **Risk no 1824 risk rating 12: - Lack of available funding to replace obsolete Aventec bedside computers on PICU.** Currently there are 15 computers that need replacing. Controls: 6 Computer on Wheels Station currently being used in place of removed/broken computers – inadequate Actions: (LF) Head of Technical Services advised that an order has now been raised and IT will send through a schedule of when the computers will be changed.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			AM advised that Surgery actively managed risks and closing risks when actions have been completed. The risks at 15+ remain the same. **Escalated risks:** **Risk 964 risk rating 15 – The process for planning and scheduling of elective lists is not sufficiently robust to prevent errors occurring.** Controls in place: The Surgical Division are recruiting every 6 months and advertising regularly in attempt to ensure significant cover. Locums allocated within the service and current members of the team are picking up ad hoc shifts. Actions: Divisional meetings established as risk is considered a Divisional priority for 2019/20. **Risk 1306 risk rating 16 – Concerns around junior doctor shortages in Surgery.** Vacancies within middle grade surgical rotas across the Surgical Division. If a vacant shift is uncovered this poses a risk to patient care and safety as the rota becomes non-compliant with national guidelines and also poses a financial risk as the vacancies are often covered by locums at an enhanced rate of pay. In relation to Risk 1815 KB asked whether a timescale of 12 weeks to have a sink installed is normal. GD advised that this type of request to Interserve is slow but Building Services will push to have installed as soon as possible. KB advised that the last report submitted by Surgery was split into 4 areas, Gait Lab, Plastics, 3A & Cardiac. Can the Surgery Division	Risk 1815 (lack of pre-operative assessment) GD to speak to Interserve re sink installation	GD	1 week

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			replicate the format in-line with the other Divisions? KB asked why the high risks not been escalated to Execs? AM advised that risk 1306 is a strategic risk and there is a plan in place looking at the next 5 years. This will need sign off at Exec level when approval is in place. Risk 964 there is a new pilot being launched and if Exec support is required the Division will escalate. KB asked the Division to provide an update for risks 1306 & 964 at all future meetings until resolved. AB advised that the Surgery Division risk register is in a good position however on-going work to complete. **Resolved** that: the Committee NOTED the contents of the paper	Surgery division to replicate format of Risk Management Reports in-line with other divisions. Risks 1306 (shortage of junior doctors in Surgery) 964 (planning and scheduling of elective lists). An update to be provided at all future IGC meetings.	AM AM AM	22nd May 19 All future IGC meetings All future IGC meetings
18/19/123	**3.2**	**Medical Division**	Adrian Hughes (AH) presented the risk management report for Medicine. Risks from the report were highlighted as follows: • Total number of risks = 103 • Number of new risks identified since the last reporting period = 15 • Number of risks closed and removed from the risk register = 16			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		• Number of risks with an overdue review date = 26 • Number of risks with no agreed action plan = 7 • Number of high/extreme risks escalated to the Executive Team = 5 (1169, 1251, 1730, 1668, 1787) **<u>New risks (with a score of 12+)</u>** **Risk no 1820 risk rating 12 - Lack of dedicated multidisciplinary PN nutritional team**. Nutritional support is a fundamental element of care for many infants and children with a great variety of medical and surgical diagnoses. When nutritional requirements cannot be met, using the gastrointestinal tract (enteral nutrition), nutrients must be given intravenously as parenteral nutrition (PN). The clinical and nutritional need for PN requires careful assessment; any decision to start PN will depend on the underlying clinical condition and nutritional status of the patient. Prescribing, compounding and administration of PN are tasks that demand meticulous planning, effective communication and a breadth of specialist expertise from multidisciplinary teams of doctors, pharmacists and other members of the pharmacy team, dieticians, nurses and clinical scientists. Every stage of the process carries risks, and although large numbers of patients are fed intravenously without adverse events every **Risk no 1821 risk rating 12 Delivery of Peer Review Standards for Haemophilia service** - Potential that we may not meet the Peer Review standards for Haemophilia service. **Risk no 1822 risk rating 12 Compliance with Haematology Peer Review Standards for Haemophilia service -** Previously formed part of risk 1539 Compliance with Haematology Peer Review Standards for Haemophilia service. The decision was taken to split			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			this risk to reflect the difference between two services. **Risk no 1831 risk rating 12 Unauthorised access to patient data within Natus System -** 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. The risk sits in Medicine however resolution of it is an IT issue. LF advised this is an unsuccessful capture of data and this is being worked through. KB asked has this been brought to the attention of Information Governance? LF to speak to JF outside of the meeting. **Risk no 1835 risk rating 12 - Inability to provide resilient 24/7 haematology laboratory service due to high sickness levels**. Sickness levels are associated with sustained workload increases and pressures of providing the 24/7 service. AH advised there is a business case going through for funding for additional staff and this will be picked up by May 19. **AH reported on the high risks from the Medical Division for this reporting period.** **Risk no 1169 score 20 – Fragile Medical Workforce within the Haematology Service.** AH advised the service remains fragile as it's difficult to recruit to the speciality. A Consultant is returning from maternity leave in September 19. The Division are looking at resilience within the dept and we should have positive news at the next IGC in May 19. **Risk no 1251 score 16 - Lack of Consultant cover for palliative care team.** The service for patients requiring palliative and end of	Risk 1831 Unauthorised access to patient data within Natus System LF to speak to JF outside of IGC re information governance concerns.	LF/JF	1 week

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			life care may be compromised. There is nurse specialist support 24/7 but Consultant support needs to be addressed urgently. Claire House has employed a part-time member of staff who has been shadowing at Alder Hey for several months and may be able to help out once the shadowing period has ended. KB advised that reliance on a single consultant is not good for their well-being long term and the Division need to look at how this is funded. AH advised the committee that the Medical Division have work to complete with the teams around the action plans for risks. There have been challenges and stresses within the division as the Head of Quality recently left. There is still have a lot of work to complete, however are confident the Division is showing assurance of effective management of risk. **Resolved** that: the Committee NOTED the contents of the paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/124	**3.3**	**Community Division**	Rachel Greer (RG) presented the risk management report for Community. Risks from the report were highlighted as follows: • Total number of risks = 46 • Number of new risks identified since the last reporting period = 5 (1843, 1800, 1804, 1809, 1811) • Number of risks closed and removed from the risk register = 6 • (1273, 1843, 1458, 1584, 1610, 713) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 4 • Number of high/extreme risks escalated to the Executive Team = 1 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **New risks** **Risk no 1811 risk rating 6 - Need to improve information sharing opportunities at Multi-agency meetings across the Region (safeguarding).** There are insufficient controls to mitigate this risk. Actions: The risk is these meetings could happen without a consultant present. Where possible request meeting is held on site however, if this is not feasible nominate a suitable experienced safeguarding nurse to represent or request an opportunity to dial in to the meeting. **Risk no 1804 risk rating 9 – Challenges in covering the Rainbow**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			doctor's rota. Staffing levels are inadequate to cover the rota however the Division is mitigating this risk through locum work. **Risk no 1809 risk rating 2 - Safe Delivery and sustainability of Community Respiratory Physiotherapy service for children with Complex Needs and Long-term respiratory conditions in Sefton.** Single handed deliver of service by Respiratory Physio in the North Sefton area. This is not a new risk it's an existing one. **<u>Risks with a risk score of 12+</u>** **Risk no 1524 - Failure of the system to provide appropriate and timely services for young adults with ADHD including primary and community care services.** Transition of patients into Liverpool is complete and preparations for Sefton patients will follow. **Risk no 1131 - Process for scanning and archiving clinical notes within Community Division.** RD expressed her concern. AM advised that Surgery Division's current scanning turnaround isn't on their divisional risk register as this is a Trust wide issue. SB advised she has met with Mandy Burns, Records, Transcription & OP GDE Manager to discuss the storage of on-site records and off-site records in the Community. This is a big issue and many records due to the Goddard Report have to be brought on site and all of these records will need scanning, which is a known risk on the register. SB advised that recently more notes have been located that nobody was aware of. AB recognised we need to do a piece of work around this. A Task & Finish Group has been formed so that	AB to bring a paper to the next IGC on Medical Records Strategy	AB	IGC 22nd May 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			the group can meet and get a broader strategy around this risk. AB has ownership of this and he is the right person to speak to. 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			
18/19/125	**3.4**	**Infection Control Service**	Jo Keward (JK) presented the risk management report for Infection Prevention Control. Risks from the report were highlighted as follows: • 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 (1769) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 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 the Integrated Governance Committee = 1 (1593) JK advised in terms of the trend of risks they are keeping to the same level with one high risk. **<u>Closed risks</u>**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1769 – risk of patients acquiring influenza from staff as less than 75% of frontline staff have been vaccinated. JK advised we have achieved our 75% of staff being vaccinated and this has now been closed. **<u>Risk with changed risk rating</u>** **Risk no 1593 score 12 – A patient can acquire a HCAI due to inadequate deep cleaning process.** IPC have increased this risk rating as the current trial machine has been with the Trust for the last 18 months. Business case was reviewed at IRG and the funding for new UV machines now with Medical and Surgical COOs. No decision as of yet. KB asked is there a plan B to this situation? JK advised that we have cleaning products in place however the Trust need the UV machines to rid pathogens. KB advised for this to be taken outside of IGC to discuss the funding. JK advised the committee that although there is ongoing work required, the Infection Control team are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	Risk no 1593 VW/JK to speak to Medicine and Surgical COO's about funding for a new UV machine and report back to IGC	VW/JK	1 week
18/19/126	**3.5**	**Facilities**	Mark Devereaux (MD) presented the risk management report for Facilities. Risks from the report were highlighted as follows: • Total number of risks = 13 • Number of new risks identified since the last reporting period = 7 (1796, 1797, 1799, 1657, 1658, 1659, 1660) • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of risks with no agreed action plan = 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 the Integrated Governance Committee = 0 **<u>New risks</u>** **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. JG suggested that the three Facilities change management improvement programmes are looked in terms of "are they delivering what we expect" and also where this should be reviewed and reported. **Risk no 1657 risk rating 8 - Industrial Action.** MD advised this is around an organisational change and workforce proposals. All staff involved have been met with and Trade Union officials have been sighted on the proposals. MD advised the committee that all risks are in review date and Facilities are satisfied with the progress at this point.	1796 & 1797 Review the delivery of the three facilities change management programmes, their delivery and review and reporting arrangements	MD	1 week
18/19/127	**3.6**	**IM&T**	Leanne Fearnehough (LF) presented the risk management report for IM&T. Risks from the report were highlighted as follows: • Total number of risks = 24 • Number of new risks identified since the last reporting period = 2 (1814, 1832)			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 19 • Number of risks with no agreed action plan = 4 • Number of high/extreme risks escalated to the Executive Team = 3 (1817, 1701, 947) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **<u>New risks</u>** **Risk no 1814 risk rating 6 - Impact of no deal Brexit.** LF advised that IT is working with L Stark, Head of Performance & Planning, and are working through with suppliers and also a Deep Dive spreadsheet has been updated which is held by Procurement and is required by NHSE. **Risk no 1832 risk rating 9 - Signing of electronic documents.** The way users sign electronic documents impacts on the visibility of that document to other users and the flow of information included in that document. LF advised she will pick this up with M Levine, Head of Clinical Systems. **<u>Escalated risks</u>** **Risk no 1701 risk rating 16 - 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	Risk no 1832 (signing of electronic documents) to pick up with ML Risk no 1701 (use of MD Analyse in Neuro and Orthopaedics) raise with the Exec Team	LF JG	1 week 1 week

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			LF advised the committee that although there is ongoing work required, the IM&T are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/128	**3.7**	**HR**	Melissa Swindell (MS) presented the risk management report for HR. Risks from the report were highlighted as follows: • Total number of risks = 9 • Number of new risks identified since the last reporting period = 2 (1823, 1833) • Number of risks closed and removed from the risk register = 2 (1732, 1734) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 3 • 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 the Integrated Governance Committee = 0 **New risks** **Risk no 1823 risk rating 9 - EU Settlement Scheme applications.** There are 65 individuals eligible to apply across the organisation. 17 members of staff have taken action however the deadline isn't until 2021.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1833 risk rating 12 Annual Divisional Cost pressures for the directorate of HR. The cost pressure relating to (DBS) Disclosure and Barring Service due to the recommendations of the Lampard Review, there are proposal for the Trust to meet the initial cost. MS advised that the outstanding actions are around finances however the rest of the risks have actions in place. MS advised that Human Resources 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			
18/19/129	**3.8**	**Finance**	John Grinnell (JG) presented the risk management report for Finance. Risks from the report were highlighted as follows: • Total no of risks = 4 • new risks since last report = 0 • risks closed and removed 0 • risks overdue 0 • no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 0. JG advised there are issues around Oracle which is creating operational difficulties for the Finance team. The team are in talks with the Oracle provider to resolve. JG advised the committee that the Finance department are satisfied with the progress at this point.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
18/19/130	**3.9**	**Estates**	John Williams (JW) presented the risk management report for Estates. Risks from the report are highlighted as follows: • There are 4 risks identified • new risks since last report 0 • risks closed and removed 2 • risks overdue 0 • no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 0. JW advised the committee that Estates have reduced their risks by 2. **Risk no 1118 risk rating 6 -Staff Training regards use of fire extinguishers.** This training has been agreed so this risk can reduce. **Risk no 437 score 6 – Risk of Boiler House Chimney Collapse**. A survey of the condition of the chimney took place by Contractors and the outcome is for the chimney to have a yearly review to monitor JW advised this can now be closed?? JW advised the committee that the Estates Dept are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	.		

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/131		**Building Services**	Graeme Dixon (GD) presented the risk management report for Building Services. Risks from the report were highlighted as follows: • There are 9 risks identified • new risks since last report 0 • risks closed and removed 1 • risks overdue 0 • no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 2 (high risks). **<u>Escalated risks</u>** **Risk no 1388 risk rating 20 – Corroded Pipework.** Project plan received for the replacement/repair of pipework which is currently underway. Building Services have weekly updates with Project Co on the progress. A separate progress report on the pipework is included on the Agenda at item no 18/19/131a **Risk 825 score 15 – Internal Balconies.** GD advised after several meetings with Project Co we now have a solution. The handrails are	Risk 825 (internal balconies) GD	GD	1 week

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			to be taken off and replaced with a metal bumper to help support the integrity of the glass. David Powell (DP) advised that Estates are happy with the solution. GD will report back to IGC with a date of when the work is to start. The risk has been reviewed and the scoring represents this. CU informed GD to be clear the Corporate report is showing this risk score as a 10? GD to review this risk. KB advised that it's good that we are getting a solution to this risk. GD advised the committee that although there is ongoing work required, Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	to review the risk score of this risk and advise whether 10 or 15 is the correct rating.		
18/19/132		**Directorate Projects**	Sue Brown (SB) presented the risk management report for Development Directorate Projects. Risks from the report were highlighted as follows: • There are 12 risks identified • new risks since last report 2 • risks closed and removed 0 • risks overdue 0 • no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 1 SB advised that all the risks for Development Directorate have been reviewed with actions in place. Risk no 1829 which includes the cost of refurbishment work of retained estate. It now looks like we can achieve the refurbishments with the money the Trust already has.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			SB advised the Committee that even though there is on-going work to complete the Development Directorate risk register, they are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/133	**3.10**	**Health & Safety**	Amanda Kinsella (AK) presented the risk management report for Health & Safety. Risks from the report were highlighted as follows: • Total no of risks = 9 • new risks since last report = 4 • risks closed and removed 1 • risks overdue 0 • no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 0 **New risks** **Risk no 1840 risk rating 9 – Regularly delivering COSHH (Control of Substances Hazardous to Health) compliance training by the Safety Team**. This is a rolling annual training programme which has been uploaded to the intranet page for staff to access. KB asked whether H&S are satisfied the identified risks are mitigated? AK advised that yes, the COSHH risk assessment training ensures this risk is mitigated. **Risk no 1856 risk rating 9 – Compliance with Risk Assessments.** The H&S team still need to work on delivery of training across the Trust			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			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			
18/19/134	**3.11**	**Business Preparedness & Associated reports**	Elaine Menarry (EM) presented the Preparedness & Associated reports. Risks from the report were highlighted as follows: • Total no of risks 13 • new risks since last report 0 • risks closed and removed 0 • risks overdue 0 • no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 0 EM advised the committee that no new risks have been identified and all current risks have agreed action plans. **Incident no 33448 & 33449 – Chemical incident - child and carer exposed to puddle containing dishwasher solution resulting in burns.** AED are holding decontamination simulation training. NHSE are to meet with Public Health as there has been a lengthy delay in responses from them. **Incident no 33768 - Water pipe leak into ceiling of neonatal surgical unit. 4 cubicles initially closed as a result.** Pipework Lead Business Continuity Card activated and Business Continuity Incident Team established, including infection control team. Unit was fully operational by 18th February 19. A McColl advised contingency plan is in place but needs formalising.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			IT network core fault resulting in difficulties around the use of bleeps and wi-fi connectivity issues. This risk is on the risk register. A task & finish group is to be established to ensure unplanned downtime business continuity action cards are available for all ward/dept. critical systems. **Incident no (Pathology to complete form) 31308 – Biochemistry server. Connectivity issues the main processing analyser had intermittent connectivity issues to its main application service causing delays in results being released into Meditech, therefore impacting on turnaround times of orders.** Trust staff were notified of the issue and what contingency arrangements were for staff to contact the laboratory for urgent test results required. **Incident no 32543/331194 – Water ingress into ICU, HDU and Theatres due to heavy rain.** Critical care outside leak has been repaired. Further drainage work is required externally. Critical care roof light repair is complete and no further leaks reported. Theatres are awaiting repairs. EM advised there is a Brexit meeting this week 17th March 2019, information that has come through from the Government & the action cards are to be discussed. EM is satisfied with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/135	**3.12**	**Information**	Jo Fitzpatrick (JF) presented the risk management report for			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
		Governance	Information Governance. Risks from the report were highlighted as follows: • Total no of risks 6 • new risks since last report 1 (1828) • risks closed and removed 2 (24 and 25) • risks overdue 0 • no of risks with no agreed action plan 1 • high risks need escalating to Execs for their support 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = (1828) **New risks** **Risk no 1828 – Preparing for a 'no deal' Brexit. Difficulty in obtaining Data flows to review incoming flows to prepare for a no deal Brexit situation means that we potentially have a small number of unknown data flows that maybe prohibited in the event of a no deal EU Exit.** What affect will this have on clinical care (blood tests/sampling results? IG Manager meeting with staff and information has been coming through. There does not appear to be a significant issue going forward. JF advised she will collate the information and report back to IGC. **Existing risks** Risk 1753 – The Data Security & Protection Toolkit. JF advised training compliance is at 70% and the Trust needs to be on 95% compliance. ES advised that the CQC look at this under Well Led that staff are providing safe service. The Toolkit has a possible risk			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			of failing if all staff don't undertake the training. MS advised she will collate a list of all outstanding staff to push this forward and Execs and Senior staff to escalate to the teams. JF advised she will send out another email prompt to staff JF advised the Committee that a lot of progress has been made and IG are confident that all risks have controls in place and are satisfied with progress made to date. **Resolved** that: the Committee NOTED the contents of the paper	Risk 1753 (DPST training compliance) MS to collate list of outstanding staff. Execs & Senior leads to escalate to teams JF to send out another email prompt	MS	1 week
18/19/136		**Medicines Management & Pharmacy**	Catrin Barker (CB) presented the risk management report for Medicines Management & Pharmacy. Risks from the report were highlighted as follows: • Total no of risks 19 (18 active, 1 Residual) • new risks since last report 0 • risks closed and removed 3 (2 residual & 1 active: (1776) • risks overdue 4 (risks 1198, 1209, 1444, 1589) • no of risks with no agreed action plan 0, • high risks need escalating to Execs for their support 1 (1787) – • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **Escalated risks**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risks no 1787 risk rating 15 - potential for error associated with prescribing, preparing and administration of parenteral nutrition score 15. This was discussed earlier under "Medicine". **Risk no 1776 – Missing Stock/CCTV. Drugs have gone missing from Pharmacy.** As these incidents are unresolved there is an on-going risk of this happening again. CB advised that there will be notices going up shortly to hopefully deter. CB advised there has been a lot of work completed and Pharmacy are satisfied with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/137		**Global Digital Excellence Programme**	Hannah Thompson (HT) presented the risk management report for Global Digital Excellence Programme reports. Risks from the report were highlighted as follows: • Total no of risks 13 • new risks since last report 0 • risks closed and removed 1 (1761) • risks overdue 0, no of risks with no agreed action plan 1 • high risks need escalating to Execs for their support 0 (high risks). • Changes in the risk profile of categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = None. **<u>Closed risks</u>** **Risk no 1761 – Cost Pressures in Community.** In order to			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			implement GDE 36 laptops will be supplied at the beginning of the project. This has now been closed. **Escalated risks** **Risk no 1668 score 15 - Test results not picked up when clinicians away from the office. Abnormal test results not reviewed and actioned by clinical staff in a timely manner. (This risk covers all Divisions and has been discussed at Patient Safety Meeting)** Nik Barnes (NB) advised the current action plan is to establish exact functionality in the current version of Meditech and see if this can be used to satisfy requirements of interested teams. Community Paediatrics is currently asking for functionality and so GDE can use this group as a pilot and the plan is to finish by end of May 2019**.** If there are any other interested teams GDE can work them to establish if the current functionality can be used to satisfy their requirements. HT advised the committee that GDE have reviewed and actioned risks and is happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/138		**Clinical Research Division**	Lucy Cooper (LC) presented the risk management report for Clinical Research Division. Risks were highlighted as follows: • Total no of risks 5 • new risks since last report 2 (1802 & 1807) • risks closed and removed 1 (72) • risks overdue 0, no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 1 (1751) • Changes in risk profile or categories of risk being reported that			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			need to be brought to attention of IGC = 0 **New risks** **Risk no's 1802 & 1807 both risk rating 6 - These relate to no deal Brexit, sponsored clinical trials and hosted trials and continuity of drugs.** LC advised the Research Division are working closely with L Stark, Head of Performance and Planning. **Escalated risks** **Risk no 1751 score 15 – 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 staff and the Director of Finance to co-produce a workable research finance model. JG advised that work is in progress however there is still a bit to do and will update at next IGC meeting. LC 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	Risk no 1751 (clinical research business model) update at next IGC Meeting	JG	22nd May 19
18/19/139		**Marketing & Communications**	There was no representative from Marketing & Communications (M&C). Risks from the report were highlighted as follows: • Total no of risks 3 • new risks since last report 0 • risks closed and removed 0 • risks overdue 2 (806 & 807)			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 0 • Changes in risk profile or categories of risk being reported that need to be brought to attention of IGC = 0 KB stated that, as this is the first time that a M&C risk register has been presented to IGC, all the risks are new. KB asked for M&C to present an overview of the risks on their risk register at the next IGC Meeting. **Resolved** that: the Committee NOTED the contents of the paper	Provide a presentation of risks on risk register for Dept	MF	22nd May 19
18/19/140		**Innovation**	Jason Taylor (JT) presented the risk management report for Innovation. Risks from the report were highlighted as follows: • Total no of risks 5, new risks since last report 0 • risks closed and removed 1 (1771) • risks overdue 0 • no of risks with no agreed action plan 0 • high risks need escalating to Execs for their support 0 • Changes in risk profile or categories of risk being reported that need to be brought to attention of IGC = 0 KB stated that, as this is the first time that an Innovation risk register has been presented to IGC, all the risks are new. KB asked for Innovation to present an overview of the risks on their risk register at the next IGC Meeting. **Resolved** that: the Committee NOTED the contents of the paper	Provide a presentation of risks on risk register for Dept	JT	22nd May 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/141	**10.**	**Corporate Risk Register**	Before looking at CRR in detail KB advised of some further enhancements to the risk management process that we are looking at over the following months and invited any comments from the attendees. • Bringing forward the scheduled review of the Risk Management Strategy. With a change of Chair this feels like the right time to do this. • Understanding the extent to which Risk Validation Meetings take place and whether they are effective in improving risk management practices. As IGC does not review the detailed risk registers we need to be able to place reliance on the effectiveness of risk management. At the moment we don't have a formal mechanism to do this so we may move towards assessing how well risk management is embedded across all areas of the Trust. **CRR** IGC needs to provide assurances to the Board on the management of risk throughout the Trust and may look to move to a more formal report in this regard. KB advised the Corporate Report doesn't make for comfortable reading at present as there are a lot of risks overdue review and with actions missing or overdue, and we need the improvements to support enable these assurances to be provided. KB also advised that, going forward, CU has been asked to provide the Corporate Risk Register to the Execs monthly and also to Trust Board quarterly. It is therefore important that significant effort is			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			taken to review these over dues given their wider circulation. JG also advised if the CQC were to visit on an unarranged visit the Trust would not look good in its current position.			
		Close of meeting	The meeting was drawn to a close due to running out of time. As there are still a number of items on the Agenda a further meeting will be arranged asap to complete the meeting.	Arrange follow up IGC meeting to complete the agenda	LC	1 week
Date and Time of Next Meeting		The next meeting of the IGC will be held on Monday 8th April 2019, 1:00pm. Institute, Tony Bell Boardroom				

INTEGRATED GOVERNANCE COMMITTEE
COMPLETED ACTIONS – January 2019

No	Item	Owner	When	Status
18/19/81	Sickness Absence	MS	~~15th Jan 19~~ 13th March 19	Sickness absence to be added to the HR risk register. Update 13.03.19 this has been added to the risk register. Completed
18/19/103	Risk 1769 – risk of patients acquiring influenza from staff as less than 75% of frontline staff have been vaccinated against flu.	J Keward/P Brown	13th March 19	JK & PB to pick this up outside of IGC Meeting. Risk now removed from risk register. Completed.
18/19/113	Risk 1753 – Data Security & Protection Toolkit. If the Trust does not provide enough evidence to the new Toolkit the Trust will fail its CQC Inspection	E Saunders/J Fitzpatrick	13th March 19	ES to discuss with JF and update the next IGC Meeting. This update will be included under agenda item 18/19/135. Completed
18/19/118	BAF – Deep Dive Reporting	K Byrne/E Saunders/C Umbers /J Grinnell	12th February 19	Schedule to be discussed at post-IGC meeting. Schedule has been approved. Completed.
A.O.B 10.	Communications to produce a Risk Management Report Innovation to produce a Risk Management Report	M Flannagan J Taylor	13th March 19 13th March 19	To prepare report for next IGC. Completed To prepare report for next IGC. Completed

Alder Hey Children's NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE

8th April 2019

Time: 13:00-15:00

Venue: Institute in the Park, Large Meeting Room

Present:

Mrs K Byrne	Non-Executive Director **(Chair)**	(KB)
Mrs M Swindell	Director of HR & OD	(MS)
Mrs E Saunders	Director of Corporate Affairs	(ES)
Mrs P Brown	Director of Nursing	(PB)
Mr A Bateman	Chief of Operations	(AB)

In Attendance:

Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mrs C Barker	Chief Pharmacist	(CB)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Mrs J Hutfield	Compliance, Risk & Contracts Manager	(JH)
Mrs J Keward	Lead Nurse Infection Prevention & Con	(JK)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Mrs R Douglas	Assoc. Chief Nurse Community	(RD)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mrs L Robinson	Quality Assur & Compliance Manager	(LR)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mrs A Chew	Assoc. Finance Director	(AC)
Ms L Calder	Minute Taker	(LC)

Apologies:

Mr J Williams	Head of Estates and Capital Planning	(JW)
Mrs H Thompson	GDE IM&T Project Manager	(HT)
Ms S Stephenson	Head of Quality (Community)	(SS)
Mrs L Cooper	Research Governance & Quality Lead	(LC)
Mr A Hughes	Director of Medicine Division	(AH)
Mrs R Greer	Assoc. Chief of Operations (Community)	(RG)
Mr S Verstraelen	Head of Quality (Surgery)	(SV)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Mr D Powell	Director of Development Directorate	(DP)
Mrs S Brown	Senior Project Manager	(SB)
Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mr C Duncan	Director of Division of Surgery	(CD)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mrs C Liddy	Deputy Dir. of Finance & Bus. Dev	(CL)
Mrs C Fox	Programme Director for Digital	(CF)
Mr M Flannagan	Director of Communications	(MF)
Mrs N Murdock	Medical Director	(NM)
Mrs C Orton	Assoc. Chief Operating Officer (Research)	(CO)
Mrs V Weston	Assoc. Dir. of Infection Prevention & Con	(VW)
Mrs H Gwilliams	Chief Nurse	(HG)
Mr J Grinnell	Director of Finance	(JG)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Miss J Gwilliams	Trust Risk Manager	(JG)
Mrs L Cooper	Divisional Director of Community	(LC)
Ms K Morgan	Deputy Head of Information	(KM)
Mr A Williams	Director of CAMHS	(AW)
Ms L Fearnehough	Head of Technical Services	(LF)
Mrs J Fitzpatrick	Information Governance Manager	(JF)
Mrs D Walker	Head of Pharmacy	(DW)
Mr J Taylor	General Manager - Innovation	(JT)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
	2.	**Minutes of previous Meeting**	The minutes of the previous meeting of the Integrated Governance Committee held on 13th March 2019 have not been reviewed, as the meeting today is a continuation of the agenda items not covered due to time constraints.			
	2.2	**Action list**	N/A			
	3.	**Risk Register Management Reviews**				
18/19/142	**3.1**	**Trust & Corporate Risk Register Review**	Cathy Umbers (CU) provided an overview of the Corporate Risk Register. CU advised the register should provide assurance to the committee that the High risks are being managed effectively; clearly the evidence from the report does not provide that assurance. The risk registers are discussed at the Risk Register Validation (RRV) meetings on a monthly basis with all divisions and corporate functions, senior staff The purpose of these meetings is to validate the risks on the registers and test the assurance, in particular around correct identification of risk, controls, gaps in controls and ensuing associated actions are in place and are meeting the documented expected date of completion, and the risks are reviewed within expected review date. The RRV meetings are a supportive measure where advice is provided about risk management and managing the risks on the register. The aims of these meetings are to embed the importance of managing risk effectively to keep patients, staff and others safe and subsequently assure the Trust Board that good risk			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			management practice is followed. CU asked the committee members if there was a specific reason why the register was in the current position (particularly in relation to overdue review of risks), despite the support provided. Lesley Robinson (LR) advised that teams are struggling to review their risks on a weekly basis and monthly would be more doable. AB advised some of the risks are systemic and won't show any changes reviewing on a weekly basis. AB also advised the Corporate Risk Register should be updated at the Exec owner's discretion as some of these high risks have endemic problems and doesn't see how a frequent review date has a bearing on these risks. KB advised that the CRR contains the highest risks that IGC Meeting focuses on and the Divisions and corporate functions are expected to make a concerted effort to bring their risks up to date and ensure actions and controls are in place and are managed. CU advised staff should be challenging themselves and reviewing the risks in line with best practice and certainly as soon as there is any change to the risk position including changes that will impact on risk score. Good risk management including effective management of the risk registers is one area the Care Quality Commission (CQC) are looking at to achieve good to outstanding for the Trust and is the key element of the Well - Led Domain, but is also a focus in the other domains. KB and CU are open for the risks to be reviewed and brought up to date over the next 2 weeks and then to go back to updating on a monthly basis if the evidence demonstrates that all the high risks are showing as being managed effectively on the CRR. KB advised the committee to complete a thorough review to get their risks up to date and then they can be moved to review on a monthly basis. KB also advised in terms of Execs discretion for updating the Corporate risks this is also to be reviewed on a monthly basis. CU is to produce a risk report for KB. **Resolved** that: the Committee NOTED the contents of the paper	All high risks to be updated and provide assurance of effective management Review the CRR to see if the high risks have been brought up to date. If so. move to monthly reporting	Risk owners & Managers CU	2 weeks 1 May 2019
18/19/143	**3.2**	**BAF Deep Dive Report**	Melissa Swindell (MS) presented on her risks within the Board Assurance Framework (BAF).			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			MS advised that she has focused on the 3 strategic risks relating to Sustainability, Engagement & Diversity. MS looked at the controls and mitigation in terms of • What are we doing about the risk? • Assurance & Evidence - how are we assured what is making an impact? • Gaps in Controls – action to achieve the target risk? **BAF risk 2.1 Sustainability of Workforce**. This risk is in relation to being unable to deliver the service due to not having the right staff in place and/or at the right time. The Trust is assuring itself that the risk is mitigated by monitoring compliance with a range of Key Performance Indicators (KPI's). MS advised when she risk assessed this strategic risk there were some gaps in controls which had no actions in place. In addition, Junior Doctors Experience was not included. There were a lot of controls for this risk and the impact was on positive engagement by staff within the Trust. CU advised from discussion that the Junior Doctors Experience will need to be included as a specific risk. **BAF risk 2.2 Engagement**. This risk is in relation to failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims. A specific area within this strategic risk is the Temperature Check which is showing as red. This will change once the staff survey starts in Quarter 3 April 19. This also has controls and mitigations in place. The Quarterly engagement check is reported to Trust Board **BAF risk 2.3 Diversity**. This risk is in relation to failure to proactively develop a future workforce that reflects the diversity of the local population and provides equal opportunities for career development and growth for existing staff. A specific area within this risk is the Apprenticeships which are showing as red, where there are gaps in controls. MS advised this risk needs updating to include Apprenticeships in the gaps in controls.	Junior doctors experience risk to be included on the BAF Risk needs updating to reflect Apprenticeship	MS MS	1 week 1 week

