**BOARD OF DIRECTORS PUBLIC MEETING**

**Tuesday 3rd December 2019 commencing at 11:00**

**Venue: Tony Bell Board Room, Institute in the Park**

**AGENDA**

| VB no. | Agenda Item | Time | Items for Discussion | Owner | Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N) | | Preparation |
|---|---|---|---|---|---|---|---|
| **STRATEGIC WORKSHOP (9:30 – 11:00)** | | | | | | | |
| **STAFF STORY (1100 – 1115)** | | | | | | | |
| **1.** | **19/20/243** | **1116** | **Apologies.** | Chair | To note apologies:<br>Fiona Marston | **N** | For noting |
| **2.** | **19/20/244** | **1117** | **Declarations of Interest.** | All | Board Members to declare an interest in particular agenda items, if appropriate. | **R** | For noting |
| **3.** | **19/20/245** | **1118** | **Minutes of the Previous Meeting.** | Chair | To consider and approve the minutes of the meeting held on: **Tuesday 5th November 2019.** | **D** | Read Minutes |
| **4.** | **19/20/246** | **1119** | **Matters Arising and Action Log.** | Chair | To discuss any matters arising from previous meetings and provide updates and review where appropriate. | **A** | Verbal |
| **5.** | **19/20/247** | **1120** | **Key Issues/Reflections and items for information.** | All | Board to reflect on key issues & discuss any queries from information items | **N/I** | Verbal |
| **Operational Issues** | | | | | | | |
| **6.** | **19/20/248** | **1135** | **Operational update** | A. Bateman | To provide an overview of operational risks for the previous month. | **A** | Verbal |
| **Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led** | | | | | | | |
| **7.** | **19/20/249** | **1145** | **Inspiring Quality Phase 1 – Progress to Date** | N Murdock | To brief the Board as to the latest developments in inspiring Quality | **A/D** | Read report |
| **8.** | **19/20/250** | **1200** | **Corporate Report**<br>**Divisional updates:**<br>- **Community**<br>- **Medicine**<br>- **Surgery**<br>**Executive Report:** | Execs<br><br>L. Cooper<br>A. Hughes<br>C. Duncan | To receive the monthly report of Trust performance for scrutiny and discussion against CQC domains:<br>**Safe, Caring, Effective, Responsive and Well Led,** highlighting any critical issues. | **A** | Read report |

| VB no. | Agenda Item | Time | Items for Discussion | Owner | Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N) | | Preparation |
|---|---|---|---|---|---|---|---|
| | | | - **Quality**<br>- **Performance**<br>- **Finance**<br>- **People** | A Bateman<br>H Gwilliams<br>J Grinnell<br>M Swindell | | | |
| 9. | 19/20/251 | 1220 | **Clinical Quality Assurance Committee:**<br>- **Chair's highlight report from the meeting on 20.11.19.**<br>- **Minutes from the meeting held on 16.10.19.** | A Marsland | To receive a highlight report of key issues from the November meeting and the approved minutes from October 2019. | A | Read minutes |
| 10. | 19/20/252 | 1222 | **Serious Incident Report**<br>- **Lessons Learnt** | H Gwilliams | To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour. | A | Read report (to follow) |
| 11. | 19/20/253 | 1225 | **Mental Health Act Report** | L Cooper | To provide assurance to Trust Board of activity in relation to the Mental Health Act (1983) for the reporting period 01 September 2017 – 31 August 2019. | A | Read report |
| 12. | 19/20/254 | 1230 | **Complaints Quarterly Report** | H Gwilliams | To receive the quarter 2 complaints report | A | Read report |
| 13. | 19/20/255 | 1235 | **Infection, Prevention, Control Quarterly report** | V Weston | To receive the quarter 2 complaints report | A | Read report |
| **Lunch (12:35 – 13:00)** | | | | | | | |
| **The Best People Doing Their Best Work** | | | | | | | |
| 14. | 19/20/256 | 1300 | **People Plan**<br>**- Pension update** | M. Swindell | To receive the monthly report.<br>To receive an update. | A | Read report (to follow) |
| 15. | 19/20/257 | 1305 | **Workforce and Organisational Development Committee**<br>- **Chair's highlight report from the meeting on 18.11.19**<br>- **Approved minutes from the previous meeting held** | C Dove | To receive a highlight report of key issues from the November meeting and the approved minutes from September 2019. | A | Read minutes |

| VB no. | Agenda Item | Time | Items for Discussion | Owner | Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N) | | Preparation |
|---|---|---|---|---|---|---|---|
| | | | **on 19.09.19.** | | | | |
| **16.** | **19/20/258** | **1310** | **Fit and Proper Person Test** | Chair | To provide a further update on the summary of the checks undertaken during the year to provide assurance to the Chair that all directors meet the requirements of Regulation 5 on an ongoing basis | **A** | Read report |
| **Game Changing Research and Innovation** | | | | | | | |
| **17.** | **19/20/259** | **1315** | **Innovation Board**<br>- **Chair's highlight report from the meeting on 18.11.19**<br>- **Approved minutes from the previous meeting held on 09.10.19.** | S Arora | To receive the terms of reference and recent key issues report from October meeting. | **A** | Read report |
| **Sustainability Through External Partnerships** | | | | | | | |
| **18.** | **19/20/260** | **1320** | **One Liverpool Plan/Integrated Partnership Board** | D Jones | To receive monthly updates on progress to date | **N** | Verbal |
| **19.** | **19/20/261** | **1330** | **Progress report against Strategic Plan to 2021** | D Jones | To receive an update on progress to date | **A** | Read report |
| **20.** | **19/20/262** | **1340** | **Update on Specialist Trust Group and system governance.** | L. Shepherd/ J. Grinnell | To update the Board on the initiatives underway | **N** | Verbal |
| **21.** | **19/20/263** | **1345** | **Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital**<br>- **Memorandum of Understanding** | A Bateman | To update the Board on progress towards the single service model. | **A** | Read report |
| **Strong Foundations** | | | | | | | |
| **22.** | **19/20/264** | **1350** | **Board Assurance Framework** | Executive Leads | To provide assurance on how the strategic risks that threaten the achievement of the trust's strategic operational plan are being proactively managed. | **A** | Read report |
| **23.** | **19/20/265** | **1400** | **Change Programme Progress Report** | J. Grinnell/ N Deakin | To receive an update on programme assurance. | **A** | Read report |

| VB no. | Agenda Item | Time | Items for Discussion | Owner | Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N) | | Preparation |
|---|---|---|---|---|---|---|---|
| 24. | 19/20/266 | 1410 | **Communications Guide and Calendar 2020** | M Flannagan | To receive an update on planned events for 2020 | N | Read report |
| 25. | 19/20/267 | 1415 | **Alder Hey in the Park Campus Development update** | D. Powell | To receive an update on key outstanding issues / risks and plans for mitigation. | A | Read report |
| 26. | 19/20/268 | 1425 | **Audit Committee Report:**<br>- **Chair's highlight report from the meeting held on 21.11.19.**<br>- **Approved Audit Committee minutes from the meeting held on 26.09.19.** | K. Byrne | To receive a highlight report of key issues from the November meeting and the approved September minutes. | A | Read report |
| 27. | 19/20/269 | 1430 | **Resources & Business Development Committee Report:**<br>- **Chair's highlight report from the meeting held on 27.11.19**<br>- **Approved RABD minutes from the meeting held on 23.10.19.** | I. Quinlan | To receive a highlight report of key issues from the October meeting and the approved October minutes. | A | Read report |
| 28. | 19/20/270 | 1435 | **Any Other Business** | All | To discuss any further business before the close of the meeting. | N | Verbal |
| 29. | 19/20/271 | 1440 | **Review of meeting** | All | To review the effectiveness of the meeting and agree items for communication to staff in team brief | N | Verbal |
| **Date And Time of Next Meeting: Tuesday 7th January 2020 at 10:00am, Tony Bell Board Room, Institute in the Park.** | | | | | | | |

| **REGISTER OF TRUST SEAL** |
|---|
| The Trust Seal was not used in November 2019<br>The Trust Seal was used in October 2019:<br>- Architect appointment for Alder Centre |

- Novation Agreement
- Car Park Lease (Medivet)

Alder Hey Children's NHS
NHS Foundation Trust

**PUBLIC MEETING OF THE BOARD OF DIRECTORS**

Minutes of the meeting held on **Tuesday 5th November 2019 at 10:00am,**
Tony Bell Board Room, Institute in the Park

| | | | |
|---|---|---|---|
| **Present:** | Dame Jo Williams | Chair | (DJW) |
| | Mrs S Arora | Non-Executive Director | (SA) |
| | Mrs K Byrne | Non-Executive Director | (KB) |
| | Mrs C Dove | Non-Executive Director | (CD) |
| | Mr. A. Bateman | Chief Operating Officer | (AB) |
| | Prof F Beveridge | Non-Executive Director | (FB) |
| | Mr J Grinnell | Director of Finance/Deputy Chief Executive | (JG) |
| | Mrs H Gwilliams | Chief Nurse | (HG) |
| | Mrs A Marsland | Non-Executive Director | (AM) |
| | Dr F Marston | Non-Executive Director | (FM) |
| | Mr I Quinlan | Vice Chair | (IQ) |
| | Mrs L Shepherd | Chief Executive | (LS) |
| | Mrs M Swindell | Director of HR & OD | (MS) |
| **In Attendance:** | Prof M Beresford | Assoc. Director of the Board | (PMB) |
| | Ms L Cooper | Director of Community Services | (LC) |
| | Mr C Duncan | Director of Surgery | (ChrD) |
| | Mr M Flannagan | Director of Communications | (MF) |
| | Dr A Hughes | Director of Medicine | (AH) |
| | Mrs D Jones | Director of Strategy | (DJ) |
| | Ms J Minford | Director of Clinical Effectiveness and Service Transformation | (JM) |
| | Mr D Powell | Development Director | (DP) |
| | Ms E Saunders | Director of Corporate Affairs | (ES) |
| | Mrs J Tsao | Committee Administrator (minutes) | (JT) |
| **Apologies:** | Mrs K Warriner | Chief Information Officer | (KW) |
| **Agenda item: 206** | Natalie Deakin | Head of Programme Management | |
| **215/216** | Kerry Turner | Freedom to Speak up Guardian | |
| **216** | Joe Fitzpatrick | Internal Communications Manager | |
| **229** | Elaine Menarry | Emergency Preparedness and Business Continuity Manager | |

**Patient Story**

Mum Gill and her son Joseph shared their story with the Board. Gill described a number of instances when they had been to see a GP or an optician regarding Joseph's health and had been advised that all tests were clear. Gill spoke of her frustration at not being listened to as she continued to be concerned about Josephs' health; ultimately she requested an MRI scan at Alder Hey. The MRI scan showed a cancerous tumour and a significant amount of fluid on Joseph's brain. Joseph has had two cycles of chemotherapy and is recovering well. A discussion was held on how diagnosis can be made earlier, Nicki Murdock said this was being looked into.

Gill commented on the new Alder Hey and the fact that it didn't feel like a hospital had helped Joseph with is initial appointments; she also appreciated being able to stay in the same room as Joseph on the High Dependency Unit as this had helped them both.

On behalf of the Board the Chair thanked Gill and Joseph for sharing their experiences with the Board and wished them well going forward.

**Patient Story**
Mrs Shilmar shared her story relating to her ten year old son who had sadly passed away earlier in the year. Mrs Shilmar said her son had been diagnosed with ASD during his early years and was later diagnosed with a terminal form of brain cancer. Mrs Shilmar spoke of a lack of awareness of autism and raised a number of areas where improvements for patients with learning disabilities and other complex needs are required. Hilda Gwilliams agreed to hold a discussion with Mrs Shilmar outside of the meeting.

Mrs Shilmar spoke highly of ward 3A where her son's end of life care had been provided. On behalf of the Board the Chair thanked Mrs Shilmar for sharing her story, offering condolences for the loss of her son and the Trust's commitment to continuous improvement with regard to care for patients with complex needs.

**19/20/200 Declarations of Interest**
There were none to declare.

**19/20/201 Minutes of the previous meetings held on Tuesday 1st October 2019**
**Resolved:**
The Trust Board approved the minutes from the last meeting held on 1st October 2019.

**19/20/202 Matters Arising and Action Log**
19/20/75 Opportunity for Non-Executives Directors to visit the Community Cluster site. Non-Executive Directors were asked to contact Julie Tsao if they would like to arrange this. The action would now be closed.

19/20/45 Hilda Gwilliams noted contact had been made with the school requesting regular update on learning, a response was awaited.

19/20/137 A paper on lessons learnt from Serious Incidents had been completed and would be circulated after the meeting, going forward this would be included in the regular monthly report. This action would now be closed.

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

**19/20/203 Key Issues/Reflections and items for information**
On behalf of the Board the Chair welcomed the two newly appointed Non-Executive Directors, Fiona Marston and Fiona Beveridge.

Louise Shepherd reported back from a meeting held with the University of Liverpool on the Starting Well strategic theme, noting a number of positive opportunities to improve health and social care. Both Professor Fiona Beveridge and Professor Michael Beresford had also attended.

The Chair thanked Lisa Cooper for facilitating the patients' forum involvement in the Annual Members meeting that had taken place on Monday 4th November; it was agreed the presentation slides would be circulated to the Board.
**Action: JT**

**Supporting Documents/Items for Information**
**Resolved:**
The Board had received the following item for information in relation to last month's regular FTSU update:
- Freedom to Speak up Index report.

3. Approved Board Minutes Public 051119 v3 - to be

**19/20/204 Operational update**

Adam Bateman provided the following update:

A number of building defects had been identified within Critical Care; temporary works had been carried out and the defects have now been resolved.

Attendances at Emergency Department continue to increase significantly; a number of initiatives are in progress to provide support to the team this includes: increasing staffing numbers, implementing an appointment system and working with Primary Care on the flow of non-emergency patients.

Three new Consultants have commenced in post on the High Dependency Unit and are currently reviewing the patient pathway. The new appointments will also support a seven day service that is due to be fully implemented next year.

Adrian Hughes noted the high demand within the Haematology service and advised that support was being provided from Manchester University NHS Foundation Trust.

**Resolved:**
The Board received the Operational update.

**19/20/205 Inspiring Quality Progress and Next Steps**

Nicki Murdock gave a presentation on progress to date against the three overarching quality improvement aims:
- To put children first
- To be the safest children's trust in the NHS
- To achieve outstanding outcomes for children

Programmes in place to support the aims include: Schwartz Rounds, Sweeney Collaborative and Patient Shadowing.

Nicki Murdock advised the Board that an external partner to support the implementation of Inspiring Quality was in the process of being selected following the recent tender exercise; the result would be reported at the next Board meeting.

It was agreed the presentation would be circulated to the Board.
**Action: JT**

**Resolved:**
The Board noted the latest developments in relation to Inspiring Quality.

**19/20/206 Change Programme Progress Report**

The Board received the latest programme assurance report noting improved governance and delivery ratings for the Park, Community, Estate and Facilities programme.

Kerry Byrne queried the overall delivery assessment at 8%. Natalie Deakin agreed to provide a quarterly deep dive on progress against delivery.
**Action: ND**

John Grinnell noted the Programme Delivery team also supports the journey to outstanding work streams and asked for an update to be received at the December Board.
**Action: ND**

3. Approved Board Minutes Public 051119 v3 - to be

**Resolved:**
The Board received the change programme progress report.

**19/20/207 Corporate Report**
The Board received the month 6 report.

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

**Community – Lisa Cooper**
*Safe*
There had been 0 Never Events and 0 Grade 3 and above pressure ulcers.

Processes for scanning of records across community services is variable and is a priority for the division to address.

*Caring*
The Forum at Alder Hey linked to Liverpool City Region partnership board regarding engagement with young people in relation to a travelling piece the council are leading on.

*Effective*
An increase in Was Not Brought was reported the data is being checked to ensure it is correct.

*Responsive*
CAMHS waiting times – significant recruitment and waiting list validation underway, a further update on progress will be received at the January Board meeting.

*Well Led*
Issues were raised around access to mandatory training within community based locations, the training team are currently looking at a number of options to resolve this.

**Medicine – Adrian Hughes**
*Safe*
There had been 0 Never Events, 0 Grade 3/4 pressure ulcers and no hospital-acquired infections (MRSA, C.difficle for over 12 months.

Patients treated for Sepsis within 60 minutes was 80% variable trend, enhanced focus will be applied as well as collaboration with digital team.

*Caring*
There had been 6 complaints and 36 PALS responses, complaints had increased since last month.

*Effective*
ED Standard continues to be a challenge. ED action plan in place, which along with recommendations from the following will bring about sustainable positive change: workforce plan; enhanced ways of working; redirecting of appropriate patients to primary care.

*Responsive*
Turnaround times consistently good in many areas(especially Pathology) though concern over MRI, CT.

3. Approved Board Minutes Public 051119 v3 - to be

*Well Led*
PDR rates are at 87.8% and are continuing to increase. Mandatory training is above 90% for fourth consecutive month.

**Surgery – Christian Duncan**
There had been 2 Never Events reported in both incidents no harm had come to either patient. Sepsis response compliance was at 100% and there were 0 grade 3 pressure ulcers.

*Caring*
There had been 3 complaints and 41 PALS responses. Complaints continued to reduce.

*Effective*
A unique tumour case had been performed effectively.

*Responsive*
There had been an increase in cancellations on the day.

*Well Led*
PDR's are in progress, mandatory training is above 90%.

Executive leads raised items by exception as follows:
John Grinnell noted the recovery group continue to meet to close the Cost Improvement Plan gap, regular updates are received at the Resources and Business Development Committee.

Melissa Swindell updated the Board on a trial taking place by the Wellbeing team to provide administrative support to managers in relation to sickness absence management in teams.

**Resolved:**
The Board received and noted the contents of the corporate report for month 6.

**19/20/208 Clinical Quality Assurance Committee**
**Resolved:**
The Board received the Chair's highlight report from the last meeting on 16th October and the approved minutes from the meeting held on 18th September 2019.

**19/20/209 Serious Incident Report**
The Board received and noted the content of the Serious Incident report for September 2019. Hilda Gwilliams stated that during this reporting period there were four new Serious Incidents, seven investigations were ongoing and one SI had been closed.

The Board noted the two Never Events that had taken place in the Surgery Division, neither of which had resulted in harm to the patient. The reporting arrangements have been complied with and a level 2 Root Cause Analysis is underway for both incidents.

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

**19/20/210 Strategy update**
**Resolved:**

3. Approved Board Minutes Public 051119 v3 - to be

As Dr Jo Blair had been unable to attend the meeting today it was agreed this item would be deferred to the next convenient date.

**19/20/211 Innovation Committee**

The Board received and approved the Innovation Committee Terms of Reference.

An update was received from the first Innovation Committee meeting held on 9th October, which Louise Shepherd had chaired. Shalni Arora take over as chair from the next meeting with Non-Executive Director support from Fiona Marston.

Agreement had been made to establish an Innovation Expert advisory board with various external members. A chair is to be identified with a notable industry reputation.

**Resolved:**
The Board received the Chair's highlight report from the meeting held on 9th October and approved **the** terms of reference.

**19/20/212 Research Management Board**

**Resolved:**
The Board received the Chair's highlight report from the meeting held on 31st October 2019.

**19/20/213 Health Education England Visit 3rd October 2019**

**Resolved:**
Initial feedback from the visit had been positive, the final report would be shared with the Board once received.

**19/20/214 People Plan**

Melissa Swindell presented the report for October highlighting:

- The Mind 'Time to Change' Pledge was successfully launched on 23rd October 2019 during 'Fab Staff Week'. To date, we have 48 managers enrolled on the Mind Mental Health Training course and training specifically for senior managers will be scheduled in the coming months.
- The Strong Foundations Programme has been very well received to date: the feedback has been positive from all three cohorts and the remaining seven cohorts are now fully booked until November 2020. The programme continues to evolve, based on participant feedback.
- The Staff Survey has launched, and as at 28th October 2019 (the halfway point) the response rate is 33%, with 4 weeks to go until the closing date; the aim is to achieve a response rate of 65% this year.

**Learning Lessons to Improve our People Practices – progress update**
Following guidance issued by Baroness Dido Harding, chair of NHS Improvement, quarterly updates will be received on the number of employment relations cases. Executive approval is required for the two suspensions requested for this quarter, one suspension was declined and the other suspension was permitted.

**Resolved:**
The Board received:
a) The People Plan update
b) The quarterly number of employment relation cases.

**19/20/215 Freedom to Speak Up (FTSU) Quarterly update**

Kerry Turner presented a paper which provided a self-assessment against the latest guidance for Boards issued by the NGO in the summer (previously circulated); Kerry advised the Board that the Trust's approach to FTSU already addressing the majority of key areas set out in the guidance. She highlighted a small number of issues which needed to be paid attention to. These include the planned review of ring-fenced time for the FTSU Guardian; currently this is one day per week, however there has been a significant rise in FTSU cases in Q2 reflecting the efforts made to raise awareness among staff and therefore consideration may need to be given to extend this time. The other main area relates to shared learning from cases on a thematic basis.

Kerry Turner provided a summary of other FTSU activities in the period including statistics on cases, progress with communications and networking opportunities.

**Resolved:**
The Board received the FTSU quarterly update.

**19/20/216 Listening into Action – Reward and Recognition**

Joe Fitzpatrick and Kerry Turner updated the Board on progress made by the reward and recognition group; events included FAB week, the Summer Festival and Christmas markets. It was noted that a mechanism to collate feedback from staff was to be established.

**Resolved:**
The Board noted progress to date on reward and recognition.

**19/20/217 Raising Concerns Policy**

**Resolved:**
The Board ratified the Raising Concerns policy which had been approved by the Audit Committee, following routine review.

**19/20/218 Fit and Proper Person Test**

**Resolved:**
The Board received the Chair's annual declaration report on compliance against FPPR under CQC Regulation 5, setting out positive assurance in relation to the fitness of its Directors.

**Resolved:**
The Board received the FPPR compliance report.

**19/20/219 Public Health Strategy – Wider Determinants of Child Health**

**Resolved:**
This item was deferred.

**19/20/220 UNICEF Child Friendly City**

Lisa Cooper presented an overview of the initiative, noting the programme aims is to create cities and communities in the UK where all children whether they are living in care or using a children's centre, have a say in the local decisions, services and spaces that shape their lives.

The Children and Young People's Forum had been providing support with the process. Delivery is expected to take a minimum of two years and a maximum of four years. On approval the Trust will receive Child Friendly City status for three years.

**Resolved:**
The Board noted progress to date against UNICEF Child Friendly City.

**19/20/221 'Our Plan' – Alder Hey's Strategic Plan to 2024 (final version)**
**Resolved:**
The Board approved the 'Our Plan' - Alder Hey Strategy to 2024.

**19/20/222 Update on Specialist Trust Group and System Governance**
A further update on progress made to date on corporate functions and a single leadership estates service being developed between Alder Hey and Liverpool Heart and Chest NHS Foundation Trust was received.

A joint communication piece on Specialist Trusts was being developed.

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

**19/20/223 Change Programme Progress Report: Growing External Partnerships**
**Resolved:**
The report had been received under item 19/20/206, there were no further comments.

**19/20/224 Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital**
Adam Bateman reported:

- Both organisations had met with NHSE Specialist Commissioners to continue negotiations to agree the final cost of the service in an attempt to bridge the current financial gap of £2.7m.
- Following an away day on 2nd October to review a proposed governance structure and strategy for the partnership a final version is due to be presented to both Trust's Boards in the new year.

**Resolved:**
The Board noted progress to date in relation to the joint Neonatal Partnership.

**19/20/225 Corporate Report Performance Metrics: Long Term Plan**
**Resolved:**
John Grinnell reported on the improved financial position, noting monthly updates would continue to be received both at Resources and Business Development Committee and Board meetings.

**19/20/226 Change Programme Progress Report: Strong Foundations**
**Resolved:**
The report had been received under item 19/20/206, there were no further comments.

**19/20/227 Board Assurance Framework (BAF)**
**Resolved:**
The Board received the BAF as at end of October. It was noted that the majority of risks had formed the basis of substantive reports to the Board or a sub-committee in the month. It was agreed that a workshop session would be held on 3rd December 2019 prior to the Trust Board meeting to review the strategic risks for the Board in the context of Our Plan, the refreshed strategy to 2024.

**19/20/228 Alder Hey in the Park Site Development Update**
**Change Programme: Park, Community, Estates and Facilities**
The Trust Board received an update on the Site Development programme.

An update on the Neonatal Scheme was received noting the next stage of the programme is to identify the procurement strategy which is due to be approved by the Board of Directors in December.

**Resolved:**
The Board received the site development programme noting progress to date with the Neonatal scheme.

**19/20/229 Emergency Preparedness Resilience and Response (EPRR) Core Standards**

**Resolved:**
The Board ratified a substantial compliance report against the annual EPRR core standards self-assessment for 2019/20.

**19/20/230 Audit Committee:**

**Resolved:**
The Board noted that a detailed report had been received on the ACORN partnership and highlighted that this was an example of where management had proactively identified the need for consulting support.

The Board also received the approved minutes from the meeting held on 23rd May 2019.

**19/20/231 Resource Business Development Committee**

**Resolved:**
The Board received and noted the Chair's highlight report from the meeting held on 23rd October 2019 and the approved minutes from the meeting held on 25th September 2019. Ian Quinlan noted the positive improvement against energy performance target levels being met.

**19/20/232 Any Other Business**
No other business was discussed.

**19/20/233 Review of meeting**
The Board discussed the patient stories from this morning and subsequent actions that would be taken in terms of follow up and process going forward.

**Date and Time of next meeting: Tuesday 3rd December 2019 at 10.00 in the Tony Bell Board Room, Institute in the park.**

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

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| **Action for October 2019** | | | | | | | |
| 03.09.19 | 19/20/145 | Corporate Report | ***Play*** - Look into the possibility of receiving reports from schools on learning. | H Gwilliams | 01.10.19 | | 01.10.19 awaiting a response from school. 05.11.19 A response from the School was still awaited. |
| **Action for November 2019** | | | | | | | |
| 03.09.19 | 19/20/146 | Board Assurance Framework | The Board discussed the pension risk in association with consultants (high earners) and the impact on services. A quality impact assessment is to be completed. | Christian Duncan/ Lisa Cooper/ Adrian Hughes | 05.11.19 | | 05.11.12 An update on this was deferred until the next meeting on 03.12.19 |
| 03.09.19 | 19/20/38.2 | Inspiring Quality Progress and Next Steps | ***Sepsis Update*** - Divisions to review their compliance against sepsis training and encourage staff/areas outstanding to complete. | Divisions | 01.10.19 | | 01.10.19: Update received a further update to be received at the Trust Board meeting on 5th November 2019 |
| **Actions for December 2019** | | | | | | | |
| 28.05.19 | 19/20/77 | Draft Annual Report and Accounts | To arrange a thank you event for achievements within the annual report. | Mark Flannagan | 02.07.19 | | 02.07.19: In process 01.10.19 A thank you event to be held at the December Trust Board |
| 01.10.19 | 19/20/172 | Long Term Plan 2019-2024 | To map out potential collaborations both locally and internationally | Adrian Hughes Hilda Gwilliams Nicki Murdock | 03.12.19 | | |
| 05.11.19 | 19/20/206 | Change Programme Progress Report | To provide a quarterly deep dive on progress against delivery | Natalie Deakin | 03.12.19 | | 03.12.19: To receive an update under the change programme progress report |
| 05.11.19 | 19/20/206 | Change Programme Progress Report | To receive an update on progress against the journey to outstanding | Natalie Deakin | 03.12.19 | | 03.12.19: To receive an update under the change programme progress report |
| **Actions for 7th January 2020** | | | | | | | |
| 01.10.19 | 19/20/179 | Quarterly Mortality Report | To include details of how far mortality reviews have come over the years | Nicki Murdock | 07.01.20 | | |

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

| Meeting date | Ref | Item | Action | By whom? | By when? | Status | Update |
|---|---|---|---|---|---|---|---|
| 01.10.19 | 19/20/179 | Quarterly Mortality Report | To review as to whether the Hospital Mortality Review Group should continue the aim of reviewing deaths at 4 months if this wasn't an achievable goal | Nicki Murdock | 07.01.20 | On Track | |

| Status | |
|---|---|
| Overdue | (red) |
| On Track | (green) |
| Closed | (blue) |

**Update to Trust Board**
**3rd December 2019**

The Inspiring Quality Programme has been progressing with the deliverables in the paper embedded below: *Inspiring Quality: Phase 1 – Starting Change.*

The purpose of this paper is to provide an update of progress to date against the key milestones of phase 1. These milestones are outlined in Figure 1 below.

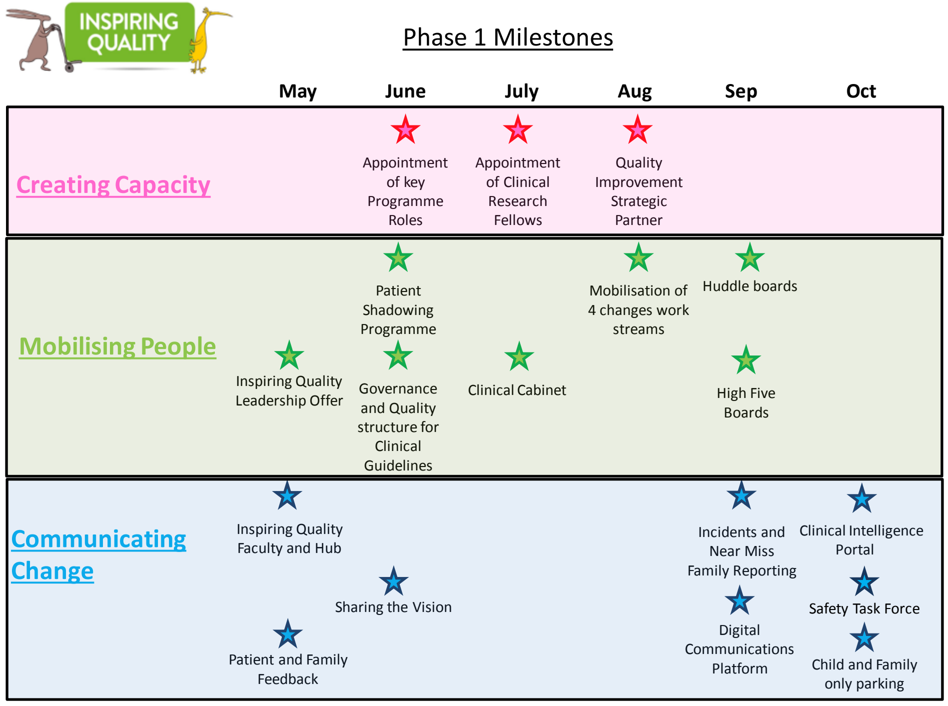



Fig 1: Inspiring Quality Phase 1 Milestones

## Inspiring Quality Leadership Offer - Strong Foundations

Strong Foundations draws on the most recent research evidence and local feedback regarding effective leadership and its impact on outcomes for staff, children and families. It aims to build emotional intelligence and equip leaders and managers to create safe and trusting working environments, in which people can grow, learn, make changes, and feel free to speak up and challenge with both courage and kindness.

The programme launched in 2019 with the majority of 2020 dates almost fully booked. In total, 183 staff have enrolled onto the course, with 45 now active on the programme. The first cohort is due to complete the course at the end of November 2019.

## Inspiring Quality Faculty and Hub

The hub, now located in room 9 on the mezzanine provides a dedicated physical space to encourage local improvement initiatives. A space for staff to collaboratively share ideas, successes and visit for advice, guidance and tools to help them with the implementation of quality improvement initiatives.

With the number of members in the Inspiring Quality virtual faculty growing and being on the verge of appointing our Inspiring Quality partners, there are big plans for our hub and faculty in 2020!

## Appointment of Key Programme Roles / Clinical Research Fellow

A number of roles have now been appointed to within the Inspiring Quality programme. These include:

- Will Calvert (research fellow to lead on patient shadowing)
- Megan Field (Inspiring Quality Project Manager)
- Jennie Williams (Senior Improvement Manager)
- Steve Kerr (Developer)
- Natalie Deakin (Inspiring Quality Programme Manager)

Once our partners have been appointed and budget for Inspiring Quality is agreed for 2020, the next round of recruitment can begin. This will focus primarily on the recruitment of clinical leads, developers and statisticians.

## Patient Shadowing Programme

Patient shadowing is now promoted in day two of the Strong Foundations Leadership offer. The programme is available for all participants who have taken part in the leadership course as well as members of the Board and Executive Team. Through Inspiring Quality we will continue to expand the offer of patient shadowing until it is available to all members of staff continuously; this is planned for February 2020. It is then envisaged that the feedback and learning from the shadowing will then provide a source of invaluable information for our improvement work.

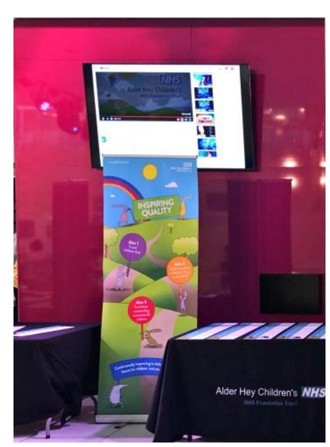
## Governance and Quality Structure for Clinical Guidelines

Now forming part of the programme of preparatory work for our upcoming CQC inspection, work is ongoing to update all of our clinical guidelines to ensure that all are within review date. In addition, a process for renewal and administrative support has also been agreed.

## Sharing the Vision

As part of our strategy weeks to share 'our plan', the Inspiring Quality team held a lunchtime event in the Atrium by which staff where asked to pledge how they would improve quality in their area or department in return for a cookie! Over 200 staff made a pledge.

Also, in July this year, Alder Hey hosted a Grand Round with Duncan Law as our guest presenter.



Duncan presented his work to date on goal based outcomes along with some handy tools and techniques to help implement measuring outcomes using this method. A few of our Inspiring Team even got to present at the children's forum, our toughest audience yet!

### Clinical Cabinet

Applications are now open for Alder Hey's Clinical Cabinet. The cabinet create a voice for clinical staff across the Trust to influence decision making at the highest level. It will provide a single point of contact for clinicians to discuss and explore opportunities and issues relating to health service development, innovation, integration, planning and monitoring with each other across the broader service. These discussions will then be condensed and presented to the board by representatives.

### Quality Improvement Strategic Partner

A strategic partner(s) is to be appointed to help provide the capacity and capability to create a culture of daily improvement alongside training on a mass scale in safe communication and quality improvement.

Applications have recently been reviewed after going out to tender for an external organisation(s) to partner with us to deliver our Inspiring Quality plan. Partners have now been chosen and details of who they are will be released shortly.

### Mobilisation of '4 changes' work streams

All '4 changes' work streams are now mobilised and although leads for each work stream have not yet been appointed, the work of the programme is being directed by our Inspiring Quality Delivery Group.

### Huddle Boards / High Five Boards

Potential software and hardware for our huddle boards has been identified however it has been decided that waiting for our partner to join us before we progress with the installation of any hardware or software would be preferable.

### Incident and Near Miss Family Reporting

Limitations to our Ulysses incident reporting system is stalling progress in this area however we have been able to support the implementation of the Meridian feedback system to allow our patients and families to provide feedback at the numerous terminals across the Trust as well as via text message. We will however keep working towards our goal of patients and families being able to report incidents directly to us.

### Digital Communications Platform

A Digital communications platform to provide a dedicated site, with mobile application, will enable the exchange of ideas and information as well as promoting good communication and collaboration.

A task and finish group was established to ascertain the essential and desirable criteria the digital communications platform. A number of suppliers were reviewed but it was agreed that Microsoft Teams (part of Office 365) in fact met all of our essential criteria and will be implemented across the Trust shortly. Members of the Inspiring Quality Delivery Group are early adopters for the use of Microsoft Teams and once up and running a channel dedicated to Inspiring Quality will be created and used to communicate to our staff about the programme.

### Safety Task Force

After further refinement of the Inspiring Quality plan with the Medical Director, safety task force groups were deemed to be our business as usual and so it was decided to remove these from the plan.

### Child and Family Only Parking

There have been recent developments in the day to day operations of our multi-storey car park which includes dedicated car parking staff who ensure that spaces on the ground and lower ground levels are reserved for our patients and families. A small task and finish group has also been established to ensure that signage is fit for purpose and clear to all users of the car park.

### Clinical Intelligence Portal

The development of a clinical intelligence portal will contribute to one of Inspiring Quality's ambitious aim of achieving outstanding outcomes for children. The Clinical Intelligence portal will provide a user-friendly single point of access to meaningful information and data which will enable clinical staff to assess performance and drive improvements in patient care. It will be simple to navigate, with clear sections for divisions and specialties and be the primary route to access centrally-held information. The portal is currently in the process of being merged onto Power BI by our Inspiring Quality developer and is soon to be initiated on to the Trust's Change Programme.

### Sweeney Collaborative

We have recently entered into a partnership with The Point of Care Foundation (POFC) to deliver the next cohort of the Sweeney Collaborative programme. POCF have offered Alder Hey three team slots to join the programme. The programme will enable staff to step into the shoes of our patients and families to see the care we deliver through their eyes. Using tried and tested tools and experiential techniques; the programme enables staff to get as close to experiencing our patient journeys as possible. Applications have now been shortlisted and the programme is due to commence in January 2020.

### Schwartz Rounds

Schwartz Rounds provide a structured forum where all staff, clinical and non-clinical, come together regularly to discuss the emotional and social aspects of working in healthcare. The rounds are open to ALL Alder Hey staff to come along and share their experiences. First Schwartz round took place in October 2019 with Louise Shepard as part of the panel and 51 attendees. Dates are now scheduled for the next 6 months and with 89% of colleagues stating they would recommend Schwartz rounds to other colleagues.

Alder Hey Children's NHS
NHS Foundation Trust

# Implementing Inspiring Quality

## Phase 1 - Starting change

Creating capacity | Mobilising people | Communicating change

**Date of paper:** 4 April 2019

## Index

1. Background

2. A synopsis of Phase 1 - Starting change

3. Creating capacity

4. Mobilising people

5. Communicating change

6. Milestones and measuring progress

7. Resources

8. An outstanding organisation

9. Appendix 1: Resource plan detail

# 1. Background

To deliver on Alder Hey's promise of providing Outstanding Care we have agreement to drive our Inspiring Quality approach across Alder Hey, to make it the core of who we are and how we work.

Our three aims are:

- **to put children first**
- **to become the safest children's Trust in the NHS**
- **to achieve outstanding outcomes for children**

We are committed to making this happen by changing how we work in four key ways:

1. We will **always do everything with children and families**; to design their care with them and to put them at the centre of decision making. This will include children and young people setting their own goals and ensuring that when they tell us something, we hear it and act upon it.

2. We will **'communicate safely'**: building a culture that is all about openness and continual learning for safety, with children and young people playing a central role in this.

3. We will **use digital and new technology to transform patient care** by adoption of evidence-based digital pathways and pioneering the routine use of artificial intelligence in healthcare, bringing innovative changes to the bedside. We will use real-time data analysis to continually improve outcomes including those that are meaningful to children and young people.

4. We will build a culture that empowers individuals and teams to take a **systematic approach to daily improvement**, including developing an Inspiring Quality Faculty to support and develop staff.

We now need to move forward and this paper outlines the key outputs which are to be delivered as we prepare to make changes to the way we work.

**This paper should be read in conjunction with the Inspiring Quality Plan and video.**

Please click here

## 2. A synopsis of Phase 1 - Starting change

The purpose of this paper is to describe the first phase of the Inspiring Quality implementation plan. Phase 1 - Starting change, will last 6 months, running from April to October 2019. During this phase, we will begin to implement Inspiring Quality in earnest and establish the foundations and conditions for lasting improvement.

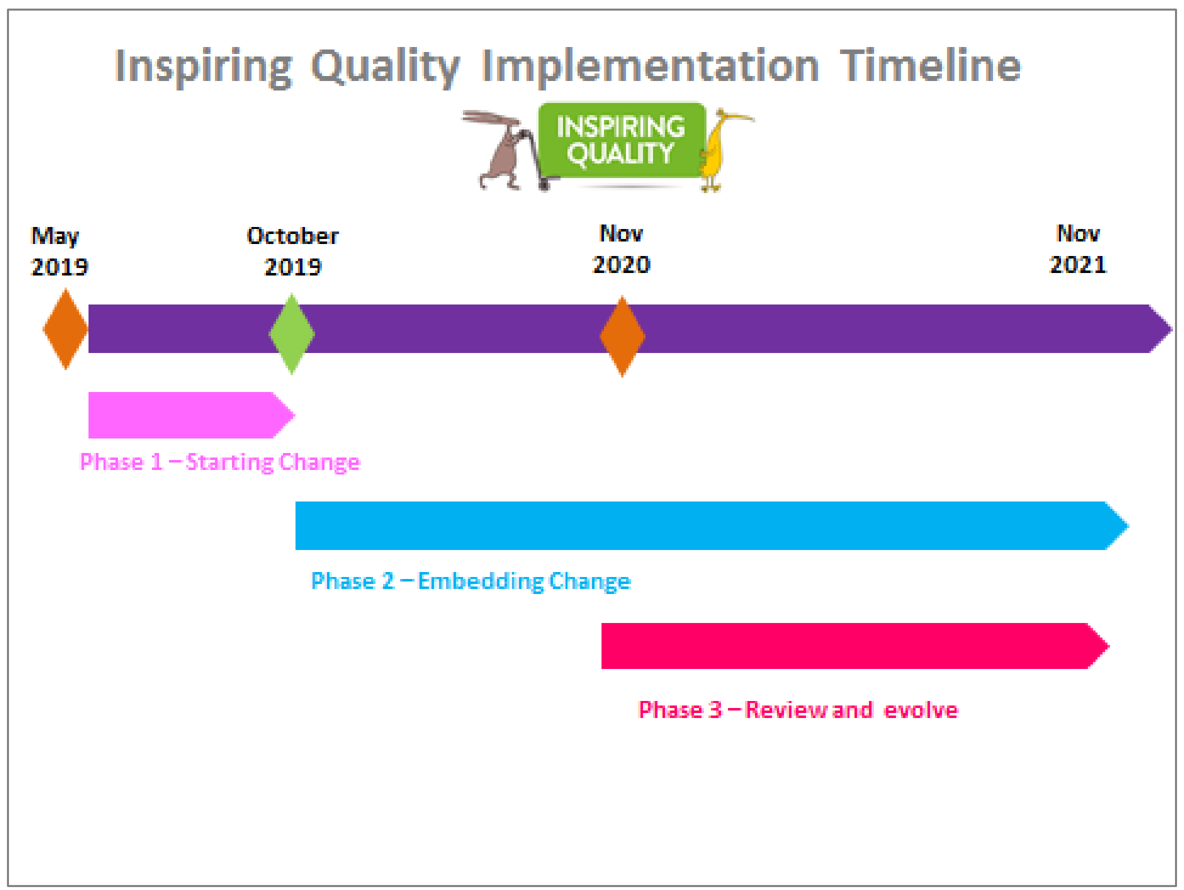
There are three main purposes of the Phase 1 work:

- **Creating capacity**
- **Mobilising people**
- **Communicating change**

Table 1: A summary of the purpose and high impact changes

| | High impact changes |
|---|---|
| Creating capacity | 1. **Appoint strategic partner(s):** to help provide the capacity and capability to create a culture of daily improvement and communicating safely.<br>2. **Recruit to key roles:** including workstream leads, research fellows, and safety and quality improvement experts. |
| Mobilising people | 3. **Inspiring Quality Cabinet:** will be established and led by clinicians working in partnership with children, young people and families.<br>4. **Inspiring Quality Leadership Faculty:** leaders from all levels will form cohorts who are trained in strong foundations for self, leading with care and daily improvement. |
| Communicating change | 5. **Sharing the vision from the top:** every department will have a personal visit from the CEO or Medical Director to share the vision of Inspiring Quality. Teams will be briefed on Inspiring Quality invited to formulate their own plan for contributing to the delivery of its three aims.<br>6. **Digital communications platform:** a dedicated site, with mobile application, will enable the exchange of ideas and information. The platform will enable communication and collaboration. |

This paper is concerned with phase 1, the first six months, of implementing Inspiring Quality. This should be placed in the context of a much longer process of delivering an organisation-wide, transformational change.



# 3. Creating capacity

Inspiring Quality is a transformational change that seeks to deliver four key changes to how we work at Alder Hey. Communicating and involving staff at this scale and delivering the ambitious three aims will require commensurate capacity (more people and re-directing people).

We will create the capacity to implement Inspiring Quality by:

## i. Appointing a strategic partner — High impact change 1

We will work collaboratively with partners to provide the capacity and capability to create a culture of daily improvement and communicating safely.

IWe committed to training,over a period of 2 years, 784 staff in communicating safely and quality improvement tools and techniques, 680 staff in child and family centred care. To deliver high quality training at this scale will require support from partner organisations.

We will undertake to appoint a strategic partner(s) using a recognised procurement process:'Invitation to participate in dialogue'. The partner will be asked to support the following training:

- Patient and family centred care
- Communicating safely- including advanced communication course, systematic tools (SBAR and PACE) and human factors
- Daily improvement- the science of quality improvement

## ii. Appointing to key roles — High impact change 2

The four 'changes to how we will work' will each have a multi-professional workstream with an appointed clinical lead. The clinical leads (open to medical, nursing, allied health professionals staff, scientific and technical) will have 1 day per week to lead the workstream. The four workstreams are outlined below:

1. Do everything with children and families
2. Communicate safely
3. Transform patient care through digital technology
4. Build a culture of Inspiring Quality.

The workstreams will also be supported by other staff, including safety experts, coaches, quality improvement experts, data analysts and research fellows. **Clinical Research Fellows** will bring an academic and research rigour, analyse our initiatives, such as patient shadowing and goal-based outcomes, and ensure that we learn and share our experience widely

There are a number of key roles that will create the capacity and capability to progress implementation of Inspiring Quality. These include:

- Improving safety of care expert

- Transformation manager
- Research fellow for ‘do everything with children and families’
- Research fellow for ‘communicate safely’
- Quality improvement expert

We will aim to appoint to all of the above roles by the end of phase 1.

# 4. Mobilising people

It is important that the change is mobilised through staff, children, young people, families and partners coming together to deliver Inspiring Quality.

Mobilisation of people will be through the following mechanisms:

## i. Inspiring Quality Cabinet

**High impact change 3**

Improving the engagement of all clinicians is essential in day to day business but is also something that can be formalised across the clinician workforce. One way to do this is to have a Clinical Cabinet to bring to the attention of the Executives and the Board, the issues that are of importance to all clinicians. Representation on this Cabinet would be by election from the three professions of clinicians; medical, nursing and allied health.

Modern healthcare is delivered by teams where each member has responsibility for the outcome of the patient. This is particularly true of paediatric care which has led the way on recognising the importance of the multi-disciplinary team. Through the Cabinet the Trust can broaden and enhance the clinical voice in setting strategy and making decisions.

It would provide a single point of contact for clinicians to discuss and explore opportunities and issues relating to health service development, innovation, integration, planning and monitoring with each other across the broader service. These discussions can then be condensed and presented to the board by representatives.

The Cabinet responsibilities could include:

- Provide clinician leadership
- Shape the strategic direction of Inspiring Quality
- provide evidence-based, trusted, independent advice
- champion innovation and health reform
- identify opportunities to improve patient outcomes and value through coordination and integration between organisations.
- implementing effective communication and engagement mechanisms providing timely, relevant and realistic advice.

**How will Inspiring Quality be governed?**

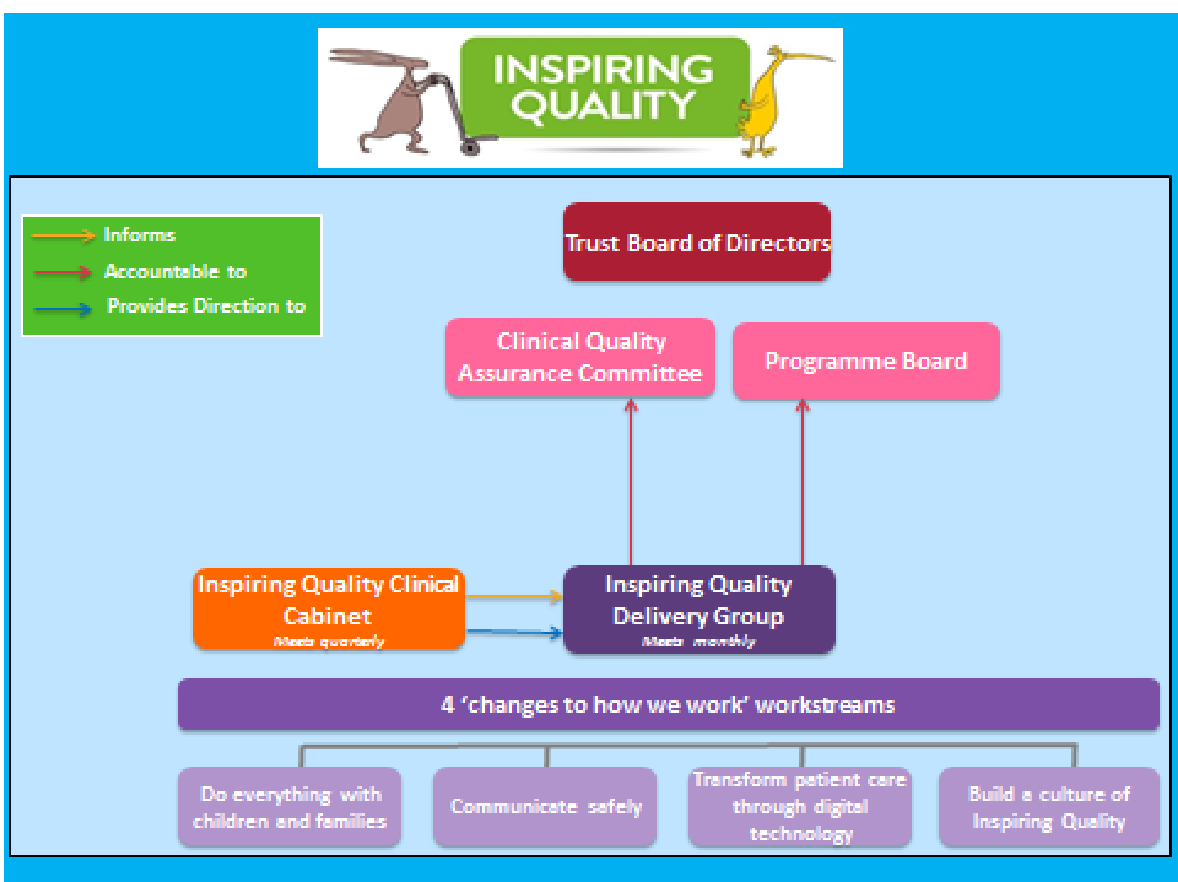
Inspiring Quality will provide assurance to the **Clinical Quality Assurance Committee** on the safety and quality aspects of its work.

Inspiring Quality will providing assurance **Programme Board** in regard to project governance and achievement of project deliverables.

The **Inspiring Quality Cabinet** will **set direction** for Inspiring Quality. It is expected to meet four times per year. The **delivery** of the plan will be through the four 'changes to how we work' workstreams and the Inspiring Quality Delivery Group.

**Children** and **families** are **members** of an extended Inspiring Quality Cabinet which will meet twice yearly.

These reporting arrangements are shown diagrammatically below:



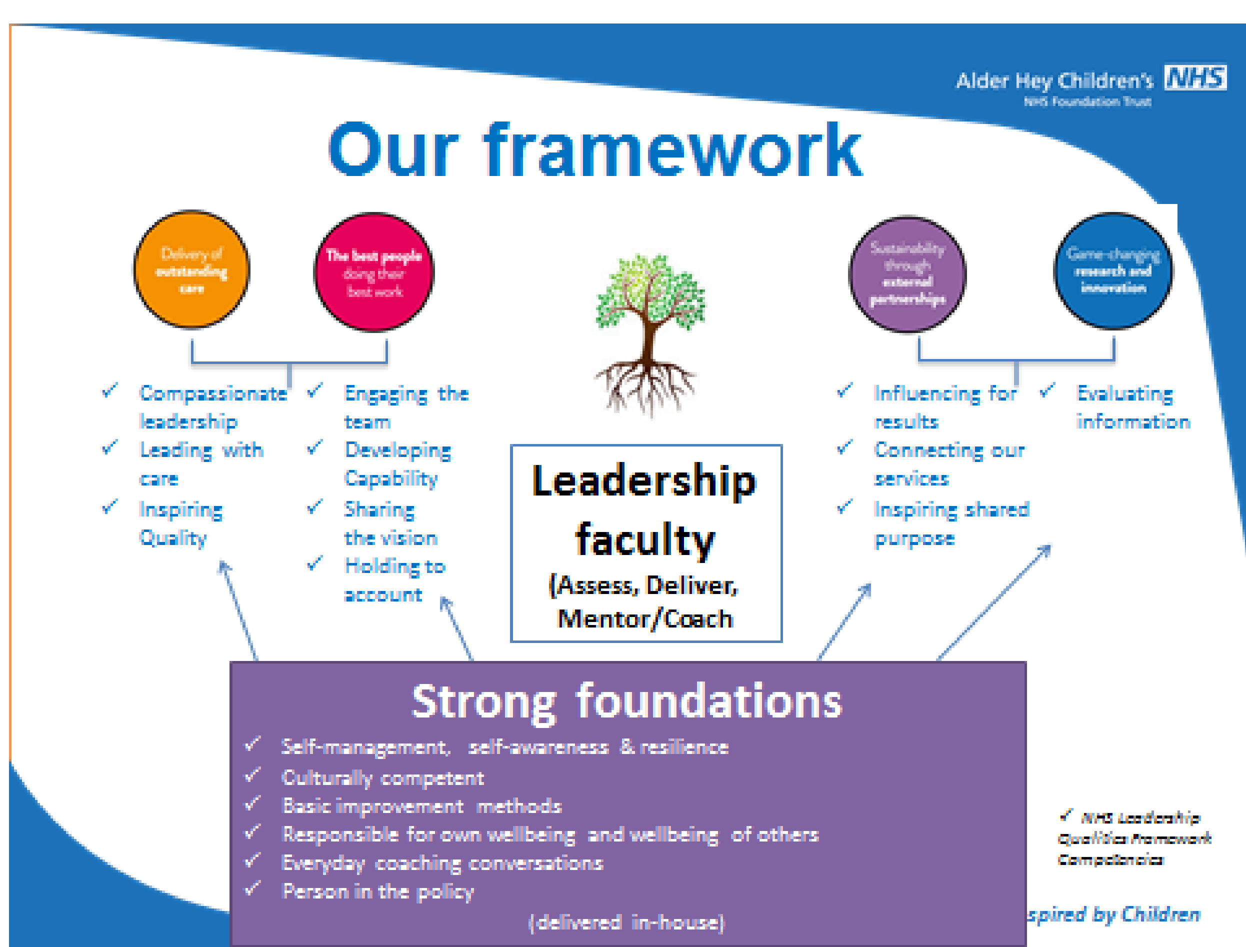

## ii. Inspiring Quality Leadership Faculty — High impact change 4

An Inspiring Quality Leadership Faculty (which will form part of the wider IQ Faculty) will mobilise the leadership of our work in Inspiring Quality. It will provide training to leaders of all levels and backgrounds. This diverse mix of leaders will form cohorts who are trained in strong foundations.

The **Programme Outline** for Strong Foundations is as follows:

Strong Foundations is a 3 day leadership training developed at Alder Hey for all current and aspiring clinical and non-clinical leaders and managers across the organisation with the aim of developing, sustaining and supporting all staff in those positions. Day 1 is about Leading Me with a focus on self-awareness, self-management and resilience and understanding difference and diversity. Day 2 shifts the focus to Leading Others with training in building trust and psychological safety, giving and receiving feedback and improvement and quality. Day 3 is about Developing Others with a focus on coaching. New learning and new connections will be supported and sustained through attendance at Action Learning Sets in between the formal training days.

The **leadership framework** is set out below:



The leadership programme will support our leaders to model Alder Hey behaviours and values.

**What makes a great Alder Hey leader?**

- Actively seeks out difference in others
- Knows that teams need to be safe and cared for and that this is their job
- Understands that they need support to grow and thrive
- Need to be human
- Can make connections with others
- Understands that self-management is critical
- Recognises and promotes talent
- Sees both creativity and standardisation as their role
- They are hopeful, but know they can't do it alone
- Will challenge with courage and kindness

### iii. Other supporting deliverables

A **Patient Shadowing Programme** for Board members and staff will also be implemented to begin the real understanding of putting patients first as well as designing the tools to enable us to measure and analyse learning from the programme.

**Incidents and Near Misses** will be reported by patients and families to create a safety culture where we learn from incidents that have occurred and action any recommendations.

A **Clinical Intelligence Portal** will be established to collect and analyse real time data for clinical and patient reported outcomes.

# 5. Communicating change

We must communicate the change to all staff, children, young people, families and key partners. The communication should achieve three goals:

- To signal that Inspiring Quality is of **paramount importance**
- To **inform**
- To be a call for **involvement** and **action**

In order to communicate the change effectively and at scale we will over the next 6 months undertake to implement the following:

### i. Sharing the vision from the top — High impact change 5

For Inspiring Quality to deliver its three aims, we must engage with all staff across the organisation to ask what Inspiring Quality means to them and how they can contribute.

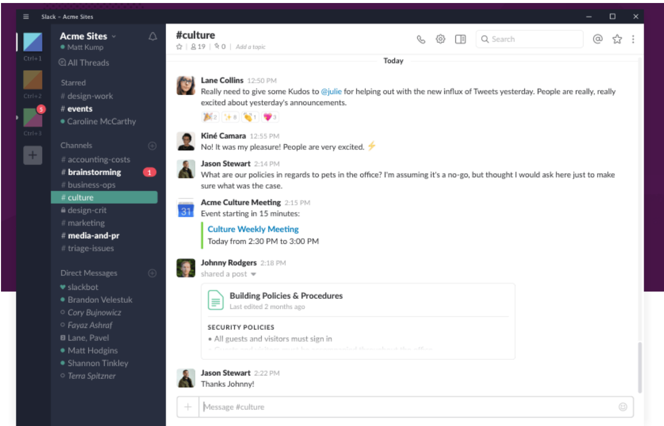
Each department will receive a visit from the CEO or Medical Director along with members of the Inspiring Quality Team to share the vision of Inspiring Quality. The purpose of these visits are to ensure that:

- All staff have an appreciation of what Inspiring Quality is; its aims and how it will be delivered
- An opportunity to ask any questions
- To inspire the team to formulate their own plan to support one or more of the Inspiring Quality aims

### ii. Digital communications platform — High impact change 6

A dedicated platform for Inspiring Quality will enable exchange of ideas and information, and support mobilisation and collaboration. This will be a new medium for communicating and team working. It will be a departure away from email as the default setting for cascading.

Communication will be live, interactive and visual. In terms of layout and format it will follow the principles of social media sites such as Facebook and Instagram.



iii. **Supporting Deliverables**

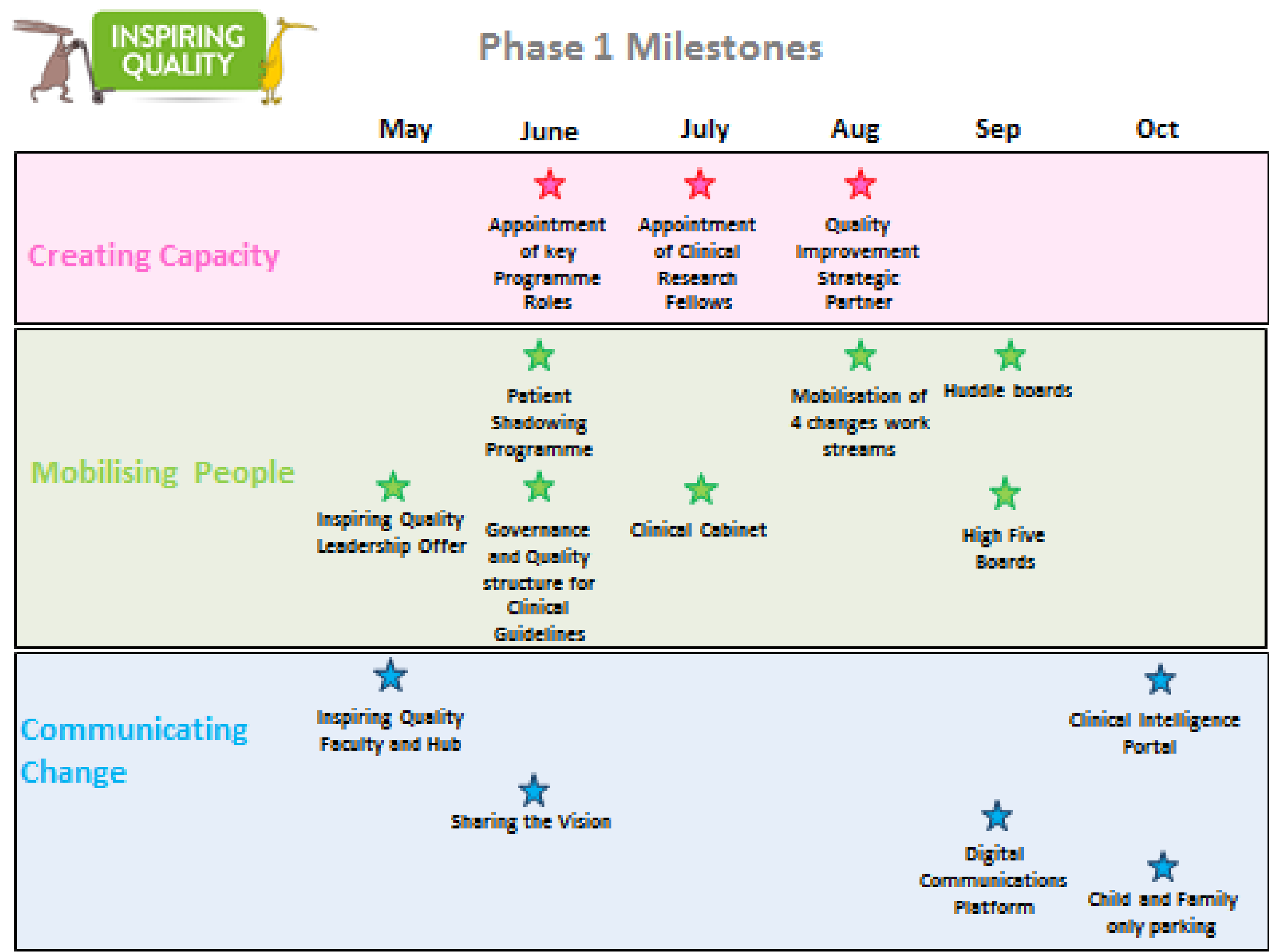
The **Inspiring Quality Hub** is now open on the Mezzanine of the Hospital. The hub provides a dedicated physical space to encourage local improvement initiatives. A space for staff to collaboratively share ideas, successes and visit for advice, guidance and tools to help them with implementation of quality improvement initiatives.

In terms of signs and symbols, we would like to implement **Guaranteed Child & Parent Only Parking** which will also signal the launch of Inspiring Quality and support one of the programme's key aims to put children first.

**Feedback Kiosks** will be introduced to collect comments and suggestions from children, young people and families and will be acted upon.

Introduction of **Huddle Boards** will encourage staff to inspire quality systematically and provide a space for teams to record quality improvements. Alongside this will be the introduction of **High Five Boards** to recognise and celebrate quality improvement.

# 6. Milestones and measuring progress



| High impact change | Measure | Date for delivery |
|---|---|---|
| **Appoint strategic partner(s)** | Strategic partner(s) selected | August 2019 |
| **Recruit to key roles** | Appointment to 8 key roles<br><br>4 workstreams estbalished | August 2019 |
| **Inspiring Quality Cabinet** | Membership of the cabinet appointed to (20 clinical representatives, and 5-10 children, young people and family representaitves) | October 2019 |
| **Inspiring Quality Leadership Faculty** | 60 leaders have started the Strong Foundations | July 2019 |
| **Sharing the vision from the top** | 50 departments have received a visit and briefing on Inspiring Quality | October 2019 |
| **Digital communications platform** | 200 users of the Inspiring Quality application/ platform | October 2019 |

# 7. Resources

## Expenditure forecast

The original resource plan was constructed and tabled to the Trust Board in December 2018.

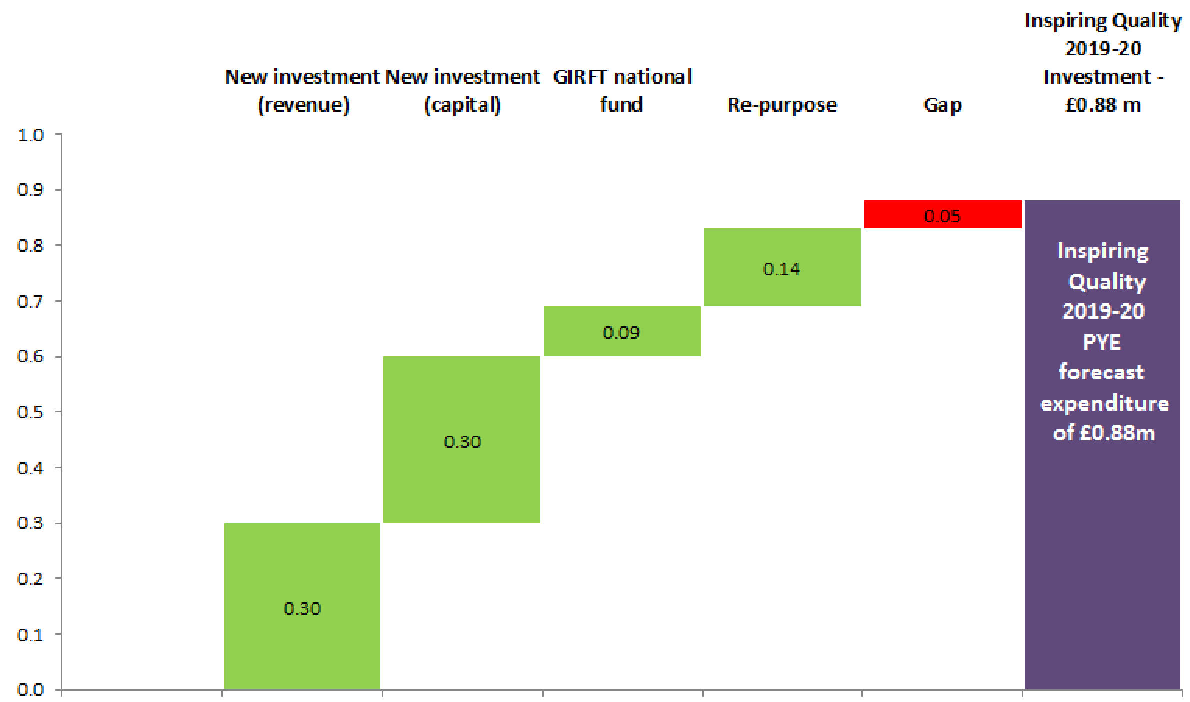
| | Original paper Requested expenditure budget for 19-20 £'000 | Forecast expenditure for 19-20 as at April 2019 £'000 |
|---|---|---|
| Revenue expenditure | 1,500 | 882 |

Please see Appendix 1 for the detail underpinning the forecast expenditure

## Investment fund update

The expenditure forecast above indicates a funding requirement in 19-20 of £0.88 m.

The latest position on funding is that investments of £0.83 m have been secured, leaving a residual funding gap of £50 k. This is set out diagrammatically below:



Our progress in securing funding compared to the plan set out in the case to Trust Board is demonstrated in the table below:

| | Funding plan in original case £'000 | Funding secured £'000 | Variance £'000 |
|---|---|---|---|
| New investment (revenue) | 300 | 300 | 0 |
| New investment (capital) | 0 | 300 | 300 |
| GIRFT national fund | 0 | 90 | 90 |
| Re-purpose | 400 | 144 | -256 |
| Charity | 500 | 0 | -500 |
| GDE | 300 | 0 | -300 |
| Total | 1,500 | 834 | -666 |

## 8. An 'outstanding' organisation

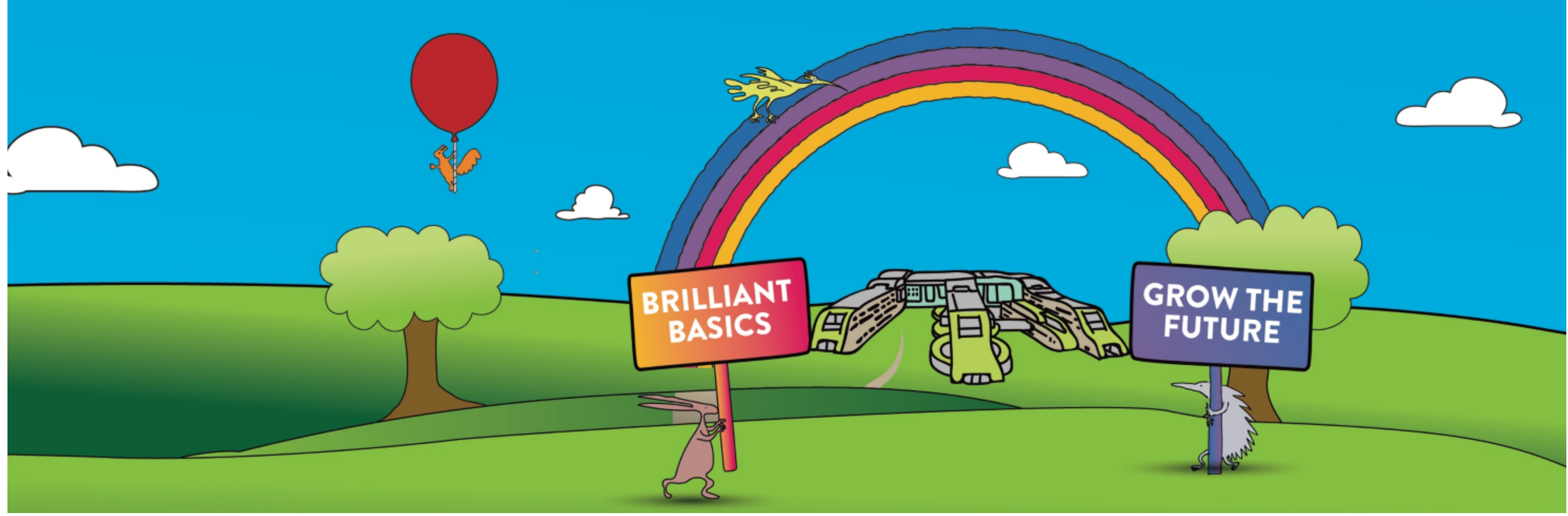
| Safe | Effective | Caring | Responsive | Well-led |
|---|---|---|---|---|
| Incident and Near Miss Family Reporting<br><br>Governance and Quality structure for Clinical Guidelines<br><br>Mobilisation of Communicating Safely work stream<br><br>Mobilisation of Safety Task Force groups with focus on deteriorating patients and medication errors | Appointment of Clinical Research Fellows<br><br>Clinical Intelligence Portal<br><br>Mobilisation of Transform Patient Care through Digital Technology work stream | Child and Family Only Parking<br><br>Patient Shadowing Programme<br><br>Mobilisation of Do everything with Children and Families work stream | Clinical Cabinet<br><br>Huddle boards<br><br>Patient and Family Feedback<br><br>High Five Boards | Sharing the Vision<br><br>Inspiring Quality Leadership Offer<br><br>Digital Communications Platform<br><br>Mobilisation of Building a culture of Inspiring Quality work stream<br><br>Inspiring Quality Faculty and Hub<br><br>Quality Improvement Strategic Partner |

# 9. Appendix 1: Resource plan detail

Resource Plan

| Aspect of Plan | High impact change | Role or item if non-pay | WTE | Band | 2019-20 | 2020-21 |
|---|---|---|---|---|---|---|
| Do everything with children & families | Design services and pathways together | Whose Shoes Events | N/A | N/A | 8 | 8 |
| | | Allowance for families | N/A | N/A | 5 | 10 |
| | | Meridian patient feedback system | N/A | N/A | 24 | 24 |
| | Children setting and recording goal based outcomes | Clinical Fellow | 1 | N/A | 47 | 56 |
| | | Developer | 0.5 | 7 | 12 | 24 |
| | | Statistician | 1 | 7 | 24 | 48 |
| | | Data entry officer | 2 | 4 | 14 | 55 |
| | | Workstream lead | 0.2 | N/A | 24 | 24 |
| Communicate safely | Safety improvement taskforce (to deliver safety culture, training and prevent harm) | Improving Safety of Care Expert | 1 | 8D | 51 | 102 |
| | | Lead Consultant | 0.2 | N/A | 16 | 24 |
| | | Improving Safety of Care Specialist | 1 | 8B | 36 | 73 |
| | | Improving patient safety coaches | 1.5 | 7 | 36 | 72 |
| | | Clinical Fellow | 0.5 | ST 5-7 | 18 | 28 |
| | | Data Analyst | 0.5 | 6 | 10 | 20 |
| | | Administrator | 1 | 4 | 14 | 27 |
| | | Workstream lead | 0.2 | N/A | 24 | 24 |
| Transform patient care through digital technology | Adopt evidence-based digital pathways | Developer | 0.5 | 7 | 0 | 0 |
| | | Data Analyst | 0.5 | 6 | 10 | 20 |
| | Pioneer the application of Artificial Intelligence | *separate investment plan* | N/A | N/A | 0 | 0 |
| | Create a Clinical Intelligence Portal | Data Analyst | 0.5 | 6 | 20 | 20 |
| | | Data Quality Officer | 0.5 | 4 | 7 | 14 |
| | | Information Analyst | 0.75 | 7 | 18 | 36 |
| | | Workstream lead | 0.2 | | 24 | |
| Build a culture of Inspiring Quality | Launch an Inspiring Quality Faculty | External training provider | N/A | N/A | 59 | 235 |
| | | Training materials | N/A | N/A | 25 | 100 |
| | | Quality Improvement Expert | 1 | 8C | 43 | 87 |
| | Empower our teams to take a systematic approach to daily improvement | Professional leave | N/A | N/A | 57 | 114 |
| | | Inspiring Quality coaches | 1.5 | 7 | 36 | 72 |
| | | Huddle boards | N/A | N/A | 26 | 0 |
| | | Project Manager | 0.75 | 6 | 20 | 30 |
| | | Workstream lead | 0.2 | N/A | 24 | 0 |
| Delivery Framework | Delivery team | Senior delivery manager | 1 | 8C | 87 | 87 |
| | | Project Manager | 1 | 6 | 40 | 40 |
| Enablers | External partnerships | International Partnership (SickKids) | N/A | N/A | 0 | 60 |
| | Communications | External agency | N/A | N/A | 20 | 20 |
| | | Production costs (video) | N/A | N/A | 7 | 7 |
| | | Software (digital platform) | N/A | N/A | 8 | 8 |
| | | | | | **882** | **1,552** |

# TRUST BOARD Report October 2019



How Did We Do?

**Executive Summary** **Month: October** **Year: 2019**

Delivery of Outstanding Care

## Safe

In month medication errors resulting in harm increased, an aggregate has been requested to identify any themes or lessons learned.

Introduction of new bar coded medication verification system (BMV) enabling improvements in relation to administration of medications checking processes.

**Highlight**

- High reporting of clinical incidents resulting in no harm and no moderate or above harms in month.
- Achieved 100% of Children and Young People treated within 60 minutes for sepsis.

**Challenges**

- Treatment of sepsis within ED remains a challenge.

The Best People Doing their Best Work

## Caring

New Meridian system is working well capturing the views of our families, terminals have been relocated in response to feedback. Divisional reports now available.

**Highlight**

- Inpatients, community and OPD areas all achieved >95% of F&F who would recommend the Trust.

**Challenges**

- Attendances within ED are some of the highest the department have experienced since opening impacting on CYP and their family's experience.

Delivery of Outstanding Care

## Effective

Waiting times in the Emergency Department are challenging but our relative performance to the national average is strong. Nonetheless, this is our top operational pressure and priority. There are improvement huddles and weekly meetings held between staff and a senior manager. We are focused on alternative pathways for non-emergency patients. We have expanded the criteria for patients that can be seen by a GP and are looking to pilot patients accessing NHS 111 from the department.

Cancelled operations are high as we accommodate an increase in emergency cases into our operating theatres, and bed occupancy is higher. We are using agency nursing on Ward 4A to ensure all beds are safely staffed. We are enhancing the weekly theatre scheduling to focus on data modelling to predict levels of planned activity.

Scanning turnaround times remain challenging, although significant improvement has been achieved in reducing turnaround times for outpatient records. We have agreed to continue using an external partner so our capacity is increased and we can focus on reducing the time to scan inpatient records.

**Highlight**

- All patients with a cancelled operation had their operation re-booked to take place within 28 days.

**Challenges**

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

Delivery of Outstanding Care

## Responsive

Access to planned care is good as demonstrated by stability in the size of the waiting list, ensuring no patients wait over 52 weeks for treatment and access to cancer care.

The SAFER patient flow bundle (link) has been rolled out and is achieving significant improvements in patients who know their planned date of discharge and an increase in discharges that happen by midday to 24%, across wards 3A and 4C.

**Highlight**

- Access to planned care is good.
- % who know their planned date of discharge.

**Challenges**

The Best People Doing their Best Work

## Well Led

In Month 7 we delivered a £0.7k surplus which was £0.2k behind the plan. This means we are now £0.1m behind our year to date plan. It is important that we recover this position by the end of Q3 in order to secure our PSF income.

Activity levels remained high in month in Outpatients and A&E which both exceeded their plan. Elective activity was 6% behind plan Non Elective was 1% behind plan.

Pay was overspent in the month bringing the cumulative position to £0.1m underspent against the plan. This was despite the temporary staffing expenditure decreasing slightly to £0.8m.

However non pay remains an area of concern and is overspent year to date by £2.8m.

CIP performance was in line with plan in month although there is still a material gap against our forecast versus target of £1.2m. A financial re-set is being taken through RABD to target key areas of improvement. Cash holdings are £81.8m which is significantly higher than plan driven mainly by capital slippage.

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

Completion of PDR's remain at just below the target of 90% and a concerted effort is required by all areas to improve this further. Additionally medical appraisals have fallen to 86.4% and a concerted effort is also required to improve this for future months.

Sickness levels have increased again to 5.7%. There is work underway to support specific teams where sickness levels are high.

### Highlight

- Activity Levels in OP.
- Mandatory Training.

### Challenges

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

Game Changing Research and Innovation

## Research and Development

- Presentation of Delivery Plan Progress to Trust Board
- Initiation of Research Division Improvement Programme
- Development of model to recognise Trust-wide research participation

**Highlight**

- Research Management Board becomes operational.

**Challenges**

- Level of staffing to support and deliver research activity.

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BRILLIANT BASICS

# Delivery of Outstanding Care

## SAFE

D Drive W Watch P Programme

| Indicator | Type | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG Green | RAG Amber | RAG Red | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 72 | 79 | 58 | 59 | 83 | 76 | 58 | 83 | 57 | 113 | 54 | 62 | 61 | | >=78 | >=74 | <74 | ✔ |
| Clinical Incidents resulting in No Harm | D | 316 | 286 | 217 | 284 | 251 | 279 | 302 | 296 | 298 | 317 | 283 | 276 | 329 | | >=326 | >=310 | <310 | ✔ |
| Clinical Incidents resulting in minor, non permanent harm | D | 90 | 94 | 67 | 78 | 84 | 105 | 94 | 108 | 76 | 70 | 73 | 74 | 91 | | <=86 | N/A | >86 | ✔ |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 1 | 1 | 2 | 1 | 0 | 0 | 0 | 1 | 3 | 0 | 0 | 0 | | <=1 | N/A | >1 | ✔ |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 | N/A | >0 | ✔ |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 0 | | 0 | N/A | >0 | ✔ |
| Medication errors resulting in harm | D | 2 | 6 | 2 | 2 | 4 | 2 | 6 | 3 | 3 | 2 | 1 | 2 | 6 | | <=3 | N/A | >3 | ✔ |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Never Events | W | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | | 0 | N/A | >0 | ✔ |
| Sepsis: Patients treated for Sepsis - A&E | D P | 65.4% | 57.6% | 51.9% | 77.4% | 71.1% | 79.4% | 58.8% | 71.1% | 65.2% | 79.3% | 76.7% | 77.8% | 78.4% | | >=90 % | N/A | <90 % | ✔ |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | 70.2% | 76.2% | 73.3% | 70.2% | 82.1% | 73.3% | 81.8% | 71.4% | 90.9% | 80.0% | 100.0% | 94.1% | 100.0% | | >=90 % | N/A | <90 % | ✔ |
| No of children that have suffered avoidable death - Internal | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Hospital Acquired Organisms - C.difficile | D | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 | N/A | >0 | ✔ |
| Hospital Acquired Organisms - MSSA | D | 2 | 0 | 1 | 1 | 0 | 4 | 1 | 1 | 0 | 0 | 1 | 1 | 0 | | <=1 | N/A | >1 | ✔ |

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## CARING

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BRILLIANT BASICS

D Drive W Watch P Programme

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Friends & Family A&E - % Recommend the Trust | D | 80.0% | 80.6% | 90.1% | 90.5% | 80.3% | 89.5% | 78.8% | 87.7% | 80.4% | 82.8% | 88.1% | 91.1% | 83.6% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Community - % Recommend the Trust | D | 93.2% | 100.0% | 100.0% | 98.5% | 100.0% | 98.6% | 88.4% | 100.0% | 93.8% | 92.9% | 92.9% | 91.9% | 95.0% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Inpatients - % Recommend the Trust | D | 98.2% | 97.9% | 98.2% | 97.0% | 96.2% | 97.8% | 97.3% | 90.6% | 90.1% | 93.2% | 92.5% | 95.5% | 96.5% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Mental Health - % Recommend the Trust | D | 84.7% | 97.5% | 100.0% | 88.9% | 76.9% | 82.9% | 80.8% | 88.7% | 100.0% | 33.3% | 78.8% | 88.5% | 66.7% | | >=95 % >=90 % <90 % | ✔ |
| Friends & Family Outpatients - % Recommend the Trust | D P | 90.3% | 91.4% | 91.7% | 87.4% | 89.1% | 91.1% | 92.7% | 91.7% | 93.5% | 91.2% | 94.4% | 93.8% | 95.3% | | >=95 % >=90 % <90 % | ✔ |
| Complaints | W | 13 | 5 | 7 | 7 | 9 | 16 | 7 | 9 | 6 | 15 | 13 | 12 | 4 | | No Threshold | |
| PALS | W | 132 | 115 | 71 | 136 | 97 | 95 | 110 | 103 | 121 | 128 | 92 | 130 | 119 | | <=119 <=132 >132 | ✔ |

Delivery of Outstanding Care

## EFFECTIVE

D Drive W Watch P Programme

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG | | | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | 1.0% | 1.1% | 2.4% | 1.4% | 1.8% | 2.5% | 2.7% | 2.1% | 1.3% | 5.3% | 5.4% | 0.0% | 1.3% | | <=3 % | N/A | >3 % | ✔ |
| ED: 95% Treated within 4 Hours | D | 90.9% | 93.8% | 95.3% | 92.1% | 90.6% | 95.6% | 93.5% | 91.3% | 89.4% | 91.8% | 94.7% | 89.0% | 86.9% | | >=95 % | N/A | <95 % | ✔ |
| ED: Number of patients spending >12 hours from decision to admit to admission | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 28 | 38 | 21 | 11 | 10 | 12 | 9 | 24 | 15 | 37 | 35 | 18 | 34 | | <=20 | N/A | >20 | ✔ |
| 28 Day Breaches | W | 0 | 6 | 6 | 4 | 1 | 1 | 0 | 0 | 1 | 2 | 0 | 1 | 0 | | 0 | N/A | >0 | ✔ |
| Average Scanning Turnaround - Inpatient | D | | | | | 44.00 | 49.00 | 49.00 | 50.00 | 55.00 | 55.00 | 65.00 | 71.25 | 73.00 | | <=7 | N/A | >7 | ✔ |
| Average Scanning Turnaround - Outpatient | D | | | | | 26.00 | 23.00 | 24.00 | 21.00 | 23.00 | 23.00 | 31.50 | 32.25 | 9.00 | | <=5 | N/A | >5 | ✔ |

Delivery of Outstanding Care

## RESPONSIVE

D Drive W Watch P Programme

| Measure | Type | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG Green | RAG Amber | RAG Red | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | 96.4% | 95.1% | 96.7% | 96.0% | 94.9% | 95.7% | 98.3% | 96.6% | 97.5% | 97.6% | 95.7% | 97.7% | 95.7% | | >=95 % | >=90 % | <90 % | ✔ |
| IP Survey: % Treated with respect | W | 99.6% | 100.0% | 99.6% | 100.0% | 99.3% | 99.5% | 99.3% | 99.0% | 98.1% | 99.2% | 97.5% | 98.4% | 97.7% | | 100 % | >=95 % | <95 % | ✔ |
| IP Survey: % Know their planned date of discharge | D P | 60.2% | 69.0% | 59.4% | 76.5% | 82.8% | 80.6% | 88.8% | 84.1% | 87.9% | 87.8% | 87.1% | 89.2% | 92.2% | | >=90 % | >=85 % | <85 % | ✔ |
| IP Survey: % Know who is in charge of their care | W | 92.2% | 92.2% | 92.5% | 96.3% | 94.3% | 93.4% | 99.3% | 90.5% | 96.3% | 90.8% | 98.0% | 98.4% | 93.7% | | >=95 % | >=90 % | <90 % | ✔ |
| IP Survey: % Patients involved in Play | D | | | | | | | | | 93.3% | 94.5% | 95.3% | 91.5% | 92.1% | | >=90 % | >=85 % | <85 % | ✔ |
| IP Survey: % Patients involved in Learning | D | | | | | | | | | 70.9% | 75.6% | 72.1% | 68.3% | 73.5% | | >=90 % | >=85 % | <85 % | ✔ |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 92.1% | 92.1% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.0% | 92.1% | 92.1% | 92.0% | 92.0% | 92.0% | | >=92 % | >=90 % | <90 % | ✔ |
| Waiting List Size | W | 12,961 | 12,934 | 12,859 | 12,872 | 12,888 | 12,746 | 12,871 | 12,876 | 12,843 | 12,883 | 12,874 | 12,826 | 12,754 | | <=12899 | N/A | >12899 | ✔ |
| Waiting Greater than 52 weeks | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 | ✔ |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | 96.7% | 100.0% | 100.0% | 100.0% | 95.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 94.4% | 100.0% | 100.0% | | 100 % | N/A | <100 % | ✔ |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | 100.0% | 100.0% | 100.0% | 100.0% | 87.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % | ✔ |
| All Cancers: 31 day wait until subsequent treatments | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % | ✔ |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | W | 100.0% | 100.0% | 100.0% | 100.0% | 87.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 88.9% | 100.0% | | 100 % | N/A | <100 % | ✔ |
| Diagnostics: % Completed Within 6 Weeks | W | 99.8% | 99.3% | 100.0% | 99.7% | 99.6% | 99.5% | 100.0% | 99.8% | 100.0% | 99.8% | 100.0% | 99.7% | 100.0% | | >=99 % | N/A | <99 % | ✔ |
| PFI: PPM% | | 98.0% | 99.0% | 100.0% | 100.0% | 100.0% | 98.0% | 98.0% | 98.0% | 98.0% | 100.0% | 99.0% | 99.0% | 99.0% | | >=98 % | N/A | <98 % | ✔ |

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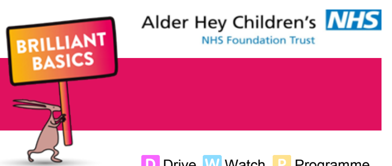
## WELL LED




D Drive W Watch P Programme

| Metric | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG Green | RAG Amber | RAG Red | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CIP In Month Variance (£'000s) | W | -174 | -285 | 151 | -199 | -74 | -75 | -163 | -54 | -47 | -26 | 176 | -165 | -22 | | >=-5% | >=-20% | <-20% | ✔ |
| Control Total In Month Variance (£'000s) | W | -462 | -48 | 564 | -20 | -433 | | -394 | -165 | 596 | -848 | 852 | 94 | -226 | | >=-5% | >=-20% | <-20% | ✔ |
| Capital Expenditure In Month Variance (£'000s) | W | -751 | 1,041 | 1,032 | 1,032 | 259 | 1,610 | 1,030 | 640 | 728 | 694 | 1,239 | 865 | 1,909 | | >=-5% | >=-10% | <-10% | ✔ |
| Cash in Bank (£'000s) | W | 20,315 | 17,580 | 23,136 | 19,983 | 22,068 | 33,699 | 34,361 | 34,449 | 37,415 | 79,086 | 80,174 | 80,807 | 81,847 | | >=-5% | >=-20% | <-20% | ✔ |
| Income In Month Variance (£'000s) | W | 624 | 684 | 142 | 456 | 355 | 19,495 | -612 | 21 | 846 | -52 | 1,348 | 666 | 1,118 | | >=-5% | >=-20% | <-20% | ✔ |
| Pay In Month Variance (£'000s) | W | -372 | -74 | -267 | -510 | -850 | -495 | 183 | -25 | -130 | -260 | 273 | 143 | -254 | | >=-5% | >=-20% | <-20% | ✔ |
| Non Pay In Month Variance (£'000s) | W | -714 | -659 | 689 | 34 | 63 | -942 | 34 | -161 | -119 | -537 | -769 | -715 | -1,089 | | >=-5% | >=-20% | <-20% | ✔ |
| NHSI Use of Resources | W | 2 | 1 | 1 | 1 | 1 | 1 | 1 | 3 | 3 | 3 | 3 | 3 | 3 | | <=3 | N/A | >3 | ✔ |
| AvP: IP - Non-Elective | W | | | | | | | 53 | 58 | 109 | 158 | 132 | 55 | -18 | | >=0 | N/A | <0 | ✔ |
| AvP: IP Elective vs Plan | W | | | | | | | -45 | -24 | -41 | -76 | 17 | -66 | -66 | | >=0 | N/A | <0 | ✔ |
| AvP: Daycase Activity vs Plan | W | | | | | | | -53 | -132 | -241 | -45 | 80 | 58 | -76 | | >=0 | N/A | <0 | ✔ |
| AvP: Outpatient Activity vs Plan | W | | | | | | | 772 | 96 | 1,299 | 2,054 | 2,639 | 2,224 | 2,786 | | >=0 | N/A | <0 | ✔ |
| PDR | W | 90.1% | 90.1% | 90.1% | 90.1% | 92.2% | 92.2% | 4.8% | 20.7% | 47.3% | 86.4% | 89.3% | 89.3% | 89.3% | | >=90 % | >=85 % | <85 % | ✔ |
| Medical Appraisal | W | | | | | | | | | | | | | | | >=95 % | >=90 % | <90 % | ✔ |
| Mandatory Training | W | 89.7% | 89.7% | 89.0% | 89.4% | 88.8% | 89.6% | 90.0% | 88.4% | 90.5% | 90.8% | 91.9% | 91.1% | 91.3% | | >=90 % | >=80 % | <80 % | ✔ |
| Sickness | D | 5.6% | 5.6% | 6.0% | 5.7% | 5.7% | 5.4% | 5.2% | 5.5% | 5.2% | 5.2% | 4.9% | 5.2% | 5.7% | | <=4 % | <=4.5 % | >4.5 % | ✔ |
| Short Term Sickness | D | 1.6% | 1.6% | 1.7% | 1.9% | 1.7% | 1.6% | 1.5% | 1.5% | 1.4% | 1.3% | 1.0% | 1.4% | 1.8% | | <=1 % | N/A | >1 % | ✔ |
| Long Term Sickness | D | 4.0% | 3.9% | 4.4% | 3.8% | 3.9% | 3.7% | 3.7% | 4.0% | 3.8% | 3.9% | 3.9% | 3.8% | 3.9% | | <=3 % | N/A | >3 % | ✔ |
| Temporary Spend ('000s) | D | 998 | 971 | 883 | 937 | 1,046 | 1,357 | 1,114 | 1,061 | 899 | 1,058 | 992 | 1,145 | 933 | | <=800 | <=960 | >960 | ✔ |
| Staff Turnover | D | 10.4% | 10.2% | 9.6% | 9.4% | 9.5% | 9.9% | 9.7% | 9.9% | 9.8% | 9.3% | 10.0% | 10.3% | 10.1% | | <=10 % | <=11 % | >11 % | ✔ |
| Safer Staffing (Shift Fill Rate) | W | 93.2% | 95.3% | 94.2% | 94.5% | 92.8% | 95.4% | 95.3% | 95.2% | 92.6% | 92.0% | 93.5% | 90.3% | 91.7% | | >=90 % | N/A | <90 % | ✔ |
| Domestic Cleaning Audit Compliance | W | 60.0% | 90.0% | 90.0% | 92.0% | 95.0% | 86.0% | 81.5% | 100.0% | 81.2% | 97.2% | 92.5% | 90.5% | 100.0% | | >=85 % | N/A | <85 % | ✔ |
| Performance Against Single Oversight Framework Themes | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | <=1 | >1 | ✔ |

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

| Measure | Type | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG Green | RAG Amber | RAG Red | Comments Available |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of Open Studies - Academic | W | 143 | 136 | 123 | 121 | 121 | 153 | 154 | 158 | 161 | 158 | 172 | 161 | 162 | | >=130 | >=111 | <111 | ✔ |
| Number of Open Studies - Commercial | W | 31 | 28 | 27 | 29 | 26 | 60 | 59 | 59 | 58 | 57 | 59 | 38 | 42 | | >=30 | >=21 | <21 | ✔ |
| Number of New Studies Opened - Academic | W | 6 | 8 | 2 | 6 | 5 | 3 | 1 | 5 | 4 | 2 | 3 | 2 | 2 | | >=3 | >=2 | <2 | ✔ |
| Number of New Studies Opened - Commercial | W | 2 | 0 | 0 | 1 | 1 | 4 | 2 | 1 | 2 | 2 | 2 | 1 | 2 | | >=1 | N/A | <1 | ✔ |
| Number of patients recruited | W | 195 | 296 | 158 | 238 | 211 | 314 | 234 | 221 | 350 | 431 | 165 | 941 | 1,228 | | >=200 | >=171 | <171 | ✔ |

Delivery of Outstanding Care

## 7.1 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Increasing Reporting | **Clinical Incidents resulting in Near Miss** D<br>Total number of Near Miss Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19. 19/20 aim is to see more than 5% reported than last year for the same month to demonstrate a learning culture.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 61 | R <74<br>A >=74<br>G >=78 | | Divisions receive weekly reports of all 'Near Miss' incidents reported to enable prioritisation of reviews and ensure lessons are learned, actions for improvement are implemented in a timely manner and feedback to staff (to minimise risk) and reporters. Staffs are encouraged to report near misses as these are considered learning opportunities. In addition the reports enable monitoring of trends/ themes and actions for improvement to be implemented in a timely manner. Progress with improvements is expected to be included in monthly CQSG division governance reports and shared across divisions. |
| Incidents: Increasing Reporting | **Clinical Incidents resulting in No Harm** D<br>Total number of No Harm Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19. 19/20 aim is to see more than 5% reported than last year for the same month.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 329 | R <310<br>A >=310<br>G >=326 | | No Action Required |
| Incidents: Reducing Harm | **Clinical Incidents resulting in minor, non permanent harm** D<br>Total number of Minor Harm Incidents reported. The threshold is based on a reduction for the period Apr 18 - Mar 19. 19/20 aim is to see volume reported less than last year for the same month.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 91 | R >86<br>A N/A<br>G <=86 | | Divisions receive weekly reports of all 'low Harm ' incidents reported to enable prioritisation of reviews and ensure lessons are learned, actions for improvement are implemented and feedback to staff (to minimise risk) and reporters. Staffs are encouraged to report 'low harm' incidents as these are considered learning opportunities to review systems and processes to minimise risk of more serious harm. These reports enable monitoring of trends and actions for improvement to be implemented. Progress with improvements is expected to be included in monthly CQSG division governance reports. |

Delivery of Outstanding Care

## 7.2 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Incidents: Reducing Harm | **Clinical Incidents resulting in moderate, semi permanent harm** D<br>Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 18 - Mar 19. 19/20 aim for the trust is 11 or less, annually.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R >1<br>A N/A<br>G <=1 | Oct-18 to Oct-19 (Actual, Average, UCL, LCL, UWL, LWL, Green) | No Action Required |
| Incidents: Reducing Harm | **Clinical Incidents resulting in severe, permanent harm** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R >0<br>A N/A<br>G 0 | Oct-18 to Oct-19 (Actual, Average, UCL, LCL, UWL, LWL, Green) | No Action Required |
| Incidents: Reducing Harm | **Clinical Incidents resulting in catastrophic, death** D<br>Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R >0<br>A N/A<br>G 0 | Oct-18 to Oct-19 (Actual, Average, UCL, LCL, UWL, LWL, Green) | No Action Required |

Delivery of Outstanding Care

## 7.3 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Reducing Medication Errors | **Medication errors resulting in harm** D<br>Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 18 - Mar 19, on trajectory with WHO global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% by 2022. 19/20 aim is less than 34 annually for the trust.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 6 | R<br>A<br>G | >3<br>N/A<br><=3 | | There has been an increase in incidents causing minor harm this month. No particular themes have been identified. Prescribers have been contacted to ask them to undertake reflections. Transcribing errors between paper and electronic prescribing systems are being reviewed by the Medication Safety Committee. Methods of alerting the relevant people when diabetic patients are admitted and information on managing insulin are being developed and details of an adverse drug reaction will be circulated to the relevant teams |
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 3)** W<br>Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 19/20 Aim is zero annually.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R<br>A<br>G | >0<br>N/A<br>0 | | No Action Required |
| Reducing Pressure Ulcers | **Pressure Ulcers (Category 4)** W<br>Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 19/20 Aim is zero annually.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R<br>A<br>G | >0<br>N/A<br>0 | | No Action Required |

Delivery of Outstanding Care

## 7.4 - QUALITY - SAFE

D Drive W Watch P Programme

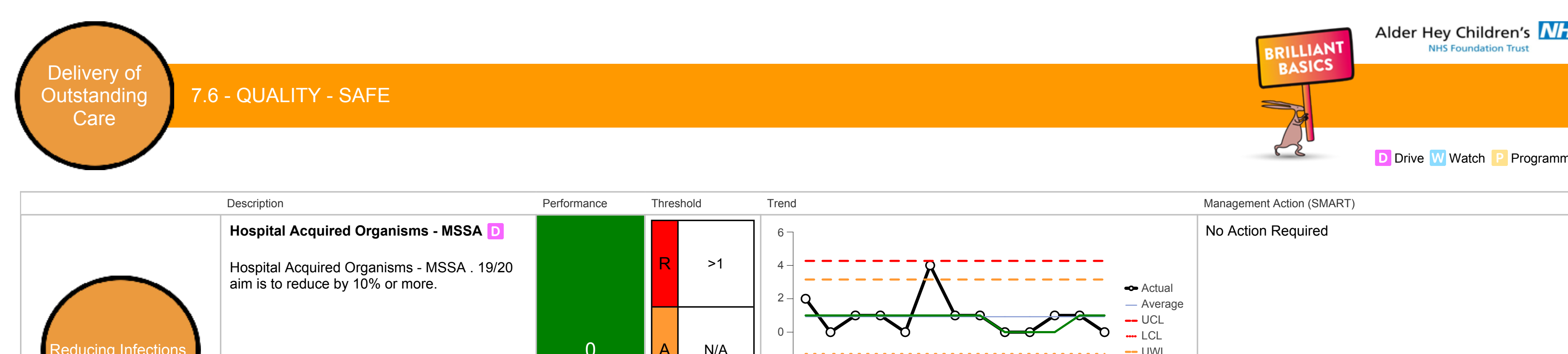
| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Never Events | **Never Events** W<br>Never Events. The threshold is based on this event never occuring. 19/20 aim is zero annually.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R >0<br>A N/A<br>G 0 | Actual, Average, UCL, LCL, UWL, LWL, Green (Oct-18 to Oct-19) | No Action Required |
| Sepsis | **Sepsis: Patients treated for Sepsis - A&E** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 19/20 aim is 90%.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 78.38 % | R <90 %<br>A N/A<br>G >=90 % | Actual, Average, UCL, LCL, UWL, LWL, Green (Oct-18 to Oct-19) | Increase in the number of acutely unwell children presenting requiring high level care. Clinicians and nurses showing continued awareness of sepsis and management and treating promptly. ED sepsis nurse providing feedback and education. |
| Sepsis | **Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P<br>Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 19/20 aim is 90%.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 100 % | R <90 %<br>A N/A<br>G >=90 % | Actual, Average, UCL, LCL, UWL, LWL, Green (Oct-18 to Oct-19) | No Action Required |

Delivery of Outstanding Care

## 7.5 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Mortality | **No of children that have suffered avoidable death - Internal** W<br>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.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R<br>A<br>G | >0<br>N/A<br>0 | Actual, Average, UCL, LCL, UWL, LWL, Green; Oct-18 to Oct-19 | No Action Required |
| Reducing Infections | **Hospital Acquired Organisms - MRSA (BSI)** D<br>The threshold is based on this event never occuring. 19/20 Aim is zero annually.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R<br>A<br>G | >0<br>N/A<br>0 | Actual, Average, UCL, LCL, UWL, LWL, Green; Oct-18 to Oct-19 | No Action Required |
| Reducing Infections | **Hospital Acquired Organisms - C.difficile** D<br>The threshold is based on this event never occuring. 19/20 Aim is zero annually.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 1 | R<br>A<br>G | >0<br>N/A<br>0 | Actual, Average, UCL, LCL, UWL, LWL, Green; Oct-18 to Oct-19 | This case is to be reviewed on Monday 25th November at an internal bacteraemia review meeting to determine if a lapse in care occurred. |




## 7.6 - QUALITY - SAFE

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Reducing Infections | **Hospital Acquired Organisms - MSSA** D<br><br>Hospital Acquired Organisms - MSSA . 19/20 aim is to reduce by 10% or more.<br><br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 0 | R | >1 | | No Action Required |
| | | | A | N/A | | |
| | | | G | <=1 | | |

The Best People doing their best Work

## 8.1 - QUALITY - CARING

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Friends & Family | **Friends & Family A&E - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 83.57 % | R <90 %<br>A >=90 %<br>G >=95 % | | 566 responses - with 551 via SMS (97.3%). Since implementing SMS overall increase over 3/12 of 135% .8 comments re booking in – 1 Positive 7 Negative, staff attitude 1 postive 4 negative and 2 comments re:lack of manners. Waiting time continues to be a trend regarding lack of communication as does signage and process to follow regarding triage.11.84% would not recommend - an increase of 6.13% from September (67 up from 39) Daily triggers to managers continue with 119 surveys generating triggers this month Volunteer role implemented to support reception staff to allow them to remain on desk |
| Friends & Family | **Friends & Family Community - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 95.03 % | R <90 %<br>A >=90 %<br>G >=95 % | | No Action Required |
| Friends & Family | **Friends & Family Inpatients - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 96.51 % | R <90 %<br>A >=90 %<br>G >=95 % | | No Action Required |

Trend chart labels: Oct-18, Nov-18, Dec-18, Jan-19, Feb-19, Mar-19, Apr-19, May-19, Jun-19, Jul-19, Aug-19, Sep-19, Oct-19. Legend: Actual, Average, UCL, LCL, UWL, LWL, Green.

## 8.2 - QUALITY - CARING

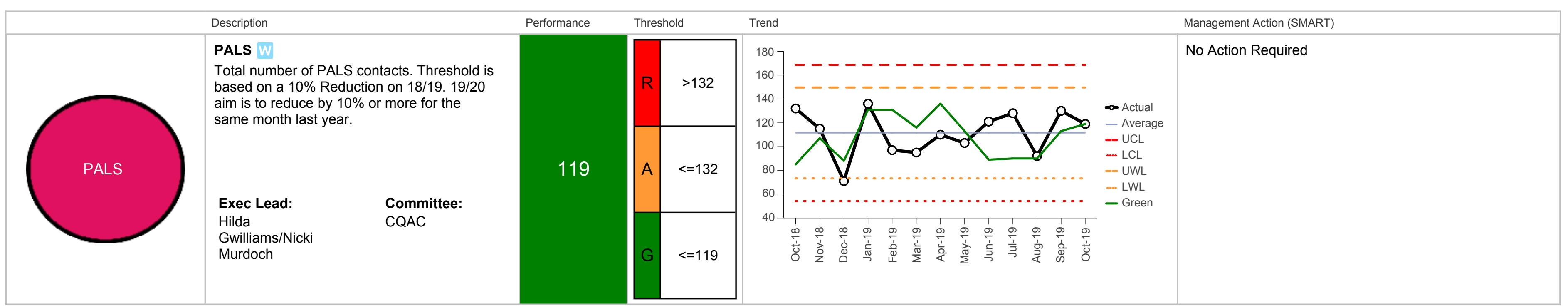
D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Friends & Family | **Friends & Family Mental Health - % Recommend the Trust** D<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 66.67 % | R <90 %<br>A >=90 %<br>G >=95 % | | Decrease of 26.68% since September with 30 recommending the Trust compared to 54 last month. On comparison within the Service we can identify that the environment of Liverpool CAMHS is the predominant trend with only 43.48 % recommending the Trust in this service compared to 81.82 % at Sefton CAMHS. Signage to Catkin building and waiting area also identified. Comments regarding staff attitude and care received were all positive. |
| Friends & Family | **Friends & Family Outpatients - % Recommend the Trust** D P<br>Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 95.25 % | R <90 %<br>A >=90 %<br>G >=95 % | | No Action Required |
| Complaints | **Complaints** W<br>Total complaints received.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 4 | No Threshold | | |

The Best People doing their best Work

## 8.3 - QUALITY - CARING

D Drive W Watch P Programme

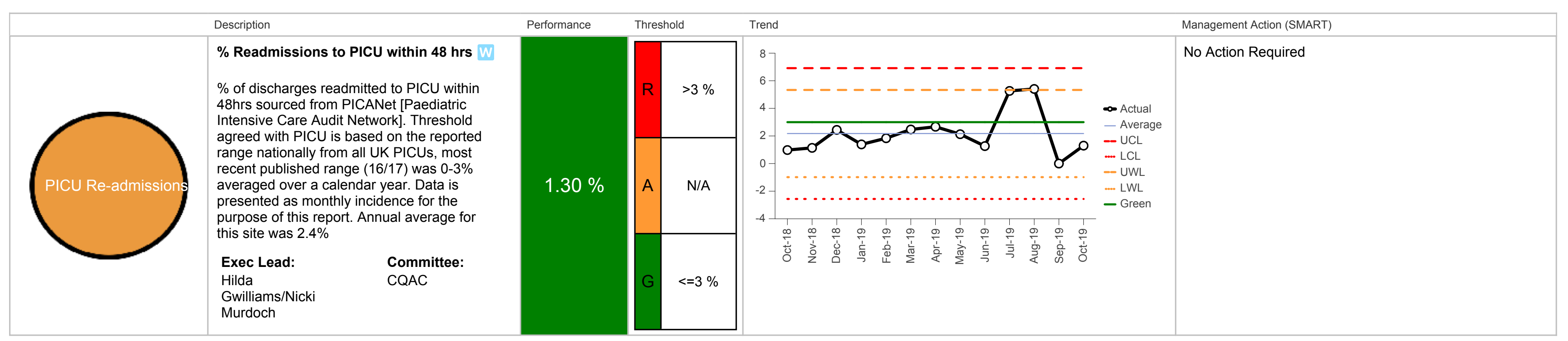


| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| PALS | **PALS** W<br>Total number of PALS contacts. Threshold is based on a 10% Reduction on 18/19. 19/20 aim is to reduce by 10% or more for the same month last year.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 119 | R >132<br>A <=132<br>G <=119 | | No Action Required |

Delivery of Outstanding Care

# 9.1 - QUALITY - EFFECTIVE

D Drive W Watch P Programme




| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| PICU Re-admissions | **% Readmissions to PICU within 48 hrs** W<br><br>% of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4%<br><br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 1.30 % | R >3 %<br>A N/A<br>G <=3 % | | No Action Required |

Delivery of Outstanding Care

## 10.1 - QUALITY - RESPONSIVE

D Drive W Watch P Programme

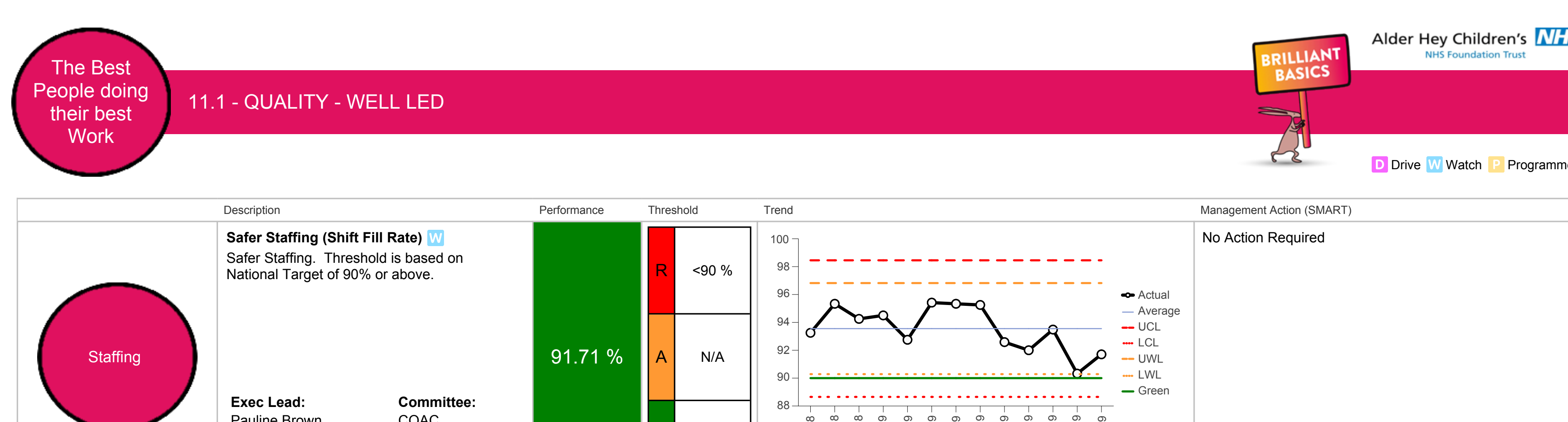
| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Inpatient Survey: Choices | **IP Survey: % Received information enabling choices about their care** W<br>Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 95.67 % | R<br>A<br>G | <90 %<br>>=90 %<br>>=95 % | | No Action Required |
| Inpatient Survey: Respect | **IP Survey: % Treated with respect** W<br>Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 19/20 is 100%.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 97.65 % | R<br>A<br>G | <95 %<br>>=95 %<br>100 % | | During October Medicine had 28 actions raised with 10 directly around respect/communication. The theme for Medicine continues around staff attitude and communication. From 211 surveys completed 205 said they were treated with respect. Surgery had 22 new actions raised with 9 from respect question .336 out of 343 answered yes to treat with respect. Most negative feedback from EDU and MDU. Training with medical students/junior doctors identified with an action to implement at induction. Bedside play sessions with Liverpool AC to commence to improve communication/engagement with children/yp |
| Inpatient Survey: Date of Discharge | **IP Survey: % Know their planned date of discharge** D P<br>Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 92.24 % | R<br>A<br>G | <85 %<br>>=85 %<br>>=90 % | | No Action Required |

Delivery of Outstanding Care

## 10.2 - QUALITY - RESPONSIVE

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Inpatient Survey: In Charge of Care | **IP Survey: % Know who is in charge of their care** W<br>% of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 93.68 % | R <90 %<br>A >=90 %<br>G >=95 % | | We have seen a decrease of 4.7% across the Trust. With a 0.8% - (5 from 211 responses ) in medicine and 7.1% (30 from 343 responses ) surgery. Feedback is now in real time with managers receiving daily triggers. Staff continue to introduce themselves "my name is" Training with medical students/junior doctors identified with an action to implement at induction. Bedside play sessions with Liverpool AC students to commence next week to improve communication |
| Inpatient Survey: Play | **IP Survey: % Patients involved in Play** D<br>% of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 92.06 % | R <85 %<br>A >=85 %<br>G >=90 % | | No Action Required |
| Inpatient Survey: Learning | **IP Survey: % Patients involved in Learning** D<br>% of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above.<br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 73.47 % | R <85 %<br>A >=85 %<br>G >=90 % | | Figures include half term. PEQL/play service manager to action with school team how summer holidays/half terms can be supported to continue learning Comments from ward 3B states teacher has been off and not replaced. Breakdown of data shows variables between Children 52.94% Medicine/ 51.43% Surgery - YP 70.97% Medicine/ 61.11% Surgical - P/C 74.23% Medicine/ 80.31% Surgical .Wording of question and capturing/accessibility of feedback for younger children to be discussed with play service manager/PEQL and IQVIA |




| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Staffing | **Safer Staffing (Shift Fill Rate)** W<br>Safer Staffing. Threshold is based on National Target of 90% or above.<br>**Exec Lead:** Pauline Brown<br>**Committee:** CQAC | 91.71 % | R | <90 % | | No Action Required |
| | | | A | N/A | | |
| | | | G | >=90 % | | |

Delivery of Outstanding Care

## 12.1 - PERFORMANCE - EFFECTIVE

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| ED 4 Hour Standard | **ED: 95% Treated within 4 Hours** D<br>Threshold is based on National Guidance set by NHS England at 95%.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 86.91 % | R <95 %<br>A N/A<br>G >=95 % | | best performance for October in the North West region. Team continue to work on action plan and anticipate new staff members commencing incrementally from November. Particularly increased consultant numbers with returners and new starters |
| ED 12 Hr Waits | **ED: Number of patients spending >12 hours from decision to admit to admission** W<br>Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 0 | R >0<br>A N/A<br>G 0 | | No Action Required |
| Cancelled Operations | **On the day Elective Cancelled Operations for Non Clinical Reasons** D<br>Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 16% based on 18/19 overall performance. This is inline with trajectory from Oct 18 - Mar 19<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 34 | R >20<br>A N/A<br>G <=20 | | Unfortunately the Trust experienced a number of theatre cancellations on the day of planned surgery owing to the limited availability of post-op ward beds. The increasing pressure on ward bed available was primarily owing to the increasing non-elective admissions and nursing rota gaps on the surgical wards resulting in the closure of beds on ward 4A. There is now an established meeting and action plan to address the ward staffing concerns. In addition the Surgical Division have implemented their elective winter plan actions to address increasing bed pressures over winter months. |

Delivery of Outstanding Care

## 12.2 - PERFORMANCE - EFFECTIVE

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Operation Breaches | **28 Day Breaches** W<br>Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 0 | R<br>A<br>G | >0<br>N/A<br>0 | | No Action Required |
| Scanning | **Average Scanning Turnaround - Inpatient** D<br>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.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 73 | R<br>A<br>G | >7<br>N/A<br><=7 | | Work continues with Outsoucring company. Outpatient records have been outsourced but Inpatients are very complex and unlikely to be outsourced. But internal resources are being redirected to Inpatients to support this process. Work with IM&T on both stopping paper production and additional outsourcing possiblities is being reviewed. A pragmatic approach to standards of scaning has been adopted with focus on quantity i.e. availability of the record being paramount. |
| Scanning | **Average Scanning Turnaround - Outpatient** D<br>Days from Clinic attendance to episode notes being scanned and uploaded on to the viewing system (Image Now). Average based on working days.<br>**Exec Lead:** Adam Bateman<br>**Committee:** RABD | 9 | R<br>A<br>G | >5<br>N/A<br><=5 | | Work continues with Outsoucring company. Outpatient records have been outsourced but Inpatients are very complex and unlikely to be outsourced. But internal resources are being redirected to Inpatients to support this process. Work with IM&T on both stopping paper production and additional outsourcing possiblities is being reviewed. A pragmatic approach to standards of scaning has been adopted with focus on quantity i.e. availability of the record being paramount. |

Delivery of Outstanding Care

## 13.1 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| RTT | **RTT: Open Pathway: % Waiting within 18 Weeks** W<br>Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 92.05 % | R<br>A<br>G | <90 %<br>>=90 %<br>>=92 % | | No Action Required |
| Waiting Times | **Waiting List Size** W<br>National threshold as part of the 18/19 NHSI plan. The target is to maintain reduction of the total waitlist size from March 2018.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 12754 | R<br>A<br>G | >12899<br>N/A<br><=12899 | | No Action Required |
| Waiting Times | **Waiting Greater than 52 weeks** W<br>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.<br>**Exec Lead:** Adam Bateman **Committee:** RABD | 0 | R<br>A<br>G | >0<br>N/A<br>0 | | No Action Required |

## 13.2 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

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

Delivery of Outstanding Care

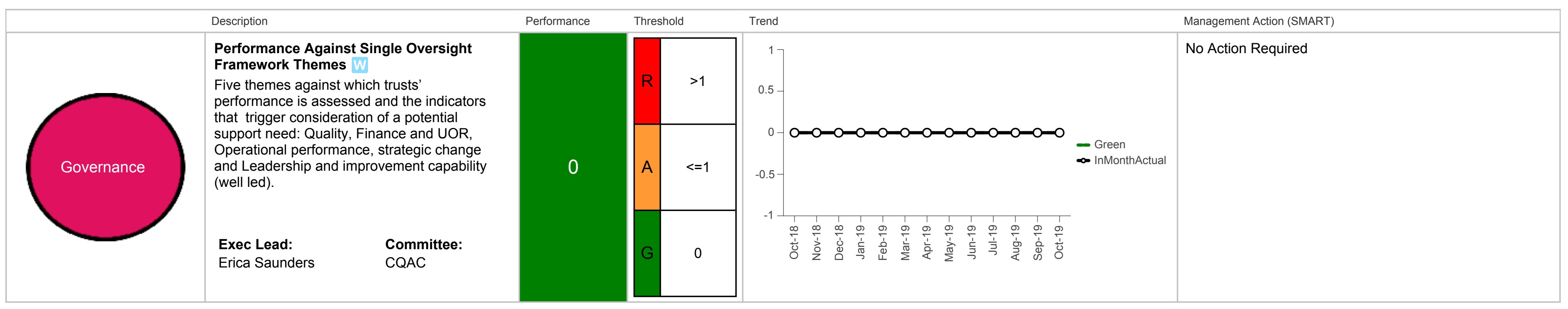
## 13.3 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

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

# 14.1 - PERFORMANCE - WELL LED

D Drive W Watch P Programme



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

The Best People doing their best Work

## 15.1 - PEOPLE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Personal Development | **PDR** W<br>Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July).<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 89.32 % | R <85 %<br>A >=85 %<br>G >=90 % | | PDR compliance was 89% at the end of the window. The L&D Team are continuing to chase up any outstanding appraisals. |
| Appraisal | **Medical Appraisal** W<br>Trust Target for compliance for medical staff, which is on a rolling 12mth period.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | | R <90 %<br>A >=90 %<br>G >=95 % | | Metric is under review |
| Training | **Mandatory Training** W<br>This is a Trust target that measures all required training including Resuscitation.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 91.27 % | R <80 %<br>A >=80 %<br>G >=90 % | | No Action Required |

The Best People doing their best Work

## 15.2 - PEOPLE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Sickness | **Sickness** D<br>% of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics<br>**Exec Lead:** Melissa Swindell **Committee:** WOD | 5.72 % | R >4.5 %<br>A <=4.5 %<br>G <=4 % | | There has been a sharp increase in sickness absence since September (0.53%) which is due to a 0.6% in increase in short term absences. Anxiety & Stress related absences continue to be our main reason for employee sickness accounting for 32% of all absences in October. Other musculoskeletal and Gastrointenstinal absences are the reason for 9% of absence. Action plans are in place for areas with significant absence. In addition a full review of all absences is being undertaken with individual action plans in place. |
| Sickness | **Short Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting less than 28 days<br>**Exec Lead:** Melissa Swindell **Committee:** WOD | 1.80 % | R >1 %<br>A N/A<br>G <=1 % | | See above |
| Sickness | **Long Term Sickness** D<br>% of Trust staff who have been absent from work due to sickness lasting 28 days or more<br>**Exec Lead:** Melissa Swindell **Committee:** WOD | 3.92 % | R >3 %<br>A N/A<br>G <=3 % | | See above |

## 15.3 - PEOPLE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Temporary Spend | **Temporary Spend ('000s)** D<br>Indicates the expenditure on premium temporary pay spend and monitors the reduction.<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 933.22 | R<br>A<br>G | >960<br><=960<br><=800 | | Business Partners together with Finance Accountants and Ass COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & Deputy Directors of HR & Finance. |
| Staff Turnover | **Staff Turnover** D<br>Trust Target which is based on a rolling 12mth period<br>**Exec Lead:** Melissa Swindell<br>**Committee:** WOD | 10.09 % | R<br>A<br>G | >11 %<br><=11 %<br><=10 % | | Half of all leavers in October came from the Division of Surgery and of those leavers 70% fell into the Nursing & Midwifery Staff Group. Overall 45% of leavers this month came from the Nursing & Midwifery staff group. |

The Best People doing their best Work

## 16.1 - FINANCE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Finance | **CIP In Month Variance (£'000s)** W<br>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.<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | -22 | R<br>A<br>G | <-20%<br>>=-20%<br>>=-5% | | No Action Required |
| Finance | **Control Total In Month Variance (£'000s)** W<br>Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | -226 | R<br>A<br>G | <-20%<br>>=-20%<br>>=-5% | | The Control Total surplus for October was £0.7m which was £0.2m behind plan. Year to date the Trust is £0.1m behind the plan. In order to secure the sustainability funding for Q3 this shortfall will need to be addressed. |
| Finance | **Capital Expenditure In Month Variance (£'000s)** W<br>Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 1,909 | R<br>A<br>G | <-10%<br>>=-10%<br>>=-5% | | No Action Required |

## 16.2 - FINANCE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Finance | **Cash in Bank (£'000s)** W<br>Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | 81,847 | R<br>A<br>G | <-20%<br>>=-20%<br>>=-5% | | No Action Required |
| Finance | **Income In Month Variance (£'000s)** W<br>Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | 1,118 | R<br>A<br>G | <-20%<br>>=-20%<br>>=-5% | | No Action Required |
| Finance | **Pay In Month Variance (£'000s)** W<br>Variance from pay plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -254 | R<br>A<br>G | <-20%<br>>=-20%<br>>=-5% | | No Action Required |

The Best People doing their best Work

# 16.3 - FINANCE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Finance | **Non Pay In Month Variance (£'000s)** W<br>Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month<br>**Exec Lead:** John Grinnell **Committee:** RABD | -1,089 | R <-20%<br>A >=-20%<br>G >=-5% | | Non Pay for the month of October was £1m overspent the majority of which was offset by income. |
| Finance | **NHSI Use of Resources** W<br>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<br>**Exec Lead:** John Grinnell **Committee:** RABD | 3 | R >3<br>A N/A<br>G <=3 | | No Action Required |
| Finance | **AvP: IP - Non-Elective** W<br>Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell **Committee:** RABD | -18.24 | R <0<br>A N/A<br>G >=0 | | The most significant adverse variance is in respiratory medicine (47 spells down on plan). |

The Best People doing their best Work

# 16.4 - FINANCE - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Finance | **AvP: IP Elective vs Plan** W<br>Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | -65.95 | R<br>A<br>G | <0<br>N/A<br>>=0 | | The most significant adverse variance is in sleep studies (40 spells down on plan). |
| Finance | **AvP: Daycase Activity vs Plan** W<br>Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | -76.07 | R<br>A<br>G | <0<br>N/A<br>>=0 | | The most significant adverse variance is in dentistry (49 spells down on plan). |
| Finance | **AvP: Outpatient Activity vs Plan** W<br>Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher.<br>**Exec Lead:** John Grinnell<br>**Committee:** RABD | 2785.62 | R<br>A<br>G | <0<br>N/A<br>>=0 | | No Action Required |

Game Changing Research & Innovation

## 17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Clinical Research | **Number of Open Studies - Academic** W<br>Number of academic studies currently open.<br>**Exec Lead:** Matthew Peak<br>**Committee:** REIC | 162 | R<br>A<br>G | <111<br>>=111<br>>=130 | | No Action Required |
| Clinical Research | **Number of Open Studies - Commercial** W<br>Number of commercial studies currently open.<br>**Exec Lead:** Matthew Peak<br>**Committee:** REIC | 42 | R<br>A<br>G | <21<br>>=21<br>>=30 | | No Action Required |
| Clinical Research | **Number of New Studies Opened - Academic** W<br>Number of new academic studies opened in month.<br>**Exec Lead:** Matthew Peak<br>**Committee:** REIC | 2 | R<br>A<br>G | <2<br>>=2<br>>=3 | | We are having short term capacity problems, within the CRD & in the trust. In the CRD, large number of studies in setup & not enough RN's & data support. In the trust, consultants with clinical pressure & not enough time for research. |

Game Changing Research & Innovation

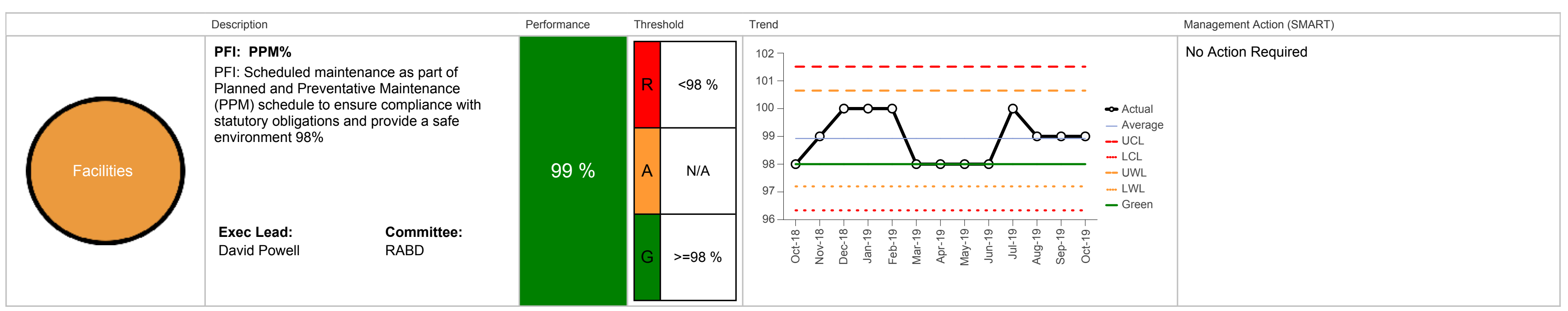
## 17.2 - RESEARCH & DEVELOPMENT - WELL LED

D Drive W Watch P Programme

| | Description | Performance | Threshold | | Trend | Management Action (SMART) |
|---|---|---|---|---|---|---|
| Clinical Research | **Number of New Studies Opened - Commercial** W<br>Number of new commercial studies opened in month.<br>**Exec Lead:** Matthew Peak<br>**Committee:** REIC | 2 | R<br>A<br>G | <1<br>N/A<br>>=1 | Actual, Average, UCL, LCL, UWL, LWL, Green (Oct-18 to Oct-19) | No Action Required |
| Clinical Research | **Number of patients recruited** W<br>Number of patients recruited to NIHR portfolio studies in month.<br>**Exec Lead:** Matthew Peak<br>**Committee:** REIC | 1228 | R<br>A<br>G | <171<br>>=171<br>>=200 | Actual, Average, UCL, LCL, UWL, LWL, Green (Oct-18 to Oct-19) | No Action Required |

## 18.1 - FACILITIES - RESPONSIVE

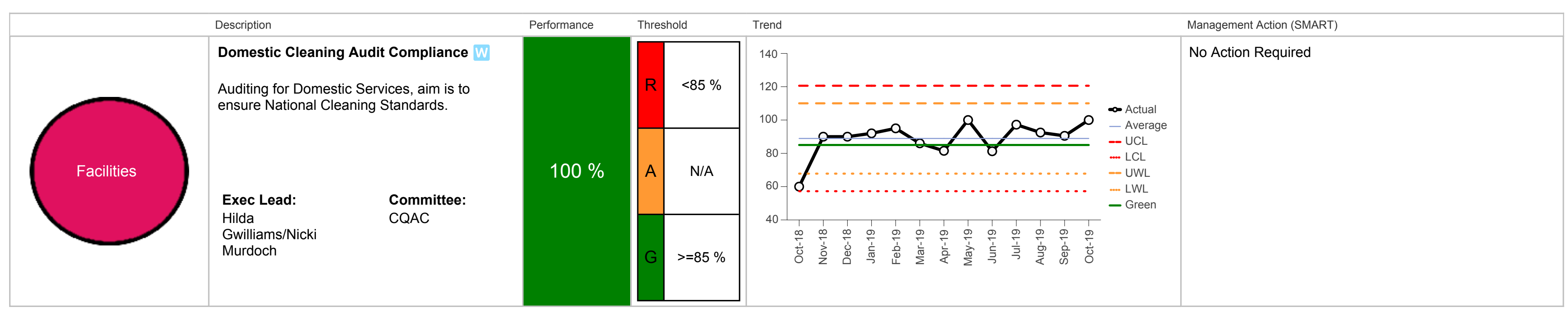
D Drive W Watch P Programme



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

## 19.1 - FACILITIES - WELL LED

D Drive W Watch P Programme



| | Description | Performance | Threshold | Trend | Management Action (SMART) |
|---|---|---|---|---|---|
| Facilities | **Domestic Cleaning Audit Compliance** W<br><br>Auditing for Domestic Services, aim is to ensure National Cleaning Standards.<br><br>**Exec Lead:** Hilda Gwilliams/Nicki Murdoch<br>**Committee:** CQAC | 100 % | R <85 %<br>A N/A<br>G >=85 % | | No Action Required |

# All Divisions

D Drive W Watch P Programme

## SAFE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 1 | 16 | 41 | No Threshold | | |
| Clinical Incidents resulting in No Harm | D | 84 | 86 | 146 | No Threshold | | |
| Clinical Incidents resulting in minor, non permanent harm | D | 11 | 21 | 45 | No Threshold | | |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 0 | No Threshold | | |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | N/A | >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | N/A | >0 |
| Medication errors resulting in harm | D | 0 | 3 | 3 | No Threshold | | |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Never Events | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | | 100.0% | 100.0% | >=90 % | N/A | <90 % |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | N/A | >0 |
| Hospital Acquired Organisms - C.difficile | D | 0 | 0 | 1 | 0 | N/A | >0 |
| Hospital Acquired Organisms - MSSA | D | 0 | 0 | 0 | No Threshold | | |

## CARING

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| Complaints | W | 3 | 0 | 1 | No Threshold |
| PALS | W | 37 | 36 | 39 | No Threshold |

## EFFECTIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| % Readmissions to PICU within 48 hrs | W | | | 1.3% | <=3 % | N/A | >3 % |
| ED: 95% Treated within 4 Hours | D | | 86.9% | | >=95 % | N/A | <95 % |

# All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| ED: Number of patients spending >12 hours from decision to admit to admission | W | | 0 | | 0 | N/A | >0 |
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 0 | 3 | 31 | No Threshold | | |
| 28 Day Breaches | W | 0 | 0 | 0 | 0 | N/A | >0 |

## RESPONSIVE

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| IP Survey: % Received information enabling choices about their care | W | | 93.8% | 96.8% | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | | 97.2% | 98.0% | 100 % | >=95 % | <95 % |
| IP Survey: % Know their planned date of discharge | D P | | 87.7% | 95.0% | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | | 97.6% | 91.3% | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | | 88.6% | 94.2% | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | | 72.0% | 74.3% | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 76.1% | 93.5% | 93.8% | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 1,222 | 3,213 | 8,319 | No Threshold | | |
| Waiting Greater than 52 weeks | W | 0 | 0 | 0 | 0 | N/A | >0 |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | | 100.0% | | 100 % | >=95 % | <100 % |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | | 100.0% | | 100 % | >=95 % | <100 % |
| All Cancers: 31 day wait until subsequent treatments | W | | 100.0% | | 100 % | >=95 % | <100 % |
| Diagnostics: % Completed Within 6 Weeks | W | | 100.0% | 100.0% | >=99 % | N/A | <99 % |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | W | | 100.0% | | 100 % | >=95 % | <100 % |

## WELL LED

| | | COMMUNITY | MEDICINE | SURGERY | RAG |
|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -36 | 215 | -399 | No Threshold |
| Income In Month Variance (£'000s) | W | 74 | 609 | 266 | No Threshold |

# All Divisions

D Drive W Watch P Programme

| | | COMMUNITY | MEDICINE | SURGERY | RAG | | |
|---|---|---|---|---|---|---|---|
| Pay In Month Variance (£'000s) | W | -43 | 127 | -286 | No Threshold | | |
| Non Pay In Month Variance (£'000s) | W | -67 | -522 | -380 | No Threshold | | |
| AvP: IP - Non-Elective | W | | -34 | 16 | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | 0 | -40 | -27 | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | | -33 | -46 | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | 437 | -199 | 1,474 | >=0 | N/A | <0 |
| PDR | W | 90.1% | 87.8% | 93.3% | >=90 % | >=80 % | <85 % |
| Medical Appraisal | W | | | | >=95 % | >=90 % | <90 % |
| Mandatory Training | W | 92.7% | 91.6% | 90.3% | >=90 % | >=80 % | <80 % |
| Sickness | D | 6.2% | 4.6% | 6.4% | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 2.3% | 1.3% | 1.9% | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 3.8% | 3.3% | 4.5% | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 42 | 284 | 513 | No Threshold | | |
| Staff Turnover | D | 10.5% | 10.3% | 10.5% | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 77.8% | 99.3% | 89.6% | >=90 % | >=80 % | <90 % |

# Medicine Division – October 2019

| | | |
|---|---|---|
| **SAFE** | Zero for the following:<br>Clinical Incidents Resulting In Moderate, Semi permanent Harm; Clinical Incidents Resulting In Severe, Permanent Harm; Pressure Ulcers (Both Category 3 And 4); Never Events; Hospital-acquired Infections For MRSA and C Difficile. | **Highlight**<br>▪ 100%: Inpatients treated for Sepsis within 60 mins –<br>▪ Zero never events, category 3/4 pressure ulcers and hospital-acquired infections (MRSA, C. difficile) for over 12 months.<br>**Challenges**<br>▪ 78.38% of patients in ED treated for Sepsis within 60 mins. 19/20 aim is 90%. |
| **CARING** | 2 complaints and 36 PALS responses. | **Highlight**<br>▪ Four fewer complaints than last month.<br>**Challenges**<br>▪ Responding to complaints still a challenge. Aiming to address root causes. |
| **EFFECTIVE** | ED Standard continues to be a challenge, despite having best performance in the North West for October. ED action plan in place, which along with recommendations from the following will bring about sustainable positive change: workforce plan; enhanced ways of working; redirecting of appropriate patients to primary care. ED huddles each week now by divisional lead.<br><br>Cancelled Operations remains low (3). 8th consecutive month with zero 28 Day Breaches. Clinical Utilisation remains above 85%. | **Highlight**<br>▪ Was Not Brought rate remains below 12% (for second month).<br>▪ Scanning outsourcing continues.<br>▪ Coding comorbidity average remains above 4.4 for 5th consecutive month.<br>**Challenges**<br>▪ One patient in ED spending >12 hours from decision to admit to admission. |
| **RESPONSIVE** | Turnaround times consistently good in many areas (especially Pathology) though concern over MRI, CT. Action plan to address this to be presented at Operational Delivery Board on 28/11/19. | **Highlight**<br>▪ 11th consecutive month to achieve RTT target though acknowledge that some areas still require focus.<br>▪ Diagnostic target consistently achieved for over 12 months.<br>▪ Percentage of patients 'knowing who is in charge of their care' above 97% for third consecutive month.<br>**Challenges**<br>▪ Consistent underachievement of MR and CT radiology targets, though these are more stringent local Alder Hey targets. |
| **WELL LED** | Mandatory training is above 90% for fourth consecutive month at 91.6%, an improvement on last month.<br><br>Shift fill rate above 99% for 12 consecutive months.<br><br>Temporary spend reduced from previous month. | **Highlight**<br>▪ Sickness improved for two out of three indicators and remained the same for the third indicator.<br>**Challenges**<br>▪ Medical workforce poor on some mandatory training metrics. |

# Medicine

D Drive W Watch P Programme

## SAFE

| Metric | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 31 | 28 | 21 | 20 | 36 | 30 | 19 | 29 | 20 | 36 | 12 | 20 | 16 | | No Threshold |
| Clinical Incidents resulting in No Harm | D | 117 | 107 | 69 | 98 | 89 | 89 | 103 | 88 | 78 | 105 | 75 | 70 | 86 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 25 | 29 | 16 | 35 | 24 | 37 | 38 | 25 | 23 | 21 | 10 | 19 | 21 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication errors resulting in harm | D | 1 | 3 | 0 | 0 | 2 | 1 | 4 | 3 | 0 | 1 | 0 | 0 | 3 | | No Threshold |
| Medication Errors (Incidents) | | 44 | 46 | 29 | 31 | 31 | 34 | 51 | 40 | 24 | 37 | 31 | 21 | 30 | | No Threshold |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Acute readmissions of patients with long term conditions within 28 days | | 4 | 6 | 3 | 3 | 3 | 2 | 2 | 3 | 3 | 4 | 4 | 1 | 7 | | No Threshold |
| Never Events | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | 72.7% | 90.0% | 81.0% | 74.2% | | 63.2% | 100.0% | 66.7% | 85.7% | 83.3% | 100.0% | 87.5% | 100.0% | | >=90 % >=80 % <90 % |
| Pressure Ulcers (Category 3 and above) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - C.difficile | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Hospital Acquired Organisms - CLABSI | | 2 | 0 | 2 | 2 | 6 | 1 | 0 | 0 | 2 | 1 | 1 | 2 | 1 | | No Threshold |
| Hospital Acquired Organisms - MSSA | D | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | | No Threshold |
| Cleanliness Scores | | 96.0% | 96.3% | 94.1% | 97.1% | 97.1% | 98.6% | 97.2% | 98.3% | 91.8% | 96.4% | 98.5% | 98.6% | 97.9% | | >=90 % >=80 % <80 % |
| Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region. | | | | | | | | 100 | 100 | 100 | 100 | 100 | 100 | 100 | | No Threshold |
| Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed. | | | | | | | | 65.6% | 55.0% | 55.0% | 58.9% | 58.9% | 58.9% | 58.9% | | No Threshold |
| Pharmacy - Dispensing for Out Patients - Routine | | 58.0% | 55.0% | 41.0% | 50.0% | 63.0% | 62.0% | 63.0% | 54.0% | 63.0% | 52.5% | 52.5% | 62.0% | 59.0% | | >=90 % >=80 % <90 % |
| Pharmacy - Dispensing for Out Patients - Complex | | 86.0% | 94.0% | 89.0% | 91.0% | 67.0% | 95.0% | 60.0% | 75.0% | 100.0% | 87.5% | 87.5% | 63.0% | 100.0% | | >=90 % >=80 % <90 % |

## CARING

| Metric | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints | W | 6 | 1 | 5 | 4 | 2 | 4 | 2 | 1 | 3 | 2 | 4 | 6 | 0 | | No Threshold |
| PALS | W | 39 | 26 | 27 | 47 | 37 | 23 | 40 | 34 | 38 | 41 | 33 | 35 | 36 | | No Threshold |

## EFFECTIVE

| Metric | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | | 2,087 | 1,985 | 1,755 | 2,040 | 1,939 | 2,186 | 2,024 | 2,117 | 1,964 | 2,198 | 1,701 | 1,769 | 2,054 | | No Threshold |
| ED: 95% Treated within 4 Hours | D | 90.9% | 93.8% | 95.3% | 92.1% | 90.6% | 95.6% | 93.5% | 91.3% | 89.4% | 91.8% | 94.7% | 89.0% | 86.9% | | >=95 % N/A <95 % |
| ED: Number of patients spending >12 hours from decision to admit to admission | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 1 | 0 | 0 | 0 | | 0 N/A >0 |
| Theatre Utilisation - % of Session Utilised | W | 80.1% | 81.2% | 86.7% | 84.5% | 83.4% | 83.6% | 81.8% | 83.3% | 82.9% | 83.6% | 85.7% | 80.2% | 83.8% | | >=90 % >=80 % <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 2 | 4 | 0 | 4 | 2 | 0 | 1 | 1 | 1 | 2 | 5 | 2 | 3 | | No Threshold |
| 28 Day Breaches | W | 0 | 1 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Clinic Session Utilisation | D P | 83.7% | 86.6% | 83.0% | 82.2% | 87.6% | 88.0% | 86.3% | 85.9% | 85.4% | 86.3% | 82.3% | 86.1% | 85.5% | | >=90 % >=80 % <85 % |

# Medicine

D Drive W Watch P Programme

| | Flag | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Hospital Initiated Clinic Cancellations < 6 weeks notice | | 37 | 36 | 29 | 29 | 58 | 32 | 64 | 62 | 62 | 40 | 43 | 39 | 38 | | No Threshold | | |
| OP Appointments Cancelled by Hospital % | | 15.2% | 15.0% | 16.3% | 16.0% | 16.1% | 14.3% | 18.4% | 19.4% | 17.5% | 16.0% | 17.7% | 14.3% | 16.9% | | <=5 % | <=10 % | >10 % |
| Was Not Brought Rate | W P | 13.3% | 11.9% | 14.2% | 12.6% | 12.9% | 10.5% | 12.2% | 12.2% | 11.6% | 12.7% | 14.2% | 11.3% | 11.4% | | <=12 % | <=14 % | >14 % |
| Was Not Brought Rate (New Appts) | W | 14.4% | 13.7% | 16.8% | 14.5% | 14.1% | 11.0% | 14.2% | 14.5% | 10.6% | 14.0% | 15.4% | 11.4% | 13.4% | | <=10 % | <=12 % | >12 % |
| Was Not Brought Rate (Followup Appts) | W | 12.9% | 11.2% | 13.3% | 11.9% | 12.5% | 10.3% | 11.5% | 11.4% | 11.9% | 12.2% | 13.7% | 11.3% | 10.7% | | <=14 % | <=16 % | >16 % |
| Coding average comorbidities | | 3.56 | 3.50 | 3.75 | 3.75 | 4.00 | 3.92 | 4.38 | 4.37 | 4.40 | 4.49 | 4.66 | 4.41 | 4.62 | | No Threshold | | |

## RESPONSIVE

| | Flag | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Convenience and Choice: Slot Availability | | 99.4% | 92.1% | 91.4% | 91.5% | 87.5% | 78.0% | 63.1% | 66.8% | 64.5% | 64.7% | 72.9% | 74.9% | | | >=96 % | N/A | <96 % |
| IP Survey: % Received information enabling choices about their care | W | 95.1% | 94.1% | 94.1% | 93.3% | 89.7% | 94.2% | 98.6% | 94.8% | 97.9% | 97.4% | 95.4% | 99.0% | 93.8% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | 99.5% | 100.0% | 100.0% | 100.0% | 100.0% | 99.4% | 99.3% | 98.6% | 97.9% | 99.5% | 97.0% | 99.0% | 97.2% | | 100 % | N/A | <95 % |
| IP Survey: % Know their planned date of discharge | D P | 56.7% | 60.8% | 55.9% | 68.7% | 75.0% | 76.0% | 85.0% | 82.1% | 82.8% | 84.1% | 83.8% | 89.0% | 87.7% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | 91.6% | 88.2% | 91.2% | 98.5% | 92.2% | 92.9% | 98.6% | 91.5% | 95.8% | 88.4% | 97.0% | 98.4% | 97.6% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | | | | | | | | | 92.7% | 94.7% | 94.4% | 93.8% | 88.6% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | | | | | | | | | 69.4% | 86.2% | 75.1% | 68.1% | 72.0% | | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 89.9% | 91.5% | 92.7% | 92.9% | 92.5% | 93.9% | 94.6% | 94.3% | 94.7% | 94.3% | 93.5% | 92.9% | 93.5% | | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 3,199 | 3,365 | 3,295 | 3,686 | 3,398 | 3,355 | 3,434 | 3,771 | 3,565 | 3,762 | 3,501 | 3,195 | 3,213 | | No Threshold | | |
| Waiting Greater than 52 weeks | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 |
| Waiting Times - 40 weeks and above | | 15 | 6 | 13 | 18 | 22 | 15 | 7 | 5 | 5 | 7 | 11 | 9 | 10 | | No Threshold | | |
| Cancer: 2 week wait from referral to date 1st seen - all urgent referrals | W | 96.7% | 100.0% | 100.0% | 100.0% | 95.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 94.4% | 100.0% | 100.0% | | 100 % | N/A | <100 % |
| Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. | W | 100.0% | 100.0% | 100.0% | 100.0% | 87.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % |
| All Cancers: 31 day wait until subsequent treatments | W | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | 100 % | N/A | <100 % |
| Diagnostics: % Completed Within 6 Weeks | W | 99.8% | 99.3% | 100.0% | 99.7% | 100.0% | 99.6% | 100.0% | 100.0% | 100.0% | 99.8% | 100.0% | 99.7% | 100.0% | | >=99 % | N/A | <99 % |
| 31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) | W | 100.0% | 100.0% | 100.0% | 100.0% | 87.5% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 88.9% | 100.0% | | 100 % | N/A | <100 % |
| Pathology - % Turnaround times for urgent requests < 1 hr | | 90.3% | 89.3% | 89.5% | 89.9% | 89.4% | 90.8% | 92.4% | 91.0% | 92.7% | 93.4% | 90.8% | 91.7% | 91.5% | | >=90 % | >=85 % | <90 % |
| Pathology - % Turnaround times for non-urgent requests < 24hrs | | 99.9% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 99.9% | 100.0% | 99.9% | 100.0% | 99.9% | 99.9% | 100.0% | | >=90 % | >=85 % | <90 % |
| Imaging - % Report Turnaround times GP referrals < 24 hrs | | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 99.0% | 100.0% | 100.0% | 100.0% | | >=95 % | >=90 % | <95 % |
| Imaging - % Reporting Turnaround Times - ED | | 94.0% | 78.0% | 83.0% | 93.0% | 88.0% | 92.0% | 75.0% | 83.0% | 94.0% | 86.0% | 96.0% | 94.0% | 100.0% | | >=90 % | >=85 % | <90 % |
| Imaging - % Reporting Turnaround Times - Inpatients | | 87.0% | 75.0% | 80.0% | 88.0% | 82.0% | 86.0% | 84.0% | 84.0% | 88.0% | 92.0% | 82.0% | 87.0% | 91.0% | | >=90 % | >=85 % | <90 % |
| Imaging - % Reporting Turnaround Times - Outpatients | | 98.0% | 85.0% | 87.0% | 82.0% | 92.0% | 85.0% | 88.0% | 86.0% | 96.0% | 92.0% | 93.0% | 94.0% | 87.0% | | >=85 % | N/A | <85 % |
| Imaging - Waiting Times - MRI % under 6 weeks | | 77.0% | 66.0% | 71.0% | 69.0% | 78.0% | 66.0% | 67.0% | 64.0% | 63.0% | 73.0% | 78.0% | 76.0% | 92.0% | | >=95 % | >=90 % | <95 % |
| Imaging - Waiting Times - CT % under 1 week | | 85.0% | 89.0% | 73.0% | 89.0% | 82.0% | 89.0% | 81.0% | 82.0% | 85.0% | 87.0% | 88.0% | 84.0% | 84.0% | | >=90 % | >=85 % | <90 % |
| Imaging - Waiting Times - Plain Film % under 24 hours | | 91.0% | 91.0% | 91.0% | 92.0% | 91.0% | 92.0% | 91.0% | 92.0% | 92.0% | 92.0% | 91.0% | 92.0% | 89.0% | | >=90 % | >=85 % | <90 % |
| Imaging - Waiting Times - Ultrasound % under 2 weeks | | 82.0% | 90.0% | 88.0% | 84.0% | 86.0% | 81.0% | 85.0% | 78.0% | 90.0% | 86.0% | 89.0% | 88.0% | 86.0% | | >=90 % | >=85 % | <90 % |
| Imaging - Waiting Times - Nuclear Medicine % under 2 weeks | | 88.0% | 100.0% | 100.0% | 92.0% | 88.0% | 81.0% | 100.0% | 60.0% | 78.0% | 68.0% | 68.0% | 100.0% | 82.0% | | >=95 % | >=90 % | <95 % |

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# Medicine

D Drive W Watch P Programme

## WELL LED

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -117 | 23 | 72 | -430 | -242 | | -140 | -302 | -215 | -308 | 946 | -8 | 215 | | No Threshold |
| Income In Month Variance (£'000s) | W | 116 | 581 | 25 | 50 | 418 | 416 | -225 | -298 | 86 | 79 | 676 | -53 | 609 | | No Threshold |
| Pay In Month Variance (£'000s) | W | -88 | -37 | -126 | -212 | -217 | -244 | -51 | 98 | 37 | -79 | 291 | 129 | 127 | | No Threshold |
| AvP: IP - Non-Elective | W | | | | | | | 17 | 20 | 89 | 111 | 68 | 3 | -34 | | >=0 N/A <0 |
| AvP: IP Elective vs Plan | W | | | | | | | -30 | -26 | -30 | -56 | -1 | -36 | -40 | | >=0 N/A <0 |
| AvP: OP New | | | | | | | | -52.10 | -72.48 | 22.41 | 93.12 | 148.81 | 182.81 | -56.52 | | >=0 N/A <0 |
| AvP: OP FollowUp | | | | | | | | -299.82 | -523.12 | -355.98 | -224.73 | -57.19 | -128.57 | -252.01 | | >=0 N/A <0 |
| AvP: Daycase Activity vs Plan | W | | | | | | | -6 | -119 | -154 | -65 | 100 | 39 | -33 | | >=0 N/A <0 |
| AvP: Outpatient Activity vs Plan | W | | | | | | | -225 | -635 | -269 | -97 | 215 | 65 | -199 | | >=0 N/A <0 |
| PDR | W | 89.2% | 89.2% | 89.2% | 89.2% | 89.2% | 89.2% | 2.8% | 14.1% | 37.4% | 83.8% | 87.8% | 87.8% | 87.8% | | >=90 % >=85 % <85 % |
| Medical Appraisal | W | | | | | | | | | | | | | | | >=95 % >=90 % <90 % |
| Mandatory Training | W | 89.4% | 90.4% | 90.0% | 91.0% | 90.1% | 90.7% | 90.7% | 89.7% | 92.0% | 91.2% | 91.9% | 91.4% | 91.6% | | >=90 % >=85 % <80 % |
| Sickness | D | 4.6% | 4.7% | 5.1% | 4.6% | 4.5% | 4.9% | 4.4% | 4.6% | 4.4% | 5.1% | 4.7% | 4.8% | 4.6% | | <=4 % <=4.5 % >4.5 % |
| Short Term Sickness | D | 1.7% | 1.8% | 1.8% | 1.9% | 1.9% | 2.0% | 1.6% | 1.4% | 1.1% | 1.6% | 1.2% | 1.6% | 1.3% | | <=1 % N/A >1 % |
| Long Term Sickness | D | 2.8% | 2.9% | 3.3% | 2.7% | 2.6% | 2.9% | 2.8% | 3.1% | 3.3% | 3.5% | 3.5% | 3.3% | 3.3% | | <=3 % N/A >3 % |
| Temporary Spend ('000s) | D | 189 | 242 | 175 | 219 | 297 | 326 | 270 | 271 | 263 | 247 | 282 | 300 | 284 | | No Threshold |
| Staff Turnover | D | 10.0% | 9.3% | 8.2% | 8.1% | 7.9% | 8.7% | 8.5% | 8.9% | 9.3% | 9.4% | 10.4% | 11.1% | 10.3% | | <=10 % <=11 % >11 % |
| Safer Staffing (Shift Fill Rate) | W | 95.5% | 97.5% | 97.2% | 96.0% | 97.0% | 103.2% | 100.2% | 101.0% | 97.5% | 97.8% | 98.8% | 102.9% | 99.3% | | >=90 % >=85 % <90 % |

# Surgery Division - October 2019

| | | |
|---|---|---|
| **SAFE** | • No Never Events<br>• No SUI's<br>• No Grade 3/4 Pressure ulcers<br>• 1x C diff – Ward 3A | **Highlight**<br>• **Sepsis 100%** in the last 3 months (only 1 child >60 mins in 5 months)<br>**Challenges**<br>• IPC work on 3A and CLABSI<br>• Flu Vaccination Rate, currently 56% (Critical Care 72%) |
| **CARING** | • 41 PALS which is consistent with September<br>• Reduction in formal complaints only receiving 1 in October | **Highlight**<br>• Complaints continue to reduce 8>7>3>1<br>• Mental Health in the Workplace training – attended by 23 leaders<br>**Challenges**<br>• Nurse staffing levels 4A / 3A |
| **EFFECTIVE** | • Theatre sessions delivered 668 (mean 134pw, range 127-141)<br>• Theatre utilisation 87%<br>• Clinic Utilisation -87% | **Highlight**<br>• Achieved 141 sessions in a week for the first time this year<br>• Clinic utilisation now consistently > 85%<br>• Pre Op Assessment, service prevented 64 cancelled operations in Q1 with triage clinics now running daily to enable "one stop" pathway<br>**Challenges**<br>• Increase in cancelled ops owing to non-elective admissions |
| **RESPONSIVE** | • 18 week RTT unchanged -94.5% (national target 92%)<br>• IP survey 95% of patients know their planned date of discharge, increased by 6% | **Highlight**<br>• There have been no 52 week breaches this year to date<br>• Continuous achievement of 100% for seeing all diagnostic tests within 6 weeks since May 2019<br>**Challenges**<br>• Increase number of ops cancelled on the day of admission |

<table>
<tr>
<td rowspan="4">WELL LED</td>
<td rowspan="4">
<ul>
<li>Mandatory training – 90.3%</li>
<li>Sickness - 6.4% (Short term 2% and Long Term 4.4%)</li>
<li>Finance:
<ul>
<li>9% income growth compared to last year</li>
<li>Forecast full delivery of CIP</li>
<li>Shortfall against budget of £0.5 Mil</li>
</ul>
</li>
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</td>
<td>Highlight</td>
</tr>
<tr>
<td>
<ul>
<li>Mandatory training > 90% for 3 consecutive months</li>
<li>Long term sickness reducing</li>
<li>AHP Day Celebrated</li>
</ul>
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<tr>
<td>Challenges</td>
</tr>
<tr>
<td>
<ul>
<li>Short term sickness increasing</li>
<li>Medical and Dental Mandatory training</li>
<li>7 risks greater than 15, listed below</li>
</ul>
</td>
</tr>
</table>

| Risk # | Score | Risks Scored ≥15 |
|---|---|---|
| **1715** | **25** | Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease. |
| **1904** | **16** | Ability to fill nursing duty rotas effectively on ward 4A |
| **1306** | **16** | Ability to recruit junior doctors to fill gaps in rotas in the Division of Surgery |
| **1588** | **15** | Inadequate Ventilation system on Critical Care Manusa cubicle. |
| **964** | **15** | Risk of elective list errors due to planning and scheduling processes |
| **1984** | **15** | Delays in children being able access Cardiac treatment, and delayed stepdowns from critical care meaning that this capacity is not available for other patients. |
| **1965** | **15** | Risk of patients lost to follow up following discharge *(specifically on Ward 1C)* |

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# Surgery

D Drive W Watch P Programme

## SAFE

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 32 | 41 | 30 | 28 | 39 | 34 | 27 | 30 | 19 | 58 | 28 | 28 | 41 | | No Threshold |
| Clinical Incidents resulting in No Harm | D | 133 | 130 | 99 | 140 | 105 | 138 | 144 | 142 | 165 | 140 | 134 | 130 | 146 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 31 | 43 | 35 | 32 | 34 | 44 | 38 | 67 | 36 | 34 | 41 | 29 | 45 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 1 | 2 | 1 | 0 | 0 | 0 | 1 | 2 | 0 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 / N/A / >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | | 0 / N/A / >0 |
| Medication errors resulting in harm | D | 0 | 3 | 2 | 2 | 2 | 1 | 2 | 0 | 3 | 1 | 1 | 1 | 3 | | No Threshold |
| Medication Errors (Incidents) | | 38 | 42 | 36 | 38 | 41 | 44 | 38 | 57 | 49 | 29 | 45 | 24 | 41 | | No Threshold |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | 0 / N/A / >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 / N/A / >0 |
| Never Events | W | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | | 0 / N/A / >0 |
| Sepsis: Patients treated for Sepsis within 60 mins - Inpatients | D P | 68.0% | 63.6% | 66.7% | 62.5% | | 90.9% | 75.0% | 75.0% | 100.0% | 75.0% | 100.0% | 100.0% | 100.0% | | >=90 % / >=80 % / <90 % |
| Pressure Ulcers (Category 3 and above) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | | 0 / N/A / >0 |
| Hospital Acquired Organisms - MRSA (BSI) | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 / N/A / >0 |
| Hospital Acquired Organisms - C.difficile | D | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | | 0 / N/A / >0 |
| Hospital Acquired Organisms - MSSA | D | 2 | 0 | 1 | 1 | 0 | 3 | 1 | 1 | 0 | 0 | 0 | 1 | 0 | | No Threshold |
| Cleanliness Scores | | 82.4% | 95.2% | 98.0% | 97.3% | 97.2% | 98.0% | 98.2% | 97.7% | | 97.0% | 97.2% | 97.7% | 97.9% | | >=90 % / >=80 % / <80 % |

## CARING

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints | W | 3 | 2 | 0 | 2 | 2 | 6 | 1 | 2 | 2 | 8 | 7 | 4 | 1 | | No Threshold |
| PALS | W | 43 | 41 | 26 | 39 | 26 | 30 | 33 | 31 | 26 | 42 | 20 | 48 | 39 | | No Threshold |

## EFFECTIVE

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Readmissions to PICU within 48 hrs | D | 1 | 1 | 2 | 1 | 2 | 2 | 2 | 2 | 1 | 5 | 4 | 0 | 1 | | No Threshold |
| % Readmissions to PICU within 48 hrs | W | 1.0% | 1.1% | 2.4% | 1.4% | 1.8% | 2.5% | 2.7% | 2.1% | 1.3% | 5.3% | 5.4% | 0.0% | 1.3% | | <=3 % / N/A / >3 % |
| Referrals Received (Total) | | 3,679 | 3,810 | 2,843 | 3,668 | 3,795 | 4,017 | 3,745 | 4,070 | 3,752 | 4,134 | 3,278 | 3,537 | 3,786 | | No Threshold |
| Theatre Utilisation - % of Session Utilised | W | 87.7% | 88.6% | 86.3% | 89.7% | 89.4% | 90.4% | 89.7% | 90.0% | 88.6% | 89.6% | 90.8% | 88.0% | 86.9% | | >=90 % / >=80 % / <80 % |
| On the day Elective Cancelled Operations for Non Clinical Reasons | D | 26 | 34 | 21 | 7 | 8 | 12 | 8 | 23 | 14 | 35 | 30 | 16 | 31 | | No Threshold |
| 28 Day Breaches | W | 0 | 5 | 6 | 4 | 0 | 1 | 0 | 0 | 1 | 2 | 0 | 1 | 0 | | 0 / N/A / >0 |
| Clinic Session Utilisation | D P | 82.8% | 84.0% | 82.2% | 83.6% | 84.9% | 88.4% | 87.7% | 87.3% | 87.0% | 89.0% | 87.1% | 86.2% | 86.8% | | >=90 % / >=80 % / <85 % |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | | 34 | 37 | 48 | 55 | 74 | 58 | 53 | 41 | 40 | 43 | 37 | 29 | 70 | | No Threshold |
| OP Appointments Cancelled by Hospital % | | 13.7% | 12.9% | 13.6% | 14.3% | 14.6% | 14.0% | 13.8% | 13.3% | 13.2% | 12.3% | 12.5% | 12.3% | 13.1% | | <=5 % / <=10 % / >10 % |
| Was Not Brought Rate | W P | 11.8% | 11.3% | 13.3% | 13.0% | 11.9% | 10.8% | 12.1% | 11.4% | 9.8% | 9.9% | 10.7% | 10.0% | 10.3% | | <=12 % / <=14 % / >14 % |
| Was Not Brought Rate (New Appts) | W | 11.7% | 12.2% | 15.3% | 12.7% | 12.0% | 11.1% | 11.7% | 11.2% | 10.9% | 10.5% | 12.0% | 10.6% | 10.8% | | <=10 % / <=12 % / >12 % |
| Was Not Brought Rate (Followup Appts) | W | 11.8% | 11.0% | 12.4% | 13.1% | 11.9% | 10.6% | 12.2% | 11.4% | 9.4% | 9.6% | 10.2% | 9.8% | 10.2% | | <=14 % / <=16 % / >16 % |
| Coding average comorbidities | | 3.70 | 3.56 | 3.99 | 3.96 | 4.12 | 3.92 | 4.08 | 4.24 | 4.15 | 4.12 | 4.22 | 4.04 | 4.08 | | No Threshold |
| CCAD Cases | | 38 | 30 | 31 | 33 | 39 | 42 | 30 | 36 | 31 | 43 | 34 | 37 | 34 | | No Threshold |

Alder Hey Children's NHS Foundation Trust

# Surgery

D Drive W Watch P Programme

## RESPONSIVE

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Convenience and Choice: Slot Availability | | 86.3% | 88.3% | 80.4% | 82.6% | 90.6% | 87.0% | 80.0% | 76.5% | 90.0% | 89.7% | 82.0% | 90.5% | | | >=96 % | N/A | <96 % |
| IP Survey: % Received information enabling choices about their care | W | 97.3% | 95.6% | 98.5% | 97.7% | 98.3% | 96.8% | 98.0% | 97.9% | 97.2% | 97.7% | 95.9% | 97.1% | 96.8% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Treated with respect | W | 99.7% | 100.0% | 99.3% | 100.0% | 98.9% | 99.5% | 99.3% | 99.3% | 98.3% | 99.0% | 97.8% | 98.1% | 98.0% | | 100 % | >=95 % | <95 % |
| IP Survey: % Know their planned date of discharge | D P | 62.7% | 73.2% | 62.0% | 81.3% | 87.8% | 83.8% | 92.4% | 85.6% | 91.3% | 90.1% | 89.0% | 89.3% | 95.0% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Know who is in charge of their care | W | 92.5% | 94.3% | 93.4% | 95.0% | 95.6% | 93.7% | 100.0% | 89.7% | 96.5% | 92.4% | 98.6% | 98.4% | 91.3% | | >=95 % | >=90 % | <90 % |
| IP Survey: % Patients involved in Play | D | | | | | | | | | 93.8% | 94.4% | 95.9% | 90.3% | 94.2% | | >=90 % | >=85 % | <85 % |
| IP Survey: % Patients involved in Learning | D | | | | | | | | | 72.1% | 68.9% | 70.4% | 68.4% | 74.3% | | >=90 % | >=85 % | <85 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 93.6% | 94.1% | 93.7% | 93.1% | 94.0% | 94.0% | 93.6% | 94.0% | 94.0% | 93.8% | 94.1% | 94.5% | 93.8% | | >=92 % | >=90 % | <90 % |
| Waiting List Size | W | 8,650 | 8,400 | 8,320 | 7,923 | 8,221 | 8,129 | 8,165 | 7,712 | 7,939 | 7,765 | 8,266 | 8,519 | 8,319 | | No Threshold | | |
| Waiting Greater than 52 weeks | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 | N/A | >0 |
| Diagnostics: % Completed Within 6 Weeks | W | 100.0% | 100.0% | 100.0% | 100.0% | 89.5% | 92.3% | 100.0% | 91.7% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | >=99 % | N/A | <99 % |

## WELL LED

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | -25 | -209 | -253 | -240 | -470 | | -405 | -63 | 282 | -525 | 455 | 531 | -399 | | No Threshold | | |
| Income In Month Variance (£'000s) | W | 449 | 131 | 47 | -56 | 208 | 364 | -372 | 159 | 370 | 53 | 775 | 771 | 266 | | No Threshold | | |
| Pay In Month Variance (£'000s) | W | -209 | 57 | -2 | -30 | -407 | -274 | 23 | -7 | -34 | -165 | -117 | -116 | -286 | | No Threshold | | |
| AvP: IP - Non-Elective | W | | | | | | | 36 | 37 | 20 | 48 | 64 | 52 | 16 | | >=0 | N/A | <0 |
| AvP: IP Elective vs Plan | W | | | | | | | -15 | 2 | -10 | -22 | 17 | -30 | -27 | | >=0 | N/A | <0 |
| AvP: OP New | | | | | | | | -206.97 | -305.45 | -341.11 | -235.53 | -168.56 | -325.33 | -189.46 | | >=0 | N/A | <0 |
| AvP: OP FollowUp | | | | | | | | 435.69 | 138.90 | 766.71 | 761.55 | 1,102.07 | 1,004.96 | 1,359.97 | | >=0 | N/A | <0 |
| AvP: Daycase Activity vs Plan | W | | | | | | | -46 | -14 | -87 | 17 | -22 | 18 | -46 | | >=0 | N/A | <0 |
| AvP: Outpatient Activity vs Plan | W | | | | | | | 367 | -99 | 484 | 645 | 1,290 | 810 | 1,474 | | >=0 | N/A | <0 |
| PDR | W | 90.0% | 90.0% | 90.0% | 90.0% | 96.6% | 96.6% | 11.6% | 42.7% | 74.4% | 93.8% | 93.3% | 93.3% | 93.3% | | >=90 % | >=85 % | <85 % |
| Medical Appraisal | W | | | | | | | | | | | | | | | >=95 % | >=90 % | <90 % |
| Mandatory Training | W | 88.6% | 87.8% | 88.0% | 90.0% | 88.4% | 89.4% | 88.8% | 87.3% | 88.6% | 89.3% | 90.3% | 90.6% | 90.3% | | >=90 % | >=85 % | <80 % |
| Sickness | D | 6.5% | 6.0% | 6.4% | 6.2% | 6.4% | 5.2% | 5.2% | 6.2% | 6.6% | 6.4% | 5.6% | 5.9% | 6.4% | | <=4 % | <=4.5 % | >4.5 % |
| Short Term Sickness | D | 1.7% | 1.6% | 1.9% | 2.1% | 2.0% | 1.6% | 1.5% | 1.7% | 1.6% | 1.6% | 1.1% | 1.5% | 1.9% | | <=1 % | N/A | >1 % |
| Long Term Sickness | D | 4.8% | 4.4% | 4.5% | 4.1% | 4.4% | 3.6% | 3.7% | 4.5% | 5.0% | 4.8% | 4.5% | 4.4% | 4.5% | | <=3 % | N/A | >3 % |
| Temporary Spend ('000s) | D | 529 | 485 | 484 | 474 | 564 | 591 | 515 | 505 | 461 | 527 | 513 | 613 | 513 | | No Threshold | | |
| Staff Turnover | D | 10.7% | 10.6% | 9.8% | 9.7% | 9.9% | 10.3% | 10.5% | 11.0% | 11.4% | 9.9% | 10.6% | 10.5% | 10.5% | | <=10 % | <=11 % | >11 % |
| Safer Staffing (Shift Fill Rate) | W | 91.3% | 93.6% | 91.9% | 93.3% | 89.3% | 89.4% | 91.9% | 91.0% | 89.1% | 89.4% | 92.5% | 86.1% | 89.6% | | >=90 % | >=85 % | <90 % |

# Community & Mental Health Division - October 2019

| | | |
|---|---|---|
| SAFE | Youth Worker commenced in A&E as part of Violence Reduction Unit initiative. This role is initially part time and funded until 31 March 2020 | **Highlight**<br>• Zero Never Events<br>• Zero moderate or severe incidents<br>• Zero Grade 3 and above pressure ulcers<br>• Safety huddles within Community Nursing Team<br>**Challenges**<br>• Increase in medication incidents (11)<br>• Provision of Tissue Viability Support to community based staff |
| CARING | Launch of 'You're not immune' video created by FRESH CAMHS participation group and premiered at Tate Museum<br>https://twinvisionphoto.co.uk/portfolio/camhs-animation/ | **Highlight**<br>• Continued increase in FFT scores for Community & outpatients (95%)<br>• Decrease in PALS<br>**Challenges**<br>• Sustaining improvements in Family & Friends scores for Mental Health (above 90%) |
| EFFECTIVE | Recruitment to Intensive Support (learning disability) team pilot project as part of Transforming Care | **Highlight**<br>• PDR rates across the division remain above 90%<br>• Review of clinical policies and guidelines across Division<br>**Challenges**<br>• Increase in Was Not Brought rates for follow up appointments<br>• Locally held paper records not included in Trust wide scanning outsourcing |
| RESPONSIVE | Review of CAMHS waiting times to clearly demonstrate time from Referral to Treatment (i.e. First Partnership) with a robust trajectory for improvement and plan in place | **Highlight**<br>• Significant decrease in waiting times for Sefton SALT – no child/young person waiting over 40 weeks.<br>• Improvement in Community Paediatric waiting times (improved RTT)<br>**Challenges**<br>• ASD & ADHD waiting times – whilst continuing to improve remain high<br>• Recruitment team challenges continue to impact on divisional recruitment plans |
| | | **Highlight** |

| | | |
|---|---|---|
| **WELL LED** | Community NHS Fab Day provided in Southport. Well attended and positive feedback from staff | • Staff Survey uptake currently at 58%<br>• Sefton community OT team 100% complete staff survey<br>• Mandatory training at 92.9%<br>• Achievement of 19/20 CIP target<br>**Challenges**<br>• Increase in staff sickness robust review underway as possible link to incorrect use of ESR<br>• Reminder to all staff to ensure timely RTW carried out and to complete ESR to update staff record. |

# Community

D Drive W Watch P Programme

## SAFE

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Clinical Incidents resulting in Near Miss | D | 4 | 6 | 4 | 3 | 3 | 3 | 6 | 15 | 7 | 5 | 7 | 8 | 1 | | No Threshold |
| Clinical Incidents resulting in No Harm | D | 53 | 37 | 31 | 38 | 41 | 41 | 48 | 54 | 41 | 52 | 57 | 67 | 84 | | No Threshold |
| Clinical Incidents resulting in minor, non permanent harm | D | 3 | 5 | 4 | 4 | 6 | 6 | 6 | 2 | 7 | 9 | 7 | 6 | 11 | | No Threshold |
| Clinical Incidents resulting in moderate, semi permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | | No Threshold |
| Clinical Incidents resulting in severe, permanent harm | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Clinical Incidents resulting in catastrophic, death | D | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Medication Errors (Incidents) | | 11 | 6 | 4 | 10 | 9 | 5 | 12 | 6 | 3 | 6 | 5 | 9 | 11 | | No Threshold |
| Pressure Ulcers (Category 3) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 4) | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Pressure Ulcers (Category 3 and above) | | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| Cleanliness Scores | | 98.0% | | | 100.0% | | | | | 99.5% | | | 98.9% | | | No Threshold |
| CCNS: Advanced Care Plan for children with life limiting condition | | 0 | | | | | | | | | 8 | | | | | No Threshold |
| CCNS: Supported early discharges from hospital care | | | | | | | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | No Threshold |
| CCNS: Prescriptions | | 0 | | | | | | | | | | | | | | No Threshold |

## CARING

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Complaints | W | 3 | 2 | 2 | 1 | 4 | 6 | 4 | 4 | 1 | 4 | 2 | 1 | 3 | | No Threshold |
| PALS | W | 38 | 41 | 11 | 36 | 29 | 33 | 30 | 30 | 43 | 37 | 28 | 38 | 37 | | No Threshold |

## EFFECTIVE

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Referrals Received (Total) | | 979 | 1,063 | 771 | 908 | 970 | 1,085 | 917 | 1,056 | 913 | 1,017 | 619 | 811 | 1,088 | | No Threshold |
| Clinic Session Utilisation | D P | 82.5% | 81.7% | 78.4% | 79.1% | 81.1% | 87.2% | 83.4% | 83.3% | 83.5% | 82.8% | 82.6% | 82.3% | 81.5% | | >=90 % >=85 % <85 % |
| Hospital Initiated Clinic Cancellations < 6 weeks notice | | 42 | 21 | 8 | 8 | 18 | 16 | 20 | 14 | 14 | 8 | 7 | 14 | 20 | | No Threshold |
| OP Appointments Cancelled by Hospital % | | 19.0% | 24.2% | 25.6% | 20.0% | 23.5% | 24.8% | 22.0% | 18.4% | 21.0% | 18.1% | 12.6% | 14.8% | 16.5% | | <=5 % <=10 % >10 % |
| Was Not Brought Rate (New Appts) | W | | | | | | | | | | | | | | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) | W | | | | | | | | | | | | | | | <=14 % <=16 % >16 % |
| CAMHS: % Patient Active Caseloads With 2 Or More Contacts | | | | | | | | 17.8% | 28.6% | 34.5% | 39.3% | 41.8% | 44.4% | 46.5% | | No Threshold |
| Was Not Brought Rate (New Appts) - Community Paediatrics | | 18.1% | 17.4% | 17.1% | 21.6% | 18.6% | 17.1% | 16.5% | 21.1% | 15.8% | 19.8% | 14.1% | 16.1% | 18.8% | | <=10 % <=12 % >12 % |
| Was Not Brought Rate (Followup Appts) - Community Paediatrics | | 10.0% | 14.0% | 12.4% | 13.1% | 11.9% | 7.7% | 14.1% | 11.3% | 12.3% | 10.1% | 11.4% | 11.4% | 12.6% | | <=14 % <=16 % >16 % |
| CAMHS: % CHOICE Was Not Brought Rate | | | | | | | | | | | | | | | | <=10 % <=12 % >12 % |
| CAMHS: % All Other Was Not Brought Rate | | | | | | | | | | | | | | | | <=14 % <=16 % >16 % |
| CAMHS: Tier 4 DJU % Bed Occupancy At Midday | | 93.5% | 104.3% | 100.0% | 95.9% | 88.8% | 118.9% | 115.7% | 100.0% | 91.4% | 98.2% | 86.2% | 84.8% | 65.9% | | No Threshold |
| CAMHS: Tier 4 DJU Bed Days | | 203 | 220 | 217 | 207 | 173 | 237 | 212 | 202 | 161 | 182 | 155 | 148 | 113 | | No Threshold |
| Coding average comorbidities | | 2.00 | 2.67 | | 2.00 | 1.50 | 6.00 | 4.00 | 2.50 | 3.00 | 3.00 | 5.50 | 5.00 | 4.00 | | No Threshold |
| CCNS: Number of commissioned packages | | | | | | | | | | | | | | | | No Threshold |

Alder Hey Children's NHS
NHS Foundation Trust

# Community

D Drive W Watch P Programme

## RESPONSIVE

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| CAMHS: Tier 4 Admissions To DJU | | 2 | 2 | | | 2 | 2 | | | 2 | 1 | | | 1 | | No Threshold |
| CAMHS: Referrals Received | | 370 | 410 | 297 | 332 | 351 | 402 | 325 | 345 | 309 | 326 | 185 | 288 | 417 | | No Threshold |
| CAMHS: Referrals Accepted By The Service | | 242 | 267 | 183 | 203 | 210 | 232 | 190 | 218 | 172 | 175 | 125 | 160 | 250 | | No Threshold |
| CAMHS: % Referrals Accepted By The Service | | 65.4% | 65.1% | 61.6% | 61.1% | 59.8% | 57.7% | 58.5% | 63.2% | 55.7% | 53.7% | 67.6% | 55.6% | 60.0% | | No Threshold |
| Community Therapies Waiting Times - Maximum Weeks Waiting | | | | | | | | | | | | | | | | No Threshold |
| Convenience and Choice: Slot Availability | | 100.0% | 100.0% | | | | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% | | | >=96 % N/A <96 % |
| RTT: Open Pathway: % Waiting within 18 Weeks | W | 87.1% | 78.8% | 78.3% | 82.7% | 78.3% | 74.2% | 75.2% | 74.9% | 73.9% | 76.4% | 71.6% | 70.8% | 76.1% | | >=92 % >=90 % <90 % |
| Waiting List Size | W | 1,112 | 1,169 | 1,162 | 1,263 | 1,269 | 1,262 | 1,272 | 1,393 | 1,339 | 1,356 | 1,107 | 1,112 | 1,222 | | No Threshold |
| Waiting Greater than 52 weeks | W | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | | 0 N/A >0 |
| CAMHS: Crisis / Duty Call Activity | | 394 | 447 | 277 | 325 | 344 | 425 | 343 | 337 | 343 | 315 | 266 | 294 | 471 | | No Threshold |
| CAMHS: RTT (First Partnership) % waiting within 18 weeks | W | | | | | | | 63.6% | 66.0% | 61.1% | 54.7% | 49.6% | 46.2% | 48.9% | | >=92 % >=90 % <90 % |
| ASD: Completed Pathways | | 64 | 43 | 25 | 63 | 67 | 75 | 69 | 62 | 84 | 44 | 72 | 74 | 78 | | No Threshold |
| ASD: Completed Pathway Compliance (% within 18wks) | | 70.3% | 65.1% | 48.0% | 36.5% | 40.3% | 58.7% | 62.3% | 29.0% | 25.0% | 13.6% | 27.8% | 32.4% | 52.6% | | >=92 % >=90 % <90 % |
| EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) | P | | | 72.7% | 83.3% | 100.0% | 86.7% | 57.1% | 66.7% | 62.5% | 72.7% | 54.5% | 71.4% | 72.2% | | No Threshold |
| EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) | P | | | | 50.0% | | | 50.0% | 50.0% | | 66.7% | 0.0% | | 0.0% | | No Threshold |
| CCNS: Number of Referrals | W | | | | | | | 138 | 163 | 156 | 147 | 149 | 132 | 129 | | No Threshold |
| CCNS: Number of Contacts | D | | | | | | | 886 | 919 | 894 | 921 | 893 | 913 | 921 | | No Threshold |

## WELL LED

| | | Oct-18 | Nov-18 | Dec-18 | Jan-19 | Feb-19 | Mar-19 | Apr-19 | May-19 | Jun-19 | Jul-19 | Aug-19 | Sep-19 | Oct-19 | Last 12 Months | RAG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Control Total In Month Variance (£'000s) | W | 57 | -69 | 114 | -37 | 14 | | -66 | 75 | -12 | -13 | 27 | 92 | -36 | | No Threshold |
| Income In Month Variance (£'000s) | W | 43 | 21 | 265 | 87 | 61 | 336 | -111 | 177 | 36 | -47 | 57 | 43 | 74 | | No Threshold |
| Pay In Month Variance (£'000s) | W | 18 | -15 | -2 | -151 | -57 | -307 | 181 | -69 | -64 | 2 | -4 | 51 | -43 | | No Threshold |
| AvP: OP New | | | | | | | | -1.48 | -10.08 | -5.63 | 29.14 | -3.08 | 113.22 | 188.67 | | >=0 N/A <0 |
| AvP: OP FollowUp | | | | | | | | 5.13 | 81.99 | 343.17 | 289.03 | 135.10 | 255.13 | 244.48 | | >=0 N/A <0 |
| AvP: Outpatient Activity vs Plan | W | | | | | | | 4 | 74 | 341 | 321 | 135 | 375 | 437 | | >=0 N/A <0 |
| PDR | W | 93.0% | 93.0% | 93.0% | 93.7% | 93.7% | 93.7% | 1.4% | 10.8% | 48.6% | 87.1% | 90.1% | 90.1% | 90.1% | | >=90 % >=85 % <85 % |
| Medical Appraisal | W | | | | | | | | | | | | | | | >=95 % >=90 % <90 % |
| Mandatory Training | W | 92.5% | 91.4% | 90.9% | 88.3% | 89.2% | 90.3% | 92.2% | 89.2% | 90.2% | 92.0% | 93.2% | 92.9% | 92.7% | | >=90 % >=85 % <80 % |
| Sickness | D | 5.4% | 6.6% | 7.6% | 7.9% | 7.5% | 7.4% | 6.7% | 6.4% | 4.9% | 4.3% | 4.4% | 4.2% | 6.2% | | <=4 % <=4.5 % >4.5 % |
| Short Term Sickness | D | 1.3% | 1.8% | 1.6% | 1.7% | 1.5% | 1.8% | 1.4% | 1.6% | 1.2% | 0.9% | 0.8% | 1.1% | 2.3% | | <=1 % N/A >1 % |
| Long Term Sickness | D | 4.1% | 4.8% | 6.0% | 6.2% | 6.0% | 5.6% | 5.3% | 4.8% | 3.7% | 3.4% | 3.6% | 3.1% | 3.8% | | <=3 % N/A >3 % |
| Temporary Spend ('000s) | D | 159 | 169 | 144 | 179 | 106 | 367 | 198 | 226 | 96 | 158 | 122 | 143 | 42 | | No Threshold |
| Staff Turnover | D | 12.5% | 12.8% | 12.9% | 12.2% | 11.9% | 12.8% | 11.8% | 11.7% | 9.9% | 10.1% | 10.2% | 10.6% | 10.5% | | <=10 % <=11 % >11 % |
| Safer Staffing (Shift Fill Rate) | W | 98.0% | 99.0% | 99.0% | 97.0% | 100.0% | 106.0% | 100.0% | 102.0% | 97.0% | 87.0% | 87.3% | 80.8% | 77.8% | | >=90 % >=85 % <90 % |

NHS
Alder Hey Children's
NHS Foundation Trust
Financial Dashboard
-M7 2019/20
BRILLIANT
BASICS
GROW THE
FUTURE

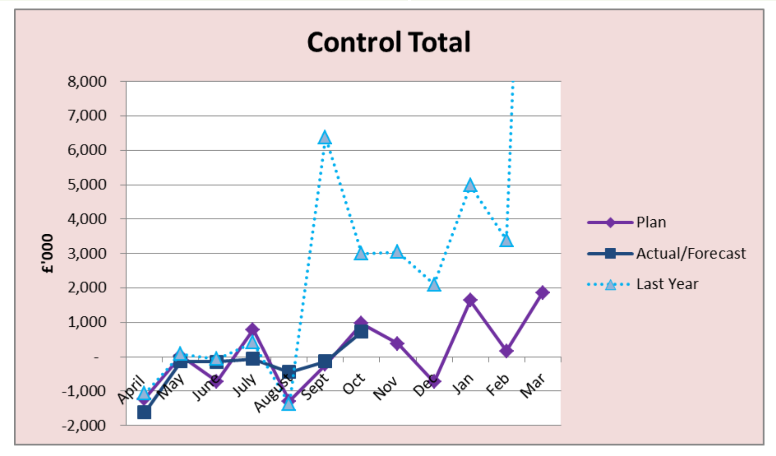
How Did We Do?

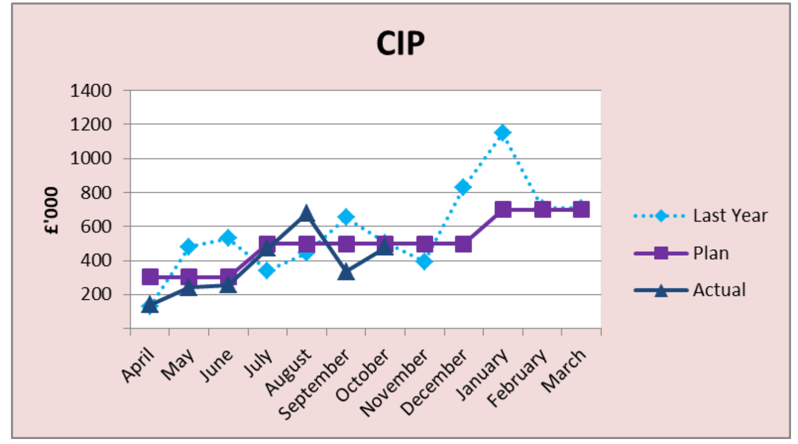
Executive Summary Month: 7 Year: 2019

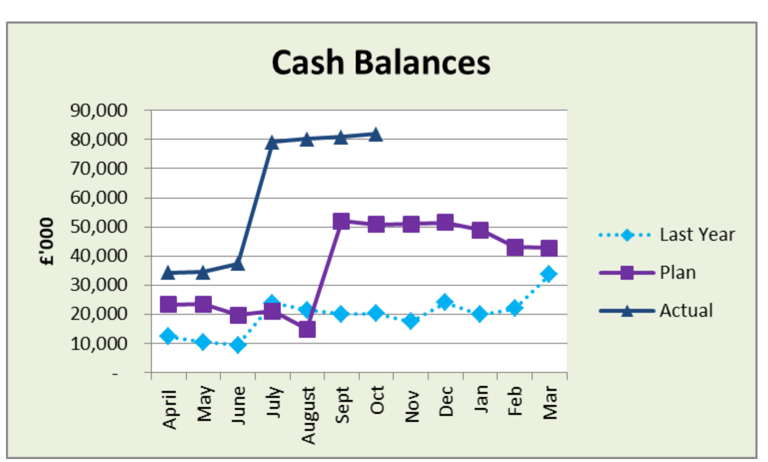
Alder Hey Children's NHS Foundation Trust

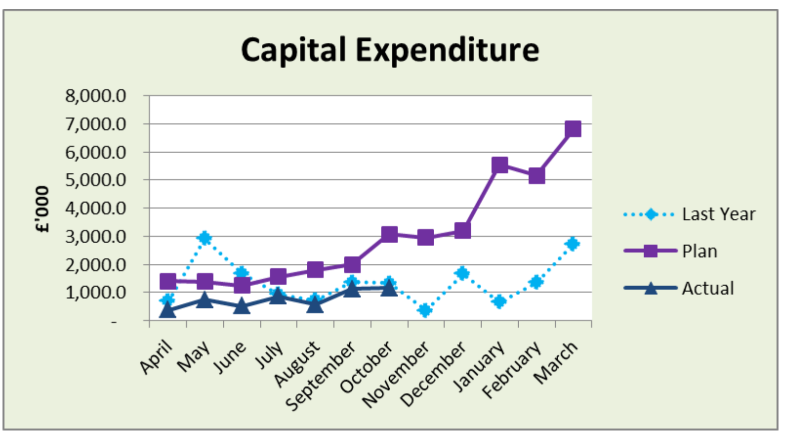
BRILLIANT BASICS GROW THE FUTURE

| Control Total in month | CIP Forecast for year | Use of Resources | Control Total Forecast |
|---|---|---|---|
| £0.7m | £4.9m | 3 | (£1m) |
| Not Achieved | Not Achieved | On Plan | Not Achieved |

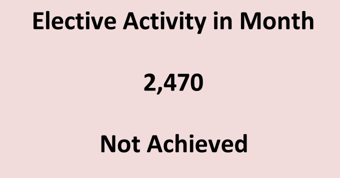


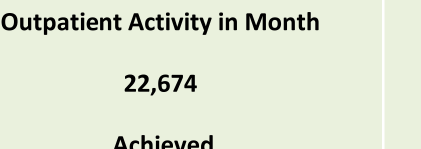



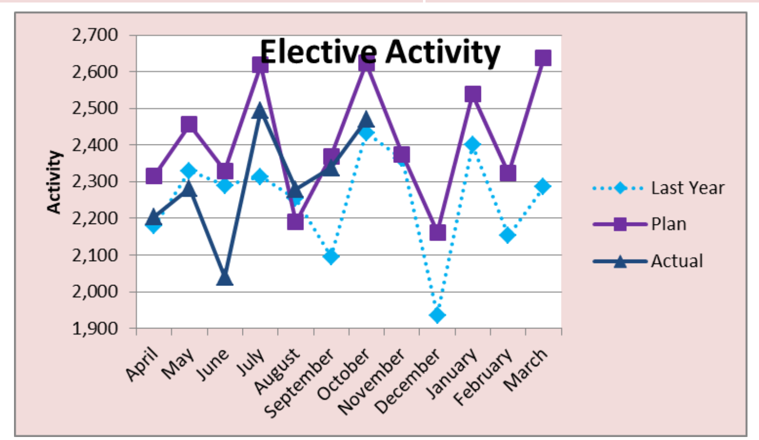



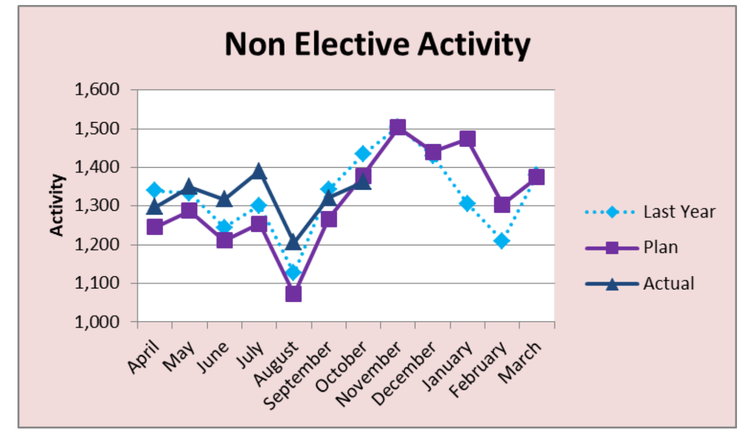
How Did We Do?

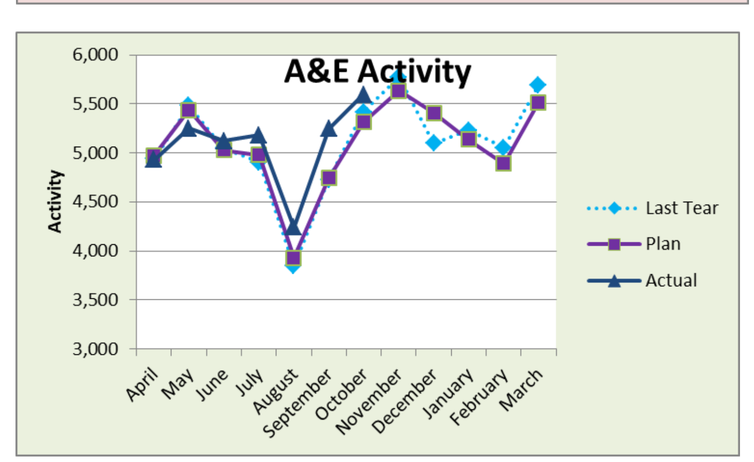


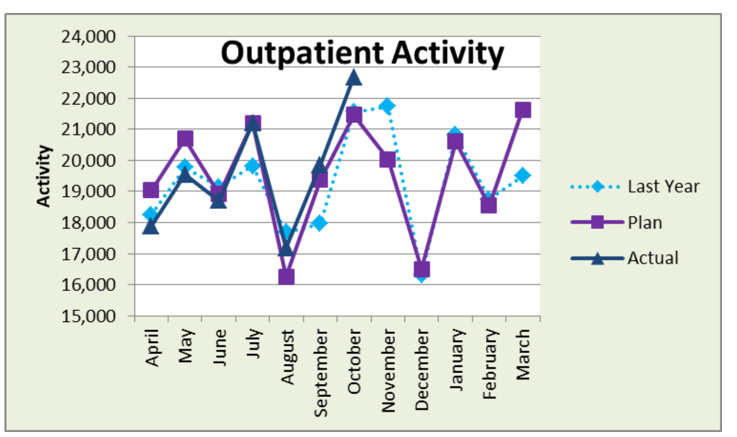


| Elective Activity in Month | Non Elective Activity in Month | Outpatient Activity in Month | A&E Activity In Month |
|---|---|---|---|
| 2,470 | 1,362 | 22,674 | 5,596 |
| Not Achieved | Not Achieved | Achieved | Achieved |



# BOARD OF DIRECTORS

**Tuesday 3rd December 2019**

| | |
|---|---|
| **Paper Title:** | **Clinical Quality Assurance Committee Assurance Report** |
| **Date of meeting:** | 20th November 2019 – Summary<br>16th October 2019 – Approved Minutes |
| **Report of:** | Anita Marsland, Committee Chair |
| **Paper Prepared by:** | Julie Creevy, CQAC Administrator |

| | | |
|---|---|---|
| **Purpose of Paper:** | Decision<br>Assurance<br>Information<br>Regulation | ☐<br>■<br>☐<br>☐ |
| **Summary and/or supporting information:** | This paper provides a summary from the recent Clinical Quality Assurance Committee meeting 20th November 2019 along with the approved minutes from the 16th October 2019 meeting. | |
| **Action/Decision Required:** | To note<br>To approve | ■<br>☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care**<br>**The best people** doing their best work<br>Sustainability through **external partnerships**<br>Game-changing **research and innovation**<br>**Strong Foundations** | ■<br>☐<br>☐<br>☐<br>☐ |
| **Resource Impact:** | None | |
| **Associated risk (s)** | Include risk(s) reference, title of risk, and current risk score. | |

## 1. Introduction

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

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

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

- Programme Assurance Update
- Models of Care Update
- Update on patient shadowing project
- Ward Accreditation update
- CQSG Key issues report
- Palliative Care report
- Board Assurance Framework
- Best in Mental Health Services report
- ASD update
- Corporate report Quality metrics
- 7DS audit service programme – approved 7DS submission

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

None

## 4. Positive highlights of note

- A positive update was provided regarding Ward Accreditation which recognised positive achievements in various Wards.

- Sustained achievement of 100% performance in delivering Sepsis treatment for inpatients within 60 minutes.

## 5. Issues for other committees

None

## 6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

**Clinical Quality Assurance Committee**
**Minutes of the last meeting held on Wednesday 16th October 2019**
**10.00 am, Large Lecture Theatre, Institute in the Park**

| | | |
|---|---|---|
| **Present:** | Anita Marsland | (Chair) Non-Executive Director |
| | Shalni Arora | Non Executive Director |
| | Denise Boyle | Associate Chief Nurse - Surgical Division |
| | Pauline Brown | Director of Nursing |
| | Lisa Cooper | Divisional Director for Community Division |
| | Mark Flannagan | Director of Communications and Marketing |
| | Anne Hyson | Head of Quality – Corporate Services |
| | Adrian Hughes | Divisional Director, Medicine Division |
| | Nicki Murdock | Medical Director |
| | Darren Powell | Pathology Manager |
| | Jill Preece | Governance Manager |
| | Tony Rigby | Deputy Director of Risk & Governance |
| | Carol Rowland | Head of Complex Care |
| | Jennie Williams | Improvement Manager |
| | Erica Saunders | Director of Corporate Affairs |
| | Sarah Stephenson | Head of Quality – Community Division Division |
| | Melissa Swindell | Director of HR & OD |
| | Cathy Umbers | Associate Director of Nursing & Governance |
| **In Attendance:** | | |
| | Julie Creevy | Executive Assistant (Minutes) |
| Agenda item: | | |
| **19/20/99** | Natalie Deakin | DMO Manager |
| **19/20/101** | James Ashton | Sepsis Nurse Specialist |
| | David Porter | Sepsis Lead, Consultant |
| | Dr. Enitan Carroll | Consultant |
| | Gerri Sefton | ANP Lead on DETECT |
| **19/20/102** | Valya Weston | Head of Service/Associate Director |
| **19/20/104** | Phil O'Connor | Deputy Director of Nursing |
| **19/20/105** | Liz Edwards | Head of Clinical Audit & NICE Guidance |
| **19/20/110** | Nicola Evans | A&E Nurse |
| **19/20/104** | **Apologies:** | |
| | Adam Bateman | Chief Operating Officer |
| | Christian Duncan | Divisional Director, Surgical Division |
| | John Grinnell | Director of Finance/Deputy Chief Executive |
| | Hilda Gwilliams | Chief Nurse |
| | Dani Jones | Director of Strategy |
| | Louise Shepherd | CEO |
| | Cathy Wardell | Associate Chief Nurse – Medicine Division |
| | Kate Warriner | Chief Digital & Information Officer |
| | Will Weston | Associate Chief of Operations, Medicine |

**19/20/105 Declarations of Interest**
None declared.

**19/20/106 Minutes of the previous meeting held on 16th September 2019**
**Resolved:**
CQAC approved the minutes of the previous meeting held on 16th September 2019.

**19/20/107 Matters Arising and Action Log**
**Action Log**

CQAC noted that the majority of items on the log were included on the agenda for discussion and could be closed and removed from the action log.
19/20/77 – Management of Bleeps, PB confirmed that HG had updated KW re management of bleeps, and a verbal update would be provided at November 2019 meeting.

19/20/90 – CQC briefing/Board session to be arranged to support Board members, CQAC noted that sessions had been diarised this item to be removed from the action log.

19/20/98
*Lack of clinical CQSG representation* – NM confirmed that she had clear ideas on addressing the lack of CQSG representation going forward, and that an offline discussion would be held with CU & PB to discuss this issue further.

*Securing a partner to support Inspiring Quality* - NM confirmed that following commencement of the tender process for Securing a Partner to support Inspiring Quality, this had resulted in 4 applications being shortlisted. Focus groups/dialogue sessions had been held on 8th October 2019. 2 clear preferences had been identified, with 4 potential partners being reviewed. NM stated that she envisaged that a Partner would be in place within the next 4 week period, with the intention to roll out throughout the organisation.

*Patient Information leaflets* – AH confirmed that work continued to improve regarding Patient Information Leaflets. Weekly sessions had been undertaken for a 4 week period. Further sessions are scheduled to commence on 17th October 2019 for Community Services, with additional further sessions planned thereafter. Community Division had shown an improved position. Staff are extremely interested in writing and designing new leaflets. Task and Finish group had been established. AH confirmed that Colin Beaver from Comms team had been involved in process. MF stated that Phil McNamara and Becky Murphy needed to be included in future discussions. MF expressed concern with regards to the development and usage of videos, and stated that previous research had shown that patients still have a preference to receive a paper leaflet to take away with them. AH stated that C&YP had been fully involved in consultation, and that the C&YP had requested the use of videos. NM asked for clarity/update regarding the plan for developing videos. AH confirmed that she had met with Innovation team and medical photography who are in the process of testing with regards to developing an orthopaedic script, however this had proven extremely time consuming.

NM welcomed the new video initiative and requested for this to be referenced as part of the CQC evidence bundle against innovative ideas. JP to include.

19/20/79 - *Mandatory training update following discussion with U.D.* – NM confirmed that due to NM's leave and an unexpected period of sickness, NM confirmed that the discussion with U.D. had not yet taken place, NM stated that she would follow this up with U.D.

*Lack of clinical representation at Nutrition Steering Group meeting* - NM confirmed that she had previously discussed this issue with LC, with regards to the lack of clinical representation, and both NM and LC had reached agreement that clinical representation would be invited on an "as and when basis".

**Quality Improvement Progress Reports**

**19/20/108 Inspiring Quality Programme Assurance Update**

CQAC received and noted the Programme Assurance update focusing on those projects under the Outstanding Care section of the change programme. CQAC noted that the overall position for Outstanding Care ratings and project ratings for this month were positive.

***Clinical Cabinet*** -

NM confirmed that the Clinical Cabinet Flyer would be shared with staff, in order for staff to nominate, NM stated that should the Trust receive an influx of responses, an election process would take place.

***Patient Shadowing*** –

NM confirmed that Dr. Will Calvert, Surgical Trainee who has a PHD in Empathy had been commissioned to support the Trust with regards to Patient Shadowing. NM stated that a full update would be provided to November CQAC meeting.

**Action:** Patient Shadowing update report to be shared at November meeting.

AM queried whether CQAC is the most appropriate forum to review this, NM confirmed that this is reviewed at Inspiring Quality Meetings ultimately.

**19/20/109 Sepsis Update**

J Ashton, Sepsis Nurse Specialist, & D Porter, Sepsis Lead, presented the Sepsis Pathway 6 month update, which detailed key progress, CQUIN info, plan for the next 6 month period and delays/contributing factors.

Key issues as follows:-

Progress

- Standard docs / sepsis status
- Improved data recording, efficiency of collection
- Subset of 'treating as sepsis' – trend to better times
- March: overall treated <60 min 74% cf 'treat as sepsis' subset 87%
- Dashboards

***Next six months***

- Established work
  - Incident reporting / RCAs / ward liaison / divisional updates / training
  - Sepsis status' in ED
  - Meditech - work agreed. ? Timeframe
  - Data reporting
  - 'Sepsis data verification form' (currently in test)

– Dashboard finalising
- Training compliance
  – Training needs analysis to be integrated into ESR
  – DETECT integration
  – Phase I implemented (awaiting phase II)
  – Vitals / MT sepsis integration form (currently in test)
- Quarter 2 – 46 cases treated as sepsis with a high proportion of cases of clinical deteriororation at 92% over a 3 month period.

NM queried whether the I.T. Systems have the functionality to record ED information. JA confirmed that there is no specific place to record Sepsis concerns, and that ED staff review blood cultures and multiple variances. Sepsis team are aiming towards creation of a timestamp within ED.

JA stated that a separate Sepsis form had been created by Sepsis team in order to provide an accuate position for ED.

LC queried the standard of record keeping and sought clarity regarding detail of location of evidence and record keeping audits, and questioned how staff are being supported. DP stated that there is a clear system in place which is not always being followed, LC stated that this needed to be a priority to address.

AM stated that Executive Team discussion is required with regards to supporting Sepsis Team.

**Action:** Executive Team discussion to take place

DB queried whether the Sepsis weekly reports are going to be shared with Divisions, DP & JA confirmed that they are shared with divisions as appropriate.

CQAC received and noted update.
AM thanked JA & DP for update.

**DETECT Update**
G Sefton, ANP Lead on DETECT & Dr. Enitan Carrol, Consultant, presented the DETECT update, which detailed a recap from baseline data, roll out update, what had been learnt, details on arrest calls, what changes are required, weekly feedback to wards regarding monitoring safety and Vital PAC observation statistics.

Key issues as follows:-
- Random snapshot of practice during May 2019, 11,500 set of obs recorded in one week, 10 in-patients wards. PEWS 3+; 60% recorded.
- 25% >30 minutes delay in data entry in EPR, after reported time taken (up to 40% in one high risk ward).
- 306 unplanned admissions to Critical Care, costing £11.5M.
- Vitals roll out, all areas are now 'live' – 4ABC, 3ABC, Burns, EDU & Cardiac 1C, SAL, Theatre recovery, CRF, MDU, Oncology day-care & RDU Night Team
- Commencing Connect roll out – Nurse in charge of the ward, Medical Teams & Surgical Teams.
- Training, re retraining and re-education is required.

- Recording of vital signs appeared to be a routine task, thus missing 'early warning function'.
- Real times e-obs to increase situation awareness required culture change.

**Changes required**

- Focus on patient safety; real time data immediately visible to entire team
- Senior clinical leader/supervisor Nurse in charge role.
- Ensure Team working, not individual working.
- Management and clinical expectation that this should occur.
- Weekly reporting and feedback to wards about monitoring safety.

PB sought clarity regarding timescales for ED, and asked whether this was on trajectory. JA confirmed that the basic framework was in place, and that there is only 1 staff member who could work on this to progress this further. PB stated that should any support be required from her, for the Sepsis team to advise as appropriate.

PB queried the process for Badger regarding neonates. JA stated that neonates are being monitored from prescription, and that clinical links will be included on electronic system, potential to include at a later date.

PB stated that the presentation was excellent, and that it was important to note that during the 6 week roll out period this had resulted in issues regarding safety, and that G Sefton had attended Senior Nurse Forum meeting on 10th October 2019 to update nursing staff. PB confirmed that this initiative had wide spread support from nursing staff. PB emphasised that the DETECT practice doe have to be live and in real time and that support is vital.

CQAC received DETECT update and noted achievements to date.

AM thanked GS & EC for tremendous update.
CQAC received and noted DETECT update.

**19/20/110 Delivery of Outstanding Care**
***Safe***

**Quarter 2 DIPC report**
CQAC received and noted the Quarter 2 DIPC report, presented by V Weston. Key issues as follows:-

- IPC team had gone out to advert for IPC staff member, who would work alongside Community Division. Interviews are scheduled on 25th October 2019, with 4 shortlisted candidates.
- Flu update – Over 1,100 staff had been vaccinated to date, which comprised of 707 front line staff. The IPC team had run out of vaccine and had just received a new delivery of stock. Next vaccination session are scheduled for 17th October 2019 between 11.00 am – 2.00 pm and would include student nurses who could obtain vaccination
- IPC conference in 2018 had been well supported by Trust staff, and that the Trust would have a stand alone conference in 2020.
- IPC are looking to show a video within the atrium to demonstrate the importance of hand washing.

- New IPC signs were circulated, NM questioned whether they were co-designed with children and queried whether the C&YP Forum had been consulted. VW stated that they hadn't been consulted on this occasion. VW noted that that she would fully consult with C&YP Forum with regards to any further introduction or creation of any new signs etc.
- VW stated that Tray liners providing key IPC messages are due to be launched week commencing 21st October 2019, and that consultation had taken place with C&YPF in this regard.
- IPC week is planned week commencing 21st October 2019 within the atrium, with additional flu sessions planned throughout the week.

PB alluded to the importance of basic infection control practices and the importance of all staff working together, i.e. staff wearing appropriate footwear etc.

MS, referred to Mandatory training compliance - 62% compliance for Infection Control, and that mandatory training for medics required prompt improvement. NM stated that IPC colleagues needed to attend forums that medical staff are in attendance at. VW stated that she would need clarity from Divisional Colleagues regarding forum dates/venues etc to enable IPC colleagues to attend such forums.

**Action**: Offline discussion to take place with VW, MS & NM.

ES referred to the significant work programme and asked for clarity for the committee in terms of which items the committee needed to focus on. ES requested that further clarity is required within the report for the next update to CQAC highlighting issues that required escalation, or key elements/key areas that required articulating to CQAC.

**Action**: Offline discussion required to support IPC to take place with VW & HG

**19/20/111** **Escalation Process update – Medicine Division**

AH provided Escalation Process Update, key issues as follows:-
AH stated that the End of Life Care and support is part of a wider issue.
AH confirmed that positive discussions had taken place with Clare House Senior Management Team regarding potential partnership working. Consultant at Clare House had indicated an interest in moving from Chester to Alder Hey, and stated that there is also an additional colleague who would be interested in joining Alder Hey.

AH stated that as a default position, in the interim that there are a number of experienced senior clinicians who had developed significant skills to enable support for patients when reaching end of life. Consultant at Chester had advised that she would support the Trust for individual patients.

CU questioned what the risk is currently, and queried whether the Risk Register needed to be amended. AM agreed that he would review this further, to ascertain whether this demonstrated any change on the Risk Register.

**Action:** AH to review and advise CU whether there was any change to Risk Register rating.

**Action:** Detailed briefing paper to be shared at November 2019 CQAC meeting.

***Effective***

**19/20/112** ***CQSG Key issues Report***

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

- Nutrition Steering Group had met twice, Terms of Reference had been agreed. Nutritional Policy had been signed off.
- Incident regarding Nutrition had been reviewed and is included on the Risk Register.
- PoC, on behalf of CQSG expressed his thanks to LC and team for continued support.
- The SEND group meet on a bi monthly basis and the minutes from the last meeting are presented at this meeting for information. Liverpool and Sefton had been inspected by Ofsted. and Sefton had been put into special measures. The CCG congratulated Alder Hey on the progress achieved. Community Speech and Language had received additional funding and now only 9 children had been waiting over 40 weeks. One big EHCP planning process made up of Schools/Health and Social Care has been undertaken.

AM requested that the key issues report be amended to read 'Ofsted' as opposed to 'CCG'

- **Picker report:** A total of 64 questions from the survey could be positively scored. Of these, 61 can be compared historically between the 2016 and 2018 surveys. 1250 were invited to complete the survey, 304 completed the survey (24%) which is average. 98% of parents felt well looked after by staff, 93% of children felt well looked after in hospital and 97% of staff agreed a plant with parent for their child's care. The report detailed Top 5 scores, most improved, bottom 5 scores and least improved from last survey. The league table showed that that Alder Hey was above average for completing the survey.

AM expressed thanks for continued support from CQSG and stated that the Committee looking forward to the Joint CQAC & CQSG meeting on 18th December 2019.

**19/20/113** ***Clinical Audit & NICE Compliance Report***

LE presented the Clinical Audit & NICE Compliance Report, key issues as follows:-

- Trust Audit Plan was formally published and presented at CQSG in August 2019.
- Clarification is required regarding a number of audits. Progress is being made and the audit plan had been amended to demonstrate Trust wide audits undertaken by the Nursing Leadership team.
- The Trust have a process for reviewing all published NICE guidance.
- Work is ongoing regarding local audit plans, local audit plans had not yet been agreed with Divisions, as LE had requested to meet with Divisional Leads in order to progress. CQAC noted that this needed to be addressed promptly. Agreed that it would be beneficial for LE to attend weekly Tuesday morning Triumvirate meeting in order to discuss further.

In addition to audit plan, a register of all activity had been developed to ensure that all clinical audit activity is held centrally and that findings and actions from audit findings could be demonstrated.

**Action**: LE to attend Triumvirate Divisional meeting.

- The Trust currently has 94 clinical guidelines developed by NICE. Significant improvement in the Division assigning guidance had been achieved. Future reports to Divisional Integrated Governance meeting would include details of the gap analysis.
- LE stated that she was pleased to report that those areas which were 'red; are now 'amber' and that there had been good engagement with divisions. NM stated that it would be beneficial to include a table articulating 1/3, 2/3 as opposed to stating partially met 64%.

NM raised issue regarding NCPOD work, and that the significant amount of work on receipt of such requests from NCPOD, and that on review of previous NCPOD recommendations, that she did not feel that the significant amount of work warranted Trust involvement. NM requested that she intended to share any future NCPOD study requests with CQAC, by way of a briefing for CQAC, in order for CQAC to consider whether any Trust involvement/participation is warranted.
CQAC were in agreement with this proposal.
AM thanked LE for update.

***Well Led***

**19/20/114 Journey to Outstanding**

ES presented the CQC 'Journey from Good to Outstanding' which detailed key milestones, key issues as follows:-

- CQAC noted that the PIR had been completed and submitted on 4th October 2019.
- Reports had been received from MIAA with regards to advisory work which had been commissioned.

**Next steps**

- Complete detailed review of reports and update/refocus plans
- Revise staff handbook
- ES highlighted the importance of prompt acceleration of communication messages. MF confirmed that discussions had taken place with comms team on 15th October 2019 in order to progress this
- All staff able to articulate Vision and Values
- Agreed 'top 3' risks
- Examples of learning from incidents
- Examples of 'most proud of' in each service

ES confirmed that sessions for Board members had been diarised, in order to support Board members and that 'mock interviews' would be scheduled. Further update is due to be provided at Executive Team meeting on 18th October 2019.

ES expressed thanks to N Deakin & C Ryder for support received.

LC stated that colleagues would benefit from a 'deep dive'/ triangulation piece of work commencing with regards to external inspections, Looked After Children etc. This was welcomed by the committee and committee agreed for appropriate colleagues to undertake an offline discussion to progress.

**Action:** ES/LC/MS/NM & PB to meet offline to discuss further.

**19/20/115 Board Assurance Framework**

ES provided Board Assurance Framework update, key issues as follows:-

ES confirmed that there is a planned recruitment trip to India in order to recruit nursing staff with the Director of Nursing and the Deputy Director of Nursing and colleagues travelling to India week commencing 18th November 2019.

CQAC received and noted BAF update.

**19/20/116 Corporate Report – Quality Metrics**

Divisional Leads provided Quality Metrics update by exception as follows:-

- Surgery – During August there had been no moderate, severe or permanent harms. 1 Medication error of heparin had been detected quickly for a child on PICU, with lessons learned shared with the division within newsletter. No grade 3 or 4 pressure ulcers, and no never events. Sepsis 100%, with 75% previous month which related to 1 patient. No MRSA or CDiff patients. 2 CLABSI's. With 6 CLABSI's to date.
  Discussion took place regarding 'targets' and NM reminded the Committee that the Trust should be resetting the target to '0' as opposed to a target of 16. AH stated that there needed to be some caution in articulating and setting targets if the targets are set as too ambitious. NM reminded committee of the importance of articulating right targets, and the importance of tracking improvements, in order for the Trust to be smarter in terms of targets. DB stated that the report stated that there had been 1 complaint, however the Division received 8 complaints. CQAC agreed that there is a need to review how complaints are reflected and recorded within the Corporate Report Dashboard, with the need for data accuracy to be reviewed.

  Committee agreed that further discussion is required offline to discuss 'target' and agreeing the terminology/language used within the corporate report.

  **Action:** NM to follow this up to enable an offline discussion with regards to targets.

- Community - The Division had 3 Grade 3 Pressures Ulcers – which was not stated on the Dashboard.
  Safe Staffing, Dewi Jones – during July & August staffing related to 1 vacancy which had been covered. Full compliment of staff in place.
  Division had received a reduction in complaints and PALS.
- Medicine - 1 Hospital acquired MSSA – case had not been fully investigated to date as the Bacteraemia Review Panel did not take place as originally planned, new date for Bacteraemia Review panel had been rescheduled.

  **Action**: PB to follow up issue regarding data accuracy with K Edwardson.

***Responsive***

***19/20/117 Quarter 2 complaints Report***

CQAC received Quarter 2 Complaints report, key issues as follows:-

- 37 formal complaints had been received during Q2, which is same number as previous year.
- Highest category of complaints related to Treatment and Procedure
- 3 day acknowledgement – 36 out of 37 were responded to within the 3 day acknowledgement, with 73% acknowledgement on same day.
- 1 complaint had been withdrawn as CCG are leading on Complaint.
- Ombudsman are visiting the Trust on 11th & 12th November 2019 for a 2 day period in order to interview 6 members of staff with regards to an extremely complex longstanding complaint. Staff involved in the process are being fully support and HG & ES had meet with team to also provide support. Legal advice had been sought.
- No out of date complaints

*PALS*

- Community Paeds highest specialty.
- 17 requests regarding facilities management with regards to car parking, this was an unusual increase and related to high disabled vehicles unable to park. NM asked why the appointment letters are not amended to pre warn patients families, to ensure that families are aware in advance. AH confirmed that she would feedback to MD to address going forward.

  **Action:** AH to feedback to MD

- Actions from complaints - CQAC were pleased to see Community information Division is included on Ulysses. MF referred to resources within the complaints team, and asked the committee whether they were comfortable with the gaps, if staff felt they were struggling. PB stated that the committee should recognise that support had been provided in order to address this issue, in order to assist the team and divisions. With regards to key learning for patients outside of timescale when families request a meeting, and families then cancel a planned meeting, a response letter would be shared with the family

**19/20/118** ***AED Action Plan***

CQAC received AED action plan, which was presented by Nicola Evans.
CQAC noted that AED remained challenging due to increased numbers of attenders. Action plan focussed on staff and IT Issues. Progress had been made in order to provide support for AED colleagues, to ensure appropriate IT support is available, which has resulted in improved IT and improved access to PC's within hub area within AED. AED had been made a priority for service desk requests, to ensure appropriate prompt support is provided when issues are raised with IT service desk.

- Key issues regarding GP streaming between 2.00 pm – 10.00 pm, with challenges with GP rota. Currently working with UC24 if there are gaps in the rota, team will look for additional rotas, and putting in evening rotas for surge periods. AED team are content that rotas are reflective of requirements. Issues regarding consultants, and the division are working hard to fill. Recruitment process is in place and staff are due to commence in November. Advert had been placed for nurse vacancies, with 2 nurses recruited in the last pool. ANPP workforce – had received investment – with 4 ANP's in training – 2 staff within 2nd year and 2 staff training in 1st year.
- Work is progressing with Porters to review how to work closer with portering team to further improve service delivery. Team continue to work with

external colleagues with regards to the Winter Plan.

- Workforce Plan – team are Developing Comprehensive Workforce Plan, with support from colleagues. Plan will result in likely cost implications, however pace is required given the increasing numbers of patients.

CQAC noted that Executive Team are well sighted on issues faced by AED colleagues. CQAC noted that senior support had been provided to AED staff and that close engagement had been provided.

AM stated that that there should be strategic ambitions to try and prevent the high numbers of attendees at AED. CR stated that the team are working with Primary Care Networks, as there is a requirement for a change of culture/need for a wider strategy given that families prefer to attend AED, as opposed to GP, Walk in centre etc.

PB asked whether any support could be provided by CQAC in order to further support AED staff. NE confirmed that staff within AED feel well supported, however NE stated that should any additional support be required in the future, NE and AED staff are aware of the process for escalation.
AM thanked NE for update.

**19/20/119** ***Consent Policy***

CQAC received the Consent Policy which was presented by SS. A short extension was provided to the policy which had been approved via an executive action. Minor changes had been made. GMC out for consultation, with expected guidance due in November 2019. Policy would be reviewed thereafter to ensure that it is in line with GMC guidance.

CQAC received and ratified the Consent policy.

**19/20/120** **Review of meeting**

CQAC reviewed the content of the meeting, and agreed that the content was good. CQAC welcomed strong presentations from Detect and Sepsis Team. CQAC felt that assurance was moving in the right direction.

CQAC noted that prompt receipt of papers is crucial to ensure that papers are issued promptly, to ensure that the committee have sufficient time to receive and review papers in advance of the meeting. All were reminded of the importance of submitting papers by deadlines provided.

CQAC agreed it would be helpful if the Board of Directors CQAC key issues report template could be circulated to committee members for information.

Action: Key issues template to be circulated.

**19/20/121** **Any Other Business**

None

**18/19/122** **Date and Time of Next meeting**

10.00 am – Wednesday 20th November 2019, Large meeting room, Institute in the Park.

**BOARD OF DIRECTORS**

**Tuesday 3rd December 2019**

| | |
|---|---|
| **Paper Title:** | Compliance with Duty of Candour and Incident Management, including investigations of moderate harm or above and Never Events |
| **Report of:** | Chief Nurse |
| **Paper Prepared by:** | Trust Risk Manager |
| **Purpose of Paper:** | Decision ☐<br>Assurance ■<br>Information ☐<br>Regulation ■ |
| **Background Papers and/or supporting information:** | Seven Steps to Patient Safety. National Patient Safety Agency 2004.<br><br>Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'.<br><br>Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015.<br><br>Serious Incident Framework. Frequently asked questions NHS England 2016.<br><br>Revised Never Events Policy and Framework ( NHSI 2018)<br>Never Events List 2018.<br><br>Incident Investigation reports. |
| **Action/Decision Required:** | To note ■<br>To approve ■ |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ☐<br><br>Game-changing **research and innovation** ☐<br>**Strong Foundations** ☐ |
| **Resource Impact:** | n/a |

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1. **Background:**

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

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

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

All investigations are monitored via the performance assurance meetings with individual divisions, focusing on the management of investigations, including lessons learned and assurance of progress with actions for improvement. In addition, the divisions present a progress update on investigations to Clinical Quality Steering Group, with exceptions reported to Clinical Quality Assurance Committee.

**Table 1** shows the Trust's 2019/20 numbers of serious incidents reported, including Never Events requiring investigation (Serious Incidents Requiring Investigation - SIRI).

During this reporting period, there was one new serious incident reported. There were no safeguarding, and no moderate harm incidents reported during this reporting period.

**Table 2** shows an overview of the five open serious incident investigations progressing in the Trust.

**Table 3** shows an overview of the three closed SIRIs during this reporting period.

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

| | SIRI (General) | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 2018/19 | | | | | | 2019/20 | | | | | | |
| **Month** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** |
| **New** | 0 | 0 | 1 | 2 | 2 | 0 | 0 | 0 | 2 | 2 | 0 | 4 | 1 |
| **Open** | 3 | 0 | 0 | 3 | 5 | 5 | 3 | 2 | 0 | 4 | 4 | 7 | 5 |
| **Closed** | 1 | 3 | 0 | 0 | 0 | 0 | 2 | 1 | 2 | 0 | 0 | 1 | 3 |
| | **Safeguarding** | | | | | | | | | | | | |
| **Month** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** |
| **New** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Open** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Closed** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | **Never Events** | | | | | | | | | | | | |
| **Month** | **Oct** | **Nov** | **Dec** | **Jan** | **Feb** | **Mar** | **Apr** | **May** | **Jun** | **Jul** | **Aug** | **Sep** | **Oct** |
| **New** | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 |
| **Open** | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| **Closed** | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| | | | | | | | **Cumulative Position** | | | | | | |
| | | | | | | | **5** | | | | | | |

**Table 2 Overview ongoing serious incidents requiring investigation (SIRI's)**

| 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 2019/23494 | 24/10/2019 | Medicine | 800 outstanding blood results found on Meditech that had not been reported on. The bloods are primarily related to immunology and anticoagulation. These bloods are not diagnostic, but can support diagnosis. | Darren Powell, Clinical Director for Laboratory Medicine | Information gathering ongoing; the RCA panel meeting is to be arranged. | The report is due for submission to the CCG and CQC 22/01/2020. | Not applicable – no harm known to have been caused at this stage. |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | The initial review shows that 774 are negative (i.e. no issues identified). The remaining 26 show a positive result, however the initial assessment suggests they are low risk. | | | | |
| StEIS 2019/21208 | 26/09/2019 | Surgery | **Never Event (retained swab):**<br><br>The patient underwent an adenotonsillectomy. The Consultant ENT Surgeon inserted a post nasal swab and has stated this was part of their routine practice. The patient was extubated, and moved to the recovery area. The nurse raised concern that a swab was missing. At this point, the Surgeon recalled that he had not removed the post nasal swab and requested the anaesthetist to deepen the anaesthetic. The patient's mouth was then opened with an anaesthetic laryngoscope to retrieve the swab. The patient did not need to be re-intubated. | **Nursing lead:** Paula Clements, Theatre Matron<br>**Medical lead:** Costas Healy, Consultant | The RCA panel meeting was held 26/10/2019, the RCA report is being written. | The report is due for submission to the CCG and CQC 19/12/2019. | Compliant |
| StEIS 2019/20741 | 19/09/2019 | Surgery | **Never Event (wrong route administration of medication):**<br><br>The patient's epidural catheter was connected to an epidural giving set | **Medical lead:** Harvey Livingstone, Consultant Paediatric Anaesthetist<br>**Allied Health Professional lead:** | The RCA report has been reviewed by the Theatre Management Team, further work is required prior to approval by a | The report is due for submission to the CCG and CQC 13/12/2019. | Compliant |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | which had inadvertently been connected to and primed with a bag of gelofusine rather than the intended chirocaine and clonidine epidural solution. The pump was stopped immediately on identification. At this time, 0.9mls had been administered. 0.25-0.3 mls was aspirated from the filter and 0.1 mls was aspirated from the epidural catheter and hub. This left approximately 0.5-0.6 mls in the epidural catheter and epidural space. The decision was made to not utilise the epidural catheter for the remainder of the case and it was re-sited at the end of the case one space below the original site. No harm is known to have been caused to the patient at this stage and on consultation with relevant experts; it is not anticipated that the patient will suffer any lasting effects. Expert advice is also being sought by the neurosurgical team. | Neil Wallis, Clinical Lead, Theatres | member of the Divisional Triumvirate. | | |
| StEIS 2019/20632 | 18/09/2019 | Surgery | **<u>Unexpected death:</u>**<br><br>A patient under the care of the cardiac team for shunt dependent circulation, sadly passed away prior to | **Medical lead:** Andrew Riordan, Consultant in Infectious Diseases<br><br>**Allied Health** | Information gathering ongoing. | The report is due for submission to the CCG and CQC 12/12/2019. An extension is to be requested due to the work pressures of the lead. | Compliant |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | their scheduled surgery taking place. Initial case review highlighted potential areas requiring further investigation in terms of the patient's pathway. | **Professional lead:** Alan Bridge, Clinical Lead, Theatres | | | |
| StEIS 2019/20104 | 12/09/2019 | Surgery | **<u>Patient found to have retinal haemorrhages post-cataract surgery:</u>**<br><br>The patient was referred to the ophthalmology service on the 7th February 2019 and was triaged by the consultant as urgent. The patient attended the cataract clinic on the 19th February 2019 whereby he was diagnosed with bilateral congenital cataracts and was listed for left eye cataract extraction on the 26th February 2019. The patient was admitted overnight and was reviewed in the cataract clinic on the 27th February 2019 and discharged. The patient was reviewed routinely thereafter and the left eye was noted to be making positive progress.<br><br>The patient was readmitted for surgery on the right eye on the 12th March 2019. The procedure was uncomplicated and patient was admitted overnight | **Service lead:** Judith Gray, Head of Optical Services<br>**Medical lead:** Adam Donne, Consultant ENT Surgeon | The RCA panel meeting was held on the 05/11/2019, an external expert is being sourced to undertake a case review and the patient is to be offered a review regarding the potential that the retinal haemorrhages may have been caused by other conditions. | The report is due for submission to the CCG and CQC 05/12/2019. An extension is to be requested to allow time for the review by an external expert to be undertaken. | Compliant |

| | | | | | | | | |
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| | | | and was reviewed in the cataract clinic on the 13th March 2019 and discharged.<br><br>The patient had a further clinic appointment on the 15th March 2019 and subsequent review on Friday 22nd March 2019. During this review, widespread retinal haemorrhages in the right fundus were identified that were not present at the reviews on the 13th and 15th March. Initial investigations were undertaken to consider non-accidental injury (NAI) including a safeguarding referral and a skeletal survey. The findings concluded that there were no abnormalities and no external signs of injury.<br><br>Following a further clinic appointment on the 29th May 2019, it was found that the patient has significant optic atrophy in the right eye and that the optic nerve has sustained a significant insult in relation to trauma, circulation or toxicity. At this moment in time the cause of the retinal haemorrhages and optic atrophy is unknown. | | | | |

**Table 3 Closed SIRIs:**

| Reference Number | Date investigation started | Division | Incident Description | RCA Lead Investigator | Progress | 60 working day compliance (or within agreed extension) | Duty of Candour applied |
|---|---|---|---|---|---|---|---|
| StEIS 2019/16286 | 24/07/2019 | Community | **Category 3 Pressure Ulcer:**<br><br>Pressure ulcer to the bottom of the patient's spine; the patient is in a wheelchair and has spina bifida and a prominent lower end of spine. Tissue Viability Nurse Specialist reviewed the patient and confirmed the pressure ulcer as a granulating Category 3 pressure damage. | **Nursing lead:** James Ashton, Sepsis Nurse Specialist<br><br>**Medical lead:** Jane Ratcliffe, Consultant | The RCA report was completed and sent to the CCG and family. | Compliant - The report was submitted to the CCG and CQC 31/10/2019. | Compliant |
| StEIS 2019/15130 | 09/07/2019 | Surgery | **Category 3 Pressure Ulcer:**<br><br>The patient recently underwent orthopaedic surgery and was discharged home with a splint in situ. The patient's parents contacted the Trust concerned with a black area on the foot; local advice was sought and the parents were advised to attend Alder Hey.<br><br>The patient was reviewed by the Tissue Viability | Kelly Black, Surgical Matron | The RCA report was completed and sent to the CCG and family. | Compliant – The report was submitted to the CCG and CQC 18/10/2019. | Compliant |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | | Nurse Specialist; the wound was debrided and the wound was classified as a granulating category 3. | | | | |
| StEIS 2019/13792 | 21/06/2019 | Surgery | **Infection Control incident:**<br><br>In June 2015, a Medicines and Healthcare products Regulatory Agency (MHRA) medical device alert was released relating to the potential of M.chimaera within heater cooler units. On the 25th January 2019, a test confirmed a positive result for environment Mycobacteria. Public Health England and MHRA were informed. On 28th January 2019, 2 new heater coolers were brought into the Trust and the contaminated theatre heater coolers taken out of service.<br><br>Final confirmation of M.Chimera received on the 12th June 2019. | **Nursing lead:** Valya Weston, Associate Director, Infection, Prevention and Control **Medical lead:** Christian Duncan, Director for the Surgical Division | The RCA report was completed and sent to the CCG. | Compliant – The report was submitted to the CCG and CQC 04/10/2019. | Non-Compliant – The Duty of Candour letters were sent to parents/carers; however this was outside the mandated timeframe. |

**END**

# BOARD OF DIRECTORS

**Tuesday 3 December 2019**
**Part 1**

| **Paper Title:** | Use of the Mental Health Act (1983) |
|---|---|
| **Report of:** | Lisa Cooper<br>Divisional Director Community & Mental Health Division |
| **Paper Prepared by:** | Dr Audrey Oppenheim<br>Consultant Child & Adolescent Psychiatrist |

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

## 1. Report Purpose

The purpose of this paper is to provide assurance to Trust Board of activity in relation to the Mental Health Act (1983) for the reporting period 01 September 2017 – 31 August 2019.

## 2. Background

The use of the Mental Health Act has increased over recent years across the country as the zone of parental responsibility has diminished following relevant case law, concerns about the capacity of the young person to give meaningful consent to treatment has increased. As such it is now recognised that the rights of many young people are actually better protected under Mental Health Act legislation.

The national and regional trend for increased use of the Mental Health Act is reflected in the admission of children and young people to both acute medical services and the Tier 4 specialist mental health unit at Alder Hey NHS Foundation Trust.

A particular area of increased admission and use of the Mental Health Act relates to the admission of older teenagers to a paediatric ward with serious restrictive eating disorders which require interventions such as nasogastric tube feeding. In addition, there has been an increase seen in Alder Hey Emergency Department to assess young people in relation to detention under Section 136 Mental Health Act. This will in part reflect the complexity of young people in the care of the Local Authority and potential lack of appropriate residential care resources.

In order to support both the increase in young people detained under the Mental Health Act and ensure that the administrative processes related to the use of the Mental Health Act e.g. applications for review following the Mental Health Act tribunal process, request for Second Opinion Appointed Doctor opinions and recall under a Community Treatment Order are followed correctly, a service level agreement with Mersey Care NHS Foundation Trust was developed and in place from 01 September 2019. This service level agreement will support the complex administration of the Mental Health Act, facilitate the review of appropriate Trust policies and promote effective staff training in relation to the Mental Health Act.

The Mental Health Act is subject to Parliamentary review and there can be significant changes to the law which has the potential to impact on practice across the Trust. An example of this is the time frame for detention and assessment under Section 136 was recently reduced from 72 to 24 hours. It is therefore important that the Trust is able to demonstrate responsivity to changes in practice and procedure in relation to the Mental Health Act and Code of Practice and sensitivity to the needs of children, young people and their families at a time of particular stress.

An example of work currently being undertaken within the Trust's community based mental health services to address the needs of children, young people and families

is the coproduction and design of appropriate information relating to the Mental Health Act. The aim of this work is to coproduce with children, young people and families Mental Health Act related information in various formats including leaflets for young people where English is not the first language or where young people have additional learning needs.

## 3. Detentions under the Mental Health Act

For the reporting period 01 September 2017 – 31 August 2019, the Trust had 13 children and young people detained under a section of the Mental Health Act.

The table below shows the breakdown of children and young people detained under the Mental Health Act for the reporting period. The sections of the Mental Health Act used are shown in Appendix One

| Location | Number |
|---|---|
| Emergency Department | 6 |
| Trust Ward | 1 |
| Tier 4 In patient Unit | 5 |
| Merseyside Police Cell | 1 |
| **Total** | **13** |

In addition, to the above it should be noted that there is currently 1 inpatient subject to a court order in relation to the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). This was updated on 13 May 2019 and expires on 13 May 2020.

## 4. Mental Health Act Training

During 2019, 95 mental health staff based within the Community and Mental Health Division attended specific training in relation to the Mental Health Act (1983) and Mental Capacity Act (2005), which was commissioned from Hill Dickinson.

Additional training in relation to the Mental Health Act (1983) will be commissioned and delivered during 2020 for staff across the trust including Emergency Department, Senior Managers and Directors.

## 5. Next Steps

The Trust Board are asked to note the contents of this report and be assured that the Trust has in place robust arrangements to deliver the appropriate requirements of the Mental Health Act (1983) and is responsive to the needs of children and young people for whom this applies.

## Appendix One: Definitions of sections of the Mental Health Act

| Section of Mental Health Act | Definition |
|---|---|
| Section 2 | The criteria for detention under Section 2 of the Mental Health Act 1983 (2007), is if a person is suffering from a mental disorder of a nature or degree which warrants their detention in hospital for assessment and possibly medical treatment for a limited period of 28 days. The assessment will be completed by 2 doctors and an Approved Mental Health Practitioner (AMHP). This section cannot be extended or renewed however the patient may be assessed prior to the end of the 28 days resulting in the section status changing to Section 3. |
| Section 3 | The criteria for detention under Section 3 of the MHA is if a person is suffering from a mental disorder of a nature or degree which makes it appropriate for them to receive medical treatment in hospital. Alternative means of treatment must have been considered prior to the decision of detaining in hospital. The section is valid for up to 6 months and can be renewed by the Responsible Clinician (RC) for a further 6 months. After this, it can be renewed for a period of up to 12 months at a time however the RC has the power to discharge at any time. |
| Section 19 | Section 19 of the Mental Health Act regulates the transfer between trusts and hospitals of those patients who are detained for assessment or treatment, as well as the transfer between detention and Guardianship. |
| Section 23 | Section 23 of the Mental Health Act gives “Hospital Managers” the power to discharge most detained patients and all Community Treatment Order (CTO) patients. They may not discharge patients remanded to hospital under Sections 35 or 36 of the Act or subject to interim hospital orders under section 38, and they may not discharge restricted patients without the consent of the Secretary of State for Justice.<br><br>“Hospital Managers”- have the authority to detain patients under the Act (e.g. Psychiatrists). They have the primary responsibility for seeing that the requirements of the Act are followed. In particular, they must ensure that patients are detained only as long as the Act allows. |
| Section 136 | Section 136 is an emergency power which allows for the removal of a person who is in a place to which the public have access, to a place of safety. |

**Trust Board 3rd December 2019**

| **Paper Title:** | **CQAC Q2 Complaints and PALS report** |
|---|---|
| **Report of:** | Head of Quality - Corporate Services |
| **Paper Prepared by:** | Anne Hyson |

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

Quarter 2:- July 2019- September 2019

Complaints & PALS (Patient Advice & Liaison Service) report

**Complaints summary**

The Trust received 37 formal complaints during this period. One complaint from this quarter was subsequently withdrawn from the process at Dads request after local resolution had been undertaken with service managers from the area. In 2018/19 Q2 the Trust received 37 formal complaints, this is exactly the same number as the same timeframe last year.

The category of complaints received in this quarter are:-

| | |
|---|---|
| Access, Admission, Transfer, Discharge | 2 |
| Consent, Communication, Confidentiality | 7 |
| Documentation (Records, Identification, IT System) | 1 |
| Medical Device/Equipment | 1 |
| Physical/Verbal Abuse | 1 |
| Treatment/Procedure | 25 |

Treatment /procedure is the highest category within this period. Examples of complaints received are:-

- ***X was diagnosed with juvenile oligoarthritis in 2015. She then developed uveitis. She has been diagnosed with adrenal insuficiency in April 2018 and been informed that this was because of steroid use. I beleive that the treatement plan of steroid use was not managed properly and she has been given two courses of prednisolone in a very short space of time. In addition we have not been informed of the possible consequences of using prednisolone and that this could lead to adrenal insuficiency. We have been informed that this condition can be revearsed within 6 month but it's been 1 year and 5 months since she's having Adrenal insufiency. I'm worried that this could be a lifelong and lifetreatening condition and i feel that this could have been avoided with a better and more consistent apprach.***

Still ongoing at time of report – due date to be responded to 23 October 2019

- ***Our Son, X has now been on haemo dialysis for just over two months and during this time the dialysis unit has been unable to provide his dialysis on 3 separate occasions. As you can understand as a parent you just want the best for your son and this is of the foremost concern for us that he isn't receiving the care that he needs. Currently we feel that as this has reoccurred on too many occasions we now would like to see further action on a resolution to this issue.***

  ***We would you to outline the following***

  ***1. As has been discussed currently the staff at AlderHey are not able to guarantee that this will not occur again and therefore we want some reassurance of***
  ***a) what can happen in the short term as a back up for if this does occur.***
  ***b) what the plan is for the longer term with regards the safeguarding reliability of the water plant.***

  ***2. With regard to X our concern is that as he has another form of dialysis that can be used then he will not get the haemo dialysis in these situations. This would not be an issue if it occurred on the odd occasion however the cumulative affect will have an issue on the levels of oxalate in his body which is of most concern to us. This is especially the case if the plant breaks on a Monday when he has already had one day without clearance as then it can***

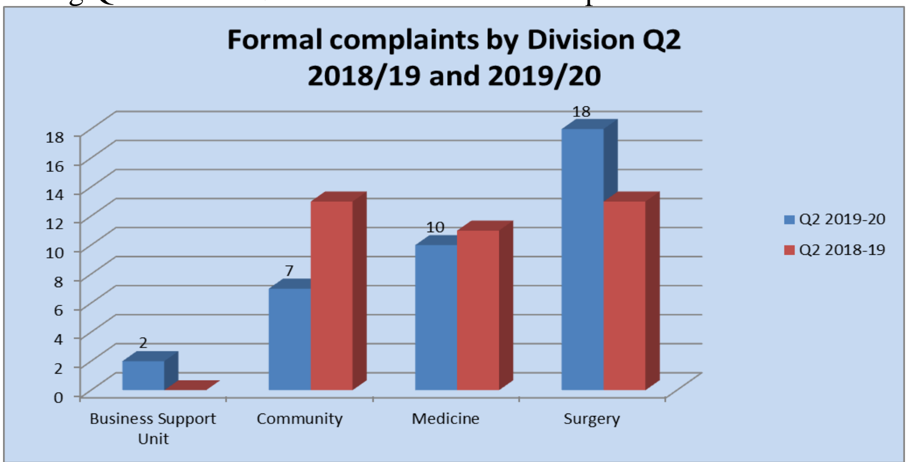
***build up to a higher level and is more likely to deposit in his body.***

***We also want to highlight that despite these issues we have received excellence care from the renal team at AlderHey and understand these issues can be frustrating for them as they strive provide the best care possible for X.***
***We just want to make sure that even if the the plant has a period of working well that you maintain the priority of any initiatives that are focused on seeking a solution for the long term.***

Letter drafted and shared with Chief Nurse 7 October for first quality check. Date due out 24 September 2019 – breached.

**Complaints by Division in Quarter 2**

The following graph demonstrates the amount of complaints received within each Division during Quarter 2 2019 – 20 and includes a comparison from the same time period in 2018/19.

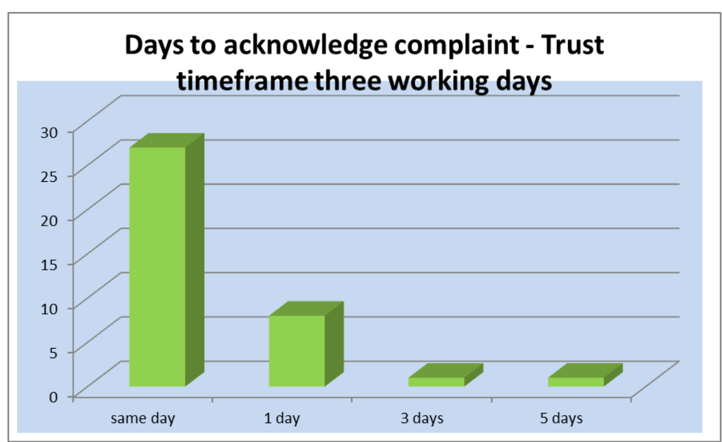



**Report against three day acknowledgement**

The Trust has three working days to formally acknowledge a complaint; this can be in an email or by phone. The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including the direct phone number) and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwwatch Advocacy.

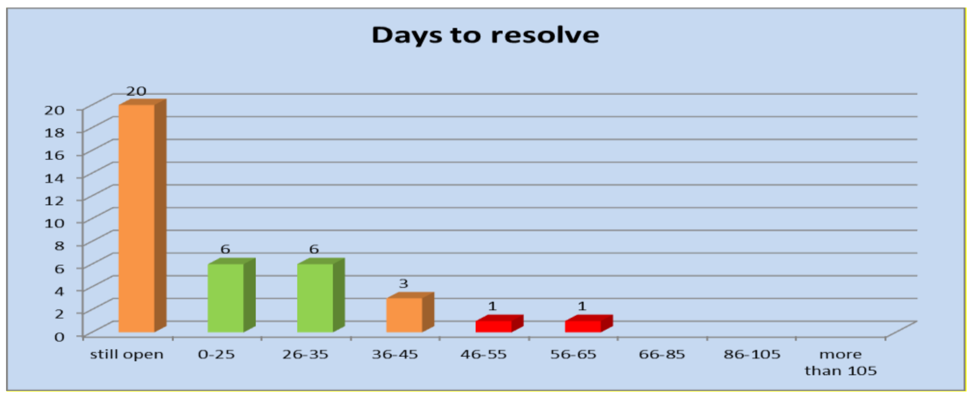
In Q2 36 out of 37 complaints were acknowledged within 3 days - 73% on the same day. The one complaint that took 5 days was sent directly to the Service Manager and was not shared with the complaints team until day 5. Information regarding what to do if a staff member receives a complaints directly is included in the policy and the training delivered to staff for managing complaints.

Alder Hey Children's NHS Foundation Trust




The Trusts internal timeframe for responding to complaints is 25 working days, however if the complaint is complex and multi organisational we can discuss this with the complainant and negotiate an extended timeframe with them and agree a new date for response.

The graph below now shows the timeframes the Trust has responded to a formal complaint within Q2 .




**Withdrawn complaints**
One complaint from this quarter was subsequently withdrawn from the process, it was agreed during the process that the CCG would lead this compliant and we provided information required to contribute to it.

**Complaint outcome**

8 complaints where upheld within this quarter,3 where not upheld and 4 where partially upheld. 19 complaints are still ongoing and one was withdrawn.

All complainants are fully up dated regarding any delays in response timeframes.

**Referrals to Parliamentary & Health Service Ombudsman**

One case from quarter 2 2018/19 advised investigating. PHSO coming in on 11 and 12 November 2019 to interview 7 staff members regarding this case. All documents/ evidence submitted as requested .

One complaint from Q4 2018 (Medicine) – received information from PHSO assessing to investigate. Advised on 11 June planning on investigating formally. All records submitted as requested

One complaint from Q3 2018 (Medicine) – received email from PHSO, advising they felt local resolution still possible. Mum did not wish to engage any further, requested her MP to raise her concerns. Responded to MP and suggested a few options for progress Mums outstanding concerns. No further contact received.

**Out of Time complaints (OOT)**

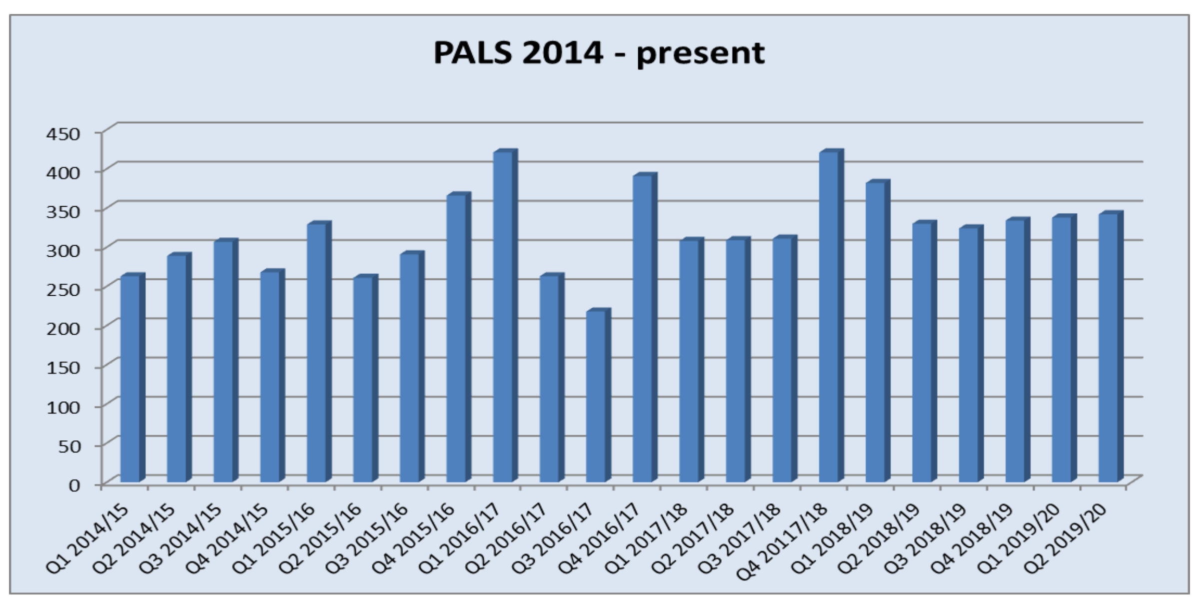
There are no out of time complaints in Q2.

**PALS summary**

In Q2 2019 -2020 PALS contacts received total 342, in comparison to the same quarter in 2018/19 this is a very slight increase of 11.

PALS concerns are received in a variety of methods, phone call, email, written and face: face. Phone calls and face: face account for 56% of the contacts whilst the written concerns account for 44%

**Fig 3**- PALS contacts from 2014/15 – Q2 2019/20. The table shows a continuing trend of circa 330 contacts per month.



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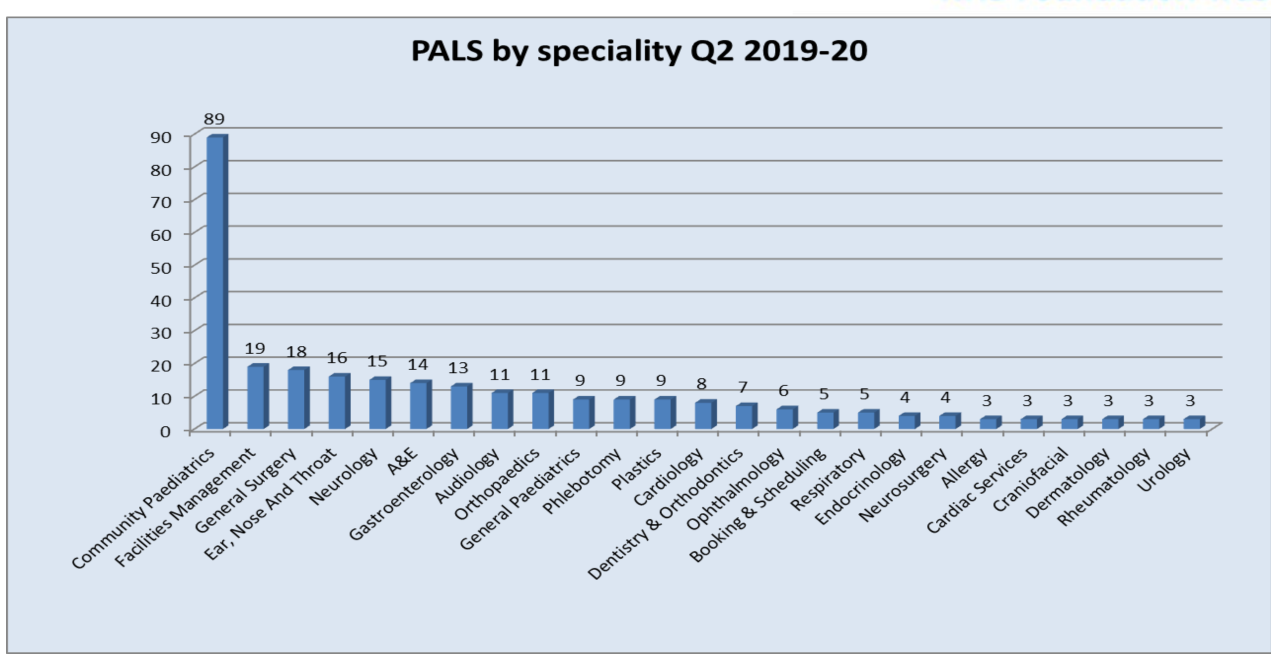
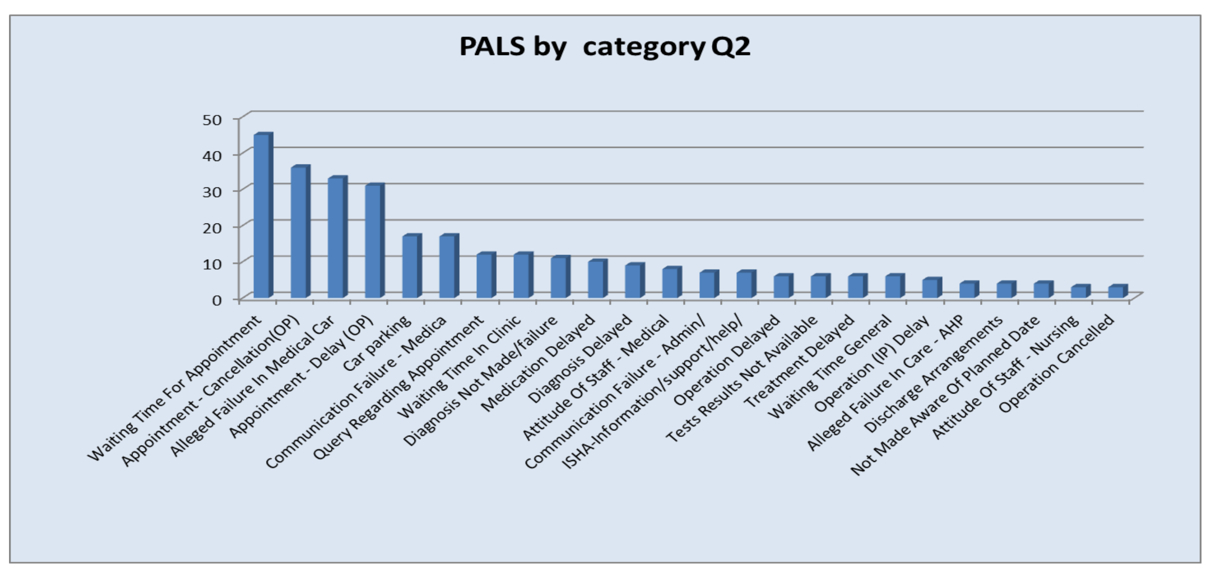



The table above clearly demonstrates the amount of PALS contacts received by specialities - Community Paediatrics remains the highest area. Unusually Facilities management is the second highest area that have received concerns raised – 17 of these relate to car parking.

The table below shows the categories in more detail:-




Seventeen compliments have been recorded this quarter on Ulysses: -, these have all been shared with the relevant teams and staff.

**Compliment received**
Dad came to office to compliment one of the Kitchen staff- dad mentioned him by the name John - short man with glasses.

Dad's appreciation was the way he deals with his son in a friendly manner and provides with the appropriate gluten free food. Dad also mentioned that John always interacts with son and keeps him involved rather than asking Dad.

**Compliment – email from Mum**

**Email from Mum:**

Morning
I just wanted to give you some feedback on the excellent care my son and our family received on Thursday, my son is unfortunately a regular visitor to alder hay and in the past has had bad experiences at our local hospital which has made him nervous about certain procedures, this week he was due his MRI scan something I had been dreading as last year he refused to even go in the room, this year it was organised for a GA so the drs could get the information they needed , unfortunately my little one doesn't like the mask, treatment rooms or cannulas, I called before the appointment to explain the lady I spoke to was lovely, I explained in the past he's had pre med then he was ok although this is unusual for just an MRI she said she'd see what they could do she called back to say no problem a bed had been organised for him for afterwards to sleep it off, I felt more at ease already.

When we arrived the lady on reception was happy and friendly nattered to Joel we went through to waiting area, all the team we dealt with were great the anaesthetic dr came out and I explained my concerns he was great, calm, listened and explained we could maybe have some help in the future with play therapy which would be great.
When we went in the nurse (Gemma) was lovely asking Joel what his favourite biscuits were for when he woke up she was kind, calm and put us at ease, in the anaesthetic room the lights were dimmed it was calm and I feel Joel was as relaxed as possible he went asleep happy.

When he woke the team were friendly Gemma and the anaesthetist came to check on his, the sister (Lucy?) came from day surgery to take him to recover she was again lovely, made us giggle, Joel said he was disappointed as the magic man (Barrington) wasn't in the hospital so the lovely sister said she knew a magic man she'd see if he'd visit, Joel was made up, on the day surgery ward a recovery nurse called Andy came he was fab did magic tricks to cheer Joel up and his brother who was a bit fed up, 'Big Dave' trick has been told to all our family members.

The whole experience and level of care we received was outstanding your team listened to concerns and dealt with them accordingly through the journey making a potentially difficult visit easy, thankyou so much your team is doing a fantastic job.
Thankyou
Jenny

**Actions /Lessons learned from complaints**

Community Division now record their lessons learned and actions on Ulysses where this can be accessed and monitored.
Examples from Q2 are :-

- **LL SO05752** - Upheld - All meetings with parents / carers regarding a problem should be handled in the same way as a complaint meeting with a recording of the meeting made and someone identified to Chair the meeting.
- Where dual notes are in use, always check paper and electronic notes to ensure the latest information is understood and communicated.

- **LL SO05787** – Not upheld .No learning from complaint - Knowlsey Pathway issue not within our control.

- **Action SO05879** – Partially upheld . Action in place to review the staffing of the Crisis Care Line target date 4/11/19.

A Hyson
**Head of Quality - Corporate Services**
**& Trust Complaints and PALS Lead.**

**END**

# BOARD OF DIRECTORS

**Tuesday 3rd December 2019**

| **Paper Title:** | Infection Prevention Services (IPS) Report |
|---|---|
| **Report of:** | Quarter 2 (1st July – 30th September 2019) |
| **Paper Prepared by:** | Valya Weston (Head of Service/Associate DIPC), Dr Christopher Parry (Consultant Microbiologist and Infection Control Doctor) and Carly Quirk (Data Analyst) |

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

# INFECTION PREVENTION SERVICES (IPS) REPORT 2019-20 Q2 (1st July 2019 – 30th September 2019)

This report provides the Board with the challenges for delivery of the Infection Prevention & Control Work Plan 2019-20.

The work plan for 2019-20 consists of 17 objectives and a total of 215 deliverables. To date ***69%*** (147/215) of the total of deliverables have been completed. ***14%*** (31/215) of the total deliverables are in progress (amber). ***0%*** *(0/215)* is classified as red. ***17%*** (37/215) are classified as grey as these are objectives that cannot yet been progressed. Please see table 1 below for RAG rating.

| Reporting Period | No of objectives | No. of deliverables | Red | Amber | Green | Grey New |
|---|---|---|---|---|---|---|
| Q1 | 17 | 215 | 1% (1) | 15% (33) | 63% (135) | 21% (46) |
| Q2 | 17 | 215 | 0% (0) | 14% (31) | 69% (147) | 17% (37) |

***Table 1: Deliverables RAG rating***

Table 2 below shows the total number of hospital acquired bacteraemia for Q2 2019-20 compared to Q2 2018-19. Table 3 shows the cumulative total for 2 2019-20 compared to the total 2018-19.

| Bacteraemia | Q2 18-19 | Q2 19-20 |
|---|---|---|
| MRSA | 0 | 0 |
| MSSA | 1 | 2 |
| E.coli | 2 | 0 |
| Klebsiella | 1 | 2 |
| Pseudomonas | 0 | 0 |
| Infections | | Infections |
| Cdiff | 0 | 0 |
| Outbreaks | 0 | 0 |

***Table 2: Hospital acquired bacteraemia Q2 2018-19 and 2019-20***

| Bacteraemia | Total 18-19 | Cumulative 19-20 |
|---|---|---|
| MRSA | 0 | 0 |
| MSSA | 10 | 4 |
| E.coli | 7 | 4 |
| Klebsiella | 8 | 4 |
| Pseudomonas | 1 | 1 |
| Infections | | |
| Cdiff | 1 | 0 |
| Outbreaks | 0 | 0 |

***Table 3: Hospital acquired bacteremia Total 2018-19 and Cumulative 2019-20***

For 2019-20 we have agreed target for each of the metrics set out below in table 4 for hospital acquired cases.

| Metric | Target 2019-20 | Target Figure | Actual Figure | Current Status |
|---|---|---|---|---|
| *HA - MRSA (BSI)* | **Zero Tolerance** | ***0*** | ***0*** | ✓ |
| *C.difficile* | **Zero Tolerance** | ***0*** | ***0*** | ✓ |
| *MSSA* | **25% Reduction from 18-19** | ***9*** | ***4*** | ✓ |
| *CLABSI (ICU Only)* | **10% Reduction from 18-19** | ***16*** | ***6*** | ✓ |
| *Gram-Negative BSI* | **10% Reduction from 18-19** | ***14*** | ***9*** | ✓ |
| *RSV* | **25% Reduction from 18-19** | **26** | ***0*** | ✓ |

***Table 4: 2019-20 Targets***

Table 5 below shows 2018-19 total against the target for 2019-20 and actual for 2019-20.

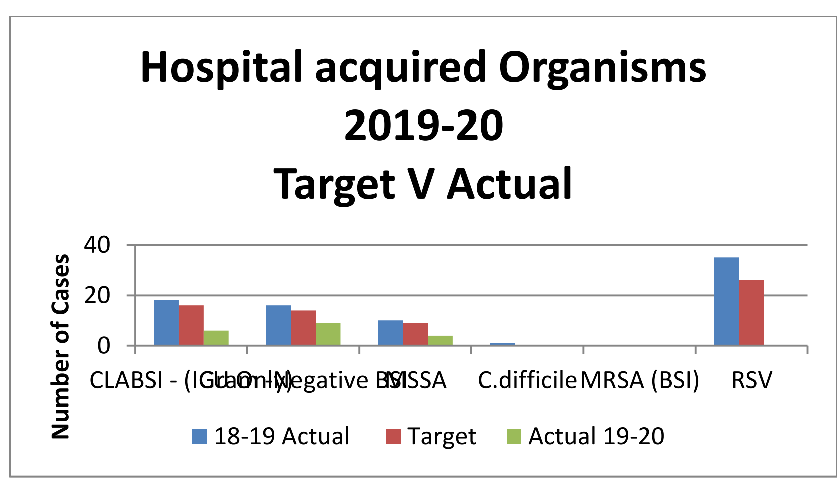
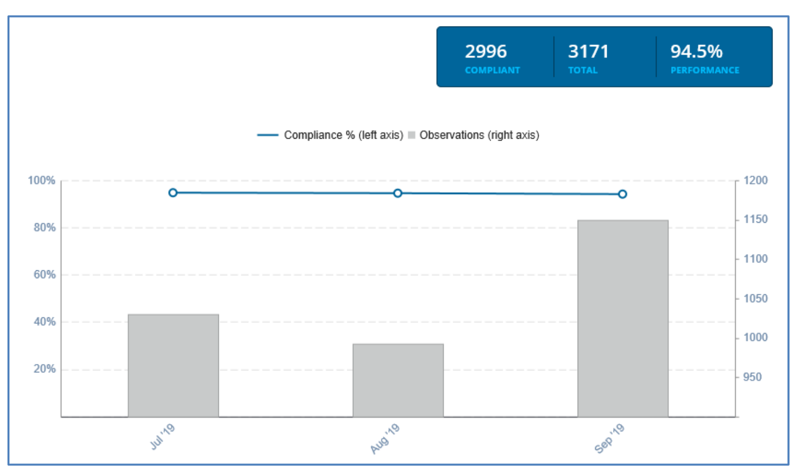



***Table 5: Metric Data Actual VS Target.***

Table 6 shows hand hygiene compliance for Q2 2019-20 across the Trust. 95% compliance out of a total of 3171 opportunities.



## *Additional Activity/Achievements*

### 1. Isolation Policy

The new Isolation policy and revised isolation posters have now been launched.
Launch of the policy has commenced with an educational/communication campaign, this culminated in an IPC event in the atrium for Infection control week beginning on 21st October 2019.
Further work to continue in the development of an isolation app to assist staff in the identification of isolation procedures.

### 2. Bacteraemia Situation Reports

Bacteraemia Situation reports for 2019/20 will be distributed on a monthly basis through the divisional governance structure for analysis and monitoring.

### 3. National Guidance on Norovirus

The Associate Director of Infection Prevention and Control has attended the first meeting of the advisory group of the Hospital Infection Society (HIS) on Norovirus, providing a paediatric perspective.

### 4. Staff Influenza Vaccinations

Commencement of the staff influenza vaccination campaign.
The CCG CQUIN target for this year is 80% of frontline to be vaccinated by end of February. Compliance with this target is being monitored and communicated on a weekly basis. It is managed by the IPC team with a set 70hrs of input from Team Prevent, our Occupational Health provider.

### 5. Cepheid Machine

The new Cepheid machine has been introduced into the laboratory for the rapid detection of CPE in rectal surveillance samples. An SOP has been developed to direct staff in the new process and the CPE policy has been revised.

### 6. Portacount Machine

Agreement has been obtained to purchase a Portacount machine. This machine will enable rapid and effective fit testing of facial masks for staff across the Trust. This will allow the Trust to achieve optimum compliance in fit testing of masks, ensuring that Trust staff are adequately protected from infection with respiratory viruses.

### 7. Community IPC Staff Member

A Business case for an additional member of staff to provide adequate and comparable IPC resource input into the Community Division was approved. Interviews for the post were held and the successful candidate is awaiting a start date.

### 8. Tissue Viability Conference

A successful Tissue Viability Conference was held on the 13th September in the Institute in the Park attended by staff across all divisions within the Trust.

## 9. IPC Paediatric one day conference

The first ever IPC Paediatric one day conference took place in Liverpool as part of the Infection Prevention Society Annual National Conference.

## *Issues for attention of the Board*

### 1. Inadequate Isolation Facilities in ICU and ED.

There are no rooms in the ICU and Emergency department  with adequate ventilation for the isolation of patients with suspected or confirmed airborne transmitted infections and High Consequence Infectious Diseases (HCID).

Potential solutions to address this situation include:

- Construction of a full ventilation system with HEPA filttration for selected rooms in ICU – awaiting feasibility study.
- Installation of isolation pods with HEPA filtered air within identified rooms in ICU and ED (Bioquel).
  **Update since last report Q1:** Discussions continue with Bioquel and 3D plans are being drawn up for approval. These plans will be discussed with a national PHE expert before being presented to the Board for consideration.

Progress on this issue is now being reported through IPCC, as action closed with CQPG.

### 2. Pseudomonas in PICU and other identified augmented areas.

There are continuing issues with *Pseudomonas aeruginosa* contamination in water outlets on PICU and other augmented care areas. This issue is monitored and actioned through the Water Safety Group. Close surveillance and mitigations in place including decontamination of colonised outlets and the use of point of use filters in augmented care areas.  Long term solutions require reaching approved hot and cold temperatures at the outlets.

### 3. *Mycobacterium chimaera* contamination in Cardiac By-pass Heater/Cooler Devices

A *Mycobacterium* spp. was detected in the two heater cooler units used for cardiac by-pass surgery in January 2019. These were identified as *Mycobacterium chimaera* by the TB Reference Laboratory in June 2019 The risk to our patients is considered to be extremely low with only 3threecases of *Mycobacterium chimaera* infection in children following cardiopulmonary bypass identified internationally. New heater cooler units have been in use since January 2019 and enhanced testing since then has not shown any further contamination.

The decision was made, in discussion with PHE, NHS England, NHS Wales and CCG, to undertake a look back exercise, writing to patients who may have in theory been exposed to *M.chimaera* during their surgery. Letters were issued to GPs (23rd October) and patient letters were issued (11th November). A helpline, supported by the cardiac liaison nurses, was established to allow patients and their parents to ask questions and to request for a follow up clinic appointment where needed. To date, 804 letters have been sent to patients and there have been 20 patients referred to clinic. PHE/NHS England/NHS Wales are being kept informed of the progress.

Further actions will be monitored through the Water Safety group and IPCC.

## 4. National High Consequence Infectious Disease (HCID) project:

Alder Hey, in conjunction with the Royal Liverpool University Hospital are part of the national network for managing HCID-*Airborne Infection* patients. Due to the issues with isolation facilities (described above), children with a confirmed diagnosis of a HCID will be transferred to the Royal Isolation Ward but will be cared for by a team of clinical personnel from Alder Hey.
This process requires that our staff (who have volunteered for this work) need to be trained in the donning and doffing of specialized personal protective equipment for the care of these patients and to protect themselves. This training needs to be repeated every six months in order that staff remain proficient in this process.

To date we have fully trained: 4 nurses; 1 respiratory physiotherapist; 6 consultants (2 from PICU, 3 Infectious Disease Consultants and 1 Microbiologist Consultant); and 1 IPC Specialist nurse. We have partially trained 5 other members of staff since April 2019. These are numbers are insufficient to care for these patients. This process needs addressing as a matter of urgency.

## 5. Estates

There have been several business continuity incidents in Q2;

**Wood Lice:**
There was a wood louse infestation within the roof spaces of the Trust culminating in the wood lice being found on the wards and other departments. Although wood lice are not vectors of disease they can indirectly spread infection and are unsightly for patients and carers. This led to considerable disruption within the Trust.

The make-up of the roof means that it is an ideal environment for wood lice to breed. The roof was sprayed several times during the infestation. There needs to be a clear plan for managing this risk in the future.

**Water Ingress:**
There were several water leaks within the Trust, especially in the PICU and HDU areas, which led to bed closures and a need for remedial repairs. Further work is required to ensure that this does not happen again. These issues are being managed by our Estates team.

## 6. Central Line Associated Blood Stream Infections (CLABSI)

Currently CLABSI data is validated and reported per 1000 catheter days from PICU only, ensuring that the data can be benchmarked nationally with other paediatric trusts.

A trust wide group has been developed to address:

- How best to capture data across the whole trust.
- Future working patterns of the vascular access team (a business case is in progress for additional staffing to enable this progress).

Progress via the Intravenous Access and Therapy group:

- Linking with national groups about a vascular access pathway incorporating an IV passport and vessel health and preservation.
- Introduction of new evidence based medical devices/dressings.

This proposed work will be presented at the CQAC meeting in December.

**BOARD OF DIRECTORS**

**3rd December 2019**

| **Paper Title:** | **People Plan Update** |
|---|---|
| **Report of:** | **Human Resources & Organisational Development** |
| **Paper Prepared by:** | **Deputy Director of Human Resources and Organisational Development** |

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

**Introduction**

The purpose of this paper is to provide the Board with a monthly strategic update against the Alder Hey People Plan. More detailed discussions about the delivery of the Operational Plan, which underpins the delivery of the strategic People Plan, take place at the bi-monthly Workforce and Organisational Development Committee.

**Our People Plan Pillars**

## 1. Health & Wellbeing

### 1.1 Time to Change

The Mind 'Time to Change' Pledge was successfully launched during on 23rd October 2019 during 'Fab Staff Week'. During the month of October, 48 managers have been trained in managing Mental health in the workplace, by mental health charity MIND. This training was well received and further training is planned early in 2020.

### 1.2 Pilot of a centralised 'wellbeing team'

The proposal to implement a centralised Wellbeing Team provided in-house by HR, has been approved by Investment Review Group (IRG). The business case supports the implementation of a team for a period of 18 months

It is anticipated that through a dedicated wellbeing team whose focus will be on supporting the coordination and administration of sickness management that we will be able to reduce overall length of sickness and therefore reduce sickness absence to 4% over a 12-18 month period, with the aim of reducing the base line cost of sickness by circa £1m. The Team is currently being recruited to.

## 2. Leadership Development and Talent Development

### 2.1 Strong Foundations

The Strong Foundations Programme has been very well received to date with our first cohort finishing their formal programme on 26th of November. The feedback has been very positive from all three cohorts who have commenced so far and the remaining 7 cohorts are now fully booked until November 2020. The programme continues to evolve based on participant feedback.

### 2.2 Mary Seacole

The Trust was unsuccessful in its bid to the Leadership Academy to host the Mary Seacole Programme on behalf of Cheshire and Merseyside, however was highly commended on our bid and the quality of training we have been delivering.We have been asked to work with the successful bidder, Liverpool Heart and Chest and have secured 15 funded places through this process. Internal delivery remains very positive; Cohort 2 are awaiting their final results; Cohort One achieved a 100% pass rate and Cohort 3 will commence in February 2020.

## 3. Future Workforce Development

### 3.1 Apprenticeships

There are currently 86 learners in the Trust registered as apprentices, 11 of which have been employed with us directly as apprentices. Discussions have taken place with City of Liverpool College to explore potential partnership opportunities.

### 3.2 Response to the Lampard Review

The Trust has commenced the implementation of the 3 yearly Disclosure and Barring Checks across the organisation in response to the recommendations from the Lampard review; 525 new checks have been undertaken since starting the project and to date, there have been no issues that have arisen in relation to these checks.

## 4. Equality, Diversity and Inclusion

### 4.1 Cheshire and Merseyside Collaborative model

Cheshire and Merseyside HRD's received a presentation from the Regional Equality, Diversity and Inclusion (EDI) Lead in October 2019 proposing a collaborative model for EDI support and delivery; we have supported this proposal in principle as this will support our Trust with a better standard of strategic expertise and input.

### 4.2 Staff Network development and support

The Staff Networks were a major focus of 'Staff Fab Week', with a new Chair appointed for the Disability Network, who we are looking forward to working with and developing plans for improvement.

## 5. The Academy

### 5.2 National Children's Hospital Educational Specialist Symposium (CHESS)

The Institute will play host to the 2nd annual national Children's Hospital Educational Specialist Symposium (CHESS) in March 2020, a high profile educational event aimed at all those involved in education. We will be hosting attendees from children's healthcare providers across the country, so is a great opportunity to showcase Alder Hey.

## 6. Compassionate and Learning Culture

### 6.1 Staff Survey

The Staff Survey is due to close on the 29th of November, and as at 26th November 2019 the response rate is 59%, with 3 days to go until the closing date. Over 2000 staff have returned their completed surveys. The communications campaign is based upon the theme of 'Your Alder Hey, Your Voice' and a concerted effort is being made by HR & OD, Communications and management teams to encourage all staff to complete their surveys by deploying a range of incentives, conversations and activities all designed to encourage more staff to get involved. Our target for this year is 65%.

### 6.2 Temperature Check

A revised version of the staff Temperature Check, a quarterly staff survey, ran in Q1 and Q2. The Workforce and OD Committee received a presentation of the overall findings from Q1 and Q2 (attached), and discussed the next steps and feedback. Divisions have also received local feedback from these surveys in order to discuss and share with their teams. The Temperature Check will be a quarterly agenda on the Board going forward.

### 6.3 Workforce KPI's – October 2019

- Sickness rates for October 2019 showed an increase in month to 5.7%, mainly attributable to an increase in short-term sickness absence.
- Overall mandatory training compliance remains above the Trust target of 90% at 91.3 %. A project is underway to review mandatory training across the Trust, aiming to improve access and quality of training.
- 89.3% of PDR's have been completed across the organisation since April 2019, only just below the Trust target of 90%. Medical appraisals remain above target at 95%. In 2019, with the aim of improving quality, we trained over 150 managers in how to have a meaningful PDR with their staff.
- Turnover has increased slightly to 10.1% this month.

**Employee Relations Activity**

### 6.3.1 Organisational Change

There are currently two Organisational Change processes which were taking place within Portering Services and the Quality and Governance service and which have now concluded (subject to appeal periods – early to mid-December 2019) These have been carried out with full Trade Union consultation and employee involvement.

### 6.3.2 Employment Tribunal Activity

There is currently one case lodged with the Employment Tribunal relating to alleged breaches of Agency Worker Regulations. Preparation for this case is underway. The case lodged with regards to alleged whistleblowing will no longer be considered by the Employment Tribunal.

### 6.3.3 Summary of Employment Relations Activity – October 2019

| Division | B&H | Investigation | Disciplinary | Grievance | Total |
|---|---|---|---|---|---|
| **Surgery** | 2 | 2 | 0 | 3 | 7 |
| **Medicine** | 0 | 1 | 0 | 2 | 3 |
| **Community** | 0 | 0 | 2 | 0 | 2 |
| **Corporate** | 0 | 2 | 0 | 0 | 2 |
| **Total** | **2** | **5** | **2** | **4** | **14** |

# Staff Temperature Check: Q1&Q2 (April-Sept 2019)

Jo Potier & Darren Shaw

INSPIRING QUALITY

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# Response rates

July-Sept = 532 (47%)

Apr-June = 404 (37%)

Jan-Mar = 199

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| Staff Engagement | Staff Survey 2018 | Temperature Check (Q1) | Temperature Check (Q2) |
|---|---|---|---|
| I look forward to going to work | 58% | 77% | 68% |
| I am enthusiastic about my job | 77% | 86% | 85% |
| Time passes quickly when I am working | 76% | 84% | 84% |
| There are frequent opportunities for me to show initiative in my role | 76% | 77% | 73% |
| I am able to make suggestions to improve the work of my team / department | 76% | 82% | 76% |
| I am able to make improvements happen in my area of work | 57% | 66% | 65% |
| Care of patients / service users is my organisation's top priority | 86% | 92% | 92% |
| I would recommend my organisation as a place to work | 72% | 73% | 74% |
| If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation | 89% | 90% | 93% |
| | | | |
| Psychological Safety Culture | Temperature Check (Q1) | Temperature Check (Q2) | |
| When someone makes a mistake in this team, it is often held against him or her | **64%** | **64%** | |
| In this team, it is easy to discuss difficult issues and problems | **66%** | **65%** | |
| In this team, people are sometimes rejected for being different | 78% | 74% | |
| It is completely safe to speak up and suggest new ideas in this team | 71% | 71% | |
| It is difficult to ask other members of this team for help | 80% | 79% | |
| Members of this team value and respect each other's contributions | 74% | 71% | |

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# Analysis by Division: Q1&Q2 average

| Staff Engagement | Trust Overall | Corporate Services | Community | Medicine | Surgery | Research |
|---|---|---|---|---|---|---|
| I look forward to going to work | 73% | 72% | 67% | 72% | 67% | 85% |
| I am enthusiastic about my job | 86% | 86% | 87% | 84% | 87% | 89% |
| Time passes quickly when I am working | 84% | 87% | 84% | 87% | 80% | 78% |
| There are frequent opportunities for me to show initiative in my role | 75% | 78% | 76% | 76% | 71% | 86% |
| I am able to make suggestions to improve the work of my team / department | 79% | 82% | 82% | 79% | 77% | 85% |
| I am able to make improvements happen in my area of work | 66% | 74% | 67% | 61% | 66% | 59% |
| Care of patients / service users is my organisation's top priority | 92% | 94% | 90% | 94% | 91% | 100% |
| I would recommend my organisation as a place to work | 74% | 77% | 73% | 77% | 70% | 74% |
| If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation | 92% | 95% | 85% | 94% | 94% | 97% |

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| Psychological Safety Culture | | Corporate Services | Community | Medicine | Surgery | Research |
|---|---|---|---|---|---|---|
| When someone makes a mistake in this team, it is often held against him or her | 64% | 64% | 65% | 67% | 61% | 63% |
| In this team, it is easy to discuss difficult issues and problems | 66% | 70% | 66% | 66% | 62% | 56% |
| In this team, people are sometimes rejected for being different | 76% | 79% | 78% | 78% | 71% | 63% |
| It is completely safe to speak up and suggest new ideas in this team | 71% | 81% | 72% | 72% | 65% | 70% |
| It is difficult to ask other members of this team for help | 80% | 76% | 86% | 82% | 75% | 86% |
| Members of this team value and respect each other's contributions | 73% | 78% | 75% | 74% | 68% | 82% |

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# Key issues

- Quality improvement & ability to make changes
- Just & fair culture
- Speaking up & listening up
- Overall more positive than annual Staff Survey but broadly consistent

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# Using the data

- Reflecting back to staff throughout the year about how it feels to work here
- To target OD interventions (triangulated with other data) – proactive & early intervention
- As one measure of the impact of elements of the People Plan
- To feedback to Divisions to increase their awareness of the organisational culture in their areas
- To keep asking – “are we asking the right questions?”
- Consider adding FTSU Index questions next year

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NHS Foundation Trust

# New questions?

The Staff Survey questions used to make up the FTSU Index are:

- % of staff responded "agreeing" or "strongly agreeing" that their organisation treats staff who are involved in an error, near miss or incident fairly (question 17a)
- % of staff responded "agreeing" or "strongly agreeing" that their organisation encourages them to report errors, near misses or incidents (question 17b)
- % of staff responded "agreeing" or "strongly agreeing" that if they were concerned about unsafe clinical practice, they would know how to report it (question 18a)
- % of staff responded "agreeing" or "strongly agreeing" that they would feel secure raising concerns about unsafe clinical practice (question 18b)

*Inspired by Children*

# BOARD OF DIRECTORS

**Tuesday 3rd December 2019**

| | |
|---|---|
| **Paper Title:** | **Workforce & OD Committee Assurance Report** |
| **Date of meeting:** | 13th November 2019 – Summary<br>19th September 2019 – Approved Minutes |
| **Report of:** | Claire Dove, Committee Chair |
| **Paper Prepared by:** | Jackie Friday, WOD Committee Administrator |

| | | |
|---|---|---|
| **Purpose of Paper:** | Decision<br>Assurance<br>Information<br>Regulation | ☐<br>■<br>☐<br>☐ |
| **Summary and/or supporting information:** | This paper provides a summary from the recent Workforce & OD Committee Assurance Committee meeting 13th November 2019 along with the approved minutes from the 19th September 2019 meeting. | |
| **Action/Decision Required:** | To note<br>To approve | ■<br>☐ |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care**<br>**The best people** doing their best work<br>Sustainability through **external partnerships**<br>Game-changing **research and innovation** | ☐<br>■<br>☐<br>☐ |
| **Resource Impact:** | None | |
| **Associated risk (s)** | BAF 1.1 – Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations – current risk IxL: 3x3<br>BAF 2.1 – Workforce Sustainability – current risk IxL: 3x3 | |

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

1. **Introduction**

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

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

2. **Agenda items received, discussed / approved at the meeting)**
   - Mandatory Training
   - Staff Survey Update
   - Apprenticeship Plan
   - HEE visit Update
   - QHQ2 Temperature Check
   - Business case to support the introduction of a wellbeing team - sickness absence management
   - Non AfC Pay Report

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   - Managing Staff Sickness/winter problems – issue for financial spend performance

4. **Positive highlights of note**
   - Re-introduction of Temperature Check

5. **Issues for other committees**
   - RABD – sickness levels
   - CQAC – outcomes for the Junior Doctors HEE visit

6. **Recommendations**

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

Alder Hey Children's NHS
NHS Foundation Trust

**ANNEX A**

**WORKFORCE & OD COMMITTEE**
**MINUTES FROM MEETING**
**19th September 2019**

DRAFT

| | | | |
|---|---|---|---|
| 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) |
| | Mr I Quinlan | Non-Executive Director | (IQ) |
| In Attendance: | Mrs P Brown | Director of Nursing | (PB) |
| | Mrs K Turner | Trust LiA Lead | (KT) |
| | Mr A Bateman | Chief Operating Officer | (AB) |
| | Mrs G Thomas | Apprenticeship Delivery Manager | (GT) |
| | Mrs S Owen | Deputy Director of HR&OD | (SO) |
| | Mrs N Murdock | Medical Director | (NM) |
| | Ms H Ainsworth | E&D Lead | (HA) |
| | Ms A Chew | Associate Finance Director | (AC) |
| | Mrs J Potier | Associate Director of OD | (JP) |
| | Ms E White | Care Pathways, Policies & Guidance | (EW) |
| | Ms S Marshall | HR Manager | (SM) |
| | Ms Z Connor | HR Business Partner | (ZC) |
| | Ms V Hughes | Head of Nurse Education & Support Worker Dev | (VH) |
| Apologies: | Mrs D Brannigan | Patient Governor (Parent & Carer) | (DB) |
| | Mr T Johnson | Staff Side Chair | (TJ) |
| | Mrs H Gwilliams | Chief Nurse | (HG) |
| | Mr C Duncan | Director of Surgery Division | (CD) |
| | Mr A Hughes | Director of Medical Division | (AJ) |
| | Ms L Cooper | Director of Children & Young People - CAMHS | (LC) |

| Agenda Item | Key Discussion Points | Action | Owner | Timescale |
|---|---|---|---|---|
| **19/65**<br>**Minutes of the Previous Meeting & Meeting Protocol** | The Committee considered the minutes of the meeting held on 26th June2019 and they were approved as an accurate record. Introductions were made to the Committee. | | | |
| **19/66**<br>**Matters Arising, Actions** | **The Committee considered the following under matters arising:**<br><br>**17/21 Programme Assurance**<br>MKS confirmed that DMO support is in place for this ongoing action. | | | |

| Agenda Item | Key Discussion Points | Action | Owner | Timescale |
|---|---|---|---|---|
| | **19/35 Apprenticeship**<br>*Apprenticeships – Produce a plan to develop how we move forward with apprenticeship/workforce. Noted on 26/06/2019 this item deferred until September 2019.* – MKS advised that the plan has been deferred until October and informed the Committee that the application to be re-entered to register is being progressed. The NCFA assurance rating of “excellent”. | Apprenticeship Plan to be brought to next meeting | GT | November |
| | **19/52 E-Rostering**<br>Put in place project support and financial support. This action is noted as **complete**. | | | |
| | **19/63 Virtual ratification/approval of policies & EA**<br>• *Medical staff covering absent colleagues and vacancies, including stepping down arrangements policy & EA*<br>• *Consultant and SAS doctor job planning policy & EA*<br>The Committee acknowledged that the above policies were virtually ratified by the CD and IQ. This action is noted as **complete.** | | | |
| **19/67**<br>**Programme Assurance ‘The Best People Doing Their Work’** | **Programme Assurance Framework – August 2019**<br>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.<br><br>In the absence of the Programme Assessor the Committee **noted** the content of the report. | | | |
| **19/68**<br>**Progress Against the People Strategy** | **WRES & WDES reporting templates**<br>WRES - Number new initiatives within last year, increase around question 22 & 24. Belief of being discrimination against; initiatives are contained within Action Plan. Chair asked that if people have formal complaints need to follow proper process, following Staff Survey need to advise all BAME staff that there is a process to support them. Suggestion of Network to give more engagement.<br><br>To be worked up outside meeting, bring back with more depth with clear message that staff who wish to raise concerns can do so safely with no punitive outcome. WDES – key areas are diversity, actual 3% disabled, staff survey 17%. More issue around B&H within WDES, much higher disabled than non-disabled, reasonable adjustments guidance is being developed.<br><br>MKS noted currently no chair of BME network, to be driven through Fab Staff week in February & also through whole of October. | Action Plan WRES & Action Plan WDES approval sought along with reporting templates – to be amended following discussions | KT & HA | October 2019 |

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| Agenda Item | Key Discussion Points | Action | Owner | Timescale |
|---|---|---|---|---|
| | The Committee **approved** the action plans for WRES & WDES subject to caveat of required updates. | | | |
| **19/69** | **Nurse Associates Recruitment**<br>***Chair declared her interest with Blackburne House as a partner organisation for training & development***<br>Associated Nurse Practitioner (ANP) is a new role created nationally, AH very forward thinking & trailblazer with a pilot to refine the process of developing the roles. Looking at both the fit & benefits, but struggling to meet target numbers and there is a need to adjust to accommodate differing needs.<br><br>Current Band 2 & 3 work force not all qualified to apply (needing GCSE English & Maths); there is some knowledge gaps as to how role fits into current structures. Recent recruitment very limited, 15 applicants, 2 shortlisted 1 recruited. Need to support these staff to develop with key skills training. Essentially previously an Enrolled Nurse role: NM suggested targeting local schools to promote role & education level needed. Chair suggested support for key skills training. Cannot currently offer key skills to non-staff but local Unis are now looking to start course for direct entry as a foundation level degree. Trying to upskill existing staff & offer development opportunities. MKS asked where the role fits within overall nurses strategy? Band 3, within a cohort of Assoc. Practitioners, not sure what role / where fitting / how many, not visible within paper. Some clarity is needed – do we grow our own staff, take from external, start grassroots? PB looking to have Nurse Assoc. on each shift on each ward. CD noted that if trying to develop workforce but only way can do a L2 course is by being apprentice, then this needs to be looked at. SO noted that Blackburne House can take anyone put forward but take-up has been minimal. MKS noted that this paper raises more questions than answers – need to have a framework around when to upskill, managerial support & awareness of opportunities. MKS need to find wider way to help mitigate issues & develop wider plan to encompass within whole strategy. NM attending event w/c 23/09 for Associate roles & has offer from speaker to come to AH & speak at future WOD. To be revisited and brought back to WOD with a wider strategy.<br><br>The Committee **noted** the progress made. | Detailed paper to be brought back | VH | TBC |
| **19/70** | **People Strategy**<br>High level & concise, will be supported by an Action Plan to sit below. Comms to be asked to give more Corporate look & feel. AB well received at Execs, slight changes in framing as to why feel compelled to implement at this time for NHS & AH, new roles there to support people & deal with demand within NHS, technology to be used to support rather than replace. NM looking at bringing different ways of working to AH, visit to Boston Children's Hospital re Physician associates etc. MF excellent way | | | |

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| Agenda Item | Key Discussion Points | Action | Owner | Timescale |
|---|---|---|---|---|
| | to support staff.<br><br>The Committee **approved** the People Strategy | | | |
| **19/71** | **Marketing & Comms**<br>Town hall events to be quarterly; common phraseology to be developed with Charity; Comms Calendar to be brought to Nov Board & annually thereafter. Will cover AGM, Staff Awards, Annual Report, campaigns, across year, linking to Plan & theme to Plan areas. Chair noted that this was a good idea; MF noted that this increases visiblility that changes are happening. Using the instant questioning app was well received, need something regularly to harness Execs & NEDs, need to target Band 7 & below to be more present & less managerial staff presence. PB noted big question is how we communicate? Need to get messages out, relate to what people want, staff on ground & determine how they want them. MKS noted Temperature Check is restarting in newer format, MF & MKS to discuss in detail. JP noted email to give feedback – will all questions be answered? MF Tuesday was about Plan, not more specific questions but those will be responded to in more appropriate manner.<br><br>The Committee **noted** the progress made. | Discuss Temperature Check in more detail | MF/MKS | |
| **19/72** | **Staff Survey plan**<br>SO noted developing comms strategy, looking for at least 60% again this year, aiming for 65% returned. Big conversations been had across divisions, Lot of points raised previously actions now in situ, training initiatives have been set-up etc. Chair noted such a good parameter to see where we are as an organisation. MKS feels bigger challenge this year than last, sense of pulling together last year following events, noted that CEO keen to have sensitive comms for this, good story to tell around actions taken, needs also to be local & team level, need to think of language, messages to make this a good well-thought out opportunity. MF need to create sense of AH community around this, to give people a voice & to allow them to see things are being acted upon. KT LIA now become embedded and moved on through HR & other groups, still a lot of emails coming through but entwined with FTSU work with JP. Using Big Conversation element of LIA piece to develop with IT. PB noted LIA big piece of engagement still part of PDR programme. Chair noted lot of visitors to Board to share experiences & how they have made changes using LIA. KT LIS starting to become BAU, staff-side group growing & developing. Chair asked re staff stories, AB noted next Board will be Staff Story on Ortho, NM noted clinical cabinet will soon be up & running, Chair noted staff stories valuable at Board to be seen to be listening and for Board to hear staff stories. NM noted in other organisations had regular newsletters, well read & discussed.. | Training on Policy for Conflict Resolution to be picked up outside | PB | |

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| Agenda Item | Key Discussion Points | Action | Owner | Timescale |
|---|---|---|---|---|
| | The Committee **noted** the progress made. | | | |
| **19/73** | **Mandatory Training**<br>Over 91%, slightly lower on IPC, Moving & Handling & IG. CQC will also look at those against staff groups, M&D leads are pushing alongside Estates & Ancillary groups. Sepsis SME working with LDT team to develop this. Chair asked what is national benchmark – MKS noted AH set their own as 90% with IG training set as 95% as set by national IG Compliance Toolkit. Critical implications of missing that is to fail toolkit plus other wide-reaching risks including financial, governance, research funding & CQC visibility risks. MKS noted CQC PIR pre-inspection communication has been received with requirement to submit data by 4th October and expectation of full inspection within 6 months of that date. Have to be ready, great opportunity but still work to do with absolutely renewed focus on getting this area fully compliant. Well-Led inspection is notified, but Core Services has no notice, AB noted suggestion for Well-Led is 21 weeks from date of PIR submission.<br><br>The Committee **noted** the progress made. | To be standard item along with CQC (JF) | MKS / JF | |
| **19/74** | **HEE Inspection**<br>Annual visit from HEE as teaching hospital / undergrad & postgrad host. Last visit identified a number of areas for development, working group working on action plan & next visit due 3rd October. MKS noted some mitigation in ENT views on GMC survey. Outcome overall quite positive, GMC will attend HEE meeting & with all work AH has put in, team are hopeful that improvements will be recognised. Action Plan addressing issues, NM noted was hoping to have new Junior Doctors Mess ready for visit (HB noted work will have commenced before visit). HB to arrange time to prep LS & MKS prior to visit, worst case scenario is no more junior doctors will be sent to AH.<br><br>The Committee **noted** the content. | LS & MKS to be prepped prior to HEE visit | HB | |
| **19/75** | **Learning Lessons to Improve our People Practices**<br>Undertook self-assessment, took to Board in July, Policy underway & working towards making live in November. Currently with Staff Side for their views. Training from solicitors for HR training to take place October, followed by thorough specific training for managers. Self-Assessment showed some areas need improvement but not far off baseline. PB really welcomed this, events in past for staff members, support anything that expedites a quicker resolution for staff. All are in agreement, just needs fine tuning.<br><br>The Committee **support** the approach in the action plan. | | | |

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| Agenda Item | Key Discussion Points | Action | Owner | Timescale |
|---|---|---|---|---|
| **19/76** | **Pay report**<br>Paper produced annually, number of staff not on AFC with increments etc. Two things for consideration:<br>1. Trust Staff not yet assimilated to AFC, options listed in paper for<br>2. Spot salary - challenge has been raised, for further discussion<br><br>The Committee **approved** the preferred option 1. | | | |
| **19/77** | **Sickness Absence**<br>April 2019 sickness figure of 4% target, currently just over 5%. Each year follows same pattern with same main reasons. Short term / long term split also in line with previous years. H&WB Improvement Plan in place for over 12 months, H&WB Agenda – massive remit & needs to be owned across whole organisation not just HR. Not correlating to improvements in sickness figures. Time To Change pledge new initiative. Chair noted cost of this is massive impact to organisation. MKS noted £1m CIP saving against pay, but £0.5m equates to 1% reduction in sickness figures. Looking for Invest to Save model. Chair noted must be a plan to invest & see visible results with ongoing reduction & saving. So noted need something very different, need to have fundamental improvements, management frustration with time taken by administering an absence. KT noted need to give managers time & support to deal with, staff need to be supported to help them back. AC noted about to put bid in for E-Roster system which should free-up manager time & give more granular detail. NM noted E-Roster will in time save time but initially will take time from staff. Also suggested maybe a timeframe for a cut-off to switch from management managed to HR managed. Chair noted need to change something, massive cost to organisation which not sustainable, to bring back to future meeting to give visibility & to see improvements. AB noted seen action to provide a support service to help staff to get back to work, also need to tackle Work-Poor, being paid weekly tied into positive behaviours & attendance for lower bands.<br><br>The Committee **noted** the content. | Plan to manage sickness to be brought to future meeting | SO | |
| **19/78**<br>**Key Workforce Risks – Review Of top Workforce Risks action planning against most significant risks** | **BAF Assurance Framework – August 2019**<br>The Committee received a regular (BAF) report under the Strategic Objective 'The Best People Doing Their Best Work'. The report is noted as read.<br><br>The Committee **noted** the content of the report. | | | |
| **19/79** | **KPIs**<br>Key points sickness (already covered); time to hire has increased; PDR position has increased. PB noted some of Bank figures will not all be Nursing, a lot of scrutiny within Nursing.<br><br>The Committee **noted** the content of the report. | | | |

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| Agenda Item | Key Discussion Points | Action | Owner | Timescale |
|---|---|---|---|---|
| **19/80** | **Workforce Risk Report**<br>Action from Integrated Governance Committee – to be brought to next meeting (higher up agenda).<br><br>The Committee **noted** the content of the report. | To be brought to next meeting | SO | |
| **19/81**<br>**Legislation, terms & conditions, employment policie4s/EIAs – review & ratification/approval.** | **Policies –** question re removed from agenda to be discussed outside. | | | |
| **19/82 Board Assurance** | The Board Assurance Summary was discussed and completed for submission to the next Trust Board in October. | | | |
| **19/83 AOB** | None. | | | |
| **Date of Next Meeting** | **Rescheduled to Wednesday 13th November 2019, 9am-11am, VEC Meeting Room, Innovation Dept.** | | | |

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**Action List**

| Minute Reference | Action | Who | When | Status |
|---|---|---|---|---|
| | | | | |
| **Meeting Protocol** | | | | |
| | **Modern Slavery** | | | |
| 19/51 | Liaise with Head of Procurement to progress processes. | **CD** | **TBC** | |
| **Programme Assurance 'Developing Our Workforce'** | | | | |
| | **Programme Assurance/progress update** | | | |
| 17/21 | • Feedback on outcomes of Change Programme Framework<br>• Noted on 19/09/2019 that DMO support is in place for this ongoing action. | ND<br>MKS | | Ongoing<br>Ongoing |
| 19/35 | Apprenticeships – Produce a plan to develop how we move forward with apprenticeship/workforce. Noted on 26/06/2019 this item deferred until September 2019. Noted on 19/09/2019 this item has been deferred. | MKS/GT | November 2019 | |
| 19/52 | E-Rostering – Put in place project support and financial support. | MKS/SO/POC | September 2019 | Complete |
| **People Strategy Overview & Progress Against Strategic Aims** | | | | |
| | **Engagement** | | | |
| 15/08<br>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<br><br>19/68 | • Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months<br>• Equality Metrics Report to be brought back to next Committee<br>• WRES/WDES Updated Plan | HA<br><br>HA/SM<br>HA | 1/4ly Update<br>6 monthly Review | Ongoing<br><br>Ongoing |
| | **Education Governance Update** | | | |
| 18/38 | • To be a regular item on the Committee Agenda. | HB | May 2019 | Ongoing |
| | **Nurse Associate Recruitment** | | | |
| 19/69 | Develop a wider plan | Vikki Hughes | December 2019 | |
| | **Marketing & Communication** | | | |
| 19/71 | Discuss temperature check in more detail | MF & MKS | November 2019 | |
| | **Mandatory Training & CQC** | | | |
| 19/73 | To be standard agenda items going forward | MKS/JF | October 2019 | Ongoing |

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|---|---|---|---|---|
| | **HEE Inspection** | | | |
| 19/74 | Prep LS & MKS prior to HEE visit | HB | | |
| | **Sickness Absence** | | | |
| 19/77 | Action Plan to manage sickness to be brought to a future meeting. | SO | December | |
| **Key Workforce Risks** | | | | |
| **19/61**<br><br>**19/80** | • Update the narrative on key workforce risks<br>• Produce an updated leavers flowchart<br>• Action from Integrated Governance Committee to be brought to next meeting | SO<br>SO/MKS<br>SO | September 2019<br>September 2019<br>October 2019 | |
| **Legislation, terms & conditions, employment policies/EA's review & ratification/approval** | | | | |
| **19/63** | Virtual ratification/approval of policies & EA<br>• Medical staff covering absent colleagues and vacancies, including stepping down arrangements policy & EA<br>• Consultant and SAS doctor job planning policy & EA | CD/IQ | September 2019 | Complete |

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# BOARD OF DIRECTORS

**Tuesday 3rd December 2019**

| | |
|---|---|
| **Paper Title:** | **Fit and Proper Persons Requirement** |
| **Report of:** | Trust Chair |
| **Paper Prepared by:** | Director of Corporate Affairs<br>Director of HR & OD |

| | | |
|---|---|---|
| **Purpose of Paper:** | Decision<br>Assurance<br>Information<br>Regulation | ☐<br>■<br>☐<br>☐ |
| **Background Papers and/or supporting information:** | CQC Regulation 5 and supporting guidance | |
| **Action/Decision Required:** | To note<br>To approve | ■<br>☐ |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care**<br>**The best people** doing their best work<br>Sustainability through **external partnerships**<br>Game-changing **research and innovation**<br>**Strong Foundations** | ☐<br>■<br>☐<br>☐<br>■ |

Alder Hey Children's NHS
NHS Foundation Trust

# BOARD OF DIRECTORS
## Fit and Proper Person Annual Assurance Report

### 1. Purpose

The purpose of this paper is to provide the Board with an annual report on compliance against FPPR and provide the Trust Board with assurance in relation to the fitness of its Directors. It is good practice for the Trust Chair to present this information as per the CQC's guidance.

### 2. Recommendation

The Board is asked to note the assurance provided by this report and the compliance demonstrated by all directors* with the provisions of the regulation.

| Role | FPP Declaration (Annual) | DBS Completion (3 yearly) | Companies House Disqualified Directors Register (Annual) | Insolvency Register (Annual) | Ongoing compliance assessment (Annual PDR) |
|---|---|---|---|---|---|
| NED (WOD) | 04/02/2019 | Update in progress | 27/02/2019 | 27/02/2019 | Yes |
| Deputy CEO/DoF | 05/02/2019 | 11/01/2017 | 27/02/2019 | 27/02/2019 | Yes |
| NED (SID) | 05/02/2019 | 12/11/2017 | 27/02/2019 | 27/02/2019 | Yes |
| Development Director | 04/03/2019 | 28/04/2017 | 27/07/2019 | 27/02/2019 | Yes |
| NED (Vice Chair) | 27/02/2019 | 26/04/2017 | 27/02/2019 | 27/02/2019 | Yes |
| Director of Corporate Affairs | 05/02/2019 | 14/11/2019 | 25/02/2019 | 25/02/2019 | Yes |
| Chief Executive | 05/02/2019 | 14/11/19 | 25/02/2019 | 25/02/2019 | Yes |
| Director of HR & OD | 08/02/2019 | 26/04/2017 | 25/02/2019 | 25/02/2019 | Yes |
| Chair | 04/05/2017 | 05/11/19 | 21/02/2019 | 21/02/2019 | Yes |
| Chief Nurse | 04/02/2019 | 28/04/2017 | 25/02/2019 | 25/02/2019 | Yes |
| Director of Surgery | 26/02/2019 | 10/05/2017 | 25/02/2019 | 25/02/2019 | Yes |
| Director of Communications | 04/02/2019 | 29/06/2017 | 27/02/2019 | 27/02/2019 | Yes |
| Director of Medicine | 18/02/2019 | 09/05/2017 | 27/02/2019 | 27/02/2019 | Yes |
| Chief Operating Officer | 05/02/2019 | 01/02/2018 | 27/02/2019 | 27/02/2019 | Yes |
| Director of Strategy | 05/02/2019 | 14/01/2018 | 27/02/2019 | 27/02/2019 | Yes |
| Medical Director | 05/01/2019 | n/a - AUS check at recruitment | 27/02/2019 | 27/02/2019 | Yes |
| NED (Audit) | 12/02/2019 | 11/09/2018 | 27/02/2019 | 27/02/2019 | Yes |
| NED (FM) | 27/08/19 | 18/11/19 | 08/10/2019 | 08/10/2019 | N/A |
| NED (Innovation) | 30/04/19 | 04/07/2019 | 31/07/2019 | 31/07/2019 | N/A |
| NED (FB) | 27/09/19 | 28/11/2019 | 07/10/2019 | 07/10/2019 | N/A |
| Director of Community and Mental Health | 04/02/2019 | 27/06/2018 | 27/02/2019 | 27/02/2019 | Yes |

27th November 2019

# BOARD OF DIRECTORS

**Tuesday 3rd December 2019**

| | |
|---|---|
| **Paper Title:** | **Innovation Committee Assurance Report from the November meeting** |
| **Date of meeting:** | 18th November 2019 |
| **Report of:** | Shalni Arora, Non-Executive Director |
| **Paper Prepared by:** | Julie Tsao, Committee Administrator |

| | | |
|---|---|---|
| **Purpose of Paper:** | Decision<br>Assurance<br>Information<br>Regulation | ☐<br>■<br>☐<br>☐ |
| **Summary and/or supporting information:** | This paper provides a summary from the recent Innovation Committee meeting held on 9th October 2019. | |
| **Action/Decision Required:** | To note<br>To approve | ■<br>☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care**<br>**The best people** doing their best work<br>Sustainability through **external partnerships**<br>Game-changing **research and innovation**<br>**Strong Foundations** | ☐<br>☐<br>☐<br>☐<br>☐ |
| **Resource Impact:** | | |

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

   Under its terms of reference, the Committee is responsible for providing the Trust Board with assurance on all aspects of innovation.

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

   Innovation Performance report
   Portfolio Review
   Alder Hey Innovation Ltd
   Acorn Action Plan
   Global Med-tech Building
   Financial Plan

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

   None to raise.

4. **Positive highlights of note**

   Global Med-Tech building case is progressing with various funding sources being explored.
   Funding to support intellectual property advice received from a high net worth individual as part of the Dragons Den event. In additional early stage start-up funding received towards two further projects.

   **Issues for other committees**
   Note for Audit Committee the Acorn report and action plan.

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

# Innovation Committee

Minutes of the meeting held on **Wednesday 9th October 2019,**
Tony Bell, Board room, Institute in the park

| | | | |
|---|---|---|---|
| **Present:** | Mrs L Shepherd | Chief Executive (Chair) | (LS) |
| | Mrs S Arora | Non-Executive Director | (SA) |
| | Mrs C Liddy | MD of Research & Innovation | (CL) |
| | Mr J Grinnell | Director of Finance | (JGr) |
| | Ms E Saunders | Director of Corporate Affairs (Item 3.1) | (ES) |
| **In Attendance:** | Mr M Flannagan | Director of Communications | (MF) |
| | Mrs E Hughes | Assoc, Chief Innovation Officer | |
| | Mrs R Lea | Assoc. Finance Director | (RL) |
| | Mrs J Tsao | Committee Administrator | (JT) |
| **Apologies:** | | | |
| | Mr I Hennessey | Director of Innovation | (IH) |
| | Mr M Peak | Director of Research | (MP) |

**19/20/02 Declarations of Interest**

There were none to declare.

**19/20/03.1 Terms of Reference**

Claire Liddy provided background of the previous Research, Education and Innovation Committee, the decision to pause on this arrangement and establish a separate Innovation Committee and Research Board.

The Innovation Committee agreed the following changes to be made to the terms of reference:

- Director of Communications to be changed to Communications Lead
- Chief Information Officer to be included under membership
- Shalni Arora to chair future meetings.
- Under Authority third sentence technology is to be removed.

**Resolved:**
Following the above changes the Committee approved the terms of reference and for them to be received at the November Trust Board.

**19/20/03.2 Innovation Performance Report**

A slide outlining the innovation structure was received. The Hub and Engagement Co-ordinator was yet to be appointed to however all posts had been included within budget.

A discussion was held on the structure of innovation going forward and the use of Alder Hey Ventures Ltd and what the resources, Funding and structure looks like going forward.

It was agreed a paper outlining a proposal will be brought to the next meeting 18th Nov Board of Living Adventures, Rachel Lea agreed to include a structure.
**Action: RL, CL, EH**

Emma Hughes noted the activities on the work-plan for quarter 2 are 31, 19 have been completed with 12 ongoing.



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Liverpool Health Ventures update for Liverpool Health Partners was discussed. The ambition is to establish a shared resource and investment fund to support nine acute and specialist trusts (initially) develop and commercialise innovation.

**Resolved:**
The Innovation Committee noted progress against the performance report.

**19/20/04** **Global Meditech Building**
The Innovation Committee received a draft paper on Global Innovation and Health Med-Tech Facility at Alder Hey Health Park Campus.

Discussion is on going with the combined authority CL to provide verbal update at next Committee

**19/20/05** **Innovation Advisory Board**
Emma Hughes presented a proposed structure to establish an Innovation Advisory Board. Objectives of the IAB included:

- Provide strategic and commercial direction to the AH Ventures LTD spin out (Tech Transfer Office)
- Give insight into useful specialist expertise and know-how outside the Trust/industry
- To grow an ecosystem around the Trust that will bring inward investment

The IAB would be split into seven areas with specialists specific to those areas being invited to be part of IAB. The IAB would meet twice a year, a chair was yet to be sourced. It was agreed guidelines with expected values and a confidentiality clause would be signed off by members.

**19/20/06** **Portfolio Review**
**Alder Play Reset**
Emma Hughes highlighted the continued interest in the Alder Play App and the possibilities for growth. Discussions have been held with suppliers and a roadmap developed to continue this. Furthermore presented was the broader Digital Front Door concept, A discussion was held on the owner for Digital Front Door, it was noted this was on the Executive Committee agenda to be discussed on 17th October 2019. Claire Liddy noted the play aspect has confirmed funding that was being funded by a charity donor with a 10 month time bar, after this time a budget would need to be agreed.

An update was given on other potential funding for projects and planned pitch day session on 18th October. Once the process had been completed a document reviewing the process would be shared with the Trust Board. Shalni said she would like to attend the 'dragons den' pitch as an observer.

**19/20/07** **Asthma Mapping/C&M Partnership Integrated Care Bid**
Emma Hughes updated the Innovation Committee on the asthma monitors project in development to provide support and early diagnosis. The technical and project due diligence is ongoingwith 12 month funding agreed by a charity.

**19/20/08** **Governance update**
**ACORN Action Plan**
KPMG was commissioned by the Trust to undertake an assurance review on the arrangements that are in place under the ACORN partnership. A total of 20 recommendations were made from the review, 7 are completed, with 13



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17.2 approved IC Minutes 09 10 19 eh

outstanding. One of the actions is in relation to 15 companies set up being reduced to 4. A paper will be brought to next Innovation Committee with an update prior to going to Trust Board in December.
**Action: RL**

**19/20/10** **Any Other Business**
No other business was reported.

**Date and Time of next meeting: Monday 18th November 2019, at 11:30am, Jean Watterson, Lecture Theatre, Institute in the Park.**

**Strategic Plan 2018-21 – Update as at November 2019**

| | Strategic Objective | Progress November 2019 |
|---|---|---|
| **Delivering Outstanding Care** | Alder Hey will be inspired by Quality which is led from the front line. | Key progress of the Inspiring Quality programme includes:<br><br>• Applications for appointment into the clinical cabinet are now open.<br>• Schwartz rounds are up and running.<br>• -Applications for the Sweeney collaborative process have been reviewed and 3 teams have been chosen to progress on to the programme.<br>• Appointment of key programme roles including Research Fellow, Senior Project Manager, IQ Project Manager, IQ Programme Manager and IQ Developer.<br>• External Partner has now been agreed.<br>• Strong Foundations Leadership Programme is established.<br>• Patient shadowing programme is now available to all Strong Foundations cohorts, Executives and Board members. |
| | Introduce digital pathways to improve patient care across all specialities | • 48 speciality packages implemented to date; a further four in the final stages of development and training will be live throughout December.<br>• Plans are in development for the remaining specialties which will be delivered on an ongoing basis with the final specialties going live as part of the MEDITECH Expanse go live scheduled for September 2020. |
| | Further improve patient services focused on 5 key priorities; Brilliant patient booking systems; Comprehensive Mental Health; Best In Outpatient Care; Patient Flow; Best in Acute Care | Brilliant Booking & Scheduling;<br><br>• Bi-directional texting has been implemented across 31 specialties, this allow families to confirm they can attend their Outpatient Department (OPD) clinic appointment or request a cancellation. Plans in place to sign up the remaining 16 specialities, where appropriate.<br>• Approx. £15k per month is being generated through the rebooking of short notice cancellations via text which in turns improves the clinic utilisation score. |

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| | | • Since the implementation of the Hybrid booking system we have seen a 89% reduction in cost of partial booking letters, specialities continue to be moved off partial booking, two areas remain Anaesthetics and Burns.<br>• Achieved a 90% reduction in the Did Not Contact (DNC) list which stands at 988 as of 25.11.19.<br>• As of 14.11.19 reminder letters have been suppressed for those patients who have successfully confirmed attendance to their Outpatients Department (OPD) clinic appointment with a valid text response. Currently 200-400 letters are being supressed per day and plans are in place to increase this number.<br>• The electronic patient pathway form (EPPF) has been re-designed to enable the capture of 'tolerance' for variance in the timescale for follow-up. Where going beyond the time scale for a follow up involves a high clinical risk tolerance should be recorded as zero (0); the patient must be prioritised to return within the timescale requested.<br>• The WNB campaign is underway across Outpatients Department (OPD); so far this has included an awareness campaign with clinic room posters, screensavers, a flash message on InTouch, a revised Outpatient induction pack and additional InTouch/Meditech training with staff, and a Was Not Brought pop up has been ordered for each Outpatient Department (OPD) floor, which will focus on the importance of cancelling unneeded appointments.<br><br>Patient Flow;<br><br>• The SAFER care bundle has been implemented across seven wards, continuous works to fully embed the SAFER principles continue across all and the percentage of children discharged before 12PM has increased by 5% to 23% in comparison to last year.<br>• Standard documentation is now in use which requires mandatory completion of an Estimated Date of Discharge. To support communication of this 'My Pads' have also been introduced across 4 wards, they are able to outline all daily interventions prior to discharge.<br>• MDT pathway has now been put in place to support the review of all patients with a length of stay 7 days or more. A suite of documents have been produced to support and standardise all Multi-Disciplinary Team meetings (MDT) that take place across the Trust. There has been a month on month improvement in the number of MDT's taking |

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| | | place which is an average of 15 per month.<br>• 'Hospital Manager of the Week' has been implemented and embedded into business as usual to ensure timely decision making and a point of contact for escalation.<br>• Full Trust wide communication of the work delivered and benefits achieved with next steps of how to continue to embed the principles and use then throughout winter to be published December 2019.<br><br>Best in Acute Care;<br><br>• Created a new team to manage Complex Patients and provide early intervention to patients with a length of stay of 7 days or greater.<br>• Designed and agreed a Future Model of Care for High Dependency Unit including required Consultant cover.<br>• Recruited 3 High Dependency Unit Consultants who will provide a partial seven day service.<br>• Re-designed and issued new pathway & threshold documents for admitting patients and requesting advice from other specialities.<br>• Full consultation process has taken place to determine the most suitable location and model for a PAU. Business case has been written to support this with finances, subject to approval pilot to commence March 2020.<br>• Acute Care Team has been supported by the Trust including funding to recruit to the team. Phase 1 of recruitment has been completed (Bed Managers, Band 7 and Clinical Site Co-Ordinators, Band 6) with phase 2 on track to be completed by January 2020 (Advanced Nurse Practitioners, Band 8A). A fully operational Acute Care Team is due to commence April 2020.<br><br>Comprehensive Mental Health;<br><br>• Capital secured for Tier 4 plans approved – work ongoing regarding the development of new care models and unit now open for 9 beds.<br>• Trailblazer (schools Liverpool) awarded funding twice. There are now 4 Liverpool teams, one specifically working with young people and transition in schools<br>• Community and Mental Health Services are now working to clinic templates which |

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| | | have improved capacity and demand management. This should positively impact on waiting times<br>• Eating Disorder and Crisis Care teams have secured additional investment from Liverpool CCG to recruit additional staff and extend the services in a planned way over the next 3 years to meet required national specifications<br><br>Best in Outpatient Care;<br><br>• Patient experience and satisfaction has been increased to 95% across outpatients (baseline of 89% March 2019). Experience has been improved through the introduction of comfort rounds, communicating waiting time's daily, improved signage flow and play and distraction.<br>• The number of outstanding ePPF forms 48hours after a clinic appointment has reduced to 6% weekly and the total number of outstanding legacy forms has reduced by 64% since March 2019.<br>• £100k has been pledged from Liverpool John Lennon Airport for play and distraction techniques across Outpatients. The requirements, for all ages, across the department have be rigorously agreed and tested with the Children and Young Peoples forum and Jungle Interactive, a play specialist company, have been engaged to produce and procure the kit. Recommendations expected back January 2020, implementation March 2020.<br>• Clinicians experience with Outpatients overall has increase to 85% (A 15% increase from previous survey in Sept 18- 45%). Next survey due Nov 2019.<br>• Audits on clinic room availability, equipment and height and weight flow continue to be undertaken across each division to understand the cause of clinic delays and will shape the improvements made going forward. |
| | Achieve outstanding performance in all CQC domains at every level | • Focused programme of work developed – Our Journey to Outstanding – which aims to take a Delivery Management Office approach to assurance against the five Clinical Quality Care domains. A range of 'hot topics' identified and prioritised with clinical Divisions.<br>• Mersey Internal Audit Agency/Advancing Quality Alliance commissioned to undertake follow up Board development programme under the Well Led framework. |

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| | Deliver the new Alder Centre | • New Alder Centre on track for handover in March 20.<br>• Main outstanding issue is securing further fundraising contribution to allow for completion of gardens and external works.<br>• Proposal for funds to complete these works going to Charity Board December 2019. |
| | Develop our Health Park vision | • Phase1 Park works have been tendered and programmed to start in January 2020 with a view to completion in summer 2020.<br>• Main Park work due for Planning Determination December 2019.<br>• Plan for early clearance of Park approved at October Board. Works planned for completion June 2020.<br>• Arrangements for Park going forward in discussion with LCC. Next meeting December 2019. |

| | Strategic Objective | Progress November 2019 |
|---|---|---|
| **Supporting the Best people to do their best work** | Our workforce must reflect the diversity of the communities we serve, and we will improve the experience of our staff from Diverse backgrounds | • EDI is now running as a project on the Change Programme.<br>• Staff Networks being refreshed.<br>• Exploring partnerships with local colleges to improve recruitment channels and pathways. |
| | We will have identified supply pipelines for all key staffing groups, working in partnership with our local HEI's | • Nurse associate roles being supported.<br>• International recruitment programme for nurses underway. |
| | Deliver at least 50 apprenticeship starts through the Academy each year | • There are now 85 learners enrolled on an apprenticeship.<br>• Application made to remain on the employer provider register, awaiting imminent OFSTED inspection. |
| | Implement the Wellbeing Strategy, supporting staff to improve all aspects of their health and wellbeing – with a focus on a reduction in sickness absence | • Wellbeing Strategy roll-out continues.<br>• Time to Change' mental health awareness programme now launched, with over 45 managers booked onto the training.<br>• Preparation for the annual Star Awards underway.<br>• A pilot 'wellbeing team' to help manage sickness absence has been approved; recruitment will commence in December 2019. |
| | Build line, clinical and system leadership capability; focused on supporting quality improvement | • 2 Mary Seacole leadership programmes delivered, with another to be delivered in February 2020. The pass rate so far has been 100%.<br>• Leadership apprenticeships continue.<br>• Strong Foundations Programme launched; 3 cohorts already live with 7 others fully booked until November 2020. |

Alder Hey Children's NHS
NHS Foundation Trust

| | Strategic Objective | Progress November 2019 |
|---|---|---|
| **Sustainability through external partnerships** | Deliver single neonatal service in partnership with Liverpool Women's Hospital | • Initial approval gained by NHS England specialist commissioners supporting the development of a 22 cot NICU at Alder Hey. Continuous negotiations under way with specialist commissioners to agree a financially sustainable phased implementation plan, with residual gap of £0.7 mil to resolve during November 2019. The 2 cardiac cots previous not approved are being reconsidered to accommodate within a 22 cot model.<br>• Leadership Team appointed for The Liverpool Neonatal Partnership to manage services across both organisations (Alder Hey Children's Hospital and Liverpool Women's Hospital) in addition to leading the development and implementation of the Neonatal Intensive Care Unit at Alder Hey. Recruitment of clinical staff commenced with additional consultants, Advanced Neonatal Nurse Practitioners and nurses recruited to work across both organisations.<br>• The prevision of clinical care at both organisations has improved over the last 18 months owing to the partnership working. Surgeons are conducting ward rounds at Liverpool Women's and Alder Hey has Neonatal Consultant and Advanced Neonatal Nurse Practitioners presence 5 days a week. This will be extended to a 7 day service from January 2020.<br>• The Neonatal Intensive Care Unit Estate development at Alder Hey is progressing having conducted visits to other Neonatal Intensive Care Units globally and held workshops involving parents and staff to support the design of the new unit. |
| | Deliver all-age Coronary Heart Disease Services in partnership with Liverpool Heart and Chest, Royal Liverpool University and Liverpool Women's Hospital | • Level 1 all-age congenital heart disease continues to be delivered successfully in Liverpool. The partnership is consistently delivering and exceeding the required surgical volumes, and more importantly achieving positive outcomes for children, young people and families. The Level 1 Partnership Board is established and meeting 6 monthly.<br>• Alder Hey were successful in becoming hosts to the new broadened all-age CHD Operational Delivery Network. This has brought an additional £200k funding into Alder Hey, and recruitment to roles in the broadened network is underway. Inaugural Operational Delivery Network Board to be scheduled for January 2020. |
| | Deliver Liverpool Children's Integrated Transformation Plan | • Significant strategic progress has been made in embedding the Children's Transformation plan into the Liverpool 'Place' plan (aka 'One Liverpool'); suggested way forward is for the Children's transformation partnership to develop the 'starting well' theme of the One Liverpool plan.<br>• Children's transformation has strengthened the system partnership further through the |

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| | | Programme Director role now being undertaken by Liverpool City Council's Families Programme Director, working to Alder Hey CEO as Chair.<br>• A refresh of the programme plan is underway in line with One Liverpool; priorities are to continue the development of the 2 x pilot community children's hubs in Aintree and Speke, development of the Infant Feeding community approach and improve the urgent care system for children and young people, in the context of the wider Urgent Care review in North Mersey. |
| | Increase specialist child health services regionally, nationally and internationally | • The North West Paediatric Partnership Board (Alder Hey and Royal Manchester Children's Hospital) continues to progress. The partnership has facilitated improvements in digital joint Multi-Disciplinary Teams, joint consultant appointments have been made in Neurosciences, and next steps are to develop a joint MDT for neuro-oncology. The partnership is working together to develop joint plans for cardiology and haematology, and working (with support of NHS England Specialist Commissioners) to frame our joint approach to the development of our co-hosted Operational Delivery Networks for 2020 and beyond.<br>• Alder Hey is working with local district general hospitals (DGHs) such as Southport and Ormskirk and Warrington to develop the 'Alder Hey with…' model. The aim of this work is to establish a partnership paediatric model that enables appropriate DGH level interventions to be delivered in a safe, joined-up way close to people's homes, whilst ensuring that there is capacity for specialist-level care and interventions to be delivered at Alder Hey. Work with Southport and Ormskirk is ongoing alongside the Trust's future plans, and the initial session with Warrington to scope potential is scheduled early December 2019.<br>• Alder Hey has now increased the number of beds within the Community and Mental Health Services Tier 4 specialist inpatient unit to 9 during 2019/20. This is with a view to increasing to 12 beds on completion of the new build. |
| | Lead the co-creation of new models of care for paediatric mental health with Mental Health and LD<br>Programme as part of the Cheshire and Merseyside Sustainability and Transformation Partnership | • Successful bid via NHS England Transforming Care to support the development and implementation of an Intensive Support Team for children and young people with LD/ASD and/or mental health. Service commences early 2020. |
| | Develop regional paediatric / neonatal services as part of Women's and Children's | • CEO's of Alder Hey and Liverpool Women's Hospital continue as joint SRO's of the Cheshire and Merseyside Women and Children's programme. |

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| | Partnership (Health and Care Partnership (HCP) (STP) | • 'Roadshow' visits to every provider in Cheshire and Merseyside were completed during early summer 2019, culminating in a Clinical Summit in July, in which a recommended approach to a 'Core / Comprehensive' service model was presented.<br>• Further development of these models has followed, and work is underway currently with Southport and Ormskirk, Liverpool Women's and Alder Hey Medical Directors to finalise for women and children; outcome expected Q4 2019/20.<br>• The aim for the programme is to move to a shared partnership model of paediatric care for C&M over the next 3-5 years, which optimises our workforce, enables us to achieve standards across organisations in Cheshire and Merseyside, and, importantly, ensures that as much appropriate care can be provided as close to children, young people and families' homes as possible. |

Alder Hey Children's NHS
NHS Foundation Trust

| | Strategic Objective | Progress November 2019 |
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| **Game changing research and innovation** | Establish a core team from Alder Hey and UoL to co-create a Strategic Plan to ensure clinical and non-clinical services are best organised to offer children, young people and families every opportunity to take part in clinical research opportunities | • Funding package for additional research infrastructure agreed in 2019 by Executive Team<br>• Interviews for Associate Divisional Research Directors (Clinical) [ADRD} in December 2019. Six applicants across three divisions<br>• All honorary Chairs (University of Liverpool) in receipt of one Programmed Activity (PA) for research<br>• Clinical Research Division Matron appointed and commences post in December 2019<br>• Research Management Board met for first time in October 2019<br>• Commercial research investment and income redistribution plans being worked up. Initial focus on Duchenne Muscular Dystrophy portfolio.<br>• Key post of Research General Manager since September 2019 which has brought stability to Clinical Research Division<br>• Agreement in principle for a Managing Director role covering Research and Innovation. |
| | Strengthen our position to attract and appoint internationally renowned leaders and new talent in paediatric research | • New Senior Lecturer in Paediatric Clinical Pharmacology post agreed<br>• Progress with first Consultant Pharmacist post at Alder Hey with major focus on research<br>• Prof Iain Buchan has affiliated his NHS honorary contract and NIHR Senior Investigator award with Alder Hey<br>• Need to re-engage with University of Liverpool following Project SHAPE and understand any opportunities for senior academic posts: previous opportunity of Chair in Paediatric Epilepsy did not progress due to personal circumstances of preferred (and only) available UK candidate. |
| | Contribute to specialist paediatric education through Alder Hey Academy | • Academy visit to Shanghai went ahead in early autumn 2019; plans are in place to develop a number of education offers with China, including respiratory and gastroenterology specialties. |
| | Co-create with staff a new set of innovation products whilst Alder Play is rolled out | • Total needs identified between April 19 to October 19 117, which is a significant increase compared to 2018/19. Of these 31 progressed to the pipeline.<br>• Active projects with investment equates to 9. 3 Further projects agreed for investment from high net worth and charity.<br>• Health Innovation Exchange Project (ERDF) completed with all output KPI achieved. |

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| | | Close down due by January 2019 |
| | Integrate front line and research activity through an increasing number of clinicians involved in research | • Appointment of ADRDs in December 2019 will add to clinical research leadership team to drive research 'integration'<br>• Over 3,000 children and young people recruited into clinical research studies in 2018/19<br>• Research income redistribution model to incentivise additional investigators and increase research capacity<br>• Alder Hey Charity has provided funding for 10 PAs (or equivalent) for research time for healthcare professionals for two years (three years depending on progress). With funding for honorary chairs equals up to £540k<br>• Successful second round of the Hugh Greenwood Legacy fund with ten awards (£400k in total) from 31 applications. Many of these applications involve new or junior Alder Hey investigators. |
| | Contribute to Liverpool Health Partner themes relevant to 'Starting Well' | • LHP Starting Well Programme Leadership Team (Beresford, Morgan, Hunt) has held priority setting consensus workshops with a range of multi-sector professionals. This will help inform the areas which will shape further research effort and Alder Hey's contribution to this.<br>• Within LHP framework, contributing to the development of a Liverpool NIHR Biomedical Research Centre (BRC) proposal (Alder Hey and Starting Well component). Position paper to be presented to LHP Board on the interdependency of Clinical Research Facility renewal and the BRC proposal. |

# Memorandum of Understanding

**Between Alder Hey Children's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust for a Liverpool Neonatal Partnership**

## 1. Introduction

The following Memorandum of Understanding (MoU) sets out the framework for collaborative partnership working between Alder Hey Children's NHS Foundation Trust (AHC) and Liverpool Women's NHS Foundation Trust (LWH) (the Parties) to jointly establish a new model of care for neonatal services: The Liverpool Neonatal Partnership.

The Liverpool Neonatal Partnership will provide care and treatment to neonatal babies across two hospitals (AHC and LWH). Through the Liverpool Neonatal Partnership, we are committed to meeting national service standards for neonatal care, improving the quality of care and families' experience of neonatal services. The Liverpool Neonatal Partnership will deliver a new Neonatal Intensive Care Unit (NICU) facility at AHC. It will also provide care from the current 44 neonatal cots at LWH. The service will be staffed by nurses with neonatal specialty training, Advanced Neonatal Nurse Practitioners (ANNP), Consultant Neonatologists, Consultant Paediatric Surgeons and Therapists.

The Parties aim to establish staffing levels that are in line with the British Association of Perinatal Medicine (BAPM) standards. Although both Parties recognise that this will require investment by commissioners, which are reflected in the phased approach set out in the joint business case.

## 2. Shared Purpose

The Parties share a commitment to the provision of the best possible care for the neonatal population of Liverpool and the North West region and will act with one voice as part of the Neonatal Network and wider health economy.

The new model of care will improve the quality of care and outcomes for babies by:

- AHC will establish a new model of care with a designated NICU provision and enhanced post-natal support at AHC (a two-site single service model) and will include the continuation of surgical support at LWH.
- Having a single leadership team for the Liverpool Neonatal Partnership that will support the delivery of a patient and family centred service for babies and families
- Neonatal surgery will continue to be performed at the AHC site
- Introducing a new clinical pathway which sees a significant reduction in unnecessary high-risk transfers for babies and which optimises neonatal and surgical care provision on each site
- Reducing unnecessary transfers that can be prevented through undertaking some minor surgical procedures at LWH following agreement of appropriate staffing and governance arrangements

- Providing dedicated neonatal intensive care provision at AHC with the appropriate supporting workforce
- Providing an optimal environment where babies will receive both neonatal and surgical expertise in one place
- Developing the clinical research capability across both trusts and their academic partners
- Supporting outstanding educational opportunities to build the right workforce for the future
- Babies in the NICU at AHC requiring surgical care receive the same level of care, support, resource and specialist input as they would receive in a medical neonatal service Toolkit for High Quality Neonatal Care (2009)

## 3. Principles & Arrangements

The parties will:

- Ensure that a Liverpool Neonatal Partnership Board and associated governance structure is established, as set out in section 4 below. The Terms of Reference of the Partnership Board and the Liverpool Neonatal Partnership Delivery Group are set out in Appendix 1 and Appendix 2, respectively;
- Ensure the commitment to safeguarding services and safety of patients will be an unbroken thread through the collaboration work between the parties;
- Uphold the principle of fairness to ensure there will be similar benefits for both parties and the populations they serve;
- Ensure mutual transparency of data in areas of collaboration;
- Be consistently transparent about strengths, weaknesses, opportunities and challenges;
- Mutually sustain any project management or implementation resources as required;
- Recognise that collaboration is intrinsically demanding on time and resources and therefore ensure the benefits outweigh the investment of time and resource;
- Establish appropriate contractual arrangements, including honorary contracts or Services Level Agreements in order to further enhance mutual understanding of the collective commitment to the service;
- Appropriately reflect the content and spirit of the MoU in each other's clinical and operational plans and strategies; and
- Operate in accordance with the stated values of both organisations and in an environment of 'no surprises'.

## 3. Decision making

The Liverpool Neonatal Partnership Board will acknowledge and agreed a set of reserved matters for the Parties respective Board of Directors. Apart from those items reserved, all actions and work programmes in support of the purpose and principles set out in this MoU will fall within the remit of the Liverpool Neonatal Partnership Board to progress and make decisions when they arise.

## 5. Governance of the Liverpool Neonatal Partnership

The existence of the Liverpool Neonatal Partnership Board will not impinge upon the legal sovereignty of the Parties, each of whom will retain responsibility for meeting all expected quality and service standards, including performance to the relevant regulatory standards including the Care Quality Commission's *Fundamental Standards* and the requirements set out in NHSI's *Single Oversight Framework*. The Board of Directors of each organisation will continue to be accountable for its own service provision in accordance with its constitution, provider license and statute. Minutes of the Liverpool Neonatal Partnership Board will be taken and made available to each of the Parties Board of Directors and any matters of concern escalated through their existing governance structures.

All levels of neonatal care will continue to be provided on the Liverpool Women's Hospital site in addition to development at Alder Hey Children's Hospital.

# Liverpool Neonatal Partnership – Governance and Reporting Structure

Liverpool Women's Hospital Executive Team

Alder Hey Children's Hospital Executive Team

Liverpool Neonatal Partnership Board

Neonatal ODN

Maternity Alliance (NHSE)

Families

Communications & Engagement

Communicate and Engage with

Liverpool Neonatal Partnership Delivery Oversight Group

Clinical Governance and Guidelines Workstream

Workforce & Infrastructure Workstream

## 6. Senior Responsible Officers

In order to ensure a clear line of accountability, each organistion will have a designated Senior Responsible Officer for the Liverpool Neonatal Partnership. The Senior Responsible Officer role will be held as follows:

- Chief Operating Officer, AHC
- Chief Operating Officer  LWH

## 7. Duration of the agreement

This MoU, including the terms of reference of the Liverpool Neonatal Partnership Board, will be kept in place until it is replaced by 'business as usual arrangements' established following full implementation of the new service, this is not expected until 31st March 2021.

## 8. Variation and Escalation

Variations may be made at any time to the MoU with the express agreement of the Parties.

The MoU will be reviewed annually or earlier if required. Any changes will be mutually agreed and signed by the Parties.

Any issues or disputes which cannot be immediately resolved by Liverpool Neonatal Partnership Board shall be escalated to each of the Parties Chief Executive (CE) for resolution. In the event that the CEs cannot resolve the issues or disputes, they shall be escalated to each of the Parties Board of Directors to resolve.

The MoU is not intended to be legally binding, or to give rise to any liability of any kind.

## 9. Confidentiality

Both Parties will adhere to all the statutory requirements relating to confidentiality, information governance and data protection (GDPR) and for the avoidance of doubt, will apply to all consultants, professional advisers and contractors employed and/or engaged by the Parties.

Information shared between the Parties will be treated in the strictest confidence and not shared with another organistion unless explicit permission is given.

This is the second original document was signed an agreed by both Trust in August 2018 this document can be found in Appendix 3 with signatures of agreement.

**Appendix 1: Terms of Reference for the Liverpool Neonatal Partnership Board**

**Liverpool Neonatal Partnership Board**

**TERMS OF REFERENCE**

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| **Constitution:** | The Liverpool Neonatal Partnership Board is established by the Alder Hey Children's Hospital NHS FT and Liverpool Women's NHS FT Board of Directors.<br><br>known as the "Liverpool Neonatal Partnership Board" |
| **Duties:** | The Liverpool Neonatal Partnership Board will<br><br>Ensure the work of the group is aligned to the shared purpose of the Partnership as described in Section 2 of the Memorandum of Understanding<br><br>• Provide the necessary Board-level support to enable the Liverpool Neonatal Partnership Delivery Group to meet the mission, values and standards of the neonatal service.<br>• Monitor the progress of the Liverpool Neonatal Partnership Delivery Group against the implementation plan via project and governance reports<br>• Review and ensure appropriate responses to strategic risks<br>• Approve and issue communications to stakeholders<br>• Ensuring the programme stays within the scope of the original business case and financial envelope and ensure benefits are realised.<br>• Report progress to the Trust Board of Directors for AHC and LWH.<br>• Ensuring the Liverpool Neonatal Partnership service plan is aligned to the commissioning, political, strategic and healthcare policy environment<br>• Attempt to provide resolution or guidance to any issues or risks escalated by the Liverpool Neonatal Partnership Delivery Group |
| **Membership:** | The Partnership Board is a decision-making forum which will provide the strategic direction necessary to deliver the new model of care; it will be jointly chaired, on a rotational basis, by the Medial Director of each Trust.<br><br>• Medical Director (joint chair) LWH & AHC<br>• Non-Executive Director<br>• Chief Nurse LWH & AHC<br>• Chief Operating Officer/ Director of Operations LWH & AHC<br>• Programme Manager Liverpool Neonatal Partnership<br>• Clinical Director for the Liverpool Neonatal Partnership<br>• Neonatal Surgical Lead and Deputy Clinical Director for the |

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| | Liverpool Neonatal Partnership<br>• Clinical Lead for Neonatal Service<br>• Lead Nurse for the Liverpool Neonatal Partnership<br>• Divisional Manager LWH & AH<br>• Group Manager Liverpool Neonatal Partnership<br>• Divisional Manager<br>• Finance representative<br>• Parent/service user<br><br>In attendance:<br>• NHSE Specialist Commissioning representative<br>• Neonatal Network<br>• Communication Lead when required<br><br>Members can participate in meetings by two-way audio link including telephone and video link. Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum. All meetings will be minuted by the Programme Administrator for the Liverpool Neonatal Partnership. |
| **Quorum:** | A quorum for this meeting will by 4 members including:<br><br>• 1 of the joint Chairs<br>• 1 (Chief Operating Officer or Director of Operations)<br>• 1Clinical or Deputy Clinical Lead/ Director<br>• 1 nursing member |
| **Voting:** | Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority. |
| **Attendance:** | **a. Members**<br><br>Members will be required to attend a minimum of 75% of all meetings.<br><br>**b. Officers**<br><br>Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed.<br><br>Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights. |
| **Frequency:** | Meetings shall be 3 times per year March, July and November meeting dates will be sent out to cover the 12 month period.<br><br>Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Programme. |

| | |
|---|---|
| **Authority:** | The Partnership Board is authorised by the Trust Boards to Investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Programme Board. |
| **Accountability and reporting arrangements:** | The Partnership Board will be accountable to the Trust Boards of both partnership Trusts<br><br>The minutes of Partnership Board will be formally recorded. A Chair's report will be submitted to the Trust Boards. The Chair of the Partnership Board shall draw to the attention of the Trust Boards any issues that require disclosure to it or require executive action.<br><br>The Partnership Board will report to the Trust Boards on its work and performance in the preceding year.<br><br>Trust standing orders and standing financial instructions apply to the operation of the Partnership Board. |
| **Reporting Committees/Groups** | The sub-committees/groups listed below are required to submit the following information to the Trust Boards<br><br>a) Chairs Report [and/or] minutes of meetings; and<br><br>b) An Annual Report setting out the progress they have made and future developments. |
| **Monitoring effectiveness:** | The Partnership Board will undertake an annual review of its performance against its duties in order to evaluate its achievements. |
| **Review:** | These terms of reference will be reviewed at least annually by the Trust Board |
| **Reviewed by relevant Sub-Committee of the Board:** | December 2019 |
| **Review Date:** | December 2020 |
| **Document Owner:** | Medical Director AHC<br>Email: Nicki.Murdock@alderhey.nhs.uk<br><br>Medical Director LWH<br>Email: Andrew Louhney@lwh.nhs.uk |

## Appendix 2: Terms of Reference for the Liverpool Neonatal Partnership Delivery Group

**Liverpool Neonatal Partnership Delivery Group**

**TERMS OF REFERENCE**

| | |
|---|---|
| **Constitution:** | The Liverpool Neonatal Partnership Delivery Group will be accountable to the Liverpool Neonatal Partnership Board and ultimately the Trust Board of Directors for LWH and ACH. |
| **Duties:** | The Liverpool Neonatal Partnership Delivery Group Delivery Group will:<br>• Execute an implementation plan that establishes a neonatal service that meets national service standards<br>• Ensure there are governance arrangements that effectively manage, and mitigate risks<br>• Ensure delivery to the programme budget and ensure prudent and appropriate use of resources<br>• Maintain an effective and auditable project administration process, including the development and monitoring of an agreed robust QIA/EIA<br>• Monitor and operationally manage the project process against the implementation plan form the agreed workstreams<br>• Identify, record and manage the project risk with appropriate escalation<br>• Construct and recommend a clinical design specification for the new NICU at ACH<br>• Review and approve join operating policies covering key areas including infection prevention control, consent, incidents, information management (Badger System) and information governance.<br>• Report on benefits and have plans to achieve all key performance indicators as set out in the business case<br>• Provide a progress report to Liverpool Neonatal Partnership Board |
| **Membership:** | The Partnership Delivery Group is the operational and managerial arm of the Liverpool Neonatal Service project; it will oversee delivery across both sites and is accountable to the Partnership Board. It will be jointly chaired by the COO of each organisation and will consist of the following members:<br><br>• Chief Operating Officer/ Director of Operations-**(Joint Chair)**<br>• Programme Manager for the Liverpool Neonatal Partnership<br>• Lead Nurse for the Liverpool Neonatal Partnership<br>• Group Manager for the Liverpool Neonatal Partnership<br>• Clinical Director for the Liverpool Neonatal Partnership<br>• Neonatal Surgical Lead and Deputy Clinical Director for the Liverpool Neonatal Partnership<br>• PICU clinical lead |

| | |
|---|---|
| | • Estates lead<br>• Infection control lead - Query should this be to the clinical group<br>• IT lead<br>• Finance representative<br>• HR<br>• Communication Lead<br><br>In attendance:<br><br>• North West Neonatal Operational Delivery Network<br>• Specialist commissioners<br><br>Members can participate in meetings by two-way audio link Including telephone, video or computer link (excepting email communication). Participation in this way shall be deemed to constitute presence in person at the meeting and count towards the quorum<br><br>The Partnership board will appoint a member of the Delivery Group as Chair and another member to be Vice Chair from the outset. The Vice Chair will automatically assume the authority of the Chair should the latter be absent |
| **Quorum:** | A quorum shall be 4 members including:<br><br>• One of the joint Chairs COO & DoO<br>• Clinical or Deputy Clinical Lead/ Director<br>• A nursing member |
| **Voting** | Each member will have one vote with the Chair having a second and casting vote, if required. Should a vote be necessary a decision will be determined by a simple majority. |
| **Attendance:** | **c. Members**<br>Members will be required to attend a minimum of 75% of all meetings.<br><br>**d. Officers**<br><br>Other officers and staff of the Trust will be invited to attend the meeting as appropriate when an issue relating to their area of operation or responsibility is being discussed. Representatives from partner organisations or other external bodies may be invited to attend as appropriate. Such representatives will not have voting rights. |
| **Frequency:** | Meetings shall be held 6 times per year. Additional meetings may be arranged from time to time, if required, to support the effective functioning of the Programme. The meeting will routinely be held on the last Thursday of each month. |
| **Authority:** | The Delivery Group is authorised by the Partnership Board to investigate any activity within its Terms of Reference. It is |

| | |
|---|---|
| | authorised to seek any information it requires from any employee and all employees are directed to cooperate with any request made by the Partnership Board. |
| **Accountability and reporting arrangements:** | The Delivery Group will be accountable to the Partnership Board. The minutes of Delivery Group will be formally recorded. A Chair's report will be submitted to the Partnership Board. The Chair of the Delivery Group shall draw to the attention of the Partnership Board any issues that require disclosure to it or require executive action.<br><br>The Delivery Group will report to the Partnership Board on its work and performance in the preceding year. Trust standing orders and standing financial instructions apply to the operation of the Delivery Group. |
| **Reporting Committees/Groups** | The sub-committees/groups listed below are required to submit the following information to the Programme Boards<br>a) Chairs Report [and/or] minutes of meetings; and<br>b) An Annual Report setting out the progress they have made and future developments. |
| **Monitoring effectiveness:** | The Delivery Group will undertake an annual review of its performance against its duties in order to evaluate its achievements. |
| **Review:** | These terms of reference will be reviewed at least annually by the Partnership Board |
| **Reviewed by relevant Sub-Committee of the Board:** | June 2018 - **update July 2019:** |
| **Document Owner:** | Adam Bateman, Chief Operating Officer<br>Adam.bateman@alderhey.nhs.uk<br><br>Gary Price, Director of Operations<br>Gary.price@lwh.nhs.uk |

**Appendix 3: Original MOU prior to revision in July 2019**

Final Single Neo
Service MOU 23 Aug

# BOARD OF DIRECTORS

**Tuesday, 3 December 2019**

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

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

# Board Assurance Framework 2019/20

## 1. Purpose

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

## 2. Review of the BAF

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

Board members will notice that corporate risks are now linked to BAF Risks – a summary of these risks can be found at appendix A. The full BAF document is included as Appendix B.

## BAF Risk Register - Overview at 27 November 2019

| BAF Risk Register - Overview at 27 November 2019 |
| --- |
| 3.4: Financial Environment (S) |
| 2.3: Workforce Equality, Diversity & Inclusion (S)    1.3: The Hospital Environment (B) |
| 4.2: Digital Strategic Development and Operational Delivery (S) |
| 3.2: Service sustainability, growth and the Trust's role in a sustainable local health economy. (S) |
| 4.1: Research, Education & Innovation (S)    3.1: Failure to fully realise the Trust's Vision for the Park (S) |
| 2.1: Workforce Sustainability (S)    2.2: Staff Engagement (S) |
| 1.4: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (S) |
| 1.2: Achievement of national and local mandatory & compliance standards (W) |
| 1.1: Not achieving Outstanding Quality for Children and Young People as defined by the Health and Social Care Act (2012). (S) |

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

## 3. Summary of BAF - at 26 November 2019

The diagram below shows that the majority of risks remained static in-month with the exception of risk 1.3 The Hospital Environment which reduced in score due to progress made on water ingress, improved temperature ranges and positive feedback on non-destructive testing of pipework and risk 1.2 which worsened 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 as defined by the Health and Social Care Act (2012)** | | 3-3 | 2-2 | STATIC | STATIC |
| 1.2 ES | **Achievement of national and local mandatory & compliance standards** | | 3-2 | 3-2 | STATIC | **WORSE** |
| 1.3 JG | **The Hospital Environment** | | 4-4 | 4-2 | STATIC | **BETTER** |
| 1.4 JG | **Sustainable operational delivery in the event of a 'No Deal' exit from EU** | | 3-3 | 3-3 | STATIC | STATIC |
| **STRATEGIC PILLAR:** The Best People Doing Their Best Work | | | | | | |
| 2.1 MS | **Workforce Sustainability** | | 3-3 | 3-2 | STATIC | STATIC |
| 2.2 MS | **Staff Engagement** | | 3-3 | 3-1 | STATIC | STATIC |
| 2.3 MS | **Workforce Equality, Diversity & Inclusion** | | 3-4 | 3-1 | STATIC | STATIC |
| **STRATEGIC PILLAR:** Sustainability Through External Partnerships | | | | | | |
| 3.1 DP | **Failure to fully realise the Trust's Vision for the Park** | | 3-3 | 3-2 | STATIC | STATIC |
| 3.2 DJ | **Service Sustainability & Growth** | | 4-3 | 4-2 | STATIC | STATIC |
| 3.4 JG | **Financial Environment** | | 4-4 | 4-3 | STATIC | STATIC |
| **STRATEGIC PILLAR:** Game-Changing Research And Innovation | | | | | | |
| 4.1 CL | **Research, Education & Innovation** | | 3-3 | 3-2 | STATIC | STATIC |
| 4.2 KW | **Digital Strategic Development and Operational Delivery** | | 4-3 | 3-2 | STATIC | STATIC |

## 8. Changes since 5 November 2019 Board meeting

### External risks

- ***Service sustainability, growth and the Trust's role in a sustainable local health economy (DJ)***
  Risk reviewed - no change to score in month. Additional evidence attached to controls and new actions added.

- ***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 review undertaken today. NHSE Webinars paused pending outcome of election. Maintained risk levels due to lack of clarity despite extensive work locally and nationally regarding supply chain. Current exit scheduled to 31 Jan 2020.

### Internal risks:

- ***Achievement of National and Local Mandatory & Compliance Standards (ES)***
  Risk score increased to reflect pressures from extremely high emergency attendances and a number of theatre cancellations on the day of planned surgery.

- ***Achievement of Outstanding Quality for Children and Young People as defined by the Health and Social Care Act (2012) (HG)***
  Risk reviewed, no change to score in-month. Additional mitigations in place until international workforce commence in January 2020.

- ***Financial Environment (JG)***
  Latest forecast is a £2.4m deficit from control total. Corporate and Divisional recovery schemes being focussed on. Increased risk relating to winter pressures and financial performance that have yet to be fully scoped.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Review in advance of December Board.

- ***Digital Strategic Development and Operational Delivery (KW)***
  Excellent progress with key actions in relation to disaster recovery, cyber security and operating model development. All actions on track for delivery against plans.

- ***Workforce Sustainability (MS)***
  Risk reviewed actions remain on track, risk rating remains the same.

- ***Staff Engagement (MS)***
  Risk reviewed actions remain on track, risk rating remains the same.

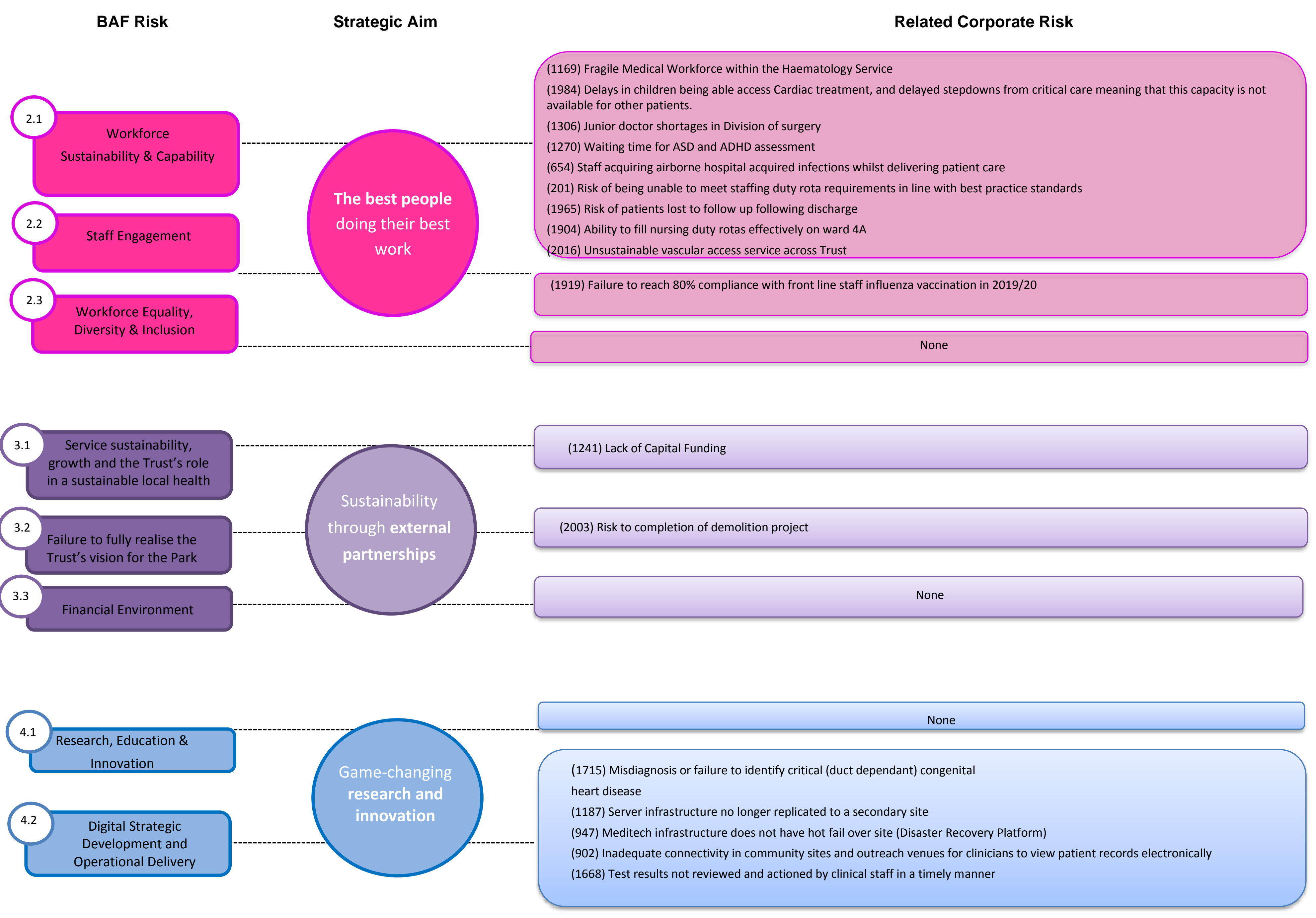
- ***The Hospital Environment (JG)***
  Risk score reduced as progress made on water ingress with no re-occurrence, improved water temperature ranges and positive feedback on non-destructive testing of pipework.

- ***Research, Education & Innovation (CL)***
  Updated and reviewed. Risk static.

**Erica Saunders**
**Director of Corporate Affairs**
**3 December 2019**

## Appendix A. Links between BAF and high scored risks – as at 26 November 2019

| BAF Risk | Strategic Aim | Related Corporate Risk |
|---|---|---|
| 1.1 Achievement of Outstanding Quality for Children and Young People as defined by the Health and Social Care Act 2012 | Delivery of **outstanding care** | (1866) Risk of patient harm due to unnecessary variability in care, due to out of date guidelines being consulted or failure to access guidance.<br>(799) Failure to control contractors on site.<br>(1921) Lack of robust mechanisms for ensuring emergency bleep system is working<br>(884) Failure of RO Plant supporting Haemodialysis<br>(1904) Ability to fill nursing duty rotas effectively on ward 4A<br>(964) Risk of elective list errors due to planning and scheduling processes<br>(1984) Delays in children being able to access Cardiac treatment, and delayed stepdowns from critical care meaning that this capacity is not available for other patients<br>(201) Risk of being unable to meet staffing duty rota requirements in line with best practice standards<br>(1787) Error in the prescribing, preparation, administration and monitoring of Parenteral Nutrition<br>(2016) Unsustainable vascular access service across Trust<br>(1169) Fragile Medical Workforce within the Haematology Service<br>(1306) Junior doctor shortages in Division of surgery<br>(1270) Waiting time for ASD and ADHD assessment<br>(654) Staff acquiring airborne hospital acquired infections whilst delivering patient care<br>(1715) Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease.<br>(902) Ability of clinical staff to view patient information electronically between systems i.e. EMIS and Meditech<br>(1668) Potential failing to respond to the results of diagnostic tests. Abnormal test results not reviewed and actioned by clinical staff in a timely manner |
| 1.2 Achievement of national and local mandatory & compliance standards | | (1524) Risk of harm due to inappropriate care of advice to patients over the age of 16 by paediatricians and specialist nurses with lack of clinical knowledge about this age group and their presentations |
| 1.3 New Hospital Environment | | (1588) Inadequate ventilation system on Critical Care (Manusa Cubicle)<br>(1388) Risk of pipe burst due to corrosion<br>(825) Risk of potential deliberate jumping from height from internal balconies<br>(2003) risk to completion of demolition project |
| 1.4 Sustainable operational delivery in the event of a 'No Deal' exit from EU | | None |


BAF Risk
Strategic Aim
Related Corporate Risk
2.1
Workforce Sustainability & Capability
2.2
Staff Engagement
2.3
Workforce Equality, Diversity & Inclusion
The best people doing their best work
(1169) Fragile Medical Workforce within the Haematology Service
(1984) Delays in children being able access Cardiac treatment, and delayed stepdowns from critical care meaning that this capacity is not available for other patients.
(1306) Junior doctor shortages in Division of surgery
(1270) Waiting time for ASD and ADHD assessment
(654) Staff acquiring airborne hospital acquired infections whilst delivering patient care
(201) Risk of being unable to meet staffing duty rota requirements in line with best practice standards
(1965) Risk of patients lost to follow up following discharge
(1904) Ability to fill nursing duty rotas effectively on ward 4A
(2016) Unsustainable vascular access service across Trust
(1919) Failure to reach 80% compliance with front line staff influenza vaccination in 2019/20
None
3.1
Service sustainability, growth and the Trust's role in a sustainable local health
3.2
Failure to fully realise the Trust's vision for the Park
3.3
Financial Environment
Sustainability through external partnerships
(1241) Lack of Capital Funding
(2003) Risk to completion of demolition project
None
4.1
Research, Education & Innovation
4.2
Digital Strategic Development and Operational Delivery
Game-changing research and innovation
None
(1715) Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease
(1187) Server infrastructure no longer replicated to a secondary site
(947) Meditech infrastructure does not have hot fail over site (Disaster Recovery Platform)
(902) Inadequate connectivity in community sites and outreach venues for clinicians to view patient records electronically
(1668) Test results not reviewed and actioned by clinical staff in a timely manner

# Board Assurance Framework 2019-20

| BAF 1.1 | Strategic Objective: Delivery Of Outstanding Care | | Risk Title: Not achieving Outstanding Quality for Children and Young People as defined by the Health and Social Care Act (2012). | | |
|---|---|---|---|---|---|
| Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led | | | Link to Corporate risk/s: 1886, 799, 1921, 1984, 1904, 884, 964, 201, 1787, 2016, 1169, 1306, 1270, 654, 1715, 902, 1668 | | |
| Exec Lead: Hilda Gwilliams | | Type: Internal, Known | Current IxL: 3x3 | Target IxL: 2x2 | Trend: STATIC |

**Risk Description**

Not having sufficiently safe service delivery models, systems and processes to deliver the highest quality care and experience for patients and families.

| 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**

Consistent and sustained compliance with internal governance processes

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| CQC Journey to Outstanding Programme | 31/03/2020 | Well-led weekly meetings embedded with focus on key actions and bi-weekly KLOE delivery groups with divisional updates and actions. In addition, self-assessment peer review programme commenced with OPD. |
| International recruitment in line with UK Guidance | 30/01/2020 | International recruitment trip completed. Full target of 75 nurses achieved, with first cohort anticipated to arrive in the UK as of 30 Jan 2020 with high levels of competencies associated to PICU / |

| | | |
|---|---|---|
| | | HDU and surgical acute areas. Surgical ACN to agree placement plans with wider nursing leadership team. |

| **Executive Leads Assessment** |
|---|
| November 2019 - Hilda Gwilliams<br>Risk reviewed, no change to score in-month. Additional mitigations in place until international workforce commence in January 2020. |
| October 2019 - Philip O'Connor<br>Risk Reviewed, no change to score in-month. Actions updated to reflect KLOE delivery groups established and meeting bi-weekly. |
| September 2019 - Hilda Gwilliams<br>No change to score in-month. Action updated to reflect actions implemented following receipt of RPIR on 13/9. |

# Board Assurance Framework 2019-20

| 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: 1524 | | |
| Exec Lead: Erica Saunders | | Type: Internal, Known | Current IxL: 3x3 | Target IxL: 3x2 | Trend: WORSE |

**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<br>- CQC rating<br>- Compliance assessment against NHSI Provider License to Board<br>- 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.<br>EP Reports to IGC |
| Divisional Executive Review Meetings taking place monthly with 'three at the top' | Divisional/Executive performance reviews |
| Weekly performance meetings in place to track progress | |
| 6 weekly meetings with commissioners (CQPG) | Meetings continue into 2019/20. ToRs attached |
| Divisional leadership structure to implement and embed clinically led services | Devolved governance structure model |
| Weekly Exec Comm Cell overseeing key operational issues and blockages. | Planned to continue during 2019/20 (held every Monday AM) |

**Gaps in Controls / Assurance**

1. Critical Care bed capacity due to building issues in the run up to winter
2. ED 4 hour target - difficult to maintain consistently due to high demand
3. Assurance required to underpin Divisional reporting on CQC standards
4. Work with CCG to manage demand & develop / fully utilise existing capacity across PC
5. Proactive management of patient flow making better use of trend analysis data

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 1. Undertake capacity & demand modelling for the surgical wards | 31/03/2020 | Modelling completed for the winter period. Best in Operative Care Steering Group now progressing annual plan based on bed occupancy |
| 2. In order to sustain high performance a task & finish group established for designing the optimal assessment unit models, and appointment based consultations for non-urgent patients. | 31/03/2020 | Extremely high attendances have continued through ED with the highest number of attendances ever during November 2019. A number of remedial actions have been identified working closely with primary care providers in order to maintain focus on patient safety and manage surge. |
| 5. Continue to monitor theatre schedule, discharge planning and capacity & demand modelling through:<br>SAFER Project Group<br>Best in Operative Care Steering Group<br>Clinical Utilisation Review<br>Best in Acute Care Programme | 31/03/2020 | Programme Assurance continues to be monitored monthly through Clinical Quality Assurance Committee |
| 3. CQC Journey to Outstanding Project | 31/03/2020 | Well Led inspection now announced (11-13 Feb 2020) which will precede a full "unannounced" detailed CQC inspection of some core services.<br><br>Journey to Outstanding Programme Approach altered to amend inspection timetable. |

**Executive Leads Assessment**

| |
|---|
| November 2019 - Erica Saunders<br>Risk score increased to reflect pressures from extremely high emergency attendances and a number of theatre cancellations on the day of planned surgery. |
| October 2019 - Erica Saunders<br>Risk reviewed. No change to score in-month and all actions remain on track for delivery of mandatory targets. ED remains a fragile area due to an increase in attendances of 11% during September 2019 reducing performance to 88.9%. An action plan for resilience and staff well-being is in place with results expected mid-November 2019. |
| September 2019 - Erica Saunders<br>Risk reviewed - no change to score in month. All actions remain on track. Challenges remain within ED due to record attendances over the summer months |

# Board Assurance Framework 2019-20

| BAF 1.3 | Strategic Objective: Delivery Of Outstanding Care | | Risk Title: The Hospital Environment | | |
|---|---|---|---|---|---|
| Related CQC Themes: Safe | | | Link to Corporate risk/s: 1588, 1388, 825 | | |
| Exec Lead: John Grinnell | | Type: Internal, New | Current IxL: 4x3 | Target IxL: 4x2 | Trend: BETTER |

**Risk Description**

A number of building concerns remain unresolved in particular pipe-work corrosion, water ingress, risk of falls and water temperatures.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Monthly issue meetings | Maintenance of issues list and issues review meeting |
| Monthly liaison meetings | Liaison minutes reported to Trust Board monthly |
| Regular reports to IGC | IGC Agendas, Reports and Minutes |
| Building Management Services Risk Register | Risk Register held on Ulysses - reported to IGC |
| NED / ED / Project Co senior group overseeing management of pipework risk | Letter of agreed actions. Minutes from meeting. |
| Water Safety Group meets monthly | Minutes |

**Gaps in Controls / Assurance**

Pipes - non-destructive testing initially looks accurate with a first phase test underway which we hope will evidence as a risk management methodology.
Water Ingress - temporary repairs in place which are proving resilient. Long term solution now planned for Spring 2020

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Plan for management of pipework to be agreed | 31/01/2020 | Final Reports awaited, however initial feedback is that non-destructive testing is proven valid and associated risk management plan can then be developed. |
| Prepare recommendation to Board on proposed pipework replacement strategy | 03/02/2020 | Timeline adjusted in line with risk management plan following non-destructive testing phase. |
| Agree a Strategy for ensuring roofing structure is water-tight | 31/12/2019 | Remedial works completed and temporary cover in place. External roof survey has been commissioned and is underway. Long term fix for roofing and sky-lights agreed and will be undertaken in Spring 2020 when weather is improved. |

**Executive Leads Assessment**

November 2019 - John Grinnell
Risk score reduced as progress made on water ingress with no re-occurrence, improved water temperature ranges and positive feedback on non-destructive testing of pipework.

October 2019 - John Grinnell
Risk reviewed - no change to score whilst awaiting rectification plans from Project Co. No water ingress in-month.

September 2019 - John Grinnell
Agreement reached with Project Co. to jointly commission an independent survey of the fabric of the roof. Awaiting outcome of non-destructive pipe testing validation meeting with Project Co. directors and members of the Board being convened to oversee.

# Board Assurance Framework 2019-20

| 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 regularly; work stream leads identified; risk assessments undertaken. Assurance framewroks completed and submitted to NHSE. |
| Internal command team structure focusing on eight key areas each week to assess level of risk and update plans based on national information. Group responds to national guidance as it is published. | Weekly report to Executive team to address deficits and escalate as required |

**Gaps in Controls / Assurance**

There may be supply issues in the event of a No deal Brexit. Our assurance is that we are in a position to respond to this and have alternatives in place for the identified high risk areas which we do.

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Guidance from NHSE is to suspend active processes pending outcome from Election. we are required to continue to work through our assurance framework on any non-green actions. | 22/12/2019 | Update report going to Board on 1 October to provide assurance in relation to business continuity plans |
| Continue to engage NHSE colleagues to ensure centrally managed mitigations are understood and adequate | 22/12/2019 | Actions as above |

**Executive Leads Assessment**

November 2019 - Lachlan Stark
Risk review undertaken today. NHSE Webinars paused pending outcome of election. maintained risk levels due to lack of clarity despite extensive work locally and nationally regarding supply chain. Current exit scheduled to 31 Jan 2020.

October 2019 - Lachlan Stark
Risk review undertaken today. NHSE Webinars set to rollout which may alter the risk rating but EU exit extension currently pushed back to 31 Jan 2020.

September 2019 - John Grinnell
Risk reviewed, no change to score. Actions updated to reflect latest position. Weekly group in place with full oversight

# Board Assurance Framework 2019-20

| 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: 1169, 1306, 1270, 654, 1984, 201, 1965, 1904, 2016 | | |
| 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<br>- Reporting at ward level which supports Ward to Board |
| Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device. | ESR self-service rolled out |
| Permanent nurse staffing pool | 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
4. Junior doctor experience not as positive as it should be

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training | 31/03/2020 | good work progresses - over 90% mandatory training across the trust with some hotspot areas still in development. |
| 2. Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. Target is 4% absence rates across the organisation. | 31/03/2020 | |
| 3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019 | 24/12/2019 | Progress delayed. reviewing in November 2019 with a roll out for business planning for 20/21 |
| Detailed action plan in response to 2018 HEE visit. Use of £60k welfare monies to re-purpose a new JD mess. JD Forum refreshed. | 29/02/2020 | |

**Executive Leads Assessment**

November 2019 - Sharon Owen
Risk reviewed actions remain on track, risk rating remains the same.

October 2019 - Melissa Swindell
Risk reviewed, actions updated.

September 2019 - Melissa Swindell
Risk reviewed, all actions remain on track, risk score remains the same

# Board Assurance Framework 2019-20

| 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: 1919 | | |
| 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 | Internal Communications Plan presented to Executives, and approved in October 2019 |

**Executive Leads Assessment**

November 2019 - Sharon Owen
Risk reviewed actions remain on track, risk rating remains the same

October 2019 - Melissa Swindell
Risk Reviewed, actions remain on track, risk rating remains the same.

September 2019 - Melissa Swindell
Risk Reviewed, actions remain on track, risk rating remains the same

# Board Assurance Framework 2019-20

| 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<br>- 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<br>- EDS Publication |
| Equality, Diversity & Human Rights Policy | - Equality Impact Assessments undertaken for every policy & project<br>- Equality Objectives |
| BME Network established, sponsored by Director of HR & OD | BME Network minutes |
| Disability Network established, sponsored by Director of HR & OD | Disability Network minutes |
| Actions taken in response to the WRES | -Monthly recruitment reports provided by HR to divisions<br>-Workforce Race Equality Standards<br>- Bi-monthly report to WOD |
| Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey | Diversity and Inclusion Action Plan reported to Board |
| 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. | 31/12/2019 | time to change plan implemented oct 19 |
| 1. Work with Community Engagement expert to develop actions to work with local community | 31/12/2019 | scoping expertise from C&M NHS resources |

**Executive Leads Assessment**

November 2019 - Sharon Owen
Risk reviewed all actions remain on track, no change in risk score

October 2019 - Melissa Swindell
Risk Reviewed, all actions remain on track, no change in risk score

September 2019 - Melissa Swindell
Risk Reviewed, all actions remain on track, no change in risk score

## Board Assurance Framework 2019-20

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

**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<br>Stakeholder events / reported to Trust Board |
| Heads of Terms agreed with LCC for joint venture approved | |
| Redevelopment Steering Group | Reports into Programme Board |
| Monthly reports to Board & RABD | Highlight reports to relevant assurance committees and through to Board |
| Capacity Lab have been engaged for a period of 3 months to complete a piece of work/proposal for setting up a Community Interest Company as well as supporting the Trust to bring partners on board with the development and providing some financial contributions | |

**Gaps in Controls / Assurance**

Fully reconciled budget with Plan.
Risk quantification around the development projects.

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Complete cost assessment and scheme rationalisation | 22/10/2019 | |
| Secure approval for plans to increase Park footprint | 12/11/2019 | Planning for Park extension submitted 31/07/2018 |
| Agree Park management approach with LCC | 31/12/2019 | Meeting with LCC Director to set up process |
| Complete cost plan for final park works | 31/12/2019 | |
| assessment of status including risk of all development projects | 31/10/2019 | |
| Secure planning | 29/11/2019 | |
| Agree plan for bringing forward Park clearance | 31/12/2019 | |
| Agree detailed plan for Phase 1 Park works | 31/12/2019 | |

**Executive Leads Assessment**

November 2019 - David Powell
Review in advance of December Board

October 2019 - David Powell
Review in advance of November Board

September 2019 - David Powell
Risk reviewed post completion of Phase 1 park tender

## Board Assurance Framework 2019-20

| BAF 3.2 | Strategic Objective: Sustainability Through External Partnerships | | Risk Title: Service sustainability, growth and the Trust's role in a sustainable local health economy. | | |
|---|---|---|---|---|---|
| Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led | | | Link to Corporate risk/s: 2003 | | |
| Exec Lead: Dani Jones | | Type: External, Known | Current IxL: 4x3 | Target IxL: 4x2 | Trend: STATIC |

**Risk Description**

Risk to service sustainability development/growth:
A) risk of failure to deliver business as usual and maximise growth opportunities due to NHS financial environment and constraints on internal infrastructure
B) Risk of failure to develop external opportunities for partnership and to proactively establish the Trust's role in the development of a sustainable local health economy
C) Risk of failing to play our part in reducing unwarranted variation in Children & Young People's services across the City and beyond.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Divisional Performance Management Framework - includes clear trajectories for challenged specialties to deliver | Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached) |
| Accreditations confirmed through national review processes | Alder Hey partake in routine Quality Systems Team (QST) Peer Reviews for range of services - e.g. CHD peer review scheduled for July 19 (evidence to follow) |
| Five year plan agreed by Board and Governors in 2014 | Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report |
| Compliance with All Age ACHD Standard | ACHD Level 1 service now up and running; developing wider all-age network to support - agreement reached to host at Alder Hey. |
| Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off (March 18, September 18) | Strategic Plan 2018-21 approved by AH Trust Board November 2018 - inclusive of international growth & development |
| Capacity Plan identifies beds and theatres required to deliver BD plan | Daily activity tracker and forecast monitoring performance for all activity. |
| Growth and sustainability through external partnerships is a key theme in the Change Programme: assurance received through Programme Board and Trust Board | Growth through Partnerships included in Strategic Business planning - both annual operational plan and the developing long term / strategic plan<br>Monitored at Programme Board and via Strategy & Ops Delivery Board |
| Gap / risk analysis against all national service specification undertaken and action plans developed | Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance. |
| Compliance with Neonatal Standards | Single Neonatal Services Business Case approved by NHS England. |
| Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate | MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly) |
| 'Our Plan' - Final - Strategic Plan to 2024: Explicit and clear about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs | 'Our Plan' approved at Trust Board October 2019 |
| 'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services | Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within. |
| Involvement of Trust Executives in partnership governance arrangements | TOR & Minutes - NW Paediatric Partnership Board |

**Gaps in Controls / Assurance**

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

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Strengthening the paediatric workforce | 31/03/2020 | 6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'.<br><br>In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements. |
| Develop Sefton and Knowsley plans for C&YP - align with One Liverpool where possible/appropriate | 31/01/2019 | |
| Collaboration with LCCG and system leaders to develop next stage of One Liverpool; develop the programme of work for C&YP / Starting Well - Children's transformation partnership to take a leadership role | 28/02/2019 | |
| Continue to develop joint partnership hosting arrangements for existing and pending ODNs with RMCH | 30/04/2020 | |

| Executive Leads Assessment |
| --- |
| November 2019 - Dani Jones<br>Risk reviewed - no change to score in month. Additional evidence attached to controls and new actions added. |
| October 2019 - Dani Jones<br>Risk reviewed: score remains as per previous month. Evidence attached to controls. |
| September 2019 - Dani Jones<br>Risk reviewed: updated to include our future and role in the wider system, 'Our Plan', staff sessions and One Liverpool plan. No change to risk level in month. |

# Board Assurance Framework 2019-20

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

**Risk Description**

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

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

**Gaps in Controls / Assurance**

1. Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan.
2. 'Grip' on CIP
3. Affordability of Capital Plans

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 3. Five Year capital plan | 31/01/2020 | Revised Capital Plan agreed by Board however latest LTP shown potential further cash shortfalls. Mitigation strategy to be further worked up based on likely delays to schemes in the latter part of the five year plan. |
| 1. Tracking actions from Sustainability Delivery Group | 31/03/2020 | on target |
| 2. Develop fully worked up CIP programme - £1.5m gap | 31/03/2020 | CIP continues to be managed weekly at SDG. Links with financial recovery and 6 workstreams which will also improve CIP position |

**Executive Leads Assessment**

November 2019 - John Grinnell
Latest forecast is a £2.4m deficit from control total. Corporate and Divisional recovery schemes being focussed on. Increased risk relating to winter pressures and financial performance that have yet to be fully scoped.

October 2019 - John Grinnell
Risk reviewed - no change to score in-month. Half yearly forecast still showing £2.8m gap. Some progress being made on recovery actions to bridge however, further step-up required. Further assessment to be undertaken at M7.

September 2019 - John Grinnell
Sustainability recovery group continues to meet weekly with an action focus on closing £3.4m gap. Significant progress being made through the targeted recovery plan

# Board Assurance Framework 2019-20

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

**Risk Description**

Failure to exploit new opportunities in research, innovation & education due to incomplete management systems.

| Existing Control Measures | Assurance Evidence (attach on system) |
|---|---|
| Establishment of RIE Board Sub-committee | Research, Education and Innovation Committee established |
| Steering Board reporting through to Trust Board | Research Strategy Committee set up as a new Board Assurance Committee |
| RABD review of contractual arrangements | Reports to RABD and associated minutes |
| Programme assurance via regular Programme Board scrutiny | Reports to Programme Board and associated minutes |
| Digital Exemplar budget completed and reconciled | |
| Innovation Co budget in place | Secured ERDF funding for Innovation Team<br>Innovation Board established |
| Establishment of Research Management Board | Research Management Board established. |
| Establish Innovation Board Committee | Committee oversight of Innovation strategy with NED expertise |

**Gaps in Controls / Assurance**

Sporadic meetings of RIE committee
Governance structure for Innovation Board to be agreed
Re-energise Research governance processes
Reporting frameworks and standards for all services to be agreed/harmonised

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| Develop a robust Academy Vision and Operating Model | 31/03/2020 | Director of Academy role approved by Executive Team. Appointment underway. |
| Agree incentivisation framework for staff and teams: for research time & innovation time. | 31/03/2020 | Research time now under pilot phase. Innovation and addressing a culture of innovation to be included in innovation 10 year strategy production. Innovation Committee strategy session planned in Q4 2019/20. |
| Complete collaboration contract with University of Liverpool. This is a strategic agreement - deadline reset to March 2020 as part of 3 year join planning with UoL VP. | 31/03/2020 | Plans, data and costs now exchanged but final agreement still to be reached. Longstop date Dec 2019, but conclusion expected before this; timescale therefore revised. |
| Complete review and implement new structures and framework for research, innovation & education | 01/10/2019 | New governance structure agreed with Chair for action in Quarter 3-4 2019/20 |

**Executive Leads Assessment**

November 2019 - Claire Liddy
Updated and reviewed. Risk static

October 2019 - Claire Liddy
Updated and reviewed

September 2019 - Claire Liddy
Updated actions and owners. risk score static

# Board Assurance Framework 2019-20

| BAF 4.2 | Strategic Objective: Delivery Of Outstanding Care | | Risk Title: Digital Strategic Development and Operational Delivery | | |
|---|---|---|---|---|---|
| Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led | | | Link to Corporate risk/s: 1715, 1187, 947, 902, 1668 | | |
| Exec Lead: Kate Warriner | | Type: Internal, Known | Current IxL: 4x3 | Target IxL: 3x2 | Trend: STATIC |

**Risk Description**

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

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

**Gaps in Controls / Assurance**

1. IT operating model assessment underway
2. Lack of secondary data centre / disaster recovery - approach agreed and progressed
3. Cyber security investment for additional controls approved - dashboards in place

| Actions required to reduce risk to target rating | Timescale | Latest Progress on Actions |
|---|---|---|
| 3. Cyber security investment for additional controls approved | 02/12/2019 | Cyber resource in place. Dashboards procured. |
| 2. Lack of secondary data centre / disaster recovery | 31/12/2019 | Equipment ordered and in the process of being configured. On track for deadline of end of 2019. |
| 1. IT operating model assessment underway | 02/12/2019 | Service Improvement Plan progressing. Proactive service implemented with key clinical areas. IT investments in new equipment being installed. Good progress with Community IT developments. |

**Executive Leads Assessment**

November 2019 - Kate Warriner
Excellent progress with key actions in relation to disaster recovery, cyber security and operating model development. All actions on track for delivery against plans.

October 2019 - Kate Warriner
On target with key dates for resilience implementation, good progress with digital futures delivery.

September 2019 - Kate Warriner
Good progress with mobilisation of digital futures strategy and actions to mitigate key resilience risks.

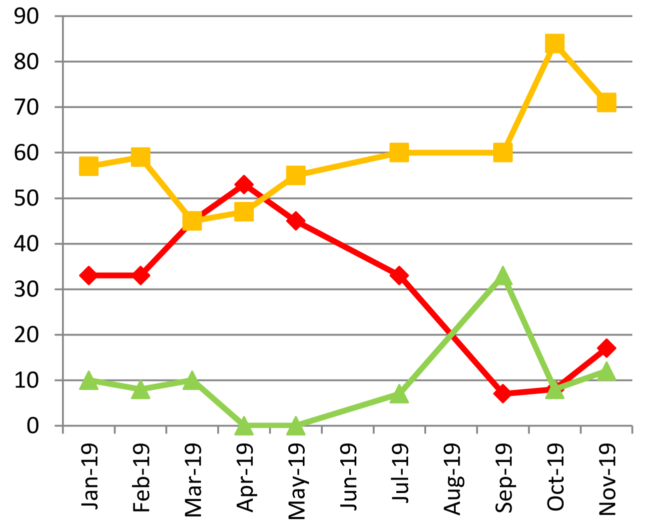
Alder Hey Children's NHS
NHS Foundation Trust

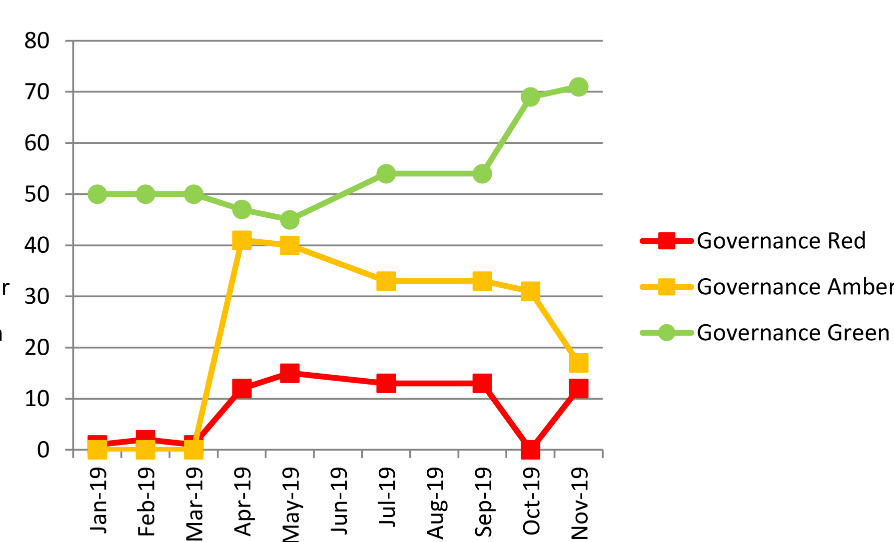
# Programme Assurance Summary
## Change Programme

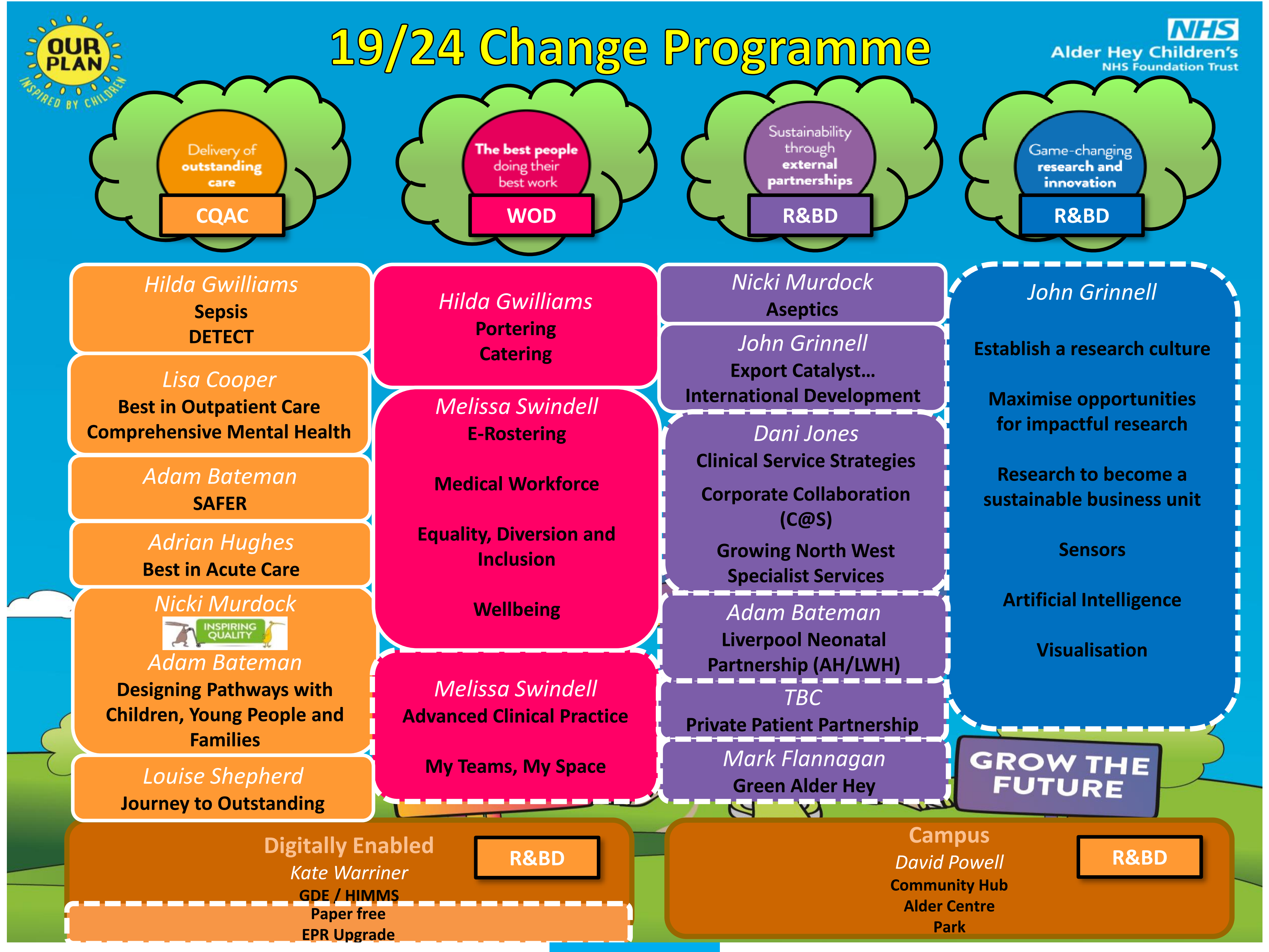
**Programme Summary** (to be completed by **Head of Programme Management**)

1. This Board report comprises of extracts from the assurance dashboard covering 6 out of the 7 themes of the change programme as reporting to the Board sub-Committees: WOD 13 November CQAC 20 October and RABD 27 October.
2. Slide 2 of this programme assurance report contains the current scope for the19/20 change programme.
3. Of the 17 projects rated in this report with regards to the **overall delivery** assessment: 12% of the projects are green rated with 71% amber and 17% red. These percentage summary a slight deterioration from the previous month.
4. The **overall governance** position is satisfactory, with 71% of the projects green rated, 17% amber and 12% red rated projects. Similarly to the overall delivery ratings, there has been a slight overall deterioration this month but more specifically due to the number of red rated projects however, some of these are due a number of newly initiated projects onto the Change Programme.

**N Deakin, Head of Programme Management and Independent Programme Assurance 27 November 19**





OUR PLAN
INSPIRED BY CHILDREN
19/24 Change Programme
NHS
Alder Hey Children's
NHS Foundation Trust
Delivery of outstanding care
CQAC
The best people doing their best work
WOD
Sustainability through external partnerships
R&BD
Game-changing research and innovation
R&BD
Hilda Gwilliams
Sepsis
DETECT
Lisa Cooper
Best in Outpatient Care
Comprehensive Mental Health
Adam Bateman
SAFER
Adrian Hughes
Best in Acute Care
Nicki Murdock
INSPIRING QUALITY
Adam Bateman
Designing Pathways with Children, Young People and Families
Louise Shepherd
Journey to Outstanding
Hilda Gwilliams
Portering
Catering
Melissa Swindell
E-Rostering
Medical Workforce
Equality, Diversion and Inclusion
Wellbeing
Melissa Swindell
Advanced Clinical Practice
My Teams, My Space
Nicki Murdock
Aseptics
John Grinnell
Export Catalyst…
International Development
Dani Jones
Clinical Service Strategies
Corporate Collaboration (C@S)
Growing North West Specialist Services
Adam Bateman
Liverpool Neonatal Partnership (AH/LWH)
TBC
Private Patient Partnership
Mark Flannagan
Green Alder Hey
John Grinnell
Establish a research culture
Maximise opportunities for impactful research
Research to become a sustainable business unit
Sensors
Artificial Intelligence
Visualisation
GROW THE FUTURE
Digitally Enabled
R&BD
Kate Warriner
GDE / HIMMS
Paper free
EPR Upgrade
Campus
R&BD
David Powell
Community Hub
Alder Centre
Park

Alder Hey Children's NHS
NHS Foundation Trust

# Programme Assurance Summary

## The Best People doing their Best Work

**Work Stream Summary** (completed by Independent Programme Assurance)

The *Improving Portering Services* project appears to be at a standstill with no evidence uploaded since January 2019.

The *Catering* project displays a very good standard of governance and all benefits/metrics are showing positive trends.

The *E-Rostering* project is a new addition to this months report with plans for *Medical Workforce*, *Well Being* and *Equality, Diversity and Inclusion* PIDS due to be presented at Programme Board in the coming weeks given their initial sign off.

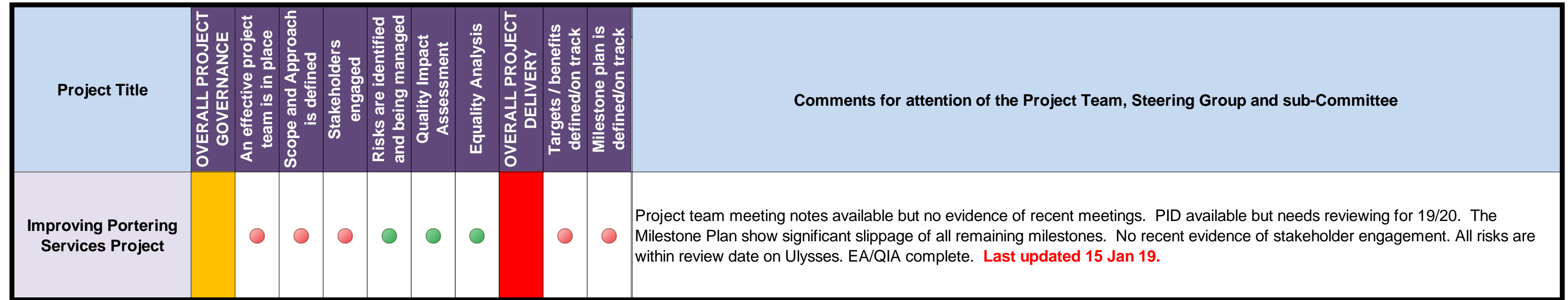
**Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 7 Nov 19**

# Independent Assurance Report – PORTERING

**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 |
|---|---|---|---|
| **OUTCOME 1.0**<br>Portering spend per month | £64,000 (per month) | £72,498 (Oct) | £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.** |

# Independent Assurance Report – CATERING

**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 (Oct 19) | Target |
|---|---|---|---|
| **OUTCOME 1.0** Profit/loss | £-28,756 (June 18) | £-15,317 | £-12,933 (July 19) |
| **OUTPUT 1.1** Increase in income | £76,296 (June 18) | £81,998 | £122,038 (July 19) |
| **OUTPUT 1.2** Reduction in expenditure | £-105,052 (June 18) | £-97,315 | £-134,971 (July 19) |
| **OUTCOME 2.0** Increase satisfaction with food served on the wards | 98% (June 18) | Q removed- no data in Oct 19. | 100% (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 | Green | Green | Green | Green | Green | Green | Green | Amber | Amber | Amber | Evidence is available for the project 'Steering Group' meetings up to 18 Sep 19.The extensive and detailed 'Review of Catering Services – Final Version' dated January 2018 is serving as a detailed PID. There is a detailed 'Catering Project Benefit Tracker 2019/20' with all benefits tracked a number of benefits showing positive trends albeit too early to ascertain whether trends will continue. May be useful to compare metrics with last year to allow for variation. There is a tracked plan milestone plan which shows the majority of milestones now complete. Evidence of stakeholder engagement is available on SharePoint. All risks are within review date on Ulysses. **Last updated 31 Oct 19.** |

# Independent Assurance Report – E-ROSTERING

**Exec Sponsor: Melissa Swindell**

To implement an electronic rostering system across the organisation.

| Key Programme Metrics | Baseline | Current (Oct 19) | Target |
|---|---|---|---|
| **OUTCOME 1.0**<br>Reduction in bank costs | £2.9M | £2.9M | £2.1M<br>(25% reduction over 3 years) |
| **OUTCOME 2.0**<br>Reduction in sickness rates | 4.9% | 4.9% | 3.5% |
| **OUTPUT 1.0**<br>Number of wards live | 0 | 0 | 20 |
| **OUTPUT 2.0**<br>Number of staff trained (Ward Managers included) | 0 | 0 | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **E-Rostering** | | | | | | | | | | | Evidence of team meetings available. A completed PID is available on SharePoint as well as bid which has submitted to NHSE. There is a benefits tracker which understandably not being tracked. There is no project plan available as of yet and again this is understandable given that the supplier has not yet been agreed. There is evidence of stakeholder engagement with external suppliers as well as internal stakeholder groups across the organisation. There are risks recoded on an Excel spreadsheet however these now need to be transferred on to the Ulysses system. There is a completed and signed EA and QIA. **Last updated 28 Oct 19.** |

# Programme Assurance Summary

## Delivering Outstanding Care

**Work Stream Summary** (completed by Independent Programme Assurance)

Overall, for the **Delivery of Outstanding Care** programme, governance and delivery ratings are good.

Some of the benefits for the *Sepsis* projects are now displaying positive trends with the clinically appropriate administration of antibiotics following Sepsis diagnosis within 60 minutes. Year 2 PID for *Sepsis* was submitted to Programme Board but requires further development before sign off.

The *Best in Outpatients* project is now green in all domains for both governance and delivery and is showing positive trends in nearly all of its measures.

Evidence is available to show the planned change in direction for some of the work streams within the *Best in Mental Health* project, focus should remain on progressing this agenda.

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

# Independent Assurance Report – SEPSIS

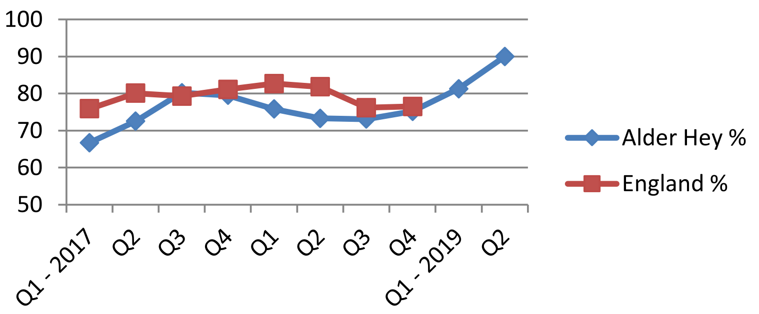
**Exec Sponsor: Hilda Gwilliams**

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 |
|---|---|---|---|
| **1.0 OUTCOME**<br>Percentage of inpatients treated for sepsis with high risk criteria in <60 mins | N/A | 90% (Q2 19/20) | 90% |
| **2.0 OUTCOME**<br>Percentage of ED patients treated for sepsis with high risk criteria in <60 mins | N/A | 65% (Q1 19/20) | 90% |
| **1.1 OUTPUT**<br>Training in relation to sepsis management for Nurses | 0 | 100% | 90% |
| **1.2 OUTPUT**<br>Training in relation to sepsis management for Clinicians | 0 | 74% | 90% |

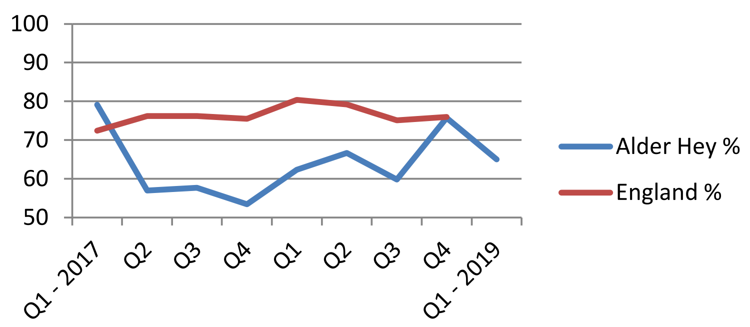
**OUTCOME 1**

**% IVAB Administration in <60 mins IP**




**OUTCOME 2**

**% IVAB Administration in <60 mins ED**




| 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 are available up to 18 September 19. 'Year 2 PID' is yet to be signed off via Programme Board. A number of benefits are trending positively however there are still a number of benefits in which evidence of tracking is not available such as training records. The current project life cycle is planned to the end of September but only tracked until the end of April 19. Considerable stakeholder engagement is now available from previous months. All risks are within their review date on the Ulysses system. EA/QIA complete. **Last updated 30 Oct 19.** |

# Independent Assurance Report – DETECT

**Exec Sponsor: Hilda Gwilliams**

The DETECT project is a research study which aims to :

- 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 |
|---|---|---|---|
| **1.0 OUTCOME** Reduction in PICU and HDU costs (Patient level costs for >11m critical care stay associated with deterioration). | £11.5m | Measured annually | £10m (£1m reduction) |
| **1.1 OUTPUT** Reduction in number of resuscitation team calls from study wards | 17 per month | 11 per month (Oct 19) | 15 per month (Dec 19) |
| **1.2 OUTPUT** Number of areas live with CareFlow | 0 | 10 wards 6 day case (Oct 19) | 10 wards 6 day case |
| **1.3 OUTPUT** Number of staff trained on CareFlow | 0 | 560 (Oct 19) | 800 |
| **1.4 OUTPUT** Reduction in annual average number of beds used for critical deterioration (6.5% reduction) | 7665 | Measured annually | 7167 |
| **1.5 OUTPUT** Reduction in Critical Care median LOS | 7.6 days | 7.3 days (Oct 19) | LOS to be better than baseline (TBC) |

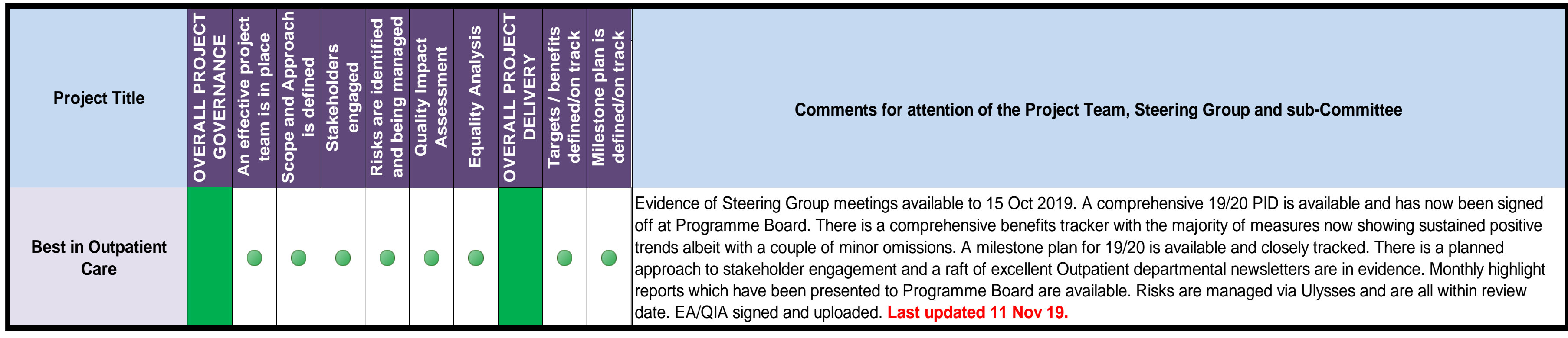
| Project Title | OVERALL PROJECT GOVERNANCE | An effective project team is in place | Scope and Approach is defined | Stakeholders engaged | Risks are identified and being managed | Quality Impact Assessment | Equality Analysis | OVERALL PROJECT DELIVERY | Targets / benefits defined/on track | Milestone plan is defined/on track | Comments for attention of the Project Team, Steering Group and sub-Committee |
|---|---|---|---|---|---|---|---|---|---|---|---|
| DETECT Study | Green | Green | Green | Green | Green | Green | Green | Amber | Amber | Green | Evidence of project team meetings are in evidence up to 3 Sep 19. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed. Benefit metrics are outlined and are now being tracked with a small number of omissions. A detailed workbook has now been uploaded which contains task logs and a comprehensive milestone plan which looks largely on track. There is a suite of stakeholder engagement in evidence. Risks are on Ulysses and within review date. EA/QIA uploaded and signed. **Last updated 12 Nov 19.** |

# Independent Assurance Report – Best in Outpatients

**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 | Target |
|---|---|---|---|
| **1.0 OUTCOME** Increase % of visitors likely to recommend OPD | 91% (Mar 19) | 90% (Oct 19) | 95% (Mar 20) |
| **2.0 OUTCOME** Increase Clinicians satisfaction with OPD (measured every 4 months measure) | 40% (Mar 18)<br>60% (Mar 19) | 85% (Oct 19) | 80% (Mar 20) |
| **3.0 OUTCOME** Reduce missing outcomes ePPF | 1253 (Mar 19) | 862 (Oct 19) | 626 (Mar 20) |
| **3.1 OUTPUT** Reduce cash up's completed after 48 hours of appointment (ePPF) | 11% (Mar 19 | 6% (Oct 19) | 5% (Mar 20) |
| **4.0 OUTCOME** Increase clinic utilisation | 84% (Mar 19) | 86% (Oct 19) | 90% (Mar 20) |
| **4.1 OUTPUT** Reduce WNB rate | 10% (Mar 19) | 12% (Oct 19) | 12% (Mar 20) |
| **5.0 OUTCOME** 5.0 Reduction in DNC list | 10128 (Mar 19) | 1571(Oct 19) | 0 (Mar 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Best in Outpatient Care | | ● | ● | ● | ● | ● | ● | | ● | ● | Evidence of Steering Group meetings available to 15 Oct 2019. A comprehensive 19/20 PID is available and has now been signed off at Programme Board. There is a comprehensive benefits tracker with the majority of measures now showing sustained positive trends albeit with a couple of minor omissions. A milestone plan for 19/20 is available and closely tracked. There is a planned approach to stakeholder engagement and a raft of excellent Outpatient departmental newsletters are in evidence. Monthly highlight reports which have been presented to Programme Board are available. Risks are managed via Ulysses and are all within review date. EA/QIA signed and uploaded. **Last updated 11 Nov 19.** |

# Independent Assurance Report – SAFER

**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 |
|---|---|---|---|
| **1.0 OUTCOME** Reduction in Trust LOS | 3.3 Days (Apr 19) | 2.93 Days (Oct 19) | 3.1 Days (Mar 20) |
| **1.1 OUTPUT** Increase in CUR compliance | 79% (Apr 19) | 83% (Oct 19) | 85% (Mar 20) |
| **1.0 OUTCOME** % of patients who know their planned date of discharge? | 67% (Apr 19) | 91% (Oct 19) | 95% (Mar 20) |
| **2.0 OUTCOME** Reduction in cancelled operations for non-clinical reasons | 27 per month (18/19) | 19 per month (average 19/20) | 20 per month (19/20) |
| **3.0 OUTCOME** Reduction of in-patient delayed discharges with a LoS <21 days | 16% (18/19) | 14.8% (Oct 19) | 12% (Mar 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| SAFER | Green | Green | Green | Green | Green | Green | Green | Green | Amber | Green | Evidence of SAFER Steering Group available up until 3 Oct 19. A comprehensive PID for 19/20 is available and has been signed off. There is a comprehensive benefits tracker which shows some but not all measures trending positively. There is a closely tracked and detailed milestone plan. Evidence of stakeholder engagement 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 12 Nov 19.** |

# Independent Assurance Report – Best in Mental Health Care

**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 |
|---|---|---|---|
| **Eating Disorder Services** | | | |
| **1.0 OUTCOME**<br>% of patients who receive their appointment within national targets | 35% (April 19) | 36% (Sep 19) | 95% (2020) |
| **Booking and Scheduling** | | | |
| **2.0 OUTCOME**<br>Reduction in WNB rate | 13.72% | 20.5% (Sep 19) | 10% |
| **3.0 OUTCOME**<br>Reduction in staff turnover rates | 15.2% | 10.6% (Sep 19) | 10% |

| 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 09 Sep 19. There is a final PID which was signed off at Programme Board on 22 Aug 19. Benefits are tracked however very few are showing a positive trend. A comprehensive milestone plan is evidenced and being tracked however there are a number of milestones which have been missed and need to be revised. 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 22 Oct 19.** |

# Independent Assurance Report – Best in Acute Care

**Exec Sponsor: Adrian Hughes**

The aim of the project is to re-design and implement a number of models of care for Alder Hey. The 5 workstreams are as follows; HDU, EDU, ACT Care Team, Out of Hours and Pathways and Thresholds.

| Key Programme Metrics | Baseline | Current | Target |
|---|---|---|---|
| **High Dependency Unit (HDU)** | | | |
| **1.0 OUTCOME** Reduction in average LOS in HDU | 4.7 (18/19) | TBC | 4.2 Days (Apr 2020) |
| **2.0 OUTCOME** Reduction of re-admissions within 48 hours | TBC | TBC | TBC (Apr 2020) |
| **1.1/2.1 OUTPUT** Number of hours with Consultant cover | 0 | 0 | 168 Hours (full 7 day cover) (Nov 19) |
| **Acute Care Team (ACT)** | | | |
| **3.0 OUTCOME** Reduction in unplanned admissions to PICU/HDU | 328 (18/19) | TBC | 279 per annum (Apri2020) |
| **4.0 OUTCOME** Reduction in unplanned admissions and bed days in Critical Care | 1600 (18/19) | TBC | 1360 per annum (Apr 2020) |
| **3.1/4.1 OUTPUT** Full recruitment to ACT team | 0 WTE | 9.38 WTE (Oct 19) | 21.04 WTE |
| **Out of Hours** | | | |
| **OUTPUT** Number of General Paediatricians onsite until later in the evening | 0 WTE | 0 WTE (Oct 19) | 3.0 WTE |

| 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** | Green | Green | Green | Green | Green | Green | Green | Amber | Amber | Amber | Evidence of Models of Care meetings up to 4 Nov 19. A high level design process is available and the 19/20 PID has now been signed off. Various data packs are in evidence and the project now has clear measures for success which are categorised into outputs and outcomes. Some of these metrics however still require baselines and tracking. A comprehensive milestone plan is available and is being tracked however there are now a number of missed milestones which need revised dates. There is evidence of stakeholder engagement including updates to Programme Board. Risks now available on Ulysses and are within review date. There is signed EA/QIA in evidence. **Last updated 12 Nov 19.** |

# Independent Assurance Report - Inspiring Quality

**Exec Sponsor: Nicki Murdock**

Alder Hey's programme of work which promotes continuous quality improvement to deliver 3 key aims; to put children first, to be the safest children's Trust in the NHS and to achieve outstanding outcomes for children

| Key Programme Metrics | Baseline | Current | Target |
|---|---|---|---|
| **1.0 OUTCOME** Children report that we 'put them first | Friends & Family Test (Oct) | TBC (Oct) | 95% of children report that we 'put them first |
| **1.1 OUTPUT** Sweeney Collaborative Programme | 0 | 0 | 3 teams scheduled to have participated in programme by March 2020 |
| **1.2 OUTPUT** Staff trained in Child and Family Centred Care | 0 | 0 | 784 staff to be trained by Nov 2021 |
| **1.3 OUTPUT** Pathways & Improvements designed with children and families | 0 | 0 | 5 pathways complete by Nov 2020 |
| **2.0 OUTCOME** Children report meeting the care goals they set | 0 | 0 | 95% of children report meeting the care goals they set |
| **3.0 OUTCOME** Specialties achieve outcomes that rank internationally | TBC | TBC | 10 specialties achieve outcomes that rank in the top 10% internationally |
| **4.0 OUTCOME** Staff report feeling able to make improvements to care | TBC Staff Survey (2018) | TBC Staff Survey (2019) | 80% of staff report feeling able to make improvements to care |
| **4.1 OUTPUT** Staff trained in Strong Foundations Leadership programme | 0 | 45 | 85 staff to be trained by November 2021 |
| **4.2 OUTPUT** Issues to be resolved by using huddle boards | 0 | 0 | 100 issues to be resolved by November 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Inspiring Quality** | | | | | | | | | | | Evidence of project meetings to 4 Nov 19. The Inspiring Quality Plan serves as a comprehensive PID. Benefits are clearly defined in the PID and a presentation entitled 'Outputs and Outcomes' now indicates the measures which the programme is intending to measure. A Phase 1 'Starting Change' paper is available which clearly maps out the next 6 months of the plan however this phase is due to come to an end at the end of Oct 19 and details of phase 2 are now required. There is evidence of wider stakeholder engagement in the form of a staff engagement session with pledges however this programme of work would benefit from a detailed communication plan. Risks are now on Ulysses and are being tracked. There are a number of EA/QIA to be complete due to the multiple projects which sit within the programme. Some of these are now available in draft. **Last updated 11 Nov 19.** |

# Programme Assurance Summary

**Work Stream Summary** (completed by Independent Programme Assurance)

### Sustainability through External Partnerships

The *Aseptics* project 's plan is now showing some slippage of milestones even after submitting an exception report to reset milestone dates only a few months back.

The *Export Catalyst* ratings for both governance and delivery have now deteriorated as the project life cycle has come to an end with no milestones planned beyond September 19.The Exec Sponsor is now required to set the direction of the project for the coming months.

### Global Digital Exemplar

The governance ratings of the GDE / HIMMS programme are satisfactory and the delivery of speciality packages looks largely on track to meet the November target.

### Park, Community Estate and Facilities

The governance and delivery ratings for the *Park, Community Estate and Facilities* programme remain good with regards to governance and satisfactory with regards to delivery however; there are still gaps with regards to the identification and tracking of SMART metrics for all the projects within the programme. Accepting that some of the start dates for these metrics are not scheduled until 2020, baselines can still be sought.

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

# Independent Assurance Report – Aseptics

**Exec Sponsor: Nicki Murdock**

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

| Key Programme Metrics | Baseline | Current | Target |
|---|---|---|---|
| **1.0 OUTPUT**<br>Increase the number of commercial research studies open to recruitment | 3 (April 19) | 3 (Sep 19) | 6 (July 2020) |
| **2.0 OUTPUT**<br>Increase in number of patients on research studies. | 2 (April 19) | 4 (Sep 19) | |
| **3.0 OUTPUT**<br>Reduction in medication errors in ASU (injectable therapy) | 5 (April 19) | 8 (Sep 19) | 2 (July 2020) |
| **4.0 OUTPUT**<br>Increase in number of ready to use products prepared in-house by ASU | 66 (April 19) | 289 (Sep 19) | 230 (Jan 2020) |

| Project Title | OVERALL PROJECT GOVERNANCE | An effective project team is in place | Scope and Approach is defined | Stakeholders engaged | Risks are identified and being managed | Quality Impact Assessment | Equality Analysis | OVERALL PROJECT DELIVERY | Targets / benefits defined/on track | Milestone plan is defined/on track | Comments for attention of the Project Team, Steering Group and sub-Committee |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Aseptics** | Green | Amber | Green | Green | Red | Green | Green | Amber | Amber | Amber | Minutes of the Quality Management Meeting of the Aseptics Services Department are available up to 20 Aug 19 and project team meetings up to 18 Jul 19. Scope is described by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' dated 16 March 2018' together with a 'Project Overview Document' dated 14 Jun 2018. A final business case dated 9th April 2019 is also evidenced. The number of ready to use products made in house has seen a marked increase in September. A 'Project Milestone Plan' is in place and being tracked and an exception report is in evidence dated 22.05.19 which resets some milestone deadlines however a number of these milestones are once again showing slippage. Project risk(s) now require review on Ulysses. EA/QIA signed off. **Last updated 5 Nov 19.** |

# Independent Assurance Report – Export Catalyst

**Exec Sponsor: John Grinnell**

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

| Key Programme Metrics | Baseline | Current | Target |
|---|---|---|---|
| **OUTPUT 1.0**<br>Sustainable Services | £200k contribution | £1m target contribution | Jan 2020 attain by Apr 2022 |
| **OUTPUT 2.0**<br>Strategy & Plans | NA | Final version of strategy document available | Sep 19 |
| **OUTPUT 3.0**<br>Pricing & Markets | NA | Documented and Agreed | Sep 19 |

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

# Independent Assurance Report – GDE

**Exec Sponsor: Kate Warriner**

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

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

| Key Programme Metrics | Baseline | Current | Target |
|---|---|---|---|
| **OUTPUT 1.0**<br>Number of specialty packages complete | 0 | 41 (Oct 19) | 52 (Nov 19) |

| Project Title | OVERALL PROJECT GOVERNANCE | An effective project team is in place | Scope and Approach is defined | Stakeholders engaged | Risks are identified and being managed | Quality Impact Assessment | Equality Analysis | OVERALL PROJECT DELIVERY | Targets / benefits defined/on track | Milestone plan is defined/on track | Comments for attention of the Project Team, Steering Group and sub-Committee |
|---|---|---|---|---|---|---|---|---|---|---|---|
| GDE | | | | | | | | | | | Digital Oversight Collaborative meeting notes available up to 30 Oct 19. Programme is RAG rated green and on target as per the programme's own assessment and on the CORA portal which is NHS Improvements digital platform. Speciality packages which are part of the GDE programme are on track to deliver its November milestone. There is evidence of some stakeholder engagement. Some risks are overdue and require review on Ulysses. **Last updated 20 Nov 19.** |

# Independent Assurance Report – Alder Centre

**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 |
|---|---|---|---|
| **OUTCOME 1.0**<br>Expansion of services on offer | Not available | Not available | 10% increase in income (April 2020) |
| **OUTCOME 2.0**<br>Increase the types of therapies delivered<br>(To include arts, horticultural and pet therapy) | Not available | Not available | Not available (April 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Alder Centre | | | | | | | | | | | Development weekly meetings are evidenced up to 13 Nov 19 and campus steering group meetings up until 15 Oct 19. Meeting notes with architects also available up until 26 Sep 19. Scope/approach defined in PID. Benefits defined in PID but no evidence of the tracking of benefits. A comprehensive Gantt chart is available but does not appear to map all dates to all milestones. Evidence of Comms/ Engagement activities. Risks are on Ulysses and are within review date. EA/QIA complete. **Last updated 19 Nov 2019.** |

# Independent Assurance Report – Community Hub

**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 |
|---|---|---|---|
| **OUTCOME 1.0**<br>Staff morale | Not available | Not available | Improvement of 10% (Sep 20) |
| **OUTPUT 1.1**<br>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** | (green) | (green) | (green) | (amber) | (green) | (amber) | (amber) | (amber) | (green) | (amber) | Actions available via the development directorate meeting up until 13 Nov 19 and campus steering group up until 15 Oct 19. A recently revised PID for 2019 has now been uploaded as of 9 Oct 19. A comprehensive Gantt chart is available which is being tracked but does nt appear to map all milestones to dates. Benefits are detailed in the PID with expected start dates in 2020. Evidence of stakeholder engagement however engagement with building users would also be beneficial. Risks are within review date on Ulysses. EA/ QIA complete but not signed by Exec Sponsor. **Last updated 19 Nov 2019.** |

# Independent Assurance Report – Park

**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 |
|---|---|---|---|
| **OUTCOME 1.0**<br>Generate income | £0 | Not available | Not available |
| **OUTCOME 2.0**<br>Support environmental sustainability | Not available | Not available | 100% increase in number of trees (2021) |
| **OUTPUT 2.1**<br>Increase community participation | 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 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Park | Green | Green | Green | Green | Green | Green | Green | Amber | Amber | Amber | Actions and agendas available for the development directorate meeting in which the park project forms part of the agenda up until 13 Nov 19 however meetings with external key stakeholders would also be beneficial at this stage of the project. PID available on SharePoint and has recently been updated. There is a comprehensive suite of benefits outlined in the PID however some benefits are not SMART and not tracked. Milestones are being tracked via a programme plan which was updated on 23 Oct 19. Evidence of stakeholder engagement including details of a planned event with the community scheduled for 30 Nov 19. Risks are on Ulysses and within review date. EA/QIA complete. **Last updated 19 Nov 2019.** |

# A Guide to Programme Dashboard Ratings

**The programme dashboard** is a pragmatic assurance framework enabling the Sub-Committees, acting with the delegate authority of the Trust Board, to gain a level of confidence that the programme will deliver the changes, in a timescale, and accrue benefits. **The touchstone for this assurance is documented evidence.**

The progress of each project across the Change Programme is rated in terms of both governance and delivery. All projects are rated monthly against seven key questions, namely:

**Governance**

1. Is an effective project team in place?
2. Is the scope and approach defined?
3. Are all stakeholders engaged?
4. Are risks identified and being managed?
5. Has an Equality Analysis/Quality Impact Assessment been completed?

**Delivery**

6. Are targets/benefits defined/on track?
7. Is a milestone plan defined/on track?

The answers to these questions are then rated and shown on the 'dashboard' by means of red, amber or green ratings.

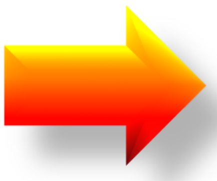
This guide is intended to assist all project teams by explaining, in straightforward terms, what the standard is for a successfully (green) rated project. It does this by describing **'why'** the evidence is important for each of the seven rated categories and then goes on to explain **'how'** the standard of evidence can best be achieved.

Alder Hey Children's NHS
NHS Foundation Trust

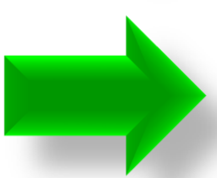
# Programme Assurance: Confidence = Evidence

## Governance

### 1. Is an effective project team in place?



**Why is this important?** The most common cause of project failure is the lack of suitably skilled people with the time available to manage the change process. It is important to consider the composition of the team as the right capability and capacity will be vital to achieving a positive outcome. The dashboard rating seeks to raise any issues for quick resolution.



**How to achieve the standard.** The dashboard rating guidance is that the Programme Assurance Framework will be seeking evidence that the project team is defined and members are fully aware of their roles and responsibilities as a part of the team. Members of the team would be expected to meet regularly, at least once a fortnight as a benchmark, to review progress against the plan and ensure that other domains of project management are being appropriately managed with all evidence logged on the programme 'SharePoint' site. All notes and minutes of project team meetings should be uploaded to the project's SharePoint domain.

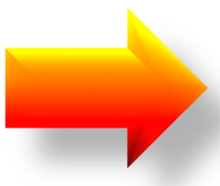
**The test** will be both the capacity and the capability; have the members of the team been given sufficient time, and have the team sufficient capability? Other likely reasons for the 'effective project team rating' to fall to amber or red will include: failure to allocate roles and responsibilities; a lack of regular (weekly) updates to the 'SharePoint' site; and a range of other project ratings falling to amber/red that may indicate an ineffective team.

Alder Hey Children's NHS
NHS Foundation Trust

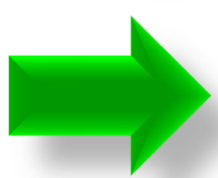
# Programme Assurance: Confidence = Evidence

**Governance**

**2. Is the scope and approach defined?**



**Why is this important?** Projects that are unclear about the breadth and depth of the remit, and lack clarity about how the project will work, will be more likely to fail. Clear definition shows respect for all those involved and the use of their valuable time; moreover, it allows stakeholders to understand the project and be able to contribute and assist in a more effective way. The dashboard rating is an objective view of this dimension.



**How to achieve the standard.** The dashboard rating guidance is that the Programme Assurance Framework will be seeking evidence that a 'Project Initiation Document' (PID) has been fully completed to a standard that would allow an interested stakeholder to fully understand the scope of the project. The Trust templates should be used as the default standard for these documents; however, it is recognised that large programmes (e.g. capital build), bespoke projects (e.g. workforce/OD) and IM&T (e.g. Meditech) may for good reason need to adapt the template or use specialist project tools and techniques to define the work. The Programme Assurance Framework will interpret these other tools pragmatically while applying the principle of clarity of scope and definition.

**The test** will be the ability of other project teams, the Programme Assurance Framework and members of the Sub-Committee to read the PID and understand the breadth of the scope and also the defined approach to delivering the change.

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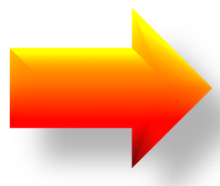
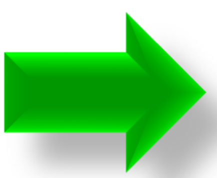
# Programme Assurance: Confidence = Evidence

## Governance

### 3. Are all stakeholders engaged?



**Why is this important?** For projects to be successful they may need to harness the support of many people beyond the immediate project group and, indeed, listen to and manage the concerns of others. Moreover, projects are likely to encounter difficulties unless they are transparent about who is involved – both in the team and as identified stakeholders – so that others can review the wider 'membership' for gaps or even opportunities to join in and help the project.



**How to achieve the standard.** The dashboard rating guidance is that the Programme Assurance Framework will be seeking evidence that the project is not only informing and sharing information but also engaging with stakeholders, and listening to and responding to their views. The engagement should demonstrate an understanding of the stakeholders ideas and concerns and that the project is offering practical opportunities for those stakeholders to discuss and shape the work being done to transform services. A successful engagement process will help to develop a more thorough understanding of the patient and staff perspective and lay the foundations for a constructive change process. It is vital that senior clinicians and managers invest time in working directly with all stakeholders so that meaningful discussions can take place and to ensure stakeholder views really do drive the planning and delivery.

**The test** will be that documentary evidence of stakeholder analysis (where required for the project), stakeholder communications and stakeholder meetings/events are all uploaded onto SharePoint as a comprehensive evidence base.

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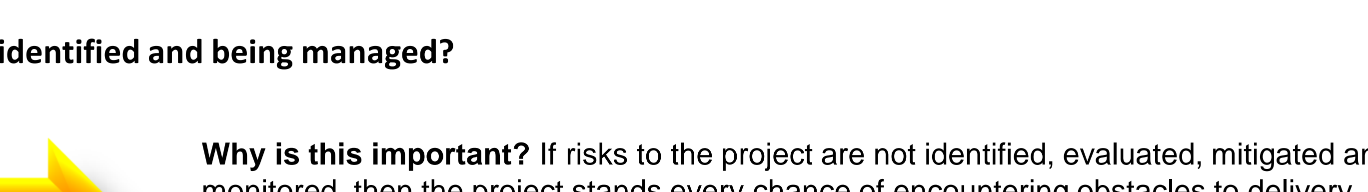
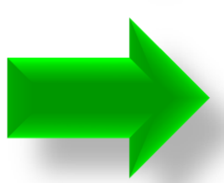
# Programme Assurance: Confidence = Evidence



## Governance

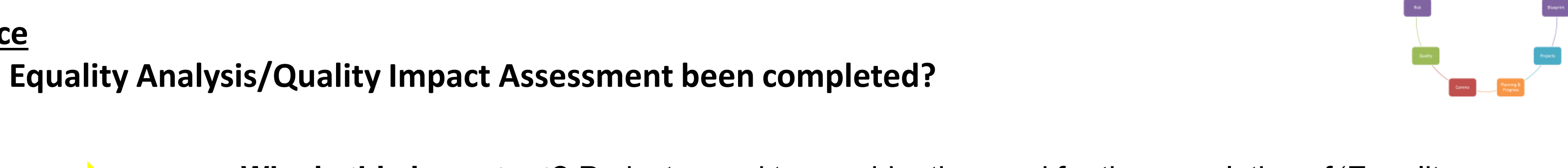
### 4. Are risks identified and being managed?

**Why is this important?** If risks to the project are not identified, evaluated, mitigated and monitored, then the project stands every chance of encountering obstacles to delivery occurring as unwanted surprises. Each project team is required to address risk and ensure that those risks are logged onto the Trust risk management system; this is to ensure that there is not a separate programme risk register but that it is embedded within the normal Trust governance framework.



**How to achieve the standard.** The dashboard rating guidance is that the Programme Assurance Framework will be seeking evidence that the project is successfully managing risks by ensuring that project team members identify, classify and communicate all risks in a consistent manner. The team should also analyse, challenge and facilitate the management of risks. It will be necessary to hold review meetings to check that mitigating actions are being followed through and ensure that risks rated as ‘high’ and ‘extreme’ are closely monitored and appropriate actions taken. The objective of the risk process is to identify and manage risks either by reducing the likelihood of occurrence or reducing their impact if they do occur. For the purposes of clarity, a risk is a threat which, if it came to fruition, could have a negative impact upon the project’s ability to achieve its objectives or realise the anticipated benefits.

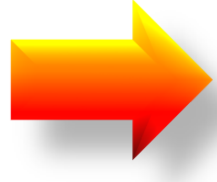
**The test** will be that the project has recorded and classified the risks on the Trust risk management system and is regularly updating the system as the project progresses.



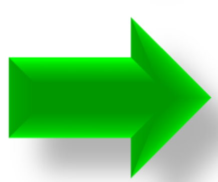

# Programme Assurance: Confidence = Evidence

**Governance**

**5. Has an Equality Analysis/Quality Impact Assessment been completed?**



**Why is this important?** Projects need to consider the need for the completion of 'Equality Analysis/Quality Impact Assessment' (EA/QIA) for the work of the project to ensure that there are no significant impact on equality and/or quality that may need to be mitigated or managed. The project needs to provide assurance that all work with significant potential impact on equality and/or quality should be subject to an assessment.



**How to achieve the standard.** The dashboard rating guidance is that the Programme Assurance Framework will be seeking evidence, in practical terms, that each project line featured on the programme dashboard will be considered for the potential impact on equality and/or quality. Only those project lines deemed to have 'significant potential impact on equality and/or quality should be subject to a EA/QIA'; for the sake of clarity, this means a negative or adverse impact on equality and/or quality. Those not considered to have such potential will not be subject to a EA/QIA; this categorisation will preserve the integrity and value of the EA/QIA process. The decisions regarding categorisation of project lines will be made, in the first instance, by the project team.

**The test** will be that the project team has read and understood the Trust 'EA/QIA – Process' (this can be found on the SharePoint site under Programme Assurance Framework/Quality…) and raised a EA/QIA template to either: record that a EA/QIA assessment is not required for the project under the terms of the defined process; or, that a EA/QIA assessment has been conducted, scored, and signed off by the key project team signatories to the document, prior to final sign off by the Director of Nursing and the Medical Director.

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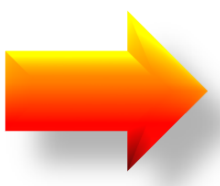
NHS Foundation Trust

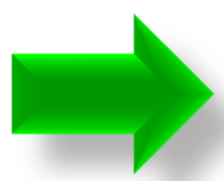
# Programme Assurance: Confidence = Evidence

## Delivery

### 6. Are targets/benefits defined/on track?

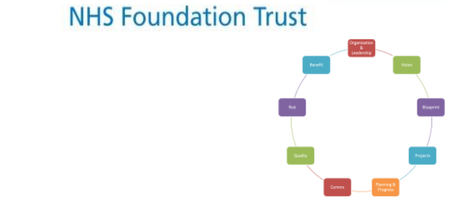


**Why is this important?** Any project that is not clear about the rationale for running the project – given the expense of resources used to do the work – will struggle to demonstrate any tangible benefit at the conclusion of the project cycle (even if the benefit is mitigation of a risk). Therefore, it is essential to quantify benefits in terms of a baseline, target and trajectory at the start of the project. This can be achieved for both quantitative and qualitative dimensions of benefits. The dashboard ratings assess whether benefits are identified/on track.



**How to achieve the standard.** The dashboard rating guidance is that the Programme Assurance Framework will be looking for evidence that the rationale for running the project is clear in terms of the 'difference' that the project objectives will make once attained. This may be repairing a system that is 'broken' to bring it back to a sustainable quality standard or advancing a service by introducing a transformational change. The benefits should be defined from the outset of the project, as it is being established, and then refined during the design of the project. It should be clear that the data to establish the baseline - the 'as is' state (and the date of that baseline) - can be accessed; thereafter, arrangements should be in place for the measurement of benefits as implementation commences.

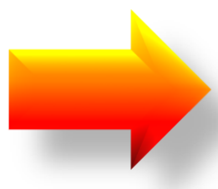
**The test** will be the identification of the benefits the project aims to deliver, quantified with a baseline and the projected improvement by an agreed date. It is advisable to show a calendar baseline with the projected improvement stated as a % or numerical improvement by an agreed date. The project should show how the benefit will be described (graph, chart, matrix) and how and at what frequency the benefit will be shown as a run-rate (trend line).



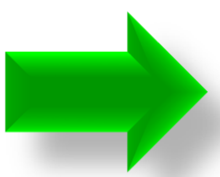

# Programme Assurance: Confidence = Evidence

## Delivery

### 7. Is a milestone plan defined/on track?



**Why is this important?** The absence of a plan will undermine any attempt to create a sense of momentum within a project team to generate the enthusiasm and energy required to underpin delivery. A milestone plan is a highly effective method of setting a tempo for the project work and it is useful for the granularity on the time line to show weekly activity. The plan will also enable team members to have specific tasks allocated with a deadline for completion.



**How to achieve the standard.** The dashboard rating guidance is that the Programme Assurance Framework will be seeking evidence that the list of activities to be completed to deliver the project objectives is clearly described to a sufficient level of detail (weekly milestones is a good discipline). These should be presented in a Gantt chart format – activities listed on the vertical axis and calendar timeline on the horizontal axis – with each activity having a date for completion.

**The test** will be that the plan includes all activities under the four project gateways - 'establishing' the project, 'designing' the project, 'implementing' the project and 'sustaining and reviewing' the project – and provides a sufficient level of detail for the stakeholders and Programme Assurance Framework to ascertain whether the project is on track. The programme dashboard is updated monthly and ratings depend upon the project plan being reviewed and updated at the same frequency. Even when there is no change, simply 'checking out' the plan on SharePoint and then 'checking in' provides the Programme Assurance Framework with a cue that the plan has been reviewed on that date.

Alder Hey Children's NHS
NHS Foundation Trust

# The Guide to Programme Dashboard Ratings

The seven key questions asked of each project are a reasonable test of the evidence that any well run project should, in any event, already have at it's disposal. Therefore, it is an efficient method of checking the quality of project work by looking – by means of the transparent 'SharePoint' site – at the live documents for each project as opposed to invoking another layer of 'project reporting'.

The guidance, therefore, is for every project team to focus on the seven questions and ensure that - at any point in the project cycle – the evidence on SharePoint provides colleagues with confidence in a project's governance arrangements and delivery.

Finally, when ratings do show 'amber' or 'red' this should be less an opportunity to discuss the 'assessment' and more a cue for immediate action to understand the nature of the problem and resolve it at the earliest opportunity. The dashboard ratings are assessed monthly by the Programme Assurance Framework and, on a change programme of this size and complexity, those ratings can be expected to remain dynamic and react to events and changing circumstances in programmes and projects.

**Natalie Deakin – Independent Assurance – Nov 19**

# BOARD OF DIRECTORS

**Tuesday 3 December 2019**
**Part 1**

| | |
|---|---|
| **Paper Title:** | **Communicating Our Alder Hey Message Guide, Calendar and a Communications Cascade** |
| **Report of:** | Mark Flannagan<br><br>Marketing and Communications Director |
| **Paper Prepared by:** | Mark Flannagan, Marketing and Communications Director<br><br>Colin Beaver, Deputy Director of Marketing and Communications |
| **Purpose of Paper:** | Decision ☐<br>Assurance ☐<br>Information ■<br>Regulation ☐ |
| **Background Papers and/or supporting information:** | **The Board is asked to receive the attached Calendar and Message Guide, and recognise that they still require finalisation but given its corporate importance the Board is asked to note.** |
| **Action/Decision Required:** | To note ■<br>To approve ☐ |
| **Link to:**<br><br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care** ■<br>**The best people** doing their best work ■<br>Sustainability through **external partnerships** ■<br>Game-changing **research and innovation** ■<br>**Strong Foundations** ■ |
| **Resource Impact:** | None identified |

## 1. Purpose

This paper provides the Trust Board with an overview of our approach to delivering consistent, strong messages about Alder Hey, internally and externally. The Board is being informed as the approach is being finalised, ready for full implementation from January 2020.

This paper outlines three parts of the whole: a Communications Cascade process; a Core Message Guide; and an annual Communications Calendar.

The Board is asked to particularly note the Communications Calendar, which will henceforth be brought annually to the Board in November for information. This allows the Board to have oversight of certain key dates (such as the Annual Members Meeting) and to understand when and how we intend to communicate Our Plan each year.

## 2. The Communications Cascade

Our new Communications Cascade approach to internal communications uses identified channels by which we will keep staff informed of important (and some not so important) information. This cascade has formalised many existing channels, as well as adding in new ones to create a bigger impact using consistent, joined up communications. This Cascade will normalise and embed internal information sharing between all staff. We will continue to look at how this works and for opportunities to develop further. The channels are as follows:

### Daily delivery

Network notices (all staff emails)
Intranet announcements
Corporate Twitter (Protected view) – TO BE DISCUSSED AND AGREED

### Weekly delivery

Monday Digest: a weekly digest of messages delivered in the week before, plus other highlights, e.g. media coverage. This will be delivered via corporate email; personal email, WhatsApp and will be available on the intranet.

### Fortnightly

‘Your Alder Hey’ e-newsletter: Focus on stories, with a ‘human interest’ perspective, but also containing classified ads to seek to engage more staff to look at the newsletter.

### Monthly

Latest from Louise meeting: Held within 48 hours of each Board meeting this will focus on progress towards Our Plan. Attendance at this is mandatory for an identified and named set of leads, with reports back to departments and Divisions about attendance.

CEO’s Month in Review: this will be digital, but with short-run printed copies dropped in staff areas, and will be a look back over the previous month, with a selection of curated story highlights, news and information; media rich; to include ‘Guest Blog’

**Quarterly**

"Town Hall" meetings with the, Chief Executive and Exec Team.: Focused on continuing a direct conversation with staff at all levels about Alder Hey in all aspects, but with a core focus on Our Plan. Held in our hospital and in a Community venue.

'Alder Hey Life': a staff newspaper focusing on stories of human interest but with the lay-out re-organised to reflect Our Plan. Print copy distributed throughout the Trust

**Annually**

'Our Plan' Annual Review: 'What have we achieved over the last 12 months'; accessible, staff-focused. Printed copy, but also online (similar to annual summary, but staff-focused)

### 3. Core Message Guide: *Our Alder Hey*

A current draft design of this is attached with this paper: but there are some further changes to follow, including the title and cover page, to make it ready for January. This is in hand. The Board is being asked to note this approach to engaging staff in our core messages.

This new publication - *Our Alder Hey* - is the place that provides everyone with core messages about Alder Hey, our Vision, Values, Our Plan, supported by stories about each of our four key elements, our "trees". It is not designed to be nor is it possible to be, a comprehensive encyclopaedia of text to use across all of our communications. Instead it provides a useful quick and easy guide which colleagues can use to tell our shared story.

It's practical use will be far and wide: from providing "boiler plate" descriptions of Alder Hey for use in presentations, papers, etc. to providing examples of the best of our stories, as a prompt for colleagues to identify and share their own. This is a tool I have used elsewhere, to great effect, resulting in a significant shift to communicating around shared messages.

To make this guide "real" we will distribute it via the above mentioned cascade and through other routes, working with colleagues to explain the guide's benefits and possible uses. We will also, in March 2020, continue the process with Alder Hey Communications Workshops for interested staff on why communications matters, how my department can help deliver better communications, and how, by using the Guide and other tools, every member of staff can convey powerful messages.

Finally, it is likely that we will evolve this guide, as appropriate, based on feedback and further development of our messages.

### 4. The Communications Calendar 2020

Alongside *Our Alder Hey* we have produced a Communications Calendar. This calendar will in future be brought to the Trust Board each November, as a key point in the year when we will agree core communications needs for the next calendar year, aligned to the four elements of Our Plan. This will be a dynamic document which we will adapt as planned events change timings, or as we change plans based on other needs.

**NOTE: The Board is asked to recognise that the attached Calendar still requires finalisation of some key dates before we issue Trust-wide.**

The core purpose of the calendar is to provide an agreed framework for our communications, aligned to messages, as a recognised way of managing priorities proactively, versus our constantly responding reactively. It also locks in certain key items and themes, to allow better long-term planning, and an annual method of agreeing corporate communication opportunities.

Within the calendar is the integration of shared activities with the Alder Hey Charity, seeking to work together within the same agreed themes, agreed in advance to deliver a more joined-up and impactful communications opportunity.

The calendar will not represent the totality of the work that needs to be done by my department but it will allow for a greater degree of prioritisation, providing a base line of activity that we know we need to deliver and, therefore, a method of judging as we go along of what we cannot deliver, where this is necessary.

**5. Next steps**

The Board is asked to note the above.

NHS
Alder Hey Children's
NHS Foundation Trust
Growing our stories
A guide to Core Messaging
OUR PLAN
INSPIRED BY CHILDREN

## HOW WE COMMUNICATE: OUR MESSAGES, OUR STORIES

**If we want colleagues, families and partners to understand the difference we make, and we intend to make in the future, we need to communicate with them clearly and with purpose.**

We need to be consistent, not just in the way we look, but in the way we sound. Anyone – of any age – should hear the Alder Hey story and understand their place in it.

Every kind of contact is an opportunity to talk about our Alder Hey. From patient leaflets to our website, media coverage and social media, we should tell our stories in a compelling, distinctive and consistent way. Here you will find some guidance on how to do this.

Everyone should have the chance to tell their story about Alder Hey and here you'll find examples to inspire you to find and use your own stories, ones that have meaning to you.

**We hope you'll refer to this guide often and talk about Our Alder Hey at every opportunity.**

We are One Alder Hey and we are very special!

## WHO IS ALDER HEY HERE FOR?

It's a simple question, but an important one that everyone should be able to answer.

**We are here for children and young people. We improve their health and emotional wellbeing by providing the highest quality, innovative care, and by working in partnership with all to improve the lives of all children and young people.**

## WHAT DO WE WANT?

Every organisation needs a clear vision for the future.

**This is ours...**

**A HEALTHIER FUTURE FOR CHILDREN AND YOUNG PEOPLE**

## HOW DO WE SAY THIS SIMPLY AND CLEARLY?

**Everything we do puts children and young people at the centre. No matter what you're communicating or who to, what you say should have children and young people at the centre.**

That is why we have developed a look for Alder Hey that is child and young person-friendly and that allows us to create an environment that feels fresh, colourful, and tailored to our audience. (If you want to find out more about this, just take a look at our brand guidelines).

We know it's not always easy to put all the amazing things we do into words. So here are some core phrases – called **"boilerplate statements"** – that you can draw on when you need. We've made them different lengths so you have something to suit all kinds of contexts.

## If someone asks you what Alder Hey is, here's how to answer them in...

### ...10-15 WORDS

Alder Hey is committed to creating a healthier future for children and young people.

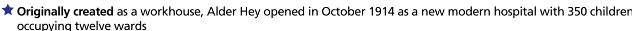
### ...50-60 WORDS

Alder Hey is committed to creating a healthier future for children and young people – and they are at the heart of everything we do. Based in Liverpool, we are the busiest children and young people's NHS Trust in the UK and have been a world leader in healthcare and research for over 100 years.

### ...10-120 WORDS

Alder Hey is committed to creating a healthier future for children and young people – and they are at the heart of everything we do. Based in Liverpool, we are the busiest children and young people's NHS Trust in the UK and have been a world leader in healthcare and research for over 100 years. We have a determined focus on delivering Outstanding care, with the Best People, working in Partnership, alongside game changing Research and Innovation. We are here for children and young people. We improve their health and emotional wellbeing by providing the highest quality, innovative care, and by working in partnership with all to improve the lives of all children and young people.

## Alder Hey has a long history. We can be very proud of all of it.



- **Originally created** as a workhouse, Alder Hey opened in October 1914 as a new modern hospital with 350 children occupying twelve wards
- **Alder Hey has delivered** a number of clinical firsts, including being the first hospital to:
  - **Test penicillin, saving a child from pneumonia in 1944**
  - **Establish the first neonatal surgical unit in the UK**
  - **Cure the UK's most commonly** encountered congenital heart defect
  - **Pioneer various splints and appliances,** including the famous Thomas Splint
- **In 2008 Alder Hey became a Foundation Trust**
- **In 2015 the new state-of-the-art children's hospital,** 'Alder Hey in the Park' was opened – Europe's only children's hospital in a park
- **Every year we provide specialist healthcare to over 330,000 children and young people.** That's the equivalent of someone every one and a half minutes
- **We have over 3,300 staff** working across 60 paediatric specialties
- **We are more than our world-class hospital** – our Community and Mental Health services look after children and young people closer to where they need it
- **We're dedicated to high quality Research and Innovation** – our partnerships deliver breakthroughs that changes lives
- **We have a presence right across Liverpool and beyond**, from Cumbria to Wales and the Isle of Man
- **We provide education and training to over 540 medical students** and over 500 nursing and allied health professional students each year
- **We enrol more children and young people** in ground-breaking research trials than any other organisation in the UK
- **We've reduced medication errors** resulting in harm by 80%,
- **We've reduced hospital** acquired infections by 48%
- **Alder Hey Children's Charity has raised over £43m** to help fund life-saving equipment, research and healthcare innovation



## WHERE ARE WE NOW?

**We have a long history of caring for children and young people, and their families and this is what informs our ability to also focus on the future. Our experience and the experiences of those whom we have cared for inform everything we do.**

It was only ten years ago that we set out our shared ambition to **'To Build a Healthier Future for children and young people and to be a recognised world leader in healthcare and research'.** We've come a long way since then and made a lot of progress towards that goal.

We care for more children and young people than ever before. We employ more people to do this, with expertise at every level. We've delivered a unique state-of-the-art campus, and developed pioneering innovation, research and partnerships around the UK and the world. However, there are still a great many challenges ahead for children and young people that we want to use our experience and authority as Alder Hey to tackle. We can't solve these problems alone, but we know we have to play our part.

### INFANT MORTALITY IS RISING IN LIVERPOOL

**30%** of our children are **born into poverty**

**35%** have **poor development**

**40%** are **obese or overweight** by the time they reach ten

**10%** of five to 16-year olds experience **mental ill-health**

## OUR VALUES

**Everything we do in achieving that vision is driven by Our Values. They shape the way we all work, as well as how we speak. We're all responsible for recognising and using Our Values in our daily roles.**

### Our Values are:

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

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

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

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

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

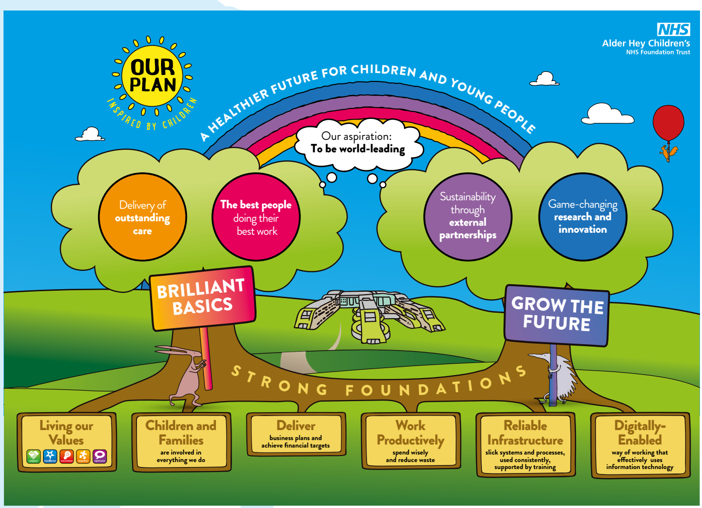
**Because Our Values are for everyone in Alder Hey to live by, every colleague is asked in their annual performance review to reflect on how they live by Our Values. Our Annual Staff Awards are given to reflect each one.**

# HOW WE'LL GET THERE: **OUR STRATEGY**

**To deliver for children and young people we have created a detailed strategy. We've called it Our Plan.**

Our Plan focuses on four key areas that will drive us to tackle the challenges we face and clearly outlines how we will work up to 2024. From getting the basics right to growing in the way we want for the future, it's all there.

If we want to achieve our aspiration of becoming an **Outstanding world-leading organisation**, we need to deliver on each one. That's why we've made sure they are built on **Strong Foundations,** infrastructures that are designed to anchor them into day-to-day experience and sustainable practice for the future.






# OUR 'TREES'

## THESE FOUR KEY AREAS FRAME OUR OBJECTIVES. THEY ARE:

BRILLIANT BASICS
- Delivering **outstanding care**
- Helping the best **people** do their best work

GROW THE FUTURE
- Using external **partnerships** to be as sustainable as possible
- Developing game-changing **research and innovation**

## WHAT DO THE 'TREES' MEAN IN PRACTICE?

- We want to be **the safest provider** of children and young people's healthcare anywhere, delivering the most effective outcomes.
- We want to be recognised formally as **the Best Place to Work**, and support staff in every way we can.
- We want to create partnerships that deliver **integrated care** around the needs of children and young people, while helping to play a leading role in delivering our status as a UNICEF Child-Friendly City.
- We want to carry on growing and become **THE place for Research and Innovation.**

OUR "TREES" ARE UNDERPINNED BY STRONG FOUNDATIONS THAT ARE THE BEDROCK FOR OUR FUTURE.

OUR STRONG FOUNDATIONS

## Digital futures

**Our vision is to create an ethos of 'Outstanding Digital Excellence'.**

From creating booking and waiting list systems that reduce delays, to empowering children to feedback in real time on their experience our guiding focus is to use digital technology to create the best experience and outcomes for children, young people, families and staff.

## The environment

**To deliver against our Vision of a healthy future we must also address one of the most fundamental challenges facing our planet today – Climate Change and the Climate Emergency that has arisen out of it.**

We are committed minimising our impact on the environment. We are also committed to working with others to address the real and present challenges of climate change.

We will put in place an active, measurable plan that makes us a truly Green Alder Hey, taking even the most difficult decisions to deliver against this plan.

10

OUR PLAN

INSPIRED BY CHILDREN

## MAKING OUR 'TREES' GROW

The **four trees** that define our objectives aren't simply ambitions – we're working hard to make them reality.

Delivering **outstanding care**

Helping the best **people** do their best work

Using external **partnerships** to be as sustainable as possible

Developing game-changing **research and innovation**

Here's how **we're** working to achieve each one, and how **you** can talk about it...

11

**We want to deliver outstanding care at every single touchpoint, and achieve outstanding outcomes for all the children and young people who need us.**

To make sure we do this we've developed a unique approach to set our culture of quality improvement. Developed with input from children and young people, staff, families, carers and partners, Inspiring Quality keeps us focused on specific clinical and patient outcomes, ensuring we keep getting better and learn as we go, whilst delivering the safest possible care.

By listening to children and young people across the region, we know that they want services built around them. They want a voice in the decisions about their treatment and care. They want Alder Hey to drive forward innovations that will change their lives.

CASE STUDY

## EMILIA'S STORY

***Nine-year-old Emilia has cerebral palsy.***

*She was with us at Alder Hey for a bilateral femoral derotation osteotomy, which involved breaking both legs at the hips, rotating the femurs 40 degrees, and securing them in place with pins and plates. Thanks to these procedures, which were performed by Mr Wright and Mr Bryson, Emilia legs will be much straighter.*

*She also had calf release surgery on her left leg while she was here, which will allow her to place her left foot fully on the ground – something she has never been able to do before.*

CASE STUDY

## AVA'S STORY

***Three-year-old Ava was born with craniosynostosis, a rare condition that affects the development of the skull in infants.***

*In June 2017, Ava had a nine and a half hour operation performed by our very own consultant surgeon Ben Robertson. With the help of his team, Mr Robertson reshaped the affected part of her skull. Ava needed lots of follow up appointments, including visits to our fantastic Speech and Language Therapy team, and now she's loving life. When Mum, Jenna and Dad, Matty got married in April 2018, Ava was their flower girl.*

CASE STUDY

## NEVE'S STORY

***When 13-year-old scoliosis patient Neve underwent corrective spine surgery, the x-rays had to be seen to be believed.***

*The procedure was performed by the brilliant Mr Munigangaiah, one of our many consultant surgeons here at Alder Hey. After just four months she had already made an amazing recovery.*

*After coming off all pain medication in just 8 days she was back to school in just four weeks, able to participate in PE and even swim again.*

**Every single person who works at Alder Hey is critical to the care of every single child or young person who needs our services, and every single person matters.**

We know that we need different people in different professions, working in different ways to deliver the NHS Long Term Plan ambitions. So we're committed to promoting positive cultures, developing compassionate and engaging leaders and ensuring that we attract and retain the best people. We want to be the best place to work, with happy staff delivering their best care.

We're a multi-disciplinary organisation, and those best people can have all kinds of skills and backgrounds, from doctors to scientists, social workers and volunteers. This in turn enables people to have less linear careers.

- **We're developing great leaders and managers,** and supporting talent through a range of key programmes
- **We're prioritising the health and wellbeing of our colleagues,** and developing an enhanced staff support system to provide advice and guidance on a range of domestic and work-related issues
- **We're working to reduce bullying and harassment** in all workplace settings
- **We're helping to 'grow the future'** through workplace development and training opportunities, developing new roles and career pathways
- **We support and encourage quality, diversity and inclusion** throughout our workforce, and are building on our success increasing opportunities to enter the workforce
- **We've established a strong culture and engagement,** from staff surveys to the Star Awards which recognise our very best

We've also developed the **Our People Plan,** which outlines how we will support all of our people and the wider children and young peoples' workforce to deliver this vision over the next four years and beyond.

It has been developed in response to insights from members of staff, and the impact of national and local workforce, and takes on board recommendations from the recently published NHS Interim People Plan (June 2016).



## Our People Plan has 5 strategic pillars:

COMPASSIONATE AND LEARNING CULTURE

*CASE STUDY*

## *MEET DR RAMANA*

***Recently, one of our amazing cardiac surgeons, Dr Ramana Dhannapuneni, received a Lifetime Achievement Award from TAL (Telugu Association of London).***

*The award was given for services to Paediatric Cardiac Surgery, as well as the fantastic work he does worldwide with Healing Little Hearts.*

*CASE STUDY*

## *MEET CHARLEY*

***Charley became a volunteer at Alder Hey at just 17, but her dream was always to become a paediatric nurse.***

*As a volunteer, she did things she never dreamed she would have the confidence or ability to do, even observing a seven-hour operation.*

*Her experience as a volunteer gave her the confidence to apply for the nursing course and her first year placement saw her come back to the people that helped kick-start it all at Alder Hey.*

*CASE STUDY*

## *MEET HOLLIE*

***Hollie has been a Theatre Care Assistant at Alder Hey for two and a half years.***

*When Hollie was just three years old, she and her twin were playing when her dress accidentally caught fire, leaving her with 60-70% burns. Hollie was a patient here at Alder Hey right up to the age of 19 but her scars no longer bother her – she even worked with the theatre teams on a burns operation. She hopes that people will see her story and take inspiration from it.*

Using external **partnerships** to be as sustainable as possible

**The future of health and care depends on successful partnerships. We're committed to being a brilliant partner in every way, providing diverse and effective partnerships that move our care on and make a difference to peoples' lives. In doing this we want to be able to contribute to the Public Health and economic prosperity of Liverpool.**

- **Our Local Partnerships** allow us to provide care close to home
- **Our Children's Transformation Programme** and 'One Liverpool' plan provide an integrated, community focused model of care and support
- **We work with Primary Care Networks (PCNs)** to find new ways of providing enhanced children and young people's services in local environments
- **We're helping to bring Women's and Children's, and Specialist Services** together for more joined up care
- **We're bringing Specialist Trusts together** for Liverpool, to pool our knowledge, expertise and resources
- **We're exploring opportunities** to improve our strong, diverse mental health service
- **We're developing new relationships** with higher education institutions
- **We're cultivating partnerships** that allow us to enhance our excellent Specialist, Tertiary and Quaternary services
- **We're developing an 'Alder Hey with…'** partnership model, using our brand name to develop shared standards and governance with local and wider partners



CASE STUDY

### Our Partnerships

*Liverpool is now a step closer to becoming internationally recognised as a Unicef Child-Friendly City. In November 2018, following work with partner agencies and young people, the city council submitted a bid to the global children's organisation reflecting its intentions to put young people at the heart of everything it does.*

*Now Unicef UK has officially accepted the bid, which kick-starts a three-to-five-year partnership of politicians, council staff and other Liverpool stakeholders working with Unicef UK to receive expert training and support.*

*As set out in the United Nations Convention on the Rights of the Child, children and young people will have a say on council decisions – ranging from major policies and decisions around the care they receive right though to getting involved in designing new spaces in the city or introducing new services.*

*Liverpool will be assessed on a regular basis throughout the programme and, if successful, it will be internationally recognised as a Unicef Child-Friendly City, joining cities and communities in 40 countries taking part.*

CASE STUDY

### Alder Hey – international hosts

*Alder Hey's Paediatric Audiovestibular Medicine and Audiology team recently hosted the 3rd Alder Hey Paediatric Vestibular Course in our Institute in the Park building. The purpose of the course was to share and teach the latest techniques in a highly specialised subject, across a wide group of professionals, from all over the world. This year was truly remarkable, as delegates from Israel, Turkey, Slovenia and New Zealand, in addition to a local audience, attended the event motivated by the department's expertise and knowledge. Our paediatric vestibular services have grown massively since they were first started by Dr Soumit Dasgupta in 2015. They now have an international presence and reputation, attracting clinicians from all over the world for observerships, alongside contributing to world academia.*

CASE STUDY

### A Centre of Clinical Excellence for Muscular Dystrophy

*Alder Hey Children's NHS Foundation Trust is now recognised by Muscular Dystrophy UK as providing outstanding care for people with muscle-wasting conditions. The Trust was awarded the centre of Clinical Excellence status by the charity alongside 16 other centres across the UK. The awards recognise excellence across a range of criteria, including the care received by patients, and help to drive up the standards of clinical support for people with muscle-wasting conditions.*

**Alder Hey is a leading light in children's research, recruiting more children and young people than any other children's healthcare provider in England and Wales.**

But at the same time as being a world-leader in children's research we are committed to delivering even more outstanding treatment using cutting-edge therapies and technologies, developed in our unique Innovation Hub.

Doing this doesn't just lead to better care and outcomes, it allows us to attract dynamic and motivated staff, enables long-term partnerships, enhances our international standing and achieves reinvestment into Alder Hey.

- **Since 2007, over 45,000 children, babies and young people** have been enrolled into clinical research studies at Alder Hey
- **We're currently leading clinical research programmes** in a diverse range of fields from complex experimental and early phase studies to applied health research
- **We're targeting future research priorities** in neonatal, cardiovascular, Public Health, Mental Health and more
- **Over the next four years we'll deliver our mission** through an engagement and education programme, business model development, enhanced infrastructure and further clinical academic posts

## RESEARCH STORIES

**Children and young people have limited access to medicines designed specifically for them. In Europe, development programmes for new paediatric medicines now need to include an evaluation of their acceptability to children and young people.**

However, despite regulatory changes, it will take decades to offer children and young people the same access to new formulations designed just for them. An alternative strategy is now emerging – using innovative approaches to devise formulations of existing medicines that are acceptable to children and young people. Our multi-sector partnership is leading the way in customised, on-demand medicines for children, using disruptive technology to offer breakthroughs in the status quo.

**With our academic partners at the University of Central Lancashire, we have developed a range of 3D printing methodologies to manufacture tablets and other oral medicines.**

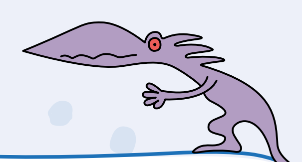
While the value of this approach has been established, there is little to no evidence showing their acceptability to children and young people.

That's why we designed and delivered a clinical study to demonstrate it. In 2018, we administered a 3D printed ingestible tablet to a child. A world first, it received high profile news coverage, including on the BBC News.

**We also have incredible innovation resources, including our one-of-a-kind Innovation Hub. We're now doing what children and young people need next, and digital innovation is at the heart of our quality improvements.**

- We're creating the world's first 'Living Trust', an environment that learns as we deliver care using sensors, artificial intelligence (AI), and visualisation
- We employ Clinical Innovation leads to work with healthcare professionals, patients, academia and industry to explore innovative ways to improve outcomes
- Our innovation business plan is designed to unleash our innovation culture across the trust, continuing our work as a global thought leader, taking an 'accelerator' approach to new products, and continuing to be a test bed for innovations

## INNOVATION STORIES

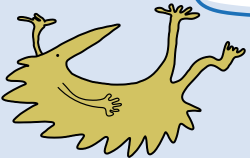


### A NEW WAY TO IDENTIFY DETERIORATION IN CHILDREN

*Staff at Alder Hey have begun using pioneering electronic hand-held devices to record children and young peoples' vital signs and detect deterioration sooner.*

*The devices are used to record breathing rate, effort of breathing, oxygen saturation, oxygen requirement, heart rate, blood pressure, capillary refill time, temperature and any nurse or parental concerns.*

*This data is then used to automatically calculate an age-specific paediatric early warning score (PEWS), which categorises the risk of developing serious illness into low, medium, high or critical. These scores and signs that can indicate the onset of sepsis are automatically flagged to staff to help them recognise deterioration earlier, and reduce the number of emergency admissions to critical care.*





## STORIES OF EXTERNAL PARTNERSHIPS

### OUR PARTNERSHIPS EXTEND NEAR AND FAR

*Our local and global partnerships take our work to new places, improving standards and delivering valued revenue streams.*

### OUR INTERNATIONAL PARTNERSHIPS

*Our International Child Health (ICH) department is already working towards our vision and has allowed us to establish and international paediatric brand with a reputation for excellence. We have a number of mutually-beneficial international health partnerships, particularly with low-income countries and support our people in undertaking humanitarian 'mission' operations, for example, delivering cardiac surgery health camps in India.*

### WE'RE BUILDING SHARED KNOWLEDGE

*We're developing our strong global reputation through education and training, with opportunities for future income generation, as well as cultivating international world-leading research in areas such as oncology, child and maternal health, infectious disease, child development and disability and Ebola.*

## STORIES OF OUTSTANDING CARE

**WE'RE CARING**

*We work hard to give care in every sense of the word, and have introduced a Vibrant Arts Programme, a Safe Haven in Outpatients for children with complex needs and support an open, caring, learning culture through methods such as Safety huddles, Quality Rounds and Schwarz Rounds.*

**WE'RE SAFE AND EFFECTIVE**

*We've invested in safe staffing levels and all children and young people can feel safe in our care. Our effectiveness is amazing, and improving all the time.*

*We have extremely low site infection rates and use, and have dramatically reduced our use of rescue analgesia for common painful procedures. We've almost eliminated the need for General Anaesthetic in ENT procedures and have reduced mortality rates.*

**OUR SERVICES PUT CHILDREN AND YOUNG PEOPLE FIRST**

*From involving them in the design of our new hospital, to improving our quality based on their insights, our work is built entirely around them and their needs. And we're involving them more all the time.*



## STORIES OF THE BEST PEOPLE

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# STORIES OF GAME-CHANGING RESEARCH AND INNOVATION

### WE'RE PIONEERING 3D PRINTING

*3D modelling allows surgeons to plan in a way which has been impossible with two dimensional scans, giving them a better understanding and assisting with reassuring family members.*

### WE'RE PIONEERING SENSOR TECHNOLOGY

*Alder Hey works with Liverpool's Sensor City – a £15m venture between the University of Liverpool and Liverpool John Moores University (LJMU) – to develop technology that allows a small wireless sensor to read defined bio-chemical markers in the blood without breaking the skin.*

### WE HAVE A BRAND NEW RESEARCH FACILITY

*In September 2012 Alder Hey opened a National Institute for Health Research Clinical Research Facility (CRF). The CRF will lead to improvement in patient health outcomes in Alder Hey demonstrating a clear commitment to clinical research which will lead to better treatments for patients and excellence in patient experience.*

### WE'RE PIONEERING SURGICAL PLANNING

*Working with the Virtual Engineering Centre, we're pioneering a new surgical planning technique using Virtual Reality to will surgeons prepare for complex operations, share knowledge and reassure family members.*



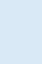

# STORIES OF GAME-CHANGING RESEARCH AND INNOVATION

### WE'RE THE WORLD'S FIRST CHILDREN'S HEALTH PARK

*Alder Hey was designed by and for children. From play decks and park views to our ward-based chefs, we respond to children, young people and families' needs, whatever they may be.*

### WE'RE DIGITALLY-ENABLED

*Our modern models of care are organised around children and families' needs, and we're digitally enabled in every possible way, from implementing a new EPR to using AI to make better decisions and helping children feel safe and welcome with the Alder Play App. We're constantly adding innovations and improvements to our environment, from an interactive virtual fish tank to sensory perception rooms, interactive games screens and the Blank Canvas Group.*

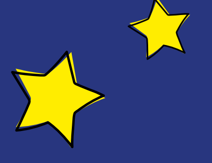


### WE DO MORE RESEARCH THAN ANYONE OF OUR PEERS

*Almost 4,000 children and young people were enrolled into clinical research studies at Alder Hey in 2016/17, more than any other children's healthcare provider in England and Wales. This placed Alder Hey within the top 10% of NHS organisations with respect to research volume.*

# ACHIEVEMENTS WORTH SHOUTING ABOUT

- Originally created as a workhouse, Alder Hey opened in October 1914 as a new modern hospital with 350 children occupying twelve wards.
- During the Great War Alder Hey was also used as a military hospital and during the Second World War it cared for allied and German soldiers, the latter of whom were guarded by American police. Any soldiers well enough to do so would help carry children to shelters during air raids.
- Alder Hey has delivered a number of clinical firsts include being the first hospital to:
  - test penicillin, saving a child from pneumonia in 1944;
  - establishing the first neonatal surgical unit in the UK;
  - curing the UK's most commonly encountered congenital heart defect
  - pioneering various splints and appliances, including the famous Thomas Splint
- In 2008 Alder Hey became a Foundation Trust.
- In 2015 the new state-of-the-art children's hospital, 'Alder Hey in the Park' was opened: Europe's only children's hospital in a park.
- The hospital was designed with the central involvement of children and young people. Over 900 children and young people provided drawings and ideas of what the new hospital should look like, with the general theme of green space.
- In September 2018 we completed our dedicated research, innovation and education centre was completed in 2018, which sits alongside the hospital as part of our wider vision of an Alder Hey in the Park Campus. Home to researchers, academics and industry partners delivers vital collaboration for better healthcare for children and young people in the future.
- In XXX 2018 our International Child Health (ICH) Department was formally launched, bringing together humanitarian work of staff, coordinating efforts to lead the way in global paediatric health care. This department is the first of its kind in a paediatric hospital in the UK and aims to promote health in under-resourced countries by assisting in research, education and development.
- In 2020 our campus will develop further with the opening of a brand new unique national family bereavement centre, the Alder Centre.
- A centre for education, Alder Hey provides education and training to over 540 medical students and over 500 nursing and allied health professional students each year.



★ **Alder Hey is:**

- ☆ A Centre of Excellence for children with cancer, heart, spinal and brain disease
- ☆ A specialist regional centre for cardiac surgery
- ☆ A Department of Health Centre for Head and Face Surgery
- ☆ One of four national centres for childhood epilepsy surgery, a joint service with the Royal Manchester Children's Hospital
- ☆ A designated children's Major Trauma Centre
- ☆ One of five specialist centres in the UK to offer SDR surgery
- ☆ The first UK Centre of Excellence for Childhood Lupus
- ☆ A Centre of Excellence for Muscular Dystrophy

★ **Alder Hey has:**

- ☆ Europe's first paediatric intra-operative 3-T MRI scanner, a pioneering technology for neurosurgery which reduces repeat operations in 90% of surgical cases.
- ☆ A hybrid operating theatre, the first in the country suitable for operating on children from different specialties including heart, brain or spinal surgery.
- ☆ Alder Hey has a thriving research portfolio and was a founding partner for the National Institute for Health Research (NIHR) Medicines for Children Research Network and is the base for its successor the NIHR Clinical Research Network for Children. It also has a reputation for research excellence in:
- ☆ Better, safer medicines for children and babies
- ☆ Infection
- ☆ Inflammatory disease
- ☆ Paediatric oncology
- ☆ International child health

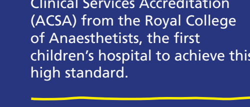
★ Alder Hey is the highest recruiting centre for children's research in the UK, with over 3,000 babies, children and young people enrolled during 2018/19.

★ **The Research team:**

- ☆ demonstrated clinical and research leadership in the licensing by the US Food and Drug Agency of Epidiolex, a cannabis oil based drug and the first available for children with severe Epilepsy.
- ☆ took part in a global first, administering the first 3D printed, ingestible tablet to a child.
- ☆ completed major multi-centre clinical trials funded by NIHR relating to: the delivery of insulin to children newly diagnosed with Type 1 Diabetes; and anti-epileptic drugs given to children presenting with refactory seizures.

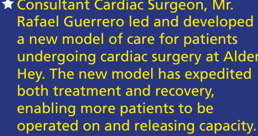
★ A national research project, led by Alder Hey and the University of Liverpool, was awarded over £1.6m to test a new treatment for babies with Bronchiolitis, a winter viral disease that causes breathing problems and feeding difficulties in babies.





★ In 2018, we launched the Alder Play App which uses gaming and augmented reality to distract patients having procedures in hospital and uses the chatbot "Ask Oli" to support children and young people with machine learning.

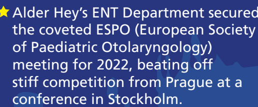
★ We work jointly with Manchester Children's Hospital to improve standards and lead the way in the development of more joined up care in the region, including in neurosciences, cardiology and burns.



★ Alder Hey was recognised by Muscular Dystrophy UK for providing outstanding care for people with muscle-wasting conditions. The Trust was awarded Centre of Clinical Excellence status by the charity, alongside 16 other centres across the UK.

★ Alder Hey received the Anaesthesia Clinical Services Accreditation (ACSA) from the Royal College of Anaesthetists, the first children's hospital to achieve this high standard.

★ Consultant Cardiac Surgeon, Mr. Rafael Guerrero led and developed a new model of care for patients undergoing cardiac surgery at Alder Hey. The new model has expedited both treatment and recovery, enabling more patients to be operated on and releasing capacity.



★ Alder Hey Academy won the Education Business Links Award at the Greater China Awards 2019! Held annually by the Department for International Trade, the Academy was nominated following the successful implementation of the Alder Hey Chinese Observership Programme which began in 2017/18.

★ Alder Hey surgeon Mr Alf Bass won the Well Child 2018 Doctor Award, recognising his leading role in the development of surgery for children with neuromuscular conditions. Well Child is the national charity for seriously ill children, committed to improving the quality of life for children across the UK with serious illness, or exceptional health needs.

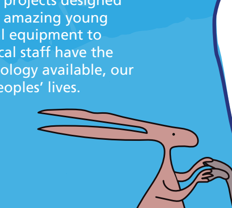
★ Alder Hey's ENT Department secured the coveted ESPO (European Society of Paediatric Otolaryngology) meeting for 2022, beating off stiff competition from Prague at a conference in Stockholm.

★ Play Specialist Pip Bradshaw won the 2018 Suzanne Storer Profile of the Year Award, an annual award given to a registered health Play Specialist by governing body Health Play Specialist Educating Trust (HPSET). Pip also came third nationally for the 'Starlight Foundation Health Play Specialist of the Year Award'.

# WORKING TOGETHER WITH OUR ALDER HEY CHILDREN'S CHARITY

**The Alder Hey Children's Charity raises vital funds to help make Alder Hey Children's Hospital world-class and patient-friendly. It also ensures that the 330,000 patients and families we care for every year experience a little Alder Hey magic – the added extras that make the hospital experience the best it can be.**

The Charity is integral to the work of Alder Hey. Since April 2013, we've raised over £43m for a range of life-saving medical equipment, facilities and projects designed to enhance and improve the lives of our amazing young patients. From funding specialist medical equipment to ensuring our brilliant surgeons and clinical staff have the most up-to-date and cutting edge technology available, our charity makes a real difference in real peoples' lives.



The more people get involved the more people we can help. So take every opportunity to tell the world about our charity and what they can do to help, from crazy fundraising ideas to fundraising in schools and joining one of our **10k charity runs.** Our campaigns use the **#JoinUsJoinIn**, so it's easy to find and share and be part of everything that's going on.



## The work our charity funds

### The Park Campus

Recently our charity helped to fund a Health and Well-being Nature Trail and Woodland Walk in the park, a haven for our families to explore and relax. It has also fully funded a specialist bereavement centre located off the Alder Centre within the campus. Created to support families who have experienced the loss of a child, fundraising is now underway to furnish it. We are currently fundraising for a unique cluster of buildings devoted to community and mental health services, providing round the clock support for children who require care outside of a hospital environment.

### Life-Saving Equipment

Our amazing NHS clinicians work around the clock to treat over 900 patients every day at Alder Hey and we're committed to supporting our NHS Foundation Trust in making sure they have the very latest equipment to do it.
This year we raised over £732,845 towards lifesaving equipment and advanced technologies, including a Kinevo Robotic Microscope for our Neurosurgery department and a range of heated cots.

### Vital Research

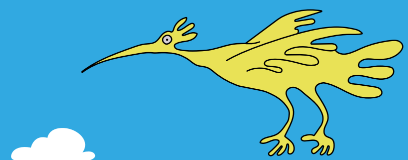
Alongside our state-of-the-art children's hospital, the Alder Hey in the Park campus incorporates our research and education centre housed within our RIBA award-winning Speakman Building. Thanks to donations we've received we're able to fund all kinds of research in areas including cancer, asthma and orthopaedic surgery.

### Game-Changing Innovation

Our Innovation Hub is dedicated to finding creative and innovative solutions that will help our patients and their families as well as our world-leading clinicians. We've built strong corporate partnerships and work with innovators from across the globe to constantly push the boundaries of what's possible.

### Alder Hey Magic

Our families, visitors and staff regularly tell us that there is a special feeling when you walk in to Alder Hey; that is the 'magic' that helps make hospital life brighter. From ward musicians and comics and art workshops to the latest distraction technology, Alder Hey Children's Charity works hard to raise funds that provide the best patient experience possible.



## Find out more...

Alder Hey Children's NHS Foundation Trust
Eaton Road
Liverpool L12 2AP

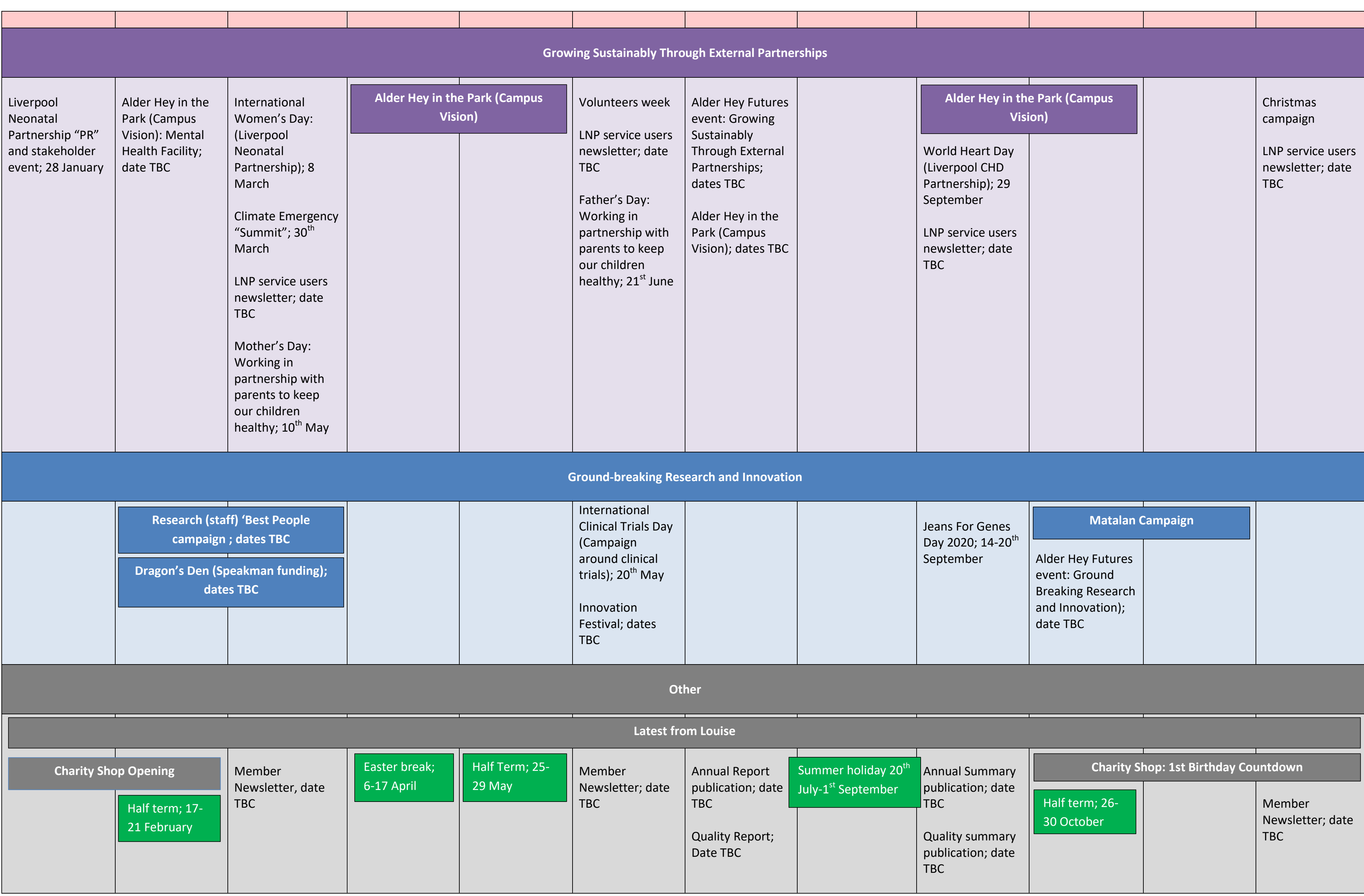
**www.alderhey.nhs.uk**

**@AlderHey**
**@alderheyhospital**
**YouTube.com/alderheyhospital**
**@alderhey**
**@AlderHeyChildrensHospital**

# ALDER HEY COMMUNICATIONS CALENDAR 2020

| January | February | March | April | May | June | July | August | September | October | November | December |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **TO NOTE:**<br><br>**Reactive work:** The following details planned work only; it does not account for unplanned work: e.g. reacting to media enquiries, crisis communications and issues management, responding to ad-hoc requests for communications to staff; managing film crews; unplanned visits, patient case studies (taking advantage of opportunities that present themselves);, etc.<br><br>**Alder Hey Children's Charity – Strategic pillars**: activity to support the AHCC pillars is incorporated into the below: The Park Campus (e.g. '…Best Place'; …Great Partnerships); Life-saving equipment (e.g. '…Best Place'); Vital Research and Game-changing Innovation'; and Alder Hey Magic (throughout, but particularly 'Outstanding care' and '…Best People'. | | | | | | | | | | | |
| **Delivering Outstanding Care** | | | | | | | | | | | |
| **CQC Campaign** | | | | | | | | **Flu campaign** | | | |
| | **Operation Ouch**; dates TBC | | | | | | | | | | |
| | **Shirley Ballas Mental Health Launch (AHCC fundraising campaign)**; dates TBC | | | | | | | | | | |
| Alder Hey Futures event: Delivering Outstanding Care; $28^{th}$ January<br><br>**CQC Full Inspection of services;**<br>Dates tbc | **CQC Well-led inspection**; 11-$13^{th}$ February<br><br>Inspired Magazine (AHCC)<br><br>World Cancer Day (Opportunity to reinforce Care message through patient stories); $4^{th}$ February<br><br>Epilepsy Day (as above); $10^{th}$ February<br><br>Rare Disease Day (as above); $28^{th}$ February<br><br>BBC Hospital broadcast; dates TBC | Isle of Man (AHCC campaign to extend audience reach); dates TBC<br><br>BBC Hospital broadcast; dates TBC | Annual Jockey Club visit (PR opportunity); dates TBC<br><br>Charity: General Fund opens; dates TBC<br><br>Easter ('celebrate with Alder Hey' PR opportunity); 10-$13^{th}$ April | Mental Health Awareness Week (Profile our Cluster and Community, plus AHCC fundraising campaign); 18-24 May<br><br>Born Survivor (AHCC) (pre-promotion and PR opportunity); $1^{st}$ May<br><br>Oli Walk (AHCC) (as above); dates TBC | Alternative Ascot (AHCC) (pre-promotion and PR opportunity); $18^{th}$ June<br><br>**CQC inspection outcome**; date TBC | Annual Member's Meeting/ Springfield Park Summer Fair; dates TBC<br><br>Nightrider (AHCC); dates TBC<br><br>Coniston Challenge (AHCC); dates TBC | Abseil (AHCC); dates TBC | Alder Centre official opening; dates TBC<br><br>Childhood Cancer Awareness Month (Opportunity to reinforce Care message through patient stories); September<br><br>World Sepsis Day (as above); $13^{th}$ September<br><br>Inspired Magazine (AHCC); dates TBC<br><br>5K run (AHCC) (pre-promotion and PR opportunity); dates TBC<br><br>Peru trek (AHCC) (pre-promotion and PR opportunity); dates TBC | Mental Health Day (Profile our Cluster and Community, plus AHCC fundraising campaign); $10^{th}$ October<br><br>Burns Awareness Day (Opportunity to reinforce Care message through patient stories); date TBC | Department of International Child Health: 2nd Birthday (event); $18^{th}$ November<br><br>Charity: General Fund opens; dates TBC | Christmas campaign; December |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Best People, Doing Their Best Work, in the Best Place** | | | | | | | | | | | |
| **Alder Hey 'Star of the Month'** | | | | | | | | | | | |
| | **Campus development (incl. car parking)** | | | | **Campus development (incl. car parking)** | | | **NHS Staff Survey campaign** | | | |
| | | | | | | | | | | **8th Annual Staff Awards campaign** | |
| **Case Study: Teapot Trust (AHCC); date TBC**<br><br>**Case Study: Arts (AHCC); date TBC** | Staff Awards Celebration Event; 7th February<br><br>Best People … Campaign (Staff Awards nominees); 10-14 February<br><br>Staff Survey: Outcomes; date TBC<br><br>Alder Hey Life Staff Newspaper; w/c 24th February (copy deadline 17th Jan)<br><br>**Case Study: Leslie and Dorothy Blond Trust (AHCC); date TBC**<br><br>**Case Study: Green Hall Foundation (AHCC); date TBC**<br><br>**Case Study: Equipment (AHCC); date TBC** | No Smoking Day (Patient Experience activity); 11th March<br><br>**Case Study: Skelton Charity (AHCC); date TBC**<br><br>**Case Study: Bain Charitable Trust (AHCC); date TBC**<br><br>**Case Study: Dinwoodie Charitable Trust (AHCC); date TBC**<br><br>**Case Study: Veolia (AHCC); date TBC**<br><br>**Case Study: Postcode Community Trust (AHCC); date TBC**<br><br>**Case Study: Arts (AHCC); date TBC**<br><br>**Case Study: Equipment (AHCC); date TBC**<br><br>**Case Study: Research (AHCC); date TBC**<br><br>**Case Study: Alder Centre (AHCC); date TBC** | Alder Hey Futures event: Doing Their Best Work in the Best Place); date TBC | International Nurses Day; 12 May (PR opportunity)<br><br>**Case Study: Geoffrey and Pauline Martin Charitable Trust (AHCC); date tbc**<br><br>**Case Study: Garfield Weston (AHCC); date TBC**<br><br>**Case Study: Arts (AHCC); date TBC**<br><br>**Case Study Equipment (AHCC); date TBC** | Alder Hey Life Staff Newspaper; w/c 22nd June (copy deadline 15th May)<br><br>Best People … Campaign (community); dates TBC<br><br>**Case Study: Hemby Trust (AHCC); date TBC** | Liverpool Pride (LGBTQ+) (celebrate equality and inclusion)<br><br>**Case Study: Autin and Hope Pilkington Charitable Trust (AHCC); date TBC**<br><br>**Case Study: Arts (AHCC); date TBC** | **Case Study: Teapot Trust (AHCC); date TBC**<br><br>**Case Study: Equipment (AHCC); date TBC**<br><br>**Case Study: Research (AHCC); date TBC** | **Case Study: Leslie and Dorothy Blond Trust (AHCC); date TBC**<br><br>**Case Study: True Colours (AHCC); dates TBC**<br><br>**Case Study: Equipment (AHCC); dates TBC** | AHP Day; date TBC<br><br>Alder Hey Life Staff Newspaper; 26th October copy deadline 18th September<br><br>Anniversary of move to 'new' hospital; 7th October (Opportunity to highlight this landmark moment – but emphasise how we have grown and developed and are much more than 'just a hospital')<br><br>Fab Staff Week | Christmas Lights switch on; dates TBC<br><br>**Case Study: Arts (AHCC); dates TBC**<br><br>**Case Study: Research (AHCC); dates TBC** | Christmas campaign<br><br>**Case Study: Skelton Charity (AHCC); dates TBC** |



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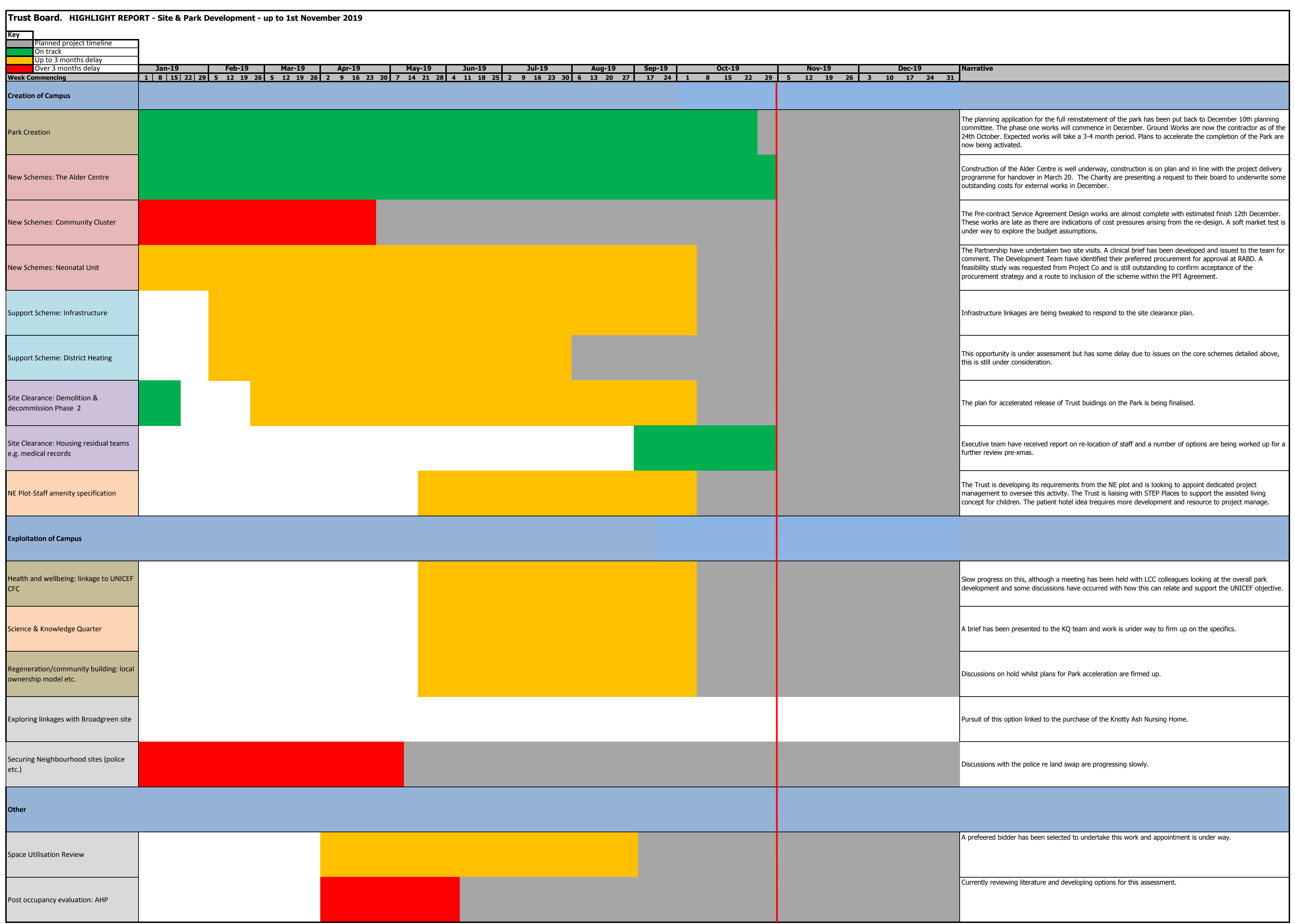
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Growing Sustainably Through External Partnerships** | | | | | | | | | | | |
| Liverpool Neonatal Partnership "PR" and stakeholder event; 28 January | Alder Hey in the Park (Campus Vision): Mental Health Facility; date TBC | International Women's Day: (Liverpool Neonatal Partnership); 8 March<br><br>Climate Emergency "Summit"; 30th March<br><br>LNP service users newsletter; date TBC<br><br>Mother's Day: Working in partnership with parents to keep our children healthy; 10th May | **Alder Hey in the Park (Campus Vision)** | | Volunteers week<br><br>LNP service users newsletter; date TBC<br><br>Father's Day: Working in partnership with parents to keep our children healthy; 21st June | Alder Hey Futures event: Growing Sustainably Through External Partnerships; dates TBC<br><br>Alder Hey in the Park (Campus Vision); dates TBC | | **Alder Hey in the Park (Campus Vision)**<br><br>World Heart Day (Liverpool CHD Partnership); 29 September<br><br>LNP service users newsletter; date TBC | | | Christmas campaign<br><br>LNP service users newsletter; date TBC |
| **Ground-breaking Research and Innovation** | | | | | | | | | | | |
| | **Research (staff) 'Best People campaign ; dates TBC**<br><br>**Dragon's Den (Speakman funding); dates TBC** | | | | International Clinical Trials Day (Campaign around clinical trials); 20th May<br><br>Innovation Festival; dates TBC | | | Jeans For Genes Day 2020; 14-20th September | **Matalan Campaign**<br><br>Alder Hey Futures event: Ground Breaking Research and Innovation); date TBC | | |
| **Other** | | | | | | | | | | | |
| **Latest from Louise** | | | | | | | | | | | |
| **Charity Shop Opening** | Half term; 17-21 February | Member Newsletter, date TBC | Easter break; 6-17 April | Half Term; 25-29 May | Member Newsletter; date TBC | Annual Report publication; date TBC<br><br>Quality Report; Date TBC | Summer holiday 20th July-1st September | Annual Summary publication; date TBC<br><br>Quality summary publication; date TBC | **Charity Shop: 1st Birthday Countdown**<br><br>Half term; 26-30 October | | Member Newsletter; date TBC |

Awareness days/weeks/months

https://www.nhsemployers.org/retention-and-staff-experience/health-and-wellbeing/sustaining-the-momentum/calendar-of-national-campaigns-2018/calendar-of-national-health-and-wellbeing-campaigns-for-2019-to-2020-table

ALDER HEY IN THE PARK PROJECT



**Trust Board.** **HIGHLIGHT REPORT - Site & Park Development - up to 1st November 2019**

| Key | |
|---|---|
| (grey) | Planned project timeline |
| (green) | On track |
| (amber) | Up to 3 months delay |
| (red) | Over 3 months delay |

Week Commencing: Jan-19: 1, 8, 15, 22, 29 | Feb-19: 5, 12, 19, 26 | Mar-19: 5, 12, 19, 26 | Apr-19: 2, 9, 16, 23, 30 | May-19: 7, 14, 21, 28 | Jun-19: 4, 11, 18, 25 | Jul-19: 2, 9, 16, 23, 30 | Aug-19: 6, 13, 20, 27 | Sep-19: 17, 24 | Oct-19: 1, 8, 15, 22, 29 | Nov-19: 5, 12, 19, 26 | Dec-19: 3, 10, 17, 24, 31

| Week Commencing | Narrative |
|---|---|
| **Creation of Campus** | |
| Park Creation | The planning application for the full reinstatement of the park has been put back to December 10th planning committee. The phase one works will commence in December. Ground Works are now the contractor as of the 24th October. Expected works will take a 3-4 month period. Plans to accelerate the completion of the Park are now being activated. |
| New Schemes: The Alder Centre | Construction of the Alder Centre is well underway, construction is on plan and in line with the project delivery programme for handover in March 20. The Charity are presenting a request to their board to underwrite some outstanding costs for external works in December. |
| New Schemes: Community Cluster | The Pre-contract Service Agreement Design works are almost complete with estimated finish 12th December. These works are late as there are indications of cost pressures arising from the re-design. A soft market test is under way to explore the budget assumptions. |
| New Schemes: Neonatal Unit | The Partnership have undertaken two site visits. A clinical brief has been developed and issued to the team for comment. The Development Team have identified their preferred procurement for approval at RABD. A feasibility study was requested from Project Co and is still outstanding to confirm acceptance of the procurement strategy and a route to inclusion of the scheme within the PFI Agreement. |
| Support Scheme: Infrastructure | Infrastructure linkages are being tweaked to respond to the site clearance plan. |
| Support Scheme: District Heating | This opportunity is under assessment but has some delay due to issues on the core schemes detailed above, this is still under consideration. |
| Site Clearance: Demolition & decommission Phase 2 | The plan for accelerated release of Trust buidings on the Park is being finalised. |
| Site Clearance: Housing residual teams e.g. medical records | Executive team have received report on re-location of staff and a number of options are being worked up for a further review pre-xmas. |
| NE Plot-Staff amenity specification | The Trust is developing its requirements from the NE plot and is looking to appoint dedicated project management to oversee this activity. The Trust is liaising with STEP Places to support the assisted living concept for children. The patient hotel idea trequires more development and resource to project manage. |
| **Exploitation of Campus** | |
| Health and wellbeing: linkage to UNICEF CFC | Slow progress on this, although a meeting has been held with LCC colleagues looking at the overall park development and some discussions have occurred with how this can relate and support the UNICEF objective. |
| Science & Knowledge Quarter | A brief has been presented to the KQ team and work is under way to firm up on the specifics. |
| Regeneration/community building: local ownership model etc. | Discussions on hold whilst plans for Park acceleration are firmed up. |
| Exploring linkages with Broadgreen site | Pursuit of this option linked to the purchase of the Knotty Ash Nursing Home. |
| Securing Neighbourhood sites (police etc.) | Discussions with the police re land swap are progressing slowly. |
| **Other** | |
| Space Utilisation Review | A prefeered bidder has been selected to undertake this work and appointment is under way. |
| Post occupancy evaluation: AHP | Currently reviewing literature and developing options for this assessment. |

# BOARD OF DIRECTORS

## Tuesday 3rd December 2019

| | |
|---|---|
| **Paper Title:** | **Audit Committee Assurance Report from the November meeting** |
| **Date of meeting:** | 21st November 2019 |
| **Report of:** | Kerry Byrne, Non-Executive Director |
| **Paper Prepared by:** | Julie Tsao, Committee Administrator |

| | | |
|---|---|---|
| **Purpose of Paper:** | Decision<br>Assurance<br>Information<br>Regulation | ☐<br>■<br>☐<br>☐ |
| **Summary and/or supporting information:** | This paper provides a summary from the recent Audit Committee meeting held on 21st November 2019 along with the approved minutes from the meeting held on 26th September 2019. | |
| **Action/Decision Required:** | To note<br>To approve | ■<br>☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care**<br>**The best people** doing their best work<br>Sustainability through **external partnerships**<br>Game-changing **research and innovation**<br>**Strong Foundations** | ☐<br>☐<br>☐<br>☐<br>■ |
| **Resource Impact:** | None | |

## 1. Introduction

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

Under its terms of reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

- Internal Audit Progress Report
- Report on the implementation of previously agreed recommendations
- External Audit plans and fees (verbal update)
- E&Y Technical Update Report
- Report on waivers of Standing Financial Instructions
- Update on the "No Child Unaccounted For" campaign
- Board Assurance Framework

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

There were no key risks or matters of concern to escalate.

## 4. Positive highlights of note

The Committee received an update on the "No Child Unaccounted For" Campaign which was requested following an audit of processes relating to instances of "Was Not Brought". The Committee was pleased to hear of a number of positive actions taken recently to improve the visibility of the pathway of all children and the follow up of non-attendance – including establishing a link to the safeguarding process.

## 5. Issues for other committees

There were no key risks or matters of concern to refer to other committees.

## 6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

# Audit Committee

Draft Minutes of the meeting held on **Thursday 26th September 2019**

**Tony Bell Board Room, Institute in the park**

| | | | |
|---|---|---|---|
| **Present:** | Mrs K Byrne (Chair) | Non-Executive Director | (KB) |
| | Mrs. A. Marsland | Non-Executive Director | (AM) |
| | Mrs S Arora | Non-Executive Director | (SA) |
| **In Attendance:** | Mr G Baines | Assistant Director, MIAA | (GB) |
| | Mr J Grinnell | Director of Finance | (JG) |
| | Ms M McMahon-Joseph | Senior Audit Manager, MIAA | (MMc) |
| | Miss J Preece | Governance Manager | (JP) |
| | Mr H Rohimun | Executive Director, Ernst and Young | (HR) |
| | Ms E Saunders | Director of Corporate Affairs | (ES) |
| | Mrs J Tsao | Committee Administrator *(minutes)* | (SS) |
| **Agenda item: 35.** | Mrs M Swindell | Director of HR & OD | (MS) |
| **Apologies:** | Mr Richard Tyler | E&Y Accounts Manager | (RT) |

**19/20/33 Minutes of the previous meeting held on 23rd May 2019**

**Resolved:**

Audit Committee approved the minutes from their last meeting held on 23rd May 2019.

**19/20/34 Matters Arising and Action List**

Under Ernst and Young Audit Year End report at the last meeting on 23rd May Audit Committee had noted a request for ledger data transaction that NEP were unable to provide within the timescale set.

Claire Liddy provided an update following a meeting with representatives from NEP earlier today, the three main areas of concern had been: accounts payable, reporting and invoicing, all of these areas had now been resolved.

18/19/67.1 Follow up audits: Following agreement for the way forward on follow-up audits to include Exec Directors being included in all chasing e-mails with key contacts/operational leads and for MIAA to provide a monthly update, it was agreed this action could be closed.

18/19/69.1 EY Update: IFRS 16 has now been published and will be operational from April 2020. The main change is leases capitalised at a minimum of £5k. Awareness training on this will be arranged for managers. Further guidance will be released in January 2020, it was agreed this action could be closed.

19/20/03 Progress report MIAA: Melissa Swindell advised the ESR Manager had now set up a process in relation to staff changing roles, this action could now be closed.

19/20/06 Internal Audit Charter: Gary Baines said going forward, review of Key Performance Indicators would include indicators on audit quality and timeliness. An audit satisfaction survey is sent out once the audit has been completed. This action could now be closed.

19/20/07 Draft Counter Fraud Annual Report 2019/20: A proposal on the identification of fraud risks within Ulysses to enable compliance with the annual self-assessment was awaited. It was agreed an update would be received at the November meeting.

19/20/22 Ernst and Young Audit Year End Report on Trust Accounts 2018/19: Hassan Rohimun said following the request to include pictures of children with the report a photo of children's hands had been added. This action could now be closed.

**19/20/35 Progress Report, MIAA**

Audit Committee received an update on the four audits that had now been finalised:

Sickness and Absence – Moderate Assurance
Maria McMahon-Joseph noted the recommendations are in relation to compliance with the policy.

Fit and Proper Person Requirements – Substantial Assurance
One of the recommendations was in relation to the process for the Board of Directors, actions are being implemented.

Control of Contractors Review – No opinion provided – consulting review
This audit was added to the Audit Plan at the request of Melissa Swindell as there were known issues that needed to be addressed. Actions have been assigned and are being implemented by the new Head of Estates and Head of Building Services.

The Chair asked MIAA if they take into account the findings within consulting reviews when preparing their Head of Internal Audit Annual Opinion. Gary Baines said the Head of Internal Audit Opinion is restricted to the work directly completed by MIAA, however there is a section in the opinion which draws out wider considerations that the Trust should reflect on when preparing its Annual Governance Statement.

The Committee discussed the use of consulting reviews versus assurance reviews and agreed that, in general, for existing/ established processes assurance reviews were appropriate. Consulting reviews were especially useful for new processes. It was reiterated that any requests for consulting reviews be approved by Audit Committee.

The Chair advised that in other organisations in which she has been involved the internal auditors have provided both a design opinion and a compliance opinion, rather than a combined opinion as is provide here. Gary Baines said this process is used in other areas and will be considered going forward.

Audit Committee considered the request to make the following changes to the Audit Plan:
Proposal to use the days originally allocated to the Cyber Security audit planned for Q2 to support the Trust with the completion of an Infrastructure review at the request of the Trust due to the resilience risks on the Corporate Risk Register.

The Chair asked MIAA to confirm that they are still on track to complete all audit fieldwork by the end of January as requested. Gary Baines confirmed that this was the case. The Chair asked MIAA to provide a list of the timings of the remaining audits following the meeting.
**Action: GB**

**Resolved:**
Audit Committee received an update on Internal Audit progress and APPROVED the above changes to the Audit Plan.

**19/20/36 Follow Up Audits**
Audit Committee received the above report. Both the Consultant Job Planning and Cyber Security audits had revised deadlines until the new financial year in April 2020.

The Committee commented that some of the recommendations were now significantly overdue.

As consultant job planning takes place annually the deadlines for the recommendations in this audit now needed to be put back to the next annual exercise.

Claire Liddy suggested that the audits on material planning are reduced from quarterly to annual updates. MIAA agreed to reflect audit budget days and confirm when the next update would be received.
**Action: MIAA**

The PFI Contract Monitoring Audit Review was undertaken in 2016/17, John Grinnell asked for milestones to be agreed on when the new build benefit realisation recommendation would be completed.
**Action: David Powell (Executive Sponsor)**

**Resolved:**
Audit Committee received the Follow Up Audit report noting actions to receive assurance against progress.

**19/20/37 Anti-Fraud progress report Quarter 2**
Maria McMahon-Joseph presented the above report on behalf of Virginia Martin highlighting the 4 key fraud areas that are reviewed on an ongoing basis. The Chair queried if the Committee should be sighted on actions taken by the Trust as a result of recommendations made in anti-fraud work. It was agreed that the anti-fraud recommendations will be added to the Follow Up Process undertaken by MIAA and progress reported to the Committee as part of that reporting.
**Action: GB**

Audit Committee discussed anti-fraud guidance available for staff and the sessions Virginia Martin holds on site; for example, for Finance and Procurement. In Virginia's absence it was unclear whether anti-fraud sessions are also provided for other areas such as IT Services and whether this and other areas should be added to the sessions provided Virginia Martin to provide an update to the next Audit Committee.
**Action: VM**

There is an outstanding action from the Trust's Fraud Risk Self- Assessment relating to bribery and corruption awareness training for staff. Virginia Martin has contacted the Learning & Development Manager a couple of times about this and has received no response. The Chair also confirmed that she had contacted the Learning & Development Manager also to support Virginia's request but is not aware that action has been taken. The Chair would contact MS outside of the meeting and ask her to take it forward.
**Action: MS**

**Resolved:**
Audit Committee received the quarter 2 Anti-Fraud progress report.

**19/20/38 E&Y Technical update report**
The Chair queried under regulation news 'CMA publishes Final Report on Audit Market Study' if the recommendations contained within are mandatory for Trusts. Hassan Rohium said it currently wasn't required however this may change.

**Resolved:**
Audit Committee received the E&Y Technical report.

**19/20/39 Integrated Governance Committee 2018/19 Annual Report**
**Resolved:**
Audit Committee received the above report and noted that in future it will be received in April alongside the other committee annual reports.

**19/20/40 Audit Committee Effectiveness Review – Proposal**
Jill Preece presented a suggested questionnaire to aid the Committee in reviewing its' effectiveness. This was based on the HFMA's "NHS Audit Committee Handbook Checklists" Audit Committee considered the above paper and agreed its' use. Jill Preece agreed to circulate a Word version of the questionnaire to both members and attendees with a return request no later than 18th October 2019. The outcome of the questionnaire will be presented back to Audit Committee.
**Action: JP**

**19/20/41 Audit Committee Terms of Reference**
Audit Committee received the amended Terms of Reference noting the inclusion for the Committee to review the effectiveness of the Trust's Whistle Blowing arrangements.

The title for the Deputy Director of Finance was to be changed to the Operational Director of Finance.
**Action: JP**

**Resolved:**
Audit Committee approved the Terms of Reference.

**19/20/42 Raising Concerns (Whistleblowing) Policy**
Audit Committee received the above policy for approval.

The policy has been adapted as per the national guidance template noting this was briefer and easier to use than the previous version.

Shalni Arora queried what the process is for those that raise concerns about their line manager.

Erica Saunders said Kerry Turner, Freedom to Speak Up Lead was currently reviewing policies to ensure staff are aware of the various processes for raising concerns. Erica Saunders agreed to circulate a paper that was presented to Trust Board on the route to follow for each type of concern.
**Action: ES**

**Resolved:**
Audit Committee Approved Raising Concerns (Whistleblowing) Policy.

**19/20/43 Acorn Assurance Review**
Audit Committee received the categorised 20 recommendations following the KPMG review of the Acorn Partnership. The need for this review was originally suggested by Claire Liddy as it is a new area of operation for the Trust which was expected to expand, and so there was a need to ensure an appropriate control environment. As it was undertaken by KPMG it is not part of the MIAA Internal Audit Plan; it is essentially an internal audit of a specialist area. Claire Liddy agreed to present an action plan and shareholder document to Audit Committee on 16th January 2020.
**Action: CL**

The main themes from the review are around governance and record keeping. An update on the action plan and commercial items is to be presented at Trust Board on 5th November 2019.

The Chair welcomed receipt of this report and thanked Claire for identifying the need and making the arrangements for it. The Chair recognised there are some significant findings identified in the report which will result in significant improvement in control. The Chair highlighted that this is a good example of when consulting reviews are useful to the Trust (rather than assurance reviews).

**19/20/44 Losses and Special Payments**
The Trust had 14 cases of losses and special payments with associated costs of £40,704 relating to the period April 2019 to August 2019 (April 2018 to August 2018 15 cases with associated costs of £22,641).

The Chair asked if the personal injury claim in relation to an electric shock could have been avoided. Erica Saunders advised claims are managed through the Health and Safety Committee.
**Action: Amanda Kinsella**

**Resolved:**
Audit Committee received the Losses and Special Payments for the period from April 2019 to August 2019.

**19/20/45 Board Assurance Framework (BAF)**
A discussion was held on whether sub-committees should receive all Board Assurance Risks or risks relevant to the committee. It was agreed Committee's would continue to receive all Board Assurance Risks

**Resolved:**
Audit Committee received and noted the contents of the BAF including the ongoing scrutiny of all strategic risks by the relevant assurance committee.

**19/20/46 Any Other Business**

Maria McMahon-Joseph is leaving MIAA at the end of the week. On behalf of the committee the Chair thanked Maria for all her support and wished her well going forward.

**19/20/47 Meeting Review**

No items required forwarding to any of the other committees.

**Date and Time of next meeting: Thursday 21st November 2019, at 14:00, Large Meeting Room, Institute in the Park.**

# BOARD OF DIRECTORS

**Tuesday 3rd December 2019**

| | |
|---|---|
| **Paper Title:** | **Resource and Business Development Committee Assurance Report** |
| **Date of meeting:** | 23 October 2019 – Summary<br>25 September 2019 – Approved Minutes |
| **Report of:** | Ian Quinlan, Committee Chair |
| **Paper Prepared by:** | Amanda Graham, RABD Committee Administrator |

| | | |
|---|---|---|
| **Purpose of Paper:** | Decision<br>Assurance<br>Information<br>Regulation | ☐<br>■<br>☐<br>☐ |
| **Summary and/or supporting information:** | This paper provides a summary from the recent RABD Committee meeting 23 October 2019 along with the approved minutes from the 25 September 2019 meeting. | |
| **Action/Decision Required:** | To note<br>To approve | ■<br>☐ |
| **Link to:**<br>➢ **Trust's Strategic Direction**<br>➢ **Strategic Objectives** | Delivery of **outstanding care**<br>**The best people** doing their best work<br>Sustainability through **external partnerships**<br>Game-changing **research and innovation**<br>**Strong Foundations** | ☐<br>☐<br>■<br>☐<br>■ |
| **Resource Impact:** | None | |

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

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

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

- **Update on current Tariff situation**
- **Detailed update of NHS/Public Sector Partnerships**
- **International work through Alder Hey Academy**
- **Finance Report** including an update on M7
- **Review of Financial recovery Plan**
- **Campus Development update**
- **Energy & Hospital Environment update**
- **Board Assurance Framework**
- **Corporate Report**
- **Marketing & Communication update**

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

- **Growing partnership / collaboration agenda –** discussion around capacity to support this
- **International strategy –** clinical capacity to support this
- **£2m+ forecast gap against control total –** Divisions key to call what will take to bridge this
- **Shortfall CIP of £1.2m** mainly Medicine & Corporate areas
- **Pressure on Campus budgets & timings –** in particular Alder Centre & Cluster / Dewi
- **Overall Capital affordability due to revenue protections**
- **Significant pressures on ED Department**

4. **Positive highlights of note**

- Progress being made on our partnerships in the wider system
- Improved energy performance – 28% reduction over last 4 years
- Long-standing hospital environment issues gaining traction

5. **Issues for other committees**

The need for the Board to reconsider the International Business Plan

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

Alder Hey Children's NHS
NHS Foundation Trust

**Resources and Business Development Committee**
**Minutes of the meeting held on: Wednesday 23rd October 2019 at 9:30pm in Tony Bell Boardroom, Institute in the Park**

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

**It was recorded that due to apologies from Claire Dove, the meeting was not quorate.**

**19/20/98** **Apologies**
The Chair noted the apologies received from Claire Dove, Claire Liddy, Dani Jones, David Powell, Erica Saunders, Hilda Gwilliams, Nicki Murdock & Natalie Deakin.

**19/20/99** **Minutes from the meeting held on 25th September 2019**
**Resolved:**
The minutes from the meeting held on the 25th September were approved, subject to several points of a commercial nature being redacted.

**19/20/100** **Matters Arising and Action log**
There were no matters arising and no updates for the Action Log.

**19/20/101** **Pay**
A number of issues have impacted uplift in pay costs: national agreements; local agreements; pension costs; Clinical Excellence Awards; pay banding claim which has resulted in all Junior Doctor working now being monitored including rest breaks etc. JG noted that some areas have potential to create major issues – are there any areas which have high individual risks? MS to provide forward scan on pay perspective end of financial year.

**ACTION – forward-scan report from pay perspective to RABD March 2020 (MS)**

**19/20/102 Finance Report**

M6 position is a £100k deficit which is ahead of plan. . Activity and income is ahead of plan in both Elective and Non Elective, offset by overspends in expenditure.

The Trust are underperforming on commissioner contracts but expectation is that will reach plan by end of year.

A slight increase in M6 for temporary pay expenditure but will continue to track on a monthly basis.

There still remains a risk to the full year forecast and delivery of the control total. All divisions have been asked to review their forecast and deliver an improvement in the M7 position. Trust recovery schemes are in place and monitored through SDG.

There has been little improvement in the CIP position over the last 2 months, the £1.5m gap against the £6m target remains. SDG to focus on CIP schemes yet to be delivered.

Cash level is higher than plan at M6 due to some slippage in capital spend. The capital programme still on plan for projected spend.

**19/20/103 PFI Monitoring Contract**

General performance good, 99% of PPM completed within month with balance completed 2 days later. No further water ingress incidents (temporary covers are now in place until Spring 2020) Energy usage against contractual target is reducing.

Board to Board update – Project Co, Laing O'Rourke & Interserve met with AH Exec representation to discuss areas of concern, a helpful discussion took place and thanks were noted to GD for his presentation to highlight the extent & history of the issues.

A clear and explicit plan for each of four areas to be provided by Project Co and agreed with Trust. A letter to confirm meeting outcomes is to be sent with follow-up meeting to be arranged. A discussion re: the next steps is to take place internally following receipt of response from that letter.

MF asked whether the concerns will continue without any action being taken; JG noted that there needs to be an opportunity to resolve the issues now senior staff have become involved. IQ questioned the reasoning behind bringing in a new expert on water issues; AB noted that this is one issue that is measurable. IQ noted that things seem to be improving but concerned around energy costs as listed in Finance report. RL noted that there are timing discrepancies between invoices and billing. JG asked for Energy as a whole to be brought to RABD next month for review.

**Action – letter to be sent to Board to Board attendees re next steps (JG)**
**Action - Energy to come to RABD November (SA/GD)**

**19/20/104 Top 5 Risks/Key Priority Areas for 2019/20**

RABD received the latest updates on the areas below:

*CIP*
Concerned that despite recovery plan in place there has been no movement on the CIP Forecast outturn figure of £4.5m figure. Aim that as more traction on recovery that these figures will show some movement – need to look at Pay recovery in more detail. CIP is a priority to deliver the full £6m target for the year to ensure not carrying forward anything into 2020/21.

CIP update to be provided linking recovery actions to CIP to next RABD.

**Action – full CIP update for next RABD (SN)**

*Capital*
Preferred bidder for park reinstatement has been selected, process for appointment to be followed. Planning permission reports being prepared for submission, however potential for some delay if not submitted in line with the next Planning deadline.

Neonatal accommodation scoping is currently undergoing review to reduce gross internal floor space, with potential need for feasibility study to refine requirements.

Alder Centre build has commenced, contract being managed tightly to control any possible shortfall due to lack of contingency.

It was noted that in future papers must not go to Board without going through RABD.

**Action – meeting LS/JG/DP/MF to be arranged (JG)**

*Facilities*
Updated later in meeting

*Digital Strategy*
Digital Futures Strategy is now in delivery mode. Progress has been made with community teams migrations, IT resilience plans are on track for delivery by the end of the calendar year and proactive daily support from technicians in clinical areas is in place.

Alder Hey has gone live in a number of wards with closed look prescribing which is a key part of HIMSS and provides enhanced safety checks for medicines administration.

HIMMS level 6 assessment visit is planned for the end of November

GDE assurance visit with NHS Digital went very well.

MF noted that on recent ward rounds, all had noted that IT had improved over last 6 months.

**19/20/105** **Programme Assurance**
Not presented – late apologies from ND

**19/20/106** **Marketing and Communications Activity Report**
Revised approach being prepared for discussion. Social media providing large amount of local & national news; CEO agreed to host new Twitter account to support that. Update for next RABD along with item on AlderPlay from national press.

**Action – update to be brought back to next RABD (MF)**

**19/20/107** **Board Assurance Framework (BAF)**
Apologies from ES

**19/20/108** **Corporate Report**
Operations - Exception reporting on ED waiting times increasing; increased staffing levels will fully impact from November. Also on Cancer Standard – one breach due to care being shared over 2 Trusts – breach details to be shared

HR – mandatory training still needs work; sickness slightly increased, new sickness management model to be trialled.

**LTP Update**
Final LTP submission due by end October 2019. Financial Improvement Trajectory (FIT) for Alder Hey is to deliver a break even from 2020/21 onwards.
The first draft submitted in September 2019 showed Alder Hey as a deficit position. RL noted that there are some emerging and potentially committed costs which need to be looked at in more detail and decisions made; these have not yet been included in the figures submitted. The next two years will be financially challenging, with further work urgently required to look at figures prior to submission before end of October. Capital plan submitted was based on surplus position and needs to be revisited.

JG has been asked by the Chief Executive to pull together some high-level discussions to work on this. SB suggested looking at outsourcing to reduce future capital investment along with potentially lower revenue costs to become more financially viable. JG noted that this was an example of the topic for discussion. AB noted that currently the Trust is not commercially minded, but this step-change appears to be requiring that skill and knowledge. JG suggested that experienced help is required to inform & support, but all decisions need to fit with the Trust ethos and be Alder Hey friendly.

Workforce assumptions based on plan plus growth and CIP. MS noted feedback from HEE from the Cheshire & Mersey Workforce Directors meeting that the two different returns have been asked for slightly different data. NHS Plan and NHS People Plan focus on certain staff groups which have impacted on the submissions made. SN noted that as a Trust there needs to be more detail & visibility of workforce figures and that there will be increased scrutiny on these plans & figures included.

AB asked whether previous figures had been used to indicate trends; SN & MS confirmed that this had been done.

**Action – high-level discussions to be arranged (JG)**

**19/20/109 Hosting of Procure North West**

Approval requested on Alder Hey hosting a procurement framework on behalf of Procure North West. Originally Alder Hey Charity approached to host the framework as this generates an income but as they are not a public body they are unable to host. Subsequently Alder Hey was approached to host the framework and procurement has commenced on the hosting of the framework.

The Trust has received external anonymous concerns regarding the reputation of Procure North West. The paper outlined that a thorough due diligence had been undertaken to assure that the organisation & individuals are suitable & appropriate to work with. As a further precaution SB has now drafted updates to SFIs to ensure correct procedures are followed in future, also safeguards have been built into the contract to protect the Trust, including full Open Book to monitor income stream. IQ asked for clarification over process for framework award. **KW asked for a summary on all key risks, to ensure Trust can make a fully informed decision.**

MF asked if there is a reputational issue what process is followed and who supports that process to give governance? MS asked whether any advice has been taken regarding the concerns that were raised. JG noted that although the model in itself is not concerning and that other Trusts are doing this, there have been concerns raised over the individual and need to be sure that this is handled correctly & appropriately, fundamentally must have the ability to exit quickly if required. MF suggested improving the context by noting the other Trusts who have done this for reference as to how they have approached the process.

IQ noted there may be benefit in undertaking full 360deg referencing. RL asked whether he has capacity to award national contracts if the framework is hosted; SB suggested his staffing would increase as more contracts were awarded. MF asked what the timeline for payment would be; SB replied that 50% of the 0.2% of contract award would be on award.

JG asked that the previous hosts are contacted; that 360deg referencing be undertaken; that the organisation are brought in to discuss process & concerns. Looking for approval to award – JG proposed the paper be taken to Board in November following some redaction. Asked for consideration from Committee with regard to if all is in line, would the Committee recommend going to Board?

**Action - As the meeting was not quorate agreement will be sought off-line.**

**19/20/110 Facilities Update**

Almost half of risk is made up by Catering. Postage is being looked at within Recovery Streams. Porters disagreement over new organisational arrangements not yet settled, new changes will be going through but concern over expected reaction. MD to look at portering management systems & bring to future RABD. Domestics recently had uplift from Band 1 to Band 2.

In terms of what has been done & what is to be done, catering reorganisation now in place. Labour & offer have been reduced particularly at weekends. May struggle to increase income due to other offers within the Hospital. JG noted that the external consultant report on Catering needs to be reviewed & realigned to fully inform RABD.

Discussion required over Institute offer of hospitality for external meetings, currently have an area that is underutilised and is a potential income source. KW suggested a deep-dive into Facilities followed by a workshop. MF noted that there may need to be a time when it is accepted that this is what the Catering provision costs and that it has to run at that cost; also need to look at future offers for external business. RL noted that the external report did have options & plans but until these are actioned there will be no impact.

JG noted that there needs to be a discussion around utilising the Institute facilities fully, also future projections for when Park finally fully open.

MS noted that Unison are asking for formal response over payment of AforC pay rates, less of an issue for Trust but has local & national implications.

**Action - full review & workshop, review of previous external report to be brought to future RABD**
**Action - Portering systems to be looked at & brought to future RABD (date to be agreed) (MD)**

**19/20/111** **Contracting Intentions 2020/21**
National guidance requires any notification of changes relating to coding and couting. If approved by commissioners these changes will improve the Trust financial position. Discussions to take place with commissioenrs as part of 20/21 contract negotiation. Note some are subject to a 18 month notice period
**Action – update to be brought back to future RABD (date to be agreed) (JG)**

**19/20/112** **Springfield Park Reinstatement Contract Award**
Only one bidder for the work (preferred bidder), bid submitted at £203k for works, asking for approval to go ahead and appoint preferred bidder. MF noted that preferred bidder has potential to support in other areas due to extensive experience in community engagement.

**Action - As the meeting was not quorate agreement will be sought off-line.**

**19/20/113** **Any Other Business**
There was no other business for discussion.

**19/20/114** **Board Assurance Review**
The Board Assurance Review was completed for submission to Trust Board.

**Date and Time of Next Meeting: Wednesday 27th November 2019, 09:30, Tony Bell Board Room, Institute in the Park.**