Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 4th February 2020 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
STAFF STORY (1000 – 1015)							
1.	**19/20/312**	**1015**	**Apologies**	Chair	To note apologies: Shalni Arora, Kerry Byrne	**N**	For noting
2.	**19/20/313**	**1016**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	**19/20/314**	**1017**	**Minutes of the Previous Meeting**	Chair	To consider and approve the minutes of the meeting held on: **Tuesday 7th January 2020.**	**D**	Read Minutes
4.	**19/20/315**	**1020**	**Matters Arising and Action Log**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	**A**	Verbal
5.	**19/20/316**	**1025**	**Key Issues/Reflections and items for information**	All	Board to reflect on key issues & discuss any queries from information items	**N/I**	Verbal
Operational Issues							
6.	**19/20/317**	**1040**	**Operational update**	A. Bateman	To highlight key operational issues from the previous month	**A**	Verbal
7.	**19/20/318**	**1050**	**Corona Virus**	N Murdock	To present an update on action plans to date.	**A**	Verbal
Strategic Update							
8.	**19/20/319**	**1100**	**Our Plan 2019/20 – The year at a glance**	Executives	To provide an overview of progress against the Trust's strategic plan	**A**	Presentation/ Read Report
9.	**19/20/320**	**1125**	**Change Programme Progress Report**	J. Grinnell/ N Deakin	To receive an update on progress against key projects	**A**	Presentation/ Read report
10.	**19/20/321**	**1130**	**Alder Hey in the Park Campus Development update**	D. Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			Going for Green – Alder Hey Sustainability Plan	D. Powell/ S Brown	To give a presentation on the current position.		Presentation
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
11.	**19/20/322**	**1145**	**Corporate Report - Divisional updates:** - **Medicine** - **Community & Mental Health** - **Surgery** **Executive exception report:** - **Quality** - **Performance** - **Finance** - **People**	A. Hughes L. Cooper A. Bass H Gwilliams A Bateman J Grinnell M Swindell	To receive the monthly report of Trust performance for scrutiny and discussion against CQC domains: **Safe, Caring, Effective, Responsive and Well Led,** highlighting any critical issues.	**A**	Read report
12.	**19/20/323**	**1215**	**Serious Incident Report**	H Gwilliams	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.	**A**	To Follow
13.	**19/20/324**	**1220**	**Clinical Quality Assurance Committee:** - **Chair's highlight report from the meeting on 15.01.20** - **Minutes from the meeting held on 18.12.19**	A Marsland	To receive a highlight report of key issues from the November meeting and the approved minutes from December 2019.	**A**	Read minutes
Lunch (12:25 – 12:55)							
The Best People Doing Their Best Work							
14.	**19/20/325**	**1255**	**People Plan:** **- Update against strategic themes** **- Progress with the Alder Hey Academy** **- Update regarding Pensions**	M. Swindell	To receive the monthly report and updates with regard to specific items.	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			issues **- Junior Doctors Report, Health Education England**	N Murdock	To provide the highlights from the recent HEE visit.		
Game Changing Research and Innovation							
15.	**19/20/326**	**1305**	**Research Strategy and Delivery Update**	J Blair/ J. Taylor	To receive the latest position with regard to the Trust's research strategy	**A**	Presentation
16.	**19/20/327**	**1315**	**Research Management Board** - **Chair's highlight report from the meeting held on 29.01.20** - **Approved minutes from the meeting held on 31.10.19**	N Murdock	To receive a highlight report of key issues from the January meeting and the approved October minutes.	**A**	To follow
Sustainability Through External Partnerships							
17.	**19/20/328**	**1320**	**Developing our Partnerships**	D Jones	To receive a progress report of current partnership working	**N**	Presentation
18.	**19/20/329**	**1330**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital**	A Bateman/ Neonatal Partnership, Leadership Team: C Dewhurst J Deeney J Minford	To update the Board on progress towards delivery of the single service model and business case.	**A**	Presentation
Strong Foundations							
19.	**19/20/330**	**1350**	**Operational Plan: Including update on 2020/21 Financial Position**	J Grinnell	To provide details on the 2020/21 Operational Planning round and associated timetable.	**A**	Presentation
20.	**19/20/331**	**1405**	**Board Assurance Framework**	Executive Leads	To provide assurance on how the strategic risks that threaten the achievement of the trust's strategic operational plan are being proactively managed.	**A**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
21.	**19/20/332**	**1415**	**Integrated Governance Committee** - **Chair's highlight report from the meeting held on 22.01.20** - **Approved IGC minutes from the meeting held on 29.11.19**	J Grinnell	To receive a highlight report of key issues from the January meeting and the approved November minutes.	**A**	To Follow
22.	**19/20/333**	**1420**	**Register of Shareholder Interests**	J Grinnell	To receive the bi monthly report	**A**	Read report
23.	**19/20/334**	**1425**	**Audit Committee Report** - **Chair's highlight report from the meeting held on 22.01.20** - **Approved Audit minutes from the meeting held on 21.11.19**	J. Grinnell	To receive a highlight report of key issues from the January meeting and the approved November minutes.	**A**	Read report
24.	**19/20/345**	**1430**	**Resources & Business Development Committee Report:** - **Chair's highlight report from the meeting held on 22.01.20** - **Approved RABD minutes from the meeting held on 27.11.19**	I. Quinlan	To receive a highlight report of key issues from the January meeting and the approved November minutes.	**A**	Read report
25.	**19/20/356**	**1435**	**Any Other Business**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
26.	**19/20/357**	**1440**	**Review of meeting**	All	To review the effectiveness of the meeting and agree items for communication to staff in team brief	**N**	Verbal
Date And Time of Next Meeting: Tuesday 4th March 2020 at 10:00am, Tony Bell Board Room, Institute in the Park.							

REGISTER OF TRUST SEAL

The Trust Seal was used once in January 2020:

Dead of Covenant for purchase of Knotty Ash Care Home X 2

Dead of Covenant for purchase of Knotty Ash Care Home Land X 2

SUPPORTING DOCUMENTS/ITEMS FOR INFORMATION	
Finance Metrics Month 8	**John Grinnell**

Alder Hey Children's NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 7th January 2020 at 10:00am,**
Tony Bell Board Room, Institute in the Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mrs S Arora	Non-Executive Director	(SA)
	Mrs K Byrne	Non-Executive Director	(KB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mr A Bateman	Chief Operating Officer	(AB)
	Mr J Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr F Marston	Non-Executive Director	(FM)
	Dr N Murdock	Medical Director	(NM)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
In Attendance:	Ms L Cooper	Director of Community Services	(LC)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
	Mrs K Warriner	Chief Information Officer	(KW)
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Prof F Beveridge	Non-Executive Director	(FB)
Agenda item: 290	Julie Knowles	Assistant Director for Safeguarding / Clinical Director for Statutory Services	
291	Dr Senthil Senniappan	Consultant	
291	Peter Laing	Endocrine ANP	
291	Karen Erlandson-Parry	Endocrine Dietitian	
291	Lucy Gait	Psychologist - Endocrine	
291	Louise Apperley	Endocrine Research Fellow	
297	Dr Nik Barnes	Chief Clinical Information Officer/ Consultant Radiology	
295	Kerry Turner	Trust Freedom to Speak Up Guardian	

Patient Story
Jonny, accompanied by his mum and Angela from Community Physiotherapy were all welcomed to share their experiences with the Board.

Jonny had been involved a serious accident two years ago and had suffered significant head injuries. Jonny's mum described the support that Alder Hey provided to both Jonny and the family

whilst Jonny was an inpatient and the feeling of not wanting to leave the hospital as the family felt so well cared for.

Mum spoke of the Alder Hey School and how they helped support Jonny transition into his School.

Mum said she was overwhelmed with the level of continued care received from the community team; Jonny is still receiving Physiotherapy that is tailored and adjusted to his needs as his recovery progresses. Mum said it would have been beneficial if she was made aware of the support that is available in the community as she had quite low expectations of the services that would be provided once Jonny was discharged.

On behalf of the Board, the Chair thanked mum, Jonny and Angela for attending and sharing their experiences with the Trust Board.

19/20/279 Declarations of Interest

There were none to declare.

19/20/280 Minutes of the previous meetings held on Tuesday 3rd December 2019

The Board received the above minutes. The Chair noted under section 19/20/253 Mental Health Act Report, Lisa Cooper and herself had met with the Police Commissioner. The Board noted that this amendment had been made and would be the version available on the Trust Website.

Resolved:

The Trust Board approved the minutes from the last meeting held on 3rd December 2019. Received

19/20/281 Matters Arising and Action Log

19/20/45: Hilda Gwilliams noted that contact had been made with the school requesting regular updates on patients' access to learning. A response had now been received and a meeting was to be arranged in the New Year.

19/20/179 Quarterly Mortality Report:

- To include details of how the mortality review process has developed over the years
- To review as to whether the Hospital Mortality Review Group should continue the aim of reviewing deaths within four months if this wasn't an achievable goal, as it was not a national requirement.

Both the above actions had been included within the Mortality report.

19/20/282 Key Issues/Reflections and items for information

The Chair congratulated Claire Dove on the announcement of her CBE, which had been awarded in the New Year's Honours.

19/20/283 Well Led Framework Follow up report

As Cath Hill had been unable to attend the meeting today due to prior commitments, Erica Saunders presented the Well Led Framework follow up review on her behalf for discussion.

The Board noted specific feedback in relation to:

- The Non-Executive Director succession plan and continuing to develop a diverse Trust Board. The Chair advised a NED Strategy session was to be arranged for March 2020, a date was currently been sourced.
- Consultant recruitment and retention plans are being reviewed.
- A Well Led workshop for Divisions had been held prior to Christmas and this had been very well received with excellent engagement in the process.

A discussion was held on the main areas of focus from the report and in particular the areas of outstanding practice and improvement identified since the main review in 2018; the Board requested that an executive summary containing these highlights be produced. Erica Saunders agreed to discuss this with Cath Hill.

John Grinnell and Erica Saunders went on to give a presentation on the 'Journey to Outstanding' with progress against the five domains: Safe, Effective, Well Led, Responsive and Caring. It was noted that the programme approach had provided a robust structure for the work being undertaken by the core team and Divisions and significant progress had been made.

Lisa Cooper noted the reference to 'child friendly leaflets' and the request from the Patient Forum for a greater variety of access points for information including online formats and You Tube clips. Jo Minford highlighted the co-production with the Forum to create different options of communication. Non-Executive Directors queried representation of children from across the city as well as different levels of support. Lisa Cooper responded that all patients are welcome to join the Forum and noted the work they do with the local community.

Resolved:
The Board received the Well-Led Follow up Review and development support noting:
- NED Strategy Session; date to be sourced for March 2020.
- Any further comments to be sent to Erica Saunders.

19/20/284 Operational update

Adam Bateman provided the following update:

Attendances at the Emergency Department reached a high peak during November and mid – December 2019. It was thought this might have been in relation to high numbers of flu or flu-like systems and it was likely that the peak might now drop. Business Continuity meetings had been set up to monitor the increase in patients. Adam Bateman noted the support from other services including General Paediatrics and Respiratory.

Louise Shepherd said she had been in contact with Jan Ledward, Chief Officer, Liverpool CCG in relation to the significant increase in attendances and was awaiting a response.

Resolved:
The Board received the Operational update.

19/20/285 Inspiring Quality

Sian Falder presented the latest position in relation to Inspiring Quality, covering the three key aims. She highlighted the inclusion of patient shadowing as well as the focus on safe communication and human factors. Nicki Murdock suggested that human factors training is carried out within clinical teams rather than by professional

group as this would be more beneficial in relation to communication and escalation. Jo Minford agreed to use this as a model going forward. A Senior Improvement Manager had now been appointed to progress with patient pathways.

Nicki Murdock reported that KPMG had been appointed as the Trust's partner to support embedding systematic daily quality improvement across the organisation including training on QI tools. It was noted that this would be monitored through programme assurance.

Resolved:
The Trust Board noted progress to date against Inspiring Quality and plans going forward.

19/20/286 Corporate Report

The Board received the month 8 report.

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

Medicine – Adrian Hughes

Safe

There had been 0 clinical incidents resulting in moderate or semi-permanent harm, 0 clinical incidents resulting in severe or permanent harm, 0 pressure ulcers (category 3 and 4), 0 never events, 0 hospital-acquired infections for MRSA and C.difficile.

Inpatients treated for sepsis within 60 minutes was an average of 90%, the improved reporting was noted however there was a under delivery of patients in Emergency Department treated for sepsis within 60 minutes.

Caring

There had been 1 complaint and 38 PALS responses.

Effective

Unprecedented demand, both in terms of attendances and acuity, has meant that the ED Standard continues to be a challenge and has deteriorated further since the previous month. The ED team has devised an action plan which continues to make progress, to bring about sustainable positive change in relation to the following areas: workforce plan; enhanced ways of working; redirecting of appropriate patients to primary care and General Paediatrics clinics. Additional ED slots from both physiotherapy and dermatology teams have been sourced as well as tactical command huddles taking place every morning.

Three Consultants had been appointed in Radiology, the Board noted the national shortage of consultant radiologists and further recruitment plans were to be implemented.

Responsive

Turnaround times were consistently good in many areas (especially Pathology) though MRI and CT were now more challenging to deliver. An action plan to address this was presented at Operational Delivery Board in November and involves recruitment of additional radiologists.

Well Led
Mandatory training is above 90% for fourth consecutive month at 91.8%, an improvement on last month.

Surgery – Andy McColl

Safe
Inpatients treated for sepsis within 60 minutes was 100% in the last 4 months, with only one child >60mins in 6 months.

There had been:
- 0 Never Events
- 0 SUI's
- 0 Grade 3/4 Pressure ulcers
- 1 x MSSA

Caring
There had been 6 formal complaints and 34 PALS responses PALS had reduced in comparison to the previous month.

The first paediatric hip replacement at Alder Hey took place in October, the patient was discharged following a two day stay.

Low Nurse staffing numbers continue to be monitored and supported in the short term through agency staff on 3A/4A.

Effective
Theatre sessions delivered was 555. Both Theatre and Clinic utilisation was at 85%. Cancelled operations in relation to bed availability had seen a small increase, linked to high numbers of ED attendances and high acuity.

Responsive
Continue to achieve 100% for seeing all patient requiring diagnostic tests within 6 weeks since May 2019.

The overall waiting list had reduced by 200 patients.

Challenges included rescheduling patients cancelled on the day of their admission within 28 days.

Well Led
Mandatory training continues to be above 90%, whilst the focus remains on reducing long term sickness.

Retire and return has been successfully used to support staffing on Ward 4A with four members of staff returning to work.

The focus to reduce the financial gap continues.

Community – Lisa Cooper
Safe

The safer staffing figures contained in previous months' reports had been reviewed for the Dewi Jones Unit and confirmed at 100%.

Provision of Tissue Viability Support to community based staff was assessed with a view to developing a business case.

Caring
Whilst Friends and Family test scores for Mental Health Services have increased, this month's analysis shows that the environment at Liverpool CAMHS (Catkin Building) is the main theme. This is being addressed with estates and facilities. It was agreed this would be discussed further outside of the meeting.

Effective
Rollout of laptops for staff across community sites is at 90% completion; improvements in network connectivity continue.

Community staff undertook NASEN training to improve understanding of contribution to Education Health Care Plans (EHCPs).

Responsive
Completion of the Staff Survey for the Division ended at 62%, flu vaccinations have increased to 49%.

ASD and ADHD waiting times in Sefton continue to be a challenge and an improvement proposal has been submitted to Sefton CCGs (awaiting confirmation of funding).

Well Led
Mandatory training compliance is at 93.5%, PDR rates remain above 90%. Staff sickness remains above Trust target but has reduced since previous month. Staff turnover rate is above Trust target; there is an active recruitment plan ongoing for areas with high turnover and over establishment for certain services e.g. CAMHS.

Executive leads raised items by exception as follows:

Safe
The roll out of the new bar coded Bedside Medication Verification system continues with regular steering group meetings to review progress and identify and action any lessons learned from the implementation.

Caring
ED has experienced the highest number of recorded attendances this month, sometimes resulting in long waits for families. Despite this 80% of families would recommend ED as a place to receive treatment.

Effective
The number of Congenital Heart Operations completed in the year to date is 298, by March 2020 it is expected that the target of 400 will be over achieved.

Dentistry sessions ring-fenced for Manchester Children's Hospital have not been used to full capacity; these sessions will be freed up for use by services waiting for further sessions and a re-assessment will be carried out of the demand by Manchester.

Well - Led
In Month 8 we delivered a £0.18k surplus which was £0.2k behind the plan. The finance team continue to support the Divisions to close the gap. An update was given of the estimated cost in relation to the high level of ED admissions.

The February Board agenda would include 2020-21 financial plans.

Completion of PDR's remains at just below the target of 90% and a concerted effort is required by all areas to improve this further. Additionally medical appraisals have fallen again to 53.3% and focus is also required to improve this for future months.

A pilot to support ward managers in relation to the management of sickness absence was due to commence in February/March 2020 for a period of 18 months. Pilot areas are to be selected.

Resolved:
The Board received and noted the contents of the corporate report for month 8.

19/20/287 Clinical Quality Assurance Committee
Resolved:
The Board received the Chair's highlight report from the last meeting on 18th December and the approved minutes from the meeting held on 20th November 2019.

19/20/288 Serious Incident Report
The Board received and noted the content of the Serious Incident report for November 2019 with the inclusion of lessons learnt. Hilda Gwilliams stated that during this reporting period there were no new Serious Incidents, five investigations were ongoing and no SI's had been closed.

The Board the discussed the SI in relation to outstanding blood test results, noting a monthly review has now been initiated.

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

19/20/289 Quarter 2 Mortality Report
Nicki Murdock presented the report noting the improvement of primary reviews within the four month internal target. Hilda Gwilliams agreed to identify and discuss support with potential additional reviewers in order to improve completion rate.

A discussion was held on the continued reduction in hospital deaths. It was agreed this would be looked into and reported back with the quarter 3 report.
Action: Nicki Murdock/Julie Grice/Karl Edwardson

Resolved:
The Board received the Quarter 2 Mortality report.

19/20/290 Safeguarding Annual Report 2018/19
Julie Knowles presented the above report noting the annual increase in referrals to the team; it is anticipated that at the end of 2018/19 the service will have seen over 4,000 referrals.

A discussion was held on the availability of FME's employed by the Police, Nicki Murdock would discuss this further with Julie Knowles outside of the meeting. Two safeguarding nurses have completed the Forensic and Medical Examinations in Rape and Sexual Assault Course (FMERSER).

Going forward a number of actions are to be taken to further improve the service including; strengthen capacity to meet increased service demands and working with the Innovation Team on how Artificial Intelligence can enhance research within safeguarding.

Resolved:
The Board received the 2018/19 Annual Safeguarding Report.

19/20/291 Childhood Obesity – Tertiary Service proposal

Dr Senthil Senniappan and members of the Endocrine team gave a presentation on a proposal for a Tier 3 Service and wider strategies for prevention of childhood obesity.

Dr Senniappan highlighted figures relating to childhood obesity in the UK, noting the high numbers within Liverpool and the increasing complications associated with it.

The national recommendation is for children with significant obesity to have timely access to weight management services, which are not provided currently.

Dr Senniappan described the introduction of the MDT's overweight and obesity programme, which has been running for 6 months. The service offers regular reviews with individualized dietary and exercise plans. Benefits from this programme included the reversal of liver fibrosis as well as a reduction in all patients' BMI.

Meetings have been held with the CCG and other partners to secure further funding; Dr Senniappan thanked Dani Jones for her support with this process.

Resolved:
The Board thanked Dr Senniappan and the Endocrine team for their presentation noting its support for their work going forward.

19/20/292 Access to Child and Adolescent Mental Health Services – Improvement Plan

Lisa Cooper presented the waiting times recovery plan with a request to approve the agreed standard for the measurement of access times for Specialist Mental Health Services at Alder Hey. Proposals include the introduction and monitoring of access times to CAMHS against the following internal standards:

- 92% referral to Choice within 6 weeks
- 92% Choice to Partnership within 12 weeks
- 92% overall pathway wait (referral to partnership) within 18 weeks
- Number of young people waiting over 52 weeks
- Average waits to cease being used as a measure.

Hilda Gwilliams requested that benchmarking information was included in further updates to demonstrate improvements made and comparisons with other providers.

Resolved:

The Board approved the agreed standard for the measurement of access times for Specialist Mental Health Services at Alder Hey; this will be reported through the Corporate report going forward.

19/20/293 Joint Targeted Area Inspection Children's Mental Health (Sefton)

Lisa Cooper reported back on from the above inspection held in September 2019.

As a result of the inspection an internal action plan has been completed and submitted to Sefton CCG. This will be monitored on a bi-monthly basis via the Trust's Clinical Quality Assurance Committee and led by the Director of Community and Mental Health Division.

Resolved:
The Trust Board noted the findings from the above inspection and monitoring of the action plan.

19/20/294 Alder Hey in the park Campus Development
Alder Hey in the Park Site Development Update
Change Programme: Park, Community, Estates and Facilities

The Trust Board received the revised report on the Site Development programme including a delivery timetable for 2019/20 through to 2023. The Board asked for reports to continue in the revised format.

The planning application for the full reinstatement of the park was approved at the planning meeting on 10th December 2019. Regular project meetings take place on a monthly basis with groundworks to ensure that the programme delivers on time and in budget.

Construction of the Alder Centre currently has a three week delay due to adverse weather conditions during the Autumn. Occupation towards the end of April is still on track as a 4 week commissioning period was included which could be reduced.

Adam Bateman noted the launch of Green Alder Hey this month. Plans included sourcing car park places close to the Trust.

Resolved:
The Board received the site development programme noting progress to date.

19/20/295 People Plan

Melissa Swindell presented the report for December highlighting:

- The Staff Survey closed on Friday 29th November 2019 with an overall response rate of 62%, the highest ever achieved. The final report is expected in March 2020 and will be shared with the Trust Board.
- Nominations for the Annual Star Awards closed on 6th December 2019; the Awards Evening will be held on Friday 7th February 2020.

Freedom to Speak Up – Communications Refresh

FTSU Guardian Kerry Turner presented latest developments to the Board. The Incident and Reporting Policy has been revised to include context of NHSI Just Culture Guide and inclusion of a reminder of clear processes for staff to report incidents and near misses.

The Ulysses module for raising concerns via FTSU is due to launch on Monday 20th January 2020 and will be audited monthly. This will replace the current FTSU local database held by the Guardian. The phase after this will include a module for 'Raise It, Change It' questions which has also been built within the Ulysses system.

Quarterly meetings have been arranged with Kerry Turner, FTSU Lead and Anita Marsland, Non-Executive lead for raising concerns.

Resolved:
The Board received:
a) The People Plan update
b) Freedom to Speak Up Communications Refresh

19/20/296 Workforce and Organisational Development Committee
Resolved:
The Board received and noted the Chair's highlight report from the meeting held on 10th December 2019 and the approved minutes from the meeting held on 18th November 2019.

19/20/297 Quarterly Digital Report
Kate Warriner presented the quarterly report noting in December 2019 the Trust was successfully accredited for Healthcare Management and Information Systems Society (HIMSS) level 6. Alder Hey is the first paediatric Trust in the UK and the first in the North of England to receive this accreditation. Plans are in place to achieve accreditation at HIMSS level 7.

A formal programme of work has been initiated with regard to the deployment of Alder Hey's next generation EPR with Meditech Expanse. Go live dates have been identified for September 2020. A programme board, chaired by Adam Bateman has been established and implementation planning is underway.

On behalf of the Board Louise Shepherd thanked Dr Nik Barnes for all his support as Chief Clinical Information Officer and wished him well in returning full time to his role as Consultant Radiologist.

Resolved:
The Board received the Quarterly Digital Report.

19/20/298 Innovation Committee
Resolved:
The Board received the Chair's highlight report from the meeting held on 10th December and the approved minutes from the meeting held on 18th November 2019.

19/20/299 One Liverpool Plan/Integrated Partnership Board
Dani Jones gave an update on developments with the 'One Liverpool' plan. Children's Transformation leads who have collaborated to define which 'critical actions' to push forward with first during 2020/21. These are aligned and follow from the Children's Transformation plan and its focus on Starting Well/Early Help. The four areas to progress first are:

- Integrated whole system healthy child programme
- Early help to families to prevent children coming into care

- Improving integration of children and family services as part of an all-age community model
- Transition – effective pathways into adulthood.

Next steps are to agree programme architecture and resources for delivery with the Liverpool Provider Alliance in January 2020.

Resolved:
The Board noted progress to date in relation to One Liverpool Plan/ IPB

19/20/301 Proposed Constitutional Change – Appointed Governors

The paper sets outs a proposal to the Trust Constitution in relation to composition of Appointed Governors.

This proposal was approved by the Council of Governors at its meeting on 11th December 2019. Subject to Trust Board approval the amended document will be submitted to NHS Improvement to be published on its website and the amendment, as agreed, presented as part of the Governors' report at the next Annual Members' meeting.

Resolved:
The Trust Board approved the proposal to amend the composition of Appointed Governors as set out in the paper.

19/20/302 Board Assurance Framework (BAF)

Erica Saunders introduced the Board Assurance Framework which had been refreshed following approval of the Trust's Strategic Plan – 'Our Plan' 2019-2024.

A Board workshop session had been held during December to look at strengths, weaknesses, opportunities and threats to the organisation to delivering our 2024 ambitions. A number of suggestions have been made on the current principal risks to reflect progress in the achievement of the strategic objectives to 2020 and to account for emerging external factors that were likely to present a risk to delivery of the Trust's refreshed strategic objectives to 2024.

The Board discussed the three main risks going into 2020/21 and agreed that these were captured by: Workforce Sustainability, Financial Sustainability and Sustainability of high quality safe services, which were all interlinked.

Board members noted that corporate risks were now linked to BAF Risks.

Corporate Risk Register

There are currently 10 high risks on the CRR. The report shows one very high risk at score of 20, five high risks at score of 16 and five at score of 15. There are two new high risks added to the CRR since the last reporting period i.e. reference 2035, (risk score 16) and reference 2067 (risk score 15) both in relation to Paediatric Diabetes Nurses.

Resolved:
The Board approved the 2019/20 BAF which was now fully aligned with the Trust's Strategic Plan and noted the Corporate Risk Register.

19/20/303 Change Programme Progress Report

Resolved:
As a number of the sub board committees had not met in December a Change Programme Progress report had not been included.

Journey to Outstanding Assurance Report
This update had been included under agenda item 19/20/283 Well Led Framework Follow up report.

19/20/304 Integrated Governance Committee Report

Resolved:
The Board received the Chair's highlight report from the meeting held on 29th November and the approved minutes from the meeting held on 11th September 2019.

19/20/305 Any Other Business
No further business was reported.

19/20/271 Review of the meeting
A discussion was held on the inclusion of summary sheets for detailed reports.

Date and Time of next meeting: Tuesday 4th February 2020 at 10:00 in the Tony Bell Board Room, Institute in the park.

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

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Action for October 2019							
03.09.19	19/20/145	Corporate Report	***Play*** - Look into the possibility of receiving reports from schools on learning.	H Gwilliams	01.10.19		01.10.19 awaiting a response from school. 05.11.19 A response from the School was still awaited. 03.12.19: A response had been received from the school and a meeting was to be arranged in the new year. The contract was being sourced to see if there had been any previous agreement in relation to learning updates from the school. 07.01.20: A meeting was to be agreed for Janaury 2020.
Actions for 2nd April 2020							
07.01.20	19/20/289	Moratlity report Quarter 2	To look into the continued reduction of deaths and report back on the findings within the Quarter 3 report	Nicki Murdock/Julie Grice	02.04.20		
Status							
Overdue							
On Track							
Closed							

NHS
Alder Hey Children's
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th February 2020

Paper Title:	**"Our Plan" Strategic Plan to 2024 – Year at a glance**
Report of:	Executive Team
Paper Prepared by:	Director of Strategy and Partnerships

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Alder Hey Strategic Plan to 2020 'Our Plan' 2020-24
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

Alder Hey Children's NHS Foundation Trust

BOARD OF DIRECTORS

"Our Plan" Strategic Plan to 2024
2019/20 – the Year at a glance

1. Purpose

The purpose of this paper is to provide the Board with assurance with regard to progress towards delivery of the Trust's strategic objectives in 2019/20 to date.

2. Recommendation

The Board is asked to note progress against the aims agreed under each strategic pillar:

- Delivery of outstanding care
- Best people doing their best work
- Game changing research and innovation
- Sustainability through external partnerships
- Strong Foundations

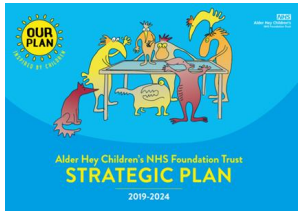
3. 'Our Plan' – Alder Hey's Strategic Journey

The Trust's vision for the future was originally set in 2011, together with an underpinning strategy to deliver its ambitious plans. This vision remains at the heart of the Trust's strategic plan which has been refreshed and refined at key points in the intervening period to reflect the external landscape, for example the NHS Long Term Plan, as well as internal drivers, such as the move to the new hospital in 2015. The most recent iteration of the strategy, 'Our Plan', reaches to 2024 and the attached paper summarises the major building blocks that will ensure the organisation sustains the conditions in which it can continue to deliver.

4. Next Steps

Alder Hey operates a well-embedded devolved management model which has been in place since 2011. The three clinical Divisions have played a significant role in the development of the Trust's current strategic plan ('Our Plan') and as part of this have consolidated their own local plans and clinical strategies for each service. This places Alder Hey in a strong position ahead of the upcoming 2020/21 Operational Planning round; the detailed guidance for which is awaited. Monitoring of progress against 'Our Plan' will be supported through development of a strategic metrics dashboard during Q4 19/20. Communication and engagement with staff on progress against Our Plan continues for example through clinical divisions and through quarterly 'Alder Hey Futures' events open to all staff at all levels.

Dani Jones
Director of Strategy and Partnerships
January 2020



Alder Hey Children's NHS Foundation Trust

"Our Plan" to 2024 – Strategic Plan Year at a glance

Trust Board – January 2020

Strategic Objective		Progress – January 2020
Delivering Outstanding Care	**Delivering the safest possible health care for Children and Young People**	During April 19 - Dec 19 Alder Hey staff achieved the following: • **Medication errors resulting in harm decreased by 15.6%** (compared to April 18 – Dec 18) • **Hospital acquired RSV reduced by 85.7%** • **Intensive Care Unit CLABSI reduced 35.7%** • **Readmission to PICU within 48 hours reduced by 22.2%** which is zero for November and December 2019 • **Friends and Family Test "In Patients" >95% last four months**, "Outpatients" demonstrating improvement ('green' twice in Q3 compared with consistent 'amber' in previous quarters) • **No Category 4 pressure ulcers last year**
	Always putting Children & Young People first	• **"Did we put you first?":** Children and Young People we asked in inpatients **said yes 95.77%** of the time. Parents in Outpatients asked **'did we put your child first?' say yes 93.72%** of the time (data from Meridien Nov 19-Jan 20) • **The Forum @AlderHey** – Launched January 2019. Inclusive, diverse and representative of all children and young people (8-19 years). Links developed to NHSE National Youth Forum and NHS National Children's Transformation Boards. Also linked with Alder Hey's volunteers, members and Trust Governors. The Forum actively participate in campaigns and events e.g. Takeover Day, and have influenced the Digital Futures strategy, Outpatients, virtual reality, ADS/ADHD videos, wall art for the Catkin Building, the Alder Play App/Ask Oli redesign, the Annual General Meeting, UNICEF Child Friendly City and Liverpool City Region plans. The Forum is a sustainable model led by C&YP, underpinned by leadership and coproduction. Meetings held in school holidays approx. 6 weekly. **Comments from Young People** • *"The Forum has given me more confidence…I feel part of a team & accepted for me being me. I don't feel judged by my autism"* • *"It has changed my life…my confidence has grown and I am not as ashamed of my disabilities"*

		• *"The forum gave me a place where I can come & be myself…the forum is my favourite place"* • **Designing Pathways with Children, Young People and Families:** developing a toolkit approach to how we engage and involve Children, Young People and Families in the review and redesign of pathways. • **The Point of Care Foundation have been appointed as a partner:** the **Sweeney Collaborative** running at the trust is a quality improvement collaborative where teams learn about patient centred quality improvement methodologies and apply them to a project within their clinical areas. • **Regular patient groups**, for example neonatal surgical patients group, links with Liverpool 'Neomates' and Bliss parent group via the Neonatal ODN, plus condition specific groups such as TOFS Hirschsprungs and Congenital Diaphragmatic Hernia.

	Achieving Outstanding Outcomes for Children & Young People	• **99.9% achievement for diagnostics targets for 3 years** ensuring children and young people receive diagnoses as quickly as possible. Alder Hey **internal targets are set significantly above the national performance targets** to strive to deliver exceptionally high quality care
		
		• **DETECT** has improved the recognition of children in the early stages of clinical deterioration such that we have improved the use of PICU beds, **equivalent to releasing three beds in PICU** which has made it less likely to cancel elective theatre lists.
		
		• **Surgical outcomes are excellent**, including;
		  • Best **results in NORCESS with 71% seizure free after operation**
		  • Lowest mortality rate in cardiac - **1% cardiac surgery mortality rate, vs 2.8% for the rest of the world**
		  • **Best outcomes for hypospadias repair in the UK**
		  • **Cholesystectomy** (gall bladder removal) – Alder Hey has high surgical volumes and have **less than 4% readmission rates** – benchmarked with 10-15% compared to centres with same volume and against a national average of 8%
		  • **Hirschprongs Disease** - Nationally 37% of patients need a stoma prior to surgery, **AH patients have a significantly low rate with c. 10%** patients needing a pre-operative stoma which is better for experience and care
		
		• **ECMO –** Between 2014-19, Alder Hey saw 161 ECMO cases, deriving a **78% 4 hour survival rate** and **62% post discharge survival rate**. This compares to a 74% 4 hour and 59% survival rate benchmarked worldwide against the same ECMO procedures in neonates and paediatrics for cardiac, respiratory and e-CPR.
		
		• **Best access to cancer care exceeding all targets set by NHS**

		• **Diabetes for children shows increased control of HbA1c levels** which have implications for complications in adulthood • Fully embedded the national programme of **Care Aims** across our **Community and Mental Health** services, working towards the individual **care goals and outcomes that children, young people and families set for themselves.**
Delivering Outstanding Care	**Alder Hey will be inspired by Quality which is led from the front line**	**Inspiring Quality** – Key programme progress includes: • Applications for appointment into the **clinical cabinet** are now open • **Schwartz rounds** are up and running with positive feedback from staff • **Three clinical teams commence QI projects** with the Point of Care Foundation 'Sweeney collaborative' process on 28/01/20 • **Appointment of key programme roles** • **External Partner appointed to implement Trust-wide systematic continuous improvement system** • **85 staff** are enrolled on the **Strong Foundations Leadership Programme** with uniformly positive feedback • **Patient shadowing** programme has commenced • **IQ Hub** providing funds and expertise to support teams in **local QI projects** e.g. CAMHS team training to provide telephone interventions for C&YP on waiting lists and evaluate whether leads to better outcomes, and support for research study into long term outcomes for congenital bowel disease with a focus on patient goal outcomes.
	Introduce digital pathways to improve patient care across all specialities	• **International accreditation achieved with HIMSS Stage 6** – Alder Hey are the first Trust in the North to achieve this and the 4th in the UK • **Successful GDE assurance** visit with remaining funding accessed • **52 speciality packages implemented**, with **clinical intelligence portal in place** to support outcomes monitoring at service level • International accreditation includes a range of **safety improvements** including **closed loop technology** and enables **international benchmarking** of digital maturity and safety • **Alderc@re** programme launched which includes **positive changes to electronic patient records** for staff in 2020
	Quality improvements to patient services focused on 5 key priorities:	**Brilliant Booking & Scheduling** • **Bi-directional texting implemented** across 31 specialties allowing families to confirm they can attend their Outpatient Department (OPD) clinic appointment or request a cancellation. We are subsequently sending up to 400 fewer letters per day and delivering postage savings. • **Effective management of patients on the waiting list for care:** patients who have not made contact for a follow-up are on a list which is reviewed and validated. This list is identified internally as a Did Not Contact list. In January 19

there were c. 10,500 patients on this list; this has now been reduced to c. 3,500 (September 19)

- Introduced an **electronic clinical prioritisation system for follow-up appointments**: we use 'tolerance' (low tolerance equals high clinical risk) to stratify the allocation of follow-up appointment with patients at the highest clinical risk prioritised to receive care first.

Patient Flow

- The **SAFER care bundle has been implemented** across seven wards, continuous works to fully embed the SAFER principles continue across all and the **percentage of children discharged before 12PM has increased by 5% to 23%** in comparison to last year.
- Standard documentation is now in use which requires **mandatory completion of an Estimated Date of Discharge**. To support communication of this **'My Pads' have also been introduced** across 4 wards, they are able to outline all daily interventions prior to discharge.
- **MDT pathway** is now in place to **review of all patients with a length of stay 7 days or more**. A suite of documents have been produced to support and standardise all Multi-Disciplinary Team meetings (MDT) that take place across the Trust. There has been a **month on month improvement in the number of MDT's** taking place which is an average of 15 per month.
- **'Patient Flow: In control'** has been implemented and embedded in to Trust business as usual. This consisted of seven changes to bed meetings and managing flow including 'Hospital Manager of the Week' which ensures timely decision making and a point of contact for escalation.

Best in Acute Care

- Created a **new team to manage Complex Patients** and provide early intervention to patients with a length of stay of 7 days or greater.
- Designed a new **Model of Care for High Dependency Unit**
- **Recruited 3 High Dependency Unit Consultants** who will provide a partial seven day service.
- Re-designed and issued new pathway & threshold documents for admitting patients and requesting advice from other specialities.
- Full consultation process has taken place to determine suitable location and model for a **Paediatric Assessment Unit**. Business case written to support this with finances, subject to approval pilot to commence March 2020.
- **Acute Care Team** has been supported by the Trust including funding to recruit to the team. Phase 1 of recruitment has been completed (Bed Managers, Band 7 and Clinical Site Co-Ordinators, Band 6) with phase 2 on track to be completed by January 2020 (Advanced Nurse Practitioners, Band 8A). A fully operational Acute Care Team is due to commence April 2020.

		Comprehensive Mental Health • **Capital secured for Tier 4 plans approved** – work ongoing regarding the development of new care models and unit now open for 9 beds. • **Trailblazer (schools Liverpool) awarded funding twice**. There are now 4 Liverpool teams, one specifically working with young people and transition in schools • **Community and Mental Health Services are now working to clinic templates** which have improved capacity and demand management. This should **positively impact on waiting times** • **Eating Disorder and Crisis Care teams have secured additional investment** from Liverpool CCG to recruit additional staff and extend the services in a planned way over the next 3 years to meet required national specifications **Best in Outpatient Care** • **Patient experience and satisfaction has been increased to 95% across outpatients** (baseline of 89% March 2019). Experience has been improved through the introduction of comfort rounds, communicating waiting times daily, improved signage, flow and play and distraction. • The **number of outstanding ePPF forms 48hours after a clinic appointment has reduced to 6% weekly** and the total number of outstanding legacy forms has reduced by 64% since March 2019. • **£100k** pledged from Liverpool John Lennon Airport for **play and distraction** techniques across Outpatients. The requirements, for all ages, across the department agreed and tested with The Forum. Implementation March 2020. • **Clinicians experience with Outpatients overall has increased to 94%** from a baseline of 45% satisfaction in September 18

Strategic Objective		**Progress – January 2020**

Having the Best people	**The best place to work; happy staff delivering the care they aspire to**	• **72% of our staff recommends Alder Hey as a place to work** (2018 Staff Survey; response rate 60%)
		• **62% response rate to the 2019 Staff Survey**, national results awaited.
		
		• **Wellbeing Strategy** under implementation, supporting staff to improve all aspects of their health and wellbeing;
		  • A pilot **'wellbeing team'** to support the management of sickness absence has been approved; recruitment commenced in December 2019
		  • **'Time to Change'** mental health awareness programme now launched, with over 45 managers booked onto the training and 100 mental health champions to be trained in 2020

doing their best work in the best place		• **Schwartz Rounds** successfully relaunched, with over 200 staff having attended the 4 rounds to date • **Annual Star Awards** scheduled for February, with fantastic standard of nominations; over 200 nominations were received. • A **new junior doctors mess** is now established at the top of the 'Tree House'
	Having brilliant leaders; supporting a diverse and talented workforce	**Diversity** - Developing our workforce to reflect the communities we serve and improving the experience of our staff from diverse backgrounds; • **EDI established as a project** on the Trust's Change programme, with the aim of raising the profile, securing greater involvement and identifying key projects which will enable the Trust to meet its ambition of a 1% year on year increase in the diversity profile of the trust. • **Reciprocal mentoring programme up and running** • **Partnerships with local colleges to improve recruitment** channels and pathways are being explored. **Leadership Capability**: Building line, clinical and system leadership focused on supporting quality improvement; • **2 Mary Seacole leadership programmes delivered**, with another to be delivered in February 2020. The **pass rate so far has been 100%** • **Leadership apprenticeships** continue • **Strong Foundations Programme launched**; 6 cohorts already live with 7 others fully booked until November 2020; more dates for the programme are to be released.
	A centre of excellence for paediatric training and research	• Deliver **at least 50 apprenticeship starts** through the Academy each year; there are currently 85 learners enrolled on apprenticeship. • Application made to remain on the **employer provider register**, awaiting imminent OFSTED inspection. • Building a partnership with Boston Children's Hospital and Ellis Brigham Hospital to create a **Physicians Associate (PA's) programme** to support the integration of PA's into new models of care in paediatric services.
	Shaping the development of the North West Paediatric workforce	• **Nurse associate** roles being supported: Alder Hey strategy to grow our own, focusing on Band 2-3 as well as external recruitment. 2 already qualified and more in training. • **International recruitment programme for nurses** underway; **75** highly skilled nurses recruited to work across surgical areas such as critical care, theatres and wards will start their employment during 2020. • Developing partnership approach to **single paediatric workforce for the North West** through the Cheshire & Merseyside Women's and Children's programme

Strategic Objective		Progress – January 2020
Sustainability through External Partnerships	**Delivering Care close to home in partnerships**	**The Liverpool Neonatal Partnership**: Single neonatal service established with Liverpool Women's Hospital; • Funding for **Neonatal Intensive Care Unit (NICU)** approved from NHSE. Leadership team appointed and clinical staff recruitment commenced; including additional consultants and Advanced Neonatal Nurse Practitioners (ANNP). **Provision of care across both sites has improved**; surgeons are conducting ward rounds at LWH and AH have Neonatal Consultant and ANNP presence 5 days a week, extending to 7 day service from January 20. NICU estate development at Alder Hey progressing; global visits to centres of excellence undertaken and workshops involving parents and staff underway to support design of new unit. **All-Age Coronary Heart Disease (CHD)**: Alder Hey deliver Level 1 service for the region in partnership with Liverpool Heart and Chest, Royal Liverpool University and Liverpool Women's Hospital; • Level 1 all-age CHD continues to be delivered successfully in Liverpool; the partnership is consistently **exceeding required surgical volumes** and achieving positive outcomes for children, young people and families. Level 1 Partnership Board established and meeting 6 monthly. • Alder Hey successful in becoming **hosts to the new all-age CHD Operational Delivery Network** (ODN). Recruitment to roles is underway and the inaugural ODN Board took place in January 2020. **"Starting Well / Healthy Children & Families"**: Alder Hey leads this segment of the 'One Liverpool' plan, through Children's Transformation partnership (chaired by Alder Hey's CEO); • This is a **system-wide** programme, with wide membership of health, local authority and voluntary sector partners. Priorities underway include (*not exhaustive*); • 2 x pilot **community children's hubs** in Aintree and Speke, implementing a multi-disciplinary community team approach for C&YP • **Infant Feeding** Pilot: community approach with primary care and community teams • Improving the **Urgent Care** system for children and young people, in the context of the wider Urgent Care review in North Mersey.
	Developing our excellent services to	**North West Paediatric Partnership Board** (NWPPB - Alder Hey & Royal Manchester Children's Hospital): • The partnership has facilitated improvements in digital joint Multi-Disciplinary Teams, joint consultant appointments in Neurosciences; next steps are to develop a joint MDT for neuro-oncology. Developing partnership plans for cardiology,

	their optimum and growing sustainably	haematology, and our joint approach to the development of our co-hosted ODNs for 2020+ with NHSE. • Established for 12 months; MOU in place and agreed by both Trust Boards in Summer 19. Governed via the NWPPB. **'Alder Hey with…':** working with district general hospitals (DGHs) to develop a partnership model to enable appropriate DGH level interventions to be delivered in a safe, joined-up way close to people's homes: • Work with **Southport and Ormskirk** is ongoing alongside the Trust's future plans. • A clinical session with **Warrington Hospital** to scope potential took place in December 2019. This was warmly welcomed by clinicians at both sites, and a subsequent programme of work will be established to frame our partnership and progress on a speciality basis. **Alder Hey co-creating new models of care for paediatric Mental Health and LD;** • Successful bid via NHSE Transforming Care to support implementation of an **Intensive Support Team for children and young people with LD/ASD and/or mental health**. Service commenced Jan 2020. • Alder Hey represented at C&M HCP mental health groups for C&YP. This includes national and regional plans regarding future delivery of Tier 4 Specialist Mental Health services and alignment of single telephone response for mental health crisis via 111 • Alder Hey increased the number of beds within the CAMHS Tier 4 specialist inpatient unit to 9 during 2019/20. This is with a view to increasing to 12 beds on completion of the new build. **Develop regional paediatric / neonatal services as part of Women's and Children's Partnership** (C&M HCP); • CEO's of Alder Hey and Liverpool Women's Hospital continue as joint SRO's of the C&M Women and Children's programme. 'Roadshow' visits to every C&M provider C&M completed culminating in a Clinical Summit in July 19; recommended a 'Core / Comprehensive' service model. • Aim to develop a partnership model of paediatric care and workforce for C&M over the next 3-5 years **Department of International Child Health**: • Humanitarian programme developed and led by passionate clinicians from Alder Hey working on international outreach models. Reassessing future international child health strategy with a view to future growth opportunities. • A partnership is being developed with Chengdu Children's Hospital to increase their expertise and services for Children.
	Contributing to the Public	• Development of **"Starting Well"** theme of One Liverpool plan (as above) and alignment with **Liverpool Health Partners'** Starting Well research theme; aim being to grow the C&YP research delivered in the North West, thereby

	Health and economic prosperity of Liverpool	ensuring local people gain the inherent outcome improvements from being involved in research. • Alder Hey contributed to and signed up to 'One Liverpool' plan, with a clear **focus on developing 'anchor institution' principles across all providers**; system plan to develop code of conduct during Spring 20 which will focus on aspects such as **local recruitment and procurement**. • Focused development of **Park / campus** to improve health and wellbeing locally, and **Green Strategy** (progress below)

Strategic Objective		**Progress – January 2020**
Delivering Game Changing Research & Innovation	**World-leading Children's research enabling outstanding treatment**	**Offer children and young people every opportunity to take part in clinical research**: establishing a core team from Alder Hey and University of Liverpool (UoL) to ensure clinical and non-clinical services are best organised to offer this; • Funding for additional research infrastructure agreed in 2019 by Executive Team • 3 Associate Divisional Research Directors (Clinical) (ADRDs) appointed in December 2019 • All honorary Chairs (UoL) in receipt of one Programmed Activity (PA) for research • Clinical Research Division Matron appointed and commenced post in December 2019 • Inaugural Research Management Board took place in October 2019 • Commercial research investment and income redistribution plans being worked up. Initial focus on Duchenne Muscular Dystrophy portfolio. • Research General Manager post filled September 2019 bringing stability to Clinical Research Division • Agreement in principle for a Managing Director role covering Research and Innovation **Attract and appoint internationally renowned leaders and new talent** in paediatric research; • New Senior Lecturer in Paediatric Clinical Pharmacology post advertised January 2020 • Progress with first Consultant Pharmacist post at Alder Hey with major focus on research • Professor Iain Buchan has affiliated his NHS honorary contract and NIHR Senior Investigator award with Alder Hey • Re-engagement with UoL following Project SHAPE to develop opportunities for senior academic posts (previous opportunity of Chair in Paediatric Epilepsy did not progress due to personal circumstances of preferred (and only) available UK candidate) **Integrate front line and research activity** through an increasing number of clinicians involved in research; • **Over 6,000 children and young people recruited into clinical research studies at Alder Hey to date** in 2019/20.

		This is a third of the total in the NW Coast region • High profile **DETECT** study impacting on all inpatients and showing early signs of significant improvement in morbidity, patient safety and reduction in critical care admissions • Appointment of **ADRDs** in Dec 2019 will support integration of clinical research with the front line • Research income redistribution model to incentivise additional investigators and increase research capacity • Alder Hey Charity has provided funding for **10 PAs** (or equivalent) for research time for healthcare professionals for two years (three years depending on progress). With funding for honorary chairs equals up to **£540k** • Successful second round of the **Hugh Greenwood Legacy fund** with ten awards (**£400k** in total) from 31 applications. Many of these applications involve new or junior Alder Hey investigators. • Plans to develop novel clinical research roles for **Physician Associates** • Successful implementation of Alder Hey monthly research clinics offering an environment for clinical researchers to exchange ideas and learn • National leadership (Prof Peak) in collaboration with Royal College of Physicians in developing policy and guidance for increasing research capacity in NHS **Contribute to Liverpool Health Partners (LHP) themes relevant to "Starting Well"**; • LHP "Starting Well" Programme Leadership Team (Beresford, Morgan, Hunt) held priority setting consensus workshops with a range of multi-sector professionals through 2019 to inform the areas which will shape further research effort and Alder Hey's contribution to this. • Significant leadership within the MRF funded **C-GULL** study: commences October 20 – the first major birth cohort study in the UK since Born in Bradford (2007) • Within LHP framework, contributing to the development of a Liverpool NIHR Biomedical Research Centre (BRC) proposal (Alder Hey and Starting Well component). Position paper to be presented to LHP Board on the interdependency of Clinical Research Facility renewal and the BRC proposal. • Professor Malucci appointed as LHP Neurosciences Programme Director in January 2020
	Delivering Digital Excellence for C&YP & Staff	• **Digital Futures Strategy** developed and approved at Trust Board July 2019 • **Significant Digital progress** this year described within 'Delivery of Outstanding Care' p3-4 report (above).
	A world-leading centre of excellence that accelerates the	• **Innovation Committee** now established and meeting regularly, 3 external advisors agreed to become members including Industry Innovation Expertise & Liverpool LEP, Venture Capitalist and Artificial Intelligence expert. • Activity and Pipeline: total new innovation needs identified and lodged with Innovation Centre between April-Dec 19 was **118** which is a significant increase compared to 2018/19. Of these needs a total of **35** were triaged into the

	impact of game changing Innovation for C&YP	pipeline as a need that meets our strategic themes and has potential impact. • **12 active projects with investment and/or resource**: Alder Play, Ask Oli Chat bot, Asthma Mapping, Asthma wearables, Transdermal sensor, Cortisol saliva sensor, Shine Hip sensor, Project Move, App Prototypes, L&D scheduling, AI augmented decision competition, 3D Pre-Operative planning Printing. Funding sources include Trust base budget, high net worth and AH charity. • **NHSX successful bid for CYP Digital Mental Health** • Alder Hey part of **AHSN NW Coast 'Liverpool Health Ventures'** scoping exercise which looks to establish a city wide innovation approach and seed fund. Feasibility funded 50% by the Combined Authority with 50% Trust match. • **Business case for 'Science Building' progressed**. Requirements include a 6000m2 space which includes 2400m2 anchor tenant and 1500m2 new clinical spaces for immersive future care models. • Alder Hey now **founding member of 'Immersive UK Board'** • **Health Innovation Exchange Project (ERDF) completed** with all output KPI achieved. Close in progress. • Next **Festival of Innovation** date confirmed as Friday 3rd July 2020.

Strategic Objective		**Progress – January 2020**
Be a catalyst for health and wellbeing through our Alder Hey in the Park campus and community infrastructure	**Develop our Health Park vision**	• **Phase 1 park works** tendered and programmed to **start January 20; completion Summer 20.** • Main park planning approval achieved December 19. • Plan for early clearance of Park approved at October 19 Trust Board. Relocation of many staff from retained estate scheduled for June/July 20. Demolition works commence Autumn 20; this will pave the way for commencement of next phase of park works early 2021. • Arrangements for Park ongoing in discussion with Liverpool City Council. • **Working with Groundworks Charity to engage local community to design a park in line with their needs.** • Hard linking Park development to Trusts' new **Green Strategy** to enhance environmental/clean air delivery.
	Deliver the new Alder Centre	• New **Alder Centre specialist bereavement centre** nearing completion – despite short poor weather delay, handover expected by end of April 2020. • Further fundraising **contribution from the Charity of £204k** has been agreed to allow for completion of gardens and external works. Current pressure is to have the Gabion wall built and pathway constructed prior to opening beginning of May 2020
	Deliver the Green Strategy	Development of the **Alder Hey Green Strategy** underway; • Focus on **Global Health Impact of climate change**, reduction in use of energy, plastics and local health impacts of climate change/air pollution • Linked with Review of Liverpool City Region climate emergency

		• Inclusive of the **voices of Children and Young People** • Developing Green Space supporting **Mental Health** • **Summit scheduled to launch March 20**

Strategic Objective		**Progress – January 2020**
Strong Foundations	**Financial Sustainability**	• **Waste – we are on track to deliver our in year efficiency target of £6m** and have developed a new framework for future efficiency programmes that the Divisions and the Executive are currently finalising which will come back to Trust Board. This aligns to our major strategic goals in the longer term plan. • **Brilliant Basics/Inspiring Quality (IQ) – The Trust has invested a total of £0.6m in IQ** which will promote a programme of Quality Improvement as part of delivering the strategy. • **Growth - our business development activities have delivered c£2m of growth in 19/20** largely through clinical strategy plans being realised. • **Partnerships** – we have agreed significant investment in Neonatal services to establish a surgical neonatal centre at Alder Hey as part of a single service model with LWH. We have embedded a financial model that supports the designated North West Congenital Heart Disease Service and started to share some corporate services across the Specialist Trust Group. • **Commercial/International** – The Trust has agreed a new approach to increasing its non NHS activities and has been successful through the Academy in generating income opportunities through observerships from Asia. • **Digital Futures** – the GDE programme will be completed by March 2020 with all milestones being met and HIMMS Level 6 award recently announced. The programme has secured £10m of inward investment into Alder Hey and current benefits identified are cumulative cash releasing of £2.2m and non-cash releasing £1.9m. Alder hey has also played a significant role in attracting central digital funding for the C&M HCP and hosts several of the programmes which total £10m of central investment. We have jointly invested in EPR Infrastructure with our fast follower partner Clatterbridge. • **Research/Innovation** – the Trust has invested £0.5m recurrently into Innovation core capability which has supported us attracting a further £0.5m philanthropic investment. The Team have also developed a funding strategy and are progressing options to create a £4m early start up seed fund. We are piloting a new financial model for research studies with an aim to enabling rapid growth of our portfolio. • **Campus** – The Board has supported, subject to us delivering a break even position sustainably, the development of a multi-year campus investment plan totalling £45m.

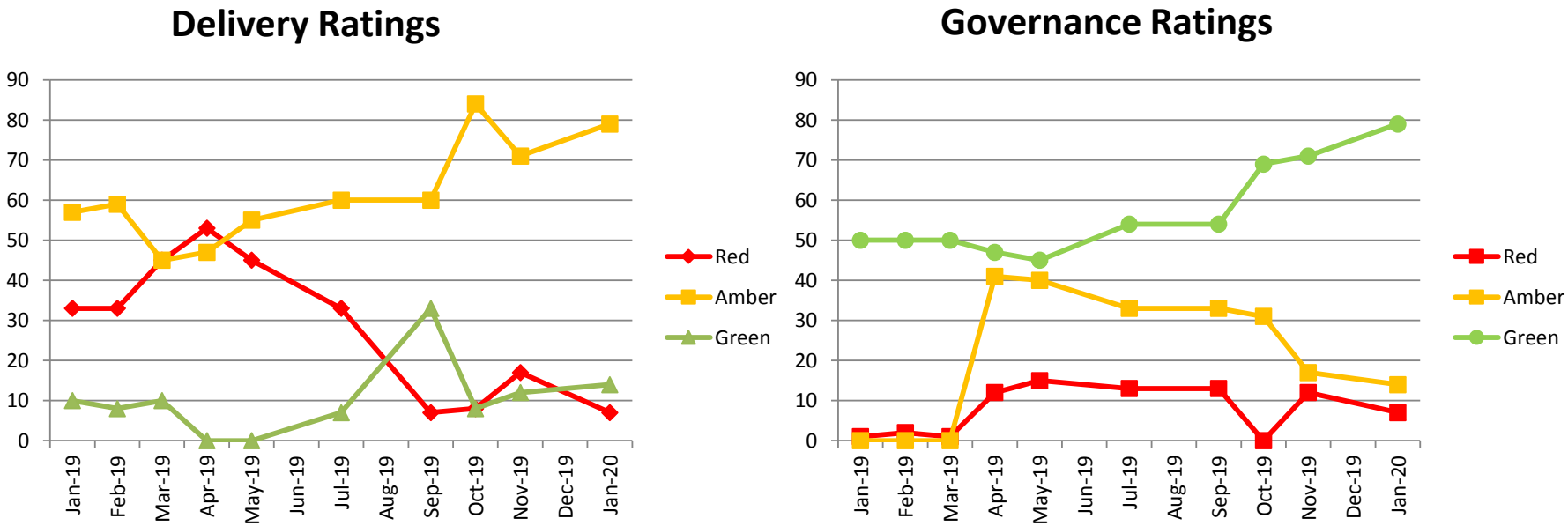
Alder Hey Children's NHS
NHS Foundation Trust

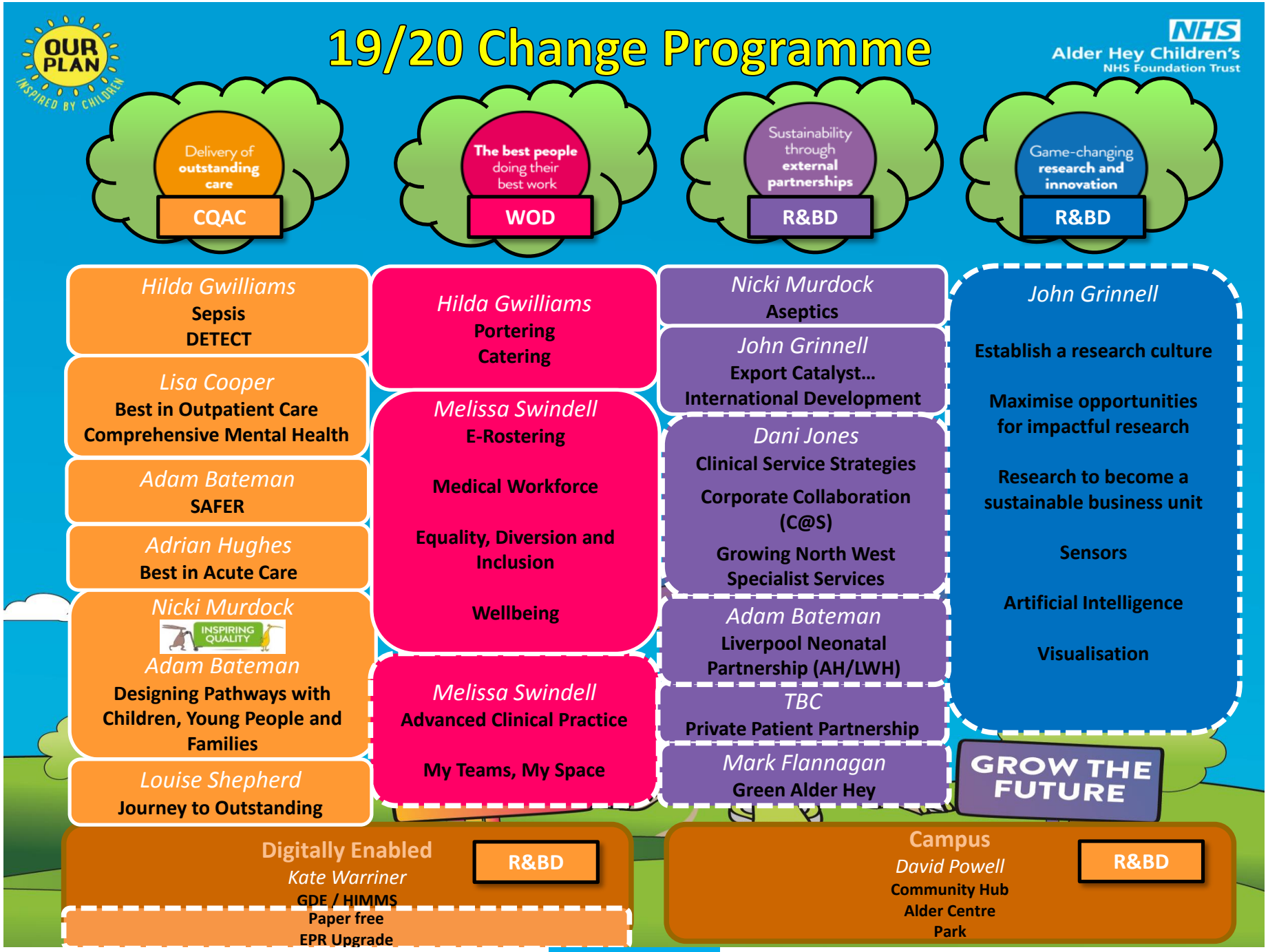
Programme Assurance Summary
Change Programme

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

1. This Board report comprises of extracts from the assurance dashboard covering 5 out of the 6 themes of the change programme as reporting to the Board sub-Committees: CQAC 15th and RABD 22nd January 2020.
2. Slide 2 of this programme assurance report contains the current scope for the19/20 change programme.
3. Of the 14 projects rated in this report with regards to the **overall delivery** assessment: 14% of the projects are green rated with 79% amber and 2% red. These percentage summaries show an improvement on the previous months ratings.
4. The **overall governance** position is good, with 79% of the projects green rated, 14% amber and 7% red rated projects. Similarly to the overall delivery ratings, there has an improvement since the previous months ratings.

N Deakin, Head of Programme Management and Independent Programme Assurance 27 January 20




OUR PLAN
INSPIRED BY CHILDREN
19/20 Change Programme
NHS
Alder Hey Children's
NHS Foundation Trust
Delivery of outstanding care
CQAC
The best people doing their best work
WOD
Sustainability through external partnerships
R&BD
Game-changing research and innovation
R&BD
Hilda Gwilliams
Sepsis
DETECT
Lisa Cooper
Best in Outpatient Care
Comprehensive Mental Health
Adam Bateman
SAFER
Adrian Hughes
Best in Acute Care
Nicki Murdock
INSPIRING QUALITY
Adam Bateman
Designing Pathways with Children, Young People and Families
Louise Shepherd
Journey to Outstanding
Hilda Gwilliams
Portering
Catering
Melissa Swindell
E-Rostering
Medical Workforce
Equality, Diversion and Inclusion
Wellbeing
Melissa Swindell
Advanced Clinical Practice
My Teams, My Space
Nicki Murdock
Aseptics
John Grinnell
Export Catalyst…
International Development
Dani Jones
Clinical Service Strategies
Corporate Collaboration (C@S)
Growing North West Specialist Services
Adam Bateman
Liverpool Neonatal Partnership (AH/LWH)
TBC
Private Patient Partnership
Mark Flannagan
Green Alder Hey
John Grinnell
Establish a research culture
Maximise opportunities for impactful research
Research to become a sustainable business unit
Sensors
Artificial Intelligence
Visualisation
GROW THE FUTURE
Digitally Enabled
R&BD
Kate Warriner
GDE / HIMMS
Paper free
EPR Upgrade
Campus
R&BD
David Powell
Community Hub
Alder Centre
Park

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Delivering Outstanding Care

Work Stream Summary (completed by Independent Programme Assurance)

Overall, for the **Delivery of Outstanding Care** programme, governance and delivery ratings are good.

Some of the benefits for the *Sepsis* projects are now displaying positive trends. All measures are now tracked on a benefits tracker and plans for the coming year are available. The Sepsis PID for 2020 however; is still required to be signed off at Programme Board.

The output metrics linked to the implementation of the DETECT study are trending positively with all planned areas now live and increasing numbers of observations logged using the new equipment.

The *Best in Outpatients* project is green in all domains for both governance and delivery and is showing positive trends in many of its measures.

Evidence is available to show the planned change in direction for some of the work streams within the *Best in Mental Health* project, focus should remain on progressing this agenda.

There is a revised plan for *Inspiring Quality* in evidence with an agenda scheduled for 13th Jan 2020 to finalise SMART metrics.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 8 Jan 20

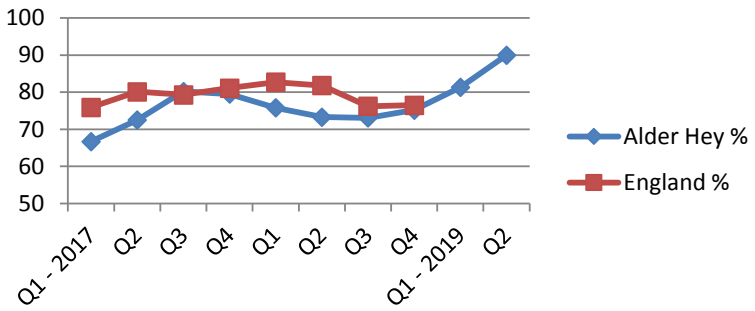
Independent Assurance Report – SEPSIS

Exec Sponsor: Hilda Gwilliams

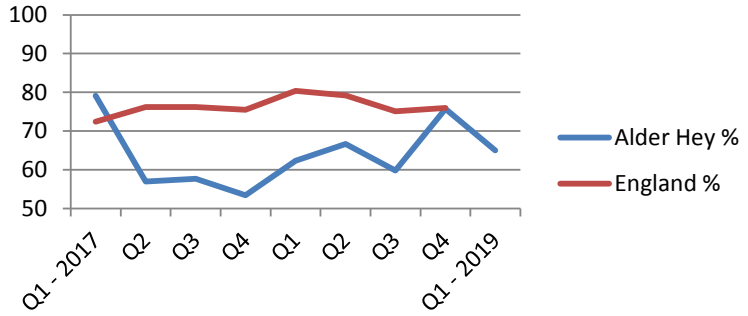
To improve the awareness about sepsis throughout the hospital. Using a framework tool to support the early identification, escalation and timely response to treatment for patients with suspected/known sepsis.

Key Programme Metrics	Baseline	Current	Target
1.0 OUTCOME Percentage of inpatients treated for sepsis with high risk criteria in <60 mins	N/A	88% (Dec)	90%
2.0 OUTCOME Percentage of ED patients treated for sepsis with high risk criteria in <60 mins	N/A	77% (Dec)	90%
1.1 OUTPUT Clinically appropriate staff have received Sepsis training	0	77% (Dec)	90%

OUTCOME 1
% IVAB Administration in <60 mins IP



OUTCOME 2
% IVAB Administration in <60 mins ED



Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Sepsis		●	●	●	●	●	●		●	●	Sepsis Steering Group minutes are availa up to 13 November 19. The PID for the next phase of the project has not yet been signed off via Programme Board but is availale on SharePoint. A number of benefits are now trending positively.There is a milestone plan which is being tracked. Considerable stakeholder engagement is now available from previous months. All risks are within their review date on the Ulysses system. EA/QIA complete. **Last updated 06 Jan 20.**

Independent Assurance Report – DETECT

Exec Sponsor: Hilda Gwilliams

The DETECT project is a research study which aims to :

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

Key Programme Metrics	Baseline	Current	Target
1.0 OUTCOME Reduction in PICU and HDU costs (Patient level costs for >11m critical care stay associated with deterioration).	£11.5m	Measured annually	£10m (£1m reduction)
1.1 OUTPUT Reduction in number of resuscitation team calls from study wards	17 per month	9 per month (Dec 19)	7 per month (August 21- 1 year post go live)
1.2 OUTPUT Number of areas live with CareFlow	0	10 wards 6 day case (Dec 19)	10 wards 6 day case
1.3 OUTPUT Number of staff trained on CareFlow	0	820 (Dec 19)	800
1.4 OUTPUT Reduction in annual average number of beds used for critical deterioration (6.5% reduction)	7665	Measured annually	7167
1.5 OUTPUT Reduction in Critical Care median LOS	7.6 days	2.8 days (Oct 19) (measured quarterly)	LOS to be better than baseline (TBC)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
DETECT Study		●	●	●	●	●	●		●	●	Evidence of project team meetings are in evidence up to 3 Dec with agenda available for 7 Jan meeting. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed. Benefit metrics are outlined and are now being tracked with a small number of omissions. Positive trends seen for training numbers and number of staff live with Connect Communication System. A detailed workbook has now been uploaded which contains task logs and a comprehensive milestone plan which looks largely on track. There is a suite of stakeholder engagement in evidence. Risks are on Ulysses and within review date. EA/QIA uploaded and signed. **Last updated 03 Jan 20.**

Independent Assurance Report – Best in Outpatients

Exec Sponsor: Lisa Cooper

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

Key Programme Metrics	Baseline	Current	Target
1.0 OUTCOME Increase % of visitors likely to recommend OPD	91% (Mar 19)	96% (Dec 19)	95% (Mar 20)
2.0 OUTCOME Increase Clinicians satisfaction with OPD (measured every 4 months measure)	40% (Mar 18) 60% (Mar 19)	85% (Nov 19)	80% (Mar 20)
3.0 OUTCOME Reduce missing outcomes ePPF	2138 (May 19)	1189 (Dec 19)	626 (Mar 20)
3.1 OUTPUT Reduce cash up's completed after 48 hours of appointment (ePPF)	11% (Mar 19	6% (Dec 19)	5% (Mar 20)
4.0 OUTCOME Increase clinic utilisation	84% (Mar 19)	81% (Dec 19)	90% (Mar 20)
4.1 OUTPUT Reduce WNB rate	10% (Mar 19)	14% (Dec 19)	12% (Mar 20)
5.0 OUTCOME Reduction in DNC list	10128 (Mar 19)	13 (Jan 20)	0 (Mar 20)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Best in Outpatient Care		●	●	●	●	●	●		●	●	Evidence of Steering Group meetings available to 26 Nov 2019. A comprehensive 19/20 PID is available and has now been signed off at Programme Board. There is a comprehensive benefits tracker with the majority of measures now showing sustained positive trends albeit with some excpetions. A milestone plan for 19/20 is available and closely tracked. There is a planned approach to stakeholder engagement and a raft of excellent Outpatient departmental newsletters are in evidence. Risks are managed via Ulysses and are all within review date. EA/QIA is signed and uploaded. **Last updated 06 Jan 20.**

Independent Assurance Report – SAFER

Exec Sponsor: Adam Bateman

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

Key Programme Metrics	Baseline	Current	Target
1.0 OUTCOME Reduction in Trust LOS	3.3 Days (Apr 19)	2.93 Days (Oct 19)	3.1 Days (Mar 20)
1.1 OUTPUT Increase in CUR compliance	79% (Apr 19)	83% (Oct 19)	85% (Mar 20)
1.0 OUTCOME % of patients who know their planned date of discharge?	67% (Apr 19)	91% (Oct 19)	95% (Mar 20)
2.0 OUTCOME Reduction in cancelled operations for non-clinical reasons	27 per month (18/19)	19 per month (average 19/20)	20 per month (19/20)
3.0 OUTCOME Reduction of in-patient delayed discharges with a LoS <21 days	16% (18/19)	14.8% (Oct 19)	12% (Mar 20)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
SAFER											Evidence of SAFER Steering Group available up until 12 Dec 19 however no minutes in evidence. A comprehensive PID for 19/20 is available and has been signed off. There is a comprehensive benefits tracker which shows some but not all measures trending positively. There is a closely tracked and detailed milestone plan. Evidence of stakeholder engagement and a comprehensive communication plan is available in the PID however a tracked communications plan would also be beneficial. Risks are within review date on Ulysses. An EA/QIA has been signed. **Last updated 02 Dec 19.**

Independent Assurance Report – Best in Mental Health Care

Exec Sponsor: Lisa Cooper

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

Key Programme Metrics	Baseline	Current	Target
Eating Disorder Services			
1.0 OUTCOME % of patients who receive their appointment within national targets	35% (April 19)	36% (Sep 19)	95% (2020)
Booking and Scheduling			
2.0 OUTCOME Reduction in WNB rate	13.72%	20.5% (Sep 19)	10%
3.0 OUTCOME Reduction in staff turnover rates	15.2%	10.6% (Sep 19)	10%

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Best in Mental Health Care											Evidence of project team meetings available until 09 Sep 19. There is a final PID which was signed off at Programme Board on 22 Aug 19. Benefits are tracked however very few are showing a positive trend. A comprehensive milestone plan is evidenced and being tracked however there are a number of milestones which have been missed and need to be revised. A stakeholder analysis has been completed but further evidence required of wider stakeholder engagement. Risks are on Ulysses and are within their review period. A signed EA/QIA has been uploaded. **Last updated 26 Nov 19.**

Independent Assurance Report – Best in Acute Care

Exec Sponsor: Adrian Hughes

The aim of the project is to re-design and implement a number of models of care for Alder Hey. The 5 workstreams are as follows; HDU, EDU, ACT Care Team, Out of Hours and Pathways and Thresholds.

Key Programme Metrics	Baseline	Current	Target
High Dependency Unit (HDU)			
1.0 OUTCOME Reduction in average LOS in HDU	4.7 (18/19)	TBC	4.2 Days (Apr 2020)
2.0 OUTCOME Reduction of re-admissions within 48 hours	TBC	TBC	TBC (Apr 2020)
1.1/2.1 OUTPUT Number of hours with Consultant cover	0	0	168 Hours (full 7 day cover) (Nov 19)
Acute Care Team (ACT)			
3.0 OUTCOME Reduction in unplanned admissions to PICU/HDU	328 (18/19)	TBC	279 per annum (Apri2020)
4.0 OUTCOME Reduction in unplanned admissions and bed days in Critical Care	1600 (18/19)	TBC	1360 per annum (Apr 2020)
3.1/4.1 OUTPUT Full recruitment to ACT team	0 WTE	9.38 WTE (Oct 19)	21.04 WTE
Out of Hours			
OUTPUT Number of General Paediatricians onsite until later in the evening	0 WTE	0 WTE (Oct 19)	3.0 WTE

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Best in Acute Care		●	●	●	●	●	●		●	●	Evidence of Models of Care meetings up to18 Nov 19. A high level design process is available and the 19/20 PID has now been signed off. Various data packs are in evidence and the project now has clear measures for success which are categorised into outputs and outcomes. Some of these metrics however still require baselines and tracking. A comprehensive milestone plan is available and is being tracked however there are now a number of missed milestones which need revised dates. There is evidence of stakeholder engagement including updates to Programme Board. Risks now available on Ulysses and are within review date. There is signed EA/QIA in evidence. **Last updated 27 Nov 19.**

Independent Assurance Report - Inspiring Quality

Exec Sponsor: Nicki Murdock

Alder Hey's programme of work which promotes continuous quality improvement to deliver 3 key aims; to put children first, to be the safest children's Trust in the NHS and to achieve outstanding outcomes for children

Key Programme Metrics	Baseline	Current	Target
1.0 OUTCOME Children report that we 'put them first	94%	96%	95% of children report that we 'put them first
1.1 OUTPUT Sweeney Collaborative Programme	0	1	3 teams scheduled to have participated in programme by March 2020
1.2 OUTPUT Staff trained in Child and Family Centred Care	0	0 (staring March 2020)	784 staff to be trained by Nov 2021
1.3 OUTPUT Pathways & Improvements designed with children and families	0	0	5 pathways complete by Nov 2020
4.0 OUTCOME Staff report feeling able to make improvements to care	TBC Staff Survey (2018)	TBC Staff Survey (2019)	80% of staff report feeling able to make improvements to care
4.1 OUTPUT Staff trained in Strong Foundations Leadership programme	0	100	85 staff to be trained by November 2021
4.2 OUTPUT Issues to be resolved by using huddle boards	0	6	100 issues to be resolved by November 2021

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Inspiring Quality		●	●	●	●	●	●		●	●	Evidence of project meetings to 2 Dec 19. The Inspiring Quality Plan serves as a comprehensive PID. Benefits are clearly defined in the PID and a presentation entitled 'Outputs and Outcomes' now indicates the measures which the programme is intending to measure. A Phase 1 'Starting Change' paper is available which clearly maps out the next 6 months of the plan however this phase is due to come to an end at the end of Oct 19 and details of phase 2 are now required. There is evidence of wider stakeholder engagement in the form of a staff engagement session with pledges however this programme of work would now benefit from a enanced plan and communications plan. Risks are on Ulysses and are being tracked. There are a number of EA/QIA to be complete due to the multiple projects which sit within the programme. Some of these are now available in draft. **Last updated 6 Dec 19.**

Exec Sponsor: Louise Shepherd

Independent Assurance Report – Journey to Outstanding

A structured programme of work to complete all tasks which we know contribute to a rating of **OUTSTANDING** in all areas from the CQC.

Key Programme Metrics	Current	Target
OUTCOME 1.0 - SAFE KLOE rating	REQUIRES IMPROVEMENT	OUTSTANDING
OUTCOME 2.0 - EFFECTICE KLOE rating	GOOD	OUTSTANDING
OUTCOME 3.0 - WELL LED KLOE rating	GOOD	OUTSTANDING
OUTCOME 4.0 - RESPONSIVE KLOE rating	GOOD	OUTSTANDING
OUTCOME 5.0 - CARING KLOE rating	OUTSTANDING	OUTSTANDING

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Journey to Outstanding		●	●	●	N/A	N/A	N/A		●	●	Evidence of project meetings up to 6 Jan 20. There is no PID available given the short project lifecycle. There is now a CQC tracker in evidence which tracks the outputs of the project. There is a detailed and complex milestone plan which is being tracked. There is a suite of evidence of stakeholder engagement and a comprehensive comms plan. Risks identified within this project will be logged on Ulysses as a BAU risk and not under a project heading as there is no specific change planned in this project. EA/QIA is not required. **Last updated 06 Jan 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

Work Stream Summary (completed by Independent Programme Assurance)

Sustainability through External Partnerships

The *Aseptics* project 's plan is still showing slippage of milestones even after submitting an exception report to reset milestone dates only a few months back.

The *Export Catalyst* ratings for both governance and delivery have now deteriorated as the project life cycle has come to an end with no milestones planned beyond September 19.The Exec Sponsor is now required to set the direction of the project for the coming months.

Global Digital Exemplar

The governance ratings of the GDE / HIMMS programme are satisfactory and the delivery of speciality packages hit its November target. The next steps for the GDE Programme are to achieve full GDE accreditation and HIMSS Level 7. Evidence eon SharePoint now needs to reflect these plans.

Park, Community Estate and Facilities

The governance and delivery ratings for the *Park, Community Estate and Facilities* programme have deteriorated this month. There are still gaps with regards to the identification and tracking of SMART metrics for all the projects within the programme and the programme plan has now not been updated for numerous month.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 15 January 20

Independent Assurance Report – Aseptics

Exec Sponsor: Nicki Murdock

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

Key Programme Metrics	Baseline	Current	Target
1.0 OUTPUT Increase the number of commercial research studies open to recruitment	3 (April 19)	3 (Dec 19)	6 (July 2020)
2.0 OUTPUT Increase in number of patients on research studies.	2 (April 19)	3 (Dec 19)	6 (July 2020)
3.0 OUTPUT Reduction in medication errors in ASU (injectable therapy)	5 (April 19)	4 (Dec 19)	2 (July 2020)
4.0 OUTPUT Increase in number of ready to use products prepared in-house by ASU	66 (April 19)	343 (2138 YTD)	230 (Jan 2020)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Aseptics		●	●	●	●	●	●		●	●	Minutes of the Quality Management Meeting of the Aseptics Services Department are available up to 9 Jan 20. Scope is described by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' dated 16 March 2018' together with a 'Project Overview Document' dated 14 Jun 2018. A final business case dated 9th April 2019 is also evidenced. The number of ready to use products made in house has seen a marked increase in September. A 'Project Milestone Plan' is in place and being tracked and an exception report is in evidence dated 22.05.19 which resets some milestone deadlines however a number of these milestones are once again showing slippage. Project risk are withi review date on Ulysses. EA/QIA signed off. **Last updated 14 Jan 20.**

Independent Assurance Report – Export Catalyst

Exec Sponsor: John Grinnell

The purpose of the Export Catalyst Project is to:

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

Key Programme Metrics	Baseline	Current	Target
OUTPUT 1.0 Sustainable Services	£200k contribution	£1m target contribution	Jan 2020 attain by Apr 2022
OUTPUT 2.0 Strategy & Plans	NA	Final version of strategy document available	Sep 19
OUTPUT 3.0 Pricing & Markets	NA	Documented and Agreed	Sep 19

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

Independent Assurance Report – GDE

Exec Sponsor: Kate Warriner

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

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

Key Programme Metrics	Baseline	Current	Target
OUTPUT 1.0 Number of specialty packages complete	0	52 (Nov 19)	52 (Nov 19)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
GDE											Digital Oversight Collaborative meeting notes available up to 30 Oct 19 and delivery meetings up until 7 Oct 19. Programme is RAG rated green and on target as per the programme's own assessment and on the CORA portal which is NHS Improvements digital platform. Speciality packages delivered their November milestone. There is evidence of some stakeholder engagement. All risks are within review date on Ulysses. **Last updated 20 Nov 19.**

Independent Assurance Report – Alder Centre

Exec Sponsor: David Powell

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

Key Programme Metrics	Baseline	Current	Target
OUTCOME 1.0 Expansion of services on offer	Not available	Not available	10% increase in income (April 2020)
OUTCOME 2.0 Increase the types of therapies delivered (To include arts, horticultural and pet therapy)	Not available	Not available	Not available (April 2020)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Alder Centre											Development weekly meetings are evidenced up to 4 Dec 19 and campus steering group meetings up until 15 Oct 19. Meeting notes with architects also available up until 26 Sep 19. Scope/approach defined in PID. Benefits defined in PID but no evidence of the tracking of benefits. A programme plan is available but does not appear to map all dates to all milestones and has not been updated in numerous months. Evidence of Comms/ Engagement activities available. Risks are on Ulysses and are within review date. EA/QIA complete. **Last updated 4 Dec 2019.**

Independent Assurance Report – Community Hub

Exec Sponsor: David Powell

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

- CAMHS
- Neurodevelopmental Assessment
- Psychological services
- Orthotics

Key Programme Metrics	Baseline	Current	Target
OUTCOME 1.0 Staff morale	Not available	Not available	Improvement of 10% (Sep 20)
OUTPUT 1.1 Increase in efficiency of desks per staff members	Not available	Not available	15% improvement in staff to desk ratio (Sep 20)

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Community Hub											Actions available via the development directorate meeting up until 4 Dec 19 and campus steering group up until 15 Oct 19. A recently revised PID for 2019 has now been uploaded as of 9 Oct 19. A programme plan is available which is being tracked but does not appear to map all milestones to dates and has not been updated for a number of month. Benefits are detailed in the PID with expected start dates in 2020. Evidence of stakeholder engagement however engagement with building users would also be beneficial. Risks are within review date on Ulysses. EA/ QIA complete and signed. **Last updated 4 Dec 2019.**

Independent Assurance Report – Park

Exec Sponsor: David Powell

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

Key Programme Metrics	Baseline	Current	Target
OUTCOME 1.0 Generate income	£0	Not available	Not available
OUTCOME 2.0 Support environmental sustainability	Not available	Not available	100% increase in number of trees (2021)
OUTPUT 2.1 Increase community participation	Not available	Not available	Not available

Project Title	OVERALL PROJECT GOVERNANCE	An effective project team is in place	Scope and Approach is defined	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT DELIVERY	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
Park											Actions and agendas available for the development directorate meeting in which the park project forms part of the agenda up until 4 Dec 19 however meetings with external key stakeholders would also be beneficial at this stage of the project. PID available on SharePoint and has recently been updated. There is a comprehensive suite of benefits outlined in the PID however some benefits are not SMART and not tracked. A Programme plan is available however this has not been updated for numerous months. Milestones are being tracked via a programme plan which was updated on 9 Oct 19. Evidence of stakeholder engagement including details of a planned event with the community scheduled for 30 Nov 19. Risks are on Ulysses and within review date. EA/QIA complete. **Last updated 4 Dec 2019.**

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
4th February 2020

Report of	Development Director
Paper prepared by	Associate Development Director
Subject/Title	Development Directorate Campus Development report on the Programme for Delivery
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board on the Campus delivery.
Action/Decision required	The Board is asked to acknowledge the content of the report, the current status, risks and actions. Decision on a request to reset of the programme delivery timetable for the next 3 years.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects budget.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Trust Directors Report

Campus Development report on the Programme for Delivery

4th February 2020

1. Introduction

The Board held in January accepted a reset of the Campus development programme and the new format of this report. It should be noted that as these projects have some longevity, on a month to month basis individual projects may see little movement from a reporting perspective. The aim is to keep the Board informed of progress, risks and actions as they arise.

As of the March Board and coming to the end of Qtr4 for 19/2020 the programme Delivery Timetable will rag rate projects from there planned commencement date.

2. Programme Delivery Timetable

Table1. Sets out the planned programme for the years 2019-2023 (financial years)

Table 1.	19/20	20/21				21/22				22/23
Scheme	Qtr. 4	Qtr.1	Qtr.2	Qtr.3	Qtr.4	Qtr.1	Qtr.2	Qtr.3	Qtr.4	Year
Initial Park Reinstatement (Phase 1)										
Alder Centre occupation										
Acquired buildings occupation										
Police station (LF) occupation										
Decommission & Demolition Phase 3 (Oncology, boiler hse, old blocks)										
Main Park Reinstatement (Phase 2/90%)										
Infrastructure works & commissioning										
Clinical Hub Construction										
Clinical Hub Occupation										
Dewi Jones Construction										
Dewi Jones Occupation										
Demolition Phase 4 (Final)										
Final Park Reinstatement (Phase 3)										
Neonatal Development Tendering and Design										
Neonatal Construction										
Neonatal Occupation										

3. Capital Cost

The development team fully appreciate the relevance of projects costs extending beyond available budget and how this could impact the overall capital monies available to the Trust and therefore will

continue to value engineer and reduce costs were ever possible without deterring from the quality of the developments. The development team are negotiating hard with potential and current contractors to reduce costs across all developments. The finance department is fully supporting the Team in monitoring and taking relevant actions to stay within the financial envelope available.

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

Table 2.

Estates Savings Target	Budget	Dec Estimate	Dec Comments
The Park	1,750	3,000	Phase 1 tender suggests the gap may reduce significantly
Alder Centre	1,681	1,931	Charity have agreed to bridge gap
C Cluster Hub	18,822	20,572	Out to market test-value engineering list to be finalised
C Cluster Dewi			Additonal 50k cost for comepletion of PCSA
Infrastructure - Utilities	1,200	1,200	
Landscaping	481	500	
Attenuation	600	600	
Infrastructure - Roads (inc s278)	858	858	
Demolition and decomm	2,356	2,656	Asbestos levels over estimated provision
Relocations	1,227	1,227	
Neonatal	11,869	13,569	Initial cost plan suggests budget pressure-under review
Institute retention	0	0	
Development team	1,100	1,631	Under review with proposed rationalisation
Community/Off site	300	300	
NE Site Development	0	0	
Institute re-works	360	360	
Office Requirement	2,700	2,970	
Medical Records	0	0	
Staff removals	250	250	
Car Park	100	100	
	45,654	**51,724**	
Revised Budget	45,615	51,724	
Under/(Over) Budget	**-39**	**6,109**	

4. Project Management

One Project Manager for the Delivery Management Office has been appointed to cover the campus projects and commences on the 26th February

Two further Capital projects Manager Posts are in the process of being recruited, one of which would be responsible for delivery of the neonatal Development and the other one for the Cluster/Hub and Dewi Jones unit. Interviews arranged for week commencing 3rd February 2020 this project. These posts are being funded from the capital budgets and recent reduction in hours/retirements.

Alder Hey Children's NHS
NHS Foundation Trust

5. Project updates

Park Reinstatement Phase 1

Current status	Risks	Actions/next steps
Planning was achieved for phase one delivery in Qtr1. 2019. Groundworks were appointed November 2019. Two engagement events with staff and the public were held during January with good responses to the design proposals. The Trust has entered into a service level agreement with Capacity, the Public services Lab for the next 6 months with an option to extend. Capacity will be working closing with ground works on engagement and event planning. They will also be working up the programme plan for the full reinstatement of the park and producing the tender documentation for engaging partners who can support funding for elements of the long term vision. There were some planning conditions which we are just in the process of implementing e.g. tree protection.	Nil at present time	Regular project meetings on a monthly basis with groundworks to ensure programme delivers on time and budget. Capacity lab engage with groundworks on a regular basis

Alder Centre

Current status	Risks	Actions/next steps
Construction currently is in a 3 week delay. Occupation towards the end of April is still on track as a 4 week commissioning period was included which could be reduced. Construction of the perimeter and retaining gabion wall, landscaping and paths (method and agreeing contractor) are currently under discussion. Dates for meeting in the run up to the move with the Alder centre team with divisional input have now been arranged.	Landscaping and external perimeter wall construction will not be delivered in line with occupation dates. New service model structure	Price and dates to be agreed with contactor end of January 2020 and construction programme for delivery to be agreed. Ensure the Division address the

	currently not agreed and worked up across the Alder Centre Unit. (Current Manager vacancy)	vacancy /cover and service model is fully developed and agreed prior to occupation of the new building. Plan now agreed with the division

Acquired Buildings Occupation (neighbouring sites)

Current Status	Risks	Action/next steps
410 Prescot Road- currently in the process of being purchased for £425k. Some minor refurbishment works are currently being costed and will be covered from the allocated budget. Expected completion on acquiring the building was the end of January 2020 however Solicitors are awaiting some outstanding information from the Vendors. Development team in regular contact with the solicitor and estate agents for r updates on progress.	Resistance from staff to move to either location.	Director led group has been set up; there is a need to agree all relocation of staff/services and manage the change process appropriately.
Knotty Ash Nursing Home Exchange of contracts occurred on 29th January 2020 with a planned date for completion of 31st January 2020. Mersey Design Architects are currently working up potential internal redesign of the building for consideration in meeting our needs. Expected works instructed/commencing in the spring and occupation in July/August 2020.	Medical records storage exceeds the space available. Refurbishment works not delivered to planned timetable.	IM&T currently working up a programme for digitisation of all stored records. Tendering of works to commence in February 2020
Ability to expand campus and link into the hospital –the Trust are still in the view that the most viable option for long term expansion space (Clinical services) would be to acquire the Vets, Job shop and Police Station on Eaton Road and will be seeking to discuss commercial deals that could be completed over the next 3-	Capital cost may be beyond future capital available.	Keep up to date with business future plans/lease and potential for purchase of said buildings. Seek to maintain an interest and respond accordingly to

5 years with current occupiers/owners.		any opportunities which present.

Police Station (lower floor) occupation

Current status	Risks	Actions/next steps
The Trust is currently in discussion with the Police service for planned occupation of 2/3rds of the lower floor from July 2020 under a lease agreement. This will then allow for relocation of some corporate services from the current retained estate buildings.	Police do not release the space while decisions are made in regards to additional police funding and its use.	Weekly discussion and communication with the police estates departments. Development team are currently working up the contingency plan. Expected to complete this end of January. This will need executive approval but will initially go to the newly formed agile working group lead by the Director of HR&OD.

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

Current status	Risks	Actions
This is currently at the planning stage and will be reliant on relocation of current building occupants to other locations and installation /diversion of current engineering and IM&T services.	Timely relocation and redirection of services are delayed	Liaison with all service providers /departments to ensure timely planning for works to be completed.

Park reinstatement Phase 2/3

Current status	Risks	Actions
Full Planning permission for the park has now been achieved via Liverpool City Council Planning process.	Funding required is not delivered through the	Weekly review of the programme and progress with Capacity Lab, with

Capacity Lab have been engaged to provide a team of people to replace the Park Co-ordinator for the next 6 months (with option to extend) to work up a plan with a partnership approach to generate funding and work with all stakeholders across the community and wider region. It is anticipated the partnership model will bring in funding to add to the £1.5m contribution from the Trust to deliver the full vision for the park. LCC have requested Simon O'Brien to lead a piece of work across the community on delivering the stakeholders vison, Simon will also link with Capacity Lab and groundworks.	partnership approach. LCC do not agree to a future Community Interest Company for Sustainability. There has been a delay to Simons input due to the recent loss of LCC Director of Leisure services which we assume will be a vacant position	weekly presence on site. Maintain regular discussion with LCC, make contact with Neil Coventry until such a point in time the Lead for leisure Services is appointed.

Infrastructure works & commissioning

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

Clinical Hub and Dewi Jones Construction

Current status	Risks	Actions
There has been further delay to the Pre-contract Services Agreement (PCSA) due to contractual obligation discussions. This has now been extended with a final construction /contract price due the middle of March followed by a short period for any Value engineering should it be required (Current construction costs are estimated as C. £14.7m which is £1.7m over the available budget). Construction is therefore expected to commence in April. The additional cost of the extended piece of work which includes detailed Room	Final construction cost of project exceeds the allocated budget.	List of value engineering options to be completed, this could translate into some reduction in space (shell and core only). There is anticipated short list of items which could be value engineered out in the first instance to bring the project cost down.

data sheets across the development is £50k. Agreement from Galliford Try to utilise our procurement system for the major purchase items which will allow transparency and assurance on market testing.	Delay to full contract agreement.	Board approval prior to final contract signature/sign off. Continue with weekly meetings with Galliford Try.

Demolition Phase 4 (Final)

Current status	Risks	Actions
N/A at current time, planned for Qtr. 4. 21/22	Cost may exceed current allocated budget.	Monitor demolition budget management on a monthly basis and work up contingency plan.

Neonatal Development

Current status	Risks	Actions
Design brief has been developed. The outstanding elements to be agreed is the approach from the PFI perspective (we have received their feasibility study), our approach to procurement which will depend on any agreement with the PFI and the location of the new unit. Exercise completed what space could be utilised on ward 1C and integrated with a new build. An Option appraisal has been developed , looking at three options: Option 1. New build at Level 1c which utilises some space from EDU (Clinically preferred option) Option 2. Extension to the end of 1c (current neonatal unit, least preferred	Costs of new unit exceed current financial envelope. Cost of PFI management of the Process versus VAT savings. Not reaching agreement with PFI risks a workable interface with the CHP being achieved. In decision on final location	Division of Surgery to take a revised and final Business Case to the Trust board for approval, date to be confirmed. Ask Gilling Dodd to work up current option 1 to RIBA Stage 1, which

option by clinicians) Option 3. New build to level 1 PICU , this would extend between finger 1-2 Based on the above options 1&3 Gilling Dodd Architects have produced some draft concept designs, these have been shared with Service and clinical representatives. Initial feedback is good. The new clinical model of care has been outlined in order to inform the design brief and develop the unit with a fully integrated family model. One Project Manager for the Delivery Management Office has been appointed to cover the campus projects. Two further Capital projects manager posts are in the process of being recruited, one of which would be responsible for delivery of this project. Discussions with Phillips with regards to encompassing new and innovative design to the unit, continues via meetings and dialogue.	Planning permission fails to be achieved within the timescale of the overall programme delivery.	would provide Gross Internal Floor Area (GIFA), Schedule of Accommodation (SOC), room adjacencies and estimated Cost in readiness for next stage. Maintain open communication with the LCC planning departments.

North East Plot Development

Current status	Risks	Actions/next steps
Stepplaces the Developer who has purchased the north east plot of land is currently in discussion with the trust on how the development could support some of Alder Hey's vision for the future some of the discussions currently include development of : • A Gym • A Nursery with an increase potentially of 40 providing 100 places in the future	Local community resistance to Trust non-development aspects and planning submission.	Maximise our offering/ support /negotiation on development content and opportunities. Appoint to a commercial part time role to lead on the East Plot development on behalf of the Trust.

• Science/Knowledge building • Varied accommodation's which could be offered to staff, trainees etc.... • Supported living accommodation and homes retirement/ ADHD/Disabled Children and families • Provision of commercial opportunities to compliment the Eaton road current offering.		

Communications

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

6. Trust Board of Directors

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

NHS
Alder Hey Children's
NHS Foundation Trust

TRUST BOARD Report December 2019

How Did We Do?

Executive Summary **Month: December** **Year: 2019**

Alder Hey Children's NHS NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Low number of near miss and no harm incidents reported, reflected in the decreased numbers of incidents reported overall in month. A reduction in reported incidents is a trend noted during holiday seasons; all staff are actively encouraged to continue to report incidents at the weekly Patient Safety Meeting.
- Two incidents resulting in moderate harm reported by Surgical Division. RCAs in progress and regulatory requirements met, inclusive of Duty of Candour.
- One incident of severe harm reported by Medical Division. All regulatory requirements met including 72 hour review, Level 2 RCA commenced, reported externally via StEIS, and Duty of Candour arrangements.
- One Never Event reported by the Surgical Division. There was 1 never event reported in December 2019, which occurred in the Surgical Division. All regulatory requirements met including 72 hour review, Level 2 RCA commenced, reported externally via StEIS, and Duty of Candour arrangements.
- All moderate and severe harm incidents and Never Events are discussed and reviewed at the weekly Patient Safety Meeting. The findings, lessons learned and actions for improvement are shared across Divisions to ensure Trust wide learning. Completed investigation reports are also available for staff on the Trust intranet to enable review and discussion within teams.

Highlight

- Low number of medication errors resulting in harm. BMV project continues at pace across wards.
- Low number of patients in year who have acquired hospital infection.

Challenges

- Slight decrease in percentage of in patients treated for sepsis within 60 minutes due to two patients who received IVAB at 69 and 89 mins. Both patients received sepsis bundle care as part of treatment; prompt identification and escalation. Ongoing training and education about sepsis bundle management.
- Electronic sepsis status due to be implemented end of January 2020 in ED which will help differentiate between possible sepsis / treat as sepsis patients in ED.

The Best People Doing their Best Work

Caring

- Lowest number of PALS issues raised in year together with low number of formal complaints. Focus on learning from complaints and sharing the learning across Divisions.

Highlight

- Over 95% of families on inpatient wards would recommend the Trust; sustained for the past 4 months. OPD and Community continue to receive high recommendations from our families.

Challenges

- 80% of families attending ED would recommend the Trust. ED Patient Experience Coordinator supporting in the department and waiting area.

Delivery of Outstanding Care

Effective

The Winter period has proved challenging to deliver low waiting times in the Emergency Department (ED) and low levels of cancelled operations. This is due to ED attendances and non-elective admissions being higher than predicted. Nonetheless, relative to the majority of NHS Trusts our resilience and performance has been good. We have continued to deliver a significant amount of elective operation, and year-to-date our ED waiting times are the 11th best in England.

We have improved the scanning service for outpatients, following the inception of a Scanning Bureau and turnaround times are now at an average of 1 day. Moving forward the objective is to work against a 24/48 hour SLA across Scanning Turnaround times.

28 day breaches occurred due to high levels of cancellations, less theatre sessions over the Christmas period and complex cases requiring multiple surgical teams to be available to undertake the case.

Highlight

- Zero readmissions within 48 hrs to the Paediatric Intensive Care Unit.
- Zero patients waiting 12 hours in the ED.

Challenges

- Cancelled operations 28 day breaches.
- Emergency Department waiting times.
- Scanning turnaround times.

Delivery of Outstanding Care

Responsive

- Overall our access to planned care remains excellent. Improvements in access times for CAMHS, ASD and ADHD are managed and supported through the Operational Delivery Board.
- There was one delay to cancer care, which was patient choice.

Highlight

- Access to planned care (as measured by open pathways and waiting list size).
- Access to diagnostics.
- Access to cancer care.

Challenges

- Waiting times for ASD, ADHD and CAMHS.

The Best People Doing their Best Work

Well Led

In Month 9 we delivered a (£0.4k) deficit which was £0.4k ahead of the plan. This means we are now in line with our year to date plan.

Activity levels were behind plan in all POD's with the exception of A&E. However high value specialties were above plan which had a positive impact on income. A&E activity was 3% above plan whilst Elective activity was 4% behind plan and Non Elective was 7% behind plan.

Pay was slightly behind the plan at (£0.1m) for the month. Temporary staffing expenditure has reduced slightly but remains high at £0.8m in the month.
Non pay expenditure remains an area of concern and is overspent in the month by (£0.6m). However this is an improvement on previous months.
The CIP target for the year of £6m has now been fully identified relating to improved use of our estates overhead and depreciation charges.
Cash holdings are £75.6m which is significantly higher than plan driven mainly by capital slippage.

A concerted effort has meant we continue to achieve mandatory training levels again. It is key that this is sustained.
Completion of PDR's remain at just below the target of 90% and a concerted effort is required by all areas to improve this further. Additionally medical appraisals remain behind target at 63.8% and a concerted effort is also required to improve this for future months.

Sickness levels have risen again to 6.4%. There is work underway to support specific teams where sickness levels are high.

Highlight

- Control Total achieved.
- Mandatory Training.

Challenges

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

Game Changing Research and Innovation

Research and Development

- Department of Health & Social Care Review of NIHR Funding.
- Research Clinic Staff & Partner Event: ECLIPSE study & Research Sponsorship.
- Appointment of Contracts Manager.

Highlight

- Senior Nurse in post.

Challenges

- Level of staffing to support and deliver research activity.

Contents

Contents

Contents

Contents

Leading Metrics

SAFE

Clinical Incidents resulting in catastrophic, death	Hospital Acquired Organisms - C.difficile	Hospital Acquired Organisms - MRSA (BSI)	Medication errors resulting in harm	Never Events	Sepsis: Patients treated for Sepsis - A&E
0	0	0	1	1	76.74 %
Dec 2019	Dec 2019	Dec 2019	Dec 2019	Dec 2019	Dec 2019

Sepsis: Patients treated for Sepsis within 60 mins - Inpatients
87.50 %
Dec 2019

CARING

Friends & Family: Overall Percentage Recommended Trust
92.19 %
Dec 2019

EFFECTIVE

ED: 95% Treated within 4 Hours
86.10 %
Dec 2019

RESPONSIVE

31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	All Cancers: 31 day wait until subsequent treatments	Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	Diagnostics: % Completed Within 6 Weeks
100 %	100 %	96.43 %	99.70 %
Dec 2019	Dec 2019	Dec 2019	Dec 2019

Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	RTT: Open Pathway: % Waiting within 18 Weeks	Waiting Greater than 52 weeks	Waiting List Size
100 %	92.03 %	0	12879
Dec 2019	Dec 2019	Dec 2019	Dec 2019

WELL LED

Cash in Bank (£'000s)	Control Total In Month Variance (£'000s)	Mandatory Training	NHSI Use of Resources	Safer Staffing (Shift Fill Rate)	Sickness
75657	358.44	92.08 %	3	91.57 %	6.40 %
Dec 2019	Dec 2019	Dec 2019	Dec 2019	Dec 2019	Dec 2019

Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG			Comments Available
Proportion of Near Miss, No Harm & Minor Harm	D	99.7%	99.3%	99.3%	100.0%	100.0%	100.0%	99.5%	99.4%	99.8%	99.3%	100.0%	99.8%	99.2%		>=99 %	N/A	<99 %	✔
Clinical Incidents resulting in Near Miss	D	58	59	84	76	59	83	58	114	52	62	63	70	45		>=63	>=60	<60	✔
Clinical Incidents resulting in No Harm	D	217	284	250	280	301	296	296	318	287	277	328	293	225		>=229	>=218	<218	✔
Clinical Incidents resulting in minor, non permanent harm	D	67	78	84	104	94	108	77	68	70	73	92	91	88		<=86	N/A	>86	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	1	2	1	0	0	0	1	3	1	1	0	1	2		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	1	0	0	1		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	D	0	1	2	0	0	0	1	0	0	1	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	D	2	2	4	2	6	3	3	2	1	2	6	3	1		<=2	N/A	>2	✔
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	1	0	1	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	1	0	0	0	0	0	0	0	2	0	0	1		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis - A&E	D P	51.9%	77.4%	71.1%	79.4%	58.8%	71.1%	65.2%	79.3%	76.7%	77.8%	78.4%	84.2%	76.7%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	73.3%	70.2%	82.1%	73.3%	81.8%	71.4%	90.9%	80.0%	100.0%	94.1%	100.0%	93.8%	87.5%		>=90 %	N/A	<90 %	✔
Number of children that have experienced avoidable factors causing death - Internal	W	0	0	0	0	0	0	0	1	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	1	0	0	0	0	0	0	1	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	D	1	1	0	4	1	1	0	0	1	1	0	1	0		<=1	N/A	>1	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG	Comments Available
Friends & Family: Overall Percentage Recommended Trust	W	95.5%	91.2%	90.1%	93.2%	91.1%	90.8%	89.7%	90.6%	92.4%	93.5%	92.9%	91.6%	92.2%		>=95 % >=90 % <90 %	✔
Friends & Family A&E - % Recommend the Trust	D	90.1%	90.5%	80.3%	89.5%	78.8%	87.7%	80.4%	82.8%	88.1%	91.1%	83.6%	80.9%	80.8%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	100.0%	98.5%	100.0%	98.6%	88.4%	100.0%	93.8%	92.9%	92.9%	91.9%	95.0%	94.1%	91.9%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	98.2%	97.0%	96.2%	97.8%	97.3%	90.6%	90.1%	93.2%	92.5%	95.5%	96.5%	95.9%	95.9%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	100.0%	88.9%	76.9%	82.9%	80.8%	88.7%	100.0%	33.3%	78.8%	88.5%	66.7%	89.1%	73.1%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	91.7%	87.4%	89.1%	91.1%	92.7%	91.7%	93.5%	91.2%	94.4%	93.8%	95.3%	94.5%	95.7%		>=95 % >=90 % <90 %	✔
Complaints	W	7	7	9	16	7	9	6	15	13	12	4	14	9		No Threshold	
PALS	W	71	136	97	95	110	103	121	128	93	130	119	103	67		<=64 <=71 >71	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	2.4%	1.4%	1.8%	2.5%	2.7%	2.1%	1.3%	5.3%	4.1%	0.0%	1.2%	0.0%	0.0%		<=3 %	N/A	>3 %	✔
ED: 95% Treated within 4 Hours	D	95.3%	92.1%	90.6%	95.6%	93.5%	91.3%	89.4%	91.8%	94.7%	89.0%	86.9%	79.4%	86.1%		>=95 %	N/A	<95 %	✔
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	1	0	1	0	0	0	0	0		0	N/A	>0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	21	11	10	12	9	24	15	37	35	18	34	44	36		<=20	N/A	>20	✔
28 Day Breaches	W	4	4	1	1	0	0	1	2	0	1	0	2	8		0	N/A	>0	✔
Average Scanning Turnaround - Inpatient	D			44.00	49.00	49.00	50.00	55.00	55.00	65.00	71.25	73.00	74.00	64.00		<=7	N/A	>7	✔
Average Scanning Turnaround - Outpatient	D			26.00	23.00	24.00	21.00	23.00	23.00	31.50	32.25	9.00	10.00	24.00		<=5	N/A	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	W	96.7%	96.0%	94.9%	95.7%	98.3%	96.6%	97.5%	97.6%	95.7%	97.7%	95.7%	96.7%	96.5%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	W	99.6%	100.0%	99.3%	99.5%	99.3%	99.0%	98.1%	99.2%	97.5%	98.4%	97.7%	97.6%	98.5%		>=95 % >=90 % <90 %	✔
IP Survey: % Know their planned date of discharge	D P	59.4%	76.5%	82.8%	80.6%	88.8%	84.1%	87.9%	87.8%	87.1%	89.2%	92.2%	92.6%	90.2%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	W	92.5%	96.3%	94.3%	93.4%	99.3%	90.5%	96.3%	90.8%	98.0%	98.4%	93.7%	98.3%	96.8%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in Play	D							93.3%	94.5%	95.3%	91.5%	92.1%	93.9%	91.2%		>=90 % >=85 % <85 %	✔
IP Survey: % Patients involved in Learning	D							70.9%	75.6%	72.1%	68.3%	73.5%	68.3%	85.4%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.1%	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%		>=92 % >=90 % <90 %	✔
Waiting List Size	W	12,859	12,872	12,888	12,746	12,871	12,876	12,843	12,883	12,874	12,826	12,754	12,827	12,879		<=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%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	96.4%		100 % N/A <100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	100.0%	99.7%	99.6%	99.5%	100.0%	99.8%	100.0%	99.8%	100.0%	99.7%	100.0%	100.0%	99.7%		>=99 % N/A <99 %	✔
PFI: PPM%		100.0%	100.0%	100.0%	98.0%	98.0%	98.0%	98.0%	100.0%	99.0%	99.0%	99.0%	99.0%	99.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG			Comments Available
CIP In Month Variance (£'000s)	W	151	-199	-74	-75	-163	-54	-47	-26	176	-165	-22	57	-147		>=-5%	>=-20%	<-20%	✔
Control Total In Month Variance (£'000s)	W	564	-21	-433		-394	-165	596	-848	852	94	-240	-205	358		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	1,032	1,032	259	1,610	1,030	640	728	694	1,239	865	1,909	-115	624		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	23,136	19,983	22,068	33,699	34,361	34,449	37,415	79,086	80,174	80,807	81,847	77,896	75,657		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	142	456	355	19,495	-612	21	846	-52	1,348	666	1,103	1,387	1,479		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	-267	-510	-850	-495	183	-25	-130	-260	273	143	-254	-39	-89		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	689	34	63	-942	34	-161	-119	-537	-769	-715	-1,090	-1,552	-1,031		>=-5%	>=-20%	<-20%	✔
NHSI Use of Resources	W	1	1	1	1	1	3	3	3	3	3	3	3	3		<=3	N/A	>3	✔
AvP: IP - Non-Elective	W					53	58	109	158	132	54	-19	-97	-109		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W					-45	-24	-42	-79	17	-67	-68	29	-43		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W					-53	-132	-240	-45	79	58	-76	-34	-21		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W					768	90	1,300	2,069	2,643	2,245	2,896	1,944	1,172		>=0	N/A	<0	✔
PDR	W	90.1%	90.1%	92.2%	92.2%	4.8%	20.7%	47.3%	86.4%	89.3%	89.3%	89.3%	89.3%	89.3%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal	W	100.0%	100.0%	100.0%	100.0%	99.7%	98.1%	97.8%	95.7%	96.6%	93.8%	88.5%	69.7%	63.8%		>=95 %	>=90 %	<90 %	✔
Mandatory Training	W	89.0%	89.4%	88.8%	89.6%	90.0%	88.4%	90.5%	90.8%	91.9%	91.1%	91.3%	91.5%	92.1%		>=90 %	>=80 %	<80 %	✔
Sickness	D	6.0%	5.7%	5.7%	5.3%	5.2%	5.5%	5.2%	5.2%	5.0%	5.3%	5.8%	5.7%	6.4%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	1.7%	1.9%	1.7%	1.6%	1.5%	1.5%	1.4%	1.3%	1.0%	1.4%	1.8%	1.9%	2.0%		<=1 %	N/A	>1 %	✔
Long Term Sickness	D	4.4%	3.8%	3.9%	3.7%	3.7%	4.0%	3.9%	3.9%	4.0%	3.8%	4.0%	3.7%	4.4%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	D	883	937	1,046	1,357	1,114	1,061	899	1,058	992	1,145	933	1,021	917		<=800	<=960	>960	✔
Staff Turnover	D	9.6%	9.4%	9.5%	9.9%	9.7%	9.9%	9.8%	9.3%	10.0%	10.3%	10.2%	10.2%	10.4%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	W	94.2%	94.5%	92.8%	95.4%	95.3%	95.2%	92.6%	92.0%	93.5%	90.8%	92.2%	96.2%	91.6%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	W	90.0%	92.0%	95.0%	86.0%	81.5%	100.0%	81.2%	97.2%	92.5%	90.5%	100.0%	82.0%	100.0%		>=85 %	N/A	<85 %	✔
Performance Against Single Oversight Framