Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 3rd September 2019 commencing at 10:00

Venue: Tony Bell Board Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
PATIENT STORY (1000 – 1015)							
1.	**19/20/133**	**10:30**	**Apologies**	Chair	To note apologies.	**N**	For noting
2.	**19/20/134**	**10:31**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**19/20/135**	**10:32**	**Minutes of the Previous Meeting**	Chair	To consider and approve the minutes of the meeting held on: **Tuesday 2nd July 2019.**	**D**	Read Minutes
4.	**19/20/136**	**10:35**	**Matters Arising and Action Log**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Verbal
5.	**19/20/137**	**10:40**	**Key Issues/Reflections and items for information**	All	Board to reflect on key issues & discuss any queries from information items	**N/I**	Verbal
Delivery of Outstanding Care							
6.	**19/20/138**	**11:00**	**Inspiring Quality Progress and Next Steps:** - **Clinical Cabinet** - **Seven Day Services** - **Sepsis Update**	N Murdock	To APPROVE the governance of the Clinical Cabinet. To note progress made since the last Trust Board update on 2nd June 2019. To note the current position	**A/D**	Read reports
The Best People Doing Their Best Work							
7.	**19/20/139**	**11:30**	**People Strategy**	M Swindell	To present the current position to the Board for noting / discussion.	**N**	Read report
Sustainability Through External Partnerships							
8.	**19/20/140**	**11:45**	**Update on Specialist Trust Group and system governance**	L Shepherd/ J Grinnell	To update the Board on the initiatives underway	**N**	Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
9.	**19/20/141**	**12:00**	**Liverpool Integrated Care Partnership**	D Jones	To provide the Board with an update on the Liverpool Integrated Partnership workshops/next steps.	**N**	Verbal
10.	**19/20/142**	**12:15**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital**	A Bateman	To update the Board on progress towards the single service model.	**A**	Read report
Lunch (12:30 – 13:00)							
Strong Foundations							
11.	**19/20/143**	**13:00**	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	J Grinnell	To receive an update on programme assurance.	**A**	To follow
12.	**19/20/144**	**13:10**	**Corporate Report** - **Community** - **Medicine** - **Surgery** - **Finance recovery plan**	J Grinnell L Cooper A Hughes C Duncan J Grinnell	To receive the monthly report of trust performance for scrutiny and discussion.	**A**	Read report
13.	**19/20/145**	**13:20**	**Board Assurance Framework**	Executive Leads	To provide assurance on how the strategic risks that threaten the achievement of the trust's operational plan are being proactively managed.	**A**	Read report
14.	**19/20/146**	**13:30**	**Board Assurance Framework Policy**	E Saunders	To APPROVE the revised policy.	**D**	Policy attached
15.	**19/20/145**	**13:45**	**Brexit Update**	J Grinnell / L Stark	To provide the Board with assurance in relation to business continuity plans.	**A**	Presentation
16.	**19/20/146**	**13:55**	**Digital update and Cyber Security**	K Warriner	The Board is asked to note the progress	**N**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
17.	**19/20/147**	**14:05**	**Proposed Change to Board composition**	E Saunders	To ratify the changes to the Board composition approved by the Council of Governors at its meeting on 17th June 2019	**N**	Read report
18.	**19/20/148**	**14:15**	**Alder Hey in the Park Site Development update**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	**A**	Read report
Committee Assurances (key risks / mitigations, issues for other committees, issues for escalation, key decisions)							
19.	**19/20/149**	**14:20**	**Integrated Governance Committee:** - **Chair's highlight report from the meeting held on the 10.07.19** - **Minutes from the meeting held on the 22.05.19** **Clinical Quality Assurance Committee:** - **Chair's highlight report from the meeting on 17.07.19** - **Minutes from the meeting held on 12.06.19** **Resources & Business Development Committee Report:** - **Chair's highlight report from the meeting held on 24.07.19** - **Minutes from the meeting held on 27.06.19**	K Byrne A Marsland I Quinlan	To note the Committee's highlight reports and approved minutes: To receive a highlight report of key issues from the June meeting and the approved minutes from the 13.3.19 and the 8.4.19. To receive a highlight report of key issues from the July meeting and the approved minutes from June 2019. To receive a highlight report of key issues from the July meeting and the minutes from the meeting held on the 27th June 2019.	**A** **A** **A**	Read minutes Read minutes Read minutes
20.	**19/20/150**	**14:20**	**Board Reporting Calendar**	E Saunders	To review and approve the Trust board reporting calendar for part 1.	**D**	Read paper
21.	**19/20/151**	**14:25**	**Any Other Business**	All	To discuss any further business before the close of the meeting.		
22.	**19/20/152**	**14:30**	**Review of meeting**	All	To review the effectiveness of the meeting and agree		

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
					items for communication to staff in team brief		
Date And Time of Next Meeting: 1st October 2019 at 10:00am, Tony Bell Board Room, Institute in the Park.							

REGISTER OF TRUST SEAL
The Trust Seal was not used in July 2019
The Trust Seal was used in August 2019:
1. Buy back option agreement:
2. Deed of Variation
3. DS1
4. Legal Charge
5. Deed of Variation (Option Land)

ITEMS FOR INFORMATION		
Freedom to Speak up: Guidance for Board on NHS Foundation Trusts	E Saunders	To brief the Board on latest guidance from NHS Improvement ahead of the next quarterly update.
Election Results 2019	E Saunders	For the Board to note the outcome of the summer elections to the council of governors
Serious Incidents Report	H Gwilliams	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.
Complaints Quarter 1 report	H Gwilliams	To provide assurance to the Board that the Trust follows it's Complaints Policy and Procedures when investigating and responding to formal complaints addressed to the Trust.
Infection, Prevention and Control Quarter 1 report	H Gwilliams/ N Murdock	To provide the Board with assurance in relation to compliance with the Health and Social Care Act 2008: code of practice on the prevention and control of infections and related guidance (Department of

		Health, 2015)

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 2nd July 2019 at 10:00am,**
Tony Bell Board Room, Institute in the Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs K Byrne	Non-Executive Director	(KB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mr J Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr N Murdock	Medical Director	(NM)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs M Swindell	Director of HR & OD	(MS)
	Mrs L Shepherd	Chief Executive	(LS)
In Attendance:	Mrs P Brown	Director of Nursing	(PB)
	Ms L Cooper	Director of Community Services	(LC)
	Mr C Duncan	Director of Surgery	(ChrD)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
	Mrs K Warriner	Chief Information Officer	(KW)
Observing:	Mr Gazanfer Ali	Member of the public	
	Mrs Sarah Barr	Chief Information Officer, Clatterbridge Cancer Centre	
	Mrs Laura Tligui	A&E Assistant Practitioner	
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Prof L Kenny	Executive Pro Vice Chancellor	(PLK)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
Agenda item: 103	Valya Weston	Associate Director of Infection, Prevention and Control	
113	Sharon Owen	Deputy Director of HR & OD	
114	Kerry Turner	Freedom to Speak Up Guardian	
	Jo Potier	Freedom to Speak up Champion	
	Chris Browne	Freedom to Speak up Champion	
	Craig O'Brien	Freedom to Speak up Champion	

Apprentice/Staff Story
Daniel Taylor, Apprentice at the Academy, Emma Palmer, Assessor and Catherine Kilcoyne Academy Manager were all welcomed to the Trust Board meeting.

Daniel's role is part of the Events Co-ordinator's team; he supports the Chinese Doctor Observership visits and recently went to Bejing and Shanghai as part of the team to further develop relationships and look at replicating the programme in other countries.

Daniel's apprenticeship will finish in 2020. Going forward Daniel said he would like to continue expanding into a leadership role at Alder Hey.

Claire Dove highlighted that not all school leavers will be at an apprenticeship level and asked if there is any scope for a trainee apprenticeship course.

The Chair thanked Daniel, Emma and Cath for attending the Trust Board meeting and highlighting the importance of the apprenticeship scheme.

Children and Young People's Forum Presentation
Esme, Shaun and Chris presented a video from their visit to London to meet with Simon Stevens, Chief Executive of NHS England and Baroness Dido Harding, Chair of NHS Improvement to share views on the NHS Long Term Plan. The event was arranged by the NHS Youth Summit.

Esme said the Children and Young People Forum meets regularly and has a growing membership, the youngest being six years old.

On behalf of the Board the Chair thanked Esme, Shaun and Chris for attending the meeting today and agreed to continue working together going forward.

19/20/96 Declarations of Interest
There were none to declare.

19/20/97 Minutes of the previous meetings held on 28th May 2019
Resolved:
The Trust Board approved the minutes from the last meeting held on 28th May 2019.

19/20/98 Matters Arising and Action Log
All other actions had either been completed or are on the agenda for a further update.

19/20/99 Key Issues/Reflections
Louise Shepherd highlighted the implementation programme for the NHS Long Term Plan had been received. This was being discussed at the weekly Executive meetings to capture the key areas for Alder Hey.

Following the apprenticeship story Nicki Murdock noted that qualification grades have been lowered for medical school entry.

BBC Radio 4 is looking to record a programme in August focused on organ retention as part of the 'Reunion' series. A small number of colleagues who were involved at the time have agreed to take part, along with two families who were affected.

Ian Quinlan noted that the identification and treatment of sepsis continues to be a concern for Alder Hey and nationally, it was noted that a focus on sepsis continues to carry a high media profile.

19/20/100 Output from Strategy session on 25th June 2019
Following the above session Dani Jones went through the current position and agreed to present a draft plan at the September Board.
Action: DJ

A communication plan with staff across all sites is due to commence next week with a summit to be held on 17th September 2019.

John Grinnell reported on the recent review of the Change Programme for 2019/20 to improve the pace and progress of delivery. Adam Bateman and Adrian Hughes spoke highly of the recent changes noting the Outpatient project and Best in Acute Care had been able to move forward at a faster pace due to the changes implemented.

John Grinnell highlighted that the focus remains on the delivery of Inspiring Quality.

Resolved:
The Trust Board received the outputs from the strategy day as well as the current position and future plans.

19/20/101 Serious Incident Report

The Board received and noted the content of the Serious Incident report for May 2019. Pauline Brown stated that during this reporting period there were no new Serious Incidents, no incidents of major harm or no never events and one SI had been closed. Of the two ongoing cases both reports had been submitted to the Liverpool Clinical Commissioning Group and the robustness of the reports had been commended by the CCG.

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

19/20/102 Nurse Staffing Report 2018/19

Pauline Brown presented the annual data to the Trust Board as required by NHS Improvement. Pauline Brown highlighted the following areas:

- The Trust's mandated monthly submission has been consistently higher than 92% throughout the year
- Where the overall fill rates for HCAs is higher than 100%, the figures are due to 'specialing' patients with higher acuity, i.e. 1-1 care
- Data showed the four occasions where the average fill rate for registered nurses was 88% or 89% and how the fill rate was mitigated.
- Performance against the 16 RCN core standards demonstrates full compliance with 14 and 2 in progress.
- Following the Ward Accreditation process three wards received gold, nine received silver and four received bronze. The Perfect Ward Programme was also in the process of being rolled out.
- At the last Trust recruitment day in June 2019, 55 nurses were recruited with 15 of them not having any previous experience.
- Eight existing members of staff have trained as nurses; this is a much higher number than the previous year.
- Following feedback on the use of the term 'Nurse Pool' this has now been changed to Staff Nurse Rotation Programme. A period referred to as the 'transfer window' is now available for staff who would like to learn skills in both medicine and surgery.
- No external nursing agencies were used last year.
- Clinical educators are now in place to support nurses who would like to broaden their skill set.
- Six places for Advanced Nurse Practitioners are available each year.
- Future plans were described to maintain and improve the Trust's strong position.

From the demographic profile, Kerry Byrne commented that a high number of staff seemed to leave aged around 36 and asked what was being done to retain these staff. Pauline Brown referred to career paths from start to finish with a number of options that are offered to nurses through the Head of Education.

The Trust Board queried if community staff are also included in the nurse rotation. Pauline Brown noted plans to extend this to Allied Health Professionals in 2020 as well.

Resolved:
The Board received details on Nursing Staffing Levels for 2018/19.

Questions raised by member of the Public

The Chair informed the Board that she had agreed that a member of the public acting as an observer could ask questions at this point in the meeting. Mr Ali asked for a response in relation to:

- Treatment for colic.
- Support for postnatal depression with breastfeeding mums
- Process for an opinion on external investigation

Pauline Brown left the meeting with Mr Ali to discuss his queries further and agree the process by which the above questions would be responded to.

19/20/103 Infection Prevention and Control Annual Report

Valya Weston presented highlights from the Annual Infection Control report; in terms of hand hygiene she informed the Board that practical assessments will now be carried out as part of mandatory training.

An increase in grade 2 pressure sores had been reported due to heightened awareness and an increase in reporting but that there had been a reduction in the incidence of grade 3.

Two staff members within the Vascular Access team are now able to insert more advanced vascular access devices.

John Grinnell highlighted a national spike of RSV infections in 2018/19 noting that internally we had set a target of a 25% reduction and asked how this was achieved. Valya Weston referred to the improved communications plan around Influenza, RSVs and general wellbeing.

Anita Marsland referred to the Antibiotic Stewardship section and the increase of ciprofloxacin in relation to Sepsis. Valya Weston noted the planned training days that are to take place with regard to antibiotic stewardship for all nurses across the Trust.

David Powell queried the figures in relation to completion of the Hand Hygiene audit are correct. Valya said she had more confidence in the numbers now that the Hand Hygiene App had been implemented, along with IPC validation audits and Gojo independent auditing.

Resolved:
The Board received the 2018/19 Infection Control Annual report.

19/20/104 Neurodevelopment Improvement update

Following discussion at the Trust Board on 3rd March 2019 Lisa Cooper presented a paper outlining the action plan to date to improve waiting times for neurodevelopmental paediatric services commissioned via NHS South Sefton; NHS Southport and Formby; NHS Liverpool and NHS Knowsley CCGs. Performance against this project plan is monitored on a monthly basis via the Divisional business meeting and Alder Hey SEND Group.

Lisa Cooper responded to Claire Dove's query confirming Asperger's Syndrome is included within these services.

Resolved:
The Trust Board noted the identified improvements as an agreed way forward for Alder Hey to deliver safe, effective and evidence based neurodevelopmental paediatric services which meets the needs of children, young people and families.

19/20/105 Update on transferred services from the former Liverpool Community Health NHS Trust

Following a recommendation from the Kirkup Review into the failings at LCH, NHS Improvement carried out a review on services that had transferred to other providers to ensure services are safe and effective.

Lisa Cooper updated the Trust Board on the staff survey results from 150 staff that had transferred to Alder Hey in April 2017. Whilst staff had said they feel supported a number of actions have been put in place including mandatory training sessions within the community and health and wellbeing sessions.

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

Resolved:
The Trust Board noted the contents of the report and was assured that identified improvement actions are being implemented within the Community and Mental Health Division in relation to services transferred from Liverpool Community Health NHS Foundation Trust.

19/20/106 Seven Day Service

In February 2019 the Trust provided its first board assurance report to demonstrate progress against the Seven Day Hospital Services (7DS) standards. A further assessment was carried out in June 2019.

There are 10 standards and an update was received against the four mandated standards:

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

Full compliance was maintained for standards 5 and 6.

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

Going forward further focus would be required on the standard in relation to clinical handover. A timeline was to be completed with the Divisions to identify support required going forward.

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

19/20/107 Mortality Report Quarter 4

Nicki Murdock reported that between January and December 2018, 55 deaths had taken place at Alder Hey, 49 of which had been reviewed with a plan in place for the outstanding 6. It was noted that the investigations are detailed and timely.

Adam Bateman asked if any further support was required to meet the 4 month timeframe that the HMRG operates to. Nicki Murdock advised that Cardiologists are required to complete a review however she would ask the team if any further support could be provided.

Resolved:
The Trust Board received the Mortality report for quarter 4.

19/20/108 Digital Update and Cyber Security:

Kate Warriner updated the Board noting:

- In relation to GDE and HIMSS Level 7 Accreditation, following an assessment of the final milestone a change control notice has been developed and is under review with NHS Digital. The notice recommends removal of Electronic Patient Record upgrade from March 2019, with addition of further ambitious digital projects including artificial intelligence, virtual reality and a digital paediatric intensive care unit.
- A gap analysis has been undertaken with regards to HIMSS accreditation, the key risk is with regard to implementation of closed loop medications. A group has been established, led with digital and pharmacy colleagues to develop a weekly delivery plan.
- Electronic Patient Record upgrade plans are underway; demonstrations of the new system have taken place.
- A range of activities have commenced with regard to paper free.

Digital Strategy

Named by the Children and Young People's Forum, 'Digital Futures', the draft digital strategy has been developed over the past three months with clinical input from staff across the Trust.

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

Our Digital Children, Young People and Families theme will be delivered through three work-streams.

In terms of governance, it is proposed that a Digital Oversight Collaborative is established. This group will replace the GDE programme board and will report into the Resources and Business Development Committee.

Nineteen Key Performance Indicators are in development for the operational IT team and will be presented at the September Trust Board.
Action: KW

The Trust Board commended Kate Warriner for the clarity provided by the Digital Futures Strategy.

Received:
The Trust Board:

- Received the Digital update.

- APPROVED Digital Futures Strategy.

19/20/109 Alder Hey in the Park Site Development Update

David Powell presented an update to the Board with regard to the key components of the site as they currently stand.

Campus

To reduce the current capital projection for the campus, the following areas would be developed as indicated:

- 24 bed Neonatal Unit – an extension will be built to 150 square metres.
- Springfield Park will be developed within the core scheme with any enhancements requiring agreement from the Charity.
- Neuro hub and CAMHS Tier 4 relocation to Alder Hey site - both areas will be developed as clinical space only with admin teams to be based close to the site.
- North East Plot – developers have agreed to include both a gym and the nursery on this site.

Resolved:

The Trust Board received the update on the Site Development.

19/20/110 Clinical Quality Assurance Committee

Anita Marsland gave a verbal update from the last CQAC meeting held on 12th June 2019 noting the escalation of an action to update 178 patient information leaflets. Pauline Brown said a recovery meeting had taken place with agreement to review all those outstanding with support from the Children and Young People's forum to ensure they are child-reader friendly.

Resolved:

The Trust Board received and noted:

- The minutes from the Clinical Quality Assurance Committee meeting held on 15th May 2019.

19/20/111 Integrated Governance Committee

Kerry Byrne gave a verbal update from the last IGC meeting held on 22nd June 2019 noting focus on high risks and maintaining regular review and scrutiny of actions assigned via risk registers.

A further joint meeting on corroded pipework was held on 25th June 2019 with Laing O'Rourke and Interserve. A timeline was agreed with outcomes from testing results. Monthly meetings are to be arranged to maintain pace on actions to achieve resolution.

Resolved:

The Trust Board received and noted:

- Integrated Governance Committee Annual Report.
- Integrated Governance Committee minutes from the last meetings held on 8th April and 13th March 2019.

19/20/112 People Strategy Update

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

- The current focus of the Reward and Recognition group is on arranging a large scale/high profile summer music event, bringing together staff and the local community on the Alder Hey and Springfield Park site

- Meetings have been taking place to prepare for the OFSTED Inspection of the apprenticeship programme at Alder Hey. Claire Dove offered support for this from Blackburne House.
- Sickness rates have decreased slightly for the fourth month consecutively from 5.31% to 5.29%. Melissa Swindell noted the high proportion of long term sickness.

Resolved:
The Trust Board received and noted:
- People Strategy report for May 2019.
- Approved Workforce and Organisational Development Committee minutes from the last meeting held on 3rd May 2019.

19/20/113 NHSI Chair Letter and Self-Assessment

Following a letter to all organisations from Baroness Dido Harding, Chair of NHS Improvement, a review of the Trust's current investigatory disciplinary procedures and processes had taken place. Sharon Owen went through the key areas identified:

- Review recommendations with staff side colleagues at the next bi-monthly case debrief
- Further training on investigations for all those involved in disciplinary procedures and investigations
- Enhanced training for all HR staff involved in disciplinary and investigation processes
- An early review of the Trust's Disciplinary Policy with staff side colleagues
- Timeliness of investigations - ensuring cases are not unnecessarily protracted and that investigations are given priority
- Investigators to be committed to timely investigations and report submission
- An Executive lead to be assigned to all cases
- More rigour applied to suspension decisions
- Quarterly detailed report to be submitted to Trust Board.

The following suggestions were made from the Trust Board:
- Change language from suspension as this is put in place to provide support for the member of staff
- Executive oversight to be aligned to Executive areas.

Resolved:
The Trust Board reviewed and APPROVED the report and associated action plan.

19/20/114 Freedom to Speak Up Quarterly Report

Kerry Turner attended with a number of the Freedom to Speak up (FTSU) Champions to report back to the Board on developments in the quarter, describing the enhanced mechanisms for staff to raise concerns and actions planned for the coming period.

In March 2019 a Freedom to Speak Up Summit was held to review the current routes and to discuss how these can be better aligned; the session was well attended, with representation from senior nurses, HR, PALS, senior management, Risk and Governance and FTSU Champions. One of the actions from the summit was to create monthly meetings, the first to be held on July 10th 2019. Anita Marsland would link in to these meetings as part of her Senior Independent Director role.

A new FTSU reporting process has been developed using Ulysses as the platform.

Dr Jo Potier, Consultant Clinical Psychologist and FTSU Champion now offers counselling support for champions and those raising concerns.

Going forward:
- Success will be measured through the national staff survey
- A Resolution Policy will replace the current Bullying and Harassment Policy.
- Continued recruitment of FTSU Champions to ensure all areas have access.

Resolved:
The Trust Board noted progress to date on Freedom to Speak Up.

19/20/115 Proposal on future management of Board business

Erica Saunders provided background on the development of a devolved management model at Alder Hey over the last 9 years, from Clinical Business Units to the current Divisional groupings in 2016. Following the Board's Well Led review further work have been undertaken with the support of external agencies to help develop thinking about next steps. The principles of bringing decision making closer to the patient were still considered the best way forward and it was proposed that the next phase in development of devolved management was for the Board to create conditions in which the Divisional leaders could take equal part in driving the strategic agenda.

The Chair encouraged cross learning taking place with each of the Divisions, it was highlighted that the monthly Operational Board is used for this to take place.
Erica Saunders commented that one of the themes emerging from the external review had been the need for greater consistency in terms of governance processes and this had been agreed at Operational Board.

The Trust Board noted a development session to be held for Non-Executive Directors to be held in the early Autumn.

Resolved:
The Trust Board noted the current position and approved the proposed future steps.

19/20/116 Tariff and Contract Risks

John Grinnell reported on future reductions to the national children's services tariff. The Children's Hospital Alliance is working to resolve the issue with the centre. It was agreed Trust Board would continue to be updated on a quarterly basis.

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

19/20/117 Programme Assurance Update

The Trust Board received the revised programme assurance report focusing on the benefits. Progress is to be made with the In the Park projects. Kerry Byrne noted clearer understanding with the new format.

Resolved:
The Trust Board received the revised report on programme assurance.

19/20/118 Resources and Business Development Committee

Resolved:
The Trust Board received a verbal update from the Resources and Business Development Committee held on 27th June 2019 noting continued focus with Alder Hey in the Park projects.

19/20/119 Corporate report including Finance Month 2

Executive leads updated with highlights as follows:

Finance

John Grinnell reported the behind plan position for month 2 noting the focus on activity as well as other key areas going forward.

Performance

Adam Bateman reported low re-admissions, all patients were rebooked within the month, meeting with the national standard.

The Emergency Department waiting time compliance has reduced to 91.3%. Adam Bateman fed back from a meeting held with frontline staff noting an increase in patients during the evening. An improvement plan to increase staffing levels and enhance IT has been put into place. It is expected benefits will be seen over the next few months.

An update on the delay of medical records being available once scanned was received; support with this has been outsourced and is due to be completed by October 2019.

Quality domains

Pauline Brown reported an overall increase in reporting. A weekly update on Sepsis is received at the Exec Comcell meetings.

Patient feedback kiosks are now available to use across the Trust.

Workforce

Overall mandatory training position is just under 90%. Compliance with Safeguarding level 3 is low among medical staff; Nicki Murdock and Melissa Swindell agreed to discuss an action plan outside the meeting.

Resolved:

The Board received and noted the contents of the Corporate Report for month 2.

19/20/120 Board Assurance Framework (BAF)

Erica Saunders reported on a piece of work that Jill Preece had completed to comprehensively update the BAF for 2019/20, including re-alignment risks against the strategic plan and removal historical risks that Executive leads had agreed could be closed.

Resolved:

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

19/20/121 Update on Specialist Trust Group and System Governance

Meetings have taken place with Chairs and Chief Executives to develop a Specialist Trust Group partnership. A Finance Director workshop is taking place on Friday 5th July 2019.

Resolved:

The Trust Board received and noted the development of the Specialist Trust Group.

19/20/122 Liverpool Integrated Care Partnership

Resolved:

Dani Jones noted the completion of the 12 week System Capability Programme. A report on the outcome of this work was expected shortly.

19/20/123 Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital

Adam Bateman noted progress as follows:

- Staff are now working across the two sites.
- A joint Neonatal Board to Board meeting is taking place tomorrow morning.
- Progress was being made to appoint the neonatal services leadership team.

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

19/20/124 Memorandum of Understanding with Royal Manchester Children's Hospital (RMCH)

Dani Jones updated the Trust Board on the development of the North West Paediatric Partnership Board and the key areas of partnership work between Alder Hey and RMCH. The formal MoU required approval of both Trust Boards.

Primary focus is on neurosciences and cardiology/congenital heart disease (CHD), with additional areas of work including Burns and North West Transport services agreed on a case by case basis.

Resolved:
The Trust Board APPROVED the Memorandum of Understanding with Royal Manchester Children's Hospital.

19/20/125 Any Other Business

No other business was discussed.

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

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for September 2019							
02.07.19	19/20/100	Output from Strategy session on 25th June 2019	To present a draft plan at the September Board	Dani Jones	03.09.17		03.09.19: This is to be discussed after the Trust Board. The final version will be presented at the November Trust Board meeting
02.07.19	19/20/106	Seven Day Service	To receive a further update	Nicki Murdock	03.09.17		03.09.19: Item on the agenda
02.07.19	19/20/108	Digital update and cyber Security	To present the 19 Key Performance Indicators for the operational IT team	Kate Warriner	03.09.17		03.09.19: To be presented under Digital update
Actions for July 2019							
28.05.19	19/20/77	Draft Annual Report and Accounts	To arrange a thank you event for achievements within the annual report	Mark Flannagan	02.07.19		02.07.19: In process
28.05.19	19/20/75	Alder Hey in the Park Site Development Update	To arrange a walkabout of the community cluster site for Non-Executive Directors	David Powell	T.B.C		On hold until final design is agreed
Status							
Overdue							
On Track							
Closed							

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd September 2019

Paper Title:	**Clinical Cabinet**
Report of:	Nicki Murdock, Medical Director
Paper Prepared by:	Nicki Murdock, Medical Director

Purpose of Paper:	Decision ☒ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Clinical Cabinet Briefing paper Terms of Reference Clinical Cabinet Alder Hey Children's NHS Foundation Trust Clinical Cabinet Flyer
Action/Decision Required:	To note ☐ To approve ☒
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☒ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☒
Resource Impact:	

1. Introduction

To note and approve briefing paper to introduce the creation of a Clinical Cabinet to ensure a mutli disciplinary group that represent clinicians across the Trust in providing independent and impartial strategic advice on cross-Trust issues that affect, quality affordable and efficient patient care.

2. Background

The Cabinet will consist of 18 members, 6 each from medical, nursing, allied health. Appointments will be by election. Each professional group will be eligible to vote for its own representatives only.

To ensure that there is continuity in the first years of establishment the first 18 months will consist of 2 from each group appointed for 2 years, 2 for three years and 2 for four years.

Thereafter new appointments will be for three year terms, with ability to renew for a second term only. After a gap of two years candidates will be able to apply again.

Quorum – 2 members of each professional group.

Meetings will entail of six meetings per year, January, March, May, July, September & November.

3. Conclusion

The Board of Directors are asked to note the contents of the Clinical Cabinet Briefing paper, together with the Terms of Reference and flyer.

4. Recommendations

To approve the creation of the Clinical cabinet.

Clinician Engagement is an issue that over the past decade has been crystallised as key to delivering great outcomes for any health service and its patients. Clinician engagement is about how clinicians are involved in the design, planning, decision-making and evaluation of activities.

What that engagement looks like can vary from service to service, taking into account both model of healthcare and culture of the service. 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 that is appropriately resourced, to bring to the attention of the Executive and the Board the issues that are of importance to all clinicians. Representation on this Council would be by election from the three professions of clinicians; medical, nursing and allied health.

Involving clinicians in the decision making of the organisation is crucial as they have the major influence over patient care, from triage at the front doors of the hospital, determination of entry to the Trust, through diagnosis, management and care to discharge, or end of life planning. It is also important that clinicians engage with other clinicians and across disciplines to ensure optimal care is provided for patients. Current arrangements within Alder Hey are such that the medical “voice” more than any other clinical profession, has more impact on the governance structure of the Trust. Modern healthcare is delivered by teams where each member of the team 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. The Trust needs to broaden the clinical voice within the decision making part of the organisation.

Not only is it important that the different professions are part of the strategic decision making in the Trust but it is also important that all professions gain an understanding of the different pressure on modern day healthcare and its delivery. Understanding of the economic, social, environmental and technology pressures is important for all those empowered to make decisions. Informed decision making is part of the ethical priority process in modern healthcare.

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.

A number of medical leaders attend executive and board meetings as de facto representatives of the clinical voice. However their ability to represent is ad hoc and not representative of the whole voice. This brief proposes the creation of a formal all-professional stream body to represent the voice of all clinicians and provide advice to improve outcomes for patients, their families and the organisation in meeting goals.

The position of the senate in the governance structure would be advisory to the board. The Senate would meet six times a year and the Executive would be invited to the first half hour to update the Senate of contemporary issues and provide answers to questions posed to them. The Senate would send six representatives to the board meeting, to present issues of importance for half an hour before lunch to allow networking at lunch with the NED's.

TOR are constructed, it is good practice for members of the Council to be appointed for three years. Early establishment would be to appoint 1/3rd for two years, 1/3rd for three years and 1/3rd for four years to ensure continuity of corporate knowledge within the Senate, whilst 1/3rd of the Senate are changed every year after the first two years.

Clinical Cabinet responsibilities include:

- provide clinician leadership
- 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.

It does not:

- provide advice on industrial matters
- provide advice on operational health service matters
- advocate for individual clinicians
- lobby on behalf of professional bodies or organisations

Elections for the Clinical Cabinet will be called in October 2019. Each profession can only vote for its' own representatives, the Allied Health professionals are amalgamated into one group. Once formed the group will establish the actual time of meeting which suits the majority of staff. The Trust will support the Cabinet by ensuring there is a suitable room available and providing secretariat support from the Inspiring Quality staff.

TOR Clinical Cabinet Alder Hey Children's NHS Foundation Trust

Vision
Actively contribute to decision-making around the design and delivery of quality services through all levels and Divisions of Alder Hey Children's NHS Foundation Trust

Purpose
A multi-disciplinary group that represents clinicians across the Trust in providing independent and impartial strategic advice on cross-Trust issues that affect quality, affordable and efficient patient care.

Guiding Principles
Children and Young People First
Empower clinicians to be actively involved in decision-making
Provide constructive advice that is inclusive, transparent and evidence-based to the Board

Appointment
The Cabinet will consist of 18 members, 6 each from medical, nursing, allied health. Appointment will be by election. Each professional group will be eligible to vote for its own representatives only.

To ensure that there is continuity in the first years of establishment the first 18 will consist of 2 from each group appointed for 2 years, 2 for three years and 2 for four years.

Thereafter new appointments will be for three year terms, with ability to renew for a second term only. After a gap of two years candidates will be able to apply again.

Quorum
2 members of each professional group.

Meetings
Six meetings per year,
January, March, May, July, September, November

Members are responsible for:

- Electing a chair, who will oversee the creation of an agenda
- Electing a secretary, who will write a dot pot communiqué after each meeting
- Championing Clinical Cabinet recommendations
- Actively communicating with the clinical constituency and working collaboratively with our partners to raise and consider issues of strategic importance to both clinicians and patients
- Modelling the behaviour of clinician leaders
- Attending at least four meetings each year
- Taking the time necessary to understand the issues that are being considered prior to meetings
- Declaring a conflict of interest if there is an issue under consideration that may have a direct influence on their ability to participate objectively

Clinical council responsibilities include:

- Providing clinician leadership
- Providing evidence-based, trusted, independent advice
- Championing innovation and health reform
- Identifying 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. These mechanisms to be to the clinical workforce as well as to the board.

It does not:

- Provide advice on industrial matters
- Provide advice on operational health service matters
- Advocate for individual clinicians
- Lobby on behalf of professional bodies or organisations

Do you want to make a difference in the Trust?

A Clinical Cabinet is being established. This will create a voice for clinical staff across the Trust to influence decision making at the highest level.

Frontline staff, at all levels are encouraged to stand for election

Clinical Cabinet responsibilities include:

- provide clinician leadership
- 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

The Cabinet will meet six times a year and will interact with the Executive and the Board to ensure the voice of all clinicians is heard

For more information read the Board Paper on the Clinical Cabinet
Available here XXX

Submission for election should be made on the proforma available here XXX

Applications close 30 September 2019

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd September 2019

Paper Title:	**7DS Seven Day Services**
Report of:	Nicki Murdock, Medical Director
Paper Prepared by:	Adrian Hughes, Director of Medicine Liz Edwards, Head of Clinical Audit and NICE Guidance Nicki Murdock, Medical Director

Purpose of Paper:	Decision ☐ Assurance ✓ Information ☐ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ✓ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ✓ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	Increased staff presence will be achieved through reorganisation of shifts initially. Increased funding is sought through the Business Case Process

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
Seven Day Hospital Services (7DS) – September 2019

1. Introduction

The Trust is committed to working towards achieving the standards set out by NHS England in 2015 to ensure that all NHS hospitals provide consultant cover each day. These are referred to as the Seven Day Hospital Services (7DS) standards.

The 10 standards are:

- Standard 1: **Patient Experience**
- Standard 2: **Time to initial consultant review**
- Standard 3: **MDT review**
- Standard 4: **Shift Handovers**
- Standard 5: **Access to consultant led diagnostics**
- Standard 6: **Access to consultant led interventions**
- Standard 7: **Mental Health**
- Standard 8: **Ongoing daily consultant-directed review**
- Standard 9: **Transfer to community, primary and social care**
- Standard10: **Quality Improvement**

2. Background

In December 2018 NHS England changed the reporting requirements to incorporate a process for Trust board assurance of progress against the standards. See Appendix A.

This process was adopted in June 2019, populating the 7DS template with supporting narrative to demonstrate work streams in place to meet all 10 standards.

With changes to the remit of NHS England and NHSI, the process for undertaking this audit will change, providing Trusts the opportunity to focus and prioritise specialties. Current focus of the NHS is on ensuring that emergency services are available 7 days a week to ensure that patients will not experience unmet need in emergency and emergent situations.

The regional 7DS lead at NHSI has attended the Trust to discuss the plans for progress from an NHSI and Trust perspective. She will liaise with the Head of Clinical Audit & NICE guidance in terms of our ongoing work and any support that may be required from NHSI and other NHS organisations, particularly those delivering children's care.

A number of "evidence based clinical pathways" developed using a multidisciplinary approach negate the need for daily consultant review. This view was accepted by the regional 7DS lead. This reflects the move by the NHS to recognize that all clinical professionals have a part to play in care of patients.

The priority standards NHSE/I are concentrating on are:

- **Standard 2:** Time to initial consultant review First consultant review within 14 hours
- **Standard 5:** Access to consultant led diagnostics Assessment based on weekday and weekend availability of six diagnostic tests to appropriate timelines, either on site or by a formal arrangement with another provider
- **Standard 6:** Access to consultant-led interventions Assessment based on weekday and weekend availability of nine interventions on a 24-hour basis, either on site or by a formal arrangement with another provider.
- **Standard 8:** Ongoing daily consultant-directed review Assessment based on consultant job plans to deliver 7DS, robust MDT and escalation protocols, local audits and reference to wider metrics.

However we are also working on the other standards, such as “Shift Handovers” and “MDT Review”.

1. **Further actions to be taken to facilitate the delivery of 7DS <u>assessment</u>**

- The 7DS steering group will meet before the end of September 2019 to agree the process for continuous monitoring of 7DS compliance – terms of reference and roles and responsibilities to be agreed.

- Establish project team – includes appointment of project lead & administration support.
  Medical Director for Medicine, Clinical Lead
  Head of Clinical Audit & NICE guidance – Audit lead & link with NHSI
  Link manager (service manager or operational manager) for each Division
  Link Clinical Director for each Division
  IM&T representative
  Individual specialty leadership (on an as required basis) to understand issues and assure on pathways
  Divisional Quality Leads (once Divisional Governance structures agreed)

- Agree programme for targeted approach to specialties within both Divisions.
- Agree programme for HDU specifically
- Liaise with commissioners to agree clinical pathways currently in use – patients cared for on such pathways will be exempt from participation in standard 8.
- Agree process for undertaking the audit
- Review of the process for reporting the updated framework within Divisional Integrated Governance Committees
- Review the additional fields required within meditech to improve data quality

2. **Further actions to be taken to facilitate the <u>delivery</u> of 7DS**

The Trust has made significant progress through its Future Models of Care (FMoC) programme of work. There are a number of individual work streams at different gestations of development:

Thresholds and Pathways: this piece of work is virtually complete, and has defined in considerable detail the clinical criteria that determine which children are admitted under the general paediatricians and which the individual medical specialty teams. Previously there was confusion (for doctors, nurses and patients & parents),and disagreement between

clinical teams regarding these thresholds and pathways, leaving individual patients to 'fall between the gaps', and often placing junior doctors at the centre of those disagreements at the critical point of acute unplanned admission to hospital. These pathways have been universally agreed and rolled out. These pathways will ensure timely access to the correct consultant for review.

HDU Model: The 'FMoC Design Group' (comprising general paediatrics, medical specialties and critical care representation) have proposed a unique working model with development of a team of Paediatric High Dependency Unit (HDU) Paediatricians to support delivery of care in Alder Hey's large HDU. This new team of consultants will comprise General Paediatricians with a "Special Interest IN" (SPIN) Paediatric High Dependency Care, ensuring consistency of care 7 days a week, eventually covering extended daytime hours. In the longer term there is a proposal for this team to expand to cover the our of hours consultant paediatric on call support for the acute take and for existing inpatients in Alder Hey, providing a far more responsive support for emergency and emergent conditions affecting children andyoung people. There is Executive support for the immediate appointment of HDU Paediatricians, with a developed case working towards appointing a team of 5 consultants in the next 2 years.

Extended Consultant General Paediatrician evening presence: following a workshop in March '19, the decision was taken to undertake a pilot of extended consultant general paediatrician on-site presence into the week-day evenings. Current practice is for consultants to remain on-site until 19.00 hours when on-call. In September 2019 a 3 month pilot of extending on-site hours to 21.00 hours will commence, providing greater support to the junior doctor on-call teams during this period of peak evening activity. Metrics are being developed to formally assess the impact of this extended consultant presence, to include patient safety, hospital patient flow, and educational and working experience for those junior doctors being supported by the general paediatricians. If this proves successful, we will develop the business case for these extended hours to become our normal working practice, and explore applicability to weekend on-call working.

Acute Care Team: Currently at Alder Hey the medical/surgical out of hours teams (Consultant, Senior and Junior Paediatric Trainees, and 2nd Foundation Year doctors) respond to deteriorating patients across the hospital. Even when fully staffed, this cohort of medical staffing compares unfavourably to other tertiary children's hospital in England of a similar size. Research shows delays in appropriate treatment contribute to poorer outcomes, including increased length of stay, unplanned admission to the High Dependency Unit (HDU) or Paediatric Intensive Care units (PICU), with the potential for increased morbidity and mortality. This coupled with a reduction in the number of paediatric trainees and the overall complexity of the hospital population showing increased in-patient acuity, means it is increasingly difficult to ensure that care in the hospital is Safe at all Times. The proposed Acute Care Team (ACT) will assist the medical workforce and the Patient Flow team to ensure that the highest quality of care is given 24 hours a day, 7 days a week. This will increase safety and improve patient flow, reducing length of stay and in-patient deterioration which will lead to reducing unplanned admissions to HDU and PICU. Recruitment to the (ACT) Team has commenced, and will reach its full complement and full potential over the next 2 years.

Shift Handover: The Medical Education Department is working with consultants and junior medical staff to develop an effective and educational handover system that improves transfer of information between medical staff at key points of the day. The dual intention is to improve the clinical safety but also the education of junior staff in the management of issues that arise out of hours.

3. Conclusion

The Trust has multiple work streams increasing the access to safe, high quality care outside of “office hours” and into the entire seven days of the week, for children and young people in the health service.

4. Recommendations

- That the Trust Board note the work being done to improve access to safe high quality care.
- That the Trust Board be assured that the Trust is working with the NHSI department to complete and submit audits to comply with the 7DS programme.
- That the Trust Board accept a report six monthly in September and March of each year.

Appendix A

In December 2018 the following guidance was published.

- In place of the proposed autumn 2018 7DS self-assessment survey, providers of acute services will undertake a trial run of the board assurance process.
- This trial run will take place from November 2018 to February 2019. All providers of acute services will complete the template and gain board assurance of the self-assessment.
- As this is a trial, providers of acute services are not required to complete any new audits to support these self-assessments. Data from the previous 7DS survey can be used as evidence.
- Full implementation of the 7DS board assessment framework will take place in March to June 2019.
- This will follow the same process of completing the measurement template and subsequent board assurance of the self-assessment.
- This self-assessment will be based on local data, such as consultant job plans and local clinical audits, as outlined in the full 7DS board assurance framework guidance.

Alder Hey Children's NHS
NHS Foundation Trust

Sepsis Summary Report (2018-2019)

Sepsis Team,
Alder Hey Children's Hospital

Board Meeting, 3rd September 2019

Prepared by:

James Ashton (sepsis nurse)

With additional input from:
Rachel Greenwood-Bibby (sepsis nurse), David Porter (sepsis lead), Glenna Smith (General Manager)

On behalf of the Sepsis Steering Group

Work on a Sepsis Pathway at Alder Hey

1 Introduction

This report describes the work that has been carried out in relation to the Sepsis Pathway and Commissioning for Quality and Innovation (CQUIN) submission data. It summarises achievements, ongoing work, key areas to work on, and ideas for future planning.

A business case to create a Sepsis Team was submitted in March 2017 following National Institute for Health and Care Excellence (NICE) guidance in 2016 and identified deficiencies in the management of sepsis. Roll-out of training and electronic sepsis screening was phased in from April to June 2017. Two sepsis nurses (1.5 whole time equivalent, WTE) were recruited and in post by July 2017 and the first CQUIN data submitted that month.

2 Antibiotic administration times & CQUIN submissions

Sepsis data submissions were required as part of NHS England and Public Health England (PHE) CQUIN targets from 2016 until April 2019. Data was submitted from Alder Hey for each quarter in the years 2017-2018 and 2018-2019 as per the agreed process with the local Commissioners. It should be noted that Alder Hey is the only children-only Trust to have done so (Great Ormond St negotiated an alternative CQUIN and Sheffield and Birmingham Children's did not submit). CQUIN targets were set concerning: screening rates for sepsis, antibiotic administration times, along with targets to reduce overall use of antimicrobials and to deliver efficient antimicrobial stewardship (AMS).

2.1 CQUIN 1: sepsis screening target

By virtue of having electronic mandatory sepsis screening, the Trust consistently achieved this CQUIN after introduction of the pathway (see figure 1). The target was for at least 90% of admissions to the Emergency Department (ED) or ward to have been screened for possible sepsis.

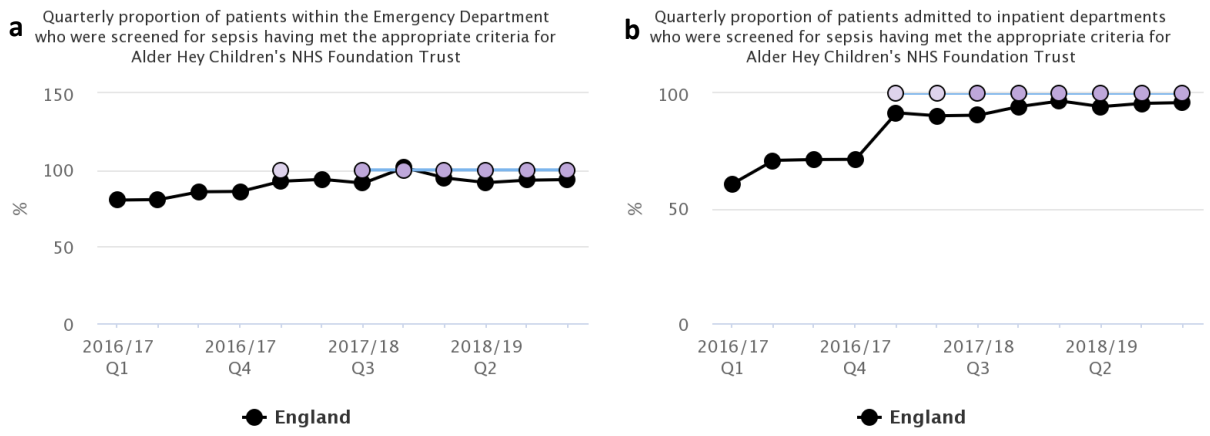


Figure 1: **Sepsis screening rates** for Emergency Department (ED) patients (**a**) or inpatients (**b**) at Alder Hey (purple) compared to England Acute Trust mean (black). Data from http://fingertips.phe.org.uk

2.2 CQUIN 2: Antibiotic administration times

This target specified that, in 90% of cases, antibiotics should be administered within 60 minutes of the diagnosis of sepsis in patients with one or more NICE-defined high risk sepsis criteria. The CQUIN was later amended to use National Early Warning Score (NEWS) criteria specifically, however this score is not validated for, and cannot be used in, paediatrics. Alder Hey continued to submit data without this amendment. Criteria were taken directly from NICE guidance, which was implemented in full. All submitted data is now available on the PHE website.

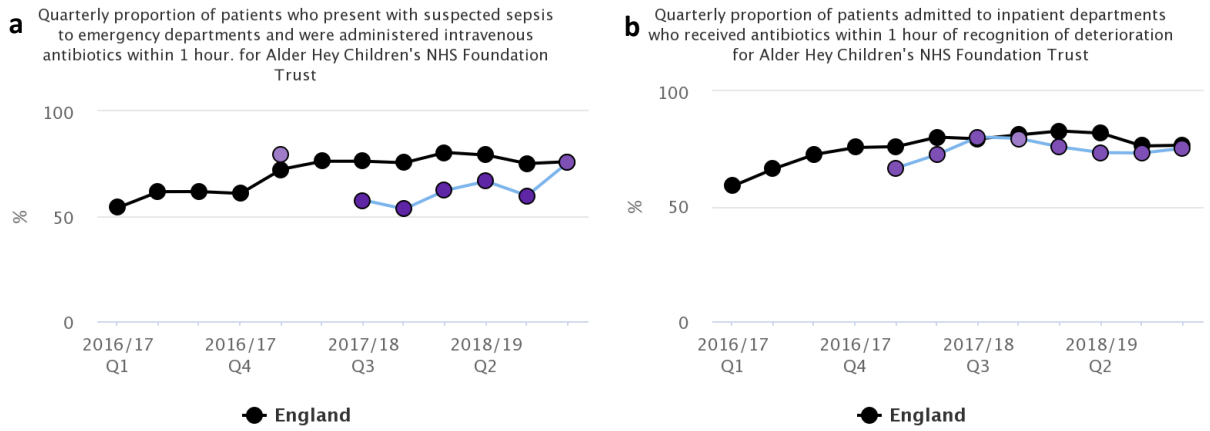


Figure 2: **Antibiotic administration within 60 minutes:** the percentage of patients receiving antibiotics within 60 minutes of the diagnosis of sepsis for ED patients (**a**) or inpatients (**b**) at Alder Hey (purple) compared to England Acute Trust mean (black). Data from http://fingertips.phe.org.uk

Year/Submission	Alder Hey	England
2018/2019 Q1	62.3%	80.4%
2018/2019 Q2	66.7%	79.2%
2018/2019 Q3	59.8%	75.1%
2018/2019 Q4	75.7%	76%
2018/2019 Average	**66.1%**	**77.7%**

ED data

Year/Submission	Alder Hey	England
2018/2019 Q1	75.8%	82.7%
2018/2019 Q2	73.3%	81.8%
2018/2019 Q3	73.1%	76.2%
2018/2019 Q4	75.2%	76.5%
2018/2019 Average	**74.4%**	**79.3%**

Inpatient data

Table 1: **Antibiotic administration within 60 minutes:** Data corresponding to Figure 2 for 2018-19.

There are a number of reasons why comparison of antibiotic administration data with other Trusts is difficult:

- No dataset from another children only Trust (CQUIN was not mandatory)
- Paediatric data from combined adult/children's Trusts cannot be separated out within each submission to allow more appropriate comparison
- More complex and time-consuming assessment and investigations in children compared to adults (e.g. more challenging vascular access and often skin anaesthetic application, need for lumbar puncture and catheter urine collection)
- Significant inaccuracies in data recorded and collected at Alder Hey (where conflicting or missing information was present those data submitted deliberately assumed the greatest delay)
- Inaccurate labelling of diagnosis of 'sepsis' in those with less urgent infectious conditions (leading to dilution of the true suspected sepsis population)

Separate attempts to compare our data with other children's centres failed as it became rapidly apparent that there were major differences in patient populations, screening criteria and data collection methods as well as no reliable definition of the diagnosis of sepsis.

It is notable that ED figures appear worse than those for inpatients in the Alder Hey data. This appears to be for several reasons:

- Time consuming assessment and investigation more frequently needed in ED compared to inpatients
- Retrospective medical documentation (leading to inaccurate or missing date & time records) – this is especially pronounced in those with the highest risk of sepsis where management in the resuscitation room is often not documented contemporaneously
- Retrospective nursing documentation of antibiotic dosing
- Older versions of electronic documentation (this does not mandate sepsis documentation so patients cannot always be identified retrospectively)
- Delays due to periods of high patient numbers

Attempts have been made to address many of the issues above, where this is possible. In particular, improved documentation has been introduced for inpatients to give every patient a 'sepsis status' (see below) and to mandate regular documentation of sepsis concerns in a more integrated way between nursing and medical staff. This documentation is still not available in the ED, rendering data collection much less accurate.

2.3 Sepsis CQUIN removed (April 2019)

The sepsis CQUIN has now been moved in to the standard contract for the Trust. Data collection methods have been improved by implementation of the sepsis status for inpatients, increasing the accuracy of identification of patients with a true sepsis concern, rather than those being treated for infection. It should be noted that between 40-50% of hospital inpatients have an active antibiotic prescription at any one time.

2.4 Progressive reduction in time to antibiotics

There has been consistent improvement in this, once changes in local methods for collecting data are removed (see figure 3). A number of clinical indications for antibiotics were not available in the prescribing options, encouraging clinicians to use an indication of 'sepsis' even where there was no recorded concern from nurses or doctors of clinical sepsis.

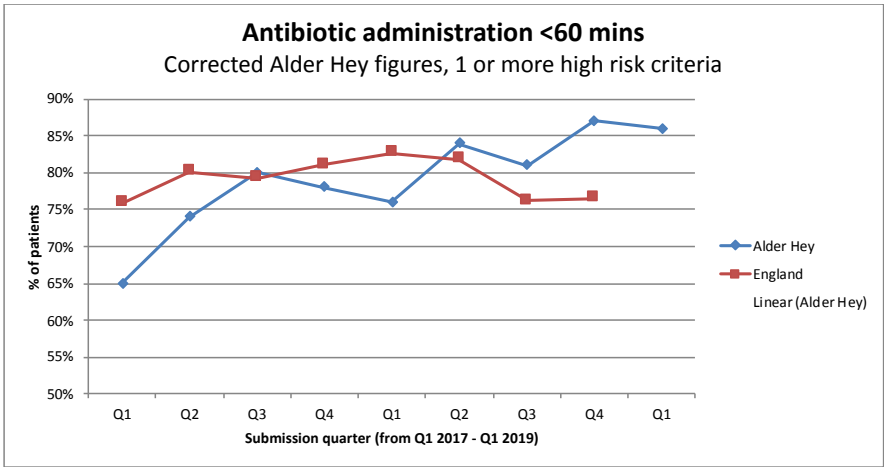


Figure 3: **Antibiotic administration times** beginning in quarter 1 (Q1) 2017 compared to NHS England average. Alder Hey data adjusted to only include patients who had a record of sepsis concern in nursing assessments (*e.g.* removing those with an antibiotic prescription indication of 'sepsis')

3 Sepsis status & e-documentation

The sepsis status was introduced to improve the accuracy of recording of sepsis concerns as a way to bridge the artificial separation between nursing and medical documentation within the medical record (Meditech). It allows a clinician to view and update concerns raised by nursing staff when care is entirely managed within Meditech (hence excluding patients managed in the Badger system on paediatric intensive care [PICU] and the neonatal surgical unit). It is not currently implemented in the ED.

For inpatients, this has led to improved documentation and has allowed work on a 'status board' to provide an overview of all patients on inpatient wards to highlight those at various stages of sepsis assessment and management. Mandatory sepsis question for nurses on every set of clinical observations are designed to make them think about the possibility of sepsis in their patients. In addition the electronic ward standard documentation requires clinicians to review the sepsis status of each patient with specifically designed fields to complete if there are sepsis concerns. It will also mandate the clinician to document if/what parts of the sepsis bundle of care have been completed.

The sepsis status has helped to generate more accurate data such as displayed in fig. 3 and to do so with less time, often avoiding the sepsis inpatient nurse trawling clinical notes manually for dates, times and actions.

4 Training & education

4.1 Training programme and e-learning

A continuous sepsis training and education programme has been established ongoing throughout the Trust and has also been delivered to several areas based in the community setting, an area recognised as previously neglected. The training is intended for all clinicians, nurses and relevant allied health professionals, whether working in the hospital or in the community setting.

A sepsis e-learning package has been designed and built in house, led by the sepsis nurses, further tailored to doctors, nurses and community staff. The package is provided through the Electronic Staff Record (ESR) to help centralised monitoring of training.

4.2 Training needs analysis

A training needs analysis for the trust has been completed and has identified the level of 'sepsis training' different areas and staff groups working in the Trust require. This is essential to ensure accurate training figures can be generated and monitored.

- HIGH level. Those who are most likely to come into contact with patients who have infection that may develop into sepsis. These staff will have to complete the training/e-learning and complete an assessment around sepsis and its management.
- MID level will be for staff who see patients but not in an acute inpatient/ED setting. These staff will have to have awareness about sepsis and signs and symptoms to look out for and where to escalate to.
- LOW level training is for staff who are not likely to come into contact with patients directly, and should not count in the overall training figures.

5 Collaboration with the DETECT research team

5.1 Implementation of real-time handheld device data entry

The sepsis team has worked closely with the DETECT team to help implement handheld device technology for nursing observations and escalation of the deteriorating patient. This research study is designed to assess the impact on patient care of the new technology but a considerable amount of work has gone in to integrating the system with Meditech and solving potential issues. Catching these warning signs early and reversing developing sepsis should reduce the number of clinical deteriorations and unplanned admissions to HDU/PICU.

5.2 Improving sepsis identification tools

Working in collaboration with the DETECT study, the sepsis team has examined criteria in the NICE sepsis guidance to determine which are effective discriminators in identifying those patients who go on to deteriorate with possible sepsis and need high dependency or intensive care. This data is being prepared for publication and has been used as an evidence-based approach to refine the local implementation of the NICE guidance. This should simplify the assessment of patients for possible sepsis without reducing sensitivity in identifying cases.

6 Incident and case reporting, external audit

All cases of probable sepsis are reviewed by the ED or inpatient sepsis nurse to identify factors that may have slowed or impaired diagnosis or treatment (see fig. 4). An external audit was undertaken in 2018 to provide independent assessment of sepsis practices. This was broadly positive with some helpful recommendations.

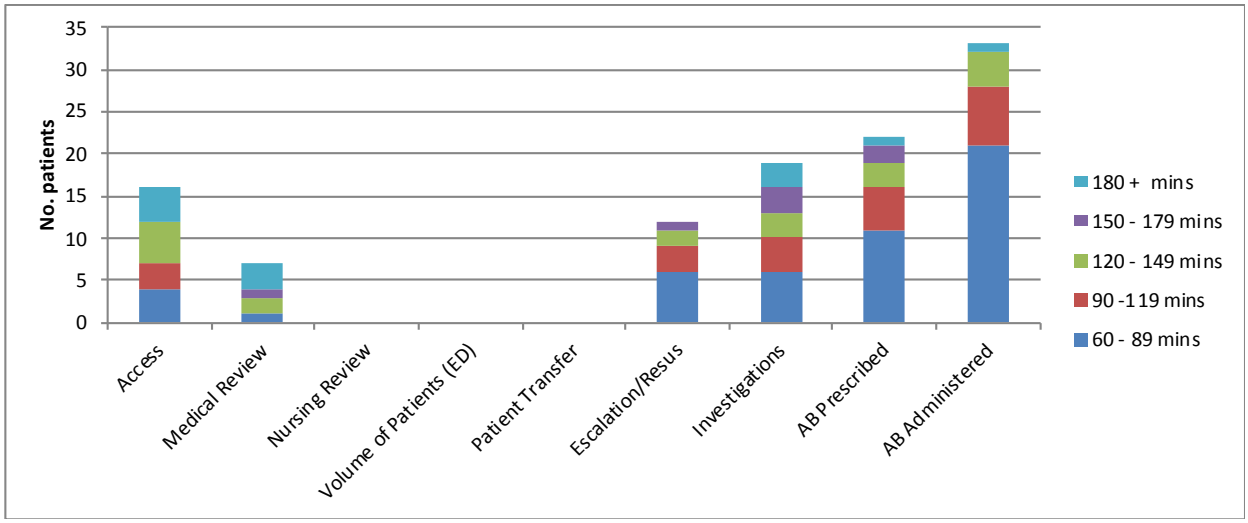


Figure 4: **Factors identified as likely contributors in delays** in sepsis identification or management between 2018-19 (data from inpatients only)

7 Continuing challenges

7.1 Balancing benefits and risks of the sepsis pathway

The sepsis pathway is intended to help ensure prompt assessment and treatment for possible sepsis. However, there are potential risks in pushing too hard to achieve antibiotic treatment within 60 minutes of a possible sepsis diagnosis. Firstly, other patients with potentially more serious conditions who are not septic should not suffer as a result of misdirected resources and effort. Secondly, appropriate assessment, investigations and other aspects of treatment should not be delayed or compromised by a focus on antibiotics. In particular, the lack of collection of appropriate microbiological samples before treatment commences can compromise diagnosis and could lead to inappropriate or longer treatment with antibiotics. Thirdly, the sepsis pathway should not excessively increase antibiotic usage (although this is inevitable to some extent). And finally, there should be a recognition of the lack of strong evidence that antibiotic administration within 60 minutes of diagnosis leads to better outcomes than, for example, 60-120 minutes.

7.2 Accuracy of data recording

Despite improvements in inpatient Meditech documentation, there are still frequent episodes of possible sepsis where data accuracy is felt to be poor. Upgrading the electronic record in ED would help. Further work is also needed with all staff groups to ensure the importance of contemporaneous note keeping wherever possible.

Antibiotic prescription indications need to be updated. This has been agreed by the Sepsis Steering Group with the intention of reducing further the number of patients labelled with ‘sepsis’ when a true clinical concern does not exist.

7.3 Training records

Compliance with mandatory sepsis training is approximately 75% amongst those Trust staff needing training for acute sepsis recognition. Achieving the intended target of 90% within Trust staff and extending this to those employed by external organisations but who work within the Trust is challenging but important. The sepsis steering group is keen that the Trust ensures appropriate time and resources are assigned to address this.

7.4 Data reporting

Generating automated and accurate reports of key performance indicators is important to reduce time spent searching documentation by the sepsis nurses but also to allow them to drive the improvements needed. This has been a complex challenge and significant strides have been made over the last few months, helped by enhanced electronic data capture for inpatients.

7.5 Benchmarking

For the reasons outlined earlier, it is unlikely that accurate benchmarking of sepsis performance will be possible between children’s services in England. However, collaboration with other centres will continue and this may become a possibility in the future.

7.6 DETECT study implementation

There are potential significant benefits for the identification and management of sepsis with the technology to be implemented in the DETECT study. However, there are also potential risks and disadvantages to introducing an additional system into the assessment process for children at Alder Hey. Continued collaboration will be necessary to try to remedy any additional problems that come to light

8 Further work and additional help

8.1 Continued improvement in indicators

Work continues to improve clinical assessment and management processes, specifically to improve antibiotic administration times, compliance with all components of the 'sepsis six' management steps and ultimately to reduce harm (critical care admissions, length of stay)

8.2 Implementation of sepsis status in ED

The sepsis status will be replaced for inpatients in a few months with the advent of the DETECT technology. It is important that the benefits of this improved Meditech documentation designed specifically for paediatric sepsis management at Alder Hey are made available to ED.

8.3 Live status board for sepsis

Correcting the status board to give the up to date sepsis status for inpatients could improve oversight for senior ward nurses, nurse practitioners and doctors to further improve the response to possible sepsis

8.4 Learning & development resources to improve training

This is important to reach the Trust 90% target, and should include all relevant clinical staff, whether employed by Alder Hey or an external agency.

8.5 Meditech resources to maintain and update assessment and documentation

There is a lack of specialised developers able to update, maintain and devise new components for complex pathways such as the sepsis pathway. Work often depends on one developer, introducing inevitable delays and a vulnerability in case of illness. Further developers with appropriate training would allow prompt correction of bugs and improvements to existing software.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd September 2019

Paper Title:	**People Strategy Update**
Report of:	**Human Resources & Organisational Development**
Paper Prepared by:	**Director of Human Resources and Organisational Development**

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

1. Staff Engagement

Reward & Recognition

The Reward and Recognition held its first summer event for staff in July with the support of local community and schools. As part of this event we gathered feedback to ensure our Reward and Recognition objectives align with staff views.

The Reward & Recognition group are in process of arranging the next staff event in October in conjunction with the Health and Wellbeing committee.

Staff Survey

The 2019 staff survey is on the horizon and HR / L&D team are currently working closely with communications and staff side colleagues to identify ideas of how we can once more improve our completion rates and in turn hopefully improve the feedback we receive from staff.

The survey is due to commence in mid-September and there will be a wide range of communications to signal the start of the Staff Survey period as this date approaches.

Temperature Checks

A revised Temperature Check questionnaire was launched for 2019/20 which focuses on two key areas; staff engagement and psychological safety.

Quarter 1 saw a large increase in completion rates with almost double the responses from the previous quarter and the results have been received and shared with divisional leads to provide insight into staff opinions on the two areas above.

Whilst this data was interesting, it will become more valuable once the data from Q2 is returned so we can identify trends, areas of improvement and areas of concern.

Improving Staff Wellbeing

The importance of staff health and wellbeing is widely recognised and as an employer we aim to champion physical, mental, emotional and financial wellbeing of everyone working in the organisation. The HR Team and Trust wellbeing group are developing the provision of tools, resources and support to ensure that staff health and wellbeing is a priority.

As part of the Trust focus on supporting mental health and wellbeing a series of training sessions in conjunction with the charity MIND have been arranged for October 2019. These have been extremely well received by managers across the Trust and further dates are in the process of being arranged.

Brexit- EU Settlement Scheme

As we approach the October 31st leave date there has been an increase in the coverage of Brexit and its possible effects on the country and as a Trust we have been working hard to prepare for the UK's anticipated exit from the European Union. In regards to the workforce the announcement that freedom of movement will cease as of 1st November 2019 for European Citizens is a concern across the NHS. As a Trust our EU colleagues make up less than 1% of the total workforce therefore we do not anticipate this to have a significant impact. However the uncertainty and lack of clarity from central government is causing concern and anxiety for EU colleagues and we are continuing to support staff and provide information and guidance.

The HR team are continuing to work with EU colleagues to support them through the Settlement Scheme process and are working with individuals to ensure that we have the correct information and data on our systems.

2. Workforce Sustainability and Capability

Agenda for Change New Pay Deal – Transition of Band 1 to band 2 staff

The HR team continue to work in partnership with staff side colleagues to ensure a smooth transition for those band 1 staff.

To date 119 out of 142 staff have transitioned from Band 1 to Band 2 in line with NHS Employers guidance. As part of the PDR process and in 1:1 meetings, line managers are revisiting the transition option with those who have not chosen to move across to a band 2.

A local Pay Progression Policy is currently being consulted on with staff side colleagues. In preparation for the new process information and guidance will be communicated across the Trust, helping staff to understand the changes and how it affects them.

Education, Learning and Development

Apprenticeships-

The Apprenticeship Team have been liaising with Higher Education Institutes in preparation for September intakes with 6 staff members due to start Higher Level Apprenticeships. In addition, a further 18 staff are due to start their Apprenticeship with external providers and the Trust as an Employer Provider.

We have increased our pool of Apprenticeship providers and have successfully procured provision with Sheffield and Liverpool University to deliver the Level 6 and Level 7 Apprenticeships.

We are in the process of providing our data to on the Public Duty target; the target affects public bodies that have more than 250 employees in England and states we must aim to have 2.3% of our workforce as new Apprentice starters.

In 2017/2018 financial year our figures were acutely below target for the reporting period. A significant amount of work has taken place during 2018/19 by the Apprenticeship team to improve uptake and engagement and a total of 54 apprenticeships were reporting as new starters during this period.

We are finalising our preparations for Ofsted visit and are in the process of ensuring we are complaint with legislation.

Mandatory Training-

The latest Mandatory Training report shows overall compliance is currently at 91.16% as of 16th of August 2019, up from 90.8% at the end of July.

Topics that are under-performing against the 90% target are Information Governance, Manual Handling Level 2 and Infection Control Level 2. Over the coming months the L&D / HR teams will be working with the SMEs as well as divisions and departments to identify potential ways to improve compliance within these areas.

The team will also continue to ensure that staff and managers are aware of all outstanding requirements and providing communication directly to individual's outstanding mandatory training.

3. Employee Relations

Organisational Change

Portering

Following a meeting with trade unions, arrangements were made to meet with key affected individuals during early March 2019 with a view to progressing along the basis of the alternative proposals. Further discussions have now taken place with the portering team in May 2019 and management are clarifying a number of points to respond to the portering team and their representatives and it is expected that a conclusion to the negotiations will be achieved by the end of August 2019

Acute Care Pathway Team

Consultation commenced during June 2019, due to conclude on 27th June 2019, related to changes in shift patterns for nursing roles who undertake separate day and night shifts to operate on a 24/7 basis to ensure a more robust service. The consultation process has concluded and arrangements are now taking place to implement the outcome of the change.

Catering Department

The catering department consultation has been extending in agreement with staff side colleagues. The proposed changes affect the rotas of the Catering Assistants, Chefs and Supervisors. This is following recommendations made from an external catering review. All group consultations and 1:1's have taken place and 2 counter proposals have been received and feedback has been given. A final meeting with staff is scheduled for August 2019; working towards implementation date in September 2019.

Employee Relations Activity

The Trust's ER activity at end July is currently is detailed below:

Total disciplinary	**6**
Total Grievance	**4**
Total Bullying and Harassment	**4**

Total Surgery	**7**
Total Medicine	**1**
Total Community	**4**
Total Corporate	**2**
Grand Total	**14**

Informal FF	**3**
Investigation	**3**
No case	**0**
Hearing	**2**
Outcome issued	**3**
Appeal	**2**
Case concluded	**0**
Fast Track	**1**

Employment Tribunal Cases

The Trust has received a notification of 3 ET cases and one notification of early conciliation.

4. Corporate Report

The HR KPIs in the July Corporate Report are:

- Sickness rates have increased slightly in month for July to 5.19%
- The Rolling 12 month sickness figure has improved with a decrease to 5.62%**.**
- Overall Mandatory training compliance shows an improved upward trend to 90.81% this includes previous Core Mandatory Training.
- The PDR window has now been closed and shows compliance at end July at 85%.

Liverpool Women's NHS Foundation Trust

Alder Hey Children's NHS Foundation Trust

Liverpool's Neonatal Partnership- Update for Boards

August 2019

Partnership Highlights	Quality and Governance
The Delivery Group proposed the partnership and service be named the 'Liverpool's Neonatal Partnership' moving forward The Leadership team have been appointed to work across both organisations: ➢ Director of the Neonatal Services- Dr Chris Dewhurst ➢ Clinical Lead for Neonatal Surgery – Ms Jo Minford ➢ Head of Nursing– Jennifer Deeney ➢ Partnership Manager – Sian Calderwood	Memorandum of Understanding revised to reflect the partnership's name, brand and governance structure. The document is undergoing partnership approval, completion estimated Sept'19
	Communication and Engagement
	• Leadership team announcement drafted • Q&A document regarding service and development under way • Communication Strategy under development • Meet and Greet of leadership team to be established • Agreed 4 weekly updates to both Trust's Boards
Finance	**Recruitment**
• Negotiation with NHSE Specialist Commissioners to confirm funding of £1.2m for 19/20 and an agreement to de-risk the £300k shortfall of committed costs • Acknowledgement that the FYE of committed costs is £1.89m which is required by the Trust's by April 2020 • £11.869 m of capital funding for the new NICU development contained in Alder Hey's 5 year capital plan	• Consultant Neonatologist recruited to support additional cover at Alder Hey • Applications received and interviews organised for two additional ANNP's • Initial recruitment of Neonatal Nurses, 10 wte to work across • both Trust's • Recruitment of Partnership Leadership Team
Estates	**Key deadlines within the next 4 weeks**
• Clinical specification brief for the NICU at Alder Hey complete • Liz Harley, Estates Advisor/ Consultant, has joined the Estates Team at AH to support the NICU project team • Artist previously used at Alder Hey in discussions with the design team at Liverpool Women's to support with the estate development at LWH	• Establish Alder Hey NICU Design Team and finalise full brief • Leadership team to deliver face-to-face briefing sessions • Comms Strategy drafted • Financial negotiations with specialist commissioners agreed • Next Neonatal Partnership Board scheduled for December 2019.

Liverpool Neonatal Partnership

Update – 8th August 2019

1 Overview of Progress

With the leadership team now appointed, a regular weekly meeting has been established with the core team including input from the Capital team to move the project forward. The budget has been reviewed and is currently identified as £12m. In line with the revised budget a review of the schedule of accommodation has been undertaken and the overall area will need to be reduced by approximately 300m2. The Partnership have created a high level clinical brief which is being developed with the Capital Team over the next few weeks.

2 RAG Status

3 Board Decisions Required (or taken in the reporting period)

1	Approval to proceed with Project Brief.
2	Approval for Project Co to be instructed on a feasibility study – noted no cost incurred.
3	Approval to proceed with project in line with £12m budget and area of 1500m2

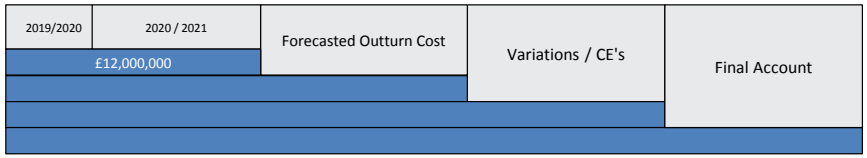
4 Items to progress over the next period

1	Clinical brief to be developed in more detail with input from key stakeholders
2	Review of the area schedule to identify potential areas to reduce
3	Clarify the strategy for the supporting office accommodation
4	Work through key adjacencies for the new build
5	Develop the Partnership structure
6	Review the strategy for single cot / multi cot rooms
7	Discussion with the Women's project team to identify lessons learnt from project to date
8	Start to develop high level policies for security / access
9	Treatment area to be flexible for laser use.
10	Partnership to decide if the unit progresses with 22 or 24 cots. Current design is 22 cots. Decision required for September.

5 Project Risks

Ref	Project Risk	Mitigation	Rating
1	O&M information unavailable from PFI.	Potential for surveys to be undertaken. PM to liaise with Graeme Dixon.	
2	Project Co may be unwilling to accept the scheme.	Cost to be developed for standalone service points to understand cost pressures on the scheme. Feasibility being undertaken by Project Co	
3	Design changes due to unclear clinical brief.	Early engagement with Users, meetings scheduled and site visit arranged.	
4	Scheme is unaffordable.	Schedule of area to be reduced and costs updated during the user engagement phase to capture any pressure on cost.	

7 Budget Position (Project Development Funding)



Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd September 2019

Paper Title:	**Alder Hey Change Programme…The Journey so Far**
Report of:	John Grinnell, Director of Finance
Paper Prepared by:	Natalie Deakin, Head of Delivery Management Office
Purpose of Paper:	Decision ☐ Assurance ☐ Information ✓ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ✓ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of outstanding care ☐ The best people doing their best work ☐ Sustainability through external partnerships ☐ Game-changing research and innovation ☐ Strong Foundations ✓
Resource Impact:	

1. Introduction

The independent assurance for Trust Board is usually an amalgamation of the reports which have been submitted to the previous sub-committees of WOD, RABD and CQAC. Given that the sub-committees have not met during August, it felt timely that a report was written which aimed to update the Board on the Change Programme in its wider context along with developments of the Delivery Management Office as opposed to the usual independent programme assurance report.

2. Background

In the last 12 months, there has been a dramatic shift in terms of engagement and development of the Trust's Change Programme. This is in terms of the team who support the Change Programme (Delivery Management Office (DMO)), the projects which feature on the Change Programme, the measurements and reporting of benefits and enhancements in governance arrangements.

Delivery Management Office (DMO)

The DMO team has gone from strength this year; starting as a team of two 18 months ago, the team is now a team of 5 and plans are in place to grow the team further to support service improvement and CIP at divisional level rather than organisation-wide transformational change alone. This branch of the team will enable the delivery of service improvements and CIP schemes using a project management framework which will increase the success of such improvements and schemes. The organogram of the team is featured in Appendix 1 and now also includes project managers from programmes such as Inspiring Quality, which enables shared learning, collaboration and integration of projects and programmes across the organisation.

The DMO Team's vision is to create a project culture where project management is a valued competency embedded in the organisation and where project leaders and their teams embrace the project management processes to ensure the best possible chance of project success and delivery.

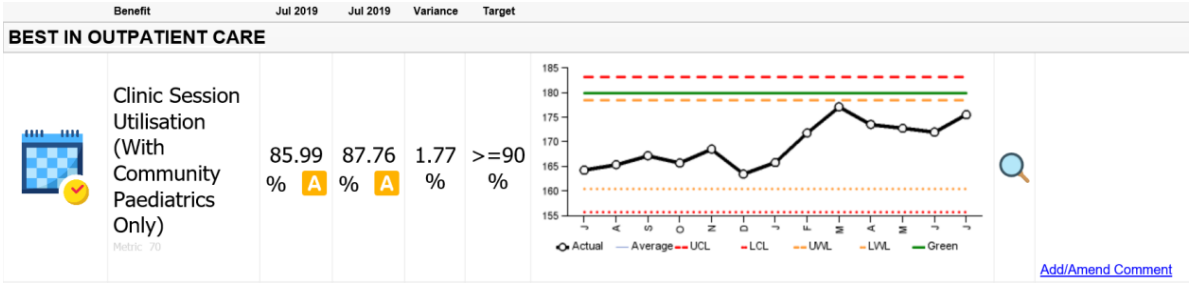
As a team, we aim to deliver this vision by the delivery of a number of objectives. One of which is to provide support, advice and guidance for staff members relating to all aspects of project management. As part of this we will be launching our first project management training sessions at the end of this year. This is an opportunity to promote project management standards and to provide opportunity for staff to gain knowledge and increase understanding of how we manage projects at Alder Hey.

Change Programme

Over previous months, the change programme (outlined in Appendix 2) shows a dramatic shift in regards to the alignment of the projects to the strategic aims and objectives of the organisation. Organisational and transformational change projects now exist on the change programme as opposed to local projects which has been the case previously.

Benefits Realisation

The focus of the DMO Team has always been on delivery and specifically the delivery of project benefits which is even reflected in the name change of the team from a traditional Project Management Office (PMO). This year has seen focus increase on benefits tracking and benefits realisation in terms of reporting with the introduction of our project benefits dashboards which has been supported and developed by our in house BI Team. These dashboards allow the tracking of benefits via a benefits dashboard, an example of which is outlined below.



In addition, changes made to the corporate report in recent months have aligned the change programme with the wider organisation objectives. Any metrics now relating to the projects within the change programme will now be identified using a 'p' symbol.

Governance Arrangements

Programme Board has developed significantly over the past 12 months with colleagues regularly being challenged on gaps in project documentation as well as the initiation and closure of projects becoming a common occurrence.

The independent programme assurance reports have also recently seen enhancements in terms of governance as reporting now includes transparency relating to project benefits.

Next Steps

- Enhancements with regards to programme assurance and the reporting to sub-committees to Board which will include increased detail regarding RAG statuses.
- Benefit dashboard development will continue with the aim of all metrics being populated automatically.
- Increased collaborative working across all programmes of work such as digital and the campus.
- Development of a basic project management training offer to all staff.

Appendix 1: DMO Team Organogram

DELIVERY MANAGEMENT OFFICE

Natalie Deakin
Change Programme Manager

Change Programme

Service Improvement

Hannah Swayne
Senior Project Manager

Ellie Johnson
Senior Project Manager

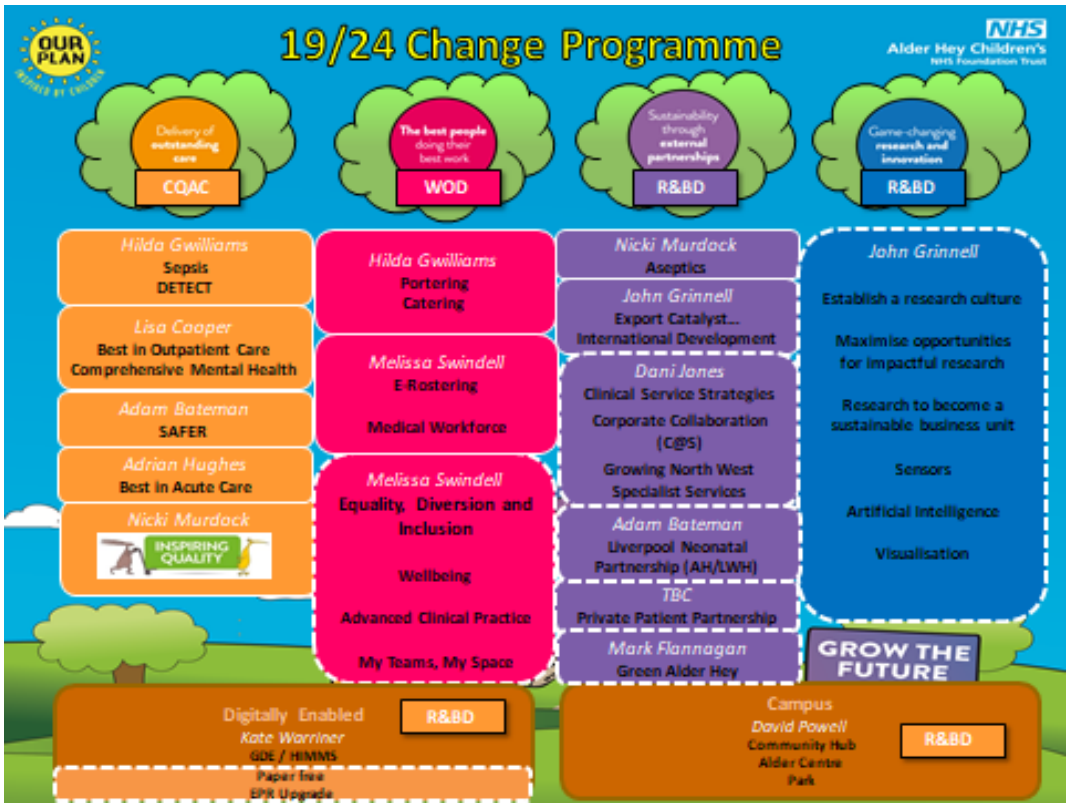
Lucy Howell
Senior Project Manager

Hannah Randles
Senior Project Manager
(Community Service Improvements)

Megan Field
Project Manager
(Inspiring Quality)

Clare Rider
Project Support

Appendix 2: Current Change Programme



NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report July 2019

How Did We Do?

Executive Summary **Month: July** **Year: 2019**

Delivery of Outstanding Care

Safe

- Incident reporting remains consistently high, with an increased number of near miss and no harm incidents reported.
- In July, 4 Moderate harm incidents reported however 2 reports relate to the same incident; therefore a total of 3 moderate harms in month, 2 in the surgical division and 1 in the community division. Duty of Candour requirements met and appropriate level of RCA investigation underway. Serious incident regarding category 3 pressure ulcer reported in line with national requirements. 72 hour review completed to identify any immediate actions and lessons learned

Highlight

- Continued low levels of hospital acquired infection suggesting effective infection control practices by staff.

Challenges

- Medication error continues to be the top theme in incident reporting. 5 errors resulted in harm in month: reviewed at weekly Patient Safety Meeting to identify learning and appropriate actions.

The Best People Doing their Best Work

Caring

- Greater number of opportunities now available to capture FFT with Meridian kiosks and continued support of the Volunteers using tablets. Audit of kiosk use undertaken, together with review of how "user friendly" the tool is, and a walkabout undertaken to review the most appropriate place for the kiosks to be placed. Appropriate improvements and actions identified for implementation
- Sending out SMS messages commenced in July, increasing the opportunity and ability for families to share their views with the Trust

Highlight

- 93% of families whose child is an in-patient would recommend the Trust.

Challenges

- Increase in formal complaints compared to previous 3 months. Thematic analysis to be undertaken.

Delivery of Outstanding Care

Effective

- In July there was a high number (n= 37) of operations cancelled on the day. Nonetheless, our cumulative year on year improvement is strong and remains on track to reduce by 25% (target of n= 240 for 2019-20). We have a continuous improvement approach to reducing cancelled operations and we have applied the learning from July's cases: we have increased the proportion of theatre lists allocated to urgent and emergency operations.
- In July the Emergency Department (ED) treated 5,199 patients, an increase of 5.5% above July 2018. The ED team have been dealing with a reduction in staffing levels and some fatigue. An improvement plan, generated with frontline staff, is being implemented. Changes are being made to some clinical pathways following a visit to Sheffield Children's Hospital, and we are actively recruiting nursing and medical staff to increase resilience in readiness for winter.

Highlight

- Strong grip on patients re-booked for their operation within 28 days.

Challenges

- ED waiting times.
- On-the-day cancellations.

Delivery of Outstanding Care

Responsive

- The SAFER programme and the specialty package documents continue to drive improvement in the % of patients who know their planned date of discharge. 12 months on the number of patients informed of their discharge date has increased by 22% to 87.8%.

Highlight

- Achieved national referral-to-treatment, cancer & diagnostic standards.
- % patients who know their planned date of discharge.

Challenges

- % patients involved in learning.

The Best People Doing their Best Work

Well Led

In month 4 we delivered a £0.1k deficit which was £0.8k behind plan which leaves us £0.8m behind our year to date plan.

Activity levels improved in month overachieving in non-elective and A&E however elective and day case levels still remain a concern.

The Pay overspend increased due to the announcement of the higher than expected medical pay award

CIP performance improved in month however there is still a material gap against our forecast versus target. A financial re-set is being taken through RABD to target key areas of improvement. Cash holdings are £79m which is significantly higher than plan driven by capital slippage and the receipt of the 2018/19 bonus PSF funding earlier than expected. Temporary staffing spend still remained high at £1m

A concerted effort has meant we are achieving mandatory training levels again. It is key that this is sustained

Completion of PDR's have significantly improved to just below 90%

Sickness levels remain significantly above target at 5.2%. A team are looking at specific actions that may support specific teams where sickness levels are high.

Highlight

- Improved CIP
- Activity Levels
- Sickness Level

Challenges

- Control Total
- Activity Levels
- Sickness Levels

Game Changing Research and Innovation

Research and Development

- Participant recruitment beginning to further increase with the impact of the whole hospital DETECT study. Alder Hey is currently the highest recruiting centre in the NW Coast region. Number of new studies opening (academic and commercial) being purposely stalled due to lack of capacity within the clinical research division. This will improve as key posts are recruited to in the coming weeks and months.

Highlight

- Progress on research business model allowing recruitment to key posts for research delivery.

Challenges

- Managing the gaps in key research and administration posts and continuing business as usual.

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Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG			Comments Available
Clinical Incidents resulting in Near Miss	D	69	65	76	72	79	59	58	83	76	58	84	58	113		>=72	>=69	<69	✔
Clinical Incidents resulting in No Harm	D	286	312	288	316	285	218	285	251	279	300	294	296	308		>=293	>=279	<279	✔
Clinical Incidents resulting in minor, non permanent harm	D	76	69	86	90	95	67	78	84	105	94	108	76	79		<=86	N/A	>86	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	1	1	2	0	1	1	2	1	0	0	0	2	3		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	1	2	0	0	0	1	0		0	N/A	>0	✔
Medication errors resulting in harm	D	3	4	4	2	6	2	2	4	2	6	3	3	5		<=2	N/A	>2	✔
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	0	0	0	0	1	1		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	2	0	0	0	0	1	0	0	0	0	0	0		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis - A&E	D P	65.5%	68.2%	54.5%	65.4%	57.6%	51.9%	77.4%	71.1%	79.4%	58.8%	71.1%	65.2%	79.3%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	71.4%	72.5%	78.2%	70.2%	76.2%	73.3%	70.2%	82.1%	73.3%	81.8%	71.4%	90.9%	80.0%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	W	0	0	0	0	0	0	0	0	0	0	0	0	1		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	1	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	D	0	0	1	2	0	1	1	0	4	1	1	0	0		0	N/A	>0	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	D	86.3%	88.2%	85.5%	80.0%	80.6%	90.1%	90.5%	80.3%	89.5%	78.8%	87.7%	80.4%	82.8%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	92.2%	100.0%	100.0%	93.2%	100.0%	100.0%	98.5%	100.0%	98.6%	88.4%	100.0%	93.8%	92.9%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	97.0%	97.0%	98.3%	98.2%	97.9%	98.2%	97.0%	96.2%	97.8%	97.3%	90.6%	90.1%	93.2%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	100.0%	89.9%	89.4%	84.7%	97.5%	100.0%	88.9%	76.9%	82.9%	80.8%	88.7%	100.0%	33.3%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	85.5%	89.7%	90.0%	90.3%	91.4%	91.7%	87.4%	89.1%	91.1%	92.7%	91.7%	93.5%	91.2%		>=95 % >=90 % <90 %	✔
Complaints	W	14	13	12	13	5	7	7	8	16	7	9	6	14		No Threshold	✔
PALS	W	100	101	125	132	115	71	136	98	95	110	102	121	128		<=90 <=100 >100	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	6.5%	0.0%	2.7%	1.0%	1.1%	2.4%	1.4%	1.8%	2.5%	2.7%	2.1%	1.3%	3.2%		<=3 %	N/A	>3 %	✔
ED: 95% Treated within 4 Hours	D	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%	93.6%	91.3%	89.4%	91.8%		>=95 %	N/A	<95 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	35	18	12	28	38	21	11	10	11	9	24	15	37		<=20	N/A	>20	✔
28 Day Breaches	W	6	7	1	0	6	6	4	1	1	0	0	1	2		0	N/A	>0	✔
Average Scanning Turnaround - Inpatient	D								44.00	49.00	49.00	50.00	55.00	55.00		<=7	N/A	>7	✔
Average Scanning Turnaround - Outpatient	D								26.00	23.00	24.00	21.00	23.00	23.00		<=5	N/A	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	94.7%	94.7%	96.3%	96.4%	95.1%	96.7%	96.0%	94.9%	95.7%	98.3%	96.6%	97.5%	97.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	99.7%	99.6%	99.5%	99.6%	100.0%	99.6%	100.0%	99.3%	99.5%	99.3%	99.0%	98.1%	99.2%		100 % >=95 % <95 %	✔
IP Survey: % Know their planned date of discharge	D P	65.7%	60.6%	55.3%	60.2%	69.0%	59.4%	76.5%	82.8%	80.6%	88.8%	84.1%	87.9%	87.8%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	94.7%	91.6%	94.9%	92.2%	92.2%	92.5%	96.3%	94.3%	93.4%	99.3%	90.5%	96.3%	90.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D												93.3%	94.5%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D												70.9%	75.6%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.0%	92.0%	92.1%	92.1%	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.1%	92.1%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	12,962	12,925	12,884	12,961	12,934	12,859	12,872	12,888	12,746	12,871	12,876	12,843	12,883		<=12899 N/A >12899	✔
Waiting Greater than 52 weeks	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%			100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	99.6%	99.5%	100.0%	99.8%	100.0%	99.8%		>=99 % N/A <99 %	✔
PFI: PPM%		96.0%	98.0%	100.0%	98.0%	99.0%	100.0%	100.0%	100.0%	98.0%	98.0%	98.0%	98.0%	100.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG	Comments Available
CIP In Month Variance (£'000s)	W	-238	-137	175	-174	-285	151	-199	-74	-75	-163	-54	-47	-26		>=-5% >=-20% <-20%	✔
Control Total In Month Variance (£'000s)	W	29	-396	359	-463	-48	564	-21	-433		-394	-165	596	-848		>=-5% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	-462	-129	2,907	-751	1,041	1,032	1,032	259	1,610	1,030	640	728	694		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	W	23,910	21,519	20,023	20,315	17,580	23,136	19,983	22,068	33,699	34,361	34,449	37,415	79,086		>=-5% >=-20% <-20%	✔
Income In Month Variance (£'000s)	W	998	741	263	624	684	142	456	355	19,495	-612	21	846	-52		>=-5% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	W	-111	-311	51	-372	-74	-267	-510	-850	-495	183	-25	-130	-260		>=-5% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	W	-858	-825	45	-715	-659	689	34	63	-942	34	-161	-119	-537		>=-5% >=-20% <-20%	✔
NHSI Use of Resources	W	3	3	2	2	1	1	1	1	1	1	3	3	3		<=3 N/A >3	✔
AvP: IP - Non-Elective	W										53	58	109	158		>=0 N/A <0	✔
AvP: IP Elective vs Plan	W										-45	-24	-41	-76		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan	W										-53	-130	-241	-42		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan	W										778	79	1,292	1,911		>=0 N/A <0	✔
PDR	W	64.7%	82.3%	88.8%	90.1%	90.1%	90.1%	90.1%	92.2%	92.2%	4.8%	20.7%	47.3%	86.4%		No Threshold	
Medical Appraisal	W	4.0%	6.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.5%	98.4%		>=95 % >=90 % <90 %	✔
Mandatory Training	W	91.6%	88.6%	88.1%	89.7%	89.7%	89.0%	89.4%	88.8%	89.6%	90.0%	88.4%	90.5%	90.8%		>=90 % >=80 % <80 %	✔
Sickness	D	5.3%	5.2%	5.4%	5.6%	5.6%	6.1%	5.7%	5.7%	5.4%	5.2%	5.5%	5.2%	5.2%		<=4 % <=4.5 % >4.5 %	✔
Short Term Sickness	D	1.5%	1.3%	1.4%	1.6%	1.6%	1.6%	1.9%	1.7%	1.6%	1.5%	1.5%	1.4%	1.3%		<=1 % N/A >1 %	✔
Long Term Sickness	D	3.8%	4.0%	4.0%	4.0%	4.0%	4.4%	3.9%	3.9%	3.7%	3.7%	4.0%	3.8%	3.9%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	D	901	1,082	820	998	971	883	937	1,046	1,357	1,114	1,061	899	1,058		<=800 <=960 >960	✔
Staff Turnover	D	11.1%	10.5%	10.7%	10.5%	10.2%	9.6%	9.5%	9.5%	9.9%	9.7%	9.9%	9.8%	9.4%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	W	95.0%	93.9%	93.1%	93.2%	95.3%	94.2%	94.5%	92.8%	95.4%	95.3%	95.2%	92.6%	92.0%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	W	97.5%	85.0%	93.8%	60.0%	90.0%	90.0%	92.0%	95.0%	86.0%	81.5%	100.0%	81.2%	97.2%		>=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

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	159	156	115	143	136	123	121	121	153	154	158	161	158		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	34	37	27	31	28	27	29	26	60	59	59	58	57		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	7	2	3	6	8	2	6	5	3	1	5	4	2		>=3	>=2	<2	
Number of New Studies Opened - Commercial	W	1	2	3	2	0	0	1	1	4	2	1	2	2		>=1	N/A	<1	✔
Number of patients recruited	W	288	249	238	195	296	158	238	211	314	234	221	350	431		>=200	>=171	<171	✔

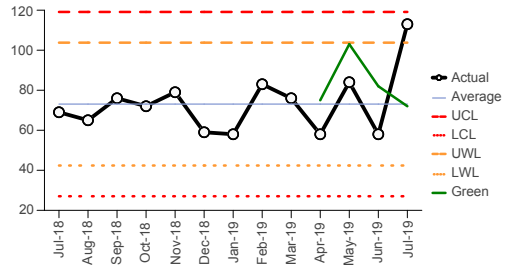
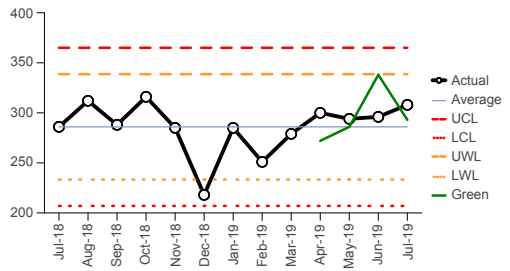
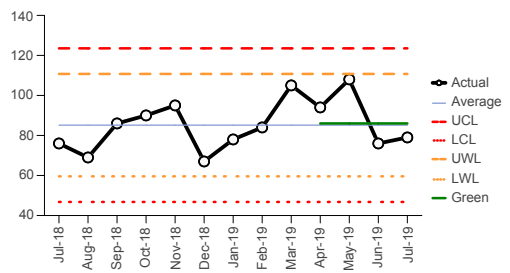
Delivery of Outstanding Care

7.1 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

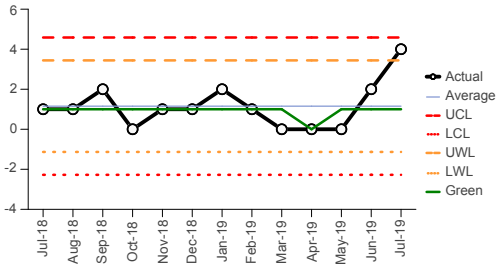
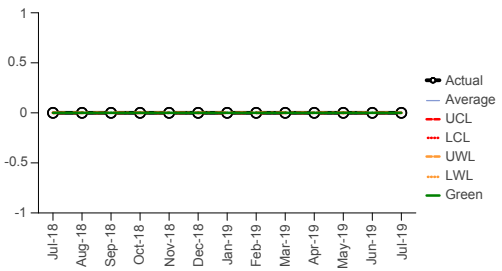
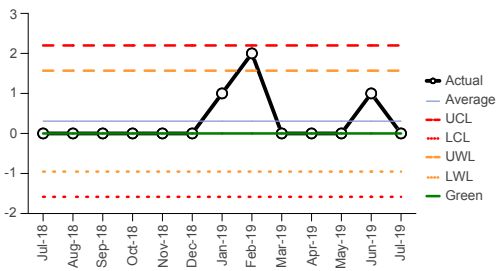
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19 (897). 19/20 aim is to see more than 5% reported than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	113	R <69 A >=69 G >=72		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19 (3328). 19/20 aim is to see more than 5% reported than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	308	R <279 A >=279 G >=293		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. The threshold is based on a reduction for the period Apr 18 - Mar 19 (1036). 19/20 aim is to see volume reported less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	79	R >86 A N/A G <=86		No Action Required

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

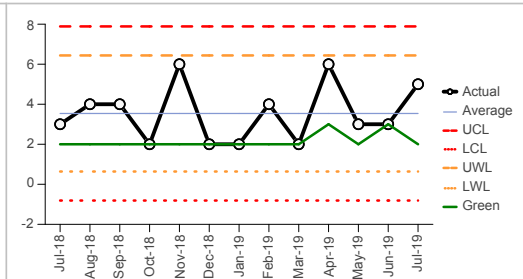
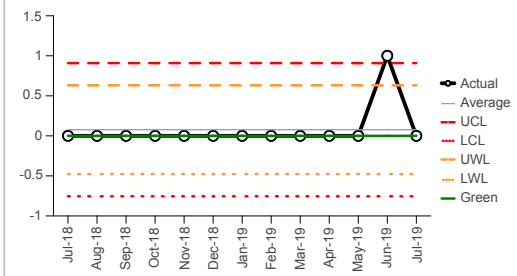
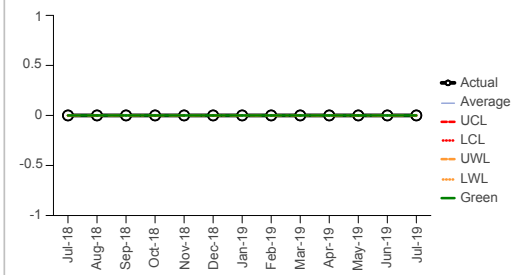
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 18 - Mar 19 (12). 19/20 aim is 11 or less, annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	3	R >1 A N/A G <=1		There were 3 moderate harm incidents reported in July 2019, 2 in the surgical division and 1 in the community division. For all 3 incidents; Duty of Candour requirements met and appropriate level of RCA investigation underway. Serious incident regarding category 3 pressure ulcer reported in line with national requirements. 72 hour review completed.
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

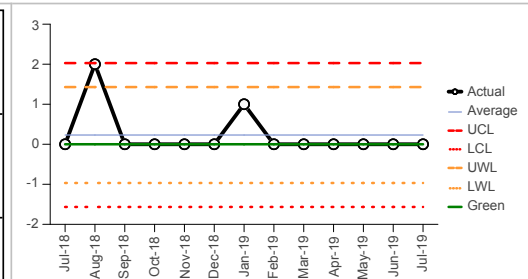
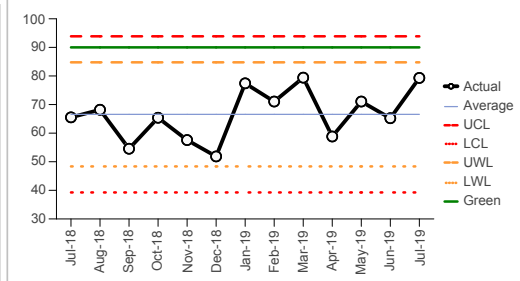
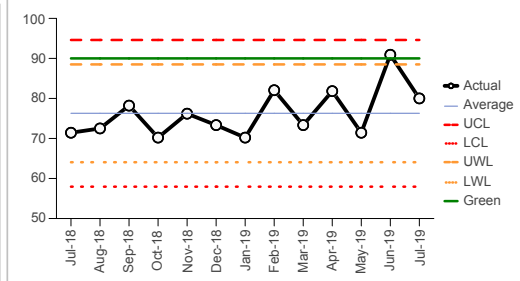
	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 18 - Mar 19 (42), on trajectory with WHO global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% by 2022. 19/20 aim is less than 34 annually **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	5	R >2 A N/A G <=2		Currently we have 3 harm levels following review.
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R >0 A N/A G 0		Level 2 RCA, Our community team was looking after this child, pressure ulcer developed before our community staff involved but wound deteriorated while child is under our care.
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

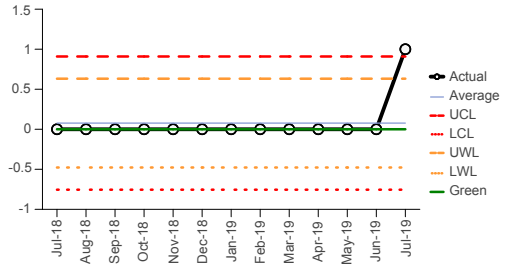
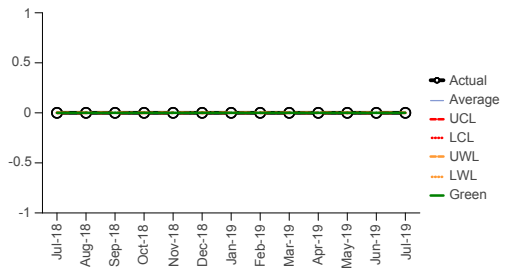
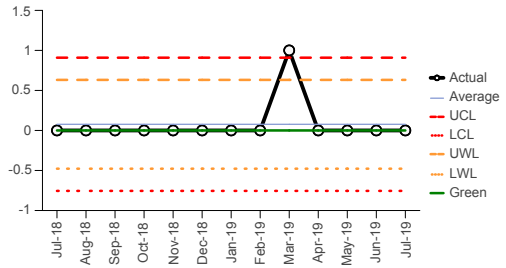
	Description	Performance	Threshold	Trend	Management Action (SMART)
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	79.31 %	R <90 % A N/A G >=90 %		Continued emphasis of importance of thinking sepsis, therefore still a high number of patients identified but still no 'sepsis status' ready for ED documentation.
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	80 %	R <90 % A N/A G >=90 %		Ward level feedback given regarding cases. High level of acuity and a number of patients identified as clinical deteriorations with quick escalation and treatment given. Aim is always 90% to be treated but important to note patients who are clinically deteriortaing also require the full sepsis bundle which we are able to now prove compliance wit this as well

Delivery of Outstanding Care

7.5 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Mortality	**No of children that have suffered avoidable death - Internal** W Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 19/20 is zero. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R >0 A N/A G 0		Due the rapid deterioration and concerns raised a RCA was undertaken and the recommendations released across the Trust. This was a potentially avoidable death and there was a possible delay in treating sepsis especially in view of her age <1 yr.
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - C.difficile** D The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

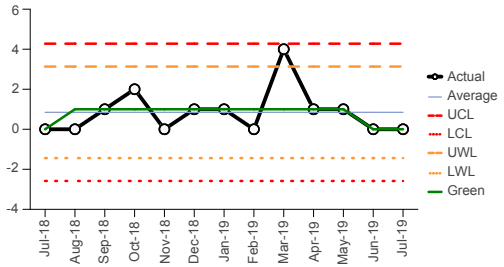
Delivery of Outstanding Care

7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

Reducing Infections

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

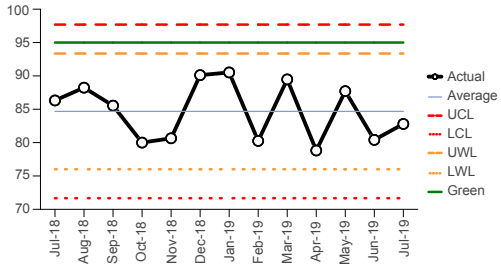
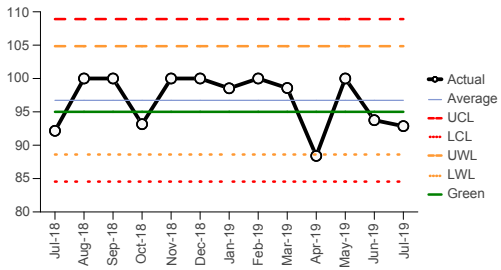
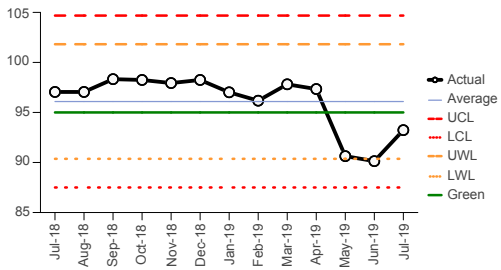
The Best People doing their best Work

8.1 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	82.80 %	R <90 % A >=90 % G >=95 %		We will continue to provide support to A&E using our volunteers in the waiting room assisting children and families and updating the board so that families are aware of the waiting times. TV's will update waiting times and call patients this should be ready for September. Works are to be carried out within the next few weeks. Attitude off staff is a theme this has been identified by the division lead. There have been a total of 180 responses during July, 102 extremely likely to recommend the Trust, 47 likely, 9 neither likely or unlikely, 7 unlikely, 5 extremely unlikely and 10 don't know
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	92.86 %	R <90 % A >=90 % G >=95 %		SMS messages will be sent out during August this will improve the numbers of feedback received giving a more accurate response. Three kiosks will be placed within the community during October. Staff training has been requested for the Meridian system to enable staff to monitor feedback and act accordingly. Total number of responses for August is 55, 38 where extremely likely to recommend the Trust, 13 likely, 2 responses said unlikely, 2 extremely unlikely
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	93.23 %	R <90 % A >=90 % G >=95 %		There were 448 children/young people and families that completed the FFT feedback during July within the inpatient wards, 330 said they are extremely likely to recommend the Trust, 87 said they would be likely, 22 neither likely or unlikely 4 extremely unlikely and 5 did not know. 6 were received by SMS and 442 using either a tablet or kiosk.

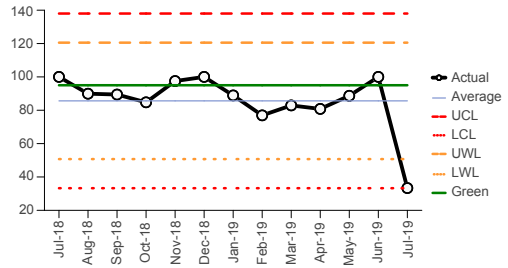
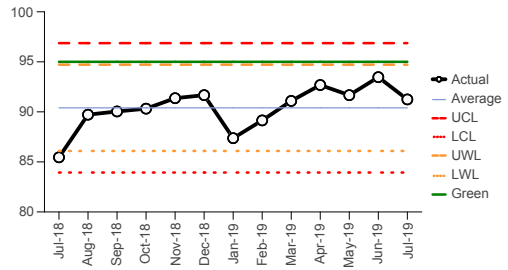
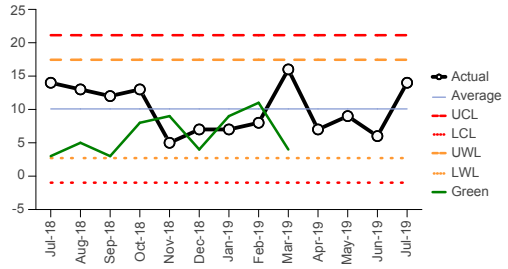
The Best People doing their best Work

8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	33.33 %	R <90 % A >=90 % G >=95 %		Three FFT feedbacks have been completed for July one from psychological services and two from Dewi Jones. Feedback from Dewi Jones said 'they did not know if they would recommend the Trust'. The one feedback from Health psychology said 'they are extremely likely to recommend the Trust'. The introduction of SMS messages should increase the volume of responses. This will be monitored during August and ways to improve will be identified between the PE Quality lead and the division lead
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	91.24 %	R <90 % A >=90 % G >=95 %		The areas of focus continue to be play and distraction in the waiting areas, and attitude of staff. A part time play specialist is to start working in outpatients in August. Patient flow has improved for Phlebotomy as families are sent back out to the Atrium to wait this relieving the overcrowding in the waiting areas. This month there were 508 responses, 390 said they are extremely likely to recommend the Trust, 77 likely, 7 neither likely or unlikely, 3 unlikely, 8 extremely unlikely and 23 did not know
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	14	No Threshold		A significant rise in total number of formal complaints received this month. Division of Surgery received the most with 8 new formals. General surgery received three - no identifiable theme within these three complaints

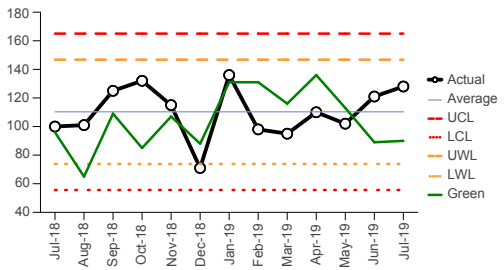
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
PALS	**PALS** W Total number of PALS contacts. Threshold is based on a 10% Reduction on 18/19 (1347). 19/20 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	128	R >100 A <=100 G <=90		This month has seen a higher than usual amount of informal concerns raised. There are no new categories or themes emerging however historically this month we would usually see a reduction in numbers of informal complaints

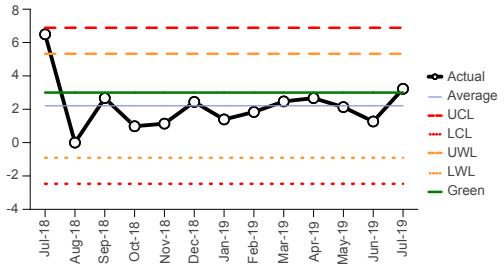
Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

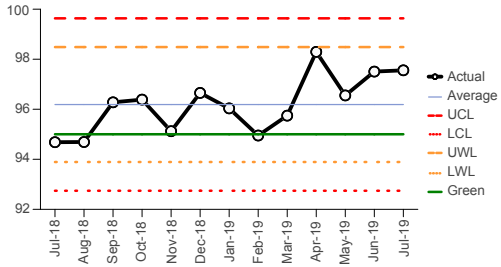
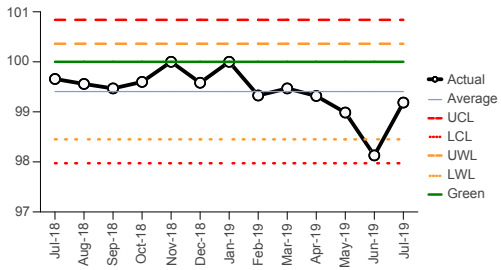
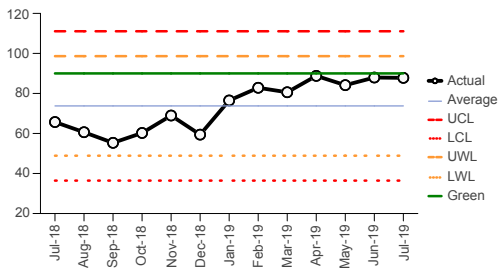
	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** W % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	3.23 %	R >3 % A N/A G <=3 %		This is a metric that is reported annually across the UK. There are accepted variations in the monthly incidence of PICU readmission within 48hrs across the year. This variance is due to a number of factors, which include seasonal illness and the elective closing of critical care beds during the summer for the annual deep clean. Please note there was also a similar spike in readmissions last July. Despite this variance the Trust has consistently been below the annual 3% ceiling for PICU readmissions, in line with the reported incidence at similar paediatric Trusts.

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

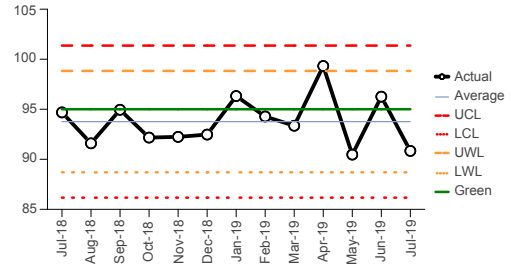
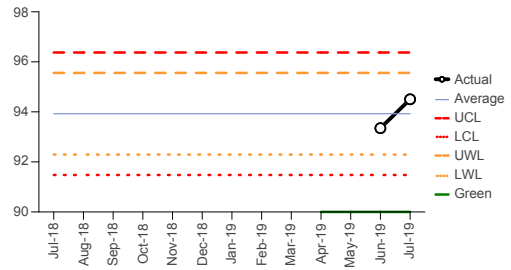
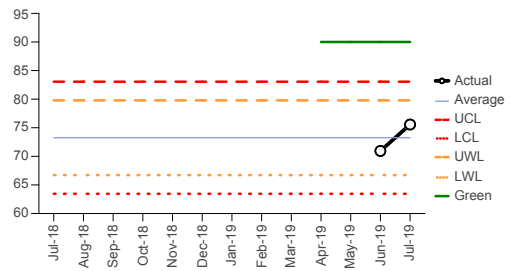
	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	97.56 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 19/20 is 100%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	99.19 %	R <95 % A >=95 % G 100 %		A huge increase compared to June's feedback. During July there have been 1014 responses across the Trust 166 of these were inpatient. Medicine had 132 responses and all said they were treated with respect there was one comment. Surgery 42 responses were treated with respect 2 were not and there were no comments. There are 2 outstanding actions for inpatients
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	87.78 %	R <85 % A >=85 % G >=90 %		The SAFER project focusing on improving efficiencies and flow, ensure all C&YP have a review before midday encouraging nurse or criteria led discharge. The GDE programmes will support more accurate and well communicated discharge dates. Close working with the pre-op service looking at information given to families pre-admission; will advise C&YP how long they are likely to be in hospital. 'MY PAD', is a visual aid in each cubicle for C&YP/ families to document progress and be fully informed of what is outstanding in their care pathway and when they are likely to go home

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	90.84 %	R <90 % A >=90 % G >=95 %		Ward staff continue to introduce themselves on each shift to all families and children, FFT will be monitored by the ward managers and escalated to the medical team. This information is now available in real time so immediate action, concerns complaints can be addressed immediately.
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	94.50 %	R <85 % A >=85 % G >=90 %		No Action Required
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	75.56 %	R <85 % A >=85 % G >=90 %		The school is on holiday until September further interaction with the teachers is required, the play manager and patient experience/quality lead will liaise with the team to discuss further support going forward

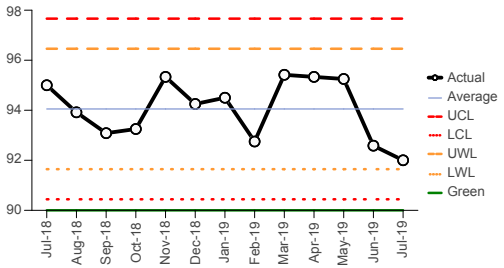
The Best People doing their best Work

11.1 - QUALITY - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** W Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	92 %	R <90 % A N/A G >=90 %		No Action Required

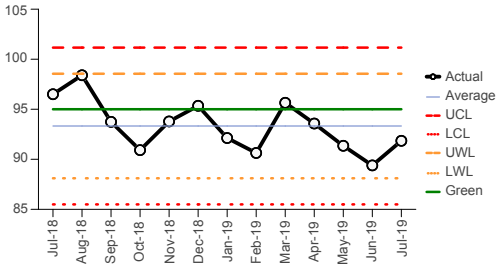
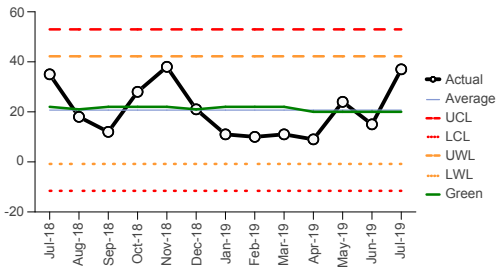
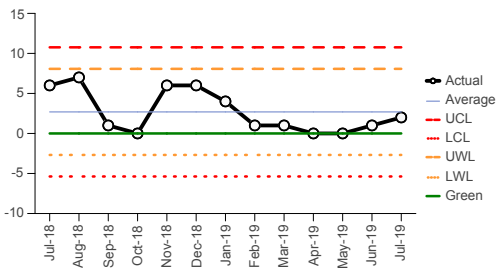
Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	91.84 %	R <95 % A N/A G >=95 %		Highest July attendances ever recorded following national ED attendance profile. Increase of 5.5% in attendances compared to July 2018 and higher attendances than both December and February 2018/19. Attendances were over predicted on 18/31 days. The highest variance between predicted and actual was 48 over predictor on 6th July. Staffing has been a challenge with 9/31 days having less consultant cover than required. 12 junior doctor shift gaps across the month and ENP stream offer on 16/31 days. Nursing staffing has had gaps on 6/31 days. PCS has operated sub-optimally due to poor shift cover
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 16% based on 18/19 overall performance (284). This is inline with trajectory from Oct 18 - Mar 19 **Exec Lead:** Adam Bateman **Committee:** RABD	37	R >20 A N/A G <=20		High number of patients cancelled due to escalating pressures on the emergency list. Additional capacity for orthopaedic and plastics trauma has been provided, and additional semi-urgent theatre lists for general surgery commence in September.
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	2	R >0 A N/A G 0		Two patients cancelled in paediatric surgery and unable to be relisted within 28 days due to complexity and expertise required for the procedure. 1st patient has had surgery on day 44 after initial cancellation, 2nd patient has surgery date booked for October 2019 (two surgeons required for surgery).

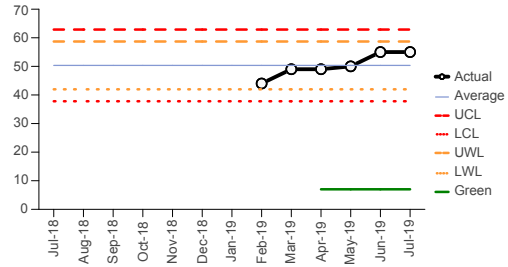
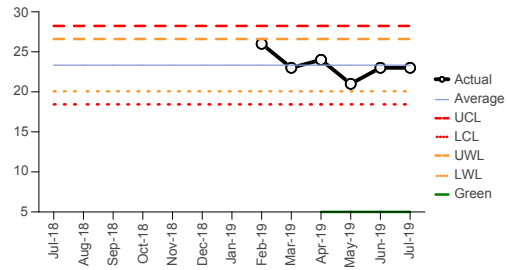
Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

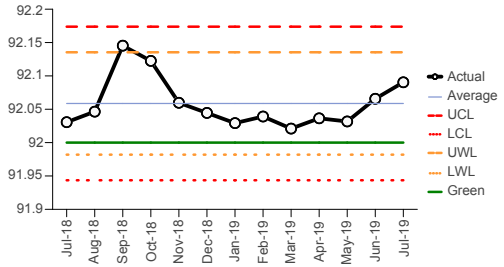
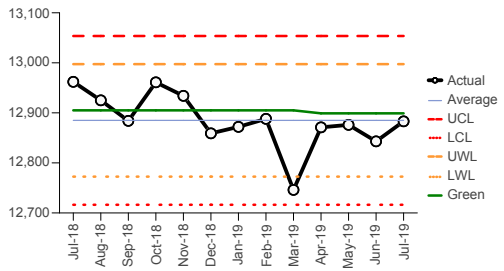
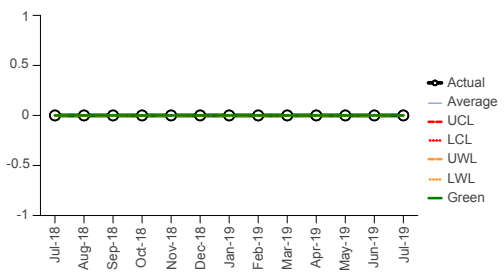
	Description	Performance	Threshold	Trend	Management Action (SMART)
Scanning	**Average Scanning Turnaround - Inpatient** D Days from being clinically coded following inpatient discharge to episode notes being scanned and uploaded on to the viewing system (Image Now). Average based on working days. **Exec Lead:** Adam Bateman **Committee:** RABD	55	R >7 A N/A G <=7		Agreement has been reached to undertake Outsourcing of Backlog and company is now engaged (Restore). A sample 'dummy' batch of records has been sent to the company for test scanning and is due to be returned and QA'd by 22/08/19. A live test batch will be sent for scanning and returned for QA by 16/09/19 with full backlog scanning due to commence 30/09/19. Additional actions and review of SOP's is also underway.
Scanning	**Average Scanning Turnaround - Outpatient** D Days from Clinic attendance to episode notes being scanned and uploaded on to the viewing system (Image Now). Average based on working days. **Exec Lead:** Adam Bateman **Committee:** RABD	23	R >5 A N/A G <=5		Agreement has been reached to undertake Outsourcing of Backlog and company is now engaged (Restore). A sample 'dummy' batch of records has been sent to the company for test scanning and is due to be returned and QA'd by 22/08/19. A live test batch will be sent for scanning and returned for QA by 16/09/19 with full backlog scanning due to commence 30/09/19. Additional actions and review of SOP's is also underway.

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

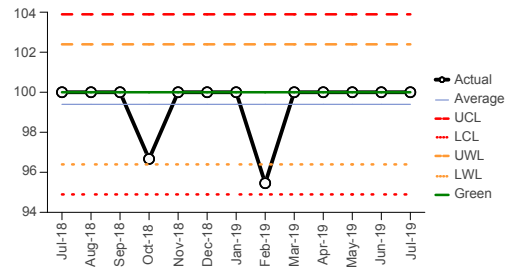
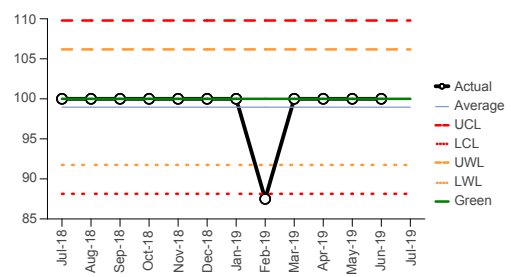
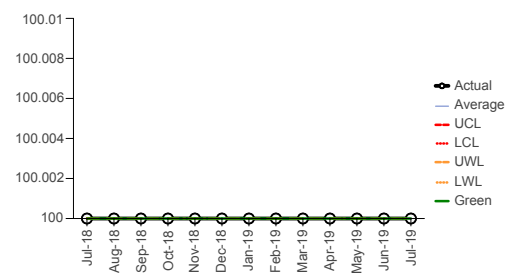
	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.09 %	R <90 % A >=90 % G >=92 %		No Action Required
Waiting Times	**Waiting List Size** W National threshold as part of the 18/19 NHSI plan. The target is to maintain reduction of the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12883	R >12899 A N/A G <=12899		No Action Required
Waiting Times	**Waiting Greater than 52 weeks** W Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 19/20 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

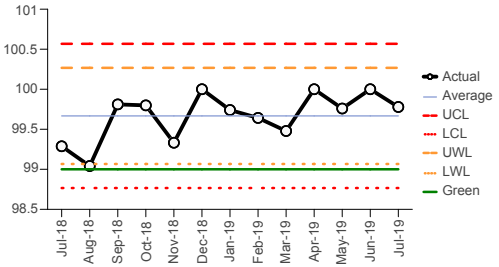
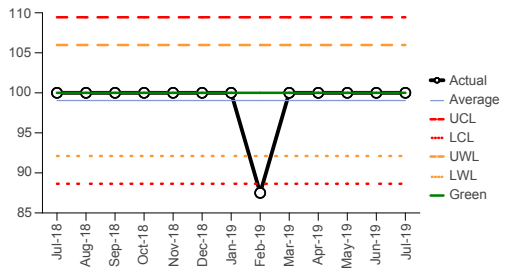
	Description	Performance	Threshold	Trend	Management Action (SMART)
Cancer RTT	**Cancer: 2 week wait from referral to date 1st seen - all urgent referrals** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** W Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	99.78 %	R <99 % A N/A G >=99 %		No Action Required
Cancer RTT	**31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required

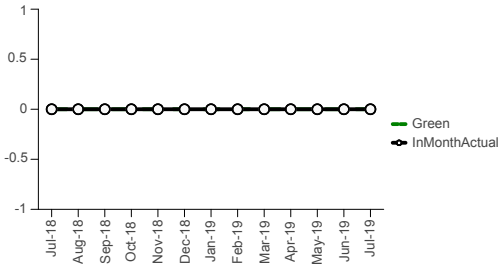
The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

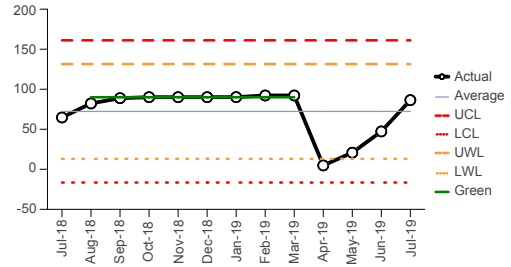
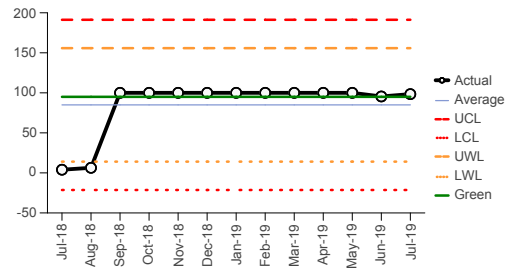
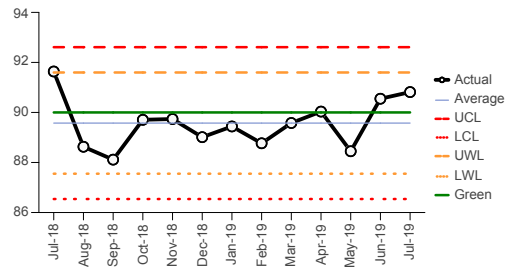
The Best People doing their best Work

15.1 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	86.37 %	No Threshold		
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	98.38 %	R <90 % A >=90 % G >=95 %		No Action Required
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	90.81 %	R <80 % A >=80 % G >=90 %		No Action Required

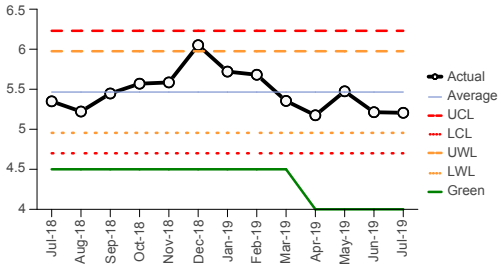
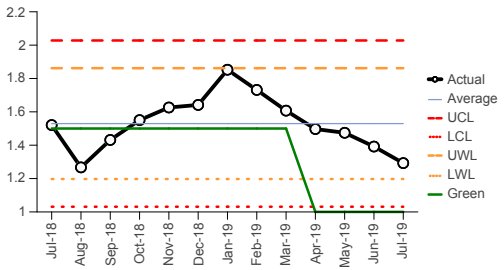
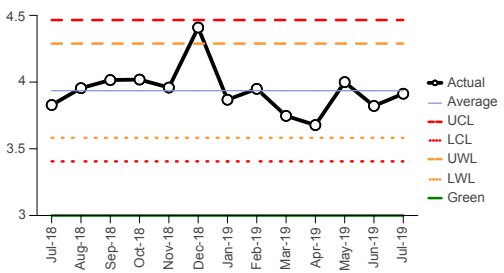
The Best People doing their best Work

15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.21 %	R >4.5 % A <=4.5 % G <=4 %		Trust absence still remains more than 1% above the target. The Trust top 3 reasons for absence continue to be Anxiety/Stress, Others Musculoskeletal and Gastrointestinal problems. Action plans are in place for areas with significant absence. In addition a full review of all absences is being undertaken with individual action plans in place.
Sickness	**Short Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.29 %	R >1 % A N/A G <=1 %		see above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	3.91 %	R >3 % A N/A G <=3 %		see above

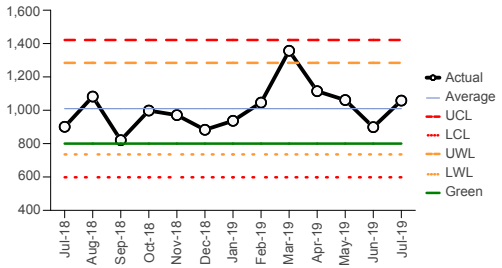
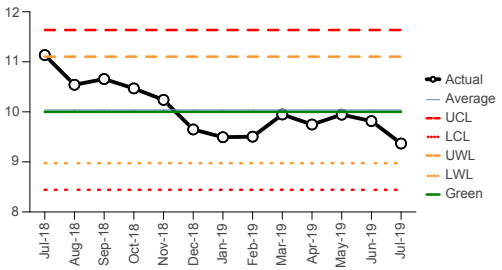
The Best People doing their best Work

15.3 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	1057.82	R >960 A <=960 G <=800		Business Partners together with Finance Accountants and Ass COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & Deputy Directors of HR & Finance.
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	9.37 %	R >11 % A <=11 % G <=10 %		No Action Required

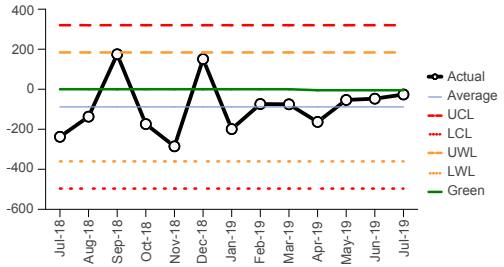
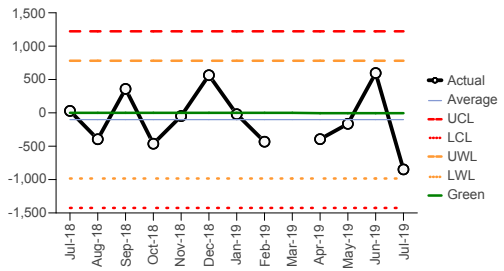
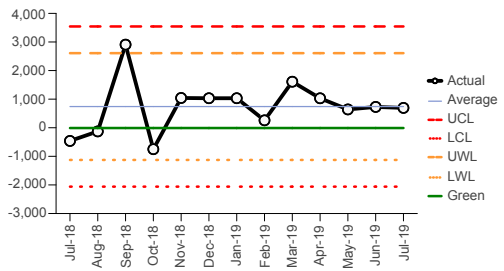
The Best People doing their best Work

16.1 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**CIP In Month Variance (£'000s)** W Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month. **Exec Lead:** John Grinnell **Committee:** RABD	-26	R <-20% A >=-20% G >=-5%		The M4 CIP performance across the Trust showed an under achievement of (£0.026m). The full year CIP target is £6m. The forecast outturn for CIP delivery is £3.9m, a forecast CIP under performance of £2.1m representing a risk to CIP delivery for the full year. The key area of under delivery is within the medicine division (£1.2m) and corporate areas (£0.4m). An action plan has been put in place to improve the CIP performance for the medicine division.
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-848	R <-20% A >=-20% G >=-5%		The Trust is reporting a control total deficit for July of (£0.1m) which is behind plan by (£0.8m). Income is behind plan by (£0.1m) and pay and non pay overspends total (£0.7m). The year to date deficit is (£1.9m) which is behind plan by (£0.8m)
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	694	R <-10% A >=-10% G >=-5%		No Action Required

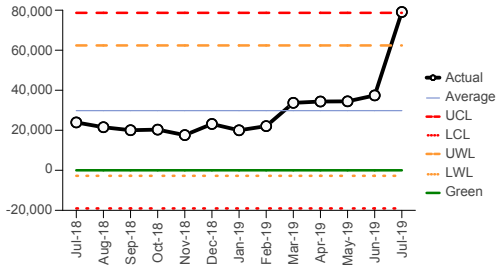
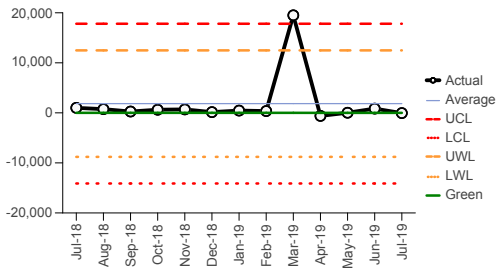
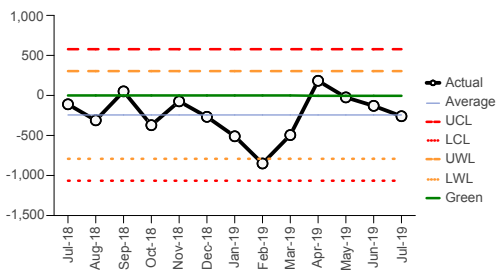
The Best People doing their best Work

16.2 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Cash in Bank (£'000s)** W Variance from Cash plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	79,086	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-52	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Pay In Month Variance (£'000s)** W Variance from pay plan. Variation between months is usual and the threshold of -5% to -20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-260	R <-20% A >=-20% G >=-5%		No Action Required

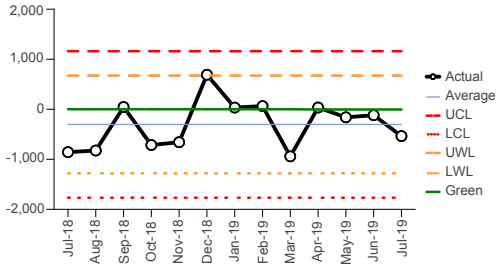
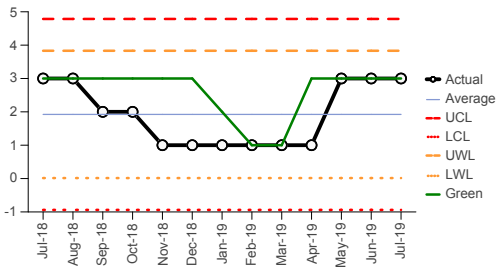
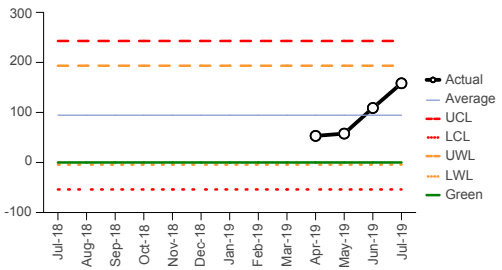
The Best People doing their best Work

16.3 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-537	R <-20% A >=-20% G >=-5%		In July expenditure on non pay exceeded the budget. This related to expenditure on clinical supplies particularly in Theatres. This is under investigation and mitigations to improve the position are being developed.
Finance	**NHSI Use of Resources** W NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	3	R >3 A N/A G <=3		No Action Required
Finance	**AvP: IP - Non-Elective** W Actvity vs Forecast for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	158.26	R <0 A N/A G >=0		No Action Required

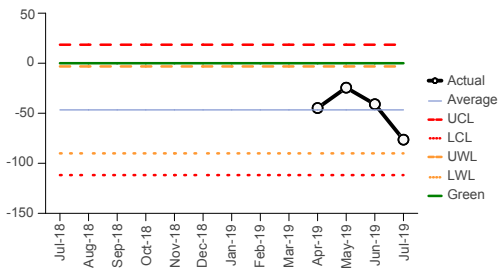
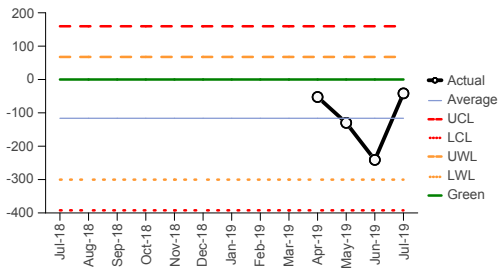
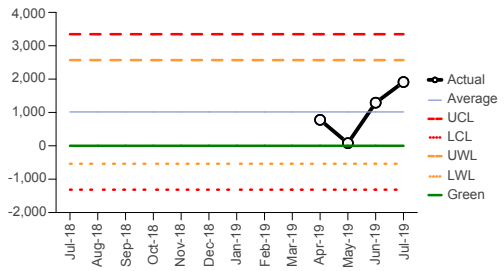
The Best People doing their best Work

16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP Elective vs Plan** W Actvity vs Forecast for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-76.41	R <0 A N/A G >=0		The most significant adverse variance is in sleep studies (26 spells down in month)
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Forecast for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-41.67	R <0 A N/A G >=0		The most significant adverse variances are in gastro (58 spells down) and ENT (28 spells down)
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Forecast for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1910.93	R <0 A N/A G >=0		No Action Required

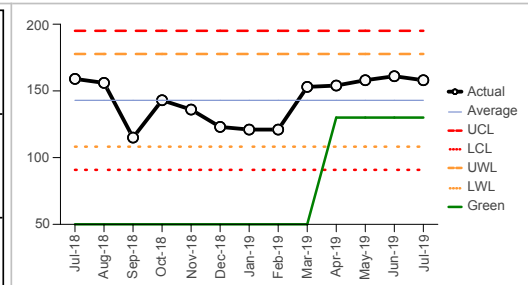
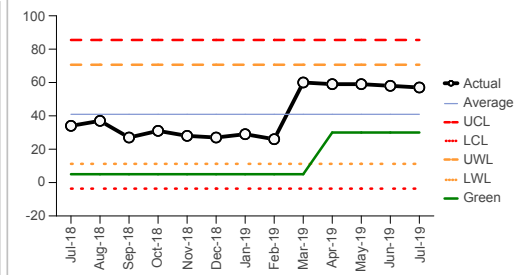
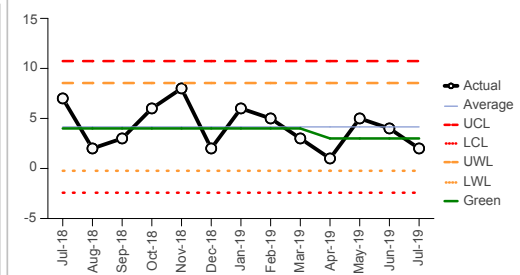
Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

GROW THE FUTURE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	158	R <111 A >=111 G >=130		No Action Required
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	57	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	R <2 A >=2 G >=3		

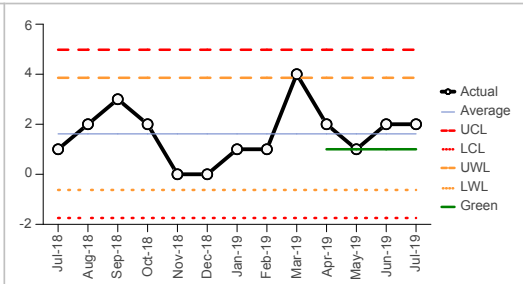
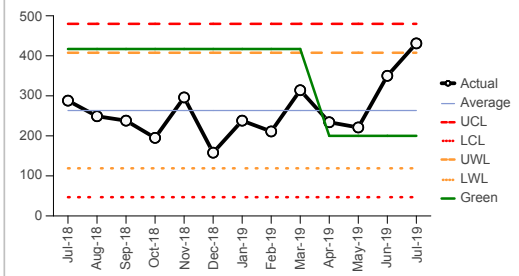
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

GROW THE FUTURE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	R <1 A N/A G >=1		No Action Required
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Matthew Peak **Committee:** REIC	431	R <171 A >=171 G >=200		No Action Required

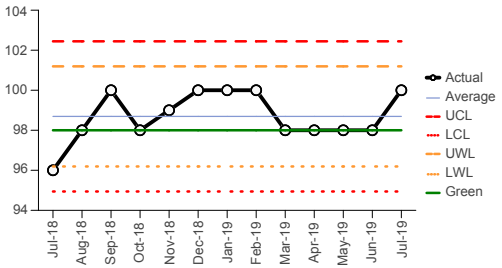
Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	100 %	R <98 % A N/A G >=98 %		No Action Required

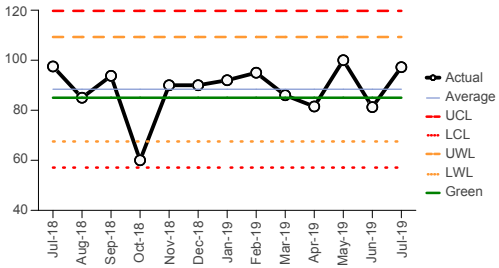
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	97.22 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG		
Clinical Incidents resulting in Near Miss	D	4	34	62	No Threshold		
Clinical Incidents resulting in No Harm	D	32	105	132	No Threshold		
Clinical Incidents resulting in minor, non permanent harm	D	4	27	41	No Threshold		
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	3	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	4	1	No Threshold		
Pressure Ulcers (Category 3)	W	1	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		80.0%	75.0%	>=90 %	N/A	<90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	N/A	>0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	N/A	>0
Hospital Acquired Organisms - MSSA	D	0	0	0	0	N/A	>0

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	3	2	6	No Threshold
PALS	W	31	38	22	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
ED: 95% Treated within 4 Hours	D		91.8%		>=95 %	N/A	<95 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	2	35	No Threshold		
28 Day Breaches	W	0	0	2	0	N/A	>0

Alder Hey Children's NHS
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All Divisions

D Drive W Watch P Programme

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		97.4%	97.7%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		99.5%	99.0%	100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge	D P		84.1%	90.1%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		88.4%	92.4%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		94.7%	94.4%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		86.2%	68.9%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	76.4%	94.3%	93.8%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,356	3,762	7,765	No Threshold		
Waiting Greater than 52 weeks	W	0	0	0	0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W		99.8%	100.0%	>=99 %	N/A	<99 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG		
Control Total In Month Variance (£'000s)	W	-11	-310	-525	No Threshold		
Income In Month Variance (£'000s)	W	-47	79	53	No Threshold		
Pay In Month Variance (£'000s)	W	2	-79	-165	No Threshold		
Non Pay In Month Variance (£'000s)	W	33	-310	-412	No Threshold		
AvP: IP - Non-Elective	W		111	48	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	-55	-23	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		-61	16	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	266	32	496	>=0	N/A	<0
PDR	W	87.1%	83.8%	93.8%	No Threshold		
Medical Appraisal	W		98.4%	98.4%	>=95 %	>=90 %	<90 %
Mandatory Training	W	92.0%	91.2%	89.3%	>=90 %	>=80 %	<80 %

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
Sickness	D	4.3%	5.0%	6.5%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	0.9%	1.5%	1.6%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.4%	3.5%	4.9%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	158	247	527	No Threshold		
Staff Turnover	D	10.2%	9.5%	9.9%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	87.0%	97.8%	89.4%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Zero for the following: Clinical Incidents Resulting In Moderate, Semi permanent Harm; Clinical Incidents Resulting In Severe, Permanent Harm; Clinical Incidents Resulting In Catastrophic, Death; Pressure Ulcers (Both Category 3 And 4); Never Events; Hospital-acquired Infections For MRSA and C Difficile.	**Highlight** • Zero never events, pressure ulcers and hospital-acquired infections (MRSA, C. difficile) for over 12 months. **Challenges** • Patients Treated for Sepsis within 60 Minutes was 80%- Variable trend - focus will be given towards this and reported at the Weekly Executive Communication Cell Meeting.
CARING	Two complaints and 38 PALS responses.	**Highlight** • **Challenges** •
EFFECTIVE	ED Standard continues to be a challenge, but has improved by over 2 percentage points since the previous month. ED action plan in place, which along with recommendations from workforce plan will bring about sustainable positive change. Cancelled Operations remains low (2). Fifth consecutive month with zero 28 Day Breaches. Clinical utilisation improved from previous month. Hospital initiated clinic cancellations markedly lower than the previous 2 months. Scanning outsourcing still on target to have started by end of September 2019.	**Highlight** • Theatre utilisation increased by three percentage points since the previous month and is on a consecutive monthly improvement for 4 months running. **Challenges** • Was not brought rate has deteriorated significantly since previous month. Focus to be given across the board, but especially for clinic templates with less than 5 patients.
RESPONSIVE	Turnaround times consistently good in many areas (especially Pathology) though concern over MRI, CT, Nuclear Medicine. Briefing paper to be composed to explain key issues within radiology and suggested mitigations.	**Highlight** • Eighth consecutive month to achieve RTT target though acknowledge that some areas still require focus. **Challenges** • Third consecutive month with less than 85% of inpatients knowing discharge date. Focused attention on improving this target for all four of the medicine wards.
WELL LED	83.8% completion of PDRs (and increasing). Mandatory training is above 90% for second consecutive month. Staff turnover less than 10% for the ninth consecutive month.	**Highlight** • July saw a £201k improvement in Cost Improvement Programme (CIP) identification. • July saw a £1.524m improvement in forecasted position for year end. **Challenges** • Sickness increased for all three indicators (investigative analysis to be completed regarding root causes).

Alder Hey Children's NHS
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Medicine

D Drive W Watch P Programme

SAFE

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Medication Errors (Incidents)	35	24	30	45	45	29	29	32	35	46	40	23	32		No Threshold
Cleanliness Scores	94.4%	96.2%	97.6%	96.3%	95.7%	95.6%	96.8%	96.8%	98.3%	97.7%	97.8%	91.8%	96.5%		>=90 % >=80 % <80 %
Clinical Incidents resulting in Near Miss (D)	27	22	32	31	26	20	20	33	30	17	29	20	34		No Threshold
Clinical Incidents resulting in No Harm (D)	86	87	85	118	100	62	86	88	80	98	89	85	105		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	20	24	27	17	24	14	28	16	32	32	30	26	27		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	1	2	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	1	1	0	0	0	1	0		0 N/A >0
Medication errors resulting in harm (D)	1	0	2	1	3	0	0	2	1	4	3	0	4		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	0	3	2	4	6	3	3	3	2	2	3	3	4		No Threshold
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	58.3%	81.8%	83.3%	80.0%	100.0%	83.3%	77.8%		60.0%	100.0%	33.3%	100.0%	80.0%		>=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	0	1	1	2	0	2	2	6	1	0	0	2	1		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	0	0	0	0	0	0	0	1	0	0	0	0		0 N/A >0
Pharmacy - Dispensing for Out Patients - Routine	63.0%	53.4%	50.0%	58.0%	55.0%	41.0%	50.0%	63.0%	62.0%	63.0%	54.0%	63.0%	52.5%		>=90 % >=80 % <90 %
Pharmacy - Dispensing for Out Patients - Complex	94.0%	78.8%	86.0%	86.0%	94.0%	89.0%	91.0%	67.0%	95.0%	60.0%	75.0%	100.0%	87.5%		>=90 % >=80 % <90 %

CARING

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Complaints (W)	4	3	6	6	1	4	3	2	3	2	1	2	2		No Threshold
PALS (W)	28	23	21	34	19	21	41	33	20	25	26	37	38		No Threshold

EFFECTIVE

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Referrals Received (Total)	1,906	1,569	1,680	2,086	1,984	1,755	2,035	1,934	2,179	2,015	2,102	1,948	2,150		No Threshold
ED: 95% Treated within 4 Hours (D)	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%	92.1%	90.6%	95.6%	93.6%	91.3%	89.4%	91.8%		>=95 % N/A <95 %
Theatre Utilisation - % of Session Utilised (W)	83.0%	77.8%	84.8%	80.4%	80.9%	86.7%	84.5%	83.8%	82.4%	81.8%	83.3%	82.4%	85.5%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	3	4	0	2	4	0	4	2	0	1	1	1	2		No Threshold
28 Day Breaches (W)	1	2	0	0	1	0	0	1	0	0	0	0	0		0 N/A >0
Clinic Session Utilisation (With Community Paediatrics Only) (D P)	82.1%	81.9%	84.5%	83.8%	85.9%	82.0%	82.1%	87.8%	88.2%	85.9%	85.3%	85.0%	86.7%		>=90 % >=80 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	44	33	27	37	36	29	29	58	32	64	62	62	40		No Threshold
OP Appointments Cancelled by Hospital %	16.5%	15.6%	14.0%	14.5%	14.3%	15.7%	15.3%	15.3%	13.7%	17.6%	18.5%	16.8%	15.1%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	12.4%	13.6%	12.4%	12.5%	11.1%	13.4%	11.8%	12.0%	9.9%	11.4%	11.2%	10.9%	12.3%		<=12 % <=14 % >14 %

Medicine

D Drive W Watch P Programme

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG		
Was Not Brought Rate (New Appts)	W	13.1%	17.4%	15.7%	14.2%	13.3%	16.6%	14.2%	13.8%	10.7%	13.8%	13.6%	10.5%	13.7%		<=10 %	<=12 %	>12 %
Was Not Brought Rate (Followup Appts)	W	12.1%	12.4%	11.2%	11.9%	10.3%	12.3%	11.0%	11.4%	9.6%	10.6%	10.3%	11.0%	11.8%		<=14 %	<=16 %	>16 %
Coding average comorbidities		3.32	3.49	3.48	3.56	3.50	3.75	3.75	4.00	3.92	4.38	4.36	4.37	4.41		No Threshold		

RESPONSIVE

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG		
Convenience and Choice: Slot Availability		95.4%	96.5%	100.0%	99.4%	92.1%	91.4%	91.5%	87.5%	78.0%	63.1%	66.8%	64.5%	64.7%		>=96 %	N/A	<96 %
IP Survey: % Received information enabling choices about their care	W	91.0%	92.4%	93.1%	95.1%	94.1%	94.1%	93.3%	89.7%	94.2%	98.6%	94.8%	97.9%	97.4%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	99.0%	99.4%	99.2%	99.5%	100.0%	100.0%	100.0%	100.0%	99.4%	99.3%	98.6%	97.9%	99.5%		100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge	D P	58.3%	54.8%	45.4%	56.7%	60.8%	55.9%	68.7%	75.0%	76.0%	85.0%	82.1%	82.8%	84.1%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	94.0%	91.7%	94.6%	91.6%	88.2%	91.2%	98.5%	92.2%	92.9%	98.6%	91.5%	95.8%	88.4%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D												92.7%	94.7%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D												69.4%	86.2%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	89.7%	90.2%	91.1%	89.9%	91.5%	92.7%	92.9%	92.5%	93.9%	94.6%	94.3%	94.7%	94.3%		>=92 %	>=90 %	<90 %
Waiting List Size	W	3,482	3,402	3,210	3,199	3,365	3,295	3,686	3,398	3,355	3,434	3,771	3,565	3,762		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		17	35	18	15	6	13	18	22	15	7	5	5	7		No Threshold		
Diagnostics: % Completed Within 6 Weeks	W	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%	99.7%	100.0%	99.6%	100.0%	100.0%	100.0%	99.8%		>=99 %	N/A	<99 %
Pathology - % Turnaround times for urgent requests < 1 hr		89.7%	92.3%	92.0%	90.3%	89.3%	89.5%	89.9%	89.4%	90.8%	92.4%	91.0%	92.7%	93.4%		>=90 %	>=85 %	<90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs		99.9%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	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%	99.0%	99.0%	99.0%		>=95 %	>=90 %	<95 %
Imaging - % Reporting Turnaround Times - ED		97.0%	89.0%	85.0%	94.0%	78.0%	83.0%	93.0%	88.0%	92.0%	75.0%	83.0%	94.0%	86.0%		>=90 %	>=85 %	<90 %
Imaging - % Reporting Turnaround Times - Inpatients		87.0%	87.0%	91.0%	87.0%	75.0%	80.0%	88.0%	82.0%	86.0%	84.0%	84.0%	88.0%	92.0%		>=90 %	>=85 %	<90 %
Imaging - % Reporting Turnaround Times - Outpatients		96.0%	98.0%	95.0%	98.0%	85.0%	87.0%	82.0%	92.0%	85.0%	88.0%	86.0%	96.0%	92.0%		>=85 %	N/A	<85 %
Imaging - Waiting Times - MRI % under 6 weeks		77.0%	72.0%	66.0%	77.0%	66.0%	71.0%	69.0%	78.0%	66.0%	67.0%	64.0%	63.0%	73.0%		>=95 %	>=90 %	<95 %
Imaging - Waiting Times - CT % under 1 week		81.0%	87.0%	85.0%	85.0%	89.0%	73.0%	89.0%	82.0%	89.0%	81.0%	82.0%	85.0%	87.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Plain Film % under 24 hours		92.0%	93.0%	93.0%	91.0%	91.0%	91.0%	92.0%	91.0%	92.0%	91.0%	92.0%	92.0%	92.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Ultrasound % under 2 weeks		82.0%	92.0%	87.0%	82.0%	90.0%	88.0%	84.0%	86.0%	81.0%	85.0%	78.0%	90.0%	86.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks		100.0%	100.0%	100.0%	88.0%	100.0%	100.0%	92.0%	88.0%	81.0%	100.0%	60.0%	78.0%	68.0%		>=95 %	>=90 %	<95 %

WELL LED

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	234	87	205	-120	20	71	-436	-245		-147	-298	-219	-310		No Threshold		
Income In Month Variance (£'000s)	W	606	533	545	116	581	25	50	418	416	-225	-298	86	79		No Threshold		
Pay In Month Variance (£'000s)	W	-37	-67	-54	-89	-37	-126	-212	-219	-247	-53	100	37	-79		No Threshold		
AvP: IP - Non-Elective	W										17	20	89	111		>=0	N/A	<0
AvP: IP Elective vs Plan	W										-30	-26	-30	-55		>=0	N/A	<0
AvP: OP New											134.61	-48.66	146.67	220.21		>=0	N/A	<0
AvP: OP FollowUp											-273.82	-470.12	-323.98	-187.73		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W										-6	-117	-154	-61		>=0	N/A	<0

Alder Hey Children's NHS
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Medicine

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		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
AvP: Outpatient Activity vs Plan	W										-139	-519	-177	32		>=0 N/A <0
PDR	W	67.2%	85.5%	88.6%	89.2%	89.2%	89.2%	89.2%	89.2%	89.2%	2.8%	14.1%	37.4%	83.8%		No Threshold
Medical Appraisal	W											100.0%	95.5%	98.4%		>=95 % >=90 % <90 %
Mandatory Training	W	91.3%	87.9%	87.6%	89.4%	90.4%	90.0%	91.0%	90.1%	90.7%	90.7%	89.7%	92.0%	91.2%		>=90 % >=80 % <80 %
Sickness	D	4.9%	4.3%	4.6%	4.6%	4.7%	5.1%	4.7%	4.5%	4.9%	4.4%	4.6%	4.4%	5.0%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.7%	1.3%	1.7%	1.7%	1.8%	1.7%	1.9%	1.9%	2.0%	1.6%	1.4%	1.1%	1.5%		<=1 % N/A >1 %
Long Term Sickness	D	3.3%	3.0%	2.8%	2.8%	3.0%	3.4%	2.8%	2.6%	2.9%	2.8%	3.1%	3.3%	3.5%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	209	229	201	189	242	175	219	297	326	270	271	263	247		No Threshold
Staff Turnover	D	11.7%	10.7%	10.4%	10.0%	9.5%	8.4%	8.3%	8.1%	8.8%	8.6%	9.1%	9.5%	9.5%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	99.0%	99.0%	98.0%	95.5%	97.5%	97.2%	96.0%	97.0%	103.2%	100.2%	101.0%	97.5%	97.8%		>=90 % >=80 % <90 %

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Medication Errors (Incidents)	38	46	49	38	43	35	39	38	42	42	56	48	32		No Threshold
Cleanliness Scores	95.4%	93.6%	94.9%	82.4%	95.2%	98.0%	97.3%	97.2%	98.0%	98.2%	97.7%		97.0%		>=90 % >=80 % <80 %
Clinical Incidents resulting in Near Miss (D)	31	34	34	33	42	30	30	38	35	29	33	26	62		No Threshold
Clinical Incidents resulting in No Harm (D)	126	154	151	129	135	101	142	102	141	143	138	169	132		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	39	36	47	61	57	43	40	49	57	47	70	40	41		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	1	0	0	0	0	0	2	1	0	0	0	2	3		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	1	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	2	3	2	0	3	2	2	2	1	2	0	3	1		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	0	1	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	83.3%	66.7%	71.4%	68.0%	63.6%	66.7%	62.5%		90.9%	75.0%	75.0%	100.0%	75.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	1	0		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI) (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile (D)	0	0	0	0	0	0	0	0	1	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA (D)	0	0	1	2	0	1	1	0	3	1	1	0	0		0 N/A >0

CARING

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Complaints (W)	5	3	1	1	1	0	1	1	3	0	0	1	6		No Threshold
PALS (W)	20	22	27	27	27	16	27	18	16	23	21	17	22		No Threshold

EFFECTIVE

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Readmissions to PICU within 48 hrs (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Referrals Received (Total)	4,249	3,380	3,241	3,679	3,808	2,842	3,661	3,768	3,998	3,691	4,051	3,730	4,093		No Threshold
Theatre Utilisation - % of Session Utilised (W)	90.4%	88.7%	86.9%	87.4%	88.2%	85.6%	89.4%	89.5%	90.6%	90.0%	90.0%	88.6%	90.1%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	32	14	12	26	34	21	7	8	11	8	23	14	35		No Threshold
28 Day Breaches (W)	5	5	1	0	5	6	4	0	1	0	0	1	2		0 N/A >0
Clinic Session Utilisation (With Community Paediatrics Only) (D P)	82.5%	83.3%	83.5%	82.5%	84.0%	82.2%	84.0%	85.8%	89.1%	87.8%	87.2%	86.9%	89.0%		>=90 % >=80 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	48	41	44	34	37	48	55	74	58	53	41	40	43		No Threshold
OP Appointments Cancelled by Hospital %	12.3%	12.6%	14.3%	13.5%	12.7%	13.4%	14.1%	14.4%	13.9%	13.6%	13.1%	13.0%	12.2%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	12.1%	13.0%	10.6%	11.7%	11.3%	13.1%	12.8%	11.8%	10.8%	11.9%	10.8%	9.2%	9.8%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	13.4%	14.6%	12.3%	11.6%	12.1%	15.0%	12.4%	11.7%	10.9%	11.4%	10.6%	10.5%	10.4%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	11.4%	12.2%	9.8%	11.8%	10.9%	12.3%	12.9%	11.8%	10.7%	12.1%	10.9%	8.7%	9.5%		<=14 % <=16 % >16 %
Coding average comorbidities	3.60	3.70	3.75	3.70	3.56	3.99	3.96	4.12	3.92	4.08	4.24	4.14	4.05		No Threshold
CCAD Cases	41	35	33	38	30	31	33	39	42	30	36	31	42		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG		
Convenience and Choice: Slot Availability		94.9%	96.6%	93.6%	86.3%	88.3%	80.4%	82.6%	90.6%	87.0%	80.0%	76.5%	90.0%	89.7%		>=96 %	N/A	<96 %
IP Survey: % Received information enabling choices about their care	W	96.6%	95.9%	98.0%	97.3%	95.6%	98.5%	97.7%	98.3%	96.8%	98.0%	97.9%	97.2%	97.7%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	100.0%	99.7%	99.6%	99.7%	100.0%	99.3%	100.0%	98.9%	99.5%	99.3%	99.3%	98.3%	99.0%		100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge	D P	69.5%	63.7%	60.6%	62.7%	73.2%	62.0%	81.3%	87.8%	83.8%	92.4%	85.6%	91.3%	90.1%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	95.1%	91.5%	95.1%	92.5%	94.3%	93.4%	95.0%	95.6%	93.7%	100.0%	89.7%	96.5%	92.4%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D												93.8%	94.4%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D												72.1%	68.9%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.9%	92.7%	93.1%	93.6%	94.1%	93.7%	93.1%	94.0%	94.0%	93.6%	94.0%	94.0%	93.8%		>=92 %	>=90 %	<90 %
Waiting List Size	W	8,573	8,549	8,704	8,650	8,400	8,320	7,923	8,221	8,129	8,165	7,712	7,939	7,765		No Threshold		
Waiting Greater than 52 weeks	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	89.5%	92.3%	100.0%	91.7%	100.0%	100.0%		>=99 %	N/A	<99 %

WELL LED

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	89	-45	-320	-25	-209	-253	-240	-470		-405	-63	282	-525		No Threshold		
Income In Month Variance (£'000s)	W	310	294	-285	449	131	47	-56	208	364	-372	159	370	53		No Threshold		
Pay In Month Variance (£'000s)	W	-41	-44	-69	-209	57	-2	-30	-407	-274	23	-7	-34	-165		No Threshold		
AvP: IP - Non-Elective	W										36	37	20	48		>=0	N/A	<0
AvP: IP Elective vs Plan	W										-15	2	-10	-23		>=0	N/A	<0
AvP: OP New											-65.91	-240.93	-284.00	-125.28		>=0	N/A	<0
AvP: OP FollowUp											412.69	81.90	727.71	621.55		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W										-46	-14	-87	16		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W										347	-159	444	496		>=0	N/A	<0
PDR	W	64.4%	83.6%	90.7%	90.0%	90.0%	90.0%	90.0%	96.6%	96.6%	11.6%	42.7%	74.4%	93.8%		No Threshold		
Medical Appraisal	W											100.0%	95.5%	98.4%		>=95 %	>=90 %	<90 %
Mandatory Training	W	90.3%	87.2%	87.8%	88.6%	87.8%	88.0%	90.0%	88.4%	89.4%	88.8%	87.3%	88.6%	89.3%		>=90 %	>=80 %	<80 %
Sickness	D	5.4%	5.6%	6.0%	6.5%	6.0%	6.4%	6.2%	6.4%	5.2%	5.2%	6.2%	6.6%	6.5%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.5%	1.4%	1.3%	1.7%	1.6%	1.9%	2.1%	2.0%	1.6%	1.5%	1.7%	1.6%	1.6%		<=1 %	N/A	>1 %
Long Term Sickness	D	4.0%	4.2%	4.7%	4.8%	4.4%	4.5%	4.1%	4.4%	3.6%	3.7%	4.5%	5.0%	4.9%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	445	509	374	529	485	484	474	564	591	515	505	461	527		No Threshold		
Staff Turnover	D	10.7%	10.3%	10.8%	10.7%	10.6%	9.8%	9.7%	9.9%	10.2%	10.4%	10.9%	11.2%	9.9%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	91.9%	90.1%	88.6%	91.3%	93.6%	91.9%	93.3%	89.3%	89.4%	91.9%	91.0%	89.1%	89.4%		>=90 %	>=80 %	<90 %

Community & Mental Health Division

SAFE	Incident reporting across the division remains high. In July the Division reported one moderate incident which was a grade 3 Pressure Ulcer. A 72 hour review was undertaken which highlighted the need to review the tissue viability service for patients in the community. This incident was reported via StEIS and Duty of Candour completed. An RCA level 2 has commenced.	**Highlight** • Zero Never Events reported • Roll out of Safety Huddles in Outpatients including use of visibility board to support staff in department to understand risks, incidents and safe staffing levels **Challenges** • Provision of tissue viability support to community services
CARING	The division is now receiving FFT information via Meridian system with the roll out of one terminal in the Catkin building.	**Highlight** • 100% of Reponses would recommend care delivered by Mental Health Team • Increase in responses to FFT in Outpatients • Reduction in the number of PALS related to communication and appointments (Community Paediatrics) **Challenges** • Theme of complaints in Community Paediatrics relating to delays in appointments. Developed a comprehensive project plan to support sustained improvements
EFFECTIVE	The complex care team have continued to support a reduction in the number of children who are in hospital over 21 days as well as reducing the number of children who have their discharge delayed for non-medical reasons. This improvement has contributed to a reduction in the number of children who have their admission cancelled on the day of surgery due to bed availability.	**Highlight** • QNIC accreditation for the Dewi Jones Unit • Successful CQC Mental Health Act inspection at DJU • Successful application to the Burdett Trust to host an additional Transition nurse post within the Trust **Challenges** • Review underway of divisional governance and audit assurance programme
RESPONSIVE	Improvements in use of Meditech across Community CAMHS services will support the division's ambition to improve access times through greater visibility of capacity and improved planning. Additional investment in services, Eating Disorders and Crisis Care, will also support improved access to services.	**Highlight** • Significant reduction in the number of children who have waited over 40 weeks to access Community Speech and Language therapy in Sefton **Challenges** • Clinic utilisation remains an area of concern and focussed efforts to improve clinic utilisation to above 90% continue across the division.

WELL LED	Mandatory training rates across the division remains above 90%. PDR compliance is at 87% with plans to achieve 90% by end of August. The Division was £11k behind plan at the end of June and £8k behind plan year to date.	**Highlight** • Improved sickness levels on Dewi Jones Unit – below Trust average • Divisional management development day in July. Focus on planning to achieve ambitions set out in NHS Long Term Plan and formulation of divisional 5 year strategy **Challenges** • Sickness levels in outpatients are above the Trust target and the division is reviewing the actions required to support improvements

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Medication Errors (Incidents)	1	8	7	8	5	4	10	9	5	10	6	3	5		No Threshold
Cleanliness Scores	94.5%	100.0%	94.0%	98.0%			100.0%					99.5%			No Threshold
Clinical Incidents resulting in Near Miss (D)	4	5	4	4	5	5	3	3	4	4	9	6	4		No Threshold
Clinical Incidents resulting in No Harm (D)	38	41	38	40	27	27	35	30	33	27	31	21	32		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	2	2	4	1	1	2	1	2	4	1	0	3	4		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	0	0	0	0	1		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
CCNS: Advanced Care Plan for children with life limiting condition	0												8		No Threshold
CCNS: Supported early discharges from hospital care	0														No Threshold
CCNS: Prescriptions	0														No Threshold

CARING

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

EFFECTIVE

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Referrals Received (Total)	1,079	667	694	980	1,066	768	904	970	1,080	890	1,014	893	966		No Threshold
Clinic Session Utilisation (With Community Paediatrics Only) (D P)	79.9%	80.7%	80.5%	82.7%	81.7%	77.9%	79.0%	81.0%	87.2%	83.4%	83.4%	83.3%	82.3%		>=90 % >=85 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	16	15	39	42	21	8	8	18	16	20	14	14	8		No Threshold
OP Appointments Cancelled by Hospital %	15.9%	22.9%	22.2%	17.5%	21.9%	23.2%	18.1%	21.3%	22.6%	20.3%	17.2%	19.1%	16.3%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts) (W)	14.7%	13.9%	9.9%	10.4%	9.3%	10.0%	13.9%	10.7%	9.9%	10.8%	11.6%	9.1%	11.1%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	13.6%	16.0%	13.1%	11.2%	14.0%	14.1%	14.0%	12.6%	11.5%	13.8%	12.7%	11.7%	12.5%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics	22.0%	26.8%	19.5%	18.2%	17.2%	16.5%	20.7%	18.0%	16.0%	15.1%	19.0%	14.1%	16.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics	13.4%	11.8%	13.2%	11.0%	15.9%	13.6%	14.1%	13.0%	8.7%	16.5%	12.4%	12.1%	11.0%		<=14 % <=16 % >16 %
CAMHS: % CHOICE Was Not Brought Rate	15.4%	8.7%	10.6%	7.3%	6.1%	11.5%	17.6%	12.6%	14.9%	16.7%	14.0%	12.7%	18.6%		No Threshold
CAMHS: % All Other Was Not Brought Rate	15.4%	19.5%	14.5%	12.8%	14.6%	15.7%	15.6%	13.8%	13.7%	14.1%	14.1%	12.7%	14.5%		No Threshold
CAMHS: Tier 4 DJU % Bed Occupancy At Midday	90.8%	85.7%	99.0%	93.5%	104.3%	100.0%	95.9%	88.8%	118.9%	115.7%	100.0%	91.4%	98.2%		No Threshold
CAMHS: Tier 4 DJU Bed Days	196	186	207	203	220	217	207	173	237	212	202	161	182		No Threshold
Coding average comorbidities	2.00	8.00	4.00	2.00	2.67		2.00	1.50	6.00	4.00	2.50	3.00	3.00		No Threshold
CCNS: Number of commissioned packages	0														No Threshold

RESPONSIVE

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

Community

D Drive W Watch P Programme

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
CAMHS: Referrals Received	354	193	262	370	410	297	332	351	402	325	344	308	327		No Threshold
CAMHS: Referrals Accepted By The Service	221	120	165	242	267	183	203	210	232	190	217	171	176		No Threshold
CAMHS: % Referrals Accepted By The Service	62.4%	62.2%	63.0%	65.4%	65.1%	61.6%	61.1%	59.8%	57.7%	58.5%	63.1%	55.5%	53.8%		No Threshold
Community Therapies Waiting Times - Maximum Weeks Waiting	43	43	45	45	46	50	50	51	54	102	106	110	115		No Threshold
Community Therapies Waiting Times - 92nd Percentile	83	85	86	54	56	102	102	58	61	120	77	111	72		No Threshold
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%	100.0%				100.0%	100.0%	100.0%	100.0%	100.0%		>=96 % N/A <96 %
RTT: Open Pathway: % Waiting within 18 Weeks W	92.2%	92.7%	87.3%	87.1%	78.8%	78.3%	82.7%	78.3%	74.2%	75.2%	74.9%	73.9%	76.4%		>=92 % >=90 % <90 %
Waiting List Size W	898	974	970	1,112	1,169	1,162	1,263	1,269	1,262	1,272	1,393	1,339	1,356		No Threshold
Waiting Greater than 52 weeks W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
CAMHS: 2 Appointments within 6 weeks	0	0	0	0	0	0									No Threshold
CAMHS: Crisis / Duty Call Activity	202	165	274	393	445	277	325	343	424	343	337	343	315		No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)-Liverpool Specialist	16.00	16.00	16.00	16.00	15.00	16.00	16.00	14.00	14.00	16.00	16.00	17.00	0.00		No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)-Sefton Specialist	30.00	31.00	9.00	24.00	30.00	18.00	35.00	28.00	24.00	17.00	20.00	0.00	0.00		No Threshold
ASD: Completed Pathways	79	80	68	58	40	22	49	57	65	56	52	82	35		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	68.4%	62.5%	61.8%	69.0%	65.0%	40.9%	34.7%	35.1%	55.4%	62.5%	21.2%	24.4%	11.4%		No Threshold
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as %) P	100.0%	93.8%	100.0%	100.0%	90.9%	90.9%	87.5%	100.0%	85.0%	75.0%	71.4%	66.7%	76.9%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as %) P	100.0%	100.0%		100.0%	100.0%		100.0%			40.0%	60.0%		50.0%		No Threshold
CAMHS: URGENT Choice 2wk Completed Wait within 92%					44.4%	36.8%	12.5%	29.6%	41.9%	27.3%	28.6%	24.2%	50.0%		No Threshold
CAMHS: URGENT First Partnership 4wk Completed Wait within 92%							33.3%	40.0%	15.8%	27.6%	18.2%	30.8%	36.0%		No Threshold
CAMHS: ROUTINE Choice 6wk Completed Wait within 92%	53.0%	30.2%	23.7%	34.3%	19.2%	12.0%	8.5%	5.4%	9.1%	19.4%	13.5%	14.0%	12.8%		No Threshold
CAMHS: ROUTINE First Partnership 12wks Completed Wait within 92%	50.0%						0.0%	6.2%	2.7%	23.1%	8.1%	9.1%	11.4%		No Threshold

WELL LED

	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s) W	51	-156	59	60	-65	115	-32	16		-59	71	-8	-11		No Threshold
Income In Month Variance (£'000s) W	39	-67	53	43	21	265	87	61	336	-111	177	36	-47		No Threshold
Pay In Month Variance (£'000s) W	13	-29	69	19	-15	-2	-151	-56	-304	183	-71	-64	2		No Threshold
AvP: OP New										-1.48	-7.08	-1.63	34.14		>=0 N/A <0
AvP: OP FollowUp										-10.87	57.99	323.17	232.03		>=0 N/A <0
AvP: Outpatient Activity vs Plan W										-12	51	322	266		>=0 N/A <0
PDR W	58.8%	78.7%	87.9%	93.0%	93.0%	93.0%	93.7%	93.7%	93.7%	1.4%	10.8%	48.6%	87.1%		No Threshold
Medical Appraisal W											100.0%	95.5%			No Threshold
Mandatory Training W	94.2%	92.7%	91.2%	92.5%	91.4%	90.9%	88.3%	89.2%	90.3%	92.2%	89.2%	90.2%	92.0%		>=90 % >=80 % <80 %
Sickness D	5.7%	5.3%	5.7%	5.4%	6.6%	7.6%	7.9%	7.5%	7.4%	6.7%	6.4%	4.9%	4.3%		<=4 % <=4.5 % >4.5 %
Short Term Sickness D	1.2%	0.8%	1.5%	1.3%	1.8%	1.6%	1.7%	1.5%	1.8%	1.4%	1.6%	1.2%	0.9%		<=1 % N/A >1 %
Long Term Sickness D	4.5%	4.5%	4.2%	4.1%	4.8%	6.0%	6.2%	6.0%	5.6%	5.3%	4.8%	3.7%	3.4%		<=3 % N/A >3 %
Temporary Spend ('000s) D	148	186	135	159	169	144	179	106	367	198	226	96	158		No Threshold

Community

D Drive W Watch P Programme

		Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Last 12 Months	RAG
Staff Turnover	D	12.9%	12.4%	12.7%	12.8%	13.0%	13.1%	12.2%	11.9%	12.8%	11.8%	11.7%	9.9%	10.2%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	101.0%	100.0%	105.0%	98.0%	99.0%	99.0%	97.0%	100.0%	106.0%	100.0%	102.0%	97.0%	87.0%		>=90 % >=80 % <90 %

NHS
Alder Hey Children's
NHS Foundation Trust

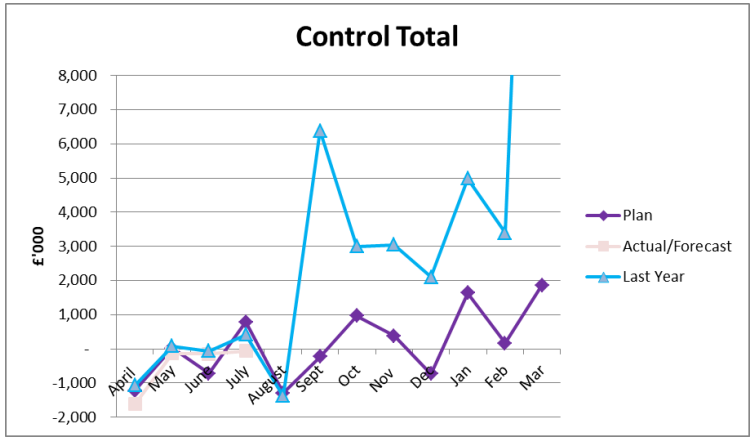
Financial Dashboard -M4 2019/20

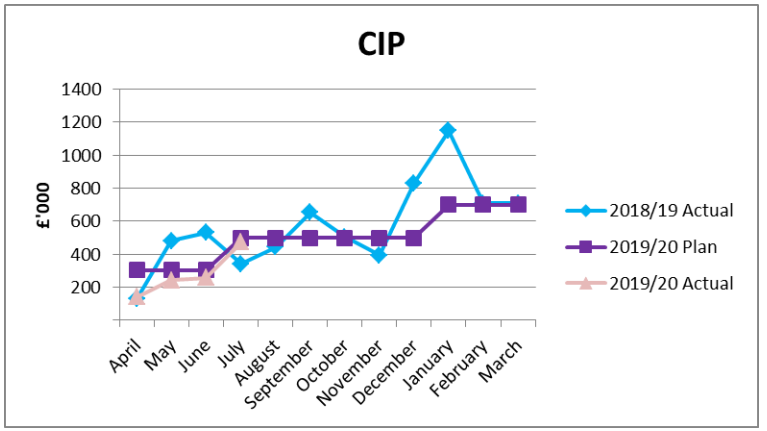
How Did We Do?

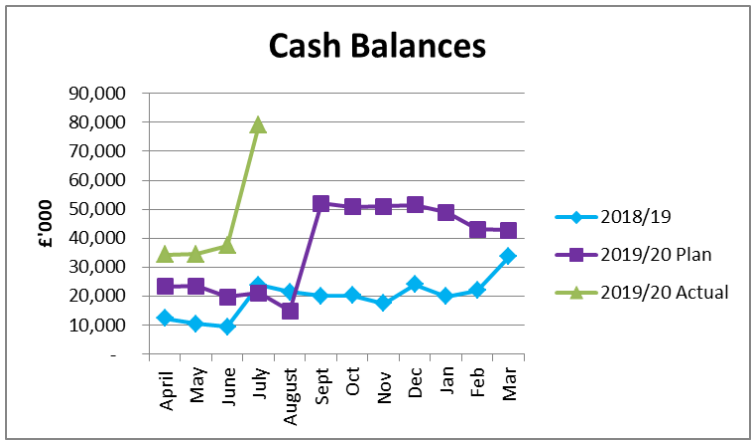
Executive Summary **Month: 4 Year: 2019**

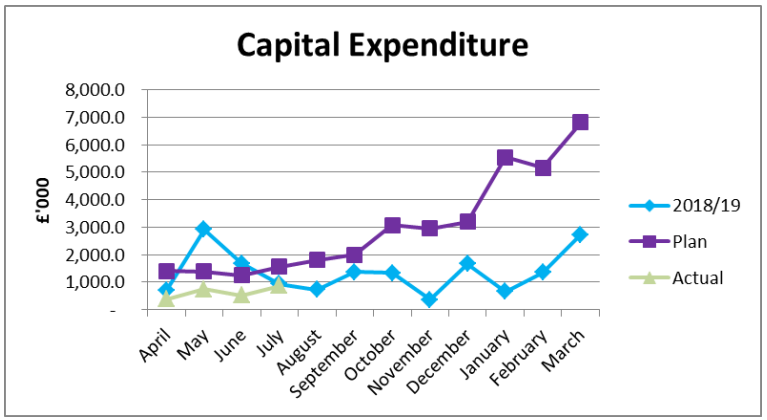
Alder Hey Children's NHS

Control Total in month	CIP Forecast for year	Use of Resources	Control Total Forecast
(£0.1m)	£3.9m	3	(£4.8m)
Not Achieved	Not Achieved	On Plan	Not Achieved

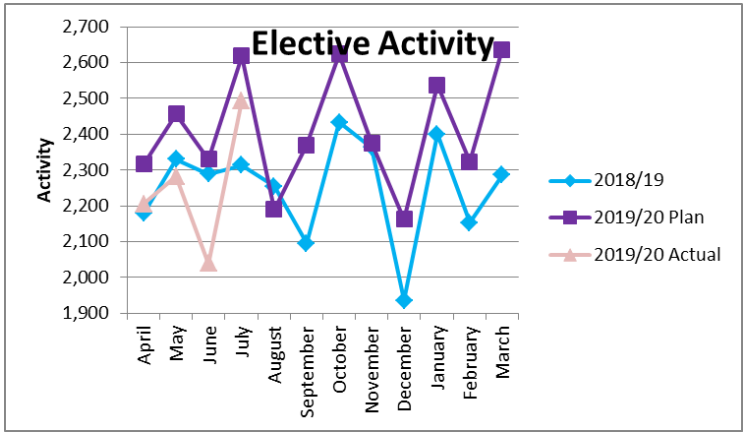


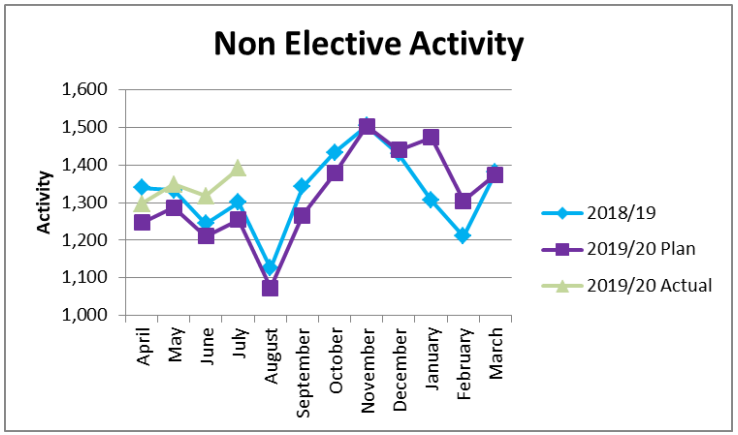


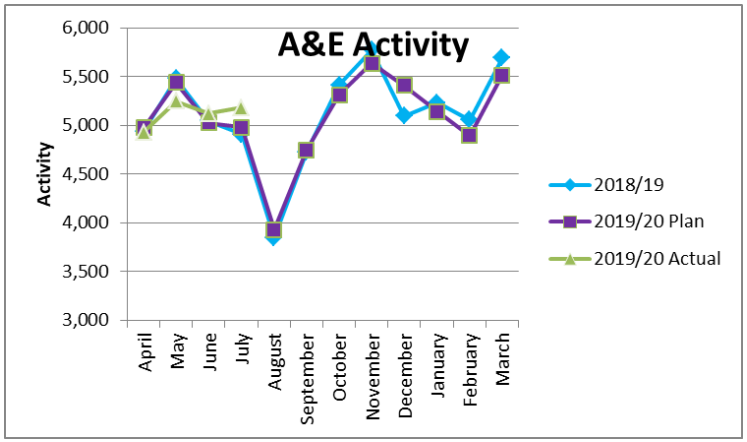


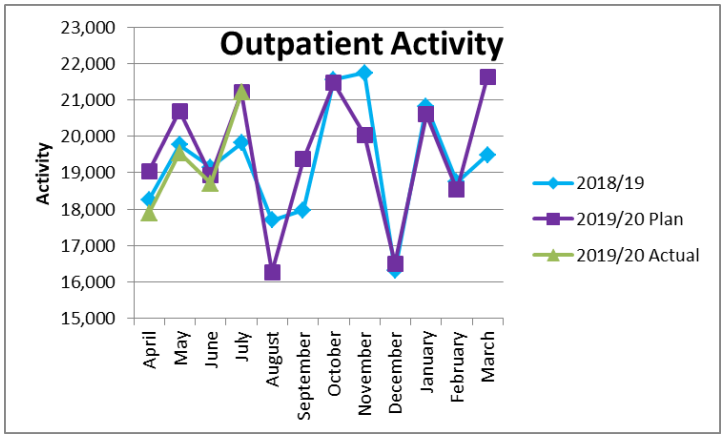


Elective Activity in Month	Non Elective Activity in Month	Outpatient Activity in Month	A&E Activity In Month
2,494	1,391	21,199	5,183
Not Achieved	Over Achieved	Over Achieved	Over Achieved









Surgery Division		
SAFE	SUI Data No Never events Hospital acquired infections Pressure ulcer data No Preventable deaths	**Highlight** • Hand hygiene Data • Anaesthetic Electronic Record Business case agreed • Sepsis response rate in May/June **Challenges** • CLABSI's • Medication Errors remain a theme • Water heater Cooler incident dating back to 2015
CARING	Data on Friends and Family Test PALS Responsiveness Complaints Responsiveness	**Highlight** • Gold accreditation retained in Surgical Day Care Unit **Challenges** •Governance infrastructure following loss of HoQ
EFFECTIVE	Mandatory Training improvements Structured Approach to the above – Resusc, IG and safeguarding The Division working together Workforce for junior doctors	**Highlight** • Recruitment into multiple teams – anaesthetics, orthopaedics, orthodontics and nursing • PDR Completion in excess of 90% • Mandatory Training 90% in August **Challenges** • IG remains a challenge

		• Medical workforce poor on some MT Metrics
RESPONSIVE	Clinic Utilisation on improving trend year on year 18 week RTT >92% Cancelled Ops better Cancelled Ops not rebooked in 28 days =0 Discharge by midday improved by 25% since last year	**Highlight** • Five Business cases approved with revenue of 0.7million • Response to business Continuity incidents x 6 • Cancelled Ops down by 59% in some metrics • Improved trauma pathway with EBC to SAL at weekends **Challenges** • Incidents are discussed at the weekly ward managers' meeting and informed discussions take place. Ward managers take learning back to their respective areas. RCA's and relevant learning from incidents is shared with Heads of Quality from other Divisions.
WELL LED	SIRI Action Log up to date Improved Overdue Risks reassessment – 2% Staff Engagement Time to Change programme nearly 50% booked by DoSC	**Highlight** • Financial Performance **Challenges** • Governance infrastructure following loss of HoQ • Financial Performance

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd September 2019

Paper Title:	19/20 Financial Recovery
Report of:	John Grinnell, Director of Finance
Paper Prepared by:	Alison Chew, Head of Operational Finance Claire Liddy, Deputy Director of Finance

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

1.0 Introduction

The purpose of this paper is to provide a briefing to the Trust Board on the following:

- 2019/20 current forecast gap against control total
- 2019/20 Recovery Approach

2.0 2019/20 Forecast - Current position

At the end of July 2019 the divisions submitted financial forecasts which did not deliver against the £1.6m control total and resulted in a year end gap, after mitigation, of £4.3m. The main reasons for this gap are:

Reason:	£'000
CIP Underachievement	2,100
Medical Pay Award	1,100
Non Pay Including Energy, Postage, clinical supplies in theatres	1,100
Total	**4,300**

The following table provides details of this gap by division:

Division	Control Total £'000	Month 4 FY Forecast £'000	Month 4 FY Variance £'000
COMMUNITY	1,417	1,060	-358
MEDICINE	9,282	7,615	-1667
SURGICAL CARE	39,106	37,874	-1232
ALDER HEY IN THE PARK	(7,181)	(8,562)	-1381
EXECUTIVE	(3,641)	(3,678)	-36
FACILITIES	(4,688)	(5,443)	-755
FINANCE	(4,096)	(4,075)	21
HUMAN RESOURCES	(2,961)	(3,111)	-150
IM&T	(3,482)	(3,503)	-21
NURSING & QUALITY	(3,052)	(3,560)	-507
ACADEMY	149	(53)	-201
INNOVATION	(298)	(298)	
INTERNATIONAL	7	(168)	-175
RESEARCH & DEVELOPMENT	617	292	-325
Divisional Total	**21,176**	**14,389**	**(6,787)**
OTHER	(19,548)	(19,209)	338
Control Total:	**1,628**	**(4,821)**	**(6,449)**
Mitigation	0	2,149	2149
Mitigated Control Total	**1,628**	**(2,672)**	**(4,300)**

The implications of the Trust not delivering the control total are the loss of PSF funding of up to £3.4m which would impact on the cash available to the Trust to invest in the capital programme.

3.0 2019/20 Recovery Approach

The Executive Team have agreed a recovery approach. This approach will aim to recover £5m to provide some head room for slippage on schemes. 5 individual work-streams have been agreed each led by an Executive with the support of a Project Manager, Accountants and the appropriate specialist staff in that area. It is estimated that the 5 work-streams will achieve 50% of the required recovery (£2.5m) with the remaining £2.5m being recovered through Divisional improvements. Details of the recovery work-streams are below:

Work stream	Executive Lead
Improving Access to Care	Adam Bateman/John Grinnell
Pay	Melissa Swindell
Energy/Rates	John Grinnell
Printing/Postage	Kate Warriner
Meds on Discharge/Waste/Testing	Nicky Murdoch/ Adrian Hughes

The Sustainability Delivery Group (SDG) as a governance structure will continue on a weekly basis and will monitor the progress of the recovery reporting weekly back to the Executive Team.

4.0 Finance Communication Plan

In order to support the financial recovery process a communication plan is being developed to engage with staff to create a shared understanding how financial control supports delivery of Outstanding Care. Key elements of the communication plan are:

- **Financial awareness**:
  - Branding of the financial approach – focussed on quality of care as end result, synced with wider Alder Hey 'Futures' strategy
  - Workshops for whole trust on Alder Hey Finance
  - Monthly info graphic to be shared on trust financial position
  - Walk around by finance department to all areas
- **Building capability and capacity for staff:**
  - Financial training
  - Understanding money flows
  - Focus on productivity and efficiency

5.0 Recommendation

The Trust Board is requested to note the actions being taken to recover the financial position and ensure the Trust achieves its Control Total surplus and qualifies for PSF funding.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3 September 2019

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

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

Board Assurance Framework 2019/20

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's operational plan are being proactively managed.

2. Review of the BAF

The diagram below gives a high level heliview of the current version, followed by a summary and a brief on the changes since the last Board meeting. The full document is included as Appendix A.

BAF Risk Register - Overview at 27 August 2019

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

3. Summary of BAF - at 27 August 2019

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

Ref, Owner	Risk Title		Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 HG	**Achievement of outstanding quality for children and young people**		3-3	2-2	STATIC	STATIC
1.2 ES	**Achievement of national and local mandatory & compliance standards**		3-2	3-2	STATIC	STATIC
1.3 JG	**New Hospital Environment**		4-4	4-2	STATIC	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**		3-3	3-3	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability**		3-3	3-2	STATIC	STATIC
2.2 MS	**Staff Engagement**		3-3	3-1	STATIC	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**		3-4	3-1	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**		3-3	3-2	STATIC	STATIC
3.2 DJ	**Service Sustainability & Growth**		4-3	4-2	STATIC	STATIC
3.4 JG	**Financial Environment**		4-4	4-3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation						
4.1 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 2 July 2019 Board meeting

External risks

- ***Service Sustainability and Growth (DJ)***
  Risk reviewed - no changes to report during the month of August.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Risk reviewed, all actions remain on track, no change in risk score.

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***
  Risk reviewed - no change to score. Regional workshop being held at the beginning of Sept when the Trust will be briefed on next steps and requirements. Internal Brexit Group re-established and is meeting bi-weekly.

Internal risks:

- ***Achievement of National and Local Mandatory & Compliance Standards (ES)***
  Risk reviewed - no change to score. All actions remain on track. Challenges remain within ED, an improvement plan is being implemented along with changes to some clinical pathways. We are actively recruiting nursing and medical staff to increase resilience in readiness for Winter.

- ***Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations (HG)***
  Risk Reviewed for the month of August. No change to score in-month. CQC Programme of work 'From Good to Outstanding' remains on track for September 2019 roll-out. Terms of Reference for MIAA support agreed.

- ***Financial Environment (JG)***
  Risk reviewed. Executive led recovery process now implemented aiming to recover £5m by end of financial year. 5 workstreams identified led by Execs with appropriate DMO, finance and Divisional support. Approx. half of £5m has been identified from workstreams and remainder will be targeted through divisional recovery. Process being managed weekly by both SDG and Execs.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Risk reviewed post Campus Steering Group - no changes to report during the month of August. All actions remain on track.

- ***Digital Strategic Development and Operational Delivery (KW)***
  Strategy approved by Trust Board July 2019. Mobilisation plans in development. New governance arrangements to be established from September. Programmes redefined on Trust Change programme to reflect strategy developments. Options appraisal for IT resilience commenced, interim disaster recovery arrangements scoped. Service development in progress.

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

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

- ***New Hospital Environment (JG)***
  Risk reviewed for the month of August - score remains static. Business continuity led by COO in relation to water ingress continues. Actions continue to be progresses regarding pipework replacement strategy.

- ***Research, Education & Innovation (CL)***
  Risk reviewed, no change to score in-month.

Erica Saunders
Director of Corporate Affairs
September 2019

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations.		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Hilda Gwilliams	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Risk Description

Not having sufficiently robust, clear governance systems and processes and people in place supported by the expected culture and values that underpin learning for improvement

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

Gaps in Controls / Assurance

CQC regulation ratings.

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	30/08/2019	Assurance Committee (CQAC) received final version of action plan with agreement to develop and implement a bespoke trust wide programme of work ensuring CQC organisational readiness is embedded and monitored.
Implement a bespoke trust wide programme of work in relation to CQC organisational readiness	16/12/2019	Programme in development with MIAA support

Executive Leads Assessment

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

August 2019 - Hilda Gwilliams Risk reviewed. No change to score in-month.
June 2019 - Philip O'Connor Staffing Paper remains on schedule for presentation at Trust Board 2nd July 2019. Recruitment event held on 15th June; secured 57 new starters.
May 2019 - Pauline Brown Nurse staffing paper presented at WOD on 3rd May providing significant assurance related to safe and appropriate front line nurse staffing levels. Positive feedback received from WOD. Paper to be presented to CCG at CQPG on 24th May and Trust Board on 2nd July. Significant assurance given by MIAA following audit of ward Accreditation process. Programme of annual nursing audit and Matron audits devised and commenced to monitor key elements of the quality of care delivered

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Achievement of national and local mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Erica Saunders	Type: Internal, Known	Current IxL: 3x2	Target IxL: 3x2	Trend: STATIC

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.	- NHSI quality concern rating - CQC rating - Compliance assessment against NHSI Provider License to Board - NHSI quarterly review meeting
Compliance tracked through the corporate report and Divisional Dashboards.	Refresh of Corporate Report undertaken for 2018/19. Monthly reporting to the Board via the Corporate Report
Risks to delivery addressed through Operational Board, RBD, CQAC, WOD, IGC & CQSG and then through to Board	Regular reporting of delivery against compliance targets through assurance committees and board
Early Warning indicators now in place	Business Intelligence Portal (Infofox) & daily monitoring report used as a source of intelligence and to highlight performance concerns
Operational Delivery Board taking action to resolve performance issues as they emerge	Ops Board Meetings continue on the last Thursday of every month - any issue fully minuted
Emergency Preparedness meetings continue to take place every 2 months which reports into IGC	Emergency Preparedness meetings continue to take place every 2 months which reports into IGC. EP Reports to IGC
Divisional Executive Review Meetings taking place monthly with 'three at the top'	Divisional/Executive performance reviews
Weekly performance meetings in place to track progress	
6 weekly meetings with commissioners (CQPG)	Meetings continue into 2019/20. ToRs attached
Divisional leadership structure to implement and embed clinically led services	Devolved governance structure model
Weekly Exec Comm Cell overseeing key operational issues and blockages.	Planned to continue during 2019/20 (held every Monday AM)

Gaps in Controls / Assurance

1. Critical Care bed capacity
2. Some areas remain fragile e.g. ED 4 hour target.
3. Assurance required to underpin Divisional reporting on CQC standards
4. Work with CCG to manage demand & develop / fully utilise existing capacity across PC
5. Proactive management of patient flow making better use of trend analysis data

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Undertake capacity & demand modelling for the surgical wards	31/03/2020	Modelling completed for the winter period. Best in Operative Care Steering Group now progressing annual plan based on bed occupancy
2. In order to sustain high performance a task & finish group established for designing the optimal assessment unit models, and appointment based consultations for non-urgent patients.	30/09/2019	ED Workforce Plan in place to address performance. Following a visit to the RLBHT changes have been implemented to Triage and there is a scheduled visit to the Sheffield in July. Workforce review is in progress.
3. Programme of work to be developed 'from Good to outstanding' - Road map to understanding presentation to be prepared for executives - Present road map to executives for approval of direction of travel - Identify project leads and arrange schedule of meetings - Development Project plan. - Briefing CQC readiness presentation to be developed for Divisions . - Arrange presentation to Divisions multidisciplinary teams - Present CQC readiness presentation. - Development CQC evidence template for Divisions. - Approval of evidence template from executives - Guidance document for evidence to be developed. - Approval of guidance document - Circulate template and guidance to Triumvirate to	31/10/2019	29/07/2019 entered by Cathy Umbers Briefing prepared for Divisions . Presented to Division of Surgery 18th July 2019. Plan to present to Division of Surgery and Division of Community by September 2019. Gap analysis template in process of development - plan to submit to Director of Corporate Affairs August 2019 and onwards to Divisions to complete. Date Extended to October 2019

- Commence evidence gathering - Monitor evidence submission - Evidence Quality check. - Present outcome of evidence profile - Trust readiness Present readiness profile.		
5. Continue to monitor theatre schedule, discharge planning and capacity & demand modelling through: SAFER Project Group Best in Operative Care Steering Group Clinical Utilisation Review Best in Acute Care Programme	31/03/2020	Programme Assurance continues to be monitored monthly through Clinical Quality Assurance Committee
Executive Leads Assessment		
August 2019 - Erica Saunders Risk reviewed - no change to score. All actions remain on track. Challenges remain within ED, an improvement plan is being implemented along with changes to some clinical pathways. We are actively recruiting nursing and medical staff to increase resilience in readiness for Winter.		
July 2019 - Cathy Umbers Action 7628 reviewed and revised to reflect the sequence of actions required to prevent the risk in terms of preparedness for CQC inspection		
June 2019 - Erica Saunders Risk Reviewed. ED performance worsened over two consecutive months - actions updated to reflect work ongoing to address.		

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.3	Strategic Objective: Delivery Of Outstanding Care		Risk Title: New Hospital Environment		
Related CQC Themes: Safe			Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell	Type: Internal, New		Current IxL: 4x4	Target IxL: 4x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

Pipes - awaiting non-destructive testing outcome to assess levels of degradation across the whole site
Water Ingress - awaiting long term resolution from Project-Co

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Plan for management of pipework to be agreed	30/09/2019	Meeting planned early Sept to receive firm plans from Project Co
Prepare recommendation to Board on proposed pipework replacement strategy	01/10/2019	Paper being prepared for October 2019 Board
Agree a Strategy for ensuring roofing structure is water-tight	30/09/2019	

Executive Leads Assessment

August 2019 - John Grinnell
Risk reviewed - no change to score in-month. Key focus on pipework actions -overall rating unlikely to change until actions complete October 2019.
Focus on water ingress in ICU - business continuity being led by COO

June 2019 - David Powell
Risk reviewed, no change to score in-month. Key focus on pipework actions - overall rating unlikely to change until actions complete October 2019

May 2019 - David Powell
Written to Project Co. to get an updated plan for pipework, response due by end of May 2019

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.4	Strategic Objective: Delivery Of Outstanding Care		Risk Title: Sustaining operational delivery in the event of a 'No Deal' exit from the European Union		
Related CQC Themes: Safe, Effective, Responsive			Link to Corporate risk/s: No Risks Linked		
Exec Lead: John Grinnell	Type: External,		Current IxL: 3x3	Target IxL: 3x3	Trend: STATIC

Risk Description

Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisation's ability to deliver services safely and maintain business continuity.

Existing Control Measures	Assurance Evidence (attach on system)
National NHS EU coordination centre established to oversee planning and provide support to local teams to resolve escalating issues. Internal team in place to implement operational guidance.	Internal team meets weekly; work stream leads identified; risk assessments undertaken.
Internal command team structure focusing on eight key areas each week to assess level of risk and update plans based on national information. Group responds to national guidance as it is published.	Weekly report to Executive team to address deficits and escalate as required

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Continuing to refine oversight arrangements and associated resources ahead of 31st October 2019 deadline	17/10/2019	Update report going to Board on 3 September to provide assurance in relation to business continuity plans
Continue to engage and lobby NHSE colleagues to ensure centrally managed mitigations are understood and adequate	31/10/2019	The Trust is in a position to respond to this and have alternatives in place for the identified high risk areas

Executive Leads Assessment

August 2019 - John Grinnell
Risk reviewed, current score remains. Business continuity plans continue to evolve as required

June 2019 - John Grinnell
Risk reviewed - current score adequate. Further review of arrangements to take place post election when we expect to receive further national guidance.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 2.1	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Sustainability		
Related CQC Themes: Safe, Effective, Responsive, Well Led, Well Led, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Risk Description

Failure to deliver consistent, high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place, at the right time.

Existing Control Measures	Assurance Evidence (attach on system)
Workforce KPIs tracked through the corporate report and divisional dashboards	Corporate Report and KPI Report to WOD
Bi-monthly Divisional Performance Meetings.	Regular reporting of delivery against compliance targets via divisional reports
Mandatory training fully reviewed in 2017, with a new system of reporting linked to competencies on ESR; enabling better quality reporting.	- Monthly reporting to the Board via the Corporate Report - Reporting at ward level which supports Ward to Board
Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.	ESR self-service rolled out
Permanent nurse staffing pool	Large-scale nurse recruitment event 4 times per year
HR Workforce Policies developed in partnership with staff side	All Trust Policies available for staff to access on intratet
Attendance management process to reduce short & long term absence	Sickness Absence Policy
Wellbeing Steering Group established	Wellbeing Steering Group Terms of Reference
Training Needs Analysis linked to CPD requirements	New Learning and & development Prospectus Launched - June 2019
Apprenticeship Strategy implemented	Bi-monthly reports to WOD and associated minutes
Engaged in pre-employment programmes with local job centres to support supply routes	Bi-monthly reports to WOD and associated minutes
Engagement with HEENW in support of new role development	Reporting to HEE
People Strategy	People Strategy report monthly to Board

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	31/08/2019	good work progresses - over 90% mandatory training across the trust with some hotspot areas still in development.
2. Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. Target is 4% absence rates across the organisation.	31/03/2020	
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	30/09/2019	Progress delayed. Looking to have in place for September 2019.

Executive Leads Assessment

August 2019 - Sharon Owen
Risk reviewed, all actions remain on track, risk score remains the same.

July 2019 - Melissa Swindell
Risk reviewed. No change in risk score. Action regarding workforce planning requires further focus and progression.

June 2019 - Melissa Swindell
Risk reviewed. All actions remain on track; no change in risk score.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 2.2	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x1	Trend: STATIC

Risk Description
Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims.

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

Gaps in Controls / Assurance
Internal Communications Strategy and Plan

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Brand paper taken to March Ops Board and detailed implementation now under way	31/03/2020	

Executive Leads Assessment
August 2019 - Sharon Owen Risk reviewed, actions remain on track, risk rating remains the same.
July 2019 - Melissa Swindell Risk reviewed. Actions on track.
June 2019 - Melissa Swindell Risk reviewed - removed gap in control relating to Leadership Strategy as this was implemented Oct 2018. No change in risk score. All other actions remain on track.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 2.3	Strategic Objective: The Best People Doing Their Best Work	Risk Title: Workforce Equality, Diversity & Inclusion		
Related CQC Themes: Well Led, Effective		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Melissa Swindell	Type: External, Known	Current IxL: 3x4	Target IxL: 3x1	Trend: STATIC

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Wellbeing Strategy	monitored through WOD
WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.	- Bi-monthly reporting to Board via WOD on diversity and inclusion issues - Monthly Corporate Report (including workforce KPIs) to the Board
Wellbeing Steering Group	Wellbeing Steering Group ToRs
Staff Survey results analysed by protected characteristics and actions taken by E&D Lead.	monitored through WOD
HR Workforce Policies	HR Workforce Policies (held on intranet for staff to access)
Equality Analysis Policy	- Equality Impact Assessments undertaken for every policy & project - EDS Publication
Equality, Diversity & Human Rights Policy	- Equality Impact Assessments undertaken for every policy & project - Equality Objectives
BME Network established, sponsored by Director of HR & OD	BME Network minutes
Disability Network established, sponsored by Director of HR & OD	Disability Network minutes
Actions taken in response to the WRES	-Monthly recruitment reports provided by HR to divisions -Workforce Race Equality Standards - Bi-monthly report to WOD
Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	Diversity and Inclusion Action Plan reported to Board
LGBTQ+ Network established	Taking forward actions for LiA - enabling achievement of a more inclusive culture. Monthly network meetings established.
Time to Change Plan	Time to Change Plan

Gaps in Controls / Assurance

1. Workforce not representative of the local community
2. BME and disabled staff reporting lower levels of satisfaction in the Staff Survey than non-BME other staff

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Work with the BME and Disability Networks to develop specific action plans to improve experience.	30/09/2019	Time to Change Plan agreed - implementation planned for Sept 2019
1. Work with Community Engagement expert to develop actions to work with local community	30/09/2019	On track for September 19

Executive Leads Assessment

August 2019 - Melissa Swindell
Risk reviewed. All actions remain on track; no change in risk score

June 2019 - Melissa Swindell
Risk reviewed. All actions remain on track; no change in risk score.

May 2019 - Sharon Owen
All actions on track

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 3.1	Strategic Objective: Sustainability Through External Partnerships		Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led			Link to Corporate risk/s: No Risks Linked		
Exec Lead: David Powell	Type: Internal, Known		Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Heads of Terms agreed with LCC for joint venture approved	
Redevelopment Steering Group	Reports into Programme Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Secure approval for plans to increase Park footprint	12/11/2019	Planning for Park extension submitted 31/07/2018
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	31/12/2019	On hold-Dependent upon residential scheme (revised target date no April 2018)
Procure works for stage 1 park reinstatement	30/09/2019	
Complete cost plan for final park works	30/09/2019	
assessment of status including risk of all development projects	31/10/2019	
Complete cost assessment and scheme rationalisation	30/09/2019	
Secure planning	31/10/2019	

Executive Leads Assessment

August 2019 - David Powell
Monthly review prior to Campus Steering Group

June 2019 - David Powell
Risk reviewed, no change to score in-month. Risk profile to be reassessed on completion of cost plan work.

May 2019 - David Powell
Park planning application in consultation

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 3.2	Strategic Objective: Sustainability Through External Partnerships	Risk Title: Service sustainability and Growth.		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Dani Jones	Type: External, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

Risk Description

Risk to service sustainability development/growth; due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities. External opportunities for partnership, and/or to reduce variation in Children & Young People's services (across the city and beyond) may not be fully optimised.

Existing Control Measures	Assurance Evidence (attach on system)
Divisional Performance Management Framework - 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.	Growth through Partnerships included in Strategic Business planning - both annual operational plan and the developing long term / strategic plan Monitored at Programme Board and via Strategy & Ops Delivery Board
Gap / risk analysis against all national service specification undertaken and action plans developed	Annual assessment against all service specifications led through quality team; SDIPs put in place in agreement with commissioners as a result to reach compliance.
Compliance with Neonatal Standards	Single Neonatal Services Business Case approved by NHS England.
Alder Hey working in partnership with Manchester Children's to ensure collaboration/sustainability where appropriate	MOU with Manchester approved at Trust Board July 19. Work plan governed via NW Partnership Board (quarterly)

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Strengthening the paediatric workforce	31/03/2020	6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'. In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements.

Executive Leads Assessment

August 2019 - Dani Jones
Reviewed the risk, considered the score. Added assurance evidence to several control measures.

June 2019 - Dani Jones
Reviewed the risk. Considered the score. Updated historical control measure actions. Removed 2 x historical/outdated control measures (trauma business case, 7 day working project)

May 2019 - Dani Jones
Controls, actions and exec assessment update

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Five Year capital plan	27/09/2019	5 year plan development continuing and funding gap reduced but not yet fully closed. Progress to be reported to Sept Board and 5 year plan to be submitted to NHSI end of Sept.
1. Tracking actions from Sustainability Delivery Group	30/09/2019	on target
2. Develop fully worked up CIP programme - £2.7m gap	30/09/2019	CIP continues to be managed weekly at SDG. Links with financial recovery and 6 workstreams which will also improve CIP position

Executive Leads Assessment

August 2019 - Alison Chew
Risk reviewed. This remains high risk. Divisional recovery plan implemented and managed weekly at SDG and Execs. Capital affordability still a challenge but progress being made.

June 2019 - John Grinnell
Risk reviewed. Given current divisional forecast and capital affordability challenges this remains a high risk, therefore no change in score.

May 2019 - Claire Liddy
Month 1 19/20 delivered a £0.4m adverse variance. Total run rate risk including CIP risk is £8m which is being mitigated through robust forward look and CiP planning exercise. Longer term risks include HRGv4+ Children's Tariff risk which transitions to £7m downside per annum. Capital 5 year planning exercise underway and will conclude in Q2, latest forecast present a cash affordability concern that is being validated.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Develop a robust Academy Business Model	30/09/2019	Framework refresh
Agree incentivisation framework for staff and teams	01/12/2019	
Complete contract with University of Liverpool	19/12/2019	Plans, data and costs now exchanged but final agreement still to be reached. Longstop date Dec 2019, but conclusion expected before this; timescale therefore revised.
Complete review and implement new structures and framework for research, innovation & education	01/10/2019	

Executive Leads Assessment

August 2019 - Jason Taylor
New Clinical Research Division delivery plan agreed 04.07.19

June 2019 - David Powell
Risk reviewed, no change to score in-month

May 2019 - David Powell
Considering structure and relationship between innovation and research

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 4.2	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Digital Strategic Development and Operational Delivery		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Kate Warriner	Type: Internal, Known	Current IxL: 4x3	Target IxL: 3x2	Trend: STATIC

Risk Description

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

Existing Control Measures	Assurance Evidence (attach on system)
Key projects and progress tracked through the GDE Programme Board and RABD Committee	Regular progress reports presented to RABD & Trust Board
Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development	
Improvement scheduled training provision including refresher training and workshops to address data quality issues	Working towards Informatics Skills and Development Accreditation (Aug 2019). Training improvements identified through refreshed Digital Strategy
Formal change control processes now in place	Board agreed change process
Executive level CIO in place	Commenced in post April 2019
Monthly update to Trust Board on digital developments	Board agendas, reports and minutes
GDE Programme Board in place & fully resourced - Chaired by Medical Director	GDE Programme Board tracking delivery
Clinical and Divisional Engagement in Digital Strategy	Implementation of fortnightly huddle with divisions. Divisional CCIOs in the process of being recruited. Community Division - commenced in post June 2019
NHSE & NHS Digital external oversight of GDE programme	NHSD tracking of GDE Programme through attendance at Programme Board and bi-monthly assurance reports.
A plan is now in place to develop new strategy and roadmap to present to Board in Summer 2019	Digital Strategy scheduled to be presented at Trust Board July 2019

Gaps in Controls / Assurance

1. IM&T Strategy - new digital strategy approved by Trust Board July 2019
2. Resilience of underlying infrastructure - options appraisal for disaster recovery to be undertaken
3. IT operating model assessment underway
4. Lack of secondary data centre / disaster recovery - options appraisal in development

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Digital Strategy & operating model work to be concluded	01/10/2019	New strategy governance arrangements to be established from September. Priority programmes identified and agreed. Organisational development programme underway.
4. Develop options appraisal	09/09/2019	Options understood, investment requirement identified, interim options scoped.
3. Undertake baseline assessment.	02/09/2019	Organisational development programme underway, skills gaps and processes being progressed, new operating model in development.
2. Procure replacement equipment	02/09/2019	Options understood, investment requirement identified, interim options scoped.

Executive Leads Assessment

August 2019 - Kate Warriner
Strategy approved by Trust Board July 2019. Mobilisation plans in development. New governance arrangements to be established from September. Programmes redefined on Trust Change programme to reflect strategy developments. Options appraisal for IT resilience commenced, interim disaster recovery arrangements scoped. Service development in progress.

July 2019 - Kate Warriner
Strategy approved by Trust Board July 2019. Mobilisation plans in development. Options appraisal for IT resilience commenced.

June 2019 - Kate Warriner
Strategy remains on track for July Board including technology road map. Baseline assessment on operating model complete. Options appraisal for disaster recovery commissioned.

Alder Hey Children's NHS
NHS Foundation Trust

RM58 – BOARD ASSURANCE FRAMEWORK POLICY

Version:	5
Name of ratifying committee:	Board of Directors
Date ratified:	03/10/2019
Name of originator/author:	Director of Corporate Affairs
Name of approval committee:	Integrated Governance Committee
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Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
5	September 2019	Director of Corporate Affairs	Current	
4	January 2018	Director of Corporate Affairs	Archived	
3	September 2016	Director of Corporate Affairs	Archived	
2	July 2015	Director of Corporate Affairs	Archived	
1	July 2014	Director of Corporate Affairs	Archived	

Record of changes made to Board Assurance Framework Policy – Version 4			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
		•	
4.5	8	It will provide an updated BAF and summary of the corporate risk register on a bi-annual basis and also an extract of the relevant risks to the other board committees.	Change in reporting
Various	Various	Updated to reflect risk registers also held at ward level	Updated to reflect risk registers also held at ward level

Contents

1 Introduction

A Board Assurance Framework (hereafter referred to as the BAF) must be driven by the objectives of the organisation. Therefore it follows that clear strategic and operational objectives need to be identified before an effective system of internal control can be established. Without clear objectives, the Trust would be unable to identify and evaluate the risks that threaten the achievement of its goals and design and operate a system of internal control to manage those risks. The corporate objectives for the Trust are determined by the Board of Directors, based on organisational, local and national priorities, stated in the Trust's operational plan and other related documents. The BAF enables the Board to demonstrate that it has been properly informed about the totality of its risks and is able to sign the Annual Governance Statement required annually by NHS Improvement.

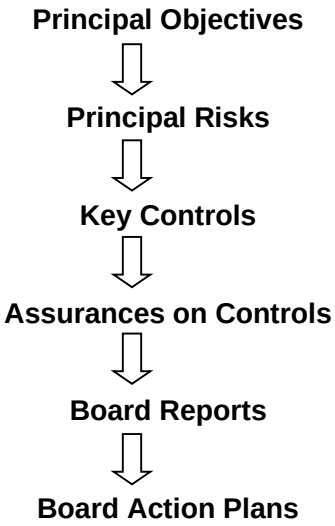
The BAF must be a dynamic tool to enable the Board to assure itself that all significant strategic risks are being managed effectively. The elements involved in this assurance process are:

- The BAF must be reviewed and updated with progress towards closing the identified risks and associated gaps in control and/or assurance at least quarterly.
- Independent scrutiny must take place to ensure that these updates are valid.
- Both of these processes must also consider whether new risks have arisen with the potential to jeopardise the achievement of the Trust's principal strategic objectives.

2 Purpose of Policy

The purpose of this policy is to set out the key structures, systems and processes by which the Board of Directors is assured, via the BAF and the underpinning risk registers that the Trust's strategic and operational objectives are being achieved through the effective management of the strategic and operational risks. See Fig.1 below.

The Board Assurance Framework



3 Duties and Responsibilities

3.1 Board of Directors

- It is the duty of Board members to ensure that they monitor the Trust's significant risks as detailed in the corporate risk register and that those corporate risks link into the high level risks on the BAF, that relate to specific strategic objectives and the associated controls and assurances in line with the work plan. In particular, the Board should focus upon progress by exception of action plans to address gaps in control and assurance.
- The Board should ensure that all systems, processes and procedures required for the BAF function effectively, including where elements have been delegated to Committees.

3.2 Board Committees

- The overall role of the Board's committees is to carry out the detailed work of assurance on behalf of the Board. They report recommendations to the Board. The Board Committee's core roles and responsibilities is to:
  - Scrutinise reports on the relevant risks to that Committee's remit from the BAF and the corporate risk register; the delivery of the Annual Plan and compliance with CQC Standards.
  - Contribute to the development of the Annual Planning cycle and ensure that this plan reflects stakeholder requirements.
  - Give the Board confidence that the systems, policies and people they have put in place to deliver the Annual Plan are operating in compliance with CQC Standards, are effective, are focused on key risks and are driving the delivery of the Trust's objectives.
  - Recommend to the Board the level of assurance required, the source of assurance required and how the reporting of assurances will be managed and coordinated.
  - Provide the Board with the evidence required of the effectiveness of controls within their remit in order to be able to sign the Annual Governance Statement and maintain unconditional registration with the CQC.
  - Scrutinise reports and evidence of assurances provided by clinicians, managers, Trust committees and independent assurers on the status of the Trust's internal controls.
  - Ensure that unacceptable levels of assurance and risks are reported to the Trust Board for their consideration.

3.3 Integrated Governance Committee

- The Integrated Governance Committee oversees the design and effective operation of the risk management process across the Trust including the management of the production of the BAF.
- The Committee provides the Board with assurance that a comprehensive corporate risk register is in place derived from the Executives' view of the major risks to the Trust and the risks being escalated from Divisions and business support functions.

- The Committee oversees the integration of clinical, organisational and financial risk management systems across the Trust with that of corporate business planning.
- It is authorised to take remedial action to resolve weaknesses and incorporate best practice.

3.4 Divisions and Business Support Functions

- All Divisions and Business Support Functions should complete and report to the Integrated Governance Committee on their specific accountabilities and responsibilities as defined in the work plans.

3.5 Director of Corporate Affairs will:

- Facilitate the process for updating the BAF.
- Ensure the Board of Directors is provided with an updated BAF every month.
- Ensure that timely risk modelling is undertaken for all new identified or emerging risks on the BAF.

3.6 Executive Directors

- Each risk identified on the BAF will have an Executive Director owner who holds accountability for updating entries in the Assurance Framework against that risk i.e. associated controls, actual assurances (reports etc), action plans and impact/likelihood score.
- Once all updates from risk owners have been received, the Executive Lead will sign off the refreshed BAF.
- The Executive Directors with responsibility for staff groups in each division will be accountable for the proactive timely and accurate review and update of all risks owned by their Divisions / corporate service. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them. It is also an opportunity to identify any emerging new risks for assessment and inclusion in the corporate risk register.

3.7 Non-executive Directors

- It is the role of all Non Executive Directors to contribute to Board and Committee discussions and make constructive challenges.
- They should identify issues, either through Committee activities or at the Board itself, of which the Audit Committee will undertake a more detailed review.

3.8 Associate Chief Operating Officers/Heads of Business Support Functions, Project and Programme Managers

- Associate Chief Operating Officers, business support function Heads of Departments, Project and Programme Managers are accountable for the

complete and accurate review and update of all risks owned by their Divisions/ service/ programme. This will include continuously supporting risk owners, control owners and action owners to scrutinise their existing risks and progress made to reduce them.

- They are also accountable for identifying any emerging new risks for assessment and escalation to the corporate risk register.

3.9 All Staff

- Contributing to the identification of risk through active participation in the risk assessment and incident reporting processes by ensuring they comply with their responsibilities identified in the risk assessment and incident reporting policies.
- Following all relevant safety precautions in line with the policy.
- Keeping mandatory training up to date through attendance and updating identified in the training needs analysis.

4 Process for maintaining the Board Assurance Framework

4.1 The BAF is utilised by the Board of Directors as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust in achieving its strategic goals.

4.2 The BAF contains information regarding internal and external assurances that organisational goals are being met. Where risks are identified, mitigations and subsequent action plans are mapped against them.

4.3 Risks are scored using a 5x5 matrix of impact and likelihood. This 5x5 matrix, in which scores for impact or consequence of the risk is multiplied by the score for likelihood of occurrence. The total score generated is known as the risk rating.

4.4 The BAF is maintained by the Director of Corporate Affairs. The information recorded on the Framework includes:

- Description of the risk
- Current risk score
- Control measures in place
- Evidence of current assurances
- Gaps in controls/ assurances
- Target risk rating
- Actions required to achieve the target risk rating – the appetite for the specific risk.

4.5 The Board of Directors has delegated responsibility of monitoring risks and assurances to the Integrated Governance Committee (IGC), which will review and update the BAF at each of its bi-monthly meetings. It will provide an updated BAF and a summary of the Corporate Risk Register to the Board on a bi-annual basis and also an extract of the relevant risks to the other Board Committees: Clinical Quality Assurance Committee, the Resources and

Business Development Committee and Workforce and Organisational Development Committee.

4.6 The Audit Committee has delegated responsibility from the Board to oversee this process, ensuring that there is adequate external review and assurance and that this is used to inform the Annual Governance Statement.

5 Process for the local management of risk (which reflects the organisation wide Risk Management Strategy)

- Each Clinical Division and Corporate Function will refresh their risk register on an annual basis as per the Trust's Risk Management Strategy.
- The locally identified risks, derived from completing the risk assessment tool, will be utilised to inform the departmental risk registers. Divisional Associate COOs/Heads of Corporate Functions are responsible for ensuring that actions are put in place to mitigate identified risks.
- The ways in which risk can be escalated from Ward and department level to Divisions and corporate levels is outlined in the Risk Management Strategy.
- Divisions/Corporate Functions will provide reports to the Integrated Governance Committee in line with that Committee's work plan.

6 Monitoring Compliance with the Processes

As stipulated within this policy, the Trust will keep the BAF under review via the Integrated Governance Committee and monthly reports to Board of Directors and its Committees.

- The reports will be presented by the Director of Corporate Affairs to the Board of Directors and its assurance committees.
- An annual audit of the Assurance Framework will form part of the internal audit programme, to support the Annual Governance Statement.
- The purpose of this annual audit is to monitor the systems and processes of the approved organisation-wide risk register.
- The Trust's BAF will be monitored to assess compliance with the key performance indicators.
- The audit process will assess whether:
    - responsibilities are clearly agreed and recorded and there is evidence to support objectives which are clearly linked to the Trust's operational plan or other strategic documentation.
    - Risks are clearly linked to objectives, their priority (impact/likelihood) has been determined and they have been attributed to a lead.
    - Risks are assessed and new/amended risks are considered and included where appropriate.
    - Controls effectively manage the risk, there is evidence that the controls are in place and that there is adequate management of controls.
    - Controls relied upon are sufficient to manage the risk i.e. expected assurances have been received and provide sufficient information to efficiently manage the risk.

- Positive assurance evidence is collated and uploaded onto performance accelerator and signed off by the accountable Executive Director.
- Where gaps in control/assurance have been identified, appropriate actions plans have been agreed to address these and are monitored consistently in line with policy standards.
- Board reports, Integrated Governance Committee minutes, Resources and Business Development Committee minutes, Clinical Quality Assurance Committee minutes, Workforce and Organisational Development Committee minutes and Audit Committee minutes provide evidence that the Assurance Framework has been effectively discussed and considered and progress/ action has been taken to address areas raised following the audit.
- The Integrated Governance Committee and Audit Committee monitor reports ensuring that recommendations/actions are implemented where monitoring has identified deficiencies. This is to ensure that lessons have been learned and agreed changes in practice made.

7. Further Information

Equality Analysis (hyperlink)

References

- *The Healthy NHS Board*
- *Taking it on Trust*
- *Board Assurance Frameworks – A Simple Rules Guide for the NHS*
- CQC Standards
- NHSI Single Oversight Framework updated November 2017
- NHSI Annual Reporting Manual 2017/18

Associated Documentation

This policy should be read in accordance with the Trust Risk Management Strategy.

Appendix A

1. Definitions

1.1 Assurance

Confidence based on sufficient evidence that internal controls including policies, procedures, practices and organisational structures are in place and operating effectively to support delivery of the strategic objectives.

1.2 Key Elements Assurance Framework

- An Assurance Framework (BAF) is a simple but comprehensive method for:
  - The management of the principal risks to meeting the organisation's objectives.
  - Providing evidence for the Annual Governance Statement. Guidance on what should be included within the Statement is provided within NHSI's Annual Reporting Manual each year.

1.3 Principal Objectives

- Principal Objectives are statements of the crucial measurable results which the organisation must achieve in order to achieve its overall goals in line with its strategic aims.
- Clinical Divisions and Corporate functions must align their objectives with the principal objectives in order to ensure that their activities contribute to the achievement of the Trust's principal objectives.
- The BAF must specify the Director who is accountable to the Board for delivering the Principal Objectives of the corporate plan.
- The Principal Objectives must be stated in terms which are:

Specific
Measurable
Achievable
Realistic
Time-based

1.4 Risk Registers

- Risk registers are held at Ward /Departmental level, Divisional level, business support function level, and at Trust Wide level, (Assurance Framework and Corporate Risk Register). The principal risks associated with each strategic objective must be identified on the BAF.
- The risk rating tool (5x5 matrix) enables staff to consider the potential harm that would be caused if a hazard or threat was realised and how likely this is to happen. The two factors of likelihood and impact/consequence are used to establish the level of risk; this will assist staff in deciding which risks take priority and highlight areas which need rapid attention.
- The Ward, Divisional/Department/Business Support Function level risk register must reflect the proactive risk assessments undertaken and

reactive risks identified through incident reporting etc. including demonstrating action taken against these risks at least monthly.

- Each Ward, Division/Department/Business Support function has responsibility to review their own risks and to inform the Integrated Governance Committee of actions completed to reduce or eliminate the identified risk.
- The Ward, Division /Department/Business Support Function risk assessments will contribute to the formulation of the high level Trust Corporate Risk Register along with other forms of risk identification. This will ensure that the risk registers are consistent and that meaningful decisions on the prioritisation and treatment of risks can be made.
- Risk Registers will be kept at Business Support Functions, Divisional and Department/Ward levels within the Trust.
- At Board level the BAF and Corporate Risk Register will include risks to the achievement of Principal Objectives together with risks escalated from business support functions, Divisions and Department/Ward levels.

1.5 Principal Risks

- Factors which potentially threaten the achievement of the principal objectives are called principal risks and need to be identified. They should be stated as "If x happens then y will be the consequence".
- Using risk profiling the principal risks to achieving the principal objective are identified and summarised on the BAF together with a score of their likelihood and potential impact.

1.6 Risk Profiling

Risk Profiling is a process that involves the identification and assessment of all risks encountered by an organisation, enabling the identification of high risk issues, facilitating the management and prioritisation of such risks.

- Risk profiling gives a risk a 'Likelihood score' of:

  1 = rare - do not expect this to happen.
  2 = unlikely - most probably will not happen.
  3 = occasionally - 50:50 chance of occurring.
  4 = likely - most probably will happen.
  5 = almost certain - confident that this will happen.

- Risk profiling gives an impact/consequence score of

  1 = almost none - no obvious harm.
  2 = minor - no permanent harm (recovery within month).
  3 = moderate - semi-permanent harm (recovery takes longer than 1 month but no more than 1 year) and/or adverse publicity for the Trust.
  4 = major - permanent harm not resulting in death or severe disability to a person or persons and/or start of a national investigation into the Trust and/or disruption of key Trust services which significantly hinder the Trust in meeting its responsibilities.

5 = catastrophic - death or permanent severe disability to a person or persons and/or significant loss of reputation for the Trust and/or loss of key Trust services which prevent the Trust meeting its responsibilities.

Note: Harm in all the above includes damage to the organisation, its finances, its reputation, its business, its patients, staff or visitors.

1.7 Identification of Risks

Potential principal risks to the achievement of the Trust's objectives are identified in two ways: the 'top down' proactive (risk assessment) identification of risks that directly affect the Trust's achievement of its principal objectives, combined with the 'bottom up' assessment of the most significant risks within the business support, programme and Clinical Risk Registers, which in turn originated in Divisions, programme and Business Support Function Risk Registers.

1.8 Controls and Assurance

- Controls are the many different things that are in place to mitigate risk and assist in securing the delivery of objectives; they should make a risk less likely to happen, or reduce its effect if it does happen.
- The Assurance Framework requires the Trust to consider the effectiveness of each control through the process of obtaining assurances that the control is in place and is operating effectively.
- The Assurance Framework summarises how the Board knows that the controls it has in place are effectively managing the principal risks together with references to documentary evidence that the assurances are working effectively.
- There are two groups of assurances on controls:
  - Internal Assurance
  - Independent Assurance
- Internal assurance is provided by the following Committees:
  - Audit Committee
  - Clinical Quality Assurance Committee
  - Integrated Governance Committee
  - Workforce and Organisational Development Committee
  - Health and Safety Committee
  - Clinical Systems Informatics Project Group
  - Information Governance Committee
- The purpose of the committees is to carry out an analysis of assurances received, identify any key gaps in the assurance mechanisms and provide an evaluation of the effectiveness of these mechanisms to inform the relevant strategic objectives on the Assurance Framework.
- The Board of Directors then receive summary reports from these committees and makes a final judgement on the level of assurances

received and any actions required to ensure delivery of the Trust's objectives and obligations.

- Independent assurance is provided by:
  - Audit Committee
  - Internal Audit and External Auditors
  - Care Quality Commission
  - Health and Safety Executive
  - Monitor/NHS Improvement

1.9 Key Controls

- Key controls are the means by which the risk's impact or likelihood may be reduced together with references to documentary evidence of the existence and effectiveness of that control mechanism. Risk control is achieved by reducing the likelihood of the risk, reducing the impact of the risk and/or transferring the risk. The risk controls are also identified through a risk profiling process and summarised on the Assurance Framework as are any gaps in risk control.

- The Board of Directors and all other Trust staff that grade risks must use the same tool.

1.10 Gaps in control and assurance

- A gap in control is deemed to exist where adequate controls are not in place, or where collectively they are not effective. A failure to put in place sufficient effective policies, procedures, practices of organisational structures to manage risks and achieve objectives.
- A gap in assurance is deemed to exist where there is a failure to gain evidence that the controls are effective. In other words a failure to gain sufficient evidence that policies, procedures, practices or organisational structures on which reliance is placed is operating effectively.
- Wherever gaps in control or assurance are identified, action plans must be clearly defined, monitored consistently for improvement and allocated to appropriate lead Directors.

1.11 Controls Performance Reports and Associated Action Plans

- Performance reports e.g. audit reports provide strong evidence of the effectiveness of control activities and should identify necessary improvements where controls are lacking. It therefore follows that performance reports generate valuable information for the Assurance Framework and that there is a clear need for performance reporting and the Assurance Framework to be strongly linked.
- Where there are deficits identified in performance action plans must be formulated and consistently monitored to ensure compliance with performance standards (strategic objectives).

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 2nd September 2019

Paper Title:	Digital and Information Technology Update
Report of:	The purpose of this report is to provide Trust Board with an update on Alder Hey Digital Futures mobilisation including key digital transformation programmes and operational IT performance
Paper Prepared by:	Kate Warriner, Chief Digital and Information Officer

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

1. Introduction

The purpose of this report is to provide Trust Board with an update on Alder Hey Digital Futures mobilisation including key digital transformation programmes and operational IT performance.

2. Background

Alder Hey NHS Children's Foundation Trust approved Digital Futures, the Trust's digital strategy in July 2019. The final designed version of the strategy is included as appendix 1 to this report.

Throughout the summer months, work has been ongoing to mobilise Digital Futures with a number of key activities in terms of governance, investment planning and programme mobilisation. In addition, work is ongoing to address a number of infrastructure risks, particularly in relation to operational Information Technology resilience and cyber security.

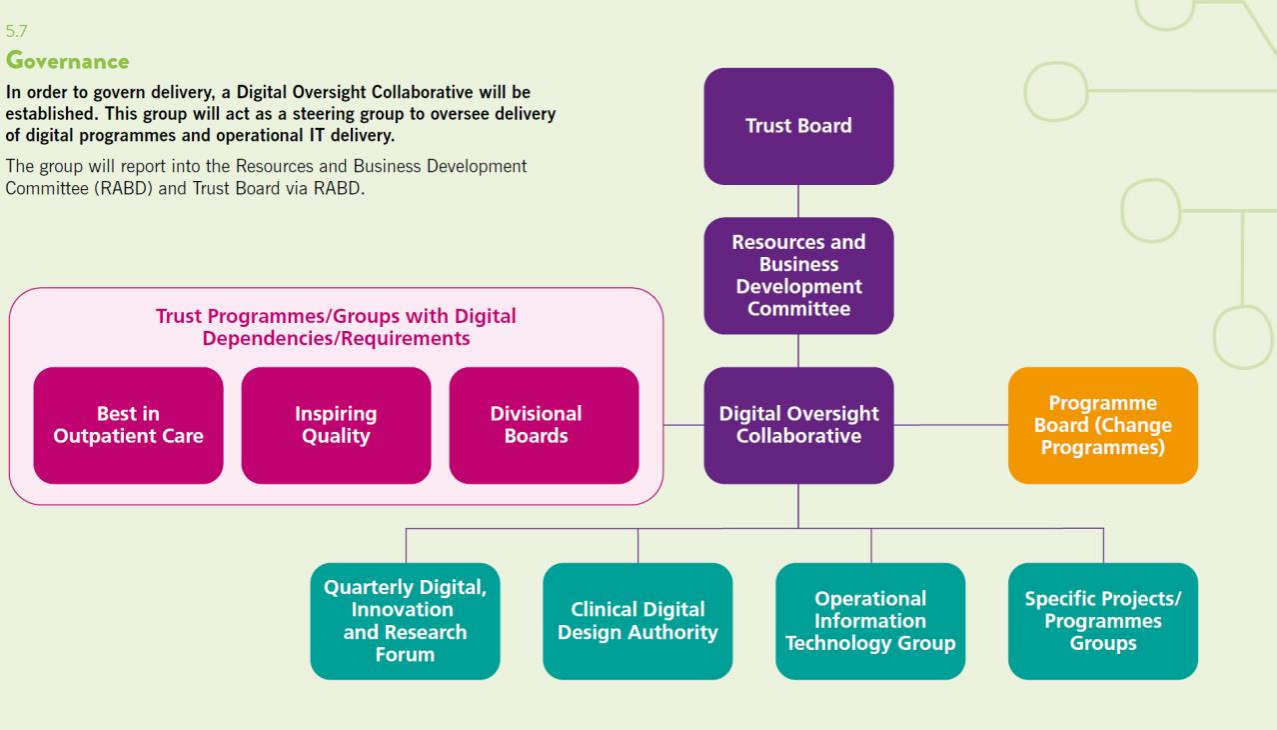
3. Digital Futures Mobilisation

3.1 Governance

From a governance perspective, a new governance structure has been approved to manage the Trust's digital agenda going forward. The new governance arrangements include the closure of the GDE board with a transition to a Digital Oversight Collaborative (DOC) from October 2019. The DOC will have oversight of the digital strategy mobilisiation, operational IT delivery and major digital programme developments.

There will be a number of groups reporting into the DOC including a clinical design authority, an operational IT group, a programme delivery group and a digital, innovation and research forum. The DOC will be chaired by the Medical Director and report into Trust Board via the Resources and Business Development Committee.

The DOC will have close relationships with Trust programmes and groups with a dependency on digital futures developments including Inspiring Quality, Best in Outpatient Care and Divisional Boards. This will ensure that the 'engine room' structure sitting under the DOC work closely with these Trust groups and can respond to ongoing needs and clinical/organisational priorities.



3.2 Investment Planning

With regards to investment planning, detailed work has been undertaken to assess current and future investment requirements, built into the Trust's capital plan.

Digital Futures sets out a number of major ambitions but also addresses a number of current key risks. These risks include developments in relation to resilience, cyber security and a national directive with regards to Microsoft product refresh for all Trust computers and servers in 2019.

In addition, the digital futures strategy highlights areas to support ongoing digital advancements. Work has been undertaken as part of mobilisation to review current clinical risk areas and horizon scan future requests. Current risks include work supported in terms of developing cardiology imaging and future developments to digitise anaesthetic charts. Other digital advancements will be developed over time in line with divisional priorities and industry developments.

3.3 Programme Mobilisation

Work has progressed with regards to programme mobilisation of the major digital transformation programmes. These include progression with programmes identified for 19/20 in the technology roadmap, plans with regards to the completion of the Global Digital Exemplar (GDE) Programme including international Healthcare Information and Management Systems Society (HIMSS) accreditation, commencement of Paperfree programme and the initiation of the Expanse programme which will see the upgrade of the Trust's Electronic Patient Record in 2020.

4. Technology Roadmap - Operational IT

There are a number of component parts to the Trust's technology roadmap for progression in 19/20:

4.1 Operational IT Service Improvement Plan

There are a range of nationally directed critical must do's and a number of local service improvements. A number are highlighted below:

- Replacement Computers – 1100 funded for replacement this year
- Windows 10 – upgrade of all devices on track by Jan 2020
- Office 365 – migration of key systems by the end of 2019, additional functionality to allow modern workplace developments
- Community Service Improvement Plan – due for completion by the end of 2019
- Review of operational IT Service Models including service desk, service management tools and partnership arrangements
- Cyber security and Resilience – ongoing developments in progress

4.2 Operational IT Performance

Work has been ongoing with regards to developing an operational IT performance dashboard from September 2019. The dashboard will desmontrate activity, resolution performance, critical systems availability, service engagement activity and trends and cyber security information.

5. Digital Transformation Programmes

5.1 GDE/HIMSS

Intense work continues with regards to the ongoing implementation of the GDE programme. As we head into the last 8 months of the programme, areas of focussed attention move to the GDE and HIMSS Level 6/7 accreditation activities.

From the inception of the GDE Programme all participating Trusts were set a goal of achieving HiMMS Level 7 alongside achieving the criteria set out in NHS England's Definition of Done.

Healthcare Information and Management Systems Society (HIMMS) is a global, cause-based, not-for-profit organization focused on better health through information and technology. HIMMS use the Electronic Medical Record Adoption Model (EMRAM) which is an internationally recognised, 8 stage model (0 – 7) that measures the adoption and utilisation of EPR functions.

HIMSS process indicates that a Level 6 accreditation is required prior to Level 7. Alder Hey took part in the on-site Level 6 Gap Assessment visit with the HIMMS Assessor in December 2018. There were some areas identified in the assessment as high quality performing areas and a number of gaps identified.

Progress has been made and is continuing to be made against identified gaps. Alder Heys formal Level 6 assessment is expected to be undertaken in November 2019. At the same time a Level 7 gap analysis will be undertaken and scheduled for Spring 2020.

5.2 Meditech Expanse

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

The Chief Operating Officer for the Trust will act as the Senior Responsible Officer supported by the Medical Director, Chief Digital and Information Officer and divisional teams. Governance arrangements are in the process of being established, a programme manager reporting into operations and digital is in the process of being appointed.

This will be a major delivery programme for the Trust in 2020 and is likely to see the first Expanse implementation for an NHS Trust creating a blueprint for others to adopt and learn from.

6. Key Risks

There are a number of key risks being managed in terms of strategy mobilisation including:

- Finance – mitigated through clarity of strategy for core requirements and approach for advancements to be progressed through
- Capacity across organisation to mobilise complex and high volume programmes of work
- Internal skills – strengthened with recent recruitment
- Resilience and cyber security developments

7. Conclusion

Good progress has been made following the approval of the Digital Futures strategy in July 2019.

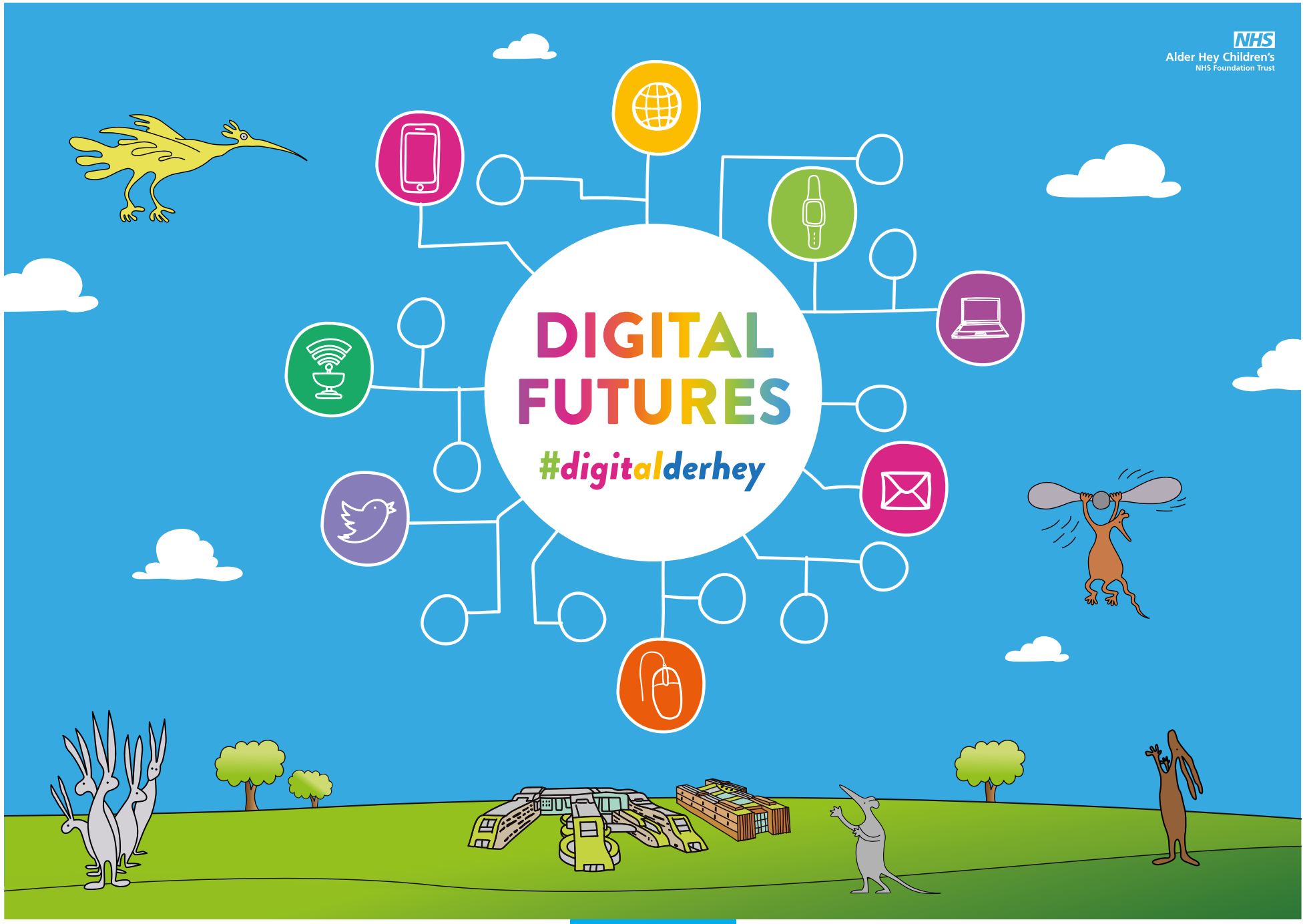
Whilst there is a significant amount of challenging work in train, plans are developed and clearly understood against priority and nationally directed programmes.

8. Recommendations

Trust Board is asked to:

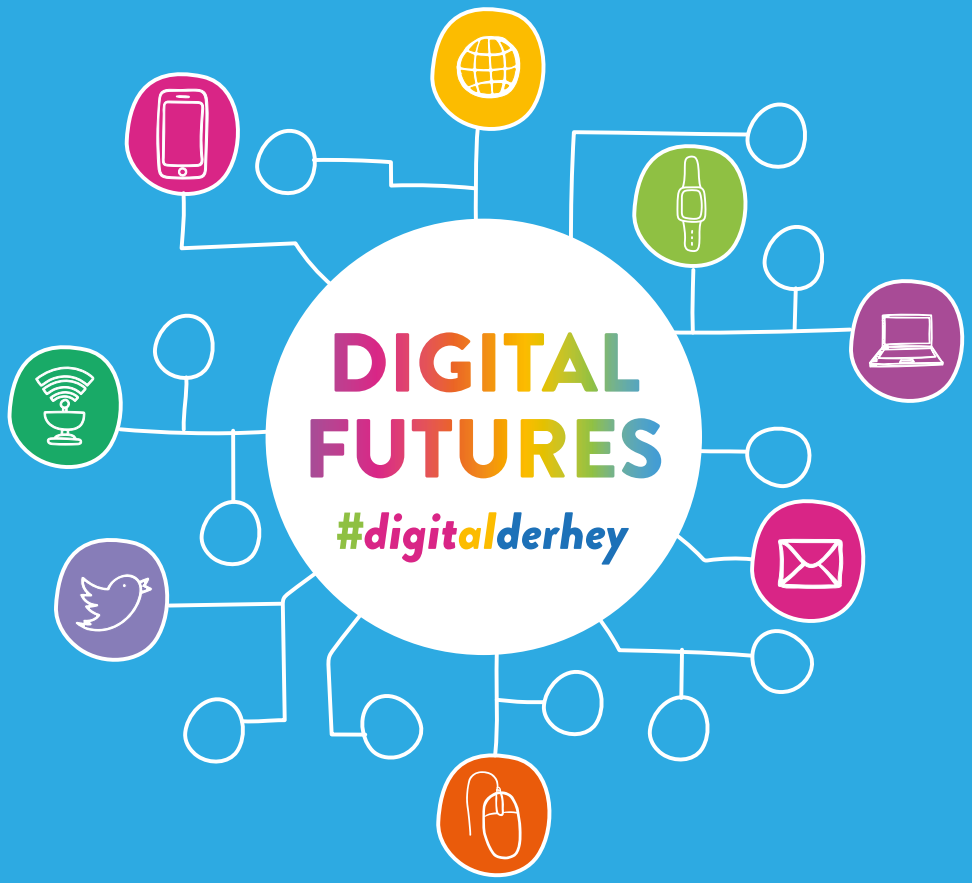
- Note the progress with the mobilisation of the digital futures strategy
- Note progress with operational IT developments
- Note major digital programme progress

Kate Warriner
Chief Digital and Information Officer
September 2019


NHS
Alder Hey Children's
NHS Foundation Trust
DIGITAL
FUTURES
#digitalderhey

Please click on the contents bars to navigate to each section

Contents



Foreword

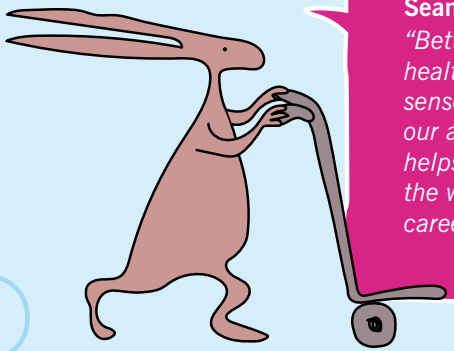
Everything we do, almost every part of our day is determined by digital technology. This technology has led to life changing inventions and has linked individuals across the world, with potential for collaboration and game-changing learning. In our NHS we are trying to mirror the difference that digital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

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

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

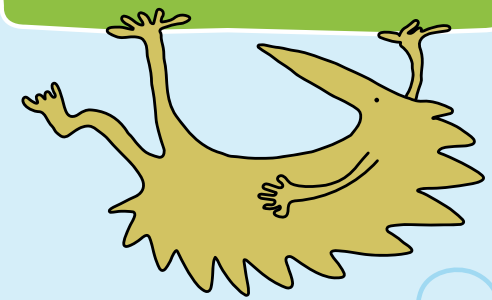
Dame Jo Williams
Chair

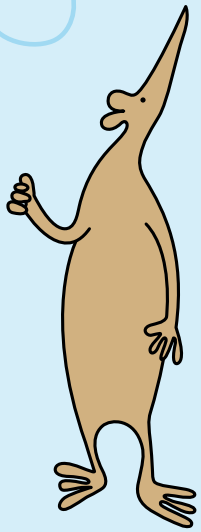
Louise Shepherd, CBE
Chief Executive



Sean Age 17
"Better use of technology in our healthcare is beneficial in every sense of the word. It determines our access to healthcare and helps us with the future, paving the way for their future such as career pathways."

Esme age 9
"We know we live in a digital world but we don't always know how we can make our voices heard by using digital media. We have seen how much benefit there is for children in apps like AlderPlay but this is only the beginning. We don't want to be silent about their care; we want information and we want to engage. A digital platform allows us that."



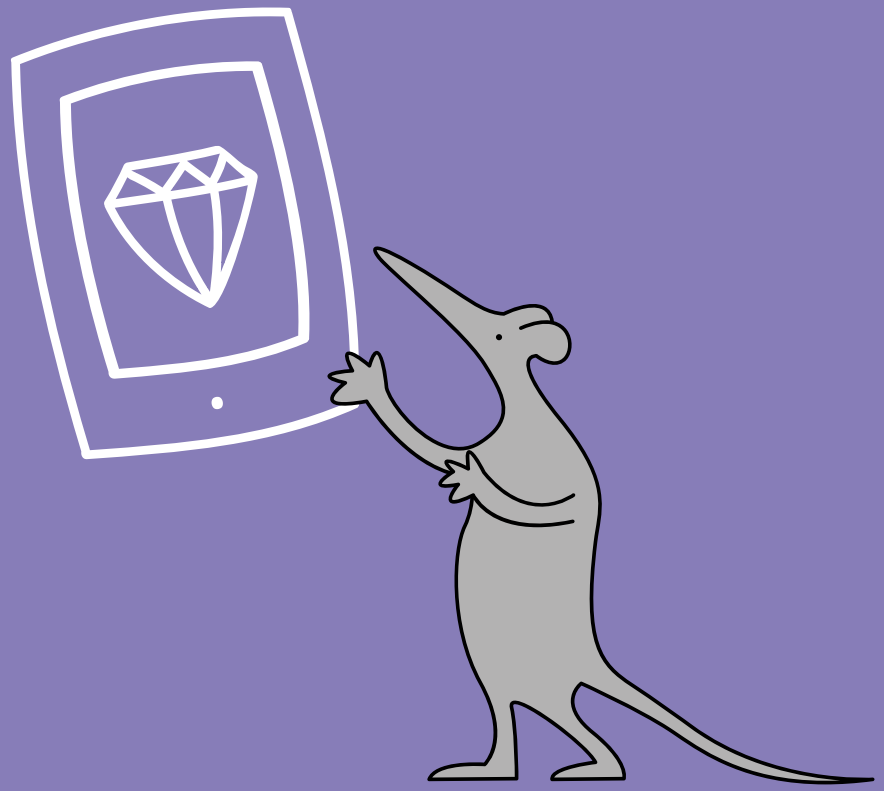


Tom Age 17
"Technology for us as young people is a large part of our everyday life. Living in this day and age the ability to use the newest technology is necessary for almost all jobs and therefore would be very useful for us to be a part of."

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

1

Our Digital Promise - Outstanding Digital Excellence



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

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

"The opportunity of digital is immense for health and care services. It is here to stay and further expand..."

Through this we will strive to:

- **Provide the best possible digital and technology services** to support, enable and drive clinical excellence, digital quality improvement, outcomes and patient safety
- **Deliver Information Technology basics well**, championing a 'Digital First' approach across Alder Hey, supported by excellent, proactive, customer focused services
- **Unleash innovation and research** to harness digital technology in order to create opportunities to adopt and evaluate digital innovations throughout the world's first 'Living Trust'
- **Maximise local, national and international partnerships** to bring in expertise and new advances in pursuit of a shared vision

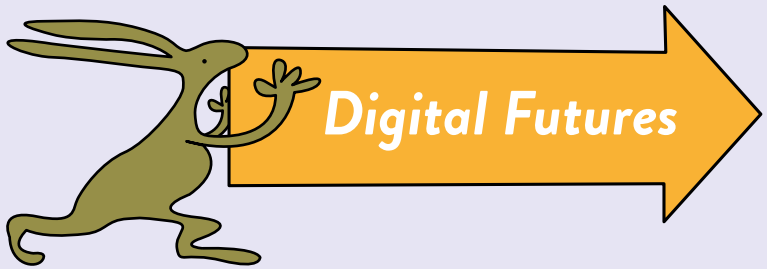
We believe that achieving Outstanding Digital Excellence, having an ethos of creating the best digital experience and delivering the best clinical outcomes should 'be our norm' and cut through everything we do internally, locally, regionally, nationally and internationally. We will not always get it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

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

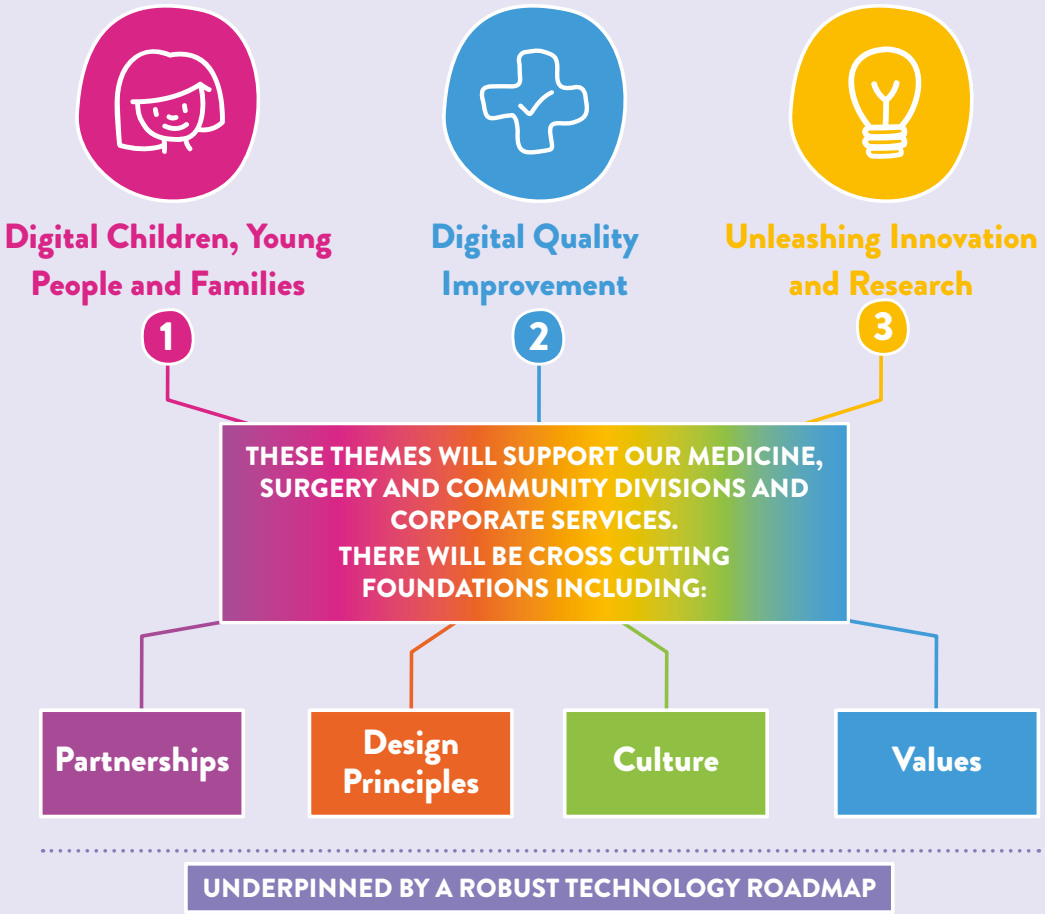
We will focus delivery on three key transformation themes:

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

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



WE WILL FOCUS DELIVERY ON THREE KEY TRANSFORMATION THEMES:

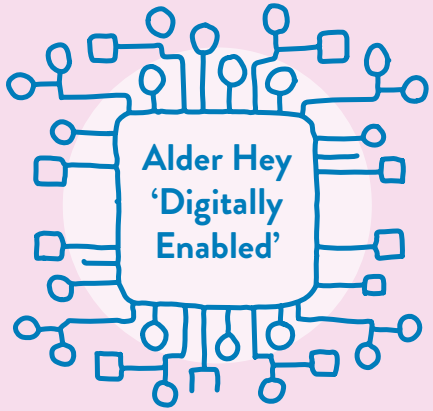


2

Framing the Digital Strategy

‘Digitally Enabled’ is identified as a strong foundation in Alder Hey’s ‘Our Plan’. It is a core tenet of the Trust’s five year strategy.

It is important to note that this cuts through our whole strategy from Brilliant Basics and Outstanding Care, supporting our people to do their best work, through to growing the future with game changing research and innovation. Improving Care through Technology is a key plank of our Inspiring Quality strategy and delivering best in outpatient care. The translation of innovative digital developments into enablers of improved patient care and experience will be supported by a robust framework of evaluation.



Outside work most of us, especially children and young people, expect a seamless digital experience that works so well we don’t think of it as digital. When this works well we just notice the result not the technology; our sat nav guiding us around traffic jams on the way to work, our favourite music wherever we are, and seeing our friends and family around the world with no effort at all. The digital experience at Alder Hey should be the same for patients, carers and staff.

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

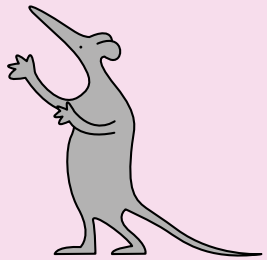
2.1

Alder Hey NHS Foundation Trust

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

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

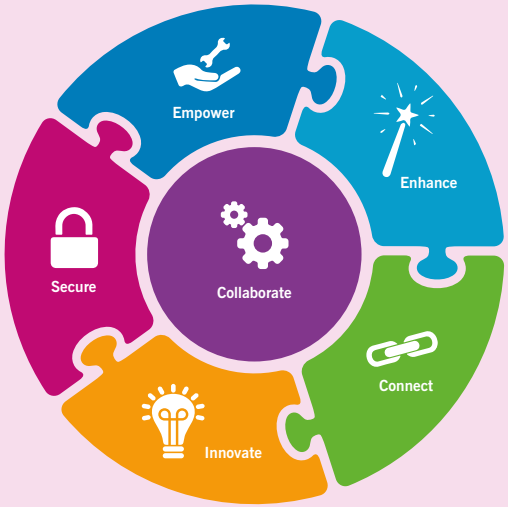
“the use and development of digital and technology are critical factors prevalent in much of what we do...



2.2

Cheshire and Merseyside Health and Care Partnership

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



DIGIT@LL IS CENTERED AROUND SIX THEMATIC HEADINGS OF:

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

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

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

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

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

2.3

NHS, Academia and Industry Partnerships

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

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

2.4

National Priorities

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

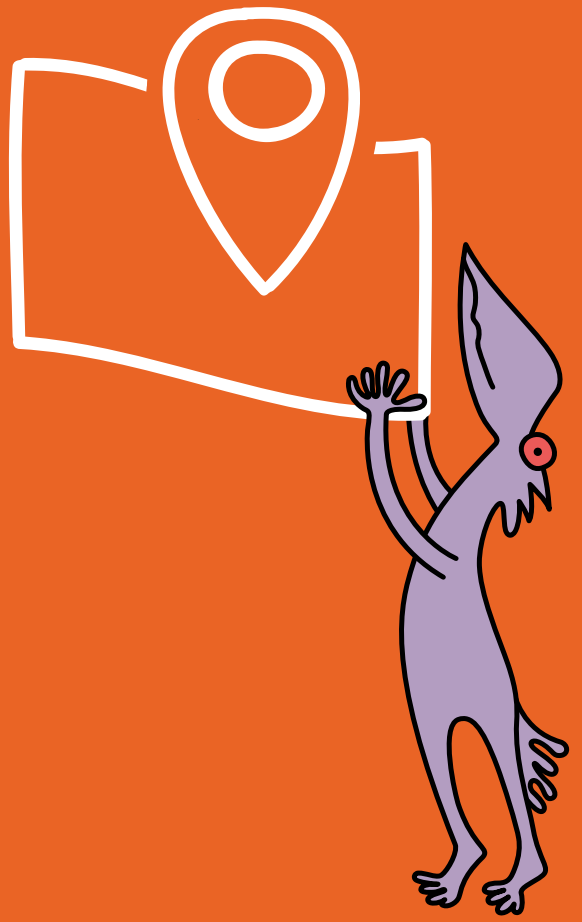
There are a range of guiding principles and priorities set out in the technology vision for the National Health Service. These include a focus on user need, privacy and security, interoperability and openness and digital inclusion. Priorities for the NHS set nationally include infrastructure and standards,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

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

Priorities for the NHS set nationally include infrastructure and standards, including cloud first, digital services designed to meet the needs of users, enablement of innovation so that cutting edge technologies can be easily implemented and the right skills and culture to drive the best outcomes for patients.

3

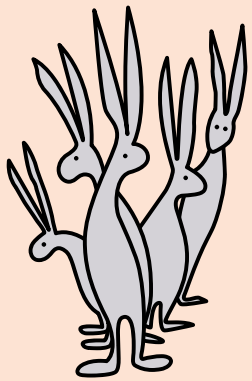
The Journey So Far



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

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

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



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

- **We are a specialist paediatric Trust** which attracts the best staff in their field of expertise delivering incredible outcomes and care for our Children and Young People
- **We have an amazing new hospital,** delivering outstanding care
- **We have wonderful community services** providing fabulous care closer to home
- **Alder Hey is the only Trust in the country that has a Bat Cave**. The Bat Cave, otherwise referred to as the **Innovation Hub**, pioneers leading innovations globally
- **Alder Hey is one of sixteen Trusts who were identified as part of the Global Digital Exemplar Programme in 2016.** This has enabled us to digitise clinical pathways, improve integration and spear head regional interoperability developments
- **There are core building blocks including an integrated Electronic Patient Record and an Electronic Document Management System.** These systems are the foundations which are allowing us to digitise customised clinical pathways to fit the workflows and pathways in place at Alder Hey with individual clinical teams thus enabling improvements to quality, patient safety and efficiency
- **Our incredible Paediatric Intensive Care Unit** has its medical devices integrated with the ICU EPR enabling safe care for our children and young people
- **Our Community teams have extensive use of a community EPR,** integrated with other community services and General Practice
- **We have an integrated approach to clinical imaging** with many 'Other Ologies' integrated into our PACS system
- **Our Orthopaedic surgeons are a global exemplar of good practice** as the first to run nationwide clinical research studies completely online
- **Our Cystic Fibrosis 'CF START' is using an innovative approach employing national registry data to collect key outcome measures.** This is the first global paediatric registry-based study of a medicine and is highlighting the potential to conduct large comparative effectiveness studies with minimal cost to the health service and to the families involved
- **Alder Hey continues our proud legacy of pioneering research into children's health and wellbeing.** We are the centre which enrols the most children and young people into important clinical research studies, ranging from discovery science to trials of important new medicines for children. The assembly of integrated child health data from different domains enables improvement in outcomes through analysis of 'big data' and application of emergent artificial intelligence methods

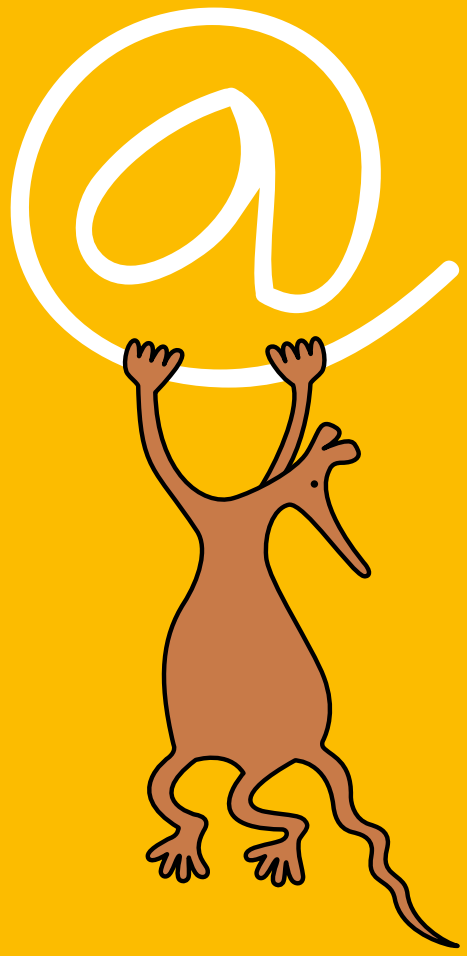
Iain Hennessey, Consultant Surgeon and Co-Director of Innovation

"Alder Hey is an incredibly special place. It is a wonderful mix of futuristic technology combined with an illustrious history. We have some really awesome local assets. Most importantly Alder Hey has a wonderful heart to it, the warmth and kindness that can be seen every day on the wards and in clinics is really one of our USP's and we need to really appreciate it and expand on it."

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

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

The warm, kind and vibrant vibe in Alder Hey is infectious to those receiving care there...



4

The Difference is Digital - A Model Alder Hey

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

We will deliver this vision to:

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

4.1

What do we mean by Outstanding Digital Excellence?

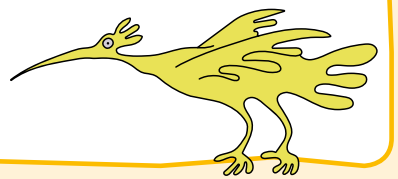
The term 'digital' means different things to different people. At its simplest definition, the term digital is about showing information in the form of an electronic image and using that information in a different way. A good example is to demonstrate the difference between analogue and digital in a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

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

Outstanding Digital Excellence

Through the term outstanding digital excellence, we mean:

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



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

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

Staff Nurse, 1C
"Make it quicker"

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

Quality, safety and experience will be improved through moving to a world-class digital environment by ensuring the right information to the right staff at the right time. Through co-design with staff, children, young people and families, our **'Living Trust'** will support delivery of excellent care, provide intuitive and innovative ways of working.

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

We need to use artificial intelligence and augmented technologies to eradicate the role of the clinician as a data entry technician.

This kills the primary purpose of what clinicians are there to do - which is to care for patients.

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

We will strive to get better and developing technologies that allow us to be better at empathy and more importantly have more time to practise it...

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

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

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

"Immersive Technology is helping us to produce advanced visualisation of the human body. This is leading to the development of better diagnostics and improved treatments. This includes the use of immersive technology for distraction therapy and mental health support at Alder Hey. Through Digital Futures, in partnership with the Children and Young Peoples Forum, these will be further developed and implemented. Virtual and Augmented Reality is helping to enhance how we share our expertise through education, both locally and globally."

4.2

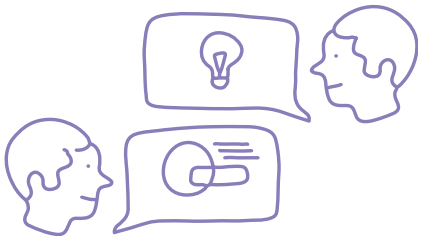
A Day in the Life...

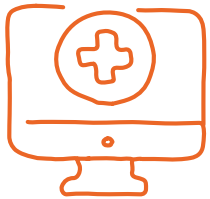
Digital services for the future will feel different for our Children, Young People and their Families and for our professionals. In order to deliver a modern health and care service, technology and digital innovations will feature in everything we do.

THE CHILD OR YOUNG PERSON'S PERSPECTIVE

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

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





OUR STAFF

For our staff, this will mean:

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

OUR TRUST, BROADER SYSTEM AND REGION

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

- Working in partnership across the whole system
- Universal approach and delivery
- Cross-organisational pathways are introduced and facilitated and the child or young person's record data shared, reducing time and improving quality of service delivery and care
- Flagging of children and young people suitable for research leading to quicker identification of patients and associated trials
- Improvements in population-health monitoring and planning, and high quality risk stratification

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

Community Speech and Language Therapist

"Working in community means starting your day in a variety of settings including: the child's home, a community clinic, the child's school or nursery setting. Therefore, I have IT systems which 'just work' in a variety of settings. I can access the child or young person's paperless record via the use of remote working devices including laptops and tethering devices.

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

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

Specific to Speech & Language Therapy, we will use apps/devices for alternative and augmentative communication to support intervention such as Skype sessions to deliver therapy."

"We will put the child & young person's needs at the forefront of our care by utilising technology..."

Outpatient Services

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

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

Children and young people will be able to digitally 'check in' for appointments and this will link to an electronic clinician's board showing real time data.

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

Inpatient Ward Staff

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

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

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

"We no longer use paper records; all of our information is captured in intuitive digital systems..."

Theatre Staff

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

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

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

Clinical Researchers

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

Consent for research is administered and recorded digitally as part of the electronic patient record. This will ensure transparency and completeness of consent and also ensure that this information is clearly accessible within the patient record for regulatory purposes.

As well as supporting efficiencies by streamlining assessment of eligibility of children for studies, we can clearly identify children who are currently involved in a research study so that all clinicians working with this child are aware of this thereby improving safety. We can also use data collected to support risk prediction.

"Core outcome sets are part of the child's electronic patient record, allowing us to clearly evaluate and capture outcomes..."

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

4.3

The World's First Living Trust

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

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

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

4.4

What Outcomes do we want to Achieve?

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

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

The safest Children's trust in the NHS:

- **Zero clinical incidents** resulting in moderate, severe or catastrophic harm
- Zero never events
- **Zero medication errors** resulting in harm
- Zero pressure ulcers
- All septic children receive their antibiotics within 60 minutes
- Zero children deteriorate unexpectedly
- **Zero readmissions** to PICU within 48 hours
- Zero hospital acquired infections

Put Children and Young People first in everything we do

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

Achieving outstanding outcomes for Children & Young People

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

4.5

External Accreditation

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

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

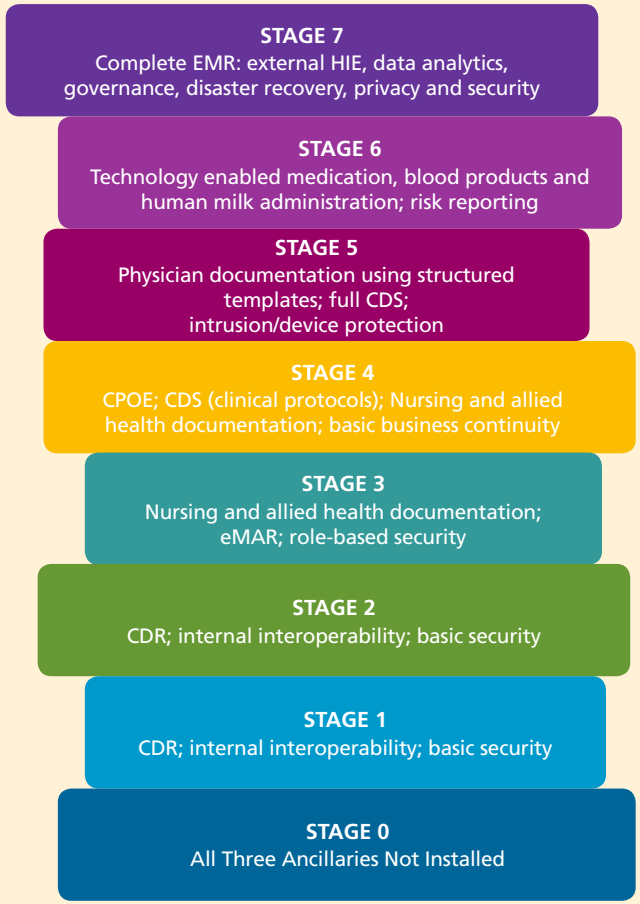
Delivering HIMSS level 7 will give us complete universal coverage across inpatient areas. Clinically this will give us the ability to deliver three important functions which have an evidenced based improvement in patient care and reduced costs.

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

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

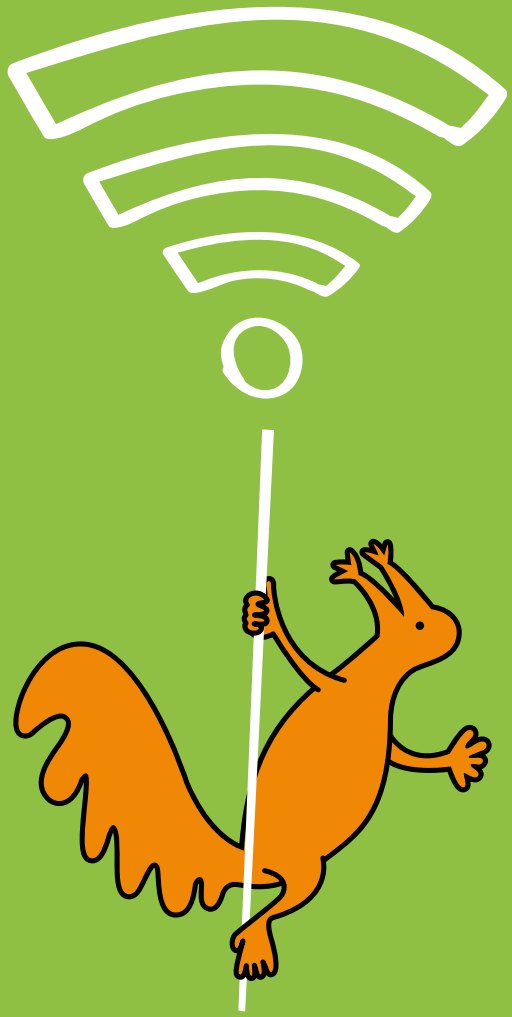
More locally, we will ensure we meet standards in terms of professionalism and staff development. We will work with the **Informatics, Skills and Development Network** to achieve the excellence in informatics accreditation.

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



5

The Nuts and Bolts of Delivery – Making IT Work



We will deliver Digital Futures through a set of interrelated themes, a portfolio of programmes, underpinning foundations and technology roadmap. We will have an integrated delivery model with key teams and divisions and a proactive approach to engagement, co-design, delivery and support.

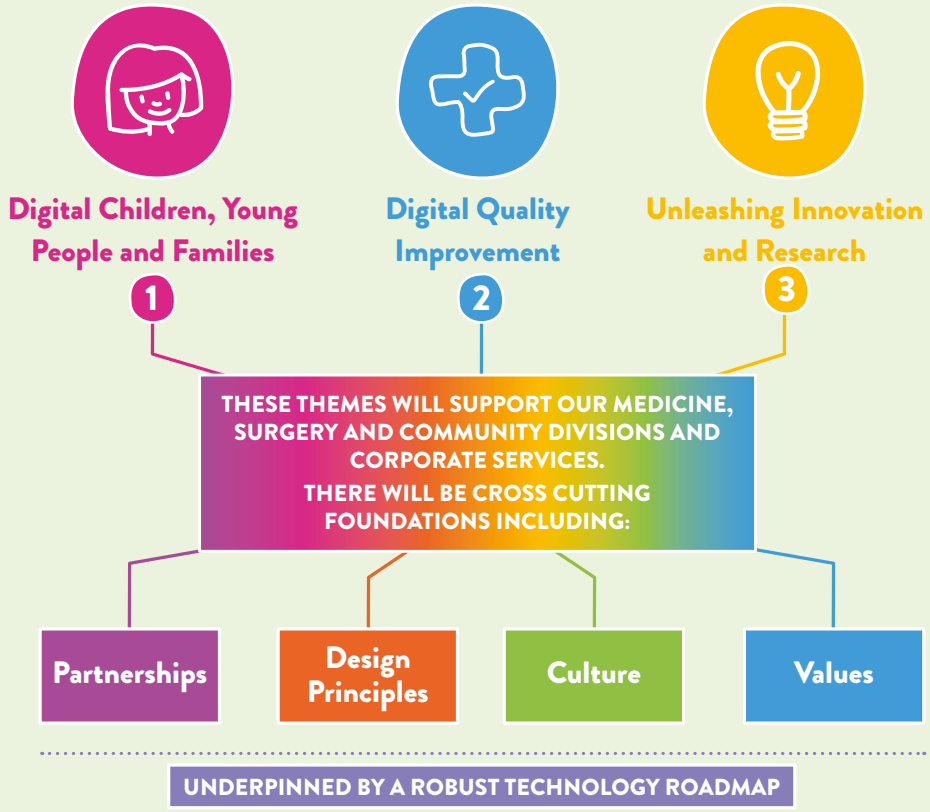
Our core themes are:

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

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

We will deliver to an agreed plan and governance model.

WE WILL FOCUS DELIVERY ON THREE KEY TRANSFORMATION THEMES:



5.1 Theme 1:

Digital Children, Young People and Families - Putting Children First

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

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

We will deliver this theme through 3 workstreams:

- **Digital Front Door**
- **Digital Communications**
- **Digital Services**

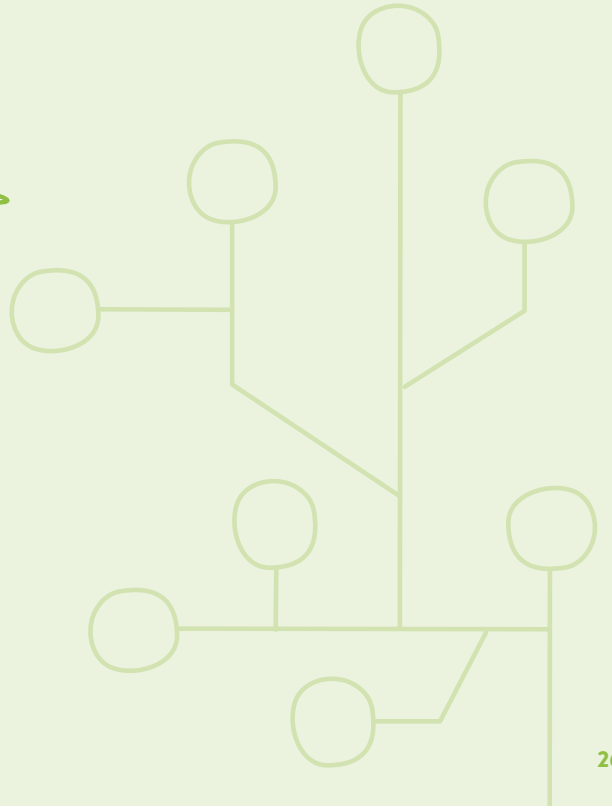
The digital front door will include development of our web presence and the Alder Play app, including access to key information. We will develop our augmented assistant and integrate key regional and national patient facing services with it.

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

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

Will Weston, Associate Chief Operating Officer, Medicine

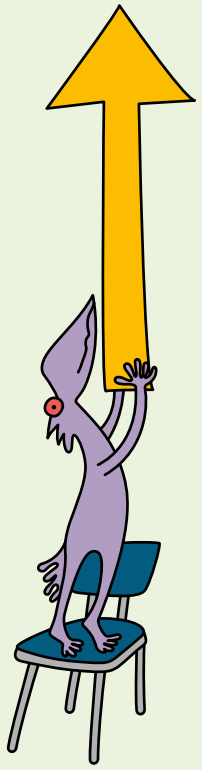
"Children and Young People are spending more time on digital, and healthcare and health care professionals need to adapt. We're integrating information technology, healthcare, wireless and mobile - an era of digital medicine. Even recording an ECG is digital. And of course, there's an app for that."



5.1 Theme 1:

Digital Children, Young People and Families - Putting Children First

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



5.2 Theme 2:

Digital Quality Improvement

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

This theme focuses on 6 themes:

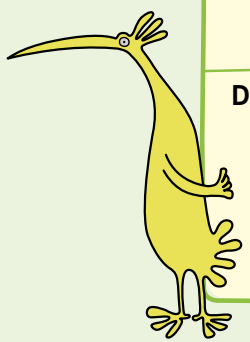
- Digital Hospital
- Digital Community
- Inspiring Quality – Continuous Quality Improvement
- Intelligence Led Care
- Digitally Enabled Staff
- System Wide Developments

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

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

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

WORKSTREAM	DELIVERABLES/PROJECTS	WHEN
Digital Hospital	• Paperfree	19/20 – 20/21
	• GDE Accreditation	19/20
	• HIMSS Level 7 Accreditation	19/20
	• EPR Upgrade	19/20 – 20/21
	• Electronic Anaesthetics Charts	19/20 – 20/21
	• Integrated observations	19/20 – 20/21
Digital Community	• Paperfree	20/21
	• Maximise EMIS	19/20 – 20/21
	• Community service improvement plan	19/20
	• Digital Outpatients	19/20 – 20/21
	• Teleclinics	20/21 – 21/22



5.2 Theme 2:

Digital Quality Improvement (continued)

Workstream	Deliverables/Projects	When
Inspiring Quality - Continuous Quality Improvement	• Ongoing development of clinical pathways	19/20 – 21/22
	• Service improvement plans linked to divisional operational priorities	19/20
	• Remove Faxes and Pagers	19/20 – 20/21
	• Digital Huddle Boards	19/20
	• Online Collaboration Tool	19/20
Intelligence Led Care	• Clinical Intelligence Portal	19/20
	• Ward to Board Intelligence	19/20 – 20/21
	• Outcomes at our fingertips	19/20 – 20/21
Digitally Enabled Staff	• Digitally enabled staff – give them the right tools, empowering staff to continually improve care	19/20
	• Hardware Right	19/20
	• Processes right	19/20
	• Tailored training	19/20
	• Continuous Service Improvement	19/20 – 21/22
	• ESR Maximisation	19/20 – 20/21
	• NHS Jobs/Recruitment Tool	20/21
	• Extranet	19/20 – 20/21

5.2 Theme 2:

Digital Quality Improvement (continued)

Workstream	Deliverables/Projects	When
System Wide Developments	• Rapid deployment of clinical prediction models between Trustworthy Research Environments (TRE) and clinical workflow systems	19/20 – 21/22
	• Deployment of Share2Care Programme	19/20 – 20/21
	• Improved Diagnostics Sharing across Cheshire and Merseyside	19/20 – 21/22

John Grinnell,
Deputy CEO/Director of Finance
"Digital Futures sets out a compelling and inspiring vision for Alder Hey with the experience of staff, children, young people and families at the heart. This is exciting as it will continue to develop us as digital leaders and importantly ensure we always focus on those receiving digital and technology services as part of Alder Hey."

5.3

Theme 3: Unleashing Innovation and Research

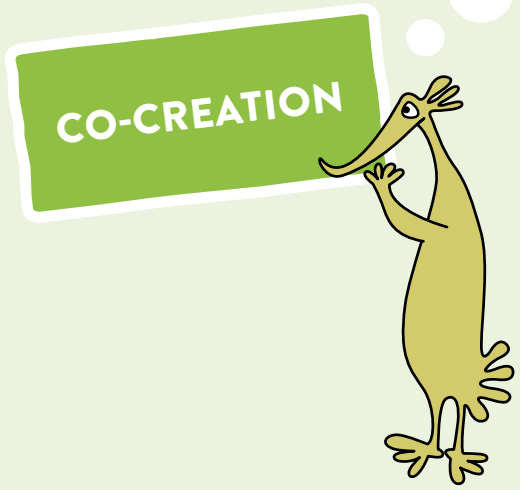
The Unleashing Innovation and Research theme supports our strategy in terms of growing the future.

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

This theme focuses on 3 key workstreams:

- **Living Trust**
- **Innovation Hub**
- **Research and Evaluation**

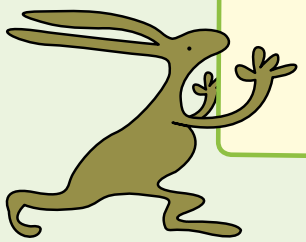
Claire Liddy,
Operational Director of Finance and Innovation
"Spread of innovation through our culture is a critical element of our strategic plan at Alder Hey. It's fantastic that 'unleashing innovation' is one of the three transformational themes in Digital Futures. This further demonstrates the aspiration we have to become a global leader in open innovation that will bring new digital health tech into Healthcare and ultimately improve outcomes and enhance experience for Children, Young People and their Families."



5.3 Theme 3:

Unleashing Innovation and Research (continued)

Workstream	Deliverables/Projects	When
Living Trust	• Sensors	19/20 – 21/22
	• Artificial Intelligence	19/20 – 21/22
	• Immersive Technology	19/20 – 21/22
Innovation Hub	• Maximise the opportunity of the Bat Cave	19/20 – 21/22
	• Evaluation & Clinical utility Test bed	19/20 – 21/22
	• Linkage with research methodologies	19/20 – 21/22
	• Global Innovation Thought Leaders	19/20 – 21/22
	• Accelerator of New Product/Solution	19/20 – 21/22
	• Development	
Research & Evaluation	• Studies led by Alder Hey clinical academics to be online wherever possible	19/20 – 21/22
	• Create an Artificial Intelligence hub with local universities to improve the diagnosis and management of paediatric illness	19/20 – 21/22
	• Development of an evaluation principles framework	19/20 – 21/22
	• Development of an evaluation regulatory framework	19/20 – 21/22



5.4

Technology Roadmap

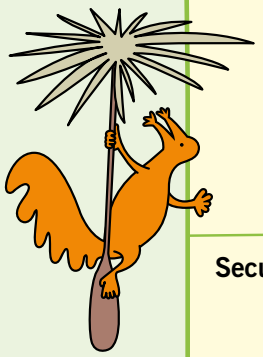
From a technology perspective, Digital Futures will be underpinned by a robust technology roadmap.

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

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

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

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



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

5.5

Design Principles, Values & Culture

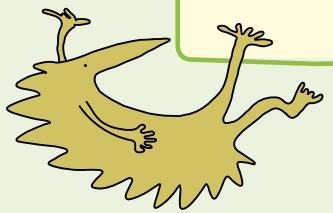
Our design principles, values and culture importantly set out how we will achieve our ambitions.

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

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

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

TRUST VALUE	DESIGN PRINCIPLE/VALUES PLEDGE
Excellence 	• **Simplify** – we will create a great experience for staff and our population by keeping things simple and not unnecessarily overcomplicating our approaches or duplicating effort • **Work with Empathy** • **Customer focused** service model with feedback loop and confidence in resolution
Innovation 	• **Unleashing Innovation Culture** – create mindset shift as part of Trust OD strategy • **Licence to Succeed, Permission to Fail** – we will create an environment and culture where we encourage innovation and learning and accept that with innovation there can be projects. **It's ok to be a geek or a nerd – unleash the inner nerd!**
Respect 	• **No 'Badges on Speedos'** – we will not use our credentials or level of hierarchy to undermine the views of others, we will be respectful of all opinions and input, and work together for our population • **We are digitally responsible** – for the Children and Young People we are here to serve, we will operate a digitally responsible environment
Together 	• **One Team Ethos** – we will work together as 'one team' with our divisions in order to provide a joined up service to staff. We will work together, not in silos • **Do With not To** – our service needs should drive the system • **Co-Design and Co-Produce with the Person at the Centre** – We will work with our population and staff to ensure that the services we develop are designed around people not organisations



PARTNERSHIPS

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

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

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

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

TRUST VALUE	DESIGN PRINCIPLE/VALUES PLEDGE
Together 	• **Work in Partnership** – we will work together as a collaboration, build and lead our digital programmes together. Digital leaders will 'walk the walk' with their clinical colleagues and vice versa, to ensure a deep level of understanding of the impact of their work • **Pool efforts and assets** – working together to leverage best value, drive economies of scale, avoid duplication and unnecessary competition
Openness 	• **Share our Learning** – We will share our work openly and transparently with one another and with external colleagues, creating learning from best practice approach. We will contribute to blueprints locally and nationally. Where appropriate, we will share, co-commission or jointly procure systems • **Open Standards** – our approach is based on open standards and being vendor agnostic, with principles of working together to implement through this approach, including agreed standards for collaboration

5.6

Service Model, Partnership and Customer Service

Integration

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

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

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

Core Clinical Team

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

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

Digital Clinical Experts

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

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

Nik Barnes, Consultant Radiologist/CCIO

"Digital Futures provides us with an excellent guide on how we can use the skills and knowledge in Alder Hey to put us at the forefront of modernisation of healthcare in the region, country and further afield. We have a framework to decide how we can make sure that quality of care and experience for our patients and staff are foremost in everything we plan. We also have the basis to design a system in which we will work together to the same aim, with good clinical guidance, using the best ideas from all areas in a single plan."

Digital Genius Bar

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

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

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

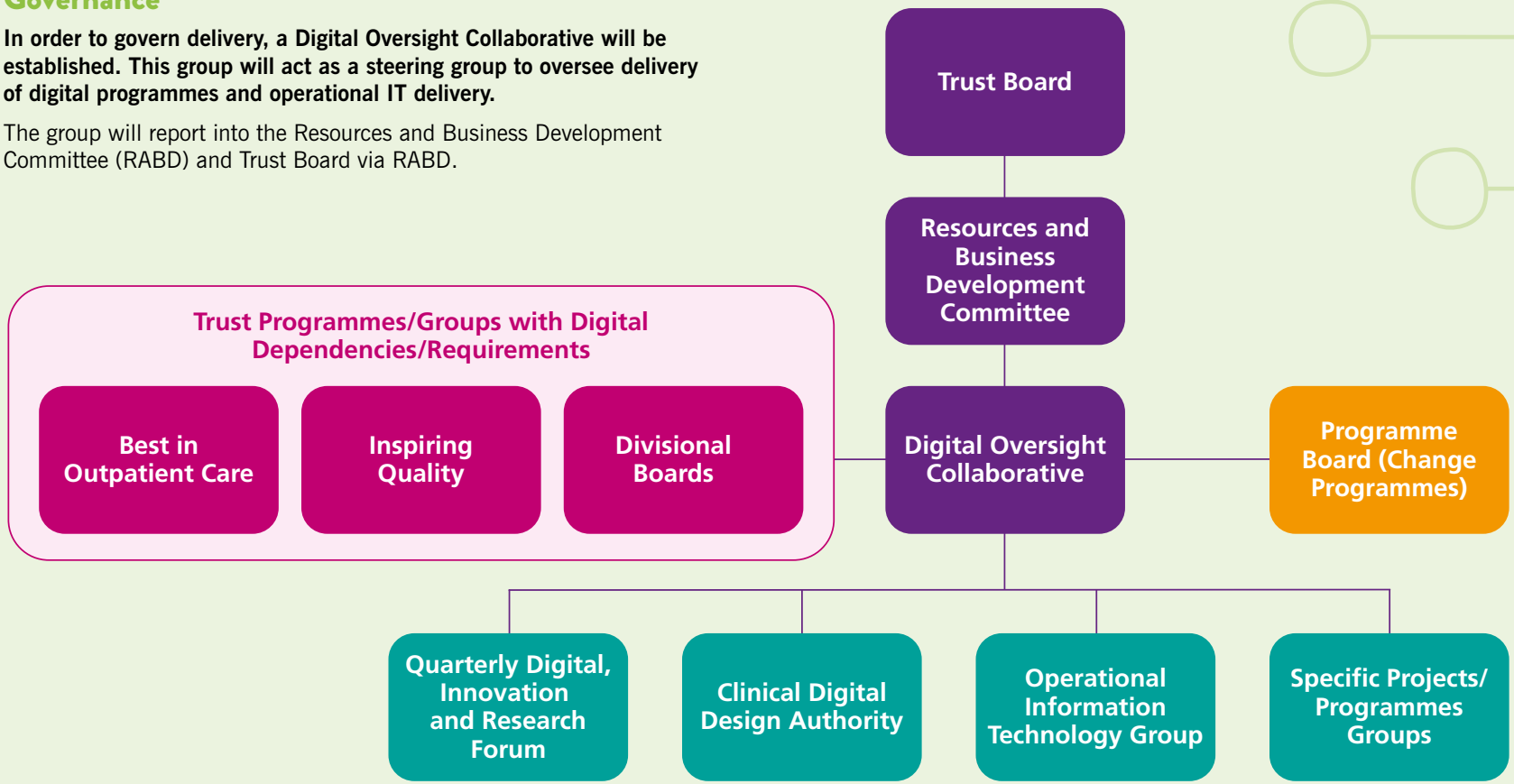
We will ensure assurance that our staff are part of a continuing programme to update/ refresh their knowledge profile of our clinical digital systems. This will be achieved through the publication of events and sessions and on-line teaching through a digital portal. Available through a desktop icon or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

5.7

Governance

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

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



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

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

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

A range of groups will be established as necessary throughout the lifetime of the strategy to oversee key programmes of work.

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

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

5.8

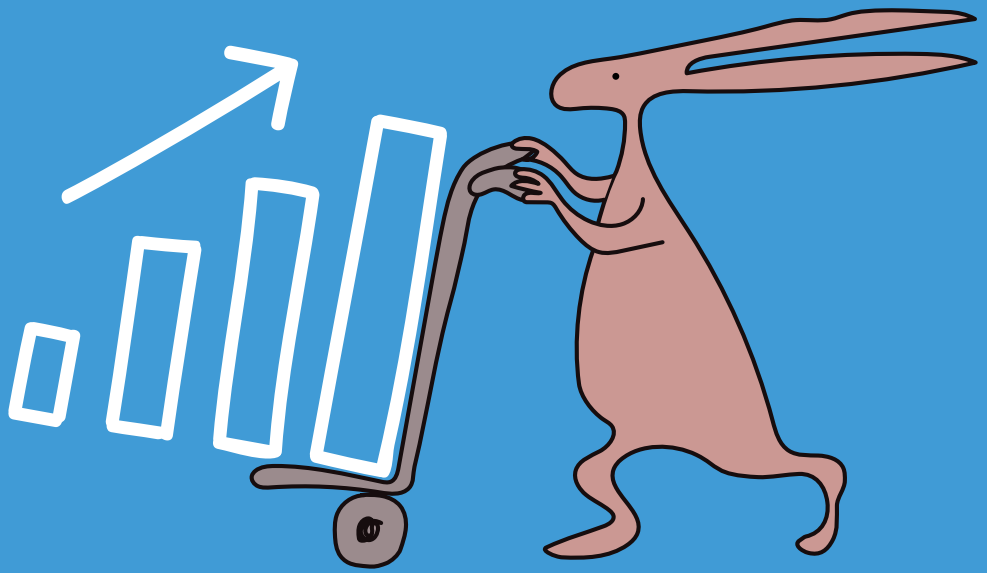
Investment

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

Digital Futures will allow bold investments into digital that will differentiate Alder Hey as a global leader. It will support radical changes that will improve quality and productivity that will drive efficiencies to reinvest in services. A robust approach to benefits realisation will be in place, reported through the Trust's programme governance arrangements.

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

6 Digital Futures



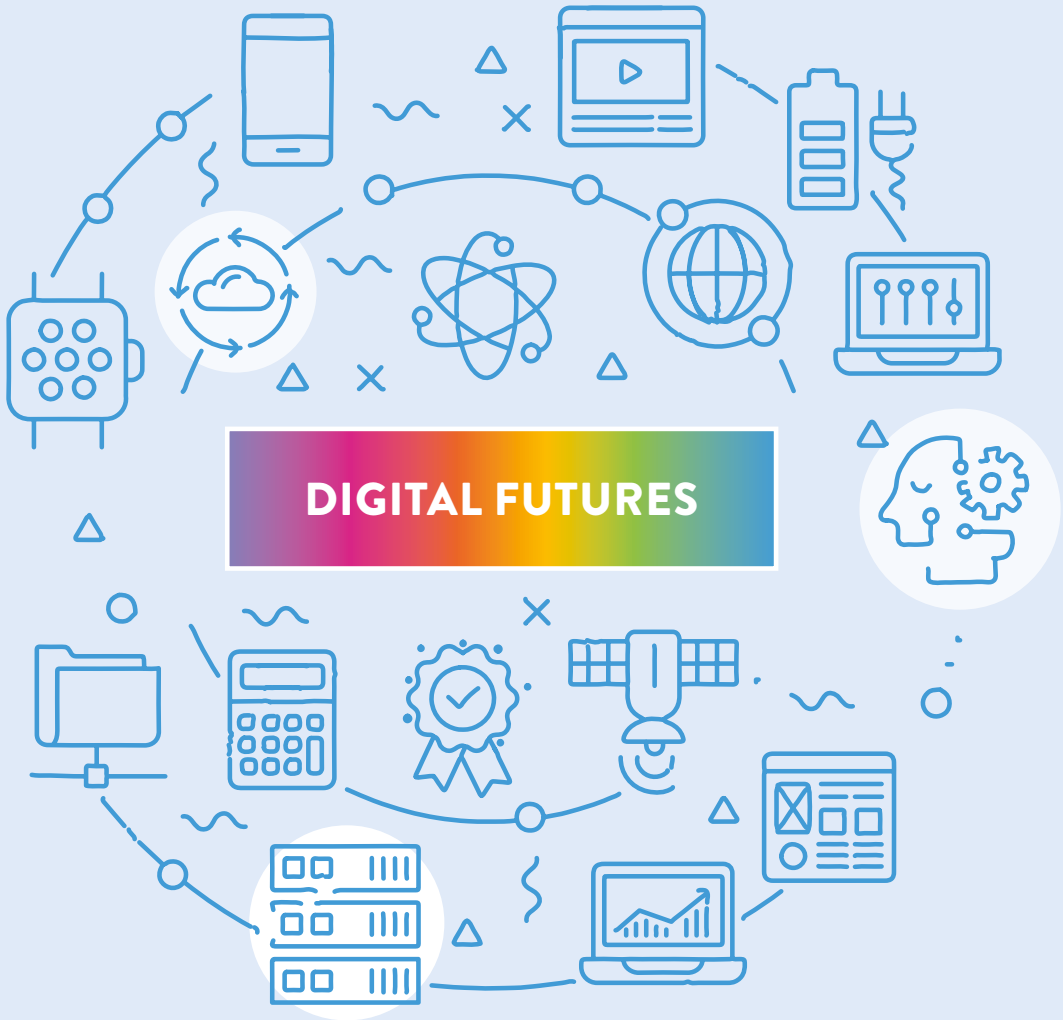
Alder Hey is a wonderful place. We deliver world class services to our Children and Young People. Building on our digital and technology developments and investments, it is a pivotal time for our next stage of delivery through Digital Futures.

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

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

Kate Warriner, Chief Digital and Information Officer

"Alder Hey is a major jewel in Liverpool's health system, delivering fantastic services to children, young people and their families. Alder Hey has delivered some major change programmes over recent years, putting us in a great position in terms of digital care and innovation. Digital Futures provides a clear vision for us to make a further step change on our exciting digital journey ahead."



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Find out more...

You can download a copy of Digital Futures from our website www.alderhey.nhs.uk

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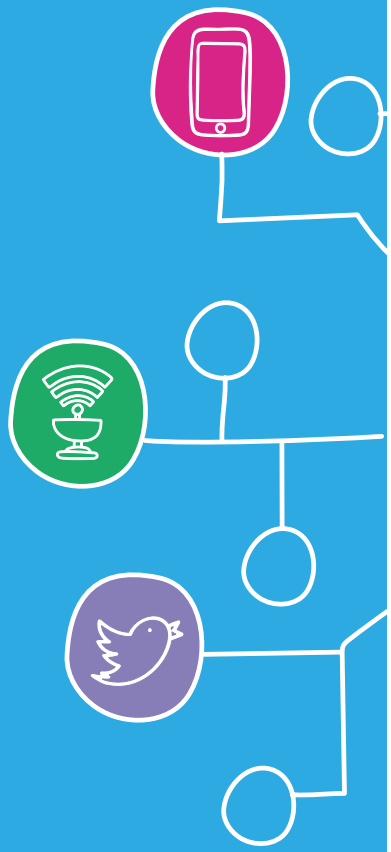
Liverpool L12 2AP



Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd September 2019

Paper Title:	Proposed Change to Board composition
Report of:	Erica Saunders, Director of Corporate Affairs
Paper Prepared by:	Erica Saunders, Director of Corporate Affairs

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☐ ✓ ☐
Background Papers and/or supporting information:	To ratify the changes to the Board composition approved by the Council of Governors at its meeting on 17th June 2019 – attached at Appendix 1	
Action/Decision Required:	To note To ratify	☐ ✓
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** **The best people** doing their best work Sustainability through **external partnerships** Game-changing **research and innovation** **Strong Foundations**	☐ ☐ ✓ ☐ ✓
Resource Impact:	N/A	

Appendix 1

Council of Governors

Proposed Change – Composition of Non-Executive Directors

1. Purpose

The purpose of this paper is to note the Council's approval to amend the Trust's current composition of the Board of Directors as it relates to the number of Non-Executive Directors.

2. Background

The Board will be aware of the strategic importance of Alder Hey's partnerships with academic institutions, with '*game-changing research and innovation'* as one of the Trust's four major pillars for delivery of our vision for the future.

In particular, Alder Hey's relationship with the University of Liverpool has been long-standing and mutually beneficial; in recognition of this, in April 2012 the Council of Governors approved a proposal to create a specific role on the Board for an unpaid, non-voting 'University Advisor'. The aim of this role at that time was to:

- Strengthen connections between Alder Hey and the University and related stakeholders;
- Share responsibility for communicating the decisions of the Board with appropriate partners;
- Contribute to strategic planning and structured decision-making.
-

This role has been undertaken by two University colleagues over the period, most recently by Professor Louise Kenny, Executive Pro-Vice-Chancellor Faculty of Health and Life Sciences. Board colleagues have found the contribution of the University Advisor invaluable in taking our vision forward.

In May 2019, the Trust Chair received correspondence from the University of Liverpool Vice Chancellor, Professor Dame Janet Beer requesting that the Trust reconsider the University's representation on the Alder Hey Board. The rationale for this is in tune with the established principle of strengthening the partnership still further, with reference to a range of developments relating to children and young people including the 'Healthy Start' research priority and all three faculties supporting the Child Friendly City UNICEF bid for Liverpool. In addition, Dame Janet also highlights that the University has in recent times nominated senior post-holders to take on formal Non-Executive roles on a number of local NHS provider boards, with each nominee subject to a formal appointment process and requests that Alder Hey now considers taking the same approach. As with all Non-Executive appointments, this would lie within the gift of the Council of Governors.

3. Proposed Amendment

Following discussions with the Nominations Committee at its meeting held on 3rd June, it is proposed that the most appropriate way to achieving both the Trust's strategic intention to improve diversity and continue to maintain a fully balanced skill mix as a Board **and** fulfil the University's request, is to create a seventh Non-Executive post, designated to the University. This can be facilitated by agreement to appoint to the maximum number of Non-Executives allowable under Trust's constitution as follows:

22. Board of Directors – composition

22.1 The Trust is to have a Board of Directors.

22.2 The Board of Directors shall be composed of not less than:

22.2.1 a Non-Executive Chair;

22.2.2 *five-seven other* Non-Executive Directors, and

22.2.3 five-seven Executive Directors

22.3 One of the Executive Directors shall be the Chief Executive.

22.4 The Chief Executive shall be the Accounting Officer.

22.5 One of the Executive Directors shall be the Finance Director.

22.6 One of the Executive Directors is to be a registered medical practitioner or a registered dentist.

22.7 One of the Executive Directors is to be a registered nurse.

22.8 The number of Directors on the Board of Directors may be increased to seven, provided always that *at least half of the Board, excluding the Chair, comprises Non-Executive Directors*.

23. Board of Directors – qualification for appointment as a Non-Executive Director

A person may be appointed as a Non-Executive Director only if –

23.1 S/he is a member of the Public Constituency; or

23.2 S/he is a member of the parent and carer class of the Patients' Constituency; or

23.3 Where any of the Trust's hospitals includes a medical or dental school provided by a university, *s/he exercises functions for the purposes of that university;* and

23.4 S/he is not disqualified by virtue of paragraph 27 below.

4. Recommendation

The Board is asked to note the proposed change to the composition of the Non-Executive cohort on the Board and mandate the Nominations Committee to undertake the appropriate recruitment process on its behalf.

Erica Saunders
Director of Corporate Affairs
September 2019

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4.09.2019

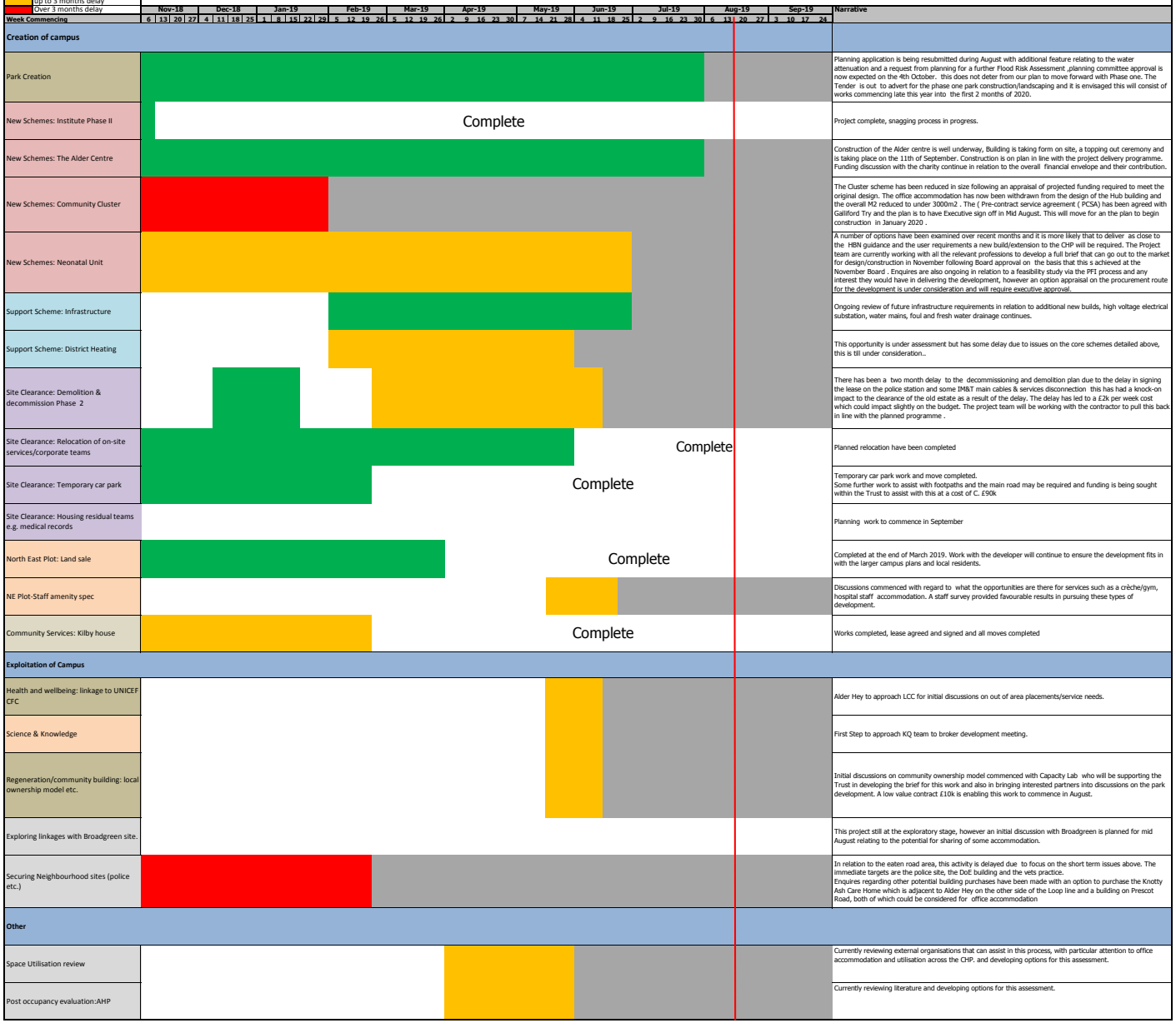
Paper Title:	**Alder Hey in the Park update report**
Report of:	**David Powell**
Paper Prepared by:	Sue Brown

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

Trust Board. **HIGHLIGHT REPORT Site & Park Development August 2019**

SRO: David Powell
Author: Sue Brown

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



Planning application is being resubmitted during August with additional feature relating to the water attenuation and a request from planning for a further Flood Risk Assessment ,planning committee approval is now expected on the 4th October. this does not deter from our plan to move forward with Phase one. The Tender is out to advert for the phase one park construction/landscaping and it is envisaged this will consist of works commencing late this year into the first 2 months of 2020.

Project complete, snagging process in progress.

Construction of the Alder centre is well underway, Building is taking form on site, a topping out ceremony and is taking place on the 11th of September. Construction is on plan in line with the project delivery programme. Funding discussion with the charity continue in relation to the overall financial envelope and their contribution.

The Cluster scheme has been reduced in size following an appraisal of projected funding required to meet the original design. The office accommodation has now been withdrawn from the design of the Hub building and the overall M2 reduced to under 3000m2 . The (Pre-contract service agreement (PCSA) has been agreed with Galliford Try and the plan is to have Executive sign off in Mid August. This will move for an the plan to begin construction in January 2020 .

A number of options have been examined over recent months and it is more likely that to deliver as close to the HBN guidance and the user requirements a new build/extension to the CHP will be required. The Project team are currently working with all the relevant professions to develop a full brief that can go out to the market for design/construction in November following Board approval on the basis that this s achieved at the November Board . Enquires are also ongoing in relation to a feasibility study via the PFI process and any interest they would have in delivering the development, however an option appraisal on the procurement route for the development is under consideration and will require executive approval.

Ongoing review of future infrastructure requirements in relation to additional new builds, high voltage electrical substation, water mains, foul and fresh water drainage continues.

This opportunity is under assessment but has some delay due to issues on the core schemes detailed above, this is till under consideration..

There has been a two month delay to the decommissioning and demolition plan due to the delay in signing the lease on the police station and some IM&T main cables & services disconnection this has had a knock-on impact to the clearance of the old estate as a result of the delay. The delay has led to a £2k per week cost which could impact slightly on the budget. The project team will be working with the contractor to pull this back in line with the planned programme .

Planned relocation have been completed

Temporary car park work and move completed.
Some further work to assist with footpaths and the main road may be required and funding is being sought within the Trust to assist with this at a cost of C. £90k

Planning work to commence in September

Completed at the end of March 2019. Work with the developer will continue to ensure the development fits in with the larger campus plans and local residents.

Discussions commenced with regard to what the opportunities are there for services such as a crèche/gym, hospital staff accommodation. A staff survey provided favourable results in pursuing these types of development.

Works completed, lease agreed and signed and all moves completed

Alder Hey to approach LCC for initial discussions on out of area placements/service needs.

First Step to approach KQ team to broker development meeting.

Initial discussions on community ownership model commenced with Capacity Lab who will be supporting the Trust in developing the brief for this work and also in bringing interested partners into discussions on the park development. A low value contract £10k is enabling this work to commence in August.

This project still at the exploratory stage, however an initial discussion with Broadgreen is planned for mid August relating to the potential for sharing of some accommodation.

In relation to the eaten road area, this activity is delayed due to focus on the short term issues above. The immediate targets are the police site, the DoE building and the vets practice.
Enquires regarding other potential building purchases have been made with an option to purchase the Knotty Ash Care Home which is adjacent to Alder Hey on the other side of the Loop line and a building on Prescot Road, both of which could be considered for office accommodation

Currently reviewing external organisations that can assist in this process, with particular attention to office accommodation and utilisation across the CHP. and developing options for this assessment.

Currently reviewing literature and developing options for this assessment.

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Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd September 2019

Paper Title:	Integrated Governance Committee Assurance Report from the 22nd May 2019 meeting
Date of meeting:	22nd May 2019
Report of:	Kerry Byrne – Non executive Director, Chair Integrated Governance Committee (IGC)
Paper Prepared by:	Cathy Umbers, Associated Director Nursing & Governance.

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the IGC meeting held on the 22nd May 2019.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	N/A

1. Introduction

The Integrated Governance 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 that the Committee oversee the design and effective operation of the risk management processes across the Trust. Ensuring processes, structures and responsibilities are in place for identifying and managing risks at all levels of the organisation from wards and departments to Board Committees.

The committee ensures:

- The Trust maintains a Board Assurance Framework that is reviewed by the Committee, and presented to the Trust Board at each of their meetings.
- Maintenance of a comprehensive Corporate Risk Register, with risks prioritised with appropriate action plans in place and managed.
- Each Division, Corporate Function and The Change Programme maintains an up-to-date risk register and are actively managing the identified risks.
- All Divisions, Corporate Functions and Projects are subject to review and challenge of their progress in embedding risk management, in line with the Committee's work programme.
-

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

- The Divisions and Corporate Functions presented their risk registers, including any identified high risks, closed risks, new risks added and any risks with a change in status. In addition, any deficits in actions to mitigate risk and omissions in management were discussed, including plans for improvement.
- The Deputy CEO, Director of Finance presented "Deep Dive" of the following Strategic Risks on the Board Assurance Framework (BAF).
  - 1.4. Risk of no deal Brexit (current risk rating 9). The risks are the Trust not receiving supplies, medicines, consumables and equipment. Also data flow across boundaries out of the UK to Europe and via versa. Business continuity plans are in place to mitigate and the Trust has undertaken desktop simulation exercises to test systems and processes. The Trust continues to test data flow and no major issues have been identified.
  - Failure to deliver control total (current risk rating 16) and the associated risks. The target control total for 2019/20 is a surplus of £1.6m. Plans to mitigate both internally and with external bodies support were outlined.

- The Corporate Risk Register showed there are currently 22 high risks on the register, inclusive of all high risks from 1st March 2019 – 30st April 2019.

High/ Extreme Risk			
15	16	20	25
10	**11**	**1**	**0**
22 of total risks			

The committee was advised that the following 10 policies were ratified by the IGC policy sub-group, subject to minor changes.

1	Secure Access Policy	19/20/23
2	ICT Network Security Policy	19/20/24
3	Bring your Own Devices Policy	19/20/25
4	Lockdown Policy	19/20/26
5	Email Internet Policy	19/20/27
6	Freedom of Information Policy	19/20/28
7	Information Lifecycle Procedures	19/20/29
8	Mobile Devices Policy	19/20/30
9	Records Management Policy	19/20/31
10	Registration Authority Policy	19/20/32

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

It was highlighted to the committee that there were a number of high risks on the register for a significant period of time, including risk 825 (2015), risk 947 (2016), risk's 1169, 799, 1251, 1306, 1524, 1312, 964, 1787 (2017), risk's 1701,1726, 1668, 1730, 1751 (2018). The Divisions and Corporate Functions were challenged to ensure there risks were being managed effectively. However the committee acknowledged that in some cases mitigating are outside the control of the Trust. Nevertheless the Trust needs assurance that everything that can be done is being done internally and this is reflected on the register. The committee will continue to monitor effectiveness of the management of these risks and all other high risks identified on the register.

The Board will revive the full Corporate Risk Register to the October Board meeting.

4. Positive highlights of note

1872 (closed) – Current risk rating 4 (was 15) **'**Lack of security surveillance'. The system upgrade complete and commissioned.

5. Issues for other committees

Risks will be escalated to the appropriate Board assurance committee based on the type of risk and level of risk (12+).

6. Recommendations

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

END

Alder Hey Children's NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE
22nd May 2019
Time: 14:00-16:00
Venue: Institute in the Park, Large Meeting Room

Present:

Mrs K Byrne	Non-Executive Director **(Chair)**	(KB)
Mrs M Swindell	Director of HR & OD	(MS)
Mrs E Saunders	Director of Corporate Affairs	(ES)
Mr P O'Connor	Deputy Director of Nursing	(PO)
Mr A Bateman	Chief of Operations	(AB)
Mr J Grinnell	Director of Finance	(JG)
Mr M Flannagan	Director of Communications	(MF)

In Attendance:

Mr A Hughes	Director of Medicine Division	(AH)
Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mrs S Brown	Senior Project Manager	(SB)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Mrs J Fitzpatrick	Information Governance Manager	(JF)
Mrs A Kinsella	Health & Safety Manager	(AK)
Ms L Fearnehough	Head of Technical Services	(LF)
Mrs R Greer	Assoc. Chief of Op (Community)	(RG)
Mr J Taylor	General Manager - Innovation	(JT)
Mr S Verstraelen	Head of Quality (Surgery)	(SV)
Mrs V Weston	Assoc. Dir. of Infection Prevention	(VW)
Mrs L Robinson	Quality Assur & Compliance Manager	(LR)

In Attendance other:

Mrs J Preece	Governance Manager	(JP)
Mr S Hooker	Observer - Public Governor	(SH)
Mr D Houghton	Senior Project Manager (Development)	(DH)
Mrs J Hutfield	Compliance, Risk & Contracts Manager	(JH)
Ms Lesley Calder	Minute Taker	(LC)

Apologies:

Mrs C Barker	Chief Pharmacist	(CB)
Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mrs C Liddy	Deputy Dir. of Finance & Bus. Dev	(CL)
Mrs N Murdock	Medical Director	(NM)
Mrs C Fox	Programme Director for Digital	(CF)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mrs L Cooper	Divisional Director of Community	(LC)
Mr D Powell	Director of Development Directorate	(DP)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mrs L Cooper	Research Governance & Quality Lead	(LC)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
	2.	**Chair's introduction**	KB referred to the agreed action from the prior meeting to move all risks to a monthly, rather than weekly review date and for risk owners to review their risks in the 2 week period following the meeting and then keep on top of them going forward to the new monthly timescale. KB then referred to the current issue with Ulysses that all risks were set to a weekly review date and that this currently couldn't be changed so this was resulting in some risks showing as overdue review when in fact they weren't. KB advised the IGC papers were issued late for this meeting making it difficult to read all the papers prior to the meeting. Going forward attendees need to submit their papers to the deadline requested. Papers will be issued immediately following the deadline so any that are late will need to be sent subsequently.			
19/20/01		**Minutes of previous Meeting**	The Committee considered the minutes of the previous meetings of the Integrated Governance Committee held on 13th March & 8th April 2019. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 13th March 2019 & 8th April 2019			
	3.	**Risk Register Management Reviews**				
Item no	**Item**	**Key Point Discussions**		**Action**	**Owner**	**Time**

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
						Scale
19/20/02	**3.0**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. AM focused on the high risks from the Surgical Division for this reporting period. • Total number of risks = 59 • Number of new risks identified since the last reporting period = 9 (1853, 1855, 1868, 1870, 1873, 1874, 1878, 1881, 1887) • Number of risks closed and removed from the risk register = 9 (1795, 1868, 1870, 1873, 1874, 1878, 1881, 1887, 942) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 5 • Number of risks with changed risk scores = 7 (1841, 1842, 1280, 1731, 1747, 1815, 1855) • Number of high/extreme risks escalated to the Executive Team = 4 (1306, 964, 1870, 1887) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **<u>High risks</u>** **Risk no 1870 (risk rating15): A patient attending the ward could deteriorate clinically and this may not be recognised due to lack of monitoring of their condition.** AM advised this risk is a significant safety risk to patients. AM met with the team on 4A and an agreement has been made that unwell patients will go through a specialist area in AED to ensure they follow the right process and a			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			SOP has been completed as part of the actions. It is expected this risk will be mitigated as soon as the SOP is embedded in practice. **Risk no 1887 (risk rating 20): Unsafe patient area; roof leaking into bed spaces 45 & 46 orange pod (HDU).** AM advised 45 & 46 orange pod was deemed not usable as rainwater was coming into the area. On the basis of repeated flooding this risk was increased to a score of 20. AM advised that a meeting was held on 13th May 19 with 'Laing O'Rourke and they are going to complete this work over the next 2 weeks. AM advised he will provide an update to next IGC to ensure this work has been completed KB recognised that the Surgical Division has a large risk register and thanked AM and the team for ensuring the risks were all within review date and being managed effectively. KB asked for the Committee's thanks to be conveyed to the team for the good work. AB advised that the Surgery Division has a healthy turnover of risks and are closing risks whilst lower/higher scoring risks are coming in. CU advised that a number of the moderate and high moderate risks appear fairly static i.e. the trend analysis graph shows limited movement This will need to be addressed going forward as these risks could be realised if actions to address the gaps are not addressed. AM advised this is a combination of new and existing risks. The Surgical Division provided assurance that they are actively managing their risks on the risk register and are in a good position however; work is on-going to manage the risks effectively. **Resolved** that: the Committee NOTED the contents of the paper	Risk 1887 to provide an update at next IGC	AM	10th July 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/03	**3.1**	**Medicine Division**	Cath Wardell (CW) presented the risk management report for Medicine. CW focused on the high risks for this reporting period. • Total number of risks = 89 • Number of new risks identified since the last reporting period = 7 (1859, 1871, 1882, 1875, 1851, 1876, 1877) • Number of risks closed and removed from the risk register = 14 (1130,1198,1346,1392, 1723, 1831,1871, 1875, 1876, 1877, 1882, 535 804, 869) • Number of risks with an overdue review date = 28 • Number of risks with no agreed action plan = 4 • Number of risks with changed risk scores = 9 (**1726, 868,** • Number of high/extreme risks escalated to the Executive Team = 5 (1169, 125, 1726, 1787, 1730) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **<u>New risks</u>** **Risk no 1882 (risk rating 9) risk of additional admissions to hospital including PICU and delays to discharge.** Cause = There is inequity in access to cough assist equipment whose responsibility to pay for are clinical commissioning groups for neuromuscular patients which is leading to delays or failure to approve, deliver or maintain equipment. AB advised you need to agree what steps are to be taken to address this as patients	Risk 1882 provide an update at next IGC on progression procuring cough assist	CW	10th July 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			shouldn't be left without the equipment due to financial implications. CW advised a pathway needs to be agreed with all regional commissioners to ensure prompt supply of equipment and appropriate support to maintain. This has been escalated to the commissioners but it still doesn't resolve the issue of where devices should be procured / maintained. AB advised the patients shouldn't be left without equipment due to financial implications. CW advised she will provide an update to IGC of the progress made to sort this issue. **Risk no 1875 (risk rating 8) The Trust is currently unable to guarantee compliance with IDDSI Standards (International Dysphagia Diet Standardisation Framework) with regard to modified food, this may lead to choking/aspiration if wrong texture given.** CW advised the catering lead has confirmed the compliance can be provided by outsourcing to an external company. In the meantime, ward chefs have been briefed and trained to prepare food of IDDSI compliance to the best of their ability which has given the assurance this risk is being mitigated. CU has asked for an update to be included on the risk to show there is enough compliance and to also add an addendum to the IDDSI report. **Risk no 1169 score 20 – Fragile Medical Workforce within the Haematology Service.** CW advised the service remains fragile as it's difficult to recruit to the speciality. A Consultant is returning from maternity leave in September 19. The Division are looking at resilience within the dept. and are doing everything possible to reduce this risk at the moment. CW also advised that additional risks are to be added to the risk register for the fragile workforce in Palliative Care to provide assurance.	equipment		

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			CW advised the Medicine Division are working with risk owners to close existing risks. CW advised that the Medicine Division are reducing their risks even though not a dramatic reduction at this time and there is still a lot of work to complete, however she is confident the Division is showing assurance of effective management of risk. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/04	**3.2**	**Community Division**	Rachel Greer (RG) presented the risk management report for Community. RG focused on the high risks from the Division for this reporting period. • Total number of risks = 44 • Number of new risks identified since the last reporting period =7 (1850, 1852, 1860, 1865, 1879, 1885, 1886) • Number of risks closed and removed from the risk register = 5 (1461, 1538, 1556, 1702, 803) • Number of risks with an overdue review date = 5 • Number of risks with no agreed action plan = 7 • Number of risks with changed risk scores = 4 (2 Increased risk scores 1577, 1642) • Number of high/extreme risks escalated to the Executive Team = 1 (1524) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			RG advised that the Quality Assurance Rounds have helped areas to identify risks which have now been added to the risk register and the Rounds are prompting staff to look at their risks. RG advised the committee that the Division are confident they are effectively managing the risks for Community, while recognising there is ongoing work required. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/05	**3.3**	**Infection Control Service**	Valya Weston (VW) presented the risk management report for Infection Prevention and Control. Risks from the report were highlighted as follows: • Total number of risks = 8 • Number of new risks identified since the last reporting period = 1 (1869) • Number of risks closed and removed from the risk register = 2 (1374, 1869) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Closed risks **Risk no 1374 risk rating 4 - (Increasing prevalence of HCAI MSSA Bacteraemia within the Trust)** This risk was closed as the 25% reduction target was met for 2018-19. This will be monitored through IPCC via MSSA situation reports. VW advised out of the batch of MSSA Bacteraemia there were 4 cases with lapses of care. AB asked if there had been a situational review completed on the MSSA as it does not feel right to close this risk until this has been reviewed. The Committee agreed the cluster review needs to be completed and depending on the findings will dictate if this risk can be closed on the risk register. VW agreed to reopen this risk on the register. VW advised the Committee that although there is ongoing work required, the Infection Control team are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	Risk 1374 "(Increasing prevalence of HCAI MSSA Bacteraemia" to be reopened and a cluster review to be completed on recent cases.	VW	12th July 19
19/20/06	**3.4**	**Facilities**	Mark Devereaux (MD) presented the risk management report for Facilities. Risks from the report were highlighted as follows: • Total number of risks = 11 • Number of new risks identified since the last reporting period = 1 (1888) • Number of risks closed and removed from the risk register = 3 (1659, 1658, 1796) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk score = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **New risk** **Risk no 1888 risk rating 9 - Staff do not have the knowledge and skills to de-escalate or deal with incidents of violence and aggression.** Non-attendance of staff attending Conflict Resolution Training. MD advised Conflict Resolution is part of Mandatory Training and Facilities have arranged for additional training sessions for front facing staff dealing with incidents of aggression and threat of violence. The Conflict Resolution Training is now one full days' training in response to what staff have asked for and they are finding it helpful. Greg Murphy (GM) is working with Learning & Development to increase attendance and awareness. MD advised all risks are within review date and Facilities are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/07	**3.5**	**IM&T**	Leanne Fearnehough (LF) presented the risk management report for IM&T. Risks from the report were highlighted as follows: • Total number of risks = 21 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Number of risks with an overdue review date = 16 • Number of risks with no agreed action plan = 2 • Number of risks with changed risk score = 1 • Number of high/extreme risks escalated to the Executive Team = 3 (947, 1187, 1701) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = No significant changes within the reporting period. KB advised IM&T need to ensure their risks are reviewed in a timely manner (particularly given that there are only 16) and reminded LF this was highlighted at the last IGC meeting. LF acknowledged there has been a lack of review of the risks and she is going to meet with CU to discuss and validate. LF informed the Committee that a review of the IM&T infrastructure is going to Trust Board July 19, around resilience. IM&T are clearer now than they were before about the direction of the service going forward. Kate Warriner (KW) the new Chief Digital and Information Officer wants to spend the next few weeks to ensure that IM&T have the necessary resilience. LF advised the committee that although there is ongoing work required, the IM&T acknowledge that this needs to be consistent **Resolved** that: the Committee NOTED the contents of the paper			
19/20/08	**3.6**	**Human Resources**	Melissa Swindell (MS) presented the risk management report for Human Resources. Risks from the report were highlighted as follows:			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Total number of risks = 9 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 2 (1739, 1833) • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **<u>Decreased risk score</u>** **Risk no 1739 current risk rating 4 - Length of time to complete internal investigations in relation to employee relations.** This risk has decreased in risk score from 6 to 4 and a number of factors have contributed to this. MS advised there has been an increase in the number of staff side representatives which has improved the position, which has resulted in a decrease in the risk score. **Risk no 1833 current risk rating 9 - Annual Divisional cost pressures of £226.5k**. This risk has also reduced in risk score from 12 to 9, and whilst an element of cost pressure remains within the HR team the particular risk associated with DBS checking has been funded. As agreed with staff side the Trust will fund the initial DBS check and thereafter all three yearly checks will be completed and an agreed method of payment will be agreed with staff via their salary. MS advised the remaining cost pressures have been			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			reviewed and cost have now significantly reduced. MS advised that Human Resources have had a thorough review of the risk register and are comfortable with their current position. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/09	**3.7**	**Finance**	John Grinnell (JG) presented the risk management report for Finance. Risks from the report were highlighted as follows: • Total number of risks = 5 • Number of new risks identified since the last reporting period = 2 (1861, 1864) • Number of risks closed and removed from the risk register = 1 805 duplicated with 1861) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **New risks** **Risk no1864 risk rating 9 – Performance issues with NEP Cloud System.** JG advised that the Finance Dept. have recently implemented and updated the system NEP Cloud, and are working with the provider on a daily basis to resolve issues that have arisen			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			following this, such as problems producing management information. JG advised the committee that the Finance department has no overdue risks and no risks without agreed action plans and are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/10		**Estates**	Jean Hutfield (JH) presented the risk management report for Estates. Risks from the report were highlighted as follows: • Total number of risks = 2 • Risks transferred from Estates to Development Directorate = 3 (1746, 1858, 1880 - transferred to Development Directorate) • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 1 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 JH advised all risks are within review date and Estates are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/10a		**Building Services**	Graeme Dixon (GD) presented the risk management report for Building Services. Risks from the report were highlighted as follows: • Total number of risks = 9 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 2 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **High risks with a score of 15+** **Risk no 1388 risk rating 20 – Pipe corrosion.** GD advised a meeting was held with Execs/Non Execs on current status. A monthly meeting is being arranged with the SPV (landlords) in order to track actions and progress. GD advised that Building Services is waiting an update from SPV regarding the pipework as there are 35 areas to date that need replacing. The work will be completed once we have a pipework specialist to complete as this work has gone out to tender again. **Risk no 825 risk rating 15 – Internal balconies.** GD advised a feasibility study was undertaken by contractors on the 26th April 19. Now awaiting the report in order to progress.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			<u>Commentary on other existing risks</u> **Risk no 837 risk rating 4 – Skylight Steven Gerrard Garden.** GD advised that the risk is children are climbing onto the planters and skylights on a daily basis. Building Services are looking at a plan of action to complete with the possibility to landscape entire area again and possibility to put a roof over the garden. **Risk no 1709 - Ceiling Tiles risk rating 8.** GD advised that there have only been 2 incidents recorded over the last few months and that significant improvements have been made. This risk should be able to be closed over the next 4 weeks. **Risk no 1756 Multi Storey Car Park Fire Alert risk rating 5.** GD advised this risk is due to changes in regulations since the fire in Liverpool One car park and Building Services are just waiting on a business case decision from the Executive Team to decide if we are going to install a sprinkler system or similar equipment to assist in the event of a fire. GD advised the committee that although there is ongoing work required, Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	Risk no 1756 (multi-storey car park fire risk) GD to chase up Execs for feedback and report back to the next IGC meeting.	GD	10th July 19
19/20/10b		**Development Directorate**	Sue Brown (SB) presented the risk management report Development Directorate. Risks from the report were highlighted as follows:			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Total number of risks = 14 • Number of new risks identified since the last reporting period = 5 (1872, 1880, 1883, 1858, 1862) • Number of risks closed and removed from the risk register = 2 (1829, 1880) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 2 (1244, 1746) • Number of high/extreme risks escalated to the Executive Team =1 (1858) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 . **New risks** **Risk no 1858 risk rating 10 - Security and fire risk controls**. SB advised this risk requires to be broken down and each individual risk registered by the Fire Officer with specific actions for each. SB to feedback progress to next IGC meeting. SB advised that the Development Directorate risks continue to reduce as progress is made and have significantly reduced their risks within this reporting period and are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	Risk no 1858 "security and fire risk control" to report back to next IGC Meeting on breaking this down into individual risks	SB	10th July 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/11	**3.9**	**Health & Safety**	Amanda Kinsella (AK) presented the risk management report for Health & Safety. Risks from the report were highlighted as follows: • Total number of risks = 10 • Number of new risks identified since the last reporting period = 1 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 1 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **<u>Realised risks</u>** **Risk no 1386 risk rating 12 – Lift Entrapment – CHP** This risk was identified following a near miss incident (patient entrapment) – AK advised that following extensive reviews of the design with the lift company, they have presented design and costings to modify each bed lift, making the hatch accessible. Cost per lift is £2k total of £6k plus VAT to modify 3 bed lifts. Decision is required to proceed. If agreed to proceed to modify bed lifts, decision will be required if modification should be rolled out to public lifts also. AK advised H&S have now received costings (£6,000) and she will now liaise with Building Services for the work to be completed. **Risk no 809 risk rating 12 – Welfare Regulations – Retained**	Risk no 1386 "lift entrapment" AK to report back to next IGC Meeting as to whether modifications have been agreed and actioned	AK	10th July 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Estate. Security breach incidents. AK advised employee narrowly missed being hit by speeding vehicle along blue light road, accessing Catkin Car Park. The building is unsecured due to recent patient access arrangements for Catkin Car Park/Clinic. Breaches are to the fire door. AK advised that the Security Breaches Report will go to the next Health & Safety Committee. AK to report progress to next IGC meeting. **Risk no 1840 risk rating 9 – Regularly delivering COSHH (Control of Substances Hazardous to Health) compliance training by the Safety Team**. AK advised there are now 30 new COSHH risk assessors across the Trust and until we have audit compliance from all key staff the risk score has been increased. AK further advised that all generic risk assessments have been completed and waiting for the Communications Team to upload on to the intranet page. AK to feedback progress to next IGC meeting. AK advised the committee that Health & Safety are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	Risk no 809 AK to report back to next IGC Meeting on speeding on the blue light road and breaches in access to the Catkin Clinic via the fire door Risk no 1840 AK to report back on the progress of the generic risk assessments being uploaded to the intranet page	AK	10th July 19
19/20/12	**3.10**	**Business Preparedness & Emergency Planning**	Elaine Menarry (EM) presented the risk management report for Business Preparedness & Emergency Planning. Risks from the report were highlighted as follows: • Total number of risks = 14 • Number of new risks identified since the last reporting period = 4 (1895, 1896, 1897, 1898)			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		• Number of risks closed and removed from the risk register = 3 (1442, 1151, 1153) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **Closed risks** **Risk no 1151 - Completion of Exercise Blackstart process.** Exercise Blackstart was successfully tested in February 2018 and will continue to be tested on an annual basis. The remaining risk from the exercise for finalising UPS arrangements has been added as a new risk (Risk ID 1896). EM advised the next Exercise is July 2019. **Risk no 1153 - Ensuring the Trust has an approved Pandemic Flu Plan.** The Trust has an approved Pandemic Flu Plan not due to expire until 2020. The remaining risk relates to exercising the Pandemic Flu Plan and this has been added as a new risk (Risk ID 1898). EM advised she needs to review the Plan with the Director of Nursing. Lead times for review are quite lengthy which EM is to look at the timescales. EM advised some systems require review however is satisfied with management of risks on the register in this area.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
19/20/13	**3.11**	**Information Governance**	Jo Fitzpatrick (JF) presented the risk management report for Information Governance. Risks from the report were highlighted as follows: • Total number of risks = 7 • Number of new risks identified since the last reporting period = 2 (1892, 1893) • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 1 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 1 Following a recent risk review meeting, it was discussed that some of the issues identified around the Data Security & Protection Toolkit required their own risks for: Training & Information Asset Management. These will be addressed separately making it easier to see what progress is being made. **<u>New risk</u>** **Risk no 1893 current risk rating is 9 – Information Asset Management & Tools -** JF advised that staff need a better understanding about what is expected of them in terms of roles and	Risk 1893 to be picked up outside of IGC. Provide an update to the	JF/ES	10th July 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			documentation/process for managing information assets that is a mandatory requirement to be recorded on the information asset register (IAR) i.e. System Level Security Policies, Disaster Recovery and Business Continuity - Risk Assessments and Data Flow Mapping recorded as a separate risk. JF will be discussing this issue with the ES and KW around the need for Information Asset Administrators and where they should reside in the organisation as well as the need for Information Asset Management Tools as part of a broader paper requested for the IG function with risks. In the event of a data breach that could be a cyber-attack or hack for example, the Trust needs to have dedicated Information Asset Owners IAOs and Information Asset Administrators (IAAs) to deal with these events. JF to speak to ES outside of IGC. JF advised the Committee that a lot of progress has been made and IG and are satisfied with progress made to date. **Resolved** that: the Committee NOTED the contents of the paper	next IGC Meeting.		
19/20/14	**3.12**	**Medicines Management & Pharmacy**	Cathy Wardell (CW) presented the risk management report for Medicines Management & Pharmacy in the absence of Catrin Barker (CB). Risks from the report were highlighted as follows: • Total number of risks = 16 (15 active, 1 residual) • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 3 (869, 1877, 1198) • Number of risks with an overdue review date = 4 (260, 1510, 1720, 1787) Review date 6-17 May 2019			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		• Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 1 (1787) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **Overdue risks** CW advised there are 4 overdue risks (which expired May 19). This was discussed at senior team meeting on 22nd May 2019 and will be addressed immediately. KB clarified that risks should be classed as overdue if they fall overdue within the reporting period (in this case to 30 April). Therefore, at this time the risks were not strictly overdue. **Moderate risks** CW advised that Medicine Management's main challenge are the moderate risks which are quite challenging (Parenteral nutrition) and some are outside of our control (such as the antimicrobial app) and this has resulted in some of these risks remaining static. The Division is aware of this and are now planning to take each risk individually and evaluate critically at the senior team meeting to support the risk owner/manager. **Risk 1344 – Pharmacy and ASU cold store risk rating 8.** CW advised this has been agreed and awaiting installation. There has still not been a confirmed date for the installation of the cold store	Risk 1344 (installation of ASU cold	GD	10th

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			back up system. GD advised the ASU cold store will be installed on 24th June 19. The electrical work is being completed in preparation for the installation date. GD to provide an update at IGC July 19. **<u>High risk</u>** **Risk no 1787 risk rating 15 - potential for error associated with prescribing, preparing and administration of parenteral nutrition.** CW advised there has been considerable work ongoing around this high risk. MDT meeting monthly. The original risk rating was 20, currently 15. CW advised the Committee that good progress has been made and Medicines Management & Pharmacy and are satisfied with progress made to date, while recognising ongoing work is required **Resolved** that: the Committee NOTED the contents of the paper	store) update to be provided at next IGC.		July19
19/20/15	**3.14**	**Global Digital Excellence**	There was no representative from the Global Digital Excellence Team to present and there was no risk management report submitted to the Committee.			
19/20/16	**3.15**	**Research Division**	Jason Taylor (JT) presented the risk management report for the Research Division. Risks from the report were highlighted as follows: • Total number of risks = 5 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team =			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			1 (1751) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **<u>High risks with a score of 15+</u>** **Risk no 1751 risk rating 15 - Unsustainable business model for clinical research and the research strategy**. JT advised this risk was first identified on 24th October 2018 and there have been no changes in the risk profile. An update to be provided at the next IGC Meeting. JT advised clinical research is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper	Risk no 1751 (clinical research business model) to provide an update at the next IGC Meeting.	LC	10th July 19
19/20/17	**3.16**	**Marketing & Communications**	Mark Flannagan (MF) presented the risk management report for Marketing & Communications. Risks from the report were highlighted as follows: • Total number of risks = 3 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 1 (806) • Number of high/extreme risks escalated to the Executive Team = • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Governance Committee = 0 MF advised he would like to meet with CU to review Marketing & Communications risk and do an accurate review and feedback to IGC July 19. **Resolved** that: the Committee NOTED the contents of the paper	MF to meet with CU to review Communications risks	MF/CU	4th June 19
19/20/18	**3.17**	**Innovation**	Jason Taylor (JT) presented the risk management report for Innovation Dept. Risks from the report were highlighted as follows: • Total number of risks = 5 • Number of new risks identified since the last reporting period = 2 (1854, 1899) • Number of risks closed and removed from the risk register = 1 (1773) • Number of risks with an overdue review date = 1 (1400) • Number of risks with no agreed action plan = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 **New risks** **Risk no 1854 risk rating 4 - ERDF - Risk of EU exit delaying grant payments.** Delay in analysis and payment of quarterly financial claims due to Brexit. JT advised that Innovation need to discuss further with the CCGs.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1770 risk rating 4 ERDF - Risk of not teaching the required level of eligible staff participation in the project. JT advised there is always the chance of staff moving on so training needs to be put in place quickly. JT advised Innovation is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/19	**4.**	**Corporate Risk Register Review Report**	Cathy Umbers (CU) presented the Risk Register for Corporate Risk Register Review Report. Risks from the report were highlighted as follows: **Summary:** This report is inclusive of all high risks on the register from 1st March 2019 – 30st April 2019. There are currently 22 high risks on the register. **New high risks identified** **Risk no 1858 Current risk rating 15 (Health & Safety) – Fire risk in the Institute in the Park** – no actions identified. This needs immediate action. **Risk no 1866 Current risk rating 16 (Transformation Team)** – May cause harm due to unnecessary variability care due to out of date guidelines – Action overdue, initial rating same as current with controls identified, **overdue review** **Risk no 1870 Current risk rating 15 (Surgery) – A patient**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			attending the ward could deteriorate clinically and this may not be recognised due to a lack of monitoring of their condition – Overdue action, initial risk rating same as current with controls identified **Risk no 1872 Current risk rating 4 (was 15) (Institute in the Park) 'Lack of security surveillance'.** System upgrade complete and commissioned. **Risk no 1884 risk rating 16 (Business Support Unit) - Caps falling off wooden fins** was 16 at last reporting period. This risk was reviewed and closed as it was a duplicate on the register. **Risk no 1887 Current risk rating 16 (Surgery) – Server infrastructure**. Overdue reviews, action overdue, no gaps in controls identified. CU advised that some of the risks have been on the risk register for a significant amount of time e.g. risk 825 (2015), risk 947 2016), 6 High risks (2017), 3 high risks (2018). This is concerning as this indicates, in some cases the actions identified are not supporting mitigation, this needs to be addressed as a priority. CU acknowledged that some risks are outside the control of the Trust, but the Trust needs to be assured that everything internally that can be done is done and this is reflected on the register. The Corporate Risks going forward will have increased Executive scrutiny and upwards to Board scrutiny. CU asked all IGC members to ensure all risks are up to date on their registers to reflect the current position at all times ensuring updated are documented as and when the risk position changes. CU acknowledged that the management of high risks has improved, and these improvements			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			need to continue **Resolved** that: the Committee NOTED the contents of the paper			
19/20/20	**5.**	**Board Assurance Framework (BAF)**	Erica Saunders (ES) presented the Board Assurance Framework. Risks from the report were highlighted as follows: ES advised there is no significant movement since the last reporting period. ES informed the Committee that the strategic risk is triangulated with the Corporate Risks. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/21	**6.**	**BAF Deep Dive Report**	John Grinnell (JG) presented the BAF risks 1.4 &3.4 to the Committee. **1.4 Risk of a no deal Brexit (current risk rating 9)** JG advised the key risks are the Trust not receiving supplies, drugs, consumables and equipment. Also data flow across boundaries out of the UK to Europe. The key actions are that there are business continuity plans in place and desktop simulations have also taken place. There are key leads for each area and (LS) Lachlan Stark, Lead, has a robust system in place. JG advised the Trust has raised concerns with NHSE regarding sharing of information for key work streams where they are leading on behalf of the wider NHS. The Trust continues to test data flow and no major issues have been identified. Theatres (burns products): - there is an arrangement with regional network.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			JG advised the areas of concern are to still be able to deal with national suppliers. We have clear lines of supply but because of lack of information from the centre we are working largely on trust. In terms of the dataflow going out of the UK to Europe there are new arrangements to ensure we can guarantee products. In the event of a no deal exit we will put strategic command in place. The Trust has taken a 3 week pause as the build up to end of March 19 was intense. Going forward we will reinstate Brexit meetings on a 3 week cycle and continue with the light touch walkabout. We will develop a 30 day countdown to the end of October 19. **3.4 Failure to Deliver Control Total (current risk rating 16)** JG advised the key risk for 2019/20 is the achievement of the Control Total as discussed at Trust Board. The target control total for 19/20 is a surplus of £1.6 million. The forecasts submitted do not currently achieve the control total 19/20. The consequence of not delivering the control total is loss of PSF income of 3.4m in 2019/20 and loss of opportunity to apply for PSF bonus schemes. This will impact on the liquidity of the Trust and could result in the capping of the capital expenditure programme and could impact on the future financial sustainability of the Trust. The Trust continues to be in underlying deficit and this could result in loss of autonomy and the ability to invest in our strategy being restricted. This includes risk to the completion of the campus, risk of expansion of strategic priorities which require funding to develop e.g. Innovation. There would also be a risk to future capital programme			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			replacement of essential medical equipment and risk to future digital expansion due to restricted capital programme. JG advised short term mitigations are the CIP recovery plan managed weekly by Sustainability Delivery Group/Execs. Further mitigations could include revising the internal financial operating framework by introducing incentives based on performance, reviewing the Trust current operating model around the divisions and improvements as a result of the Change Programme. JG advised the long term mitigations are lobbying the Tariff nationally through children's alliance network, the 5 year LTFM backed by the change programme e.g. digital, workforce transformation etc, the clinical strategy developments and the review of investment plans to ensure affordability. In addition to the achievement of the Control Total in 19/20 there is also a major financial risk associated with capital projects planned over the next 5 years which are currently not affordable. AB asked how tariff lobbying is agreed with CCGs? JG advised the Trust tariff lobbying is with the NHSi/E central pricing teams who set the tariffs on behalf of local and specialised commissioners. JG also advised there is a 5 year plan around Clinical teams and a structured piece of work around strategy of the clinical teams which the Trust needs to look at the plans over the Summer. **Resolved** that: the Committee NOTED the contents of the presentation			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/22	**7.**	**CQC Action Plan**	Erica Saunders (ES) presented the CQC Action Plan to the Committee. The Committee agreed for the CQC Action Plan to come off the IGC agenda as there are few actions outstanding now and they are being monitored via other assurance committees such as CQAC. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/23 - 19/20/32	**8.**	**Policies Ratified at IGC Policy Sub Group Meeting**	Cathy Umbers (CU) informed the Committee that to date the IGC Policy Sub Group Meeting have held 2 meetings on 5th April & 26th April 2019 and have approved 16 policies subject to changes. There will be future IGC Policy Sub Group Meetings arranged as and when new or amended policies are presented for approval prior to final sign off at IGC Meeting. **Resolved** that: the Committee RATIFIED the contents of the papers subject to changes.			

COMPLETED ACTION LIST – MARCH/APRIL 2019

No	Item	Owner	When	Status
18/19/94	CQC Action Plan	All	~~15th Jan 19~~ ~~13th March 19~~ 22nd May 19	Update 22.05.19 ES advised that a lot of progress has been made with the remaining actions and there are now only a small number of actions outstanding. ES advised we will try to get formal closure on this at next month's Contractors Meeting. Going forward this will be taken though Clinical Quality Assurance Committee. CU requested for this be reflected on the risk register. Completed.
18/19/108	2 Fire risks outstanding which JS has reviewed	J Hutfield/J Spark	13th March 19 Immediate	Update 22.05.19 JS confirmed the 2 risks outstanding. Risk 1118 Fire Extinguisher Training scheduled for 18th June has been cancelled and this risk has now been closed. JS advised there is a new action entered on this risk relating to the purchase of IT fire extinguisher training package submitted to CPG. Risk 1858 this is similar to the Fire risk Institute in the Park and this risk has been transferred to D Houghton in the Development Directorate. Completed
18/19//109	Risk no 1388 – Corroded Pipework.	G Dixon	22nd May 19	Update 22.05.19 GD advised after the last Corroded Pipework meeting held on 7th May 19, a monthly meeting to be set up with the Execs & Non-Execs to provide a clear action plan with timescales to action up with Project Co. Completed.
18/19/119	CQC Plan – Risks and themes arising from plan	E Saunders	~~13th March 19~~ 22nd May 19	Update 22.05.19 discussed as part of action 18/19/94. Completed.
	Set up a Policy Sub Group to review policies in detail before presentation to IGC. This meeting will require a senior representative from each division. This can be 8a or above.	All	1 week	Update 22.05.19 2 IGC Policy Sub Group Meetings have taken place to date. Completed.
18/19/122	Risk no 1815 risk rating 12: - Risk to patient safety from lack of pre-operative assessment. Outpatient	G Dixon	1 week	Update 22.05.19 GD advised the sink has now

No	Item	Owner	When	Status
	leadership team have reviewed an available outpatient room and the division are actively chasing to have a sink installed to turn into a clinic room, which currently there is a 12 week wait.			been installed however to a different room that was requested by the Outpatient Leadership team. The action has been resolved. Completed.
18/19/122	Surgery Risk Management Report division to replicate format of Risk Management Reports in-line with other divisions.	A McColl	22nd May 19	AM to format the risk management report in line with other divisions. Completed.
18/19/122	Risk 964 1306 – The process for planning and scheduling of elective lists is not sufficiently robust to prevent errors occurring. The Surgical Division are recruiting every 6 months and advertising regularly in attempt to ensure significant cover. Risk 1306 - Concerns around junior doctor shortages in Surgery. Vacancies within middle grade surgical rotas across the Surgical Division. If a vacant shift is uncovered this poses a risk to patient care and safety as the rota becomes non-compliant.	A McColl A McColl	All future IGC Meetings All future IGC Meetings	Update 22.05.19 report included in the Surgical Division Risk Management Report. Completed. Update 22.05.19 report included in the Surgical Division Risk Management Report. Completed.
18/19/135	Risk 1753 – The Data Security & Protection Toolkit. JF advised training compliance is at 70% and the Trust needs to be on 95% compliance. MS advised she will collate a list of all outstanding staff to push this forward and Execs and Senior staff to escalate to the teams. JF advised she will send out another email prompt to staff	M Swindell J Fitzpatrick Execs & Senior Leads	1 week	MS advised that the Mandatory Training compliance has been raised at the Exec Meeting and the L&D team are focused on every staff member which is included in the compliance reports. MS advised if anyone feels the compliance records are not correct to let L&D know. Completed
18/19/131	Risk – Internal Balconies. GD advised after several meetings with Project Co we now have a solution. The handrails are to be taken off and replaced with a metal bumper. The risk has been reviewed and the scoring represents this. CU informed GD to be clear the Corporate report is showing this risk score as a 10? GD to review this risk.	G Dixon	1 week	Update 20.05.19 GD advised that the risk has been updated. Completed.

No	Item	Owner	When	Status
18/19/139	KB advised to Marketing & Communications that as they are a new Department delivering to the IGC meeting could they provide an outline of risks on their risk register at the next IGC Meeting	M Flannagan	22nd May 19	Update 22.05.19 Now included on agenda for each meeting. Completed.
18/19/140	KB advised that Innovation are a new Department delivering to the IGC meeting could they provide an outline of risks on their risk register at the next IGC Meeting.	J Taylor	22nd May 19	Provide an outline of risks in next IGC Report. Update JT to provide the outline of risks on the Innovation agenda item 19/20/18. Update 22.05.19 Now included on agenda for each meeting. Completed.

INTEGRATED GOVERNANCE COMMITTEE
ACTION LIST – MAY 2019

No	Item	Owner	When	Status
18/19/83	Risk no 1746 - Fire risk within the Institute in the Park	~~J Hutfield/J Spark~~ S Brown	~~15th Jan 19~~ ~~13th March 19~~ ~~22nd May 19~~ 10th July 19	Update 13.03.19 AK submitted a Fire Risk in Institute Assurance Report. To be discussed at IGC 22nd May 19. Update this risk was transferred over to Development Directorate. SB to provide an update at next IGC Meeting.
18/19/86	Risk no 799 – Failure to control contractors	M Swindell/A Kinsella	~~26th Nov 18~~ ~~15th Jan 19~~ ~~13th March 19~~ ~~22nd May 19~~ 10th July 19	Update 22.05.19 MS advised she met with MIAA as there are still some outstanding actions which are being tracked down within the dept. The MIAA report will feed into IGC. GD advised that the out of hours contractors can sign in to the Trust. There are 2 sign in systems Retained Estates Dept.MS to provide an update at the next IGC meeting in July.
18/19/101	Risk no 1668 score 15 – Test results not picked up when clinicians away from the office	J Grinnell/A Hughes	~~Immediate~~ ~~22nd May 19~~ 10th July 19	Update 22.05.19. JG to get an update by the next IGC meeting in July 19.
18/19/102	Staff to monitor & update overdue risks & make arrangements for when designated person/s are unavailable to review.	All	On-going action	Update 22.05.19 As mentioned earlier, KB advised the review date for risks has now been changed to monthly (from weekly) and adherence to reviewing risks on this basis will be monitored by the Governance Team. This action can be removed as timeliness of review of risks is considered at each IGC meeting.
18/19/109	Assurance reports for Risk No 1709 - Ceiling Tiles, Risk no 825 - Internal Balconies	G Dixon	~~13th March 19~~ ~~22nd May 19~~ 10th July 19	Update 22.05.19 GD advised the ceiling tiles have dramatically reduced and this risk will be closed within the next 4 weeks. The internal balconies - there is a feasibility study being completed and GD will report back to IGC July 19.
18/19/114a	Risk 1344 – Pharmacy and ASU cold store. All been agreed awaiting installation	A Kinsella/G Dixon	~~Immediate~~ ~~22nd May 19~~	Update 22.05.19 GD advised the ASU cold store will be installed on 24th June 19. The electrical work is being completed in preparation for the

No	Item	Owner	When	Status
			10th July 19	installation date. GD to provide an update at IGC July 19.
18/19/114a	Risk no 1787 current score 15 – Potential errors associated with prescribing, preparing and administration of parenteral nutrition	C Barker	~~13th March 19~~ ~~22nd May 19~~ 10th July 19	Update 22.05.19 this risk is starting to be put through as a Corporate risk and taken through the Corporate meetings. CB to update IGC July 19.
18/19/123	Risk no 1831 **-** As part of an audit of IT / clinical systems conducted in January 2018 it was identified that a file share related to the Natus System which is used within the Neurophysiology can be accessed by all users. Unsuccessful capture of data. LF advised this is an unsuccessful capture of data and is being worked through. KB asked has this been brought to the attention of Information Governance. LF to speak to JF outside of the meeting.	L Fearnehough/J Fitzpatrick	~~1 week~~ 10th July 19	Update 22.05.19 LF advised that the IT team are currently working on system level securities to address this issue and will ensure risk is closed once completed. LF and JF met outside of IGC to link this to the Data Security & Protection Toolkit. LF to provide an update to IGC July 19.
18/19/124	Risk no 1131 - Process for scanning and archiving clinical notes within Community Division.	A Bateman	~~22nd May 19~~ 10th July 19	Update 22.05.19 AB advised that the Booking & Scheduling Manager M Burns has set up a Task & Finish Group. There is a plan being looked at to outsource some of the scanning. AB also advised there are other risks associated to the scanning and it's more than just actioning/mitigating this risk. AB has received the action plan and will attach this to the risk. AB will provide a brief update at each IGC until resolved.
18/19/125	Risk no 1593 – A patient can acquire a HCAI due to inadequate deep cleaning process Business case was reviewed at IRG and the funding for new UV machines now with Medical and Surgical COOs. KB advised for this to be taken outside of IGC to discuss the funding.	V Weston/J Keward	~~1 week~~ 10th July 19	Update 22.05.19 VW advised she has just increased this risk to a 16 as the company they had loaned the machine from have asked for it to be returned. VW advised Infection Control team are looking at a UV & Fogging Machine to lease will cost £100,000 and that this figure is in the business case however there is a lack of clarity around the way the budget is funded with IRG. The Trust now needs to fast track this. JG & A McC to meet

No	Item	Owner	When	Status
				outside of IGC and will feedback to IGC July 19.
18/19/126	Risk no's 1796, 1797 Change to food ordering process & lack of financial back of house system. JG advised this is not an operational day to day risk and Catering need to look at an Improve Programme going forward. CU advised the risk assessment needs reviewing and to look at a Change Management Programme and where this reports into.	M Devereaux	~~1 week~~ 10th July 19	Update 22.05.19 MD advised the Catering Dept. are about to install a new system over the next 4 weeks and once in place will eliminate this risk. MD will confirm the progress at the next IGC July 19.
18/19/127	Risk no 1832 - Signing of electronic documents. The way users sign electronic documents impacts on the visibility of that document to other users. LF advised she will pick this up with M Levine, Head of Clinical Systems.	L Fearnehough/M Levine	~~22nd May 2019~~ 10th July 19	Risk no 1832 LF to pick up with ML.
18/19/127	Risk no 1701 - MD Analyse is a legacy application used within both Neuro and Orthopaedics in order to document clinical outcomes. LF advised this is an historical system which is old and unsupported and the supplier no longer exists. IT is working with the clinical teams to look at companies to support them. JG advised he will raise this issue with the Exec team.	J Grinnell	1 week 10th July 19	Risk no 1701 raise with the Exec Team. Update 22.05.19 LF advised this risk has been raised to Nik Barnes Consultant Radiology/IT who is now liaising with the Medical Director. LF to provide an update at IGC July 19.
18/19/138	Risk no 1751 – Unsustainable business model for clinical research and the research strategy is the only high risk. The need is to reach an agreement on the finance model that supports growth of the clinical research division. There is ongoing work between senior CRD and Director of Finance to co-produce a workable research finance model. JG advised that work is in progress and will update at next IGC meeting.	J Grinnell	~~22nd May 19~~ 10th July 19	Update 22.05.19 JG advised the Clinical Research will have a medium term plan the first week in June 19. It is a significant model which has come back through Board. There is a way forward and a business strategy however until a broader strategy is determined we cannot resolve the financial implications. JG to update IGC July 19.
18/19/142				Update 22.05.19 KB informed the committee that it was agreed at the last meeting to move to monthly

No	Item	Owner	When	Status
	Review the CRR to see if the high risks have been brought up to date. If so. move to monthly reporting	C Umbers	~~1st May 19~~ 10th July 19	reporting and that the teams were to get the risks up to date. It shows in the individual reports that there have been some improvements. KB advised the risks will be monitored over the next few meetings and if there is a decline in report management this timescale will be reviewed.
18/19/143	Junior Doctors Experience include on the BAF	M Swindell	10th July 19	Update 20.05.19 MS advised this has not been completed but will ensure it is included. MS to provide an update.
18/19/143	Exec training on BAF Masterclass on using Ulysses training for Execs	J Gwilliams	2 weeks	Update 22.05.19 JG to liaise with JP with the arrangements for the training.
18/19/145	Corroded Pipework Meeting	L Calder	1 weeks 10th July 19	LC arranged this meeting. Execs to provide an update at next IGC Meeting.
18/19//145a	Control of Contractors update	M Swindell	22nd May 19 10th July 19	MS to provide an update at next IGC in May 19. Completed. Update 22.05.19 work is being completed to resolved. MS to provide an update to the next IGC Meeting.

No	Item	Owner	When	Status
19/20/02	Risk 1887 **-** Unsafe patient area; roof leaking into bed spaces 45 & 46 orange pod (HDU) **-** update to be provides at next IGC	A McColl	10th July 19	AM to provide an update at IGC July 19.
19/20//03	Risk 1882 - risk of additional admissions to hospital including PICU and delays to discharge - update to be provided at next IGC	C Wardell	10th July 19	CW to provide an update at IGC July 19.
19/20//05	Risk 1374 **-** Increasing prevalence of HCAI MSSA Bacteraemia within the Trust – risk to be reopened	V Weston	10th July 19	VW to re-open risk and complete a cluster review.

No	Item	Owner	When	Status
	and a cluster review to be completed.			
19/20/10a	Risk 1756 – Multi-storey car park fire alert. GD is awaiting feedback on a business case approval from the Execs.	G Dixon	10th July 19	GD to chase up with the Execs and report back to next IGC meeting.
19/20/10b	Risk 1858 – Security and fire risk controls. SB advised this risk requires to be broken down into individual risks.	S Brown	10th July 19	SB to feedback progress to next IGC Meeting.
19/20/11	Risk 1840 – Regularly delivering COSHH compliance training. All generic risk assessments have been completed and waiting for communications to upload to the intranet page.	A Kinsella	10th July 19	AK to provide an update of the completion of uploading to intranet page to the next IGC Meeting.
19/20/13	Risk 1893 – Information Asset Management Tool. The Trust need to decide who is responsible and if we have a data breach. JF to speak to ES outside of IGC Meeting.	Jo Fitzpatrick	10th July 19	JF to feedback on progress to the next IGC Meeting.
19/20/16	Risk no 1751 – Unsustainable business model for clinical research and the research strategy. Risk was first identified o 24th Oct 19 and there has been no changes to the risk profile.	J Taylor	10th July 19	JT to provide an update at the next IGC Meeting.
19/20/17	Marketing & Communications - arrange meeting with CU to review risks.	L Calder	5th June 19	LC to arrange a meeting with Marketing & Communication and Cathy Umbers.
19/20/13	Risk 1893 - Risk no 1893 – Information Asset Management & Tools - JF to speak to ES outside of IGC	J Fitzpatrick/E Saunders	10th July 19	JF and ES to speak about risk outside of IGC

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd September 2019

Paper Title:	**Clinical Quality Assurance Committee Assurance Report**
Date of meeting:	17 July 2019 – Summary 12th June 2019 – Approved Minutes
Report of:	Anita Marsland, Committee Chair
Paper Prepared by:	Julie Creevy, CQAC Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Clinical Quality Assurance Committee meeting 17 July 2019 along with the approved minutes from the 12 June 2019 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated Risk:	Risk number 1251 – lack of consultant cover for palliative care (score 16)

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
   - Outpatient & Brilliant Booking Update
   - Research Annual Update
   - CQC Action Plan & monitoring update
   - End of Life/Palliative Care Exception report
   - Quarter 1 DIPC Report
   - Quarter 1 Complaints Report
   - Corporate Reports Quality Metrics
   - Resus Huddle Presentation
   - Board Assurance Framework
   - Mandatory Training figures position statement
   - Minor Harm Analysis report
   - CQAC Terms of Reference
   - CQSG Key issues report

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   Management actions to date were discussed including new appointment of Senior Nurse providing key leadership and monitoring going forward.

4. **Positive highlights of note**
   Assurance provided in relation to completion of CQC action plan with some elements transitioning to business as usual. Future audit to be undertaken in relation to completed actions.

5. **Issues for other committees**
   None.

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

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 12th June 2019
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Adam Bateman	Chief Operating Officer
	Denise Boyle	Associate Chief Nurse - Surgical Division
	Pauline Brown	Director of Nursing
	Kerry Byrne	Non Executive Director
	Mark Flannagan	Director of Communications and Marketing
	Jeannie France-Hayhurst	Non-Executive Director
	Adrian Hughes	Divisional Director, Medicine Division
	Anne Hyson	Head of Quality – Corporate Services
	Tony Rigby	Deputy Director of Risk & Governance
	Erica Saunders	Director of Corporate Affairs
	Sarah Stephenson	Head of Quality – Community Division
	Melissa Swindell	Director of HR & OD
	Cathy Umbers	Associate Director of Nursing & Governance
	Stefan Verstraelen	Head of Quality – Surgery
	Cath Wardell	Associate Chief Nurse – Medicine Division
In Attendance:		
	Jill Preece	Governance Manager
	Julie Creevy	Executive Assistant (Minutes)
Agenda item:		
19/20/45	Natalie Deakin	Change Programme Manager
19/12/47	Andrew Williams	Director of Mental Health
19/20/53	Michelle Perrigo	Clinical Claims Manager

19/20/44	**Apologies:**	
	Lisa Cooper	Divisional Director for Community Division
	Rose Douglas	Associate Chief Nurse, Community Division
	Christian Duncan	Divisional Director, Surgical Division
	John Grinnell	Director of Finance/Deputy Chief Executive
	Hilda Gwilliams	Chief Nurse
	Dani Jones	Director of Strategy
	Nicki Murdock	Medical Director
	Matthew Peak	Director of Research
	Rachel Greer	Associate Chief of Operations, Community
	Will Weston	Associate Chief of Operations, Medicine Division

19/20/45 Declarations of Interest
None declared.

AM welcome Kerry Byrne, Non Executive Director, Kerry joined the Board of Directors in September 2018, Kerry Chairs the Integrated Governance Committee meeting. Kerry was attending CQAC meeting in order to observe the committee.

19/20/46 Minutes of the previous meeting held on 15th May 2019
Resolved:
CQAC approved the minutes of the previous meeting held on 15th May 2019.

19/20/47 Matters Arising and Action Log

Action Log

19/20/05 Sepsis Update – Committee noted that this is on the agenda for CQAC to receive an update at the July 2019 meeting.. This action has now been closed on the outpatients CQC action plan and will be managed via the risk register.

AH provided an update regarding information leaflets although not specifically Child Friendly leaflets, which was what was highlighted by the inspectors at the last CQC inspection. The report outlined the current position and actions to address, across all divisions Key issues as follows:-

The Trust currently has 374 information leaflets that have gone through the formal approval process, of which 178 (47.5% are currently out of date

- Community - 52 leaflets in total – 18 out of date (34.6% out of date)
- Surgery - 123 leaflets in total – 93 out of date (76% out of date)
- Medicine - 179 leaflets in total – 60 out of date (33.5% out of date)
- Corporate - 19 leaflets in total – 7 out date (37% out of date)
- Medicine/Surgery combined - 1 leaflet – in date

Discussions had taken place with AH & PB, and as a result the risk associated with this issue has been risk assessed and is now on the risk register – high risk (15). In particular it was highlighted that out of date information leaflets risk invalidating consent as it could affect the validity of informed consent. A further risk will be added to the risk register to highlight the risk around child friendly information leaflets. Aim is for action plan around both these risks to be finalised within the month. PB confirmed that she plans on discussing with colleagues through the ACCN network with a view to determining what other trusts are doing around this and enable joint support working to achieve the aims of providing family and children appropriate leaflets PB stated that this will prevent prevent duplication of work . CQAC noted the risk's regarding the current position. PB advised that In addition going forward the quality ward rounds will include information on each services position and ongoing work around leaflet management including child friendly leaflets.Divisional performance meetings are to also include update on performance in respect of information leaflets available and ongoing work. Discussions are required within specialty team meetings to ensure an appropriate plan is in place, to ensure full compliance. Monthly updates to be shared with Divisions Integrated Governance meetings for information and action. MF stated that the communications team could provide support with regards to any templates/tools required.

CQAC noted that the update report highlighted a deteriorated position, and that progress had not been as rapid as planned. AM stated that she would escalate this to Board of Directors/Executive team, in order to increase profile, given that the current situation is unacceptable. AM confirmed that CQAC would continue to keep this issue high on CQAC agenda, with Quarterly reports to be submitted?

Action: AM to escalate to Board of Directors & Executive Team,
Action: CQAC to receive progress update report at CQAC in September 2019.
Action: AH to add patient/children information leaflets to risk register

Action: Triumvirate(s) to ensure Division plans in place and monitored via local governance processes and include on QAR'S and performance reports.

19/20/08 – Programme Assurance Update – PB confirmed that Executive Team receive weekly updates for each of the pillars, - this item to be removed from the action log.

19/20/10 'CQAC to receive analysis of minor harm incidents at July CQAC meeting' – this item is included on July agenda.

19/20/14 – 'Update regarding medical representation at Nutritional Steering Group meeting'– PB confirmed that L Cooper Chairs the Nutritional Steering Group, PB confirmed that she would follow this action up with NM with regards to NM exploring medical representation engagement going forward at the Nutritional Steering Group meetings.

Action: PB follows up with N Murdock.

19/20/17 'Divisional Governance Reports – meeting regarding infection control provision to extend into community division', PB confirmed that a meeting had taken place in order to discuss the Business Case, and that the Business Case is due to be presented at the next Investment Review Group meeting on 18th June 2019, this item to be removed from the action log.

19/20/48 Programme Assurance Update

ND presented the Programme Assurance Update, key issues follows:-
Overall for the Delivery of Outstanding Care programme, both governance and delivery ratings had improved again this month with the SAFER project achieving green ratings. Additions had been made for baselines and targets for DETECT and Best in Acute Care. Focus to remain on completing any outstanding gaps in terms of targets and baselines. The lack of positive trends on metrics for the Comprehensive Mental Health project needs to be addressed by the Executive Sponsor. Year 2 PID for Sepsis required sign off. This should be addressed by the Executive Sponsor.

KB stated that the new report was helpful and informative, KB queried why the DETECT programme did not appear to include detail regarding timely performance and questioned why this was not in place. ND stated that the DETECT programme was primarily a research study, which is difficult to align to the project. ND clarified that baselines had only been measured for this month, and that the programme team are expecting to see defined targets and measures for the next reporting period. PB confirmed that the Sepsis team had executive leadership and NM/HG & PB had attended regular meetings with the Sepsis team in order to support them.

CQAC noted that Best in Acute Care had a number of 'TBC' – AB stated that the team are currently undertaking work, in order to obtain a baseline and that they envisaged this would result in improvements for the next meeting.

AM stated that an executive summary would be beneficial going forward in order to provide CQAC with a summary for the slides that are presented to the Board of Directors and sub committees, ND confirmed that an executive summary would be included in the future.

AM thanked ND for her update.

19/20/49 Inspiring Quality monitoring/assurance

AB provided an Inspiring Quality monitoring/assurance update which included details of aims, changes to the way staff will work, areas of focus, starting the change, creating capacity, mobilising people, and phase 1 milestones, whilst details 6 high impact changes:-
Key issues as follows:

AB provided an update regarding phase 1, together with a position statement regarding the 6 high impact changes which were planned for delivery by October 2019 MS confirmed that Jo Pottier, Clinical Psychologist had been appointed as new Associate Director of OD, JP would continue with title of Clinical Psychologist – 2 days per week currently and would take up Associate Director of OD position from 1st August 2019, JP had been instrumental in establishing the together programme which ensure that individuals have skills in self-management and coaching in order to support upcoming leaders. Faculty structures are in the process of being established and will be shared imminently. The team have a definitive list of proposed leaders and letters would be sent inviting staff to attend the programme and this has been endorsed by the CEO & Chair. Programme to commence in July 2019.

- Next steps plan developed – by August 2019, partner in place.
- Mobilisation of people boards in place by September 2019.
- Communication programme in place later in the year.
- Big conversation plans to be undertaken with staff, within next couple of months.

JFH stated that this was a comprehensive and most exciting presentation and that the outside market forces drive quality and that the Trust should be open to using other Trusts ideas. AM stated that she was delighted regarding the plan to establish a clinical cabinet, AB stated that NM would provide an update at the next meeting with regards to progress of the Clinical Cabinet.

Action: NM to provide update regarding Clinical Cabinet.

AM queried whether NEDS needed to be involved within the leadership faculty– MS stated that this would be extremely welcomed, CQAC were in agreement for NED involvement, KB reiterated that this would be beneficial and would add value.

19/20/50 Comprehensive Mental Health update

AW presented a Comprehensive Mental Health update, which included an Overview of the proposed model.

CQAC noted achievements made with regarding to Dewi Jones Unit, Eating Disorder (EDYs), Crisis Care, Mental Health Support Team in Schools CAMHS Booking & Scheduling and additional developments, together with drivers for ongoing development, key issues as follows:-

Additional Developments:-

- Development of a model for the alternative care of young people with learning difficulties and complex neurodevelopment presentations (Transforming Care)
- Aiming for a 12 week maximum wait whilst national standards are agreed (2 weeks urgent care).

- £200K investment from Liverpool for a Primary Mental Health Initiative following a successful GP pilot.
- Improve models of working between Neurodevelopment paediatrics and our mental health services.

CQAC received and noted the Comprehensive Mental Health update.
AM thanked AW for update.

19/20/51 Research Annual Report
This item was deferred to July 2019 CQAC in the absence of Lucy Cooper.

19/20/52 CQC Action plan & monitoring
ES reported that the CQC Engagement meeting had taken place on 11th June 2019, reviewing how residual actions were being managed. G Smith & C Wardell had attended a meeting on 5th June 2019 with regards to End of Life to enlist executive support, with a task and finish group approach currently being developed.

ES stated that with regards to those outstanding actions which are ongoing, from the CQC agreed , that providing the Trust internal monitoring and assurance processes are robust, that this would satisfy CQC inspectors. ES/PB/CW focused on articulating what the internal assurances are, and ensuring internal monitoring mechanisms are in place, as part of 'business as usual'. ES stated that it was a productive meeting, with focus on a number of RCA's and associated actions for improvement ES confirmed that she was currently waiting receipt of the notes following the CQC meeting.

CW reiterated that it was a positive meeting. PB flagged with the CQC the new initiative regarding response team and how this would support best practice around manging deteriorating patients in a timely manner preventing escalation to HDU/PICU.

AM queried following review of the CQC action log at the last CQAC meeting, whether CQAC were content, all agreed that they were content. CW stated that the remaining action was progressing well and near completion. All agreed that divisions are appropriately sighted on outstanding actions.

Action: CQAC to receive substantive reports regarding remaining outstanding actions at July 2019 meeting.

19/20/54 End of Life/Palliative Care Exception Report

CW presented an End of Life/Palliative Care Exception report, regarding CQC Action Plan progress which highlighted changes/shortfalls regarding consultant standards, risks, options nursing review, action plan and next steps. Key issues as follows:-

- Currently Alder Hey is compliant with the National Service Specification, but not with the NICE guidance for medical cover which indicated that there should be 24/7 consultant cover. To facilitate a consultant on call service the Trust would need a minimum of 3 or 4 consultants to deliver that level of service. The Trust currently is on a block contract arrangement with Specialised Commissioners which does not provide funding for additional consultant cover.

Since the last meeting, the consultant who was expected to take up post had decided not to pursue any further. CQAC noted that there was not a large/extensive pool of consultants in palliative care nationally available. AH stated that there is a General Paediatrician who works in Chester trained in palliative care, who is well known to the Trust, however she feels that that this is currently not a role she can commit to. AH stated that there is a need to agree a process to enable colleague at Chester to be included within Alder Hey structure, which would allow the Trust to commence a SPIN (Special Interest IN) training programme, and following a 12 month period, could then apply for grid programme (to accommodate GRID Specialty Training), and essentially adopt a 'grow your own' approach. Until such time CQAC noted the challenges nationally. AH stated that the NICE standards are very aspirational, until the training issues are dealt with effectively. In mitigation, AH stated that Alder Hey have a number of clinicians who care for children with multiple significant complex needs who all have palliative care skills, and colleague who has completed SPIN module and as an interim will be approached to more formally support the palliative care service in Alder Hey. CQAC noted that there was no quick solution. CQAC questioned whether the NICE guidance quoted in the report is for paeds. or what you would expect for adults – confirmed that it applys to Paediatrics. Discussion took place regarding the feasibility of meeting the guidelines standards, highlighting that no other organisation are meeting the guideline standards, although Alder Hey are working on a long term plan including providing, 24 hour specialist nursing cover

JFH stated that the Trust needed to firmly and promptly write to NICE regarding this issue stating that this issue is a universal problem which is broken, and despite Trust best endeavours the Trust is not able to adhere to NICE guidelines. CW stated that assurance could be given since she had recently met with AB, and that the team have actioned as much as possible.

AB agreed that a letter should be issued, and that the Trust should aim to further improve compliance, i.e. through networks or developing sub specialties task and finish group which should assist in this regard.

CU stated that it needs to be clear what are the issues and associated risks, as it appears we may be confusing to separate issues. Firstly identifying any risk to providing a safe service for our children, and implementing actions to minimise the identified risks. Secondly complying with the gold standards outlined in NICE guidance around providing a 24 hour on call cover and identifying any risks around not providing that level of service. CW stated that end of life, children are receiving safe care

CU stated that the team needed to be very clear and concise when articulating the risks to avoid confusion.

CQAC questioned whether the Trust are currently providing a safe service for Patients – ES clarified that there had been no regulatory breaches with regards to end of life, and that the concern was regarding NICE guidelines.

JFH stated the importance on strengthening appropriate teams.
AM stated that the consensus is that there is a clear need to fully articulate the Trust position, and providing clarity. CQAC noted that the task & finish group should address current issues in this regard, with CU to review how this is

being articulated on the risk register and advise accordingly JFH stated that should the committee find it helpful in the future that she could liaise with Antoinette Sandbach, MP if CQAC required.

CQAC agreed that an offline discussion would be required with CW and CU to progress this further, to ensure clarity. CW reiterated that the Trust are providing a safe service, however noting that there are challenges with individual, given that one individual cannot solely provide cover 24/7 and that challenges are ongoing due to having sole individual. CQAC noted that the task & finish group are reviewing options. CW stated that she is confident that the T&F Group would address the risks and ensure a safe service is provided going forward.

CQAC noted that the team have an action plan and that CQAC would receive a detailed position statement/update at July 2019 meeting with regards to action plan/next steps.
Action: Position statement/update to be received at July CQAC meeting.

19/20/55 Corporate Report – Quality Metrics

PB provided an update on Corporate Report-Quality metrics, key issues as follows:-

- PB stated that during the first month of the year, near misses had reduced, with key message articulated through weekly patient safety meetings.
- PB confirmed that the divisions are providing update reports for July CQAC meeting.
- There had been no SIRI or moderate harm incidents during Aril 2019.
- Medication errors resulting in harm – 6 incidents during April 2019, PB stated that this is a comparatively low number, although fully appreciating that any medication error resulting in harm is 1 too many.
- 10 times errors, PB stated that a special commendation was made to Ward 1C in April 2019 regarding numbers of potentially significant Medication errors that could have occurred, if not prevented by ward staff on 1C, this had demonstrated excellent vigilance by ward staff.
  D Boyle stated that there had been 2 medication errors within the Surgery Division, relating to 1 child who was allergic to amitop who didn't have a red allergy band on. DB is working with the team in order to ensure staff are vigilant to ensure that any child with an allergy has an allergy band in place.
  Other incident related to a 10 times overdose of sodium chloride where Dextrose was administered. This is being addressed though incident management processes.
- There had been no Category 3 and 4 pressure ulcers. Metrics had been reintroduced around Category 2 pressure ulcers which will be included within the metrics to be shared with CQAC going forward, with the aim to reduce Category 2 pressure ulcers.
- There were no never events during this reporting period.
- The Trust continued to see mixed responses across the Trust regarding the Friends and Family Test. PB stated that the kiosks provided by Meridian were not currently being used as widely as anticipated, and that cards and iPads were continuing to be used in the interim. Specific areas of focus regarding ED & Outpatients. PB had requested Arts for Health Lead to support friends and families to improve the patient experience.
- Complaints had reduced to 7 complaints during April 2019.
- PALS had remained static.
- PB reported that an extra ordinary patient safety meeting had taken place

on 4th June 2019, in order to monitor actions, whilst ensuring all actions had been fully completed, in order to reduce risk, as a result 40 incidents were closed off; a further extra ordinary meeting is scheduled during July 2019

- PB stated that MIAA undertook audit review of Sepsis, which resulted in moderate assurance, with emphasis on work required regarding 'red rating' around antibiotic administration as this received a 'red rating' – CQAC to receive an update at July 2019 meeting.
- Infection control rates remained on trajectory.
- Play and learning – PB confirmed that this had been split out, and that results would be evident next month.
- DB stated that there had been a reduction in CLABSI's, with significant work taking place within PICU, with 10% reduction in year.
- Medical Division remained low for hospital acquired infections.
- PB stated that the Trust enacted Business Continuity plans, following confirmation of a child with measles. There has been an excellent response from all staff involved across the organisation 40 children potentially affected all contacted and provided with appropriate follow up care.

KB queried whether the Trust had a formal action plan regarding Friends and Family which included timescales regarding improvements. PB confirmed that the Trust had a plan in place, and that the team are heavily involved with the Charity, in order to ensure that all children have access to fixed toys; this was also encompassed within the action plan. PB/CW had met on 6th June 2019 regarding ED experience, with regards to supporting patients and families within the waiting room, in order to ensure a calm environment and positive patient experience. Volunteers are also supporting staff and parents to address any issues that may arise within waiting rooms. CW working with team to formulate plan.

CQAC agreed that it would be beneficial to receive the ED report to CQAC at July 2019 meeting.

Action: CQAC to receive ED Action plan at July 2019 meeting.

AM stated that Sepsis continued to be challenging, and highlighted the importance of CQAC continuing to scrutinise. Previous discussion had taken place at May 2019 Board of Directors meeting. CQAC noted that colleagues continued to work hard in this regard in order to ensure continued improvements. AH stated that discussion had taken place regarding standards which the Trust had set, and whether to set incremental standards which was not felt appropriate by colleagues. AH stated that clinicians are working hard, and that this would result in colleagues receiving improved results. This should be achieved through training, standard documentation, with the aim of seeing improved analysis. AM stated that this had been noted at the Board of Directors meeting regarding continued efforts made to date.
AM thanked PB & AH for update.

19/20/56 Board Assurance Framework

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

- ES stated that this year's nurse staffing report had been shared at Workforce & Organisation Development Committee, (WOD) in the context of guidance around safeguarding workforce standards, ES & HG had

reviewed the report, and noted that the Trust is ahead of trajectory. ES confirmed that the report would be presented at Board of Directors at the July 2019 meeting.

- Ward Accreditation scheme – 2nd strategic risk – performance against targets – continual improvements were noted, demonstrating a robust start to the year. ED stated that ED had not sustained the previous strong level of performance in March 2019, however the ED department had been extremely busy. The team are currently reviewing peak periods in order to ensure that appropriate staffing levels are maintained at surges during the evening, with the team reviewing how additional improvements can be made.
- SS stated that within strategic risk 1.3, regarding the new hospital environment, t there was currently no narrative regarding pipework, or the roof leakage. ES confirmed that the BAF report was established prior to the above incidents occurring, and that these issues would be included in the next BAF report. Agreement at Com Cell had been made in order to utilise the 'red button. 'In respect of leaks PB stated that there have been issues relating to Pathology, theatre corridor, breastfeeding room, but these were being addressed as a matter of priority

19/20/57 Clinical Claims Report

M Perrigo provided a Clinical Claims Report which detailed claims received between 1st April 2018 and 31st March 2019, which included in overview of clinical claims activity, breakdown of new clinical claims, analysis of new claims, comparison of the numbers of clinical claims and comparison of the number of clinical incidents reported to the NhSR by Paediatric Trusts, closed claims, together with lessons learnt and details of ongoing coroners cases, . key issues as follows:-

- Two high value claims that had been ongoing for some time have settled in 2018/19. Both with lump sums and then periodical payments for the remainder of the patient's life.
  Inquests and lessons learnt between 1st April 2018 and 31st March 2019
- For the time period of this report there were 17 new Coroners cases which is an increase to 2017/18 (10) and 11 of the new cases were from December 2018 onwards. All except 1 of the new inquests required statements from staff these statements can be from multiple clinicians if the patient is complex. 4 of the new cases had internal investigations. 7 cases had legal representation for the Trust, 5 of which the Trust has been successful in securing Inquest funding.
- There were No Regulation 28 Prevention of future deaths orders made in this time period.
- An inquest training day was held on 6th March 2019 which included a Mock inquest with coroner and legal representatives, and a Schwartz Round. Formal feedback is being gathered through a questionnaire, feedback on the day had been extremely positive, and the team are currently reviewing the possibility of organising a 2nd training day for staff, this was welcomed by PB who echoed the positive training event for staff and stated that it would be helpful to increase the number of colleagues to attend an additional training day.
- PM advised that the increased workload has resulted in reduced capacity.

CQAC noted the issue regarding resources. AM queried whether there was any support that CQAC could assist with. MP stated that she had approached Hill

Dickinson following agreement from HG with regards to support for the Trust, in respect of Clinical Claims had secured 2 days per week support from Hill Dickinson, but recently this had reduced to I day. However Hill Dickinson have agreed going forward to provide 3 days support with the potential to increase to 5 days if required.
AM thanked MP for comprehensive report.

19/20/58 Management of External Agency Visits Inspection & Accreditation Policy

ES & JP presented the Management of External Agency Visits & Accreditation policy which was due for review. JP confirmed that the policy is fit for purpose. Changes made were on page 3, to include updated language. Policy had been presented at CQSG for ratification on 11th June 2019. JP requested for colleagues not to wait for annual update requests from JP, and for colleague to share visit detail with JP promptly as and when they occur, including outcome reports. , in order to ensure that the process is streamlined.

CQAC approved the Management of External Agency Visits Inspection & Accreditation Policy.

19/20/59 CQSG Key issues report

PB presented the CQSG key issues report, key issues as follows:
Information regarding patient safety meeting themes, fairly steady, device issues, sample errors, transfer and treatment proc. 81% reported in 24 hours, important to continue education regarding prompt reporting. 1% good 19% improve upon.

- CAS reports had all completed alerts closed within deadline.
- Transition received regular reports at CQAC which had been reported at last CQSG.
- Ward accreditation received significant assurance from MIAA and JA had worked hard to support. Commencing new methodology for collecting matron information – perfect ward to go live in July 2019 – with report to CQAC following first quarter.

Action: CQAC to receive Ward accreditation position statement in October 2019

- Transfusion – key issue regarding training records migrating to ESR, this is being addressed with Sharon Owen.
  CQAC noted that there are no issues that needed to be escalated to CQAC.
  AM passed on sincere thanks to CQSG members for continued support.

19/20/60 Any Other Business

AM on behalf of CQAC passed on sincere thanks to JFH for continued support to CQAC during JFH tenure. AM thanked JFH for her personal support received to date. In turn, JFH thanked Chair and committee members. for continued support. CQAC committee members wished JFH best wishes for future.

18/19/65 Date and Time of Next meeting

10.00 am – Wednesday 17th July 2019, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Wednesday 24th July 2019

Paper Title:	**Resource and Business Development Committee Assurance Report**
Date of meeting:	24 July 2019 – Summary 27 June 2019 – Approved Minutes
Report of:	Ian Quinlan, Committee Chair
Paper Prepared by:	Amanda Graham, RABD Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent RABD Committee meeting 24 July 2019 along with the approved minutes from the 27 June 2019 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

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)

- **Top Risks/Key Priority Areas for 2019/20** with the following approvals:
  - Operational IT investment (subject to Finance confirmation);
  - Expanse programme initiation;
  - Procurement exercise for Digital Anaesthetic Record system.
- **Finance Report**
  - A focus on the financial recovery actions that are taking place
- **Programme Assurance**
- **Board Assurance Framework**
- **Corporate Report**

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

- **Capital programme projected overspend** – work ongoing to bring back in line with budget
- **Current CIP situation** – ongoing actions to reach CIP targets
- **Digital resilience** - options to improve operational resilience

4. Positive highlights of note

- Progress made on Digital Futures roadmap
- Commitment to progress the Digital Anaesthetic Record system

5. Issues for other committees

None noted

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

Resources and Business Development Committee
Draft Minutes of the meeting held on: Thursday 27th June 2019 at 13:30pm 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)
In attendance	Mark Flannagan	Director of Communications	(MF)
	Amanda Graham	Committee Administrator (*minutes*)	(AG)
	Nicki Murdock	Medical Director	(NM)
	Melissa Swindell	Director of HR & OD	(MS)
	Kate Warriner	Chief Information Officer	(KW)
Apologies	Claire Dove	Non-Executive Director	(CD)
	Louise Shepherd	Chief Executive	(LS)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Dani Jones	Director of Strategy & Partnerships	(DJ)
	Alison Chew	Associate Finance Director	(AC)
	Sue Brown	Associate Development Director	(SB)
	Mark Devereaux	Head of Soft Services	(MD)
	Graeme Dixon	Head of Building Services	(GD)
Agenda Item:			
39	Alan Hughes	Project Accountant	(AH)
47	Jason Taylor	Innovation Manager	(JPT)

19/20/49 **Apologies**
The Chair noted the apologies received from Claire Dove, Erica Saunders, Dani Jones, Graeme Dixon, Mark Devereaux, Sue Brown and Alison Chew.

Please note that this meeting was not quorate.

19/20/50 **Minutes from the meeting held on 22nd May 2019**
Resolved:
The minutes from the meeting held on the 22nd May were approved.

19/20/51 **Matters Arising and Action log**
Action log - all green; no updates.

19/20/52 **Top 5 Risks/Key Priority Areas for 2019/20**

RABD received the latest updates on the areas below:

Estates
JG gave an brief update followed by presentation from CL. This will be taken to Trust Board on 2nd July. There is a need to ensure teams feel well-looked-after. Now seven years into new hospital with some medical and IT equipment facing end-of-life and requiring replacement, alongside desired Campus development plans. Financial forecast has been revised for the Campus. These discussions and decisions are for Trust Board. IQ asked for clarity on landscaping and planning requirements which was given by CL. A discussion followed about payment for equipment etc. by others including sponsorship. Office / desk space utilisation across the site needs to be reviewed, including agile / home working in conjunction with Trust Strategies. JG noted that a blended option of the options is

the most likely outcome. Neonatal options were discussed; NM suggested that the neonatal unit is built to the budget originally envisaged rather than skimming from the Community scheme.

JG suggested that giving the priorities more detail and determining the core outcomes would provide Board with information for more in-depth debate and decision-making. IQ advised 3-stage option: What does hospital need; how much will that cost; where does that money come from. If any imbalance overall, then adjustment is made within each / all of the stages. The Charity contribution is £5m across whole scheme. MF suggested having a conversation around separate capital appeals for the hospital. NM asked whether building Neonatal unit at LWH, which was ruled out by clinical teams on grounds of paediatric benefit. IQ suggested American equity as a funding option; SN noted that there is also more local equity within housing associations. CL noted that Innovation Board will be looking at donors for funding future research / innovation.

CIP
SN presented an update on CIP position to date. The forecast position is £3.6m or 60% delivery of full year target of £6m. An action plan is in place to mitigate under delivery of CIP. The trusts is forecasting to deliver £5m, £1m year-end forecast risk to full CIP delivery.

JG asked for more detail for next meeting on the potential financial benefits from the new projects presented to Ops Board that are to be initiated on the change programme projects.

Action:
SN to provide more detail on the potential financial benefits from new/ refreshed change programme projects.

Facilities
A paper was circulated on Institute catering. To be discussed outside RABD.

Action:
Catering discussion to be held outside RABD.

Digital Strategy

RABD received progress to date and a draft of the Digital Strategy which is scheduled to be presented at Trust Board on 2nd July 2019, the contents of which were positively noted.

Strategy focus is on staff experience and experience of children young people and their families. Governance arrangements have been reviewed including the establishment of a digital oversight collaborative for digital transformation and operational IT. KPIs are being set which will be reported from September.

Trust Board cyber training earlier in June supported the Trust's aspiration to be the safest Children's Trust. KW is currently commissioning further work on cyber security for discussion at private Board. IQ noted that this was an exciting IT strategy.

Resolved:
RABD received an update on the Digital Strategy and supported the recommendation for the strategy to be approved by Trust Board.

(SN left)

19/20/53 **PFI Monitoring Contract**
Deferred to July RABD.

19/20/54 **Finance Report**
Several issues are ongoing with recovery plans and other issues being managed within the weekly sustainability meeting.
AH have not yet signed the 2019/20 NHSE contract as it could leave AH at risk of a funding-gap. CCG contracts have been signed and AH have been approached to become part of "Sign as One" contract again, with potential caveats to support AH's strategy & plans. NHS Wales contract recently agreed after a period of impasse. There were no significant issues to report with the IoM contract.
Concerns were noted around current financial position at Month 2, with concerns at divisional level including Medicine and Surgery. AB noted that numbers coming through the day-case unit are increasing, however also noted that surgery utilisation will increase from September following recruitment of new consultants.
CL is currently looking at a devolved financial management framework for divisions alongside divisional funding for them to access, including offering £2m of legacy funds. NM suggested matching as the NHS offer to AH, for positive behaviours, positive actions.
The supplementary section in the Finance report will provide RABD and Trust Board with clearer oversight for financial sustainability. RABD will be receiving a paper on the management of risks including detrimental changes to the Children's Tariff, GDE maintenance, Campus Development cost risks and Neonatal cost risk. AB noted concern that only weeks following setting of a budget, that budget is widely adrift from the reality, suggesting that there are problems with either divisions or forecasting & budget-setting tools. JG responded by explaining that there is an expectation of working £6m smarter this financial year, offset by other factors including budgets being overspent & areas overstaffed. IQ asked whether the divisions in question would be asked to come & present to RABD; JG responded by noting that Medicine are likely to come as there is an acknowledgment of struggle with their budget and they are currently developing a recovery plan. Surgery and Facilities both need to be given more support to determine straightforward actions to help resolve the issues.

Action:
Recovery plan for Medicine to be brought to RABD – date TBC.

19/20/55 **Programme Assurance**
ND noted re: para 3 on the summary page – the new approach has recognised that some areas have not identified what their measurable outcomes will be.
JG noted that LS is to Chair a new group on Campus Development. AB suggested looking at creating a strong, well-led, coherent Facilities division. To be taken outside RABD for further discussion and evaluation before being brought back to a future RABD.

Action:
Plan for Facilities Division to be brought to RABD – date TBC.

19/20/56 **Marketing and Communications Activity Report**

Report received – Website to be brought back to future RABD. Sustainability Plan to be brought to future RABD with update at next RABD.

Action:
Website to be brought to RABD – date TBC.
Sustainability Plan update to be brought to next RABD.

19/20/57 Board Assurance Framework (BAF)

JG asked for any comments. It was noted that the Access Standard was to be covered within the Corporate Report.

Resolved:
RABD received the Board Assurance Framework.

19/20/58 Corporate Report

Access Standards work is to be commissioned externally to mitigate that risk. Also workforce numbers are not as resilient over last few months, staff have been asked & responded with suggestions and Medicine have established
A Task & Finish group has been established for scanning backlog as some clinical documents are taking up to 50 days. It is hoped that a partner company will be taking that on within 8 weeks.
The number of cancelled operations has risen slightly but all were rescheduled within required 28 days.
Sickness – figures went up in May; each case has been reviewed individually and majority are "long term" (over 4 weeks). Predominantly (80%) female workforce with associated health risks, but a mix of demographic, cultural and economic factors. IQ asked if there are any financial caps for long-term sick; MS noted that NHS Terms & Conditions are for a 12m cap split 6m / 6m full / half pay. Corporate report & all divisions receive divisional figures split long term / short term.
Mandatory training - figure down to 88% as the recording method has been changed to show the training that everyone has to do.

19/20/59 Any Other Business

No other items of business were reported.

Date and Time of Next Meeting: Wednesday 24th July 2019, 09:30 – 11:30, Tony Bell Board Room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS
2019/20 ANNUAL AGENDA TIMETABLE
Papers to be with Julie Tsao 7 working days prior to the meeting

Agenda Item	2 Apr	7 May	28 May	2 July	3 Sept	1 Oct	5 Nov	3 Dec	7 Jan	4 Feb	3 Mar	Purpose
PATIENT / STAFF STORY												
												
BOARD BUSINESS												
Minutes of the Previous Meeting	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Decision**
Matters Arising and Action Log	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Assurance**
Key Issues/Reflections	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Noting / Info**
KEY STRATEGIC ISSUES												
Review of delivery of the Trust's Strategic Plan (Execs)											✓	**Reflection / Internal Challenge**
Board performance appraisal (BoD)								✓				**Reflection / Internal Challenge**
Integrated Business Plan & 2019/20 Budget (John Grinnell)	✓											**Decision**
NHSI Operational Plan	✓											**Approve**
International Child Health (Barry Pizer)	✓											**Assurance**

Agenda Item	2 Apr	7 May	28 May	2 July	3 Sept	1 Oct	5 Nov	3 Dec	7 Jan	4 Feb	3 Mar	Purpose
Review Annual Plan to NHSI											✓	**Review**
Liverpool Integrated Partnership (Louise Shepherd)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Information**
Strategic Plan to 2024 (Dani Jones)	**As required**											**Assurance**
Research Strategy	**Q3**			**Q4**		**Q1**			**Q2**			**Assurance**
Inspiring Quality	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Assurance**
Operational Plan (update)							✓				✓	
DELIVERY OF OUTSTANDING CARE												
Quarterly Mortality Report (Julie Grice / Karl Edwardson)	**Q3**			**Q4**		**Q1**			**Q2**			**Assurance**
Safeguarding Annual Report (Julie Knowles)	✓											**Assurance**
Complaints (Anne Hyson)		✓			✓			✓			✓	**Regulation / Assurance**
Digital Futures (Kate Warriner)					✓		✓		✓		✓	**Assurance**
Winter Preparedeness (Adam Bateman)						✓						**Assurance**
Serious Incidents Report (Jo Gwilliams)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Assurance**
Alder Hey in the Park Site Development updates (David Powell)	**As required**											**Assurance**
Staff Influenza Vaccination Programme – Update	✓											**Assurance**
DIPC Report (Valya Weston)		**Q4**			**Q1**			**Q2**			**Q3**	**Regulation / Assurance**
Nurse Staffing Report 2019/20 (Hilda Gwilliams / Pauline Brown)			✓									**Regulation / Assurance**
Quality Account (Tony Rigby)			✓				✓					**Regulation / Assurance**

Agenda Item	2 Apr	7 May	28 May	2 July	3 Sept	1 Oct	5 Nov	3 Dec	7 Jan	4 Feb	3 Mar	Purpose
Organ Donation Annual Report (Nicki Murdock)								✓				**Assurance**
SUSTAINABILITY THROUGH EXTERNAL PARTNERSHIPS												
Joint Neonatal Partnership – AH & LWH (Adam Bateman)	✓		✓		✓		✓		✓		✓	**Assurance**
STRONG FOUNDATIONS												
Annual Report & Accounts 2019/20 (Erica Saunders)			✓									**Regulatory/ Decision**
Recognition of the Trust as a Going Concern	✓											**Regulatory/ Decision**
Board Self–Certification of Compliance with the Provider License (Erica Saunders / Jill Preece)		✓										**Regulatory/ Decision**
Alder Hey Ventures (David Powell)	✓											
Programme Assurance update: - Deliver Outstanding Care. - Growing External Partnerships. - Solid Foundations. - Park Community Estates and Facilities.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Assurance**
Register of Shareholder Interests (John Grinnell)		✓		✓		✓		✓		✓		**Regulatory**
Corporate Report (Karl Edwardson)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Assurance**
Register of Interests (Erica Saunders)		✓										**Regulatory**
Tariff and Contract Risks (John Grinnell)												**Assurance**
Board Assurance Framework (Jill Preece)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Assurance**
Corporate Risk Register (Cathy Umbers / Jill Preece)					✓						✓	**Assurance**

Agenda Item	2 Apr	7 May	28 May	2 July	3 Sept	1 Oct	5 Nov	3 Dec	7 Jan	4 Feb	3 Mar	Purpose
Election results (Jill Preece/Erica Saunders)					✓							**Information**
Annual Communications Calendar							✓					**Assurance**
THE BEST PEOPLE DOING THEIR BEST WORK												
People Strategy (Melissa Swindell)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	**Assurance**
NHSI Chair Letter and Self-Assessment	✓			✓		✓			✓			**Assurance**
Freedom to Speak Up (Kerry Turner)	✓			✓		✓			✓			**Regulatory**
Staff Survey (Melissa Swindell)	✓											**Regulatory**
Equality Act (Melissa Swindell)	✓											**Regulatory**
Medical Revalidation Update (Nicki Murdock)					✓						✓	**Assurance**
COMMITTEE ASSURANCES (key risks/mitigations, issues for other committees, issues for escalation, key decisions)												
Clinical Quality Assurance (Julie Creevy)	March	April	May	-	June/ July/	Sept	Oct	Nov	Dec	Jan	Feb	**Assurance**
Resources & Business Development (Amanda Graham)	March	April	May	-	June/ July/ Aug	Sept	Oct	Nov	Dec	Jan	Feb	**Assurance**
Audit (Julie Tsao)	Jan				April	May			Nov			**Assurance**
Workforce, Organisational Development (Jackie Friday)		Feb			April	June	Sept		Oct		Dec	**Assurance**
Integrated Governance Committee (Lesley Calder)	Jan				March	July		Sept		Nov		**Assurance**
Innovation Board				-								**Assurance**
Committee Annual Reports		✓										**Assurance**