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			KB asked the question are these long-term risks and are you comfortable the controls and actions will achieve the outcome i.e. mitigate the risk? MS advised some of the areas are not progressing due to capacity. ES advised we have tried many different ways however we have found that the strategic risks progress slowly due to their nature. ES suggested a Master Class in BAF training on the Ulysses system for the Execs as a refresher of prior training. More understanding and consistency on how the Execs use the system is required. KB advised the BAF risks should change over time. J Gwilliams (JG) is a super-user on the Ulysses system and she would be the best person to provide training to the Execs. KB advised it's a helpful exercise to look at the BAF and for another deep dive to be presented at the next IGC Meeting May 2019. **Resolved** that: the Committee NOTED the contents of the paper	Exec training on BAF Master class on using Ulysses	JG	Immediate
18/19/144	**3.3**	**CQC Action Plan**	Erica Saunders (ES) presented the CQC Action Plan. Risks from the report were highlighted as follows: ES advised the Trust is monitoring the action plan through the Board sub committees and the Division's Integrated Governance committees. The CQC Action Plan submitted to IGC is the full up to date plans. The BRAG rating is showing that most actions are completed with small number of areas showing as in progress and on track to complete by target date. The services are embedding all the evidence in the action plan to show assurance. The triumvirates in each division are aware of the evidence to assure and sign-off and approve when a deadline submission needs to be moved. ES advised there has been fantastic work completed to date. The Trust now needs to think how we record action plans going forward. Some areas you are never going to achieve "completed" on the action plan as they will be ongoing e.g. Safeguarding & Vulnerable Adults. This is perpetually updated however is an on-going issue and as long as			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			the Trust is tracking the evidence we can accept these areas are completed. There are also some audits completed on this. This is reviewed at the IGC Community Meeting and there are no specific concerns. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/145	**3.4**	**Interim report on corroded Pipework (linked to risk 1388. Risk rating 16)**	There was no representative to present the interim report on corroded Pipework. KB advised after reading the report she felt there is nothing solid in place to resolve this issue. It was agreed for a separate meeting to be arranged as soon as possible to get an update on the report. LC to arrange as soon as possible. **Resolved** that: the Committee NOTED the contents of the paper	Corroded Pipework Meeting	LC	1 week
18/19/145 a		**Control of Contractors Report**	Melissa Swindell (MS) presented the Control of Contractors Report. MS advised in the report it is highlighted that we are having issues with the control of contractors in different areas on site. MS also advised that the MIAA are completing an audit on this. Some of the issues are the physical checks and Estates now have an additional member of staff to support this. KB asked what the Trust should be doing to mitigate this risk. The Trust need to understand which departments are bringing contractors on site and when. MS to report back with an update at the next IGC Meeting. **Resolved** that: the Committee NOTED the contents of the paper	Control of Contractors update at IGC May 19	MS	22nd May 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/145 b		**Fire Risk Institute in the Park**	Melissa Swindell (MS) presented the Fire Risk Institute in the Park. MS advised that she met with D Powell (DP) and J Spark (JS) on 5th March 2019 to discuss the Fire Risk Institute in the Park. JS does have a risk on the risk register (risk no 1746, score 12). There are two areas to this risk. Firstly, it is the evacuation of the building out of hours risk; secondly, it's an out of hours risk to staff with limited mobility or requiring wheelchair access. The Trust is clear what the actions are and this needs to be monitored correctly. Once we have a security person in post in the Institute this risk will close. MS will provide an update at the next IGC meeting. **Resolved** that: the Committee NOTED the contents of the paper	Fire Risk Institute in the Park	MS	22nd May 19
18/19/147		**EU Exit Action Plan**	Elaine Menarry (EM) presented the EU Exit Action Plan. EM advised the main reason for developing plans is if the UK exits the EU without a deal this will create the requirement for customs checks. This will have significant delays to the delivery of all goods to the UK. Lachlan Stark (LS) advised the No Deal EU Exit Business Continuity Plan updates and action cards have been completed for Medical Devices, Radiology, and Pathology. Whilst contingency arrangements have progressed, Human Resources, Theatres, IM&T, Medicine Division, Interim Estate, Research, Information Governance and Facilities need to confirm updates to their plans. This is being monitored via the EU Exit Assurance Group. For medicines and vaccines there is a deal in place with medicines however there is a contingency plan in place if there are any shortages. For clinical trials there are no issues with a 'no deal' situation and we have assurance of this. There are no high risks identified. All work to date for Information Governance shows there			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			are no gaps. At the last Exit meeting the team approached the divisions again to ensure all areas are delivered. Leads are to ensure they have action cards and contingency plans in place. LS advised if there is a no deal on Friday 12th April 19 the Trust were scheduled to commence with Exercise Black Start however due to the extensive planning taking place for No Deal EU Exit it has been advised by Health Education England to defer this exercise to a date in May 19. EM advised this risk is not on the risk register. KB advised for IGC we have assurance that the no deal risk is being monitored. LS advised we have followed the action cards from HE England and we have gone over and above with our preparation. It is very unlikely the UK will come out of the EU on Friday and we have done all we can do and we will continue to react. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/148-18/19/154	**3.6**	**Policies for Information**	Cathy Umbers (CU) provided an update on the Policies presented to the IGC Policy Sub Group Meeting: CU advised an IGC Policy Sub Group Meeting has been set up and the first meeting took place on 5th April 2019. There were 5 policies at the meeting that were ratified subject to changes. CU advised there is a second meeting scheduled on 26th April 2019 to ratify a further 9 policies that have already been approved at Information Governance Steering Group.			
	10.	**Any other business**				
Date and Time of Next Meeting			The next meeting of the IGC will be held on Wednesday 22nd May 2019, 1:00pm. Lecture Theatre 4, Institute			

INTEGRATED GOVERNANCE COMMITTEE
ACTION LIST – March 2019

No	Item	Owner	When	Status
18/19/83	Risk no 1746 - Fire risk within the Institute in the Park	J Hutfield/J Spark	~~15th Jan 19~~ ~~13th March 19~~ 22nd May 19	JH to address outside of IGC. Update 15.01.19 JH is addressing all risks and actions and John Spark (JS) will provide an update for the next IGC March 19. JG advised we need to be tighter on this area as there will be more Uni staff based in the Institute by the end of Jan 19 and asks for JS to get a report to KB before the next IGC in March 19. Update 13.03.19 AK submitted a Fire Risk in Institute Assurance Report. To be discussed at IGC 22nd May 19.
18/19/86	Risk no 799 – Failure to control contractors	M Swindell/A Kinsella	~~26th Nov 18~~ ~~15th Jan 19~~ ~~13th March 19~~ 22nd May 19	MS to pick up with AK when she returns from leave. Update 15.01.19 AK is meeting with Interserve and will report back to IGC. Each time a contractor has an unauthorised visit to the Trust it is now being report as an incident on Ulysses. AB asked should we have a zero tolerance of this written in the policy. KB has asked AK to provide details of breaches that are happening to understand how we take this forward. Update 13.03.19 AK submitted a Breaches of Control of Contractors Policy. To be discussed at IGC on 22nd May 19.
18/19/94	CQC Action Plan	All	~~15th Jan 19~~ ~~13th March 19~~ 22nd May 19	CQC action plan. When completion dates are being reviewed and revised staff are to provide a reason why they are being revised. Update 15.01.19 ES advised not all areas are adhering to this to date and asked for all areas to remain vigilant. ES asked for this to remain on the action list. (This will now be

No	Item	Owner	When	Status
				discussed at the follow up 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	~~Immediate~~ 22nd May 19	This is an agenda item for GDE Meeting. JG & AH to look at. Update 13.03.19 this will be discussed at next GDE Board. Can we keep open till next IGC on 22nd May 19.
18/19/102	Staff to monitor & update overdue risks & make arrangements for when designated person/s are unavailable to review.	All	On-going action	Designated person/s of risks. Ongoing
18/19/108	2 Fire risks outstanding which JS has reviewed	J Hutfield/J Spark	13th March 19 Immediate	JH to speak to JS and provide an update at the next IGC Meeting. Update 13.03.19 J Williams to speak to JS for an update and email to LC.
18/19//109	Risk no 1388 – Corroded Pipework.	G Dixon	22nd May 19	GD to provide an update to May 19 IGC Meeting once he knows further information.
18/19/109	Assurance reports for Risk no 1388 - Corroded Pipework, Risk No 1709 - Ceiling Tiles, Risk no 825 - Internal Balconies	G Dixon	~~13th March 19~~ 22nd May 19	GD to complete and submit to the next IGC Meeting. Update 13.03.19 1138 report submitted to IGC 13.03.19. 1709 risk score reduced. 825 risk score reduced. Completed. To be discussed at IGC 22nd May 19.
18/19/114a	Risk 1344 – Pharmacy and ASU cold store. All been agreed awaiting installation	A Kinsella/G Dixon	~~Immediate~~ 22nd May 19	AK to speak to GD asap to chase up to find out where this is up to. Update 13.03.19 still awaiting confirmation of installation. Update IGC 22nd May 19.
18/19/114a	Risk no 1787 current score 15 – Potential errors associated with prescribing, preparing and administration of parenteral nutrition	C Barker	~~13th March 19~~ 22nd May 19	CB to consider more radical changes needed to reduce the score of this risk considering risks & benefits and report back to IGC. Update 13.03.19 CB advised that staff are undertaking training and there is an update of bags. This will stay on until resolved.
18/19/119	CQC Plan – Risks and themes arising from plan	E Saunders	~~13th March 19~~ 22nd May 19	ES to identify risks and themes arising from CQC Plan. Update 13.03.19 a lot of work has been completed however still work to complete. To be discussed at IGC 22nd May

No	Item	Owner	When	Status
				19
	Set up a Policy Sub Group to review policies in detail before presentation to IGC, This meeting will require a senior representative from each division. This can be 8a or above.	All	1 week	Volunteers to email LC. 2 IGC Policy Sub Group Meetings have taken place to date. Completed.
18/19/122	Risk no 1815 risk rating 12: - Risk to patient safety from lack of pre-operative assessment. Outpatient leadership team have reviewed an available outpatient room and the division are actively chasing to have a sink installed to turn into a clinic room, which currently there is a 12 week wait.	G Dixon	1 week	GD to speak to Interserve re sink installation
18/19/122	Surgery Risk Management Report division to replicate format of Risk Management Reports in-line with other divisions.	A McColl	22nd May 19	AM to format the risk management report in line with other divisions
18/19/122	Risk 964 1306 – The process for planning and scheduling of elective lists is not sufficiently robust to prevent errors occurring. The Surgical Division are recruiting every 6 months and advertising regularly in attempt to ensure significant cover. Risk 1306 - Concerns around junior doctor shortages in Surgery. Vacancies within middle grade surgical rotas across the Surgical Division. If a vacant shift is uncovered this poses a risk to patient care and safety as the rota becomes non-compliant.	A McColl A McColl	All future IGC Meetings All future IGC Meetings	An update to be provided at all future IGC meetings An update to be provided at all future IGC meetings
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.	L Fearnehough/J Fitzpatrick	1 week	Risk 1831 LF to speak to JF outside of IGC

No	Item	Owner	When	Status
	Unsuccessful capture of data. LF advised this is an unsuccessful capture of data and is being worked 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 2019	AB to bring a paper to next IGC on Medical Records Strategy
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	1 week	Risk no 1593 VW/JK to speak to Medicine and Surgical COO's
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	1796 & 1797 Catering need to look at an improvement programme, risk assessment & a change management programme.
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/M Levine	22nd May 2019	Risk no 1832 to pick up with ML
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	J Grinnell	1 week	Risk no 1701 raise with the Exec Team

No	Item	Owner	When	Status
	them. JG advised he will raise this issue with the Exec team			
18/19/131	Risk – Internal Balconies. GD advised after several meetings with Project Co we now have a solution. The handrails are to be taken off and replaced with a metal bumper. The risk has been reviewed and the scoring represents this. CU informed GD to be clear the Corporate report is showing this risk score as a 10? GD to review this risk.	G Dixon	1 week	GD to review score of this risk
18/19/135	Risk 1753 – The Data Security & Protection Toolkit. JF advised training compliance is at 70% and the Trust needs to be on 95% compliance. MS advised she will collate a list of all outstanding staff to push this forward and Execs and Senior staff to escalate to the teams. JF advised she will send out another email prompt to staff	M Swindell J Fitzpatrick Execs & Senior Leads	1 week	MS to collate list of outstanding staff. Execs & Senior leads to escalate to teams JF to send out another email prompt
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	JG to update at next IGC Meeting
18/19/139	KB advised to Marketing & Communications that as they are a new Department delivering to the IGC meeting could they provide an outline of risks on their risk register at the next IGC Meeting	M Flannagan	22nd May 19	Provide an outline of risks in next IGC Report
18/19/140	KB advised to Innovation that as they are a new Department delivering to the IGC meeting	J Taylor	22nd May 19	Provide an outline of risks in next IGC Report

No	Item	Owner	When	Status
	could they provide an outline of risks on their risk register at the next IGC Meeting			

INTEGRATED GOVERNANCE COMMITTEE

ACTION LIST – April 2019

No	Item	Owner	When	Status
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	1st May 2019	Review the CRR to see if the high risks have been brought up to date. If so. move to monthly reporting
18/19/142	All high risks to be updated and provide assurance of effective management	Risk owners and managers	2 weeks	All high risks to be updated and provide assurance of effective management
18/19/143	Junior Doctors Experience include on the BAF	M Swindell	1 week	Risk to be included on the BAF risk register
18/19/143	BAF 2.3 Apprenticeships to be included in existing control measures and gaps in controls of. this risk	M Swindell	1 week	Apprenticeships to be included in BAF risk 2.3.
18/19/143	Exec training on BAF Masterclass on using Ulysses training for Execs	J Gwilliams	2 weeks	JG to train the Execs on how to complete the BAF on Ulysses
18/19/145	Corroded Pipework Meeting	L Calder	1 weeks	LC to arrange this meeting.
18/19//145a	Control of Contractors update	M Swindell	22nd May 19	MS to provide an update at next IGC in May 19.
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.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

2nd July 2019

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for May 2019
Background Papers:	
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	none
Link to: **Trust's Strategic Direction Strategic Objectives**	The Best People Doing their Best Work
Resource Impact:	None

1. Staff Engagement

Reward & Recognition

The current focus of the Reward and Recognition group is on arranging a large scale/high profile summer music event, bringing together staff and the local community on the Alder Hey and Springfield Park site. The group will engage with local schools and school choirs and will follow the similar style as the Fab week, collecting Pledges based on “Inspiring quality” incorporating views from staff on what motivates them and how we can support and enhance their wellbeing at work.

Staff Survey

Big Conversations continue to take place within divisions and departments to support staff in understanding their results and setting goals for the year ahead.

The Trust wide action plan discussed at Board was also discussed at the Staff Wellbeing Steering Group to identify key areas of focus related to Health and Wellbeing.

Temperature Checks

A revised Temperature Check questionnaire was launched for 2019/20 which focuses on two key areas; staff engagement and psychological safety.

The new questionnaire should provide us with useful insight into how Alder Hey staff are feeling as well as a useful prediction of how we are likely to perform within specific areas of the annual Staff Survey.

Improving Staff Wellbeing

The importance of staff health and wellbeing is widely recognised and as an employer we aim to champion physical, mental, emotional and financial wellbeing of everyone working in the organisation. The HR Team and Trust wellbeing group are developing the provision of tools, resources and support to ensure that staff health and wellbeing is a priority. Numerous initiatives have been adopted, to support the promotion and championing of health and wellbeing across the organisation. This includes committing to the Time to Change pledge and changing how we think and talk about mental health and empowering staff to challenge stigma and share their story. The Trust has developed a time to change action plan which has was approved by the Time to Change team in May 2019. In addition we are also working in conjunction with NHS Improvement and have developed a Health and Wellbeing

action plan which details the strategies, initiatives and milestones required to help improve health and wellbeing.

Brexit- EU Settlement Scheme

In April we held a breakfast session held to support staff with information and guidance in applying for the EU settlement scheme, this was supported by the HR department and executive support. The HR department continue to be contact with individuals through specific communications on-going with on a 1:1 basis with EU colleagues. The HRBP's are supporting the divisions in offering wrap round support to staff including signposting and guidance.

2. Workforce Sustainability and Capability

Agenda for Change New Pay Deal – Transition of Band 1 to band 2 staff

HR continue to work in partnership with staff side colleagues to ensure a smooth transition for those band 1 staff.

To date 117 out of 142 staff have transitioned from Band 1 to Band 2. In line with NHS Employers guidance, during PDR's and in 1:1 meetings, line managers will revisit the transition option with those who have not chosen to move across to a band 2.

A local Pay Progression Policy is currently being consulted with staff side colleagues. Ongoing communications will be circulated across the Trust, helping staff to understand the changes and how it affects them.

Education, Learning and Development

Apprenticeships-

Two new Tutors have joined the HR & OD Team, to deliver internal provision in the following apprenticeships; Healthcare Support Services Level 2, Team Leader Level 2 and Customer Service Level 2. Internal Delivery will commence in June 2019.

Ofsted Inspectors are due to visit the Trust for an unannounced monitoring visit.

Meetings have taken place with the Head of Nurse Education to discuss clear pathways for HCAs and are supporting a process to identify staff that need upskilling with English and maths and an Apprenticeship in Healthcare.

Mandatory Training-

In May 2019 a decision was taken to no longer report Core Mandatory Training and Overall Mandatory Training as separate figures in order to improve clarity of the mandatory training position. Instead the reported figure would be Overall Mandatory Training which would include all topics including Resuscitation.

The latest Mandatory Training report shows overall compliance is currently at 89.35% as of 21st of June 2019, up from 88.45% at the end of May.

The previous outlier – Information Governance has had an enhanced focus over the last few months and compliance for this topic continues to improve and is now at 81%.

The team will also continue to ensure that staff and managers are aware of outstanding requirements and providing communication directly to individual's outstanding mandatory training.

3. Employee Relations

Organisational Change

Portering

Following a meeting with trade unions, arrangements were made to meet with key affected individuals during early March 2019 with a view to progressing along the basis of the alternative proposals. Further discussions have now taken place with the portering team in May 2019 and management are clarifying a number of points to respond to the portering team and their representatives with a view of concluding negotiations during July 2019.

Palliative Care/Oncology Team

A consultation process has concluded resulting in the specialist nurse (Band 8a) roles no longer being required at that level and being replaced with a Clininal Manager role (Band 8a). Interviews have taken place for the 'ring-fenced' candidates which were unsuccessful and the vacancy will now be advertised further. Individuals at risk will be offered suitable alternative roles at Band 7.

Acute Care Pathway Team

Consultation commenced during June 2019, due to conclude on 27th June 2019, related to changes in shift patterns for nursing roles who undertake separate day and night shifts to operate on a 24/7 basis to ensure a more robust service.

Day Case Theatres

The Surgical Day Case (SDC) Surgical Admissions Lounge unit currently have separate staffing models and a format of working which have previously enabled the departments to provide continuity of care to patients and families whilst also meeting the flexible working requirements of the staff. As part of service development from November 2018 the department will be introducing a process of staggered admissions. Batched admissions will help the service to manage activity times and staffing requirements and also enable the service to provide a safe and high quality admission route for patients.

In order to support these changes the SDC and SAL services will need to review the current shift patterns across both teams. The current arrangements are not currently conducive to supporting a batched admission process and a dynamic nursing model is required that enables the service to provide safe, effective quality care and enhance patient experience.

Catering Department

A number of staff briefing sessions were conducted on 14th March 2019 to launch the proposed organisational change within the dept. The proposed changes affect the rotas of the Catering Assistants, Chefs and Supervisors. This is following recommendations made from an external catering review.

The 30 day formal consultation process has now passed, but an extension has been agreed with staffside. All group consultations and 1:1's have taken place. The Chefs have submitted 2 counter proposals regarding the rota and feedback has been given. The Final meeting with staffside is scheduled for 28th June 2019, with implementation proposed towards the end of July 2019.

Employee Relations Activity

The Trust's ER activity at end May is currently is detailed below:

Case description	No. of cases
Capability No UHR	**1**
411 Community	1
Disciplinary	**9**
411 Alder Hey in the Park	1
411 Community	3
411 Facilities	1
411 Medicine	3
411 Surgery	1
Grievance	**2**
411 Surgery	2
Harassment	**5**

411 Alder Hey in the Park	2
411 Nursing & Quality	1
411 Surgery	2
Grand Total	**17**

Employment Tribunal Cases

The Trust has received a notification of 2 ET cases.

4. Corporate Report

The HR KPIs in the May Corporate Report are:

- Sickness rates have a decreased slightly for the fourth month consecutively from 5.31% to 5.29%
- The Rolling 12 month sickness figure has increased to **5.72%** from 5.69% previous month**.**
- Overall Mandatory training compliance is at **88.45%** a downward trend from 90.03% but this was previously Core Mandatory Training, this figure has actually increased since last month.
- The second month in the PDR window shows compliance for end May at **21%**

Alder Hey Children's NHS
NHS Foundation Trust

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
3rd May 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)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
In Attendance:	Mrs P Brown	Director of Nursing	(PB)
	Ms A Chew	Associate FD – Operational Finance	(AC)
	Mr N Davies	HR Business Partner (Part attendance)	(ND)
	Mrs K Turner	Trust LiA Lead	(KT)
	Mrs H Ainsworth	Equality & Diversity Manager	(HA)
	Mr A Bateman	Chief Operating Officer	(AB)
	Ms Z Connor	HR Business Partner	(ZC)
	Mrs G Thomas	Apprenticeship Delivery Manager	(GT)
	Ms C Cain	HR Business Partner	(CC)
Apologies:	Mrs D Brannigan	Patient Governor (Parent & Carer)	(DB)
	Mr T Johnson	Staff Side Chair	(TJ)
	Mr A Bateman	Chief Operating Officer	(AB)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr A Hughes	Director of Medical Division	(AJ)
	Mr P OConnor	Deputy Director of Nursing	(POC)
	Ms L Cooper	Director of Children & Young People - CAMHS	(LC)
	Mrs S Owen	Deputy Director of HR&OD	(SO)
	Mrs N Murdock	Medical Director	(NM)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Ms R Greer	Associate COO, Community Division	(RG)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/31 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 1st March 2019 and they were approved as an accurate record. Introductions were made to the Committee.			
19/32	**Modern Slavery** The Director of HR&OD gave a brief verbal update to outline the developments to ensure we are meeting our obligations and that regulatory practices are embedded into all Trust processes on modern slavery requirements. The Director of Children & Young People – CAMHS has shared information around regulations and work has			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	commenced with the Director of Marketing & Communication and Team. CD advised of the requirement to report on our supply chain/procurement processes (e.g. suppliers of uniforms brought in from abroad) and children/safeguarding processes, along with a look at equality in the future by this Committee. PB advised that at the Senior Nurse Forum, child protection is 'stitched in' as part of safeguarding processes. MKS advised this overall piece of work will be progressed immediately. The Committee **noted** the progress made.			
19/33	**Annual Report** The Committee received the Annual Report for 2018-2019 prepared by Director of HR&OD and Non-Executive Chair of the Committee. The Committee noted the annual report will be presented to May's Trust Board. MKS outlined the achievements and the plan for the next 12 months. The Committee **approved** the annual report			
19/34 **Matters Arising, Actions**	**The Committee considered the following under matters arising:** No outstanding items were discussed.			
19/35 **Programme Assurance 'The Best People Doing Their Best Work'**	**Programme Assurance Framework – April 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 Director of HR&OD shared with the Committee that conversations have commenced at the weekly Executive Meeting to see how the change programme links into the 19/20 plan and advised that further meetings with Executives will bottom out the strategic direction. MKS acknowledged that some of the operational programmes (see under the dotted line of report) are still work in progress, but confirmed that by the next Committee we will be in a clearer position as to which projects are going to be initiated going forward. The Change Programme Manager gave a brief summary of the current dashboard. Closure of the 'Apprenticeship' project was agreed at Programme Board, all benefits have been met and milestones delivered. The 'Improving Portering Services' project requires a thorough review which should include charting the course of the project			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	through this year and to its eventual closure. The 'Catering' project displays a very good standard of governance and initial trends for benefits/metrics appear positive. The Committee agreed the Apprenticeship programme was run well and acknowledged the apprenticeship scheme will change the look of workforce going forward. To support the development of Apprenticeship's and the new type of workforce required in the future, the Chair requested a plan be put in place going forward, i.e. to develop processes for succession planning/diversity challenges/nurse practitioners/adult unemployment/entry level opportunities for volunteers/graduate apprenticeships. GT advised that the best people to sell apprenticeships at schools are the apprentices themselves. Alder Hey has been chosen as Employer/Apprentice Ambassadors for the Liverpool City Region, so the Trust is actively involved, this will be part of the next phase. The Committee discussed the change of focus/merits of the new Trust Board Assurance Proforma and recognised that it was clearer than the previous proforma used. The Committee accepted not everything can be covered in one document (i.e. Any risks should be recorded on the risk register). The Committee noted that the detail recorded for assurance purposes for Trust Board was sufficient. The Committee **noted** the comments made and **agreed** with the content of the Trust Board Assurance Proforma.	Produce a plan to develop how we move forward with apprenticeship/ workforce	MKS/GT	
19/36	**2019/20 Programme** MKS advised the Committee that the successes of the 'Supporting the Best People to do their Best Work' programme for 2018/19 will be shared with the Trust Board this month. MKS verbally outlined achievements/progress made under the 5 Strategic Objectives set 2018/19, highlights are: • LGBTQ1+ Network now established • Launched the Reciprocal Mentoring Programme for BAME and disabled staff • 63 learners enrolled on an apprenticeship • Alder Hey has been chosen as employer/Apprenticeship Ambassadors for the Liverpool City Region. • Implementation of the Wellbeing Strategy • Leadership apprenticeships very successful – 20 staff enrolled to date • Leadership Strategy ratified and rolling out; Strong Foundations Programme Developed and ready for launch. Additional achievements • Staff Survey 2018 – highest response rate at 60% (2000 staff)			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• Vocational Learning – following implementation of Vocational Placement Adviser role – numerous achievements • Recruitment – hosted 4 successful nursing recruitment events recruiting 115 nurses in total. • Learning & Development – significant increase in the use of e-learning of mandatory training and maintained 90% compliance; achieved 90% compliance for PDRs; Comprehensive training needs analysis undertaken • Library & Medical Education – Library Quality Assurance Framework 96% compliance; funding secured and development of a bespoke APP for junior doctors induction; introduction of junior doctors forum. • Workforce – Implemented Agenda for Change pay reforms; developed stronger partnerships with staff side in order to facilitate better partnership working; corporate division sickness reduced by 50% since November 2018; facilities down to 7%; significant reduction in long term sickness cases across Corporate areas. KT alluded to the established Network meetings and informed the Committee that attendance was sporadic due to conflicting work commitments of those on the network. KT sought the support/advice of senior management to elevate/promote the importance of these established networks to see improved attendance. CD suggested that a clear action plan should be established for the Trust Board outlining the purpose/milestones with narrative of what the different Networks support. The Committee acknowledged that improved technology (i.e. joining meetings remotely) may be an option in the future to support attendance. HA confirmed that each Network has a designated administrator and an action plan in place, this helps to focus the group. The Committee **noted** the progress made and the Chair commended the achievements made.			
19/37 Progress against the People Strategy	**Key Themes People Strategy** The Committee received a presentation delivered by the Director of HR&OD outlining the Strategic Themes for 2019-2024. The purpose of the presentation is to outline the following themes, put in place to support the 'best people doing their best work programme', this will open up conversations to develop improved processes to support the Trust: • Leadership & Talent Management • Health & Wellbeing • Future Shape of the Workforce ○ Internally Focused			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	○ Externally Focussed/Partnerships • Equality, Diversity and Inclusion • Culture and Engagement Enabling: • Workforce systems i.e. e-rostering CD advised that processes to support agile working requires more input. The Committee noted that the Chief Digital Information Officer for IM&T will be sharing with Trust Board a digital strategy in June 2019. Procedures/developments to support agile working/digital desk/people systems will be progressed as part of this piece of work. The Committee **noted** the content of the presentation.			
19/38	**Staff Survey Update (verbal)** The Committee received a brief verbal update delivered by the Director of HR&OD. MKS advised that the results of the 2018 Staff Survey have been issued by the HR Business Partners to the Divisions for progression of conversations with the teams. The Committee **noted** the progress made.			
19/39	**Nurse Workforce Report & Presentation** The Committee received a report and presentation prepared by the Chief Nurse. PB advised that the report and presentation is due to be presented at CQAC on 15th May 2019, followed by Trust Board 2nd July 2019. The report provides the required assurance that the Trust has safe nurse staffing levels and appropriate systems in place to manage the demand across all in-patient and day case wards, along with informing the Committee of the proposed workforce improvement s in 2019/2020. The report is noted as read. See the following highlights: The presentation informed the Committee on the safer staffing levels with the national requirement set 90% - the Trust is consistently higher at 92% with no compromise to patient safety. PB reflected on the annual audit compliance against 16 RCN core standards, repeated on March 2019, with the Trust showing year on year improvements against core standards since the first audit was undertaken in 2014. As outlined in the report/presentation in the last financial year 92.6 WTE B5 nurses were recruited as a result of local and national campaigns. In addition, the Trust has successfully externally recruited to key senior nursing leadership posts. In relation to			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	retention of front line nursing staff, the Trust saw a decrease in the average leaver rate in 2018/19 from 6.5 WTE to 5.7 WTE per month compared to 2017/18. In 2018, a review of the process for newly qualified nurses who join the Trust was undertaken in collaboration with the universities and student nurses which resulted in the development of the Staff Nurse Rotation Program: a standardised approach to staff working and gaining experience in different areas of the Trust, developing their knowledge and skills, and helping to retain our nursing workforce. PB advised that it is planned to roll out the nurse rotation program to all nurses. Temporary staffing: NHSP and agency – there is a continued drive to reduce the use of bank and agency staff, which in addition to reducing expenditure, also provides safer nursing care with staff employed directly by the Trust. Wards and departments continue to use NHSP predominantly to fill staffing gaps such as short term sickness. In 2018, the senior nursing leadership team undertook a piece of work to better predict the requirement for temporary staffing based on recruited staff, average leaver rate and the opening of additional winter beds. The use of front-line nurse agency staff has been zero in 2018/19, with the only agency nurse usage required to support the specialist CAMHS team. The Committee noted that Alder Hey has the lowest use of agency staff in England. Going forward, PB outlined the proposed workforce development s for 2019/20 to 2021/22, with particular attention to the following: • “Proud to Care’ programme to be devised which will underpin the Trusts objectives. • Nurse Associate & Pharmacy Technicians: The long term plan is to train and recruit an appropriate number of Nurse Associates/PharmacyTechnicians to support each shift on each ward. PB alluded to a national piece of work taking place, this will be progressed with Cheshire & Merseyside region. CD initiated a discussion about the national headlines relating to low salaries and how this may impact on our nursing staff. KT advised that from a financial perspective a number of nursing staff do struggle. PB advised that the wellbeing of nurses is a big area of focus at the Trust, particularly in relation to high sickness. Retirement has seen good succession planning put in place this year. KT advised that Staff Side would be keen to work in partnership in any processes relating to retention and the Proud to Care Programme, PB welcomed this input form			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Staff Side colleagues. The Committee acknowledged that good staffing levels and educational development of nursing staff is central to support achievements required. The Chair recognised achievements made. The Committee **noted** the content of the report and presentation.			
19/40	**Marketing & Communications Activity Report** The Committee received the Marketing & Communications Activity report prepared by the Director of Marketing & Communications. MF advised that this report has previously been presented to RABD in March. It was agreed to circulate the April version to the Committee. The Committee **noted** the progress made.			
19/41	**EDS2 Summary Report 2018/19** The Committee received an annual report prepared by the Equality & Diversity Manager. HA advised that once the grading has been approved, the summary report will be published on the Trust website and shared with Commissionaires to comply with our public sector equality duty. The report is noted as read. HA advised that the goals relevant to Workforce are Goal 3 'A Representative and Supported Workforce' and Goal 4 'Inclusive Leadership'. In-depth discussion commenced with particular attention brought to 'outcome' of Goal 3.1 'Fair NHS recruitment and selection processes lead to a more representative workforce at all levels'. The Committee noted that this year's panel graded outcome of Goal 3.1 as 'developing' as opposed to 'achieving'. The Committee debated the reasons behind this decision and it was acknowledged that a lot of advances had been made with this goal. The Committee **approved** the report.			
19/42	**Workforce Equality Diversity & Inclusion (EDI) Annual Report 2019** The Committee received a report prepared by the Equality & Diversity Manager. The report outlines progress in 2018/19; key priorities for 2019 and references a number of reports charting specific equality duties that are required to be published. The report is noted as read. In-depth discussion commenced, HA alluded to the priorities for 2019/20 (agree an assurance process for progressing Workforce Equality, Diversity and Inclusion – EDI – Objectives 2018-2021) and the proposed establishment of an operational committee to agree/drive objectives/milestones. CD acknowledged that positive action is required to support change.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	The Committee **approved** the annual report.			
19/43	**Apprenticeship Closure Report/Presentation** The Committee received a presentation prepared by the Apprenticeship Manager. The purpose of the report is to update the Committee on the key deliverables/achievements; lessons learned and report on outstanding tasks and next steps. GT confirmed that following agreement by Programme Board to close the Apprenticeship project (the project achieved green rating across the board for 8 months), a sustainability and review will be held every 4 months to ensure the benefits are sustained and the momentum continues. The report is noted as read. The Committee noted the content of the report.			
19/44 **Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks**	**Board Assurance Framework – Deep Dive (March/April 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. The Deep Dive outlines what steps are in place to support the risk. The Committee noted the content of the report.			
19/45	**Key Workforce Risks KPIs – March 2019** The Committee received a regular report prepared by the Deputy Director of HR concerning the key risks relating to workforce monitoring for March 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: ZC advised that overall sickness reports a slight drop, with absences relating to Stress being 33% of all absences in March. MKS advised the HR team are doing great work with the Divisions; we will stretch/review the Trust target this year to 4%. PDR's have reached the target of 90% completions. Currently reviewing the process in line with the changes to the pay deal and how we will need to adjust the PDR process to meet the needs of the agreed deal. The Committee **noted** the content of the report.			
19/46 Sub Committee Minutes	The Committee received the minutes for the following for information. • JCNC – 29.01.2019 • LNC – 19.12.2018 The Committee **noted** the content of the minutes.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/47 Legislation, terms & conditions, employment policie4s/EIAs – review & ratification/approval.	The Committee noted that no policies were received for ratification.			
19/48 AOB	The Director of HR & OD advised that Jo Potier will become a member of this Committee following her appointment to Associate Director of Organisational Development/Consultant Clinical Psychologist.			
Date of Next Meeting	**Wednesday 26th June 2019, 2pm, Room 5, Mezzanine**			

Action List

Minute Reference	Action	Who	When	Status
Meeting Protocol				
	Review of Reporting Timetable for 2019-2020 & Annual Report			
19/17	• Issue the Annual Report virtually to the Committee for sign off • Present a regular Marketing & Communications Activity Report to the Committee	MKS MF	March April	Complete Complete
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.	JG MKS		Ongoing Ongoing
19/35	Apprenticeships – Produce a plan to develop how we move forward with apprenticeship/workforce	MKS/GT	August 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	RG/AMc	ASAP	
	Wellbeing			
18/49	NHSI Health & Wellbeing Improvement Programme Update • Pick up with Sarah Smith sickness data availability for CommCell	MKS	ASAP	

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board

July 2019

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Deputy Director of Human Resources & Organisational Development
Subject/Title:	Learning Lessons to Improve our People Practices
Background Papers:	Baroness Harding letter to Trust Chief Executives and Chairs. NHSI Advisory group recommendations related to case of Amin Abdullah
Purpose of Paper	To present to the Trust Board a self-assessment of the Trust's disciplinary policy and practices, and to provide assurance that the Trust are working to best practice guidance and NHSI recommendations.
Action/Decision Required:	To review and support the approach outlined in the proposed action plan.
Link to: **Trust's Strategic Direction Strategic Objectives**	The Best People Doing their Best Work
Resource Impact:	Not yet known

Learning Lessons to Improve our People Practices

1. Introduction

As outlined in the letter from Baroness Dido Harding, Chair of NHS Improvement, in May 2019 (Appendix 1) addressed to all trust chairs and chief executives, NHS organisations have been asked to review the guidance and recommendations issued (Appendix 2), and assess the Trust's current investigatory and disciplinary procedures and processes in comparison and, importantly, make adjustments where required to bring the Trust in line with this best practice guidance.

In addition to this, Baroness Harding also set out a requirement for all Trusts to review a set of key questions for any cases currently being considered, and for all future cases.

2. Purpose of the report

The purpose of this report is to:

- provide the Trust Board with a comprehensive response to the guidance, and recommendations that are pertinent to the organisation, (some recommendations are national and therefore for healthcare regulatory bodies such as the GMC and NMC to consider).
- Provide assurance to the Board that an in-depth self-assessment has been undertaken against the recommendations, and that actions have been developed which enable to the Trust to fully adhere to the best practice guidance.

3. Recommendations

The Board are asked to review and approve the report and associated action plan, subject to any changes which may occur as a result of the Board discussion.

4. The process

The outcome of the independent investigation conducted by Veritas into the management of the disciplinary process resulting in the dismissal of Mr Amin Abdullah at Imperial College Healthcare NHS Trust was published in August 2018, alongside a small number of actions that Imperial had subsequently implemented.

The Trust were made aware of this review in late 2018 and in response, the senior HR management team undertook an initial review of the Trust's policies and practices in January 2019. A number of actions were put in place as a result, which included bi-monthly debrief meetings with staff side to review all cases and to embed a 'lessons learned' approach.

Further to the publication of the recommendations from the Advisory group in May 2019 the Trust disciplinary and investigation processes have been subject to a more thorough and robust review.

The Senior Operational HR team, led by the Deputy Director of HR & OD, have undertaken a review against each recommendation and compared these to current policy and practice in relation to the investigation and disciplinary procedures. This review has identified any adjustments and actions needed to ensure our practices and policies are in line with best practice guidance

Current and ongoing disciplinary cases (of which there are nine) have also been assessed against the key questions within Baroness Harding's letter.

5. Current Position

Having undertaken a comprehensive assessment of our current policy and practice against the guidance, it was evident that the Trust's existing policies and practices are already underpinned by the ACAS code of conduct on disciplinary and grievance procedures, and these have been developed and agreed in partnership with Trade Union colleagues. The team did not find any significant issues or gaps in current policy or practice, however did identify, when reviewed against the recommendations, areas of practice where the Trust could make further improvements, and these are detailed in the action plan.

6. Next Steps

A comprehensive action plan against all of the recommendations has been developed, highlighting any adjustments that will be needed to ensure best practice is followed.

The key areas of focus that have been identified include:

- Review of these recommendations with staff side colleagues at the next bi-monthly case debrief
- Further training on investigations for all those involved in disciplinary procedures and investigations.
- Enhanced training for all HR staff involved in disciplinary and investigation processes
- An earlier review of the Trust's Disciplinary Policy with staff side colleagues
- Timeliness of investigations - ensuring cases are not unnecessarily protracted and that investigations are given priority
- Investigators to be committed to timely investigations and report submission
- An Executive Lead to be assigned to all cases
- More rigour applied to suspension decisions
- Quarterly detailed report to be submitted to Trust Board

Sharon Owen, Deputy Director of HR & OD, June 2019

Title: Learning Lessons to Improve our People Practices			Date: June 2019
Recommendations by the NHSI Advisory Group	**Alder Hey self-assessment against NHSI recommendations**	**Actions Required**	**Responsibility/ Owners/deadline**
#1 Recommendation –NHS trusts should improve their processes and decision-making in respect of investigations and disciplinary hearings, as follows:			
1(a) Adhering to best practice guidance **i. The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice guidance, principally the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).**	The Trust's current disciplinary policy and process (including that of the MHPS policy for medical staff) has been informed and underpinned by ACAS code of practice on disciplinary and grievance procedures. The MHPS policy follows the GMC's principles of a good investigation. Each of the respective policies has been consulted on with union colleagues at both JCNC and LNC.	The ACAS code clearly underpins the current policy, however an earlier than required review of the disciplinary policy will take place and be consulted on at Policy Review Group (PRG) with staffside colleagues. To be reviewed again when the NMC guidance becomes available.	Sharon Owen, Deputy HRD to discuss at Policy Review Group (PRG) with staff side colleagues **July 2019 PRG**
ii. Employers should take every measure to ensure complete independence and objectivity is maintained at each stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are recognised and appropriately mitigated (this may require the sourcing of independent external advice and expertise).	Policy and practice is clear in respect of conflict of interest. Should any conflict be identified this has always been mitigated. This has included the use of investigators external to the organisation, if needed to reduce conflict of interest.	For complete transparency a Conflict of Interest declaration will be required from all involved in the process. There are elements of the policy and toolkit that could be made clearer specifically in relation to the training of investigators.	HR Business Partners to complete – **July 2019** Melissa Swindell HRD & Sharon Owen, Deputy HRD to review provision of Trust investigation Training for all managers and HR both external and internally **July 2019**

1(b) Applying a rigorous decision-making methodology **Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, employers should apply a decision-making methodology that provides for full and careful consideration of context and prevailing factors when determining next steps (a recommended or prescribed decision-making methodology could be included within the common management framework proposed below).**	Alder Hey Policy and practice follows the principles that all disciplinary issues should be handled in a fair and consistent way in line with the ACAS Disciplinary and Grievance code of practice. HR Business Partners will challenge any proposed formal action if it is possible to address issues of conduct in an alternative way. For patient safety related incidents the Incident Decision Tree (IDT) developed by the National Patient Safety Agency (NPSA) has been used to ensure our staff involved in such incidents are treated fairly. Nationally this has recently been replaced by the NHSI Just Culture guide and needs to be incorporate into our Trust Policy. A clearer decision making methodology should also be considered for incidents that are not patient safety related. Using the principles of the MHPS policy will assist with this.	Using the principles of the MHPS policy in the disciplinary policy will make more transparent and robust the decision making applied. Our Trust disciplinary policy will incorporate the NHSI Just Culture guide.	PRG group – **July/August 2019** HR Business partners – **August 2019**
1(c) Implementing a common management framework **The procedures established by 'Maintaining High Professional Standards in the Modern NHS (a framework for the initial handling of concerns about doctors and dentists)' should inform the development and implementation of a common management framework for handling concerns**	As above the proposal is to take the main principles from the current Trust MHPS policy to inform the disciplinary policy	see above (1b)	See above (1b)

relating to all NHS Staff, regardless of profession, role or the type of NHS organisation they work for. Once implemented, CQC should consider including the application of the common management framework by employers, together with scrutiny of the quality and outcomes of local investigation and disciplinary procedures, within the 'Well-led' assessment domain.			
#2 Recommendation – people are fully supported and resources appropriately committed to ensure the professional conduct of investigation and disciplinary processes, as follows:			
2(a) Ensuring people are appropriately trained and competent **Employers should only appoint individuals as case managers, case investigators and panel members who have received up to date comprehensive training and who, through such training, are able to demonstrate the aptitude and competencies (in areas such as objective critical thinking and assessment of information, awareness of relevant aspects of employment law and best practice, and appreciation of race and cultural factors) required to undertake these roles.**	Training is provided for investigators and/or continual HR support is provided to all those involved in the process. The pool of trained investigators needs to be reviewed and increased. Those who have had previous training will require refresher training. However there is interim assurance that HR support, coaching and advice is provided throughout.	As above (1a) There will be a comprehensive programme of training and education as part of the disciplinary review.	Melissa Swindell HRD & Sharon Owen, Deputy HRD to review provision of Trust investigation Training **July 2019**
2(b) Allocating sufficient time and resources **Before commencing investigation procedures, organisations should ensure that appointed case managers, case investigators and other individuals charged with specific responsibilities are allocated sufficient time and resources that**	Whilst this is clearly articulated in Trust policy the practice often does not comply with policy in this respect. Timely investigations are key and require prioritisation. It is imperative that the protraction of any case is not resultant of	Cover letter from HRD to be issued at the outset of all investigations to those involved in the process. The purpose of this is twofold; to give senior oversight on the case and also to clarify roles and	HR Business Partner to draft letters – **July 2019**

will fully support the timely completion of investigation and disciplinary processes Within the overall context of 'resourcing', full consideration should also be given to the extent to which individuals involved in these processes (especially panels) are truly independent.	case investigators capacity. Investigators to receive full line management support to prioritise investigations.	responsibilities of all involved. Ensuring those who have signed up are committed to completing in a timely way. Commissioning manager to oversee and monitor progress on investigation weekly. Progress report of all cases, to be reported quarterly to the private business session of the Trust Board including any suspensions, rationale, duration of investigation and compliance against our own policy. Nominated Executive lead to have oversight on assigned cases. (To be excluded on any possible appeals).	Melissa Swindell HRD, **– October 2019** **Melissa Swindell,** HRD to agree with Executives with immediate effect**.**
2(c) Following a rigorous process in deciding to apply suspensions **Employers should ensure that a decision to suspend an individual is not taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Where such action is required as a response to immediate safety or security issues, senior level opinion should be secured at the earliest opportunity following the decision. Any decision to suspend should be a measure of last resort that is proportionate, time bound and only taken when there is full justification for doing so. The continued suspension of any individual should be subject to appropriate senior-level oversight.**	No one is suspended without HR advice and involvement. The decision to suspend is never taken lightly, which is reflected in low number of suspension at any one time. We always explore all alternatives to suspension as we are cognisant of the impact this can have on our staff. However there is not currently a decision tool to help managers arrive at an informed and transparent decision to suspend.	Introduction of a suspension check list to share with senior managers in helping make an informed decision if suspension is appropriate. Any proposal to suspend a member of staff must be agreed with the HRD and another independent member of the Executive team.	HRBP's to produce a suspension checklist consulting with staff side as part of policy review **– July 2019** HR Dept to initiate notifications to HRD with immediate effect **June 2019**

2(d) Protecting the health and wellbeing of staff involved in disciplinary processes **Concern for the health and welfare of individuals involved in investigation and disciplinary procedures should be paramount and continually assessed, and appropriate professional occupational health assessments and interventions (together with signposting to Employee Assistance Programmes, where available) are provided to any member of staff who either requests or is identified as requiring such support.**	The health and wellbeing of staff is high priority in our case management processes as we know that employees who are subject to such processes can find this a very difficult time. The Supporting Staff Policy is instigated at the initiation of any investigation process, which includes a mentor/support for the duration of the investigation. The Alder Centre offer staff counselling and Occupational Health services are offered throughout. Staff are also signposted to other support organisations as appropriate, which may include Mind, Mersey etc	As part of the consultation with staff side colleagues all additional support mechanisms will be considered – the Supporting Staff Policy may also require an earlier than planned update to ensure this is clearly captured and all means of support signposted. Jo Potier, Consultant Clinical Psychologist (CCP) commences in her post of CCP/Associate Director of OD on 1st August 2019, and we will seek her professional input to ensure we have explored and considered all means of support. Emphasis on meeting with the staff member or verbally where appropriate – followed up in writing by commissioning manager.	Sharon Owen, Deputy HRD, to lead at PRG a review of the supporting staff policy **August 2019** **Jo Potier** to professionally advise on maximising staff support **August 2019**
ii. A communication plan should be established with individuals who are the subject of an investigation or disciplinary procedure and this plan should form part of the associated terms of reference. The underlying principle should be that all communication, in whatever form, is timely; comprehensive and unambiguous; sensitive; and compassionate. Wherever possible,	A template letter in the policy toolkit is completed at the outset and issued to the staff member subject to investigation, which stipulates the process, methods and frequency of communication. If suspension has been deemed necessary communication of this is ordinarily all undertaken in person and followed up in writing. However	Modify letters as part of the policy review to include a clear communication plan to be agreed and appended.	HRBP's to set up a task and finish group with reviews all letters and templates associated with the disciplinary policy. This will be consulted on as part of PRG. **July/Aug 2019**

contact with individuals should be undertaken in person, or otherwise verbally, and supported in writing.	communication following this is usually in written form only. We recognise the need to improve ongoing face to face communications with staff members who are subject to investigation.		HRBP's to liaise with commissioning managers with immediate effect to encourage communication in person if appropriate.
iii. Where a member of staff who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, the board should take prompt action to address the identified harm and its causes.		Recommendation noted and endorsed by the Board.	
iv. In cases where legal proceedings conclude that an individual has been wrongfully treated as a consequence of a poorly or inappropriately applied investigation and/or disciplinary process, NHS England and NHS Improvement should obtain assurance that the employer has taken/is taking appropriate measures to: understand how the situation arose; mitigate the same mistakes being replicated; hold responsible persons to account for any wrongful actions; and provide support to the wronged individual. In this latter respect, consideration should be given to extending participation in the whistle blowers' support scheme to include such individuals.		Recommendation noted and endorsed by the Board.	

#3 Recommendation – investigation and disciplinary processes should be open to improved scrutiny through sharing of appropriate information and proactive reporting of progress, as follows:			
Board Level Oversight **i. Employers should establish mechanisms by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Data collation and reporting should include: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions; decision-making relating to outcomes; impact on patient care and staff; and lessons learnt, all of which the CQC should consider including in its assessment of the 'Well-led' domain.**	Existing monthly People Strategy board report which contains high level information in relation to the number of cases currently being managed, including those at Employment Tribunal.	Establish quarterly report to private business session of the Board meeting to include the suggested areas of inclusion.	Melissa Swindell, HRD, **October 2019**

APPENDIX 1

Chief Executive and Chair's Office
Wellington House
133-155 Waterloo Road
London SE1 8UG

Tel: 020 3747 0000

To:
NHS trusts and NHS foundation trusts chairs and chief executives

23 May 2019

Dear colleagues

Learning lessons to improve our people practices

I am writing to share with you the outcomes of an important piece of work recently undertaken in response to a very tragic event that occurred at a London NHS trust three years ago.

In late 2015, Amin Abdullah was the subject of an investigation and disciplinary procedure. The protracted procedure culminated in Amin's summary dismissal on the grounds of gross misconduct. Tragically, in February 2016 just prior to an arranged appeal hearing, Amin took his own life. This triggered the commissioning of an independent inquiry undertaken by Verita Consulting, the findings of which were reported to the board of the employing Trust and to NHS Improvement in August 2018. The report concluded that, in addition to serious procedural errors having been made, throughout the investigation and disciplinary process Amin was treated very poorly, to the extent that his mental health was severely impacted. Verita's recommendations were accepted by the Trust, in full, and have largely been implemented.

Subsequently, NHS Improvement established a 'task and finish' Advisory Group to consider to what extent the failings identified in Amin's case are either unique to this Trust or more widespread across the NHS, and what learning can be applied. Comprising of multi-professional stakeholders and subject matter experts representing both the NHS and external bodies, together with an advocate for Amin's partner, the Group conducted an independent analysis of both the Verita findings and several historical disciplinary cases, the outcomes of which had attracted criticism in Employment Tribunal proceedings and judgements. HR directors of provider organisations were advised of the Group's activity and invited to share details of any local experiences and/or examples of measures being taken to improve the management of employment issues.

The analysis highlighted several key themes associated with the Verita inquiry which were also common to other historical cases considered. Principal among these were: poor framing of concerns and allegations; inconsistency in the fair and effective

application of local policies and procedures; lack of adherence to best practice guidance; variation in the quality of investigations; shortcomings in the management of conflicts of interest; insufficient consideration and support of the health and wellbeing of individuals; and an over-reliance on the immediate application of formal procedures, rather than consideration of alternative responses to concerns.

The NHS England and NHS Improvement People Committees in Common received a detailed report on the outcomes of the Advisory Group's activities, which included recommendations that aim to ensure the captured learning is used to best effect in informing positive changes across the NHS. The Committees recognised that, sadly, Amin's experiences are far from unique and acknowledged there needs to be greater consistency in the demonstration of an inclusive, compassionate and person-centred approach, underpinned by an overriding concern to safeguard people's health and wellbeing, whatever the circumstances. This view certainly echoed many of the comments we have received from across the NHS during our recent People Plan engagement.

Some of the proposed recommendations will require further discussion with key stakeholders, including regulatory and professional bodies (in particular, I am keen that consideration and assessment of the 'health' of organisational culture, including aspects relating to the management of workplace issues, is given more prominence in the 'well-led' assessment domain). The majority, though, can be immediately received and applied.

Enclosed with this letter is additional guidance relating to the management and oversight of local investigation and disciplinary procedures which has been prepared based on the Advisory Group's re-commendations. You will recognise the guidance as representing actions characteristic of responsible and caring employers and which reflect our NHS values. I would ask that you, your HR team and your Board review them and assess your current procedures and processes in comparison and, importantly, make adjustments where required to bring your organisation in line with this best practice. I would draw your attention to item 7 of the guidance and ask you to consider how your Board oversees investigations and disciplinary procedures. Further, with respect to any cases currently being considered and all future cases, I would ask you to review the following questions (and, where necessary, take corrective action in response):

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?

- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?

- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is respected at all times and in all communications, and that your duty of care is not compromised in any way, at any stage.

- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

In highlighting these issues, which I know will be important to you and your teams, I would like to thank all those colleagues who directly contributed to and informed the work completed by the Advisory Group. I would particularly like to acknowledge the endeavours of Amin's partner Terry Skitmore and his advocate Narinder Kapur, without whose dedication and sacrifices the Amin Abdullah inquiry and subsequent development work by NHS Improvement would not have taken place.

I know that we are all keen to ensure we treat our people fairly and protect their wellbeing. Implementing the attached guidance consistently well across the NHS will contribute to that goal. It is tragic that we are learning these lessons after Amin's death, but we owe it to him and the others who have suffered in similar circumstances to act now.

Thank you for your attention to these vital issues.

Best wishes

Baroness Dido Harding
Chair, NHS Improvement

Enclosure:

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

Copies:

Chair, Care Quality Commission
Chair, NHS Providers
Chair, Nursing and Midwifery Council
Chief Executive, NHS Employers

Additional guidance relating to the management and oversight of local investigation and disciplinary procedures

1. Adhering to best practice

a) The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice, principally that which is detailed in the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

b) All measures should be taken to ensure that complete independence and objectivity is maintained at every stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are acknowledged and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

2. Applying a rigorous decision-making methodology

a) Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, a comprehensive and consistent decision-making methodology should be applied that provides for full and careful consideration of context and prevailing factors when determining next steps.

b) In all decision-making that relates to the application of sanctions, the principle of plurality should be adopted, such that important decisions which have potentially serious consequences are very well informed, reviewed from multiple perspectives, and never taken by one person alone.

3. Ensuring people are fully trained and competent to carry out their role

Individuals should not be appointed as case managers, case investigators or panel members unless they have received related up to date training and, through such training, are able to demonstrate the aptitude and competencies (in areas such as awareness of relevant aspects of best practice and principles of natural justice, and appreciation of race and cultural considerations) required to undertake these roles.

4. Assigning sufficient resources

Before commencing investigation and disciplinary procedures, appointed case managers, case investigators and other individuals charged with specific responsibilities should be provided with the resources that will fully support the timely and thorough completion of these procedures. Within the overall context of 'resourcing', the extent to which individuals charged with such responsibilities (especially members of disciplinary panels) are truly independent should also be considered.

5. Decisions relating to the implementation of suspensions/exclusions

Any decision to suspend/exclude an individual should not be taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Except where immediate safety or security issues prevail, any decision to suspend/exclude should be a measure of last resort that is proportionate, timebound and only applied when there is full justification for doing so. The continued suspension/exclusion of any individual should be subject to appropriate senior-level oversight and sanction.

6. Safeguarding people's health and wellbeing

a) Concern for the health and welfare of people involved in investigation and disciplinary procedures should be paramount and continually assessed. Appropriate professional occupational health assessments and intervention should be made available to any person who either requests or is identified as requiring such support.

b) A communication plan should be established with people who are the subject of an investigation or disciplinary procedure, with the plan forming part of the associated terms of reference. The underlying principle should be that all communication, in whatever form it takes, is timely; comprehensive; unambiguous; sensitive; and compassionate.

c) Where a person who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, prompt action should be taken in response to the identified harm and its causes.

7. Board-level oversight

Mechanisms should be established by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Associated data collation and reporting should include, for example: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions/exclusions; decision-making relating to outcomes; impact on patient care and employees; and lessons learnt.

APPENDIX 2

Advisory Group Recommendations

Recommendation 1

The Advisory Group recommends that NHS trusts should improve their processes and decision-making in respect of investigations and disciplinary hearings, as follows:

1(a) Adhering to best practice guidance

i. The development and application of local investigation and disciplinary procedures should be informed and underpinned by the provisions of current best practice guidance, principally the Acas 'code of practice on disciplinary and grievance procedures' and other non-statutory Acas guidance; the GMC's 'principles of a good investigation'; and the NMC's 'best practice guidance on local investigations' (when published).

ii. Employers should take every measure to ensure complete independence and objectivity is maintained at each stage of an investigation and disciplinary procedure, and that identified or perceived conflicts of interest are recognised and appropriately mitigated (this may require the sourcing of independent external advice and expertise).

1(b) Applying a rigorous decision-making methodology

Consistent with the application of 'just culture' principles, which recognise that it is not always appropriate or necessary to invoke formal management action in response to a concern or incident, employers should apply a decision-making methodology that provides for full and careful consideration of context and prevailing factors when determining next steps (a recommended or prescribed decision-making methodology could be included within the common management framework proposed below).

1(c) Implementing a common management framework

The procedures established by 'Maintaining High Professional Standards in the Modern NHS (a framework for the initial handling of concerns about doctors and dentists)' should inform the development and implementation of a common management framework for handling concerns relating to all NHS Staff, regardless of profession, role or the type of NHS organisation they work for. Once implemented, CQC should consider including the application of the common management framework by employers, together with scrutiny of the quality and outcomes of local investigation and disciplinary procedures, within the 'Well-led' assessment domain.

Recommendation 2

The Advisory Group recommends that people are fully supported and resources appropriately committed to ensure the professional conduct of investigation and disciplinary processes, as follows:

2(a) Ensuring people are appropriately trained and competent

Employers should only appoint individuals as case managers, case investigators and panel members who have received up to date comprehensive training and who, through such training, are able to demonstrate the aptitude and competencies (in areas such as objective critical thinking and assessment of information, awareness of relevant aspects of employment law and best practice, and appreciation of race and cultural factors) required to undertake these roles.

2(b) Allocating sufficient time and resources

Before commencing investigation procedures, organisations should ensure that appointed case managers, case investigators and other individuals charged with specific responsibilities are allocated sufficient time and resources that will fully support the timely completion of investigation and disciplinary processes Within the overall context of 'resourcing', full consideration should also be given to the extent to which individuals involved in these processes (especially panels) are truly independent.

2(c) Following a rigorous process in deciding to apply suspensions

Employers should ensure that a decision to suspend an individual is not taken by one person alone, or by anyone who has an identified or perceived conflict of interest. Where such action is required as a response to immediate safety or security issues, senior level opinion should be secured at the earliest opportunity following the decision. Any decision to suspend should be a measure of last resort that is proportionate, timebound and only taken when there is full justification for doing so. The continued suspension of any individual should be subject to appropriate senior-level oversight.

2(d) Protecting the health and wellbeing of staff involved in disciplinary processes

i. Concern for the health and welfare of individuals involved in investigation and disciplinary procedures should be paramount and continually assessed, and appropriate professional occupational health assessments and interventions (together with signposting to Employee Assistance Programmes, where available) are provided to any member of staff who either requests or is identified as requiring such support.

ii. A communication plan should be established with individuals who are the subject of an investigation or disciplinary procedure and this plan should form part of the associated terms of reference. The underlying principle should be that all communication, in whatever form, is timely; comprehensive and unambiguous;

sensitive; and compassionate. Wherever possible, contact with individuals should be undertaken in person, or otherwise verbally, and supported in writing.

iii. Where a member of staff who is the subject of an investigation or disciplinary procedure suffers any form of serious harm, whether physical or mental, this should be treated as a 'never event' which therefore is the subject of an immediate independent investigation commissioned and received by the board. Further, the board should take prompt action to address the identified harm and its causes.

iv. In cases where legal proceedings conclude that an individual has been wrongfully treated as a consequence of a poorly or inappropriately applied investigation and/or disciplinary process, NHS England and NHS Improvement should obtain assurance that the employer has taken/is taking appropriate measures to: understand how the situation arose; mitigate the same mistakes being replicated; hold responsible persons to account for any wrongful actions; and provide support to the wronged individual. In this latter respect, consideration should be given to extending participation in the whistleblowers' support scheme to include such individuals.

Recommendation 3

The Advisory Group recommends that investigation and disciplinary processes should be open to improved scrutiny through sharing of appropriate information and proactive reporting of progress, as follows:

3(a) Using latest research; sharing relevant information with other NHS organisations via appropriate communications routes; and collating and reporting data for board scrutiny

i. Culture-change and leadership development interventions associated with the NHS People Plan should be informed by contemporary research and insight relating to the impact of investigation and disciplinary procedures on the welfare of staff and the workplace environment (there is a requirement for further research and insight in this area, which could be commissioned from independent expert organisations such as the Health Foundation).

ii. Via the appropriate People Plan workstream(s), NHS England and NHS Improvement should capture and promulgate initiatives, interventions and improvements relating to the conduct of investigation and disciplinary procedures that either have been implemented, or are being progressed, at local employer level. In doing so, there should be an emphasis on highlighting practices which aim to resolve issues and concerns without recourse to formal procedures.

iii. Employers should establish mechanisms by which comprehensive data relating to investigation and disciplinary procedures is collated, recorded, and regularly and openly reported at board level. Data collation and reporting should include: numbers of procedures; reasons for those procedures; adherence to process; justification for any suspensions; decision-making relating to outcomes; impact on patient care and staff; and lessons learnt, all of which the CQC should consider including in its assessment of the 'Well-led' domain.

Recommendation 4

The Advisory Group recommends that guidance relating to investigation and disciplinary processes is up to date and fit for purpose, as follows:

4(a) Reviewing current guidance issued by regulatory bodies

Healthcare regulatory bodies should consider reviewing their respective guidance and standards issued to their registrants, which relate to the management and conduct of local investigations and disciplinary procedures, to ensure consistency and alignment.

Recommendation 5

Pending the acceptance and implementation of these recommendations, the Advisory Group recommends the following action is taken:

Interim guidance is developed in partnership with trades union bodies, through the Social Partnership Forum, that sets out NHS England's and NHS Improvement's expectations of employers regarding their conduct in applying and managing local investigation and disciplinary procedures. NHS England and NHS Improvement should further consider how they should provide oversight of adherence to the interim guidance.

BOARD OF DIRECTORS

Tuesday 2nd July 2019

Report of:	Director of Corporate Affairs FTSU Guardian/LiA Lead
Paper Prepared by:	FTSU Guardian
Subject/Title:	Freedom to Speak Up – Progress Update Report
Background Papers:	FTSU Board reports from September 2016 onwards
Purpose of Paper:	To provide the Board with a summary of progress to date to improve and enhance mechanisms for staff to raise concerns and describe the actions planned for the coming period
Action/Decision Required:	The Board is asked to note the progress made to date and to support the further actions outlined
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Best people doing their Best Work**
Resource Impact:	To be identified

BOARD OF DIRECTORS

FREEDOM TO SPEAK UP PROGRESS REPORT

1. Purpose

The purpose of this paper is to provide the Board with a summary of the work undertaken by the Trust since the advent of the national Freedom to Speak Up initiative, how this aligns with the existing mechanisms in place for staff to raise concerns and to outline the actions planned for the coming six to twelve month period.

2. Recommendation

The Board is asked to note the progress made to date, support the overall direction of travel and the specific initiatives proposed.

3. Key Areas of Work

3.1 Alignment of all speaking up arrangements

Currently there are a significant number of routes via which concerns can be raised by staff at Alder Hey, illustrated in the table below. However, there is insufficient assurance that these routes are properly aligned, which prevents a lack of clarity of 'what's really going on'. In March 2019 a Freedom to Speak up Summit was held to review the current routes and to discuss how these can be better aligned; the session was well attended, with representation from senior nurses, HR, PAL's, management, Risk and Governance and FTSU Champions. One of the actions from the summit was to create monthly meetings, the first to be held on July 10th 2019, with the same representation, the purpose of which is to discuss all concerns raised, ensure feedback has been given and that learning can be shared.

FTSU	Listening into Action	Incident reporting
Raise it, Change it	Staff support/debriefs	Human Resources
Staff Side Reps	Human Factors	Staff Survey-Annual/Quarterly
Staff Networks	Exit Interviews	Occupational Health

Further to this, a new FTSU reporting process has been developed using Ulysses as the platform. The benefits of this is increased governance around the reporting of concerns through the FTSU route, which will ensure that amongst other things, that there is timeliness in feedback to the reporter and learning is captured. The biggest area of focus in the development phase has been establishing that staff reporting using this route can feel confident that their concern is viewed only by the FTSU Guardian and Champions, ie on a 'closed' system. This has been achieved and will be a key message to staff prior to it going 'live'.

Following implementation of the new FTSU reporting process, the next phase will be to establish a similar model for the 'Raise it, Change it' process, which will triangulate incident reporting, FTSU concerns and 'Raise it, Change it' concerns by theme.

Staff surveys, both annually and quarterly, continue to be an invaluable source of information for the FTSU team and therefore we remain linked to the output of this data, to ensure that we are sighted on any potential 'hotspots' across the Trust and can address issues in a timely way, linked to our approach to engagement and our culture of openness. We are also working with our HR partners with regard to exit interviews, including internal movement, again to understand any potential areas of concern and to give valuable insight into the Trust's speaking up culture.

3.2 Update on cases raised with FTSU in the last Quarter

During the last quarter, a total of six cases were brought to the FTSU team by Trust staff, of which three related to bullying and harassment, one to a patient safety issue, one to a relationship breakdown and one to staff safety. Two cases have been closed and one is pending closure; of the remaining three, two are currently being investigated and one has asked for further time to decide on whether to proceed. A total of three individuals who have brought cases have chosen to be anonymous.

Of the two cases that have been closed during this quarter, both have expressed that they would use this route again to raise a concern and rated the service highly.

The Trust has been reporting its FTSU activity to the National Guardian's Office on a quarterly basis and has also completed the NGO 2018/19 data reconciliation; this data will be reviewed during the summer months and a report published by NGO in early September. This report will give clarity to the national cases being reported and will be insightful to organisations.

3.3 Participation in local and national networks

The Trust Guardian attended the National Guardian's Conference in March and attendance at the North West Regional FTSU continues. The Trust's FTSU Guardian will take up the position of Co-Chair for the region in October which will precede her appointment as network chair in March 2020.

Training for all new Champions, the NED Lead for FTSU and the Director of Corporate Affairs is to be scheduled during the summer period and it is hoped to arrange for this to be delivered internally; failure to secure this will result in their attendance at the NGO training day in London.

3.4 Freedom to Speak Up Champions

Currently we have eight FTSU Champions, including one newly appointed, with a further three pending. In terms of recruitment to this position we have asked staff to submit an Expression of Interest application, which is followed by an informal meeting with the FTSU Guardian. Whilst we are assured that we do have FTSU Champions from all Divisions, we are continuing to strive towards ensuring that are FTSU team represents our diverse community and have extended invites to all three staff networks within the Trust, we have also been invited to the Junior Doctors' Forum, as we are also actively seeking representation from this staff group.

We have established monthly FTSU meetings and Champions are also encouraged to attend both the NGO conference and NW Regional meetings. All Champions are encouraged to deliver the FTSU presentation at Trust induction and at team meetings.

3.5 Leadership Training

Freedom to Speak Up is included in the newly developed Strong Foundations programme, with guidance given to managers on how best to support staff that chose to use FTSU as a route to raising concerns and to understand the role of Freedom to Speak up within Alder Hey.

3.6 Communication Plan

Visibility of our FTSU team is a key factor in promoting the principles of the work that we undertake; it also allows for staff to raise concerns on an 'ad hoc' basis. We have purchased 'pull up' posters to promote the FTSU team's work and the Champions will also have a photographic display board (similar to our Board of Directors) which will be mounted in the Atrium.

Freedom to Speak up will be included in the Summer Festival scheduled for July and for Fab Staff week in October; there will also be a month long campaign during the month of October promoting a 'Speak Up Safely' culture which is in line with the National Guardian's Office recommendation

3.7 Responding to national case studies

There are currently six Case Reviews that have been undertaken by the NGO, the latest review only being received in June 2019. In light of this and as a recommendation from the NGO, we will be carrying out a gap analysis against the recommendations made in the report to ensure that all are implemented locally and where there are any gaps that a clear action plan is in place.

4. Issues for discussion/consideration by the Board

- Provision of ring-fenced time for the FTSU Champions – it is proposed that an assessment of the time required is undertaken with local champions to reflect on their respective activities. Consideration also needs to be given to how our champions are going to be supported in carrying out their duties under the FTSU banner, once an agreed 'time out' has been reached.

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5. Next Steps

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- Develop measures of success.
- Work with HR partners/Staff side on the replacement of the Bullying and Harassment Policy and the Grievance Policy with a Resolution Policy
- Review how we ensure that the FTSU team has psychological support
- How do we ensure that our students are aware of FTSU - possibly via presentation by Alder Hey's FTSU team at local 'feeder' universities.

Kerry Turner
Erica Saunders
June 2019

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 6 of the 7 themes of the change programme as reporting to the Board sub-Committees: CQAC 12 April, WOD 26 June and RABD 27 June .
2. Slide 2 of this programme assurance report contains the current scope for the19/20 change programme.
3. Of the 19 projects rated in this report with regards to the **overall delivery** assessment: 5% of the projects are green rated with 58% amber and 37% red. These percentage summary assessments again show improvement from the previous month. Executive Sponsors should support their project teams to attain greater confidence in delivery.
4. The **overall governance** position is satisfactory with 39% of the projects green rated, 56% amber and 5% red. Although the governance position is satisfactory and has again improved from the previous month, there is still room for improvement in some areas.

N Deakin, Head of Programme Management and Independent Programme Assurance 25 June 19

CIP Summary (to be completed by **Finance Department**)

CIP Position as at 4th June

Change Programme Pillar	Division	Community	Medicine	Surgical Care	Alder Hey in the Park	Facilities	Nursing & Quality	Finance	IM&T	Human Resources	Executive	Academy	R&D	Innovation	International	Total
	Division Target £'000	475	2,328	2,201	199	194	87	112	94	92	101	7	99	6	3	5,997
CIP delivery by change programmme pillar		£000's														
Deliver Outstanding Care		19	288	439	0	0	0	0	0	0	0	0	0	0	0	746
Growing Through External Partnerships		0	0	0	0	0	0	0	30	0	0	0	0	0	0	30
The Best People Doing Their Best Work		0	46	0	50	0	0	72	0	0	0	0	0	0	0	168
Game Changing Research and Innovation		0	0	0	0	0	0	0	15	0	0	0	0	0	0	15
Park, Community Estate & Facilities		0	0	0	57	0	0	0	0	0	0	0	0	0	0	57
Global Digital Exemplar (GDE)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Divisional Business		383	572	1,425	0	51	0	18	155	0	0	0	0	0	0	2,605
Total Forecast outturn		403	906	1,864	107	51	0	90	200	0	0	0	0	0	0	3,621

Change Programme 19/20

£ = High Impact Scheme

Trust Board

Programme Assurance Framework, DMO & Delivery Board

Alder Hey Children's NHS
NHS Foundation Trust

CQAC

Delivering Outstanding Care

Safety
Hilda Gwilliams
Sepsis
DETECT study

Brilliant Basics
Adam Bateman
Best in outpatient care
SAFER
Best in mental health care
Best in acute care

Inspiring Quality
Nicki Murdock

WOD

Best People doing their Best Work
Melissa Swindell
Hilda Gwilliams

Portering

Catering

E-Rostering (£)

AHPs 2023 & Beyond

Health and well being(£)

Temporary staffing (£)

Culture / place to work

Workforce for the future

R&BD

Sustainability through Partnerships
Dani Jones

Aseptics

Collaboration at scale (£)

Single neonatal service

NW Pediatric Partnerships(AH/Manc)

All age CHD network

Corporate Transformation (Collaboration at Scale) (£)

Green Alder Hey

RE&I

Game Changing Research and Innovation
John Grinnell

Export Catalyst

Research Strategy (£)

Innovation growth (£)

Academy growth (£)

Private patients (£)

R&BD

Digital *Kate Warriner*

Speciality Packages

Voice Recognition

Paperless (£) (20/21)

EPR Upgrade (20/21)

TO BE INITIATED

R&BD

Park, Community Estate & Facilities *David Powell*

Hospital Moves. **Alder Centre.**

Community Cluster. **Park.** **Energy**

Healthcare campus

Tier 4

Community

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, both governance and delivery ratings have improved again this month with the *SAFER* project achieving all green ratings.

Additions have been made for baselines and targets for *DETECT and Best in Acute Care.* Focus should remain on completing any outstanding gaps.

The lack of positive trends on metrics for the *Comprehensive Mental Health* project should be addressed by the Exec Sponsor.

Year 2 PID for *Sepsis* still requires sign off. This should now be addressed by the Exec Sponsor.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 4 June 19

Programme Contribution to CIP Status – as at 4th June 19

Change Programme Pillar	Division	Community	Medicine	Surgical Care	Alder Hey in the Park	Facilities	Nursing & Quality	Finance	IM&T	Human Resources	Executive	Academy	R&D	Innovation	International	Total
	Division Target £'000	475	2,328	2,201	199	194	87	112	94	92	101	7	99	6	3	5,997
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Growing Through External Partnerships		0	0	0	0	0	0	0	30	0	0	0	0	0	0	30
The Best People Doing Their Best Work		0	46	0	50	0	0	72	0	0	0	0	0	0	0	168
Game Changing Research and Innovation		0	0	0	0	0	0	0	15	0	0	0	0	0	0	15
Park, Community Estate & Facilities		0	0	0	57	0	0	0	0	0	0	0	0	0	0	57
Global Digital Exemplar (GDE)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Divisional Business		383	572	1,425	0	51	0	18	155	0	0	0	0	0	0	2,605
Total Forecast outturn		403	906	1,864	107	51	0	90	200	0	0	0	0	0	0	3,621

Independent Programme Assurance Report

Sepsis

June 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	Current	Target
Percentage of inpatients treated for sepsis with high risk criteria in <60 mins	N/A	75%	90%
Percentage of ED patients treated for sepsis with high risk criteria in <60 mins	N/A	76%	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%

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
Sepsis											Sepsis Steering Group minutes to 17 Apr 19. 'Year 2 PID' now uploaded but still in draft form. New benefits / targets now need to be signed off at Programme Board and CQAC. Milestone Plan for 'year 2' PID is now in evidence with milestones until Sep 19 however some milestones have been missed and no revised dates available. The communications plan 2018-20 gives a high level list of activities but they are not tracked for completion. All risks are within review date on Ulysses system. EA/QIA complete. **Last updated 7 May 19.**

Independent Programme Assurance Report
DETECT

June 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

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
DETECT Study		●	●	●	●	●	●		●	●	Evidence of project team meetings are in evidence up to 7 May 19 and an agenda for 4 June 19 is also available. 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. There is a suite of stakeholder engagement however wider stakeholder engagement should now be considered as the first implementation date of the 6th of August on 4A is only a couple of months away. A comprehensive risk register is contained within the workbook and managed but these risks now need uploading and managing via Ulysses. EA/QIA uploaded but now requires additional signatures and a data protection impact assessment is available in draft. **Last updated 31 May 19.**

Independent Programme Assurance Report
Best in Outpatients

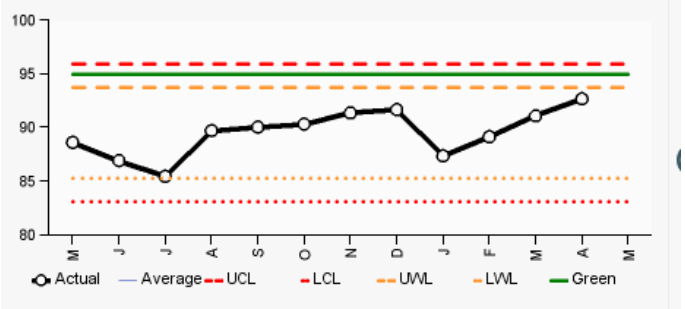
June 19

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	Current (April)	Target
Increase % of OPD visitors likely to recommend Alder Hey	91% (Mar 19)	**93%**	95% (Mar 20)
Increase Clinicians satisfaction with OPD (every 6m measure)	40% (Mar 18) 60% (Mar 19)	**60%**	80% (Mar 20)
Reduce missing outcome forms ePPF	1253 (Mar 19)	**1150**	752 (Mar 19) 526 (Mar 20)
Increase Clinicians use of InTouch	TBC	**TBC**	TBC
Increase staff development	TBC	**TBC**	TBC
Reduction in Phlebotomy PALS for waiting times	TBC	**13**	0

% of OPD visitors likely to recommend Alder Hey



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
Best in Outpatient Care		●	●	●	●	●	●		●	●	Evidence of Steering Group meetings available to 9 Apr 2019. A comprehensive 19/20 PID is available. There is a suite of benefits being tracked however only 1 has reached its target. A milestone plan for 19/20 is now required to be developed which mirrors the milestones set out in the PID. 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 4 June 19.**

Independent Programme Assurance Report
Brilliant Booking

June 19

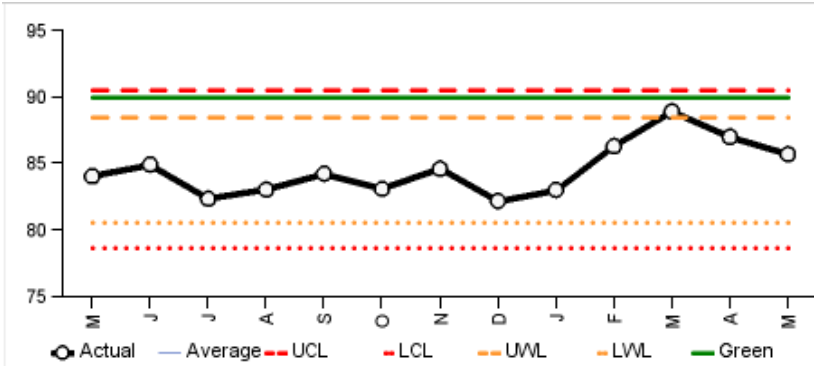
Exec Sponsor: Adam Bateman

The project will:

- Move from a process where patients can be booked months ahead and are asked to ring up and make an appointment 3 weeks before their appointment is due (regardless of capacity)to a process whereby patients are given an appointment in order of clinical priority and appointments are only booked 6 weeks in advance to allow for hospital cancellations and allow easier co-ordination of appointments for complex patients.
- Introduce a text messaging which reminds families of their appointment and gives them an opportunity to confirm or cancel without needing to phone.

Key Project Metrics	Baseline	Current	Target
Clinic Utilisation	84% (Sep 18)	86% (May 18)	90% (June 19)
Reduction in partial booking letter costs	£40,321 (17/18)	£20,228 (Apr 18-Nov 18)	£0 (June 19)
Number of DNCs	12,590 (Sep 18)	10,731 (May 19)	0 (June 19)

Clinic Utilisation



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
Brilliant Booking and Scheduling											Project team meetings are scheduled and documented up to 19 Feb 19 which is expected given that an exception report is in evidence which details the transfer of any remaining milestones into the Best in Outpatient Care Project . A comprehensive PID is available for 18/19 and the 19/20 PID forms part of the wider Outpatient PID. Specialty plans for all specialities are available and are being closely tracked with the generic plan showing that all specialities have now transferred on to the new 'hybrid booking' process. There is a comprehensive suite of stakeholder engagement updated to 7 March 19 with presentations available to all specialities in preparation for Hybrid Booking Go Live. Risks are detailed and are within their review period. EA/QIA signed off and uploaded. **Last updated 4 June 19.**

Independent Programme Assurance Report

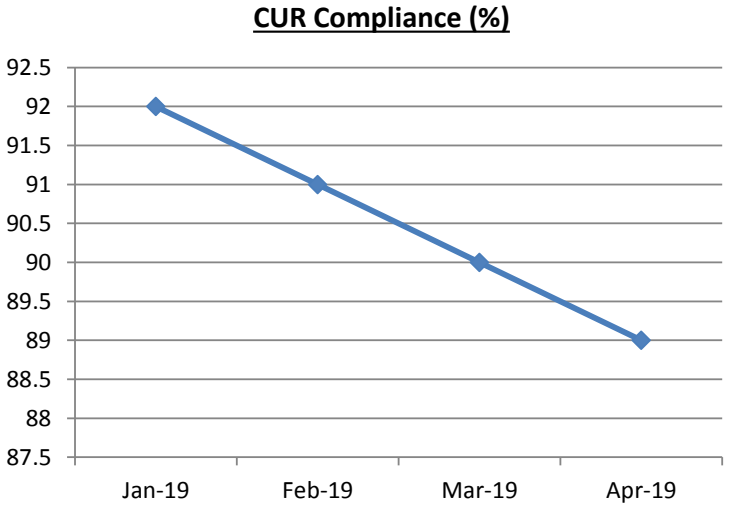
SAFER

June 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	Target
Trust Length of Stay (LoS)	3.3 days	2.05 days (May)	3.1 days
Reduction in cancelled operations	35 per month (18/19)	13 (May)	26 per month (19/20)
CUR Compliance	79%	88% (May)	85%
Reduction in CUR Non-Qualified Bed days to achieve CQUIN	11.41%	8.99%	10.41%



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SAFER		●	●	●	●	●	●		●	●	Evidence of SAFER Task Force meetings evidenced to 25 May 19. A comprehensive PID is available with a suite of benefits with just a couple of baselines now required. There is a comprehensive benefits tracker which shows positive trends for the majority of measures. 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 3 June 19.**

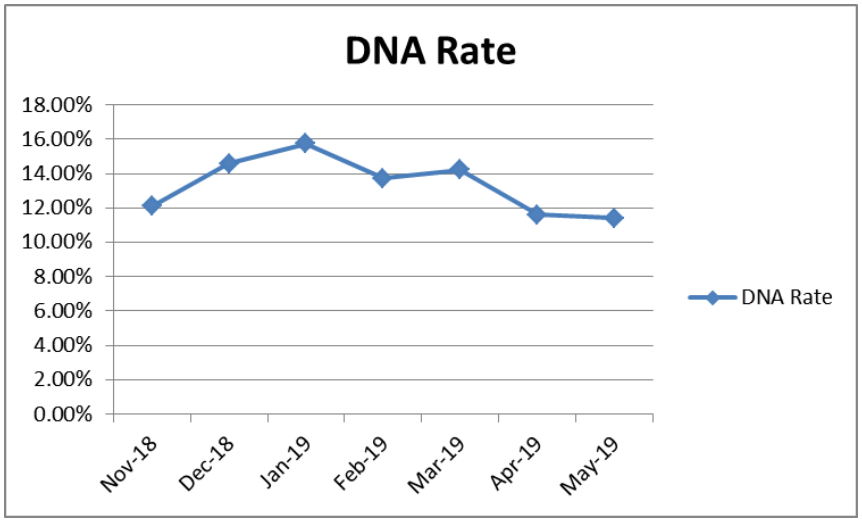
Independent Programme Assurance Report
Best in Mental Health Care

June 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	Target
Reduced DNA rates	17.8% (April 2018)	11.4% (May)	10%
Prevented attendances to AED	Not measured	10 (March)	15
Reduction in patients who attend AED but are already open to CAMHS	228 (2017/18)	244 (March)	182 (2019/2020)



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
Best in Mental Health Care											Evidence of project team meetings available until 13 May 19. There is a comprehensive PID available and a recent exception report dated 23 Apr 19. 3 out of the 5 benefits are able to be measured with none of the 3 showing positive trends. 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 3 June 19.**

Independent Programme Assurance Report
Best in Acute Care

June 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)	6.8% (April 19)	10% (71 patients)
Increase discharges before 12pm across all in-patient wards	20%	26% (April 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%	92.9% (April 19)	95%

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
Best in Acute Care											Evidence of Models of Care workshops available up to 20 May 19 and an agenda for 3 June 19 is also available. A high level design process is available and the 19/20 PID is very near completion with only some minor omissions. Various data packs are in evidence and the project now has clear measures for success but these now need tracking. A comprehensive milestone plan is available and is being tracked. There is evidence of stakeholder engagement including updates to Programme Board. Risks now available on Ulysees. There is signed EA/QIA in evidence. **Last updated 3 June 19.**

Independent Programme Assurance Report
Inspiring Quality

June 19

Exec Sponsor: Nicki Murdock

The project deliver 3 aims:
1. To put children first
2. To be the safest children's Trust in the NHS
3. To achieve outstanding outcomes for children

Key Programme Metrics	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
Reduction in the number of children who deteriorate unexpectedly	TBC	N/A	25% reduction in the number of children who deteriorate unexpectedly
Reduction in medication error that lead to harm	TBC	N/A	10% reduction in medication error that lead to harm
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

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
Inspiring Quality		🟢	🟢	🟡	🔴	🔴	🔴		🟡	🟡	Evidence of project meetings to 13 May 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 some evidence of stakeholder engagement and this programme of work would benefit from a detailed communication plan. There are no risks on Ulysees and the EQ/QIA are yet to be completed. **Last updated 4 June 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.

A considerable number of projects are now to be initiated in ***The Best People doing their Best Work*** programme. It is crucial that these projects are initiated as soon as possible to allow any projects with a contribution to CIP to have the greatest financial impact.

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

Programme Contribution to CIP Status – as at 4th June 19

Change Programme Pillar	Division	Community	Medicine	Surgical Care	Alder Hey in the Park	Facilities	Nursing & Quality	Finance	IM&T	Human Resources	Executive	Academy	R&D	Innovation	International	Total
	Division Target £'000	475	2,328	2,201	199	194	87	112	94	92	101	7	99	6	3	5,997
CIP delivery by change programmme pillar		£000's														
Deliver Outstanding Care		19	288	439	0	0	0	0	0	0	0	0	0	0	0	746
Growing Through External Partnerships		0	0	0	0	0	0	0	30	0	0	0	0	0	0	30
The Best People Doing Their Best Work		0	46	0	50	0	0	72	0	0	0	0	0	0	0	168
Game Changing Research and Innovation		0	0	0	0	0	0	0	15	0	0	0	0	0	0	15
Park, Community Estate & Facilities		0	0	0	57	0	0	0	0	0	0	0	0	0	0	57
Global Digital Exemplar (GDE)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Divisional Business		383	572	1,425	0	51	0	18	155	0	0	0	0	0	0	2,605
Total Forecast outturn		403	906	1,864	107	51	0	90	200	0	0	0	0	0	0	3,621

Independent Programme Assurance Report
Catering

June 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	Target
Increase in income	76,296 (June 18)	93,179 (May)	122,038 (July 19)
Reduction in expenditure	-105,052 (June 18)	-128,176 (May)	-134,971 (July 19)
Profit/loss	-28,756 (June 18)	-34,997 (May)	-12,933 (July 19)
Increase satisfaction with food served on the wards	98% (June 18)	98% (May)	100% (July 19)
Reduce treetops waiting times and improve flow	Br'fast av. 2.54sec Lunch av. 4.04s (Sept 18)	B-2m46s (May) L-2m25s (May)	20% reduction = av. (B=2.19m) (L=3.15m) (July 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
Catering		●	●	●	●	●	●		●	●	Evidence is available for the project 'Steering Group' meetings up to 19 June 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 and 3 out of 5 of the 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. A comprehensive Gantt chart plan has been prepared arising from the review which is tracked up to 10 June 19 but now shows numerous delays to milestones. Evidence of stakeholder engagement is available on SharePoint. All risks are within review date on Ulysses. **Last updated 18 June 19.**

Independent Programme Assurance Report
Portering

June 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)	71,000 (May)	47,000 (per month)

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
Improving Portering Services Project		🔴	🟡	🔴	🟢	🟢	🟢		🔴	🔴	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)

Global Digital Exemplar

Going forward and following a discussion with the Executive Sponsor of the *GDE Programme*, it has been agreed that, by exception, the assurance evidence for the GDE programme will be accessed via the NHS Digital Platform known as 'CORA' as opposed to SharePoint. CORA is a nationally mandated system for NHS centrally funded digital programmes and using this system for assurance purposes will avoid duplication. Governance ratings for the GDE Programme have improved this month however delivery ratings should be addressed imminently by the Exec Sponsor.

Sustainability through External Partnerships

The governance of the 'Aseptics' project is maintained to a good standard however the overall delivery rating requires improvement.

Park, Community Estate and Facilities

The governance and delivery ratings for the Park, Community and Facilities programme have deteriorated this month. The lack of SMART metrics for 4 out of the 5 projects within this programme requires urgent attention from the programme's Exec Sponsor.
The Energy project now needs to be addressed immediately as its position has not altered since December 2018.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 27 June 19

Programme Contribution to CIP Status – as at 4th June 19

Change Programme Pillar	Division	Community	Medicine	Surgical Care	Alder Hey in the Park	Facilities	Nursing & Quality	Finance	IM&T	Human Resources	Executive	Academy	R&D	Innovation	International	Total
	Division Target £'000	475	2,328	2,201	199	194	87	112	94	92	101	7	99	6	3	5,997
CIP delivery by change programmme pillar		£000's														
Deliver Outstanding Care		19	288	439	0	0	0	0	0	0	0	0	0	0	0	746
Growing Through External Partnerships		0	0	0	0	0	0	0	30	0	0	0	0	0	0	30
The Best People Doing Their Best Work		0	46	0	50	0	0	72	0	0	0	0	0	0	0	168
Game Changing Research and Innovation		0	0	0	0	0	0	0	15	0	0	0	0	0	0	15
Park, Community Estate & Facilities		0	0	0	57	0	0	0	0	0	0	0	0	0	0	57
Global Digital Exemplar (GDE)		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Divisional Business		383	572	1,425	0	51	0	18	155	0	0	0	0	0	0	2,605
Total Forecast outturn		403	906	1,864	107	51	0	90	200	0	0	0	0	0	0	3,621

Independent Programme Assurance Report
Aseptics

June 19

Exec Sponsor: Dani Jones

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.

These objectives are in line with the Trust Strategy to "do the basics brilliantly and grow the future".

Key Programme Metrics	Baseline (2019)	Current	Target
Increase the number of commercial research studies open to recruitment	3	3	6 (July 2020)
Reduction in **medication errors** in ASU (injectable therapy)	4	4	2 (July 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 4 April 19 and project team meetings up to 18 Apr 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. Some of the targets and benefits are being closely tracked, others need to identify a sustainable way of measuring improvement. Benefits tracker last updated on 19 June 19, with none of the measures yet reaching aspired thresholds. A 'Project Milestone Plan' is in place and being tracked up to 24 June 2019 however a considerable number of milestones have been revised numerous times. Project risks are within review date on Ulysses. EA/QIA signed off. **Last updated 19 June 19.**

Independent Programme Assurance Report
GDE

June 19

Exec Sponsor: Kate Warriner

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

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 Delivery Group action log in evidence to 18 June 19. There is no SoPB document for 19/20 and this has not been updated since 16 Oct 18. There is a 'GDE Programme Dashboard' which RAG rates progress and looks largely on track. There is evidence of some stakeholder engagement. All risks are within review date on Ulysses. **Last updated 14 June 19.**

Independent Programme Assurance Report
Specialty Packages

June 19

Exec Sponsor: Kate Warriner

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.

The aim of the project is to *"work with individual multi-disciplinary Specialty teams to develop a digital clinical system solution that fits with the clinical requirements of their patients and the associated working processes."*

Key Programme Metrics	Baseline	Current	Target
Number of specialty packages complete	0	33	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
Speciality Packages						N/A	N/A				Limited evidence of meetings taking place. PID is available. Overall benefits profile and schedule is shown on the SoPB tracker; however a more updated version is now required as the version on SharePoint was last updated in March 18. Project Plan was last updated on 20 June 2019 but now needs to be closely tracked. The recently uploaded workbook indicates progress per speciality and now indicates dates for completion. A high level plan is also available. Evidence of stakeholder engagement last uploaded on 16 Oct 18. Comprehensive risk log within workbook however some risks are out of their review date. QIA/EA will be assured and assessed at project level. **Last updated 20 June 19.**

Independent Programme Assurance Report
Voice Recognition

June 19

Exec Sponsor: Kate Warriner

Completion of this project will result in the integration of voice recognition software into both Medisec and Meditech. Medisec is the application that is used for the clinic letters and Meditech is the electronic patient record.

Key Programme Metrics	Baseline	Current	Target
Reduction in Transcription backlog	Average 19 days turnaround time between 02/01/17 to 31/03/17	2 days turnaround time	Elimination of backlog; turnaround time to be within 3 day target
Reduction in operational costs	£160k Transcription team costs between 02/01/17 to 31/03/17	£6k overspend per month	No transcription team overspend currently at £14.5k per month
Reduction in operational costs	Transcription time between 02/01/17 to 31/03/17	Reduction of WTE by 25%	Reduction of WTE by third by 31/03/18 and a further third by 31/03/19
Reduction in time spent transcribing letters	2.5 minutes	1 minute 13 seconds	Better than baseline
Improved user satisfaction	NPS survey based on current workflow	Survey results show an improvement in user satisfaction	Better than baseline
Reduction in clinical time to complete the following Meditech forms: PPF, ASR, Op form, and Nursing Discharge Plan	Measurement without ability to use FD	Reduction in time to complete Op form only	Measurement with ability to use FD

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
Voice Recognition											Limited evidence of effective project team meetings. PID and detailed project workbook on SharePoint. Details of financial benefits on separate document however these have not been realised as planned. Project Plan has no outstanding actions. Comms/engagement activities are detailed in workbook. Risks register is held and all risks are within review date in workbook as of 31 Mar 19. EA/QIA has been signed and uploaded. **Last updated 14 June 19.**

Independent Programme Assurance Report
Hospital Moves

June 19

Exec Sponsor: David Powell

To undertake a number of departmental hospital moves on the residual estate to allow for the decommissioning of specific buildings in preparation for the commencement of park developments. The aim is to retain as few buildings as possible whilst ensuring clinical care can continued to be delivered in a safe and secure environment.

Key Programme Metrics	Baseline	Current	Target
Staff morale	Not available	Not available	Improvement of 10% (Dec 20)
Patient, Carer's and Staff satisfaction with facilities	Not available	Not available	Improvement of 20% (May 21)
Increase in efficiency of desks per staff members	Not available	Not available	30% improvement in staff to desk ratio (Sep 20)
Reduction in number of fixed desks	622	Not available	426 (Dec 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
Hospital Moves		🔴	🟢	🔴	🟡	🟢	🟢		🔴	🟡	Minutes of the 'Hospital Moves Steering Group' are available to 14 Aug 2018 and there is an agenda for the meeting planned for 16 Oct 2018; there are notes of the 'Records and Transcriptions meeting' up to 17 Sep 18. The PID dated 9 Jan 18 is available on SharePoint and provides a comprehensive summary of scope and approach. There is no evidence for the tracking of benefits outlined in the PID. There is a lack of any recent information regarding communications and engagement. There is a plan for hospital moves within the wider programme plan which is broadly on track. Risks are now witihin review date on Ulysees. EA/QIA signed, important to review during the project as different accommodation options are decided upon. **Last updated 13 June 19.**

Independent Programme Assurance Report
Community Cluster

June 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. 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. A highlight report for March to be presented at Programme Board is available. Evidence of stakeholder engagement. Risks on Ulysees are past review date. EA/ QIA complete but not signed by Exec Sponsor. **Last updated 13 June 2019.**

Independent Programme Assurance Report
Alder Centre

June 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											Steering Group agenda for 21 Nov 18 but no minutes on SharePoint. Evidence of recent meetings with architects. Scope/approach defined in PID. Benefits defined in PID but no evidence of the tracking of benefits. Milestone Plan has been revised recently and is being closely tracked however shows the commencement of building work has slipped significantly from original planned date. Limited evidence of Comms/ Engagement activities. Risks are on Ulysses and are recently past their review date. EA/QIA complete. **Last updated 14 June 2019.**

Independent Programme Assurance Report
Park

June 19

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											Steering Group reports available to 21 November 2018.Evidence of reports suggest a planned steering group for January but no evidence whether or not this took place. Updated PID on SharePoint showing comprehensive suite of benefits however some benefits are not SMART and not tracked. There is a high level project plan with milestones mapped through to end of project life cycle. A comprehensive benefits tracker has now been uploaded which indicates whether benefits are on/off track. There is a comprehensive and detailed Milestone Plan which is not being tracked. There is a suite of evidence of stakeholder engagement however more recent evidence is now required. Risks are on Ulysees but are out of review date. EA/QIA complete. **Last updated 13 June 2019.**

Independent Programme Assurance Report
Energy

June 19

Exec Sponsor: David Powell

To reduce energy cost and usage to contractual target of 46.7 G. Once achieved the project will investigate methods of reducing further by means of energy awareness for staff.

Key Programme Metrics	Baseline	Current	Target
Reduce energy consumption	Not Available	Not Available	46.7G

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
Energy	N/A										Monthly energy committee minutes available until 13 Nov 18. The POD available on SharePoint gives no details of financial benefits expected for 2018/19. The project plan for 18/19 contains only 6 actions and was last updated July 2018 (2 of these relate to usage monitoring and 2 relate to a compensation claim; more detail is required if this is to be considered a project). There is no baseline established for the key metric and no tracking visable. QIA signed off for the 18/19 programme. **Last updated 17 Dec 18.**

NHS
Alder Hey Children's
NHS Foundation Trust

Corporate Report May 2019

How Did We Do?

Executive Summary **Month: May** **Year: 2019**

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Increased number of near-miss incidents, and incidents resulting in no or low harm coupled with no incidents resulting in moderate or severe harm. This demonstrates a continued culture of high reporting amongst staff
- Weekly Patient Safety Meeting continues to have high level of attendance and engagement from across the Divisions with wide evidence of lessons learned and improvements made to minimise the risk of reoccurrence. An Extraordinary Patient Safety Meeting was held by the Medical Director and Director of Nursing to review progress and close incidents as appropriate where the action had been formally transferred to another Trust Committee for example Medication Safety Committee. This resulted in the completion of over 40 incidents with evidence of associated actions
- Sepsis status now being used across inpatient areas which looks to identify those patients with sepsis rather than those where treatment is for infection

Highlight

- Reduction in CLABSI rate on PICU since March 2019. CLABSI Summit held to identify risk factors and devise an action plan to enable sustained improvement.

Challenges

- Time to administer antibiotics within 60 minutes for patients identified as septic. Three delays however patients were treated in under 70 minutes and all had appropriate responses and intervention – challenge in gaining intravenous access. Sepsis Nurse continues to feed back to wards / Divisions

The Best People Doing their Best Work

Caring

- Greater number of opportunities now available to capture FFT with Meridian kiosks and continued support of the Volunteers using tablets. Work underway to make the kiosks more prominent to families to encourage them to to use this feedback method, with wrap arounds being designed which will then be fitted. SMS will be live at the end of June which will further increase the opportunity for families to share their views with the Trust
- Themes analysed and shared with teams and Divisions to facilitate improvements

Highlight

- 5% increase in the number of friends and families who would recommend the OPD this quarter compared to same quarter last year, with more than 90% responding favourably. This reflects the hard work and changes the OPD team have made to improve the experiences of children, young people and families

• Formal complaints and PALS lower than the same time period last year. Where a complaint is upheld, complaint responses detail the action that has or will be taken to prevent another child or family having a similar experience and the Division monitor this through their governance structure	**Challenges** • Slight decrease in FFT for inpatients, with feedback highlighting the importance of a daily opportunity to discuss care and management with qualified staff

Delivery of Outstanding Care

Effective

• The Emergency Department waiting time compliance has reduced to 91.3%. The COO have undertaken a listening exercise with frontline staff to better understand recent challenges. There is a focus on enhanced staffing levels and improving IT in our improvement plan. • A task & finish group is established to address delays in scanning turnaround times. In July we expect to use a partner to assist with clearance of the backlog	**Highlight** • All patients who had an operation cancelled were re-booked for treatment within 28 days **Challenges** • ED waiting time standard below national standard • Scanning turnaround times

Delivery of Outstanding Care

Responsive

• At an aggregate level our access to planned care, diagnostic care and cancer care remains strong. There are however some services that have long waiting times and some challenges. For example, in radiopharmacy has had significant service disruption to product supply constraints from Royal Liverpool. A weekly safety huddle is in place to mitigate the impact of this.	**Highlight** • Full-delivery of national standards relating to referral to treatment for planned care, diagnostics and cancer care **Challenges** • Access to planned care as measured by the open pathway standards is challenging in community paediatrics, audiology and neurology.

The Best People Doing their Best Work

Well Led

- The Trust made a £0.1m deficit in M2 which was nearly £0.2m behind plan. Cumulatively we have now delivered a £1.7m deficit which is £0.5m behind plan. This is of concern as we will have to recover this position in month 3 to meet our Q1 trajectory.
- Main drivers of the underperformance are in the Medicine Divisions, Facilities and Energy costs. All of which are subject to a recovery plan.
- Activity levels are of a particular concern with a real focus required on day case rates.
- Full year forecasts are£8n off plan which is material. A reforecast positon is due at the end of Q1 with a focus on significantly improving this position. Residual areas of concern remain the Medicine Division, facilities and some specific corporate areas.
- Cash balances remained at £35m which is ahead of plan by £10m. The largest driver is higher than average accruals as we work through the backlog of creditor payments caused by the upgraded ledger system implemented earlier in the year.
- The Use of Resources rating is 3 which is driven by our current deficit.
- Mandatory training is below target at 88% - this is expected to improve to meet the target in the coming weeks.
- Sickness levels remain above target at 5.3%. Temporary staffing spend is also high at £1m.

Highlight

- Pay expenditure in line with budget
- Safer staffing fill rate
- Cash in bank

Challenges

- Mandatory Training
- Control Total Delivery
- Activity Levels
- Sickness Levels & Temporary Spend

Game Changing Research and Innovation

Research and Development

- The research portfolio of open studies across academic and commercial sectors continues to show a small decrease over the year to date. This is in part due to saturation within the research delivery workforce and lack of capacity to deliver more studies. It may also be due to the lack of new studies nationally which are feasible for the Alder Hey patient population.

Highlight

- Revised business model for research, including mechanisms for professional involvement incentivisation, agreed in principle and continuing to progress as planned.
- Plans to improve front line and research activity through an increasing number of clinicians involved in research are continuing to progress as planned.

Challenges

- Currently around 12 commercial studies in the contracting stage which can't be progressed because of lack of financial capacity within the Clinical Research Division.
- Staffing within the Division has been significantly reduced due to a number of leavers, this still remains a challenge.

Contents

Contents

Contents

Contents

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG			Comments Available
Clinical Incidents resulting in Near Miss	98	78	69	66	76	73	81	59	58	83	76	62	84		>=103	>=98	<98	✔
Clinical Incidents resulting in No Harm	278	322	286	308	288	315	284	219	284	249	278	293	300		>=286	>=272	<272	✔
Clinical Incidents resulting in minor, non permanent harm	69	86	76	72	86	90	94	67	79	86	106	97	102		<=86	N/A	>86	✔
Clinical Incidents resulting in moderate, semi permanent harm	1	2	1	1	2	0	1	1	2	1	0	0	0		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	1	2	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	3	4	3	4	4	2	6	2	2	4	2	6	3		<=2	N/A	>2	✔
Pressure Ulcers (Category 3)	1	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Never Events	0	0	0	2	0	0	0	0	1	0	0	0	0		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis - A&E	55.6%	57.1%	65.5%	68.2%	54.5%	65.4%	57.6%	51.9%	77.4%	71.1%	79.4%	58.8%	71.1%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	72.7%	78.9%	71.4%	72.5%	78.2%	70.2%	76.2%	73.3%	70.2%	82.1%	73.3%	81.8%	71.4%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	1	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - RSV	0	0	0	0	0	5	10	13	2	3	1	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	1	0	0	0	1	2	0	1	1	0	4	1	1		<=1	N/A	>1	✔
Hospital Acquired Organisms - CLABSI - ICU Only	2	2	0	1	0	2	1	3	0	1	3	1			<=1	N/A	>1	✔
Hospital Acquired Organisms - Gram Negative BSI	0	1	0	1	2	2	2	2	1	3	0	0	1		<=1	N/A	>1	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	82.6%	83.9%	86.3%	88.2%	85.5%	80.0%	80.6%	90.1%	90.5%	80.3%	89.5%	78.8%	87.7%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	96.8%	96.4%	92.2%	100.0%	100.0%	93.2%	100.0%	100.0%	98.5%	100.0%	98.6%	88.4%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	95.5%	94.9%	97.0%	97.0%	98.3%	98.2%	97.9%	98.2%	97.0%	96.2%	97.8%	97.3%	90.6%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	82.6%	88.9%	100.0%	89.9%	89.4%	84.7%	97.5%	100.0%	88.9%	76.9%	82.9%	80.8%	88.7%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	88.6%	86.9%	85.5%	89.7%	90.0%	90.3%	91.4%	91.7%	87.4%	89.1%	91.1%	92.7%	91.8%		>=95 % >=90 % <90 %	✔
Complaints	11	11	14	13	12	13	5	7	6	8	16	7	9		No Threshold	✔
PALS	127	99	100	101	125	132	115	71	137	98	95	109	104		<=113 <=126 >126	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	2.5%	2.7%	6.5%	0.0%	2.7%	1.0%	1.1%	2.4%	1.4%	1.8%	2.5%	2.7%	1.1%		<=3 %	N/A	>3 %	✔
Bed Occupancy (Accessible Funded Beds)	84.9%	88.5%	83.9%	76.2%	79.9%	85.8%	85.3%	73.7%	72.9%	80.8%	79.1%	77.7%	84.6%		<=89 %	<=93 %	>93 %	✔
ED: 95% Treated within 4 Hours	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%	93.6%	91.3%		>=95 %	N/A	<95 %	✔
Average LoS - Elective (Days)	2.87	2.89	3.13	2.80	2.79	3.05	2.90	3.58	2.35	3.04	3.14	3.05	3.03		<=2.9	N/A	>2.9	✔
Average LoS - Non-Elective (Days)	2.01	2.01	1.85	2.03	1.73	2.05	1.98	1.92	1.81	1.90	1.70	1.85	2.00		<=2.0	N/A	>2.0	✔
Theatre Utilisation - % of Session Utilised	88.6%	87.9%	89.3%	87.0%	86.6%	86.5%	87.2%	85.8%	88.7%	88.7%	89.7%	88.9%	89.1%		>=90 %	>=80 %	<80 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	30	43	35	18	12	28	38	21	11	10	11	9	23		<=20	N/A	>20	✔
28 Day Breaches	5	6	6	7	1	0	6	6	4	1	1	0	0		0	N/A	>0	✔
Clinic Session Utilisation	84.0%	84.9%	82.4%	83.0%	84.2%	83.1%	84.6%	82.2%	83.1%	86.3%	89.0%	87.2%	86.4%		>=90 %	>=85 %	<85 %	✔
Was Not Brought Rate	11.5%	12.2%	12.4%	13.5%	11.4%	11.8%	11.5%	13.3%	12.7%	11.9%	10.1%	10.9%	10.9%		<=12 %	<=14 %	>14 %	✔
Average Scanning Turnaround - Inpatient										44.00	49.00	49.00	50.00		<=7	N/A	>7	✔
Average Scanning Turnaround - Outpatient										26.00	23.00	24.00	21.00		<=5	N/A	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	91.6%	96.2%	94.7%	94.7%	96.3%	96.4%	95.1%	96.7%	96.0%	94.9%	95.7%	98.3%	96.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	98.8%	99.7%	99.7%	99.6%	99.5%	99.6%	100.0%	99.6%	100.0%	99.3%	99.5%	99.3%	99.0%		100 % >=95 % <95 %	✔
IP Survey: % Know their planned date of discharge	76.1%	63.7%	65.7%	60.6%	55.3%	60.2%	69.0%	59.4%	76.5%	82.8%	80.6%	88.8%	84.1%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	90.9%	92.7%	94.7%	91.6%	94.9%	92.2%	92.2%	92.5%	96.3%	94.3%	93.4%	99.3%	90.5%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play															>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning															>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	92.0%	92.1%	92.0%	92.0%	92.1%	92.1%	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%		>=92 % >=90 % <90 %	✔
Waiting List Size	13,238	12,879	12,962	12,925	12,884	12,961	12,934	12,859	12,872	12,888	12,746	12,871	12,876		<=12905 N/A >12905	✔
Waiting Greater than 52 weeks	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	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%			100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	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)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	99.8%	99.2%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	99.6%	99.5%	100.0%	99.8%		>=99 % N/A <99 %	✔
Number of Super Stranded Patients (21+ Days)	27	32	29	32	29	32	28	24	35	39	33	21	22		<=33 N/A >33	✔
PFI: PPM%	99.0%	99.0%	96.0%	98.0%	100.0%	98.0%	99.0%	100.0%	100.0%	100.0%	98.0%	98.0%	98.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG	Comments Available
CIP In Month Variance (£'000s)	104	153	-238	-137	175	-174	-285	151	-199	-74	-75	-163	-54		>=-5% >=-20% <-20%	✔
Control Total In Month Variance (£'000s)	154	285	29	-396	359	-463	-48	564	-21	-433		-394	-165		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	-333	1,701	-462	-129	2,907	-751	1,041	1,032	1,032	259	1,610	1,030	640		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	10,455	9,455	23,910	21,519	20,023	20,315	17,580	23,136	19,983	22,068	33,699	34,361	34,449		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	591	425	998	741	263	624	684	142	456	355	19,495	-612	21		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	-7	-38	-111	-311	51	-372	-74	-267	-510	-850	-495	183	-25		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	-431	-102	-858	-825	45	-715	-659	689	34	63	-942	34	-161		>=-5% >=-20% <-20%	✔
NHSI Use of Resources	3	3	3	3	2	2	1	1	1	1	1	1	3		<=3 N/A >3	✔
AvP: IP - Non-Elective	1,338	1,248	1,318	1,134	1,344	1,439	1,508	1,432	1,309	1,215	1,385	53	58		>=0 N/A <0	✔
AvP: IP Elective vs Plan	435	398	424	399	390	442	419	328	412	401	457	-45	-24		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	1,905	1,917	1,894	1,873	1,722	2,007	1,954	1,623	2,011	1,764	1,850	-53	-139		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	19,471	18,764	19,626	17,748	17,992	21,322	21,402	16,142	20,869	18,943	20,860	763	30		>=0 N/A <0	✔
PDR	11.3%	31.1%	64.7%	82.3%	88.8%	90.1%	90.1%	90.1%	90.1%	92.2%	92.2%	4.8%	20.7%		No Threshold	✔
Medical Appraisal	69.0%	2.0%	4.0%	6.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 % >=90 % <90 %	✔
Mandatory Training	92.0%	92.1%	91.6%	88.6%	88.1%	89.7%	89.7%	89.0%	89.4%	88.8%	89.6%	90.0%	88.4%		>=90 % >=80 % <80 %	✔
Sickness	4.6%	4.9%	5.3%	5.2%	5.4%	5.6%	5.6%	6.0%	5.7%	5.7%	5.3%	5.2%	5.4%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	1.2%	1.4%	1.5%	1.3%	1.4%	1.6%	1.6%	1.6%	1.8%	1.7%	1.6%	1.5%	1.4%		<=1 % N/A >1 %	✔
Long Term Sickness	3.4%	3.5%	3.8%	4.0%	4.0%	4.0%	3.9%	4.4%	3.8%	3.9%	3.7%	3.7%	3.9%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	973	947	901	1,082	820	998	971	883	937	1,057	1,357	1,114	1,061		<=800 <=960 >960	✔
Staff Turnover	10.7%	10.8%	11.2%	10.6%	10.7%	10.5%	10.3%	9.7%	9.5%	9.6%	10.0%	9.8%	9.9%		<=10 % <=11 % >11 %	✔
% of Correct Pay Achieved	99.4%	99.5%	99.5%	99.5%	99.4%	99.4%	99.5%	99.5%	99.5%	99.5%	99.5%	99.6%	99.6%		>=99.5 % >=99 % <99 %	✔
Safer Staffing (Shift Fill Rate)	96.5%	94.8%	95.0%	93.9%	93.1%	93.2%	95.3%	94.2%	94.5%	92.8%	95.4%	95.3%	95.2%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	85.0%	65.5%	97.5%	85.0%	93.8%	60.0%	90.0%	90.0%	92.0%	95.0%	86.0%	81.5%	100.0%		>=85 % N/A <85 %	✔
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

Game Changing Research & Innovation

R&D

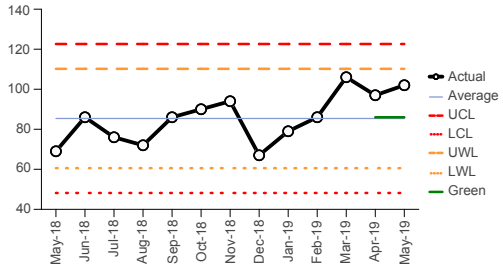
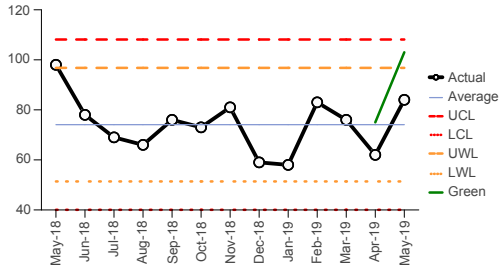
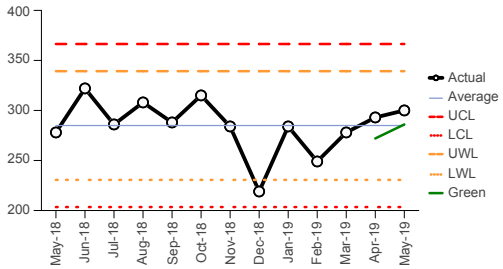
Alder Hey Children's NHS
NHS Foundation Trust

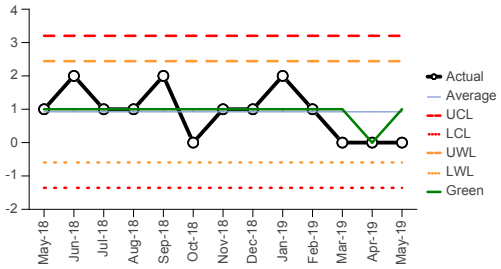
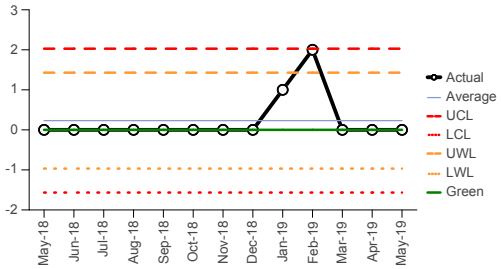
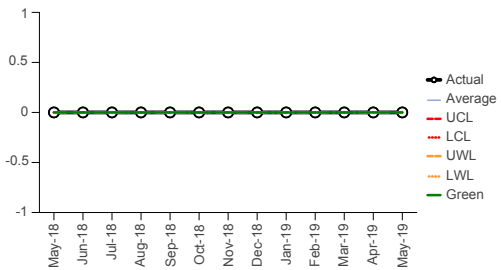
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	153	159	159	156	115	143	136	123	121	121	153	154	158		>=130	>=111	<111	✔
Number of Open Studies - Commercial	33	34	34	37	27	31	28	27	29	26	60	59	59		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	2	5	7	2	3	6	8	2	6	5	3	1	5		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	0	0	1	2	3	2	0	0	1	1	4	2	1		>=1	N/A	<1	✔
Number of patients recruited	308	245	288	249	238	195	296	158	238	211	314	234	221		>=200	>=171	<171	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

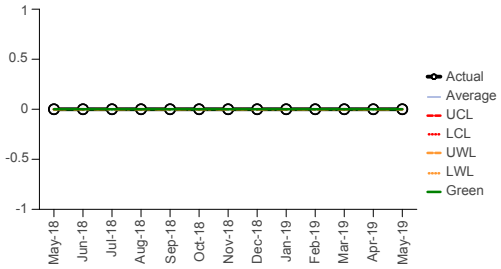
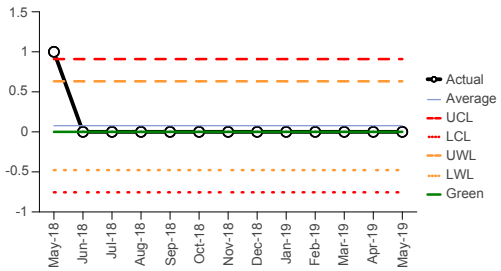
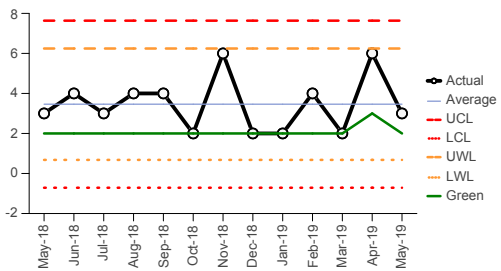
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** Total number of Minor Harm Incidents reported. The threshold is based on a reduction for the period Apr 18 - Mar 19 (1036). 19/20 aim is to see volume reported less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	102	R >86 A N/A G <=86		A weekly report is now sent to senior staff in each division for all clinical incidents from previous week is to enable them prioritise reviews and ensure lessons are learned actions for improvement are implemented in a timely manner and feedback to staff (to minimise risk) and reporters The report is intended to support divisions to focus on trends and themes for low harm and near miss incidents including developing and implementing actions for improvement, these are expected to be included in the monthly divisions governance reports to CQSG. A report will be submitted to CQAC July m
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** 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	84	R <98 A >=98 G >=103		A weekly report is now sent to senior staff in each division for all clinical incidents from previous week is to enable them prioritise reviews and ensure lessons are learned actions for improvement are implemented in a timely manner and feedback to staff (to minimise risk) and reporters The report is intended to support divisions to focus on trends and themes for low harm and near miss incidents including developing and implementing actions for improvement, these are expected to be included in the monthly divisions governance reports to CQSG. A report will be submitted to CQAC July m
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** 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	300	R <272 A >=272 G >=286		No Action Required

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** 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 catastrophic, death** 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 severe, permanent harm** 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

Alder Hey Children's NHS Foundation Trust

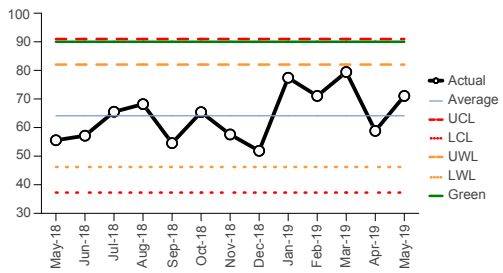
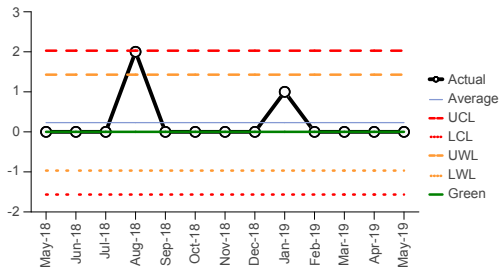
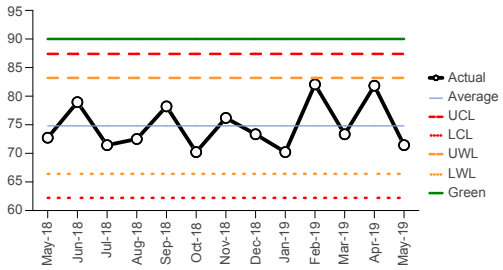
	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** 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 Medication Errors	**Medication errors resulting in harm** 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	3	R >2 A N/A G <=2		During May, there were 3 incidents associated with non-permanent harm. Inappropriate dosing or choice of analgesia culminating in poor pain control was reported by the Acute Pain team in 2 incidents. Both have been referred back to the prescribers for their own reflection and to assist with Trust-wide learning. The other incident related to a missed dose of a supportive drug as part of a chemotherapy protocol which led to a prolonged hydration infusion. This was discussed within the speciality meetings and agreed learning needs will be addressed with Nursing Practice Educators. AMR (MSO)

Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

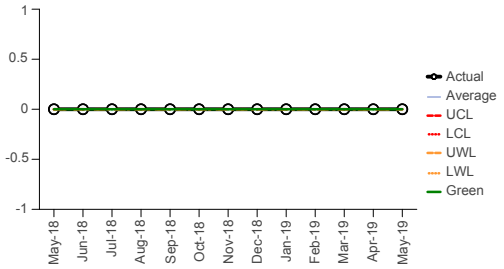
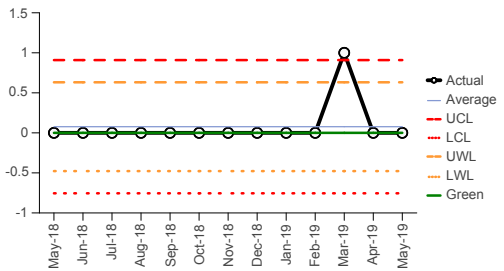
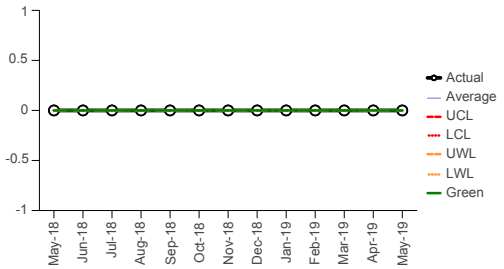
BRILLIANT BASICS

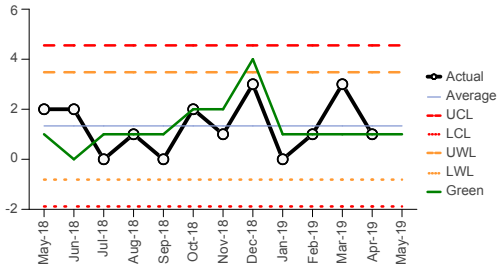
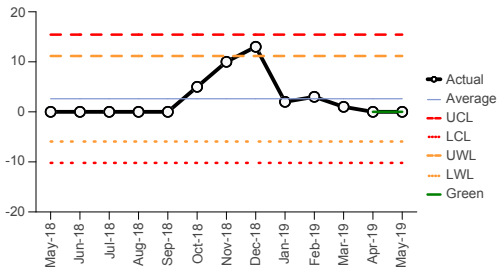
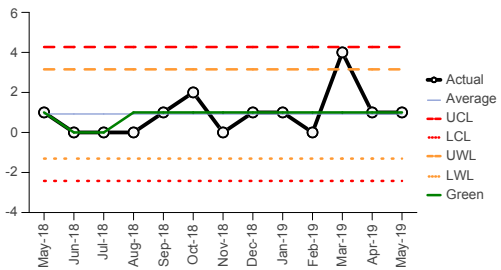
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	71.05 %	R <90 % A N/A G >=90 %		Data identified approx same number of patients treated as previous month but a decrease in mean administration time and an increase in those treated in less than 60 minutes. Still a number of patients presenting clinically unwell requiring immediate resus care. Sepsis nurse to continue to monitor and feeback to ED staff both good practice and possible improvements if required.
Never Events	**Never Events** 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 within 60 mins - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	71.43 %	R <90 % A N/A G >=90 %		Sepsis status being used across inpatient areas. Identified 14 patients with a treat as sepsis 'status'. Identified a number of patients with a marked clinical deterioration requiring escalation of treatment. Sepsis status looks to be identifying those patients with sepsis rather than those where treatment is for infection. Three 'delays' were still treated in under 70 minutes. Sepsis Nurse to continue feeding back to wards.

Delivery of Outstanding Care

7.5 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

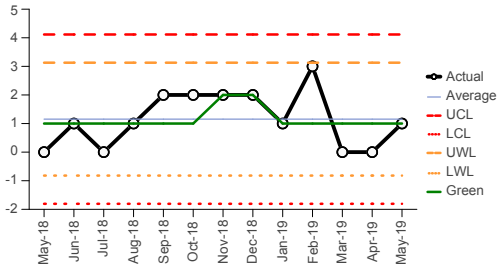
	Description	Performance	Threshold	Trend	Management Action (SMART)
Mortality	**No of children that have suffered avoidable death - Internal** Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 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 - C.difficile** 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 - MRSA (BSI)** 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

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - CLABSI - ICU Only** Hospital Acquired Organisms - CLABSI on ICU Ward Only. 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC		R >1 A N/A G <=1		No Action Required
Reducing Infections	**Hospital Acquired Organisms - RSV** Hospital Acquired Organisms - RSV. 19/20 aim is to reduce by 25% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MSSA** Hospital Acquired Organisms - MSSA . 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required

Delivery of Outstanding Care

7.7 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

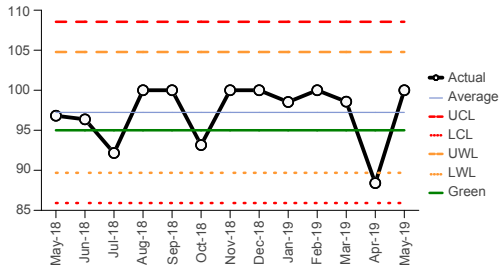
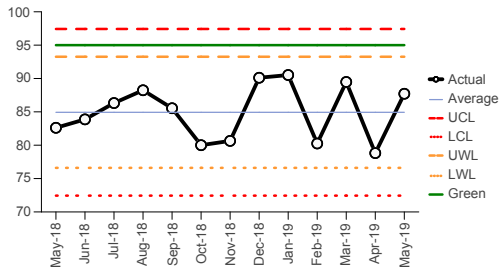
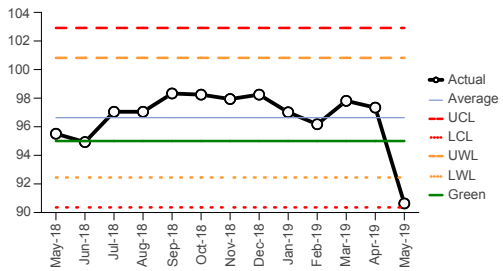
	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - Gram Negative BSI** Gram - Negative BSI to include E Coli, Klebsiella and Pseudomonas . 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required

The Best People doing their best Work

8.1 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

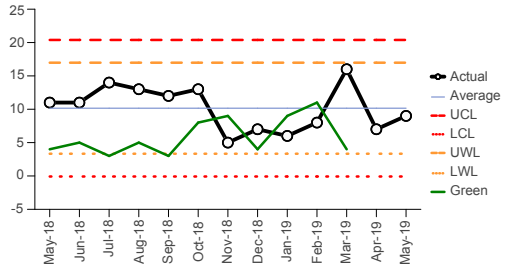
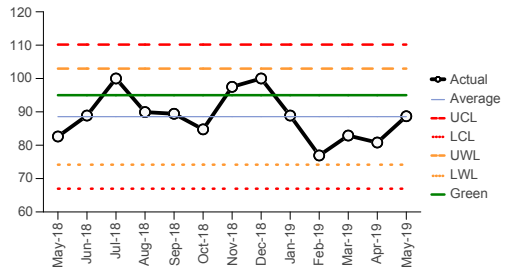
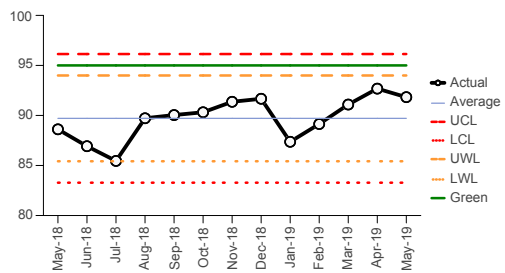
	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family A&E - % Recommend the Trust** 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	87.71 %	R <90 % A >=90 % G >=95 %		179 CYP and families were asked the question 4 said they would not recommend. The main comments are around cleanliness, friendliness of staff, and communication with what was happening & waiting times. This is a great improvement on April. Volunteers continue to support A&E assisting C&YP/ families with play FFT feedback, meeting and greeting. Updating the wobble board with waiting times needs to be consistent. The FFT kiosk is in situ this will enable the A&E staff to monitor and manage their responses in real time.
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** 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	90.63 %	R <90 % A >=90 % G >=95 %		This is a decrease from last month. There were 510 children/young people and families asked the question with 15 negative responses. This was around wanting better pain assessment, the opportunity for daily discussion with qualified staff

The Best People doing their best Work

8.2 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

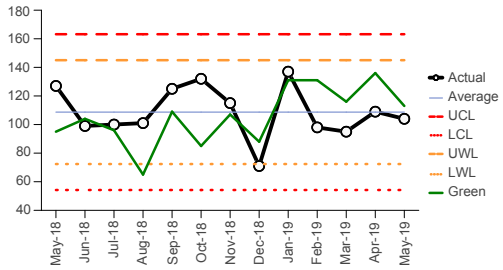
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** Total complaints received. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	9	No Threshold		Medicine – 1 formal complaint , Surgery - 2 formal complaints, Community - 4 formal complaints, Business support - 2 formal complaints
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** 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	88.68 %	R <90 % A >=90 % G >=95 %		The positive responses continue to improve. There is a FFT kiosk place in CHAMS which should encourage higher numbers of feedback. SMS will be live at the end of June, this will also increase numbers in of feedback
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** 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	91.83 %	R <90 % A >=90 % G >=95 %		999 CYP and families were asked if they would recommend out patients 16 were negative responses. Department managers have access to this information through Meridian in real time. Volunteers are being utilised in calling patients and taking blood samples to the labs which has improved patients flow. Checking in machines have been moved from the middle of the Atrium to the front entrance, which will be monitored for overcrowding. Signs have been put up to direct families. Feedback around staff attitude has been addressed.

The Best People doing their best Work

8.3 - QUALITY - CARING

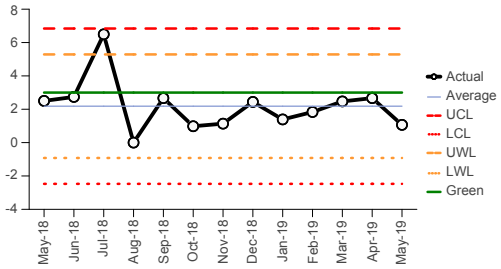
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
PALS	**PALS** 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	104	R >126 A <=126 G <=113		No Action Required

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

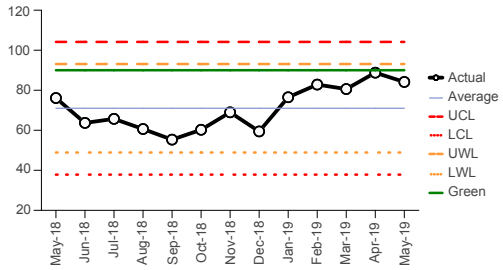
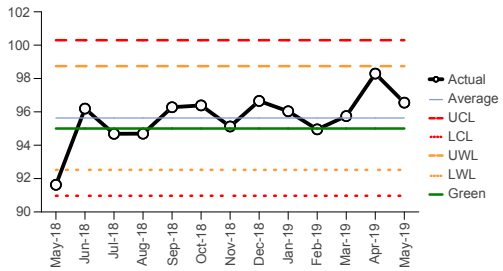
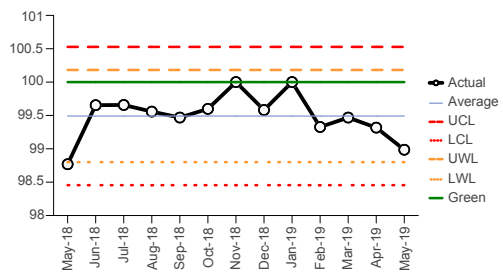
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % 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	1.06 %	R >3 % A N/A G <=3 %		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

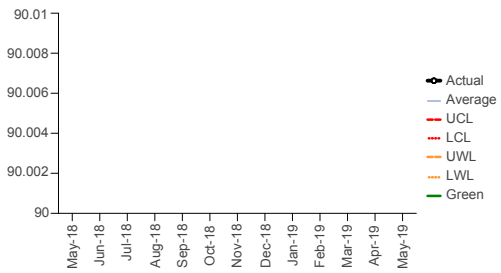
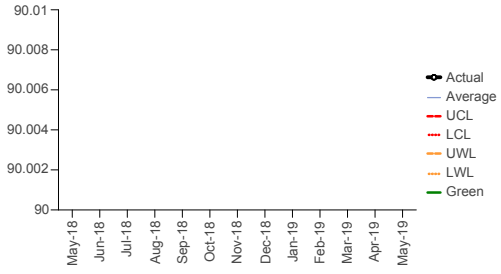
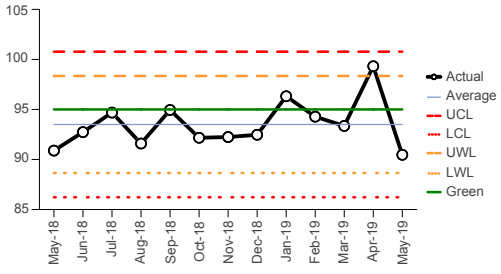
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** 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	84.13 %	R <85 % A >=85 % G >=90 %		The SAFER project focusing on improving efficiencies and flow, ensure all C&YP have a review before midday encouraging nurse or criteria led discharge. The GDE programmes will support more accurate and well communicated discharge dates. Close working with the pre-op service looking at information given to families pre-admission; will advise C&YP how long they are likely to be in hospital. 'MY PAD', is a visual aid in each cubicle for C&YP/ families to document progress and be fully informed of what is outstanding in their care pathway and when they are likely to go home
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** 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	96.55 %	R <90 % A >=90 % G >=95 %		Ward staff continue to introduce themselves on each shift to all families and children, FFT will be monitored by the ward managers and escalated to the medical team. This information is now available in real time so immediate action, concerns complaints can be addressed immediately.
Inpatient Survey: Respect	**IP Survey: % Treated with respect** 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	98.99 %	R <95 % A >=95 % G 100 %		Staff are aware of the Trust values and how this should be demonstrated, the Trust values are visible to clinical and non-clinical staff, C&YP and families. Staffs that are identified as not treating C&YP and their families with respect will be supported and managed appropriately. Any PALS, complaints or family friends test survey feedback both positive and negative is shared at ward level. Any themes/trends will be added to the high level patient experience survey action plan by the patient experience/quality lead and shared at CQSG.

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

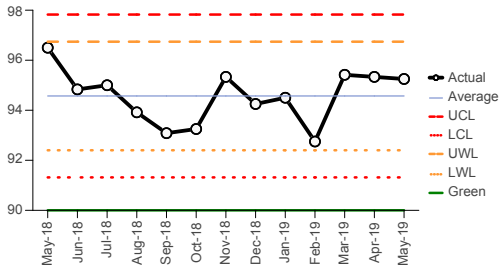
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** % 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		R <85 % A >=85 % G >=90 %		83.05% of CYP said they had been involved in play during May this is a massive improvement more data around learning only will be available for Junes report
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** % 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		R <85 % A >=85 % G >=90 %		83.05% of CYP said they had been involved in play during May this is a massive improvement more data around learning only will be available for Junes report
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** % 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	90.47 %	R <90 % A >=90 % G >=95 %		Ward staff continue to introduce themselves on each shift to all families and children, FFT will be monitored by the ward managers and escalated to the medical team. This information is now available in real time so immediate action, concerns complaints can be addressed immediately.

The Best People doing their best Work

11.1 - QUALITY - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

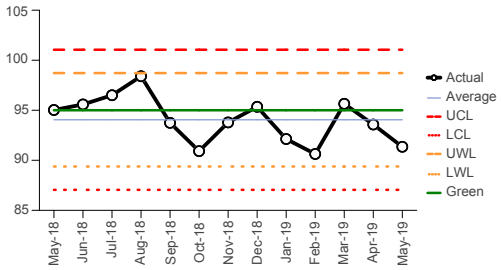
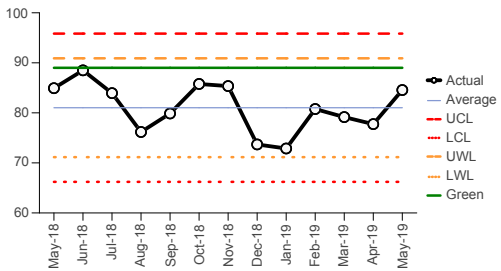
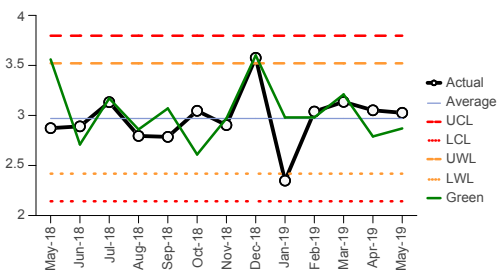
	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	95.25 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

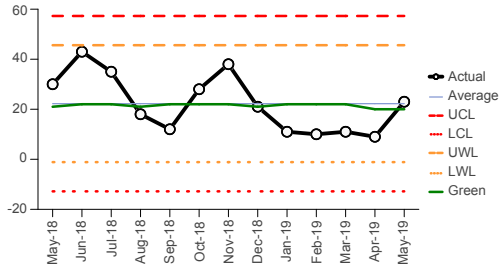
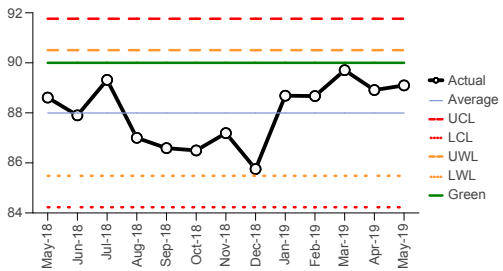
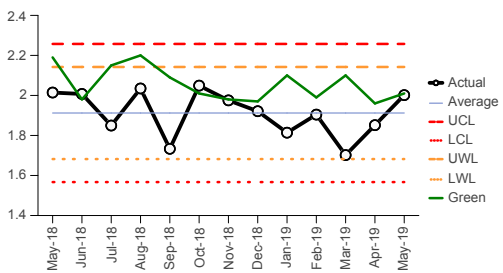
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	91.35 %	R <95 % A N/A G >=95 %		ED performance worsened over two consecutive months. Listening workshop taken place. Action plan in progress to improve position. Action plan to be visible within departments so entire team are aware of improvements being made. Learning also to be taken from RLBUHT and Sheffield. RLBUHT already taken place. Workforce review to be complete y end of June 19.
Bed Occupancy	**Bed Occupancy (Accessible Funded Beds)** Percentage of funded beds that are occupied in accessible wards 3A, 4A, 3C and 4C, this is based on 3 occupancy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	84.56 %	R >93 % A <=93 % G <=89 %		No Action Required
LoS: Elective	**Average LoS - Elective (Days)** Average Elective Length of Stay (days). 19/20 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	3.03	R >2.9 A N/A G <=2.9		An increase in LOS has noted in a small number of specialties that has been linked to the discharge of a number of long stay patients. Ongoing transformation programmes continue to drive improvement; revised metrics are currently being agreed and will be presented to June Programme Board for ratification.

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

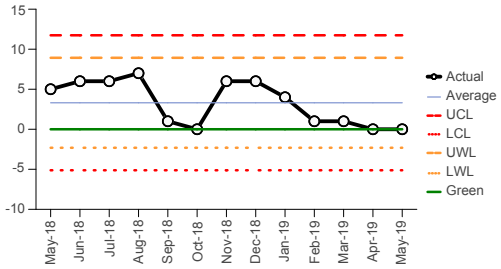
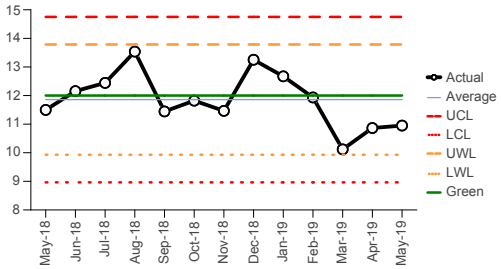
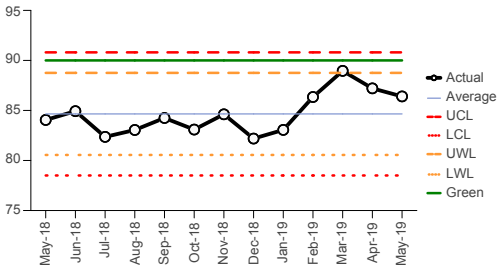
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** 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	23	R >20 A N/A G <=20		11 patients cancelled in May due to a high number of patients waiting for emergency surgery. There is daily allocation for both orthopaedic and plastic trauma; semi-urgent capacity for general surgery is begin reviewed as no theatre space is currently allocated to this group of patients.
Theatre Utilisation	**Theatre Utilisation - % of Session Utilised** Threshold is based on the productive theatre improvement measures at greater than or equal to 90% utilisation of theatres. **Exec Lead:** Adam Bateman **Committee:** RABD	89.10 %	R <80 % A >=80 % G >=90 %		Improvement in month to 89.1%, despite increase in patient cancellations on the day. The theatre scheduling project has now commenced and will involved reviewing current capacity vs demand for all specialties to ensure available theatre space is optimised. Theatre utilisation will be one of the benefits proposed through this project.
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 19/20 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	2.00	R >2.0 A N/A G <=2.0		No Action Required

Delivery of Outstanding Care

12.3 - PERFORMANCE - EFFECTIVE

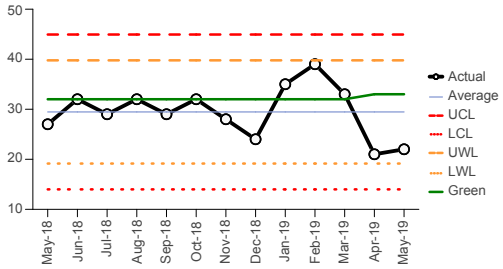
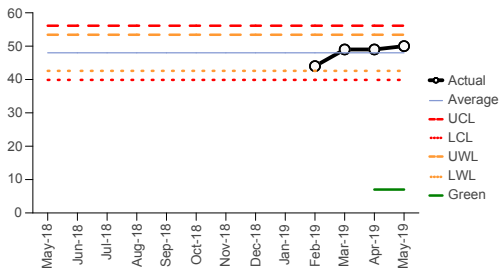
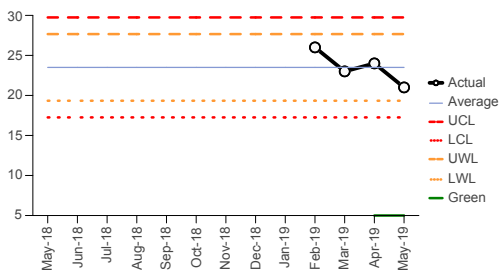
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** 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
Was Not Brought	**Was Not Brought Rate** The target of 12% is a local target aligned to outpatient improvement workstreams (Hybrid Booking, Patient Demogrpahic Checking and bidirectional automate text reminders). **Exec Lead:** Adam Bateman **Committee:** RABD	10.95 %	R >14 % A <=14 % G <=12 %		No Action Required
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and Was Not Brought patients. **Exec Lead:** Adam Bateman **Committee:** RABD	86.40 %	R <85 % A >=85 % G >=90 %		A modest reduction noted for May. Specialty review has identified reductions in Diabetes and T&O which will require further analysis. The Booking improvement programme will now restart under the umbrella of the Out Patient Improvement programme and is set to formally commence at the end of June. It is anticipated that the refreshed programme will deliver further improvements to utilisation.

Delivery of Outstanding Care

12.4 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

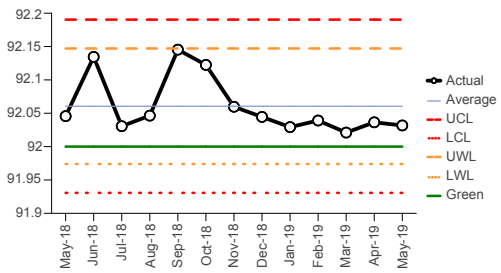
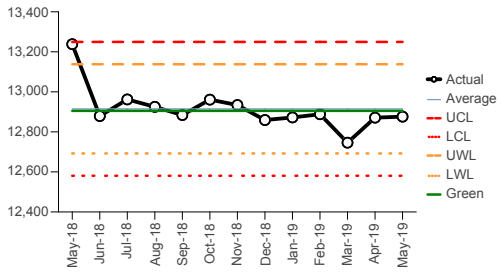
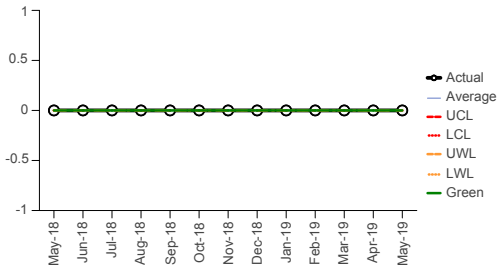
	Description	Performance	Threshold	Trend	Management Action (SMART)
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. This excludes patients on ICU/HDU/NEO and Cardiac HDU. **Exec Lead:** Adam Bateman **Committee:** RABD	22	R >33 A N/A G <=33		No Action Required
Scanning	**Average Scanning Turnaround - Inpatient** 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	50	R >7 A N/A G <=7		A Task & Finish Group has been created to focus on improving the scanning turnaround times, the group will feed into the Clinical Records Committee. The department is also undertaking additional hours scanning out of hours. Progress is monitored week and reported via Comm Cell. The department is in the process of recruiting to the vacancies within the Scanning Team. Records, Transcription and OPD GDE Manager has been attending Divisional/Department meetings to improve on the quality of the documents that are sent for scanning, this would improve times with prepping and scanning.
Scanning	**Average Scanning Turnaround - Outpatient** 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	21	R >5 A N/A G <=5		A Task & Finish Group has been created to focus on improving the scanning turnaround times, the group will feed into the Clinical Records Committee. The department is also undertaking additional hours scanning out of hours. Progress is monitored week and reported via Comm Cell. The department is in the process of recruiting to the vacancies within the Scanning Team. Records, Transcription and OPD GDE Manager has been attending Divisional/Department meetings to improve on the quality of the documents that are sent for scanning, this would improve times with prepping and scanning.

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

BRILLIANT BASICS

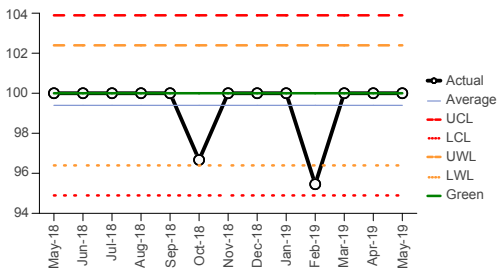
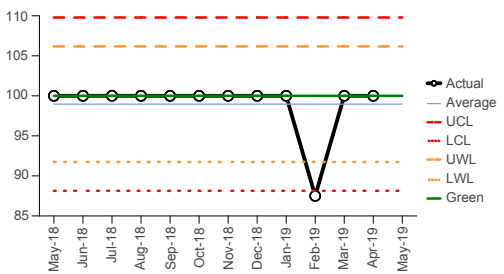
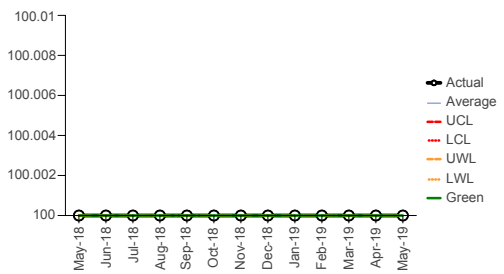
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** 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	92.03 %	R <90 % A >=90 % G >=92 %		No Action Required
Waiting Times	**Waiting List Size** 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	12876	R >12905 A N/A G <=12905		No Action Required
Waiting Times	**Waiting Greater than 52 weeks** 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

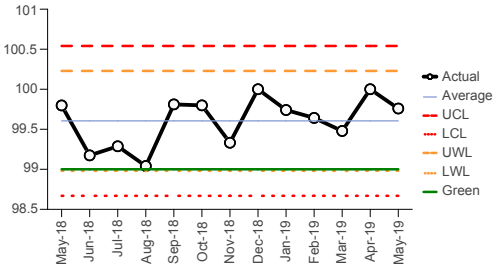
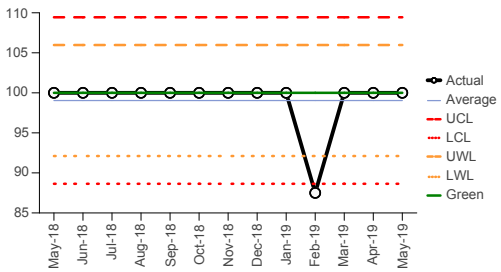
Alder Hey Children's NHS Foundation Trust

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

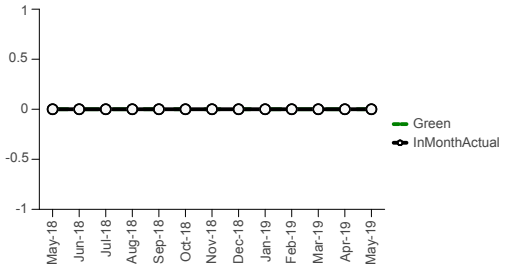
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	99.76 %	R <99 % A N/A G >=99 %		No Action Required
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required

The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

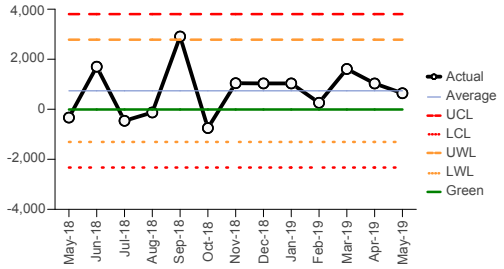
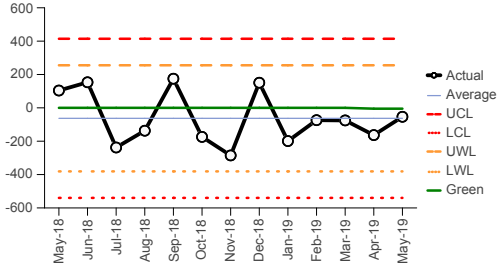
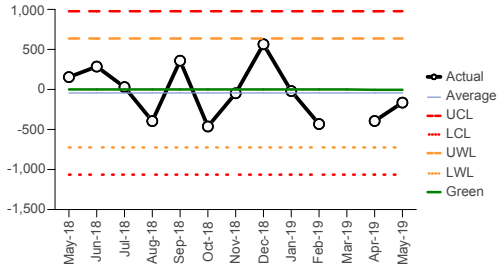
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Governance	**Performance Against Single Oversight Framework Themes** 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 - FINANCE - WELL LED

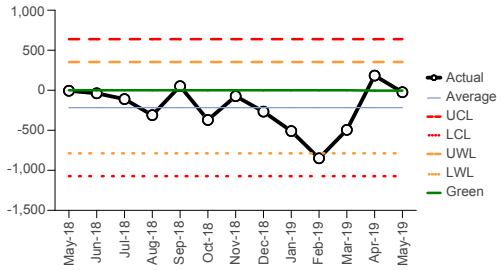
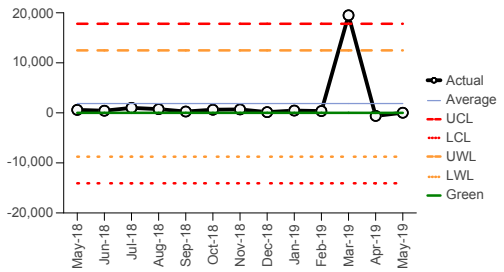
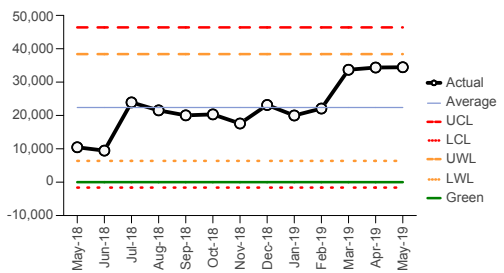
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Capital Expenditure In Month Variance (£'000s)** 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	640	R <-10% A >=-10% G >=-5%		No Action Required
Finance	**CIP In Month Variance (£'000s)** 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	-54	R <-20% A >=-20% G >=-5%		The CIP identified for the year is £3.6m which is £2.4m behind the annual plan. Schemes to bridge this gap need to be identified as soon as possible.
Finance	**Control Total In Month Variance (£'000s)** 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	-165	R <-20% A >=-20% G >=-5%		The Trust is reporting a Control Total deficit for the month of £0.1m which is £0.2m behind the plan. This relates mainly to expenditure on drugs and clinical supplies.

The Best People doing their best Work

15.2 - FINANCE - WELL LED

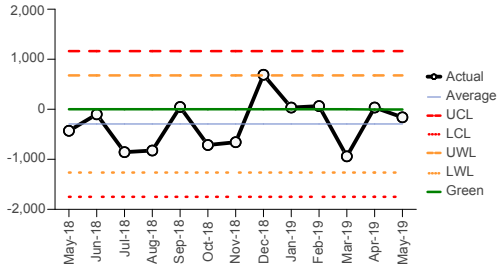
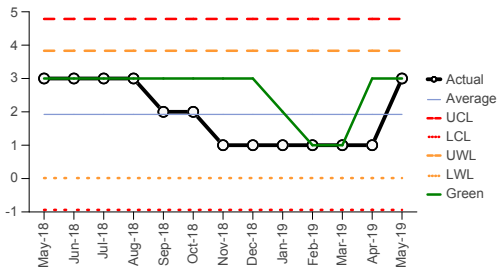
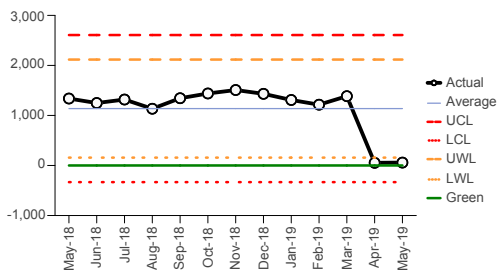
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Pay In Month Variance (£'000s)** 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	-25	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Income In Month Variance (£'000s)** 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	21	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Cash in Bank (£'000s)** 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	34,449	R <-20% A >=-20% G >=-5%		No Action Required

The Best People doing their best Work

15.3 - FINANCE - WELL LED

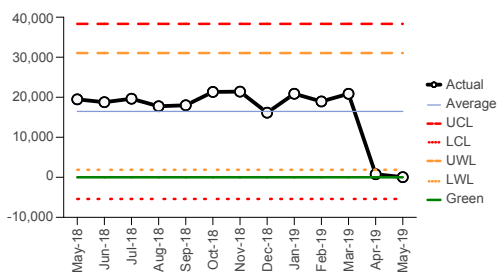
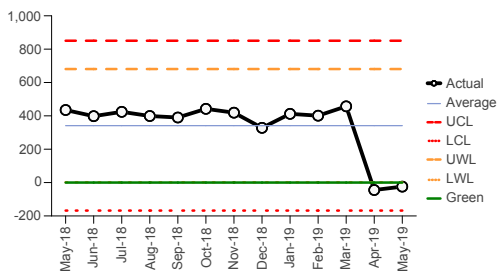
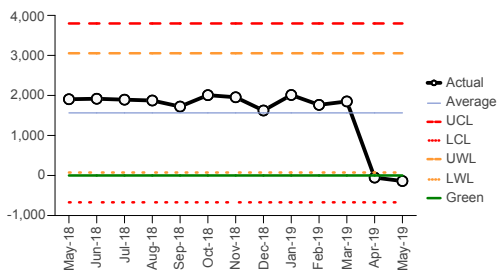
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** 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	-161	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**NHSI Use of Resources** 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** Actvity vs Forecast for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	57.70	R <0 A N/A G >=0		No Action Required

The Best People doing their best Work

15.4 - FINANCE - WELL LED

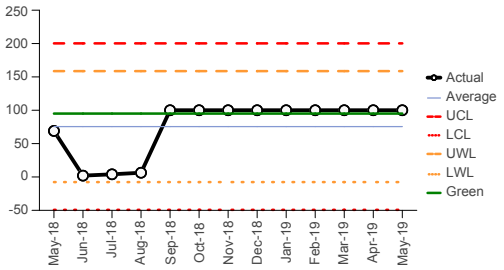
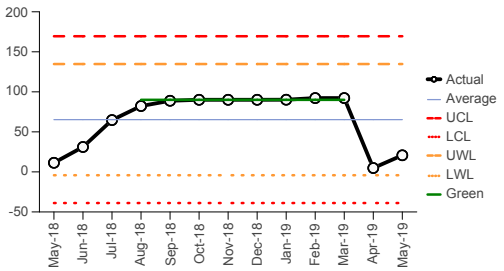
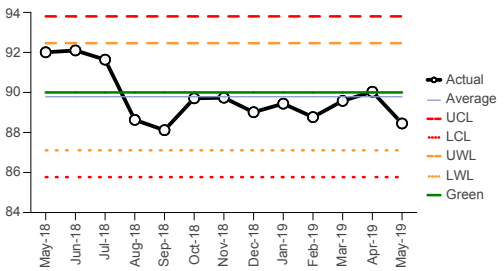
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** Actvity vs Forecast for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	30.10	R <0 A N/A G >=0		No Action Required
Finance	**AvP: IP Elective vs Plan** Actvity vs Forecast for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-24.44	R <0 A N/A G >=0		The most significant adverse variances are in sleep studies and ENT.
Finance	**AvP: Daycase Activity vs Plan** Actvity vs Forecast for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-139.00	R <0 A N/A G >=0		The most significant adverse variances are in gastro and rheum.

The Best People doing their best Work

16.1 - HR - WELL LED

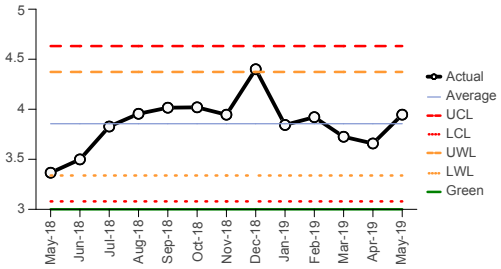
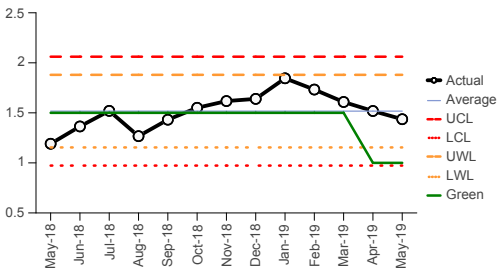
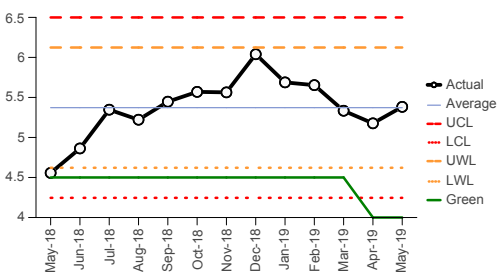
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Personal Development	**PDR** 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	20.73 %	No Threshold		The Trust is halfway through the PDR window, workshops to support managers are ongoing and well attended.
Training	**Mandatory Training** This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	88.45 %	R <80 % A >=80 % G >=90 %		Mandatory Training is now just measured as an overall figure and includes all Resusication competencies, there still continue to be challenges with Information Governance and Safeguarding Level 3 compliance. The Information Governance lead is continuing to offer additional face to face sessions and provide regular reminders to staff and managers to complete their training. Learning and Development are continuing to support this with regular reports to divisional and departmental managers as well as direct emails to staff who are outstanding any mandatory training.

The Best People doing their best Work

16.2 - HR - WELL LED

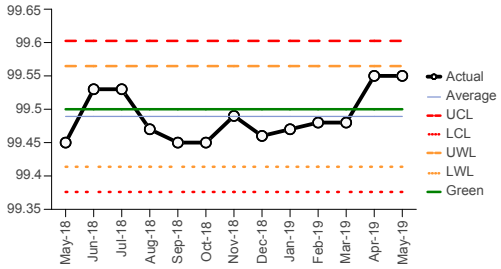
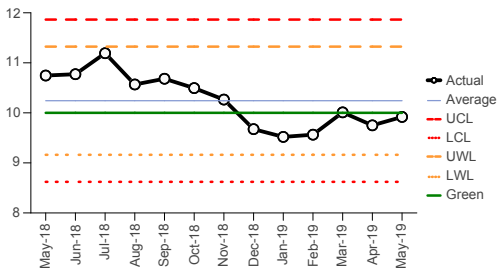
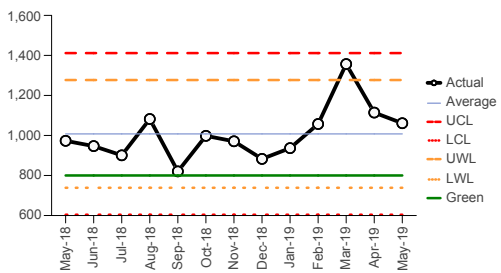
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Long Term Sickness** % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	3.95 %	R >3 % A N/A G <=3 %		See above
Sickness	**Short Term Sickness** % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.44 %	R >1 % A N/A G <=1 %		See above
Sickness	**Sickness** % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.38 %	R >4.5 % A <=4.5 % G <=4 %		The absence contimues to decrease but still remains more than 1% above the Trust target. Absences relating to Anxiety, Stress & Depression have come down furtherand account for 27% of all absences in May, this is followed by Gatrointestinal problems (10%) and Other Musculoskeletal Problems (8.3%). 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.

The Best People doing their best Work

16.3 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

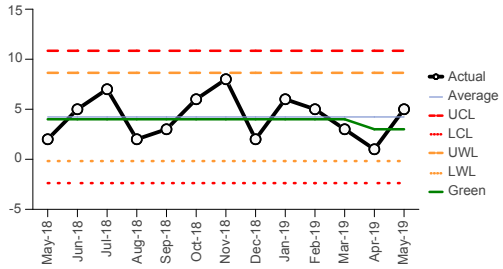
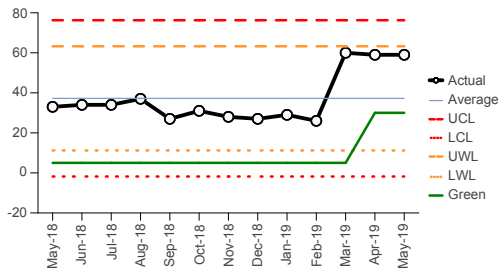
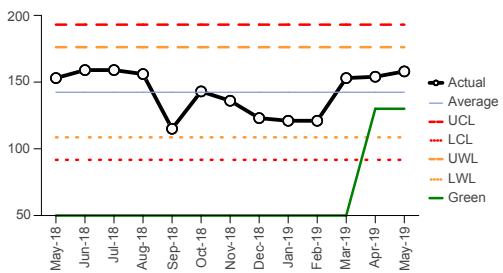
	Description	Performance	Threshold	Trend	Management Action (SMART)
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.55 %	R <99 % A >=99 % G >=99.5 %		No Action Required
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	9.92 %	R >11 % A <=11 % G <=10 %		No Action Required
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	1061.13	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.

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

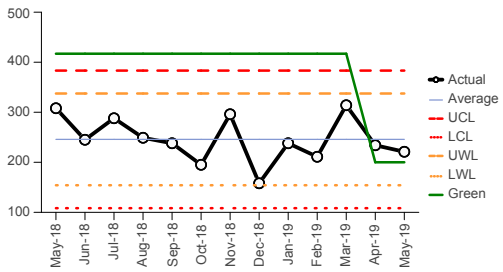
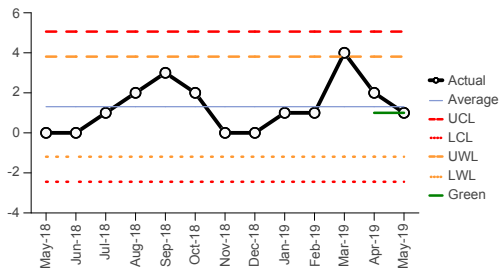
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Academic** Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	5	R <2 A >=2 G >=3		No Action Required
Clinical Research	**Number of Open Studies - Commercial** 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 Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	158	R <111 A >=111 G >=130		No Action Required

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

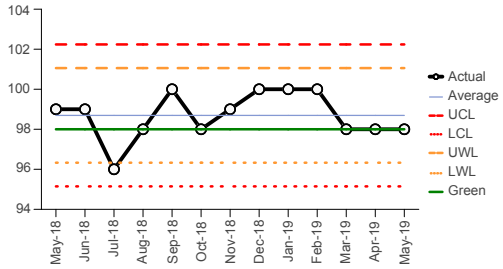
GROW THE FUTURE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of patients recruited** Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Matthew Peak **Committee:** REIC	221	R <171 A >=171 G >=200		No Action Required
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	1	R <1 A N/A G >=1		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

	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	98 %	R <98 % A N/A G >=98 %		No Action Required

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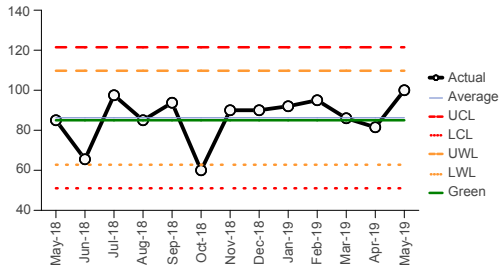
19.1 - FACILITIES - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	100 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

SAFE

	COMMUNITY	MEDICINE	SURGERY	RAG
Total no of incidents reported Near Miss & Above	40	147	241	No Threshold
Clinical Incidents resulting in minor harm & above	0	30	64	No Threshold
Clinical Incidents resulting in Near Miss	9	29	32	No Threshold
Clinical Incidents resulting in No Harm	31	88	145	No Threshold
Clinical Incidents resulting in minor, non permanent harm	0	30	64	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0 N/A >0
Medication errors resulting in harm	0	3	0	No Threshold
Pressure Ulcers (Category 3)	0	0	0	0 N/A >0
Pressure Ulcers (Category 4)	0	0	0	0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	3	0	No Threshold
Medication errors resulting in moderate, sever harm or death	0	0	0	0 N/A >0
Never Events	0	0	0	0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients		33.3%	75.0%	>=90 % N/A <90 %
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0 N/A >0
Hospital Acquired Organisms - RSV	0	0	0	0 N/A >0
Hospital Acquired Organisms - MSSA	0	0	1	No Threshold
Hospital Acquired Organisms - CLABSI - ICU Only			1	No Threshold

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	4	1	0	No Threshold
PALS	30	26	22	No Threshold

All Divisions

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
Readmissions to PICU within 48 hrs	0	0	0	No Threshold
% of acute readmissions within 48 hrs of discharge (exc Oncology)	0.0%	1.4%	1.0%	No Threshold
Readmissions within 48 hrs	0	29	16	No Threshold
Outbreak Acquired Organisms - Other	0	0	0	No Threshold
Outbreak Infections	0	0	0	No Threshold
Referrals Received (Total)	1,014	2,069	4,026	No Threshold
ED: 95% Treated within 4 Hours		91.3%		>=95 % N/A <95 %
Average LoS - Elective (Days)		3.34	2.81	No Threshold
Average LoS - Non-Elective (Days)		1.43	2.87	No Threshold
Theatre Utilisation - % of Session Utilised		83.3%	90.0%	>=90 % >=85 % <80 %
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.1%	1.9%	<=0.8 % N/A >0.8 %
On the day Elective Cancelled Operations for Non Clinical Reasons	0	1	22	No Threshold
28 Day Breaches	0	0	0	0 N/A >0
Clinic Session Utilisation	82.5%	85.2%	87.5%	>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	17.5%	18.4%	13.2%	<=5 % <=10 % >10 %
Was Not Brought Rate	12.2%	11.3%	10.3%	<=12 % <=14 % >14 %
Incomplete Pathway Forms in Outpatients	947	5,041	9,248	No Threshold
Referral Turnaround (days to log)	4.96	4.74	4.54	No Threshold
Referral Turnaround (Consultant to Action)	7.16	5.83	3.85	No Threshold
Coding average comorbidities	3.00	4.26	4.12	No Threshold
CAMHS: Was Not Brought Rate - New	10.3%			<=6 % <=8 % >8 %
CAMHS: Was Not Brought Rate - Follow Up	13.9%			<=10 % <=16 % >16 %

All Divisions

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Received information enabling choices about their care		94.8%	97.9%	>=95 % / >=90 % / <90 %
IP Survey: % Treated with respect		98.6%	99.3%	100 % / >=95 % / <95 %
IP Survey: % Know their planned date of discharge		82.1%	85.6%	>=90 % / >=85 % / <85 %
IP Survey: % Know who is in charge of their care		91.5%	89.7%	>=95 % / >=90 % / <90 %
IP Survey: % Patients involved in play and learning		91.0%	96.2%	>=90 % / >=85 % / <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	74.9%	94.3%	94.0%	>=92 % / >=90 % / <90 %
Waiting List Size	1,393	3,771	7,712	No Threshold
Waiting Greater than 52 weeks	0	0	0	0 / N/A / >0
Diagnostics: % Completed Within 6 Weeks		100.0%	91.7%	>=99 % / N/A / <99 %
Number of Stranded Patients (7+ Days)		30	18	No Threshold
Number of Super Stranded Patients (21+ Days)		15	7	No Threshold
CAMHS: 2 Appointments within 6 weeks	0			No Threshold
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	24.00			No Threshold
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	9.00			No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	16.00	0.00	0.00	No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	20.00	0.00	0.00	No Threshold

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	90	-318	-63	No Threshold
Income In Month Variance (£'000s)	177	-298	159	No Threshold
Pay In Month Variance (£'000s)	-61	90	-7	No Threshold
Non Pay In Month Variance (£'000s)	-25	-110	-216	No Threshold

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective		20	37	>=0	N/A	<0
AvP: IP Elective vs Plan	0	-26	2	>=0	N/A	<0
AvP: OP New	-10.08	-48.66	-248.93	>=0	N/A	<0
AvP: OP FollowUp	36.99	-343.12	218.90	>=0	N/A	<0
AvP: Daycase Activity vs Plan		-125	-15	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	27	-392	-30	>=0	N/A	<0
PDR	10.8%	14.1%	42.7%	No Threshold		
Medical Appraisal	100.0%	100.0%	100.0%	>=95 %	>=90 %	<90 %
Mandatory Training	89.2%	89.7%	87.3%	>=90 %	>=80 %	<80 %
Actual vs Planned Establishment (%)	93.7%	94.5%	96.4%	No Threshold		
Sickness	5.2%	5.1%	6.0%	<=4 %	<=4.5 %	>4.5 %
Attendance (HR)	94.8%	94.9%	94.0%	>=95.5 %	>=90 %	<90 %
Short Term Sickness	1.7%	1.4%	1.6%	<=1 %	N/A	>1 %
Long Term Sickness	3.5%	3.7%	4.4%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	208	288	505	No Threshold		
Staff Turnover	12.3%	9.1%	10.7%	<=10 %	<=11 %	>11 %
% of Correct Pay Achieved	99.6%	99.6%	99.6%	>=99.5 %	>=99 %	<99 %
Safer Staffing (Shift Fill Rate)	102.0%	101.0%	91.0%	>=90 %	>=80 %	<90 %

Medicine

SAFE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	1	4	0	3	2	4	6	3	3	3	2	2	3	No Data Available	No Threshold
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0

CARING

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Complaints	7	4	4	3	6	6	1	4	3	1	3	2	1		No Threshold
PALS	31	27	28	23	21	34	19	21	41	33	20	24	26		No Threshold

EFFECTIVE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Referrals Received (Total)	1,949	2,012	1,905	1,570	1,678	2,085	1,984	1,753	2,027	1,922	2,172	1,999	2,069	No Data Available	No Threshold
ED: 95% Treated within 4 Hours	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%	93.6%	91.3%		>=95 % N/A <95 %
Average LoS - Elective (Days)	2.66	4.01	3.84	2.85	3.18	2.89	3.08	3.54	2.88	3.10	2.87	3.17	3.34		No Threshold
Average LoS - Non-Elective (Days)	1.55	1.59	1.28	1.45	1.35	1.54	1.64	1.45	1.39	1.53	1.21	1.34	1.43		No Threshold
Theatre Utilisation - % of Session Utilised	75.6%	78.6%	83.0%	77.8%	84.8%	80.4%	80.9%	86.7%	84.5%	83.8%	82.4%	81.8%	83.3%		>=90 % >=80 % <80 %
Clinic Session Utilisation	83.7%	84.9%	82.2%	82.0%	85.0%	83.8%	85.9%	82.2%	82.3%	88.2%	88.4%	85.7%	85.2%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	14.2%	12.9%	16.4%	15.7%	14.0%	14.5%	14.2%	15.6%	15.3%	15.3%	13.6%	17.5%	18.4%	No Data Available	<=5 % <=10 % >10 %
Was Not Brought Rate	11.0%	12.6%	12.3%	13.6%	12.3%	12.4%	11.0%	13.3%	11.8%	12.0%	9.7%	11.1%	11.3%		<=12 % <=14 % >14 %
Coding average comorbidities	3.31	3.24	3.32	3.49	3.48	3.56	3.50	3.75	3.74	3.99	3.92	4.38	4.26	No Data Available	No Threshold

RESPONSIVE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	90.2%	89.5%	89.7%	90.2%	91.1%	89.9%	91.5%	92.7%	92.9%	92.5%	93.9%	94.6%	94.3%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	99.8%	99.1%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	100.0%	99.6%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	122	408	223	75	178	-115	15	69	-444	-254		-187	-318		No Threshold
AvP: IP - Non-Elective	858	773	823	672	931	1,017	1,103	1,026	925	849	918	17	20		>=0 N/A <0
AvP: IP Elective vs Plan	122	102	118	105	85	112	100	81	107	93	119	-30	-26		>=0 N/A <0
AvP: OP New	2,529.00	2,595.00	2,563.00	2,132.00	2,270.00	2,553.00	2,545.00	2,184.00	2,537.00	2,424.00	2,825.00	136.61	-48.66	No Data Available	>=0 N/A <0
AvP: OP FollowUp	3,199.00	3,155.00	3,001.00	2,870.00	3,088.00	3,569.00	3,598.00	2,706.00	3,610.00	3,159.00	3,438.00	-168.82	-343.12	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Plan	1,072	1,027	1,036	1,068	961	1,089	1,009	919	1,085	964	941	-6	-125		>=0 N/A <0
AvP: Outpatient Activity vs Plan	5,728	5,750	5,564	5,002	5,358	6,122	6,143	4,890	6,147	5,583	6,263	-32	-392		>=0 N/A <0
PDR	13.4%	35.5%	67.2%	85.5%	88.6%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	2.8%	14.1%		No Threshold
Mandatory Training	92.8%	92.4%	91.3%	87.9%	87.6%	89.4%	90.4%	90.0%	91.0%	90.1%	90.7%	90.7%	89.7%		>=90 % >=80 % <80 %
Sickness	4.0%	4.4%	5.8%	5.1%	5.3%	5.2%	5.3%	6.1%	5.8%	5.6%	5.9%	5.2%	5.1%		<=4 % <=4.5 % >4.5 %
Temporary Spend ('000s)	276	196	227	261	212	217	261	197	247	324	354	287	288		No Threshold

Surgery

SAFE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0

CARING

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Complaints	2	1	5	3	1	1	1	0	1	1	3	0	0		No Threshold
PALS	36	28	20	22	27	27	27	16	27	18	16	23	22		No Threshold

EFFECTIVE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Referrals Received (Total)	4,091	3,834	4,250	3,380	3,239	3,678	3,799	2,837	3,638	3,751	3,987	3,683	4,026	No Data Available	No Threshold
Average LoS - Elective (Days)	2.94	2.55	2.68	2.72	2.66	2.97	2.72	3.38	2.10	2.85	3.16	2.92	2.81		No Threshold
Average LoS - Non-Elective (Days)	2.78	2.63	2.61	2.72	2.49	3.15	2.69	2.91	2.65	2.45	2.59	2.61	2.87		No Threshold
Theatre Utilisation - % of Session Utilised	90.6%	89.5%	90.4%	88.7%	86.9%	87.4%	88.2%	85.6%	89.4%	89.5%	90.6%	90.0%	90.0%		>=90 % >=80 % <80 %
Clinic Session Utilisation	85.0%	85.8%	82.8%	83.8%	84.3%	82.8%	84.5%	82.9%	84.2%	86.2%	89.7%	88.7%	87.5%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	12.3%	12.3%	12.4%	12.6%	14.3%	13.6%	12.8%	13.4%	14.1%	14.4%	14.1%	13.8%	13.2%	No Data Available	<=5 % <=10 % >10 %
Was Not Brought Rate	10.6%	11.2%	12.0%	12.9%	10.6%	11.7%	11.2%	13.2%	12.8%	11.7%	10.1%	10.4%	10.3%		<=12 % <=14 % >14 %
Coding average comorbidities	3.46	3.64	3.60	3.70	3.75	3.70	3.56	3.99	3.95	4.11	3.91	4.05	4.12	No Data Available	No Threshold

RESPONSIVE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	92.5%	93.1%	92.9%	92.7%	93.1%	93.6%	94.1%	93.7%	93.1%	94.0%	94.0%	93.6%	94.0%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.5%	92.3%	100.0%	91.7%		>=99 % N/A <99 %

WELL LED

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	33	-24	89	-45	-320	-25	-209	-253	-240	-470		-405	-63		No Threshold
AvP: IP - Non-Elective	479	474	495	462	413	422	405	406	384	366	467	36	37		>=0 N/A <0
AvP: IP Elective vs Plan	311	294	302	293	304	328	319	245	305	308	335	-15	2		>=0 N/A <0
AvP: OP New	4,625.00	4,418.00	4,495.00	3,972.00	3,834.00	4,451.00	4,382.00	3,347.00	4,253.00	3,819.00	4,376.00	-67.91	-248.93	No Data Available	>=0 N/A <0
AvP: OP FollowUp	5,847.00	5,397.00	6,064.00	5,815.00	5,717.00	6,962.00	7,154.00	5,318.00	6,810.00	6,170.00	6,444.00	414.69	218.90	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Plan	815	858	825	782	736	894	909	680	861	756	884	-46	-15		>=0 N/A <0
AvP: Outpatient Activity vs Plan	10,472	9,815	10,559	9,787	9,551	11,413	11,536	8,665	11,063	9,989	10,820	347	-30		>=0 N/A <0
PDR	10.0%	33.5%	64.4%	83.6%	90.7%	90.0%	90.0%	90.0%	90.0%	96.6%	96.6%	11.6%	42.7%		No Threshold
Mandatory Training	89.9%	90.9%	90.3%	87.2%	87.8%	88.6%	87.8%	88.0%	90.0%	88.4%	89.4%	88.8%	87.3%		>=90 % >=80 % <80 %
Sickness	4.7%	5.5%	5.4%	5.6%	6.0%	6.5%	6.0%	6.4%	6.2%	6.4%	5.2%	5.2%	6.0%		<=4 % <=4.5 % >4.5 %
Temporary Spend ('000s)	419	480	445	509	374	529	485	484	474	564	591	515	505		No Threshold

Community

SAFE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0

CARING

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Complaints	2	3	5	4	3	2	2	1	1	4	5	4	4		No Threshold
PALS	28	20	21	27	43	36	40	11	35	27	31	30	30		No Threshold

EFFECTIVE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Referrals Received (Total)	1,094	851	1,080	664	692	979	1,061	765	901	968	1,070	879	1,014	No Data Available	No Threshold
Average LoS - Elective (Days)							1.00	3.00							No Threshold
Average LoS - Non-Elective (Days)												0.00			No Threshold
Clinic Session Utilisation	79.2%	78.7%	79.9%	80.7%	80.5%	82.7%	81.6%	77.7%	79.1%	81.0%	87.2%	83.2%	82.5%		>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	10.8%	16.8%	16.2%	23.3%	22.3%	17.7%	22.1%	23.6%	18.3%	21.4%	22.8%	20.7%	17.5%	No Data Available	<=5 % <=10 % >10 %
Was Not Brought Rate	14.7%	14.2%	13.8%	15.7%	12.6%	11.1%	12.9%	13.4%	13.9%	12.4%	10.9%	12.0%	12.2%		<=12 % <=14 % >14 %
Coding average comorbidities	2.33		2.00	8.00	4.00	2.00	2.67		2.00	1.50	6.00	4.00	3.00	No Data Available	No Threshold

RESPONSIVE

	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	96.1%	95.3%	92.2%	92.7%	87.3%	87.1%	78.8%	78.3%	82.7%	78.3%	74.2%	75.2%	74.9%		>=92 % >=90 % <90 %

WELL LED

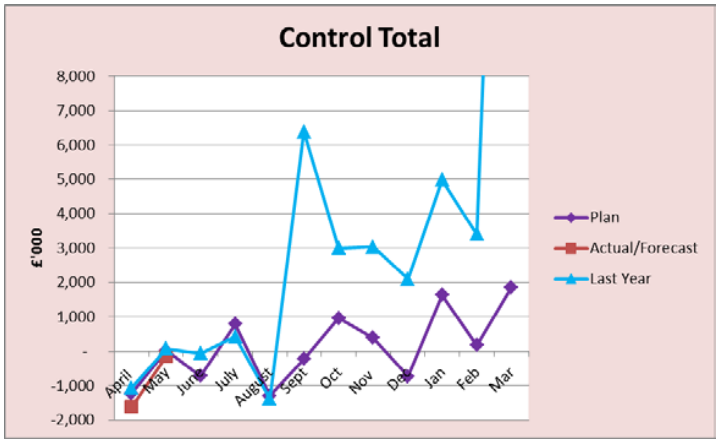
	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-70	30	62	-144	87	54	-61	118	-23	26		-20	90		No Threshold
AvP: IP Elective vs Plan												0	0		>=0 N/A <0
AvP: OP New	446.00	422.00	408.00	311.00	356.00	532.00	531.00	337.00	407.00	389.00	415.00	-3.48	-10.08	No Data Available	>=0 N/A <0
AvP: OP FollowUp	2,614.00	2,495.00	2,502.00	1,938.00	2,141.00	2,631.00	2,630.00	1,812.00	2,606.00	2,422.00	2,705.00	-16.87	36.99	No Data Available	>=0 N/A <0
AvP: Outpatient Activity vs Plan	3,060	2,917	2,910	2,249	2,497	3,163	3,161	2,149	3,013	2,811	3,120	-20	27		>=0 N/A <0
PDR	9.3%	31.9%	58.8%	78.7%	87.9%	93.0%	93.0%	93.0%	93.7%	93.7%	93.7%	1.4%	10.8%		No Threshold
Mandatory Training	95.0%	94.1%	94.2%	92.7%	91.2%	92.5%	91.4%	90.9%	88.3%	89.2%	90.3%	92.2%	89.2%		>=90 % >=80 % <80 %
Sickness	5.2%	3.9%	3.5%	3.4%	4.1%	4.0%	5.2%	5.2%	5.3%	5.3%	4.8%	4.8%	5.2%		<=4 % <=4.5 % >4.5 %
Temporary Spend ('000s)	180	142	131	154	125	131	150	121	151	91	339	181	208		No Threshold

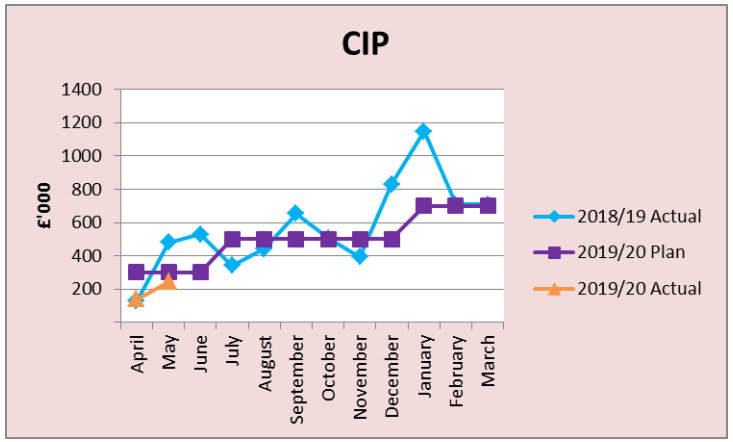
Alder Hey Children's NHS
NHS Foundation Trust

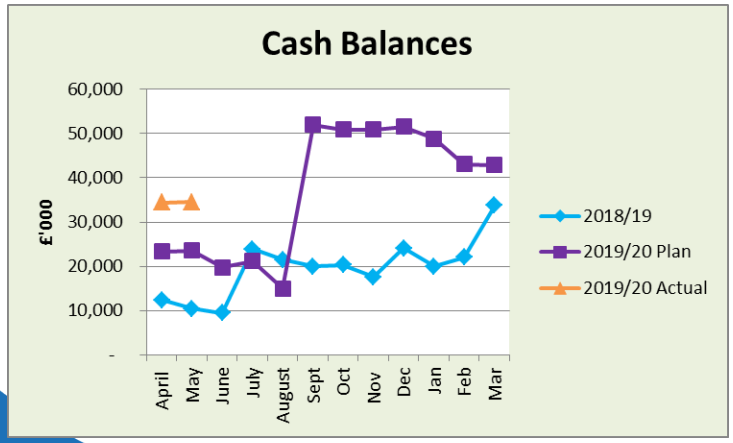
Month 2 2019/20
Financial Dashboard
Trust Board

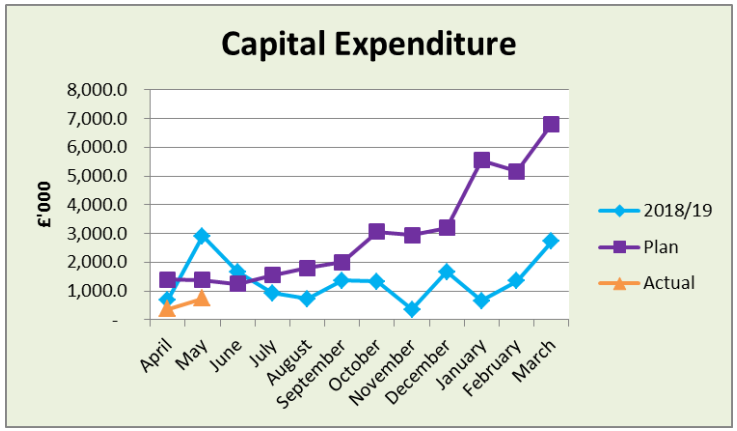
Inspired by Children

Control Total in month variance	CIP Forecast for year	Use of Resources	Control Total Forecast Risk
(£0.2m)	(£3.6m)	3	(£7.9m)
Not Achieved	Not identified	On Plan	Not Achieved

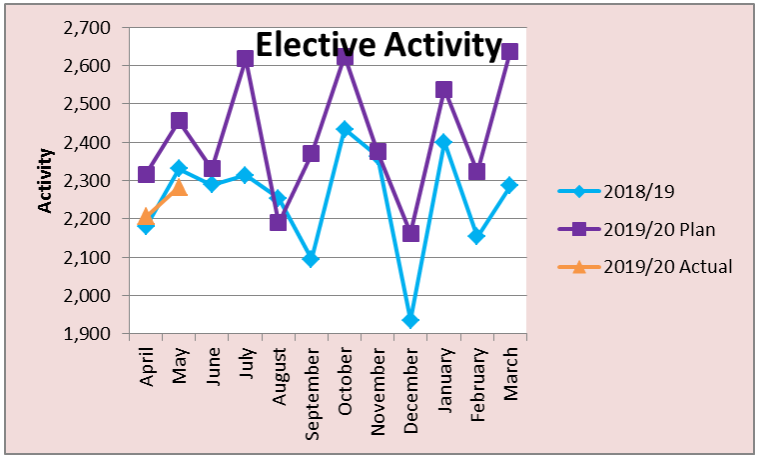


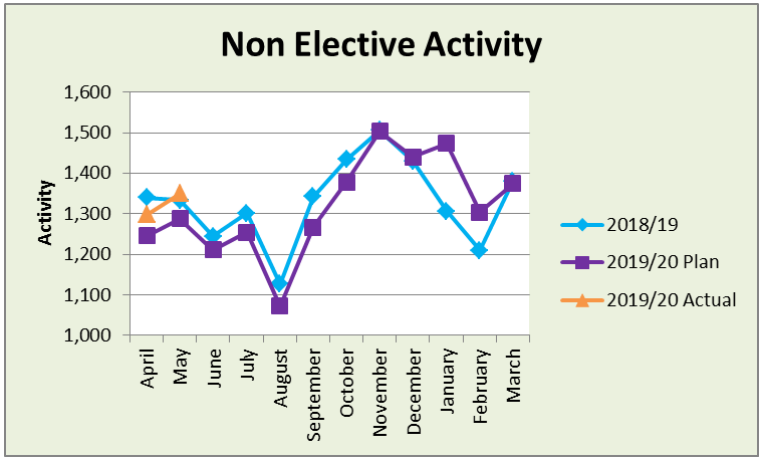


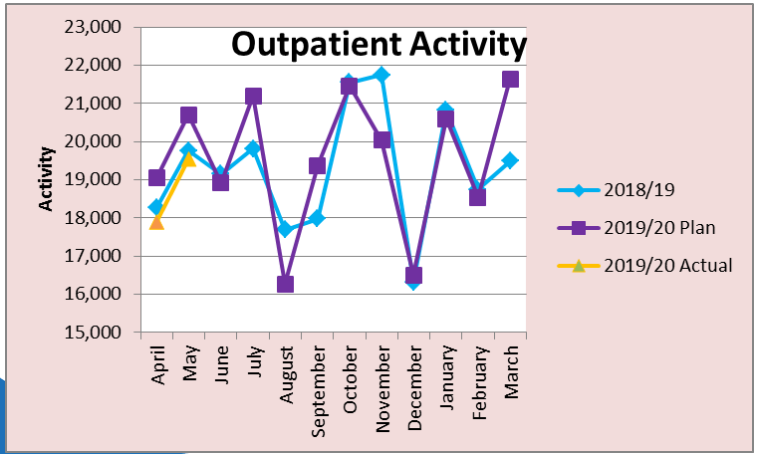


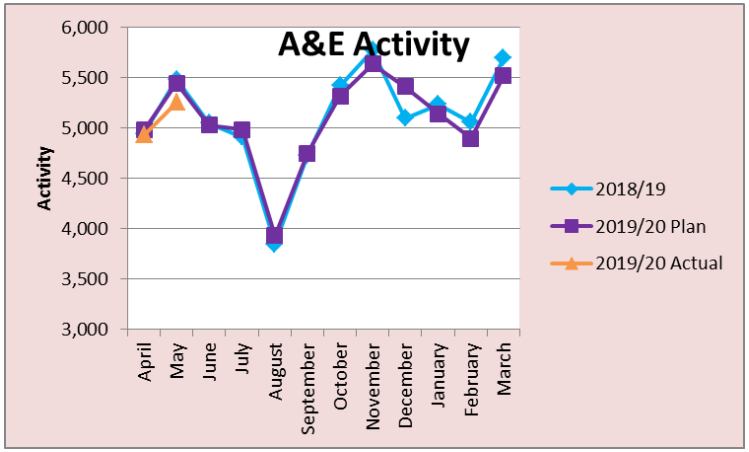


Elective Activity in Month (174)	Non Elective Activity in Month 62	Outpatient Activity in Month (1,144)	A&E Activity In Month (191)
Not Achieved	Achieved	Not Achieved	Not Achieved









Inspired by Children

Strategic Risks

Alder Hey Children's NHS Foundation Trust

	Risk	Total Value £k	Action
Cash	Capital development affordability	£(33,000)	• Campus group formed to review schemes and target cost reduction to ensure affordable. • MDT review of IT and Medical equipment needs
	National Tariff and MFF changes expected to reduce income	£(4,920)	• AH a member of complexity project led by national pricing team. Continue to lobby at national level
Recurrent Control Total Pressures	Commissioner Contract challenges	£(2,100)	• Managed through contract process to ensure steady state
	GDE Programme recurrent maintenance cost	£(800)	• Funded through savings identified
	Emerging cost pressures without income source e.g. strategic investment, Quality and safety, workforce change	£(2,000)+	• Workforce plan developed that exploits digital, innovation and research to allow and invest to save.
	Revenue consequences of Campus schemes	TBC Circa £(4,000)	• To be refined once schemes are finalised
	Delivery of Neonatal service (incl BAPM standards) over and above commissioner envelope	£(3,000)	• Issue escalated and urgent meeting scheduled with NHSE

Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
2nd July 2019

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team Governance Manager
Subject/Title	Board Assurance Framework Review (June 2019)
Background papers	Monthly BAF Reports
Purpose of Paper	To provide the Board with the BAF update Report
Action/Decision required	The Board is asked to discuss and note the Board Assurance Framework – June position
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 & innovation**
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.

2. Review of the BAF

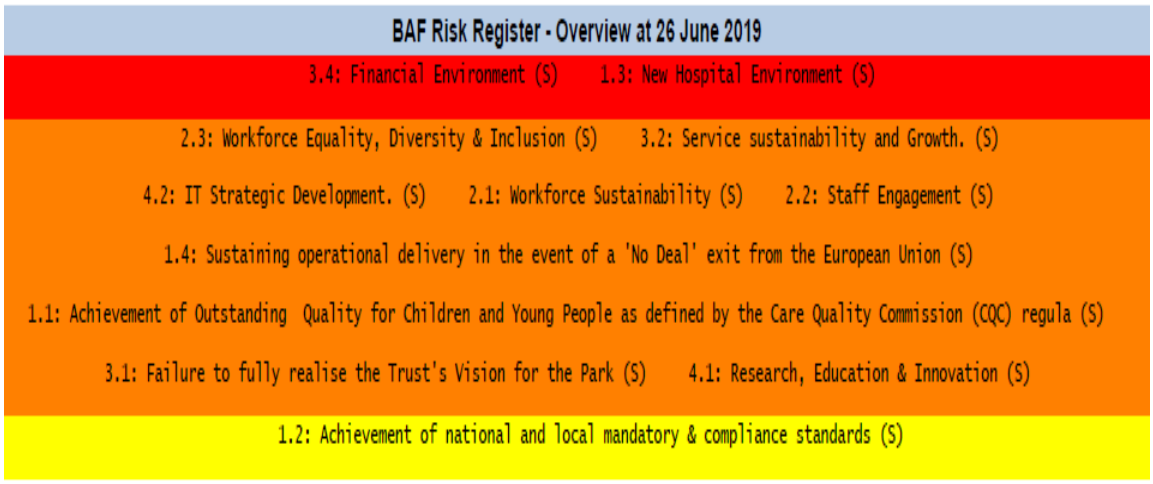
A thorough review of the BAF has now been undertaken to align to the Trust's Strategic Plan to 2024.

A redesign exercise has also been undertaken to improve its layout and provide greater assurance to Non-Executive Director colleagues on how the Executive Team are effectively managing the strategic risks that threaten the achievement of the trust's operational plan.

Changes to the document have been simplistic, but contribute greatly to a more comprehensive report that provides better read-across in terms of matching each existing control measures with assurance evidence and also gaps in controls and actions required to achieve target risk rating.

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 26 June 2019



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

3. Summary of BAF - at 25 June 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 DP	**New 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 DP	**Research, Education & Innovation**		3-3	3-2	STATIC	STATIC
4.2 KW	**IT Strategic Development**		3-3	3-2	STATIC	STATIC

8. Changes since 28 May 2019 Board meeting

External risks

- ***Service Sustainability and Growth (DJ)***
  Reviewed the risk. Considered the score – no change in month. Updated historical control measure actions. Removed 2 x historical/outdated control measures (trauma business case, 7 day working project)

- ***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 - current score adequate. Further review of arrangements to take place post-election when we expect to receive further national guidance.

Internal risks:

- ***Achievement of National and Local Mandatory & Compliance Standards (ES)***
  Risk Reviewed. ED performance worsened over two consecutive months - actions updated to reflect remedial works.

- ***Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations (HG)***
  Staffing Paper remains on schedule for presentation at Trust Board 2nd July 2019. Recruitment event held on 15th June; secured 57 new starters.

- ***Financial Environment (JG)***
  Risk reviewed. Given current divisional forecast and capital affordability challenges this remains a high risk, therefore no change in score.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Risk reviewed no change to score in-month. Risk profile to be reassessed on completion of cost plan work.

- ***IT Strategic Development (KW)***
  Strategy remains on track for July Trust Board. Baseline assessment on operating model complete Options appraisal for disaster recovery commissioned.

- ***Workforce Sustainability (MS)***
  Risk reviewed. All actions remain on track; no change in risk score.

- ***Staff Engagement (MS)***

Risk reviewed - removed gap in control relating to Leadership Strategy which was implemented Oct 2018. No change in risk score. All other actions remain on track.

- ***New Hospital Environment (DP)***
  Risk reviewed no change to score in-month. Key focus on pipework actions - overall rating unlikely to change until actions complete October 2019

- ***Research, Education & Innovation (DP)***
  Risk reviewed, no change to score in-month

Erica Saunders
Director of Corporate Affairs
2nd July 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
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	31/05/2019	Monthly monitoring continues via Board and assurance committees. All must do actions complete. Should do actions will continue to be monitored through monthly review at committees and Board.

Executive Leads Assessment

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.

May 2019 - Pauline Brown Nurse staffing paper presented at WOD on 3rd May providing significant assurance related to safe and appropriate front line nurse staffing levels. Positive feedback received from WOD. Paper to be presented to CCG at CQPG on 24th May and Trust Board on 2nd July. Significant assurance given by MIAA following audit of ward Accreditation process. Programme of annual nursing audit and Matron audits devised and commenced to monitor key elements of the quality of care delivered
April 2019 - Hilda Gwilliams CCG event in relation to CIP QIAs complete, positive outcome. Annual workforce report complete and due to be presented at WOD in May followed by Trust Board in June.
March 2019 - Hilda Gwilliams Preparations underway in relation to the Trust's CIP plans and Quality Impact Assessment mandated processes to be presented by the Chief Nurse and Medical Director at the CCG first week in April.

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
2. Some areas remain fragile e.g. ED 4 hour target.
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.	01/07/2019	Listening workshop taken place and action plan in place to improve ED position. Workforce review to be completed by end of June 2019
3. CQC organisational readiness piece commenced	31/07/2019	Presentation to Execs 20/6. Detailed roll-out plans being developed
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	

Executive Leads Assessment

June 2019 - Erica Saunders
Risk Reviewed. ED performance worsened over two consecutive months - actions updated to reflect work ongoing to address.

May 2019 - Erica Saunders
This risk to be rolled over into new financial year and actions updated as per operational plan

April 2019 - Erica Saunders
All access targets met for March including ED 4 hour wait placing Alder Hey as one of only ten trusts nationally to achieve against this standard.
Target number of CCAD cases exceeded (410 for the year - highest level of performance for Trust)

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care		Risk Title: New Hospital Environment		
Related CQC Themes: Safe			Link to Corporate risk/s: No Risks Linked		
Exec Lead: David Powell	Type: Internal, New		Current IxL: 4x4	Target IxL: 4x2	Trend: STATIC

Risk Description

Sale of PFI Project co. whilst a number of commissioning risks are still present could lead to lack of focus and problems in maintaining safe environment

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

Gaps in Controls / Assurance

Some repeat/overlap reporting
Some lack of clarity over risk ownership/H&S role

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Replacement programme for pipe work to be agreed with builder	02/09/2019	Stocktake call with Project Co. 25 June supported by an action plan
Prepare recommendation to Board on proposed pipework replacement strategy	01/10/2019	Paper being prepared for October 2019 Board
Senior team meeting with Project Co to discuss pipework plans	30/06/2019	Meeting held

Executive Leads Assessment

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

May 2019 - David Powell
Written to Project Co. to get an updated plan for pipework, response due by end of May 2019

April 2019 - David Powell
Pipework discussed at Liaison Committee - planned series of meetings with Project Co

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 ridsk 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	
Continue to engage and lobby NHSE colleagues to ensure centrally managed mitigations are understood and adequate	31/07/2019	

Executive Leads Assessment

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	31/07/2019	
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	30/06/2019	

Executive Leads Assessment

June 2019 - Melissa Swindell
Risk reviewed. All actions remain on track; no change in risk score.

May 2019 - Sharon Owen
All actions on track

April 2019 - Melissa Swindell
All actions on track

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	
High level leadership strategy has been approved; the plan will be rolled out during 19/20	31/12/2019	Leadership Strategy implemented - Oct 2018

Executive Leads Assessment

June 2019 - Melissa Swindell
Risk reviewed - removed gap in control relating to Leadership Strategy as this was implemented Oct 2018. No change in risk score. All other actions remain on track.

October 2018 - Melissa Swindell
refer to September 2018 executive update.

August 2018 - Melissa Swindell
Refer to executive update.

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	30/06/2019	Commissioned for Sept 2019

Executive Leads Assessment

June 2019 - Melissa Swindell
Risk reviewed. All actions remain on track; no change in risk score.

May 2019 - Sharon Owen
All actions on track

October 2018 - Sharon Owen
Refer to Executive upate

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

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
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)
Procure works for stage 1 park reinstatement	30/09/2019	
Complete cost plan for final park works	30/09/2019	
assessment of status including risk of all development projects	31/10/2019	
Complete cost assessment and scheme rationalisation	30/09/2019	

Executive Leads Assessment

June 2019 - David Powell
Risk reviewed, no change to score in-month. Risk profile to be reassessed on completion of cost plan work.

May 2019 - David Powell
Park planning application in consultation

April 2019 - David Powell
Planning application is with Council and consultations being held with the public.

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 and Growth.		
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; due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities. External opportunities for partnership, and/or to reduce variation in Children & Young People's services (across the city and beyond) may not be fully optimised.

Existing Control Measures	Assurance Evidence (attach on system)
Divisional Performance Management Framework.	Monthly to Board via RABD and Board.
Clear trajectories for challenged specialities to deliver.	Divisional Performance Review meetings
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)
Change Programme Projects (Strategic Partnerships & International Clinical Business and non NHS Patient Services)	- Strategic Partnerships & International Clinical Business and non NHS Patient Services - 7 Day Working Project - CIPs in new Change Programme subject to assurance and sub-committee performance management.
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.
Weekly meeting with divisions established to review forward look re elective and day case patient bookings to ensure activity scheduled meets contract requirements	Key developments monitored through Divisions
Growth and sustainability through external partnerships is a key theme in the Change Programme.	- Growth through Partnerships included in Strategic Business planning - both annual operational plan and developing long term plan. - Monitored at refreshed 'Sustainability Through External Partnerships Steering Group' (proposal to develop this during Q2 2019 into Strategy & Ops Delivery Board - to maximise alignment to the strategy and delivery agendas).
Internal review of service specifications as part of Specialist Commissioning review	Compliance with final national specifications.
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 (evidence to follow)
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey leading the partnership development of the future model of Paediatric Urgent Care in Liverpool	Clinical Network Partnership development with Manchester Children's Hospital.

Gaps in Controls / Assurance

1. Workforce constraints in specialised services.
2. Early warning indicators for leading indicators.
3. Inability to recruit to highly specialist roles due to skill shortages nationally.
4. 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.
5. Potential elective underperformance due to cancelled sessions.

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.

Executive Leads Assessment

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)
May 2019 - Dani Jones Controls, actions and exec assessment update
April 2019 - Dani Jones Agreement reached for Alder Hey to host the expanded all-age ACHD network; plans underway with Level 1 partners to shape. Alder Hey maintain senior presence at every stage of Liverpool's System Capability Programme; final session scheduled for 15th May, expectation that agreed 'One Liverpool' programme of work retains existing links with Children's Transformation Plan.

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: 4x4	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. 5 Year capital plan	31/07/2019	Revised 5 year capital plan under development. Progress to be reported to July Board
1. Tracking actions from Sustainability Delivery Group	30/09/2019	on target
2. Develop fully worked up CIP programme - £2.7m gap	30/06/2019	CIP Position improved however Divisional forecasts still showing a potential £1.6m gap

Executive Leads Assessment

June 2019 - John Grinnell
Risk reviewed. Given current divisional forecast and capital affordability challenges this remains a high risk, therefore no change in score.

May 2019 - Claire Liddy
Month 1 19/20 delivered a £0.4m adverse variance. Total run rate risk including CIP risk is £8m which is being mitigated through robust forward look and CiP planning exercise. Longer term risks include HRGv4+ Children's Tariff risk which transitions to £7m downside per annum. Capital 5 year planning exercise underway and will conclude in Q2, latest forecast present a cash affordability concern that is being validated.

April 2019 - John Grinnell
year end surplus target achieved which included strong end of year performance from divisions, end of year contract agreements and two material transactions relating to the agreed land sale and PFO contractual reset. Alongside PSF incentive and bonus culminated in 49.9m surplus (pre audited accounts). Focus now on underlying position for 19/20 that without PSF see us remain in underlying deficit. Work to be done to bridge CIP gap (currently £2+m.)

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: David Powell	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

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 Business Model	30/09/2019	Framework refresh
Agree incentivisation framework for staff and teams	01/12/2019	
Complete contract with University of Liverpool	01/07/2019	.
Complete review and implement new structures and framework for research, innovation & education	01/10/2019	

Executive Leads Assessment

June 2019 - David Powell
Risk reviewed, no change to score in-month

May 2019 - David Powell
Considering structure and relationship between innovation and research

April 2019 - David Powell
Occupation of building almost complete

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Game-Changing Research And Innovation	Risk Title: IT Strategic Development.		
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: 3x3	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

Existing Control Measures	Assurance Evidence (attach on system)
Key projects and progress tracked through the GDE Programme Board and RABD Committee	Regular progress reports presented to RABD & Trust Board
Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development	
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
Formal change control processes now in place	Board agreed change process
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. Divisional CCIOs in the process of being recruited. Community Division - commenced in post June 2019
NHSE & NHS Digital external oversight of GDE programme	NHSD tracking of GDE Programme through attendance at Programme Board and bi-monthly assurance reports.
A plan is now in place to develop new strategy and roadmap to present to Board in Summer 2019	Digital Strategy scheduled to be presented at Trust Board July 2019

Gaps in Controls / Assurance

1. IM&T Strategy out of date - update work in progress to produce digital strategy for Summer 2019
2. Resilience of underlying infrastructure - options appraisal for disaster recovery to be undertaken
3. IT operating model assessment underway
4. Lack of secondary data centre / disaster recovery

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Procure replacement equipment	02/09/2019	equipment is now installed however delay in ensuring appropriate electrical back up in place which is being rectified. Awaiting final solution on electrical supply.
1. Digital Strategy & operating model work to be concluded	08/07/2019	Good progress on digital strategy, on track to take to board in July. Operating Model baseline assessment undertaken.
4. Develop options appraisal	31/07/2019	Options appraisal in development, investment identified via Trust Capital Programme
3. Undertake baseline assessment.	02/09/2019	Baseline assessment complete. Options and recommendations for future delivery in development

Executive Leads Assessment

June 2019 - Kate Warriner
Strategy remains on track for July Board including technology road map. Baseline assessment on operating model complete. Options appraisal for disaster recovery commissioned.

May 2019 - Kate Warriner
Strategy on track for July Trust Board. Options appraisal with regards to resilience of key systems to be undertaken as integral part of technology roadmap

April 2019 - John Grinnell
New CIO in post, Digital Strategy & operating model in development. Strategy due for July Trust Board.

Neonatal Single Service
Board Update-July 2019

BOARD OF DIRECTORS

Tuesday 2nd July 2019

Report of:	Adam, Bateman Chief Operating Officer
Paper Prepared by:	Mary Passant, Programme Manager Sian Calderwood, Service Manager Alder Hey Jen Deeney, Head of Neonatal Nursing & Operations Liverpool Women's
Subject/Title:	Update on single neonatal service
Background Papers:	
Purpose of Paper:	To inform the Board of the latest position on this development
Action/Decision Required:	Consider support of the high-level milestone plan
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Sustainability through external partnerships Delivering outstanding care
Resource Impact:	

Neonatal Single Service
Board Update-July 2019

Introduction

This short paper provides an update for Boards on the Neonatal Partnership and ambition to create a single neonatal service across the two Trusts.

Key reasons where identified as to why a new model of care for neonatal babies in Liverpool is critical:

- Firstly, the single service will provide a **safer service for babies** and will be a step change towards achieving the national service specifications and standards.
- Secondly, the **quality of care and clinical outcomes** for babies will be improved by strengthening the joint working between both organisations in order to provide increased levels of neonatology and surgical expertise and also an appropriate environment for all babies to be nursed in the same dedicated service.
- Thirdly, the **experience** of mothers and families will be improved by reducing the number of unnecessary transfers between hospitals by 50% (**transfers** are also **associated with increased morbidity and mortality**).

The key milestones of the roadmap to achieving these are:

- 7 Day working at AHCH Neonatal Unit (September 2018)
- Daily ANNP Presence at AHCH Neonatal Unit (September 2018)
- Twice Daily Ward Round at AHCH Neonatal Unit (During 2019)
- New Fit for Purpose Neonatal environment opens at LWH (July 2020)
- New Fit for Purpose HDU Neonatal environment opens at AHCH (During 2020)
- New Fit for Purpose NICU Neonatal cots open at AHCH (April 2021).
- Job descriptions for the Neonatal Single Services leadership team have been produced and are with HR for ratification some of them need to be banded through Agenda for Change process, there has been 2 meetings with senior members of both Trust to try and agreed the process for appointment and this has not been resolves
- A SLA is being developed to ensure seamless services which allow staff to work on both sites.
- 11 nurses have been recruited for the single neonatal services
- Both Trust and Specialist Commissioners have agreed this is a single neonatal services and not a single surgical services as suggested in the original business case

Trust Boards are asked to note progress made to date:

In April 2019, a Neonatal focused nursing secondment was agreed at AHCH and results are beginning to appear, both within the culture and in improved performance. The change was for the unit to have a specific unit nursing lead, rather than sharing this leadership with another unit.

So far, this neonatal specific lead nurse has supported the AHCH unit in many positive developments, including;

- increasing the number of nurses on formal training, going on study days and engaging with the network,
- improved a range of infection control performance metrics,
- initiated AHCH staff visits to experience LWH unit operation,
- created positive staff orientated initiatives such as:
    - lead nurses for areas of practice,
    - establishing information system buddies to help improve data quality,
    - initiated a weekly ward meeting and
    - created opportunities for staff to bring their own improvement ideas and get involved more in the unit. One example of a staff suggestion was a wall of positivity, which has since been introduced and highlights lots of the good work the unit is doing. The wall of positivity at time of writing is shown below:
    - started to recruit nursing staff

.

At this Single Service workshop in April 2019 the group of clinical and managerial staff began to shape the programme of work, it was agreed that the Neonatal Single Services Leadership team should be appointed and this team should develop the plans, benefits and governance structure. At the end of the workshop the group wanted to communicate the following key messages from the workshop about the Single Service:

- The Single Service is going to happen (and in the right way),
- Leadership Team needs to be appointed
- We are committed and are all in this together,
- We are doing this for the Babies and their Parents.

Risks.

The leadership team needs to be in place at this stage to lead on the changes required, if Trust can agree on the recruitment process this will have a significant impact on the progress that can be made at this stage.

Staff have begun to work across the two units, and there is a risk that the clinical guidelines and policies that should be used become confused leading to poor quality outcomes or incidents.

To support the single service, there are capital estates projects for Neonatal facilities initiated at each hospital, but are on differing timescales. There is a risk that these environments aren't sufficiently similar and these impacts of the family experiences and the consistency of the ways of working for staff working between the two units.

These key risks will be discussed and management plans developed at the upcoming Delivery Group on 8th November.

Neonatal Single Service
Board Update-July 2019

Next Steps

The next steps are to get agreement by both Trust Executive teams that the appointment of the neonatal single neonatal services leadership team should progress.

The next Neonatal Partnership Board is due to take place on (Extraordinary Partnership Board is being planed to try and resolve the issues around the appointment of the leadership team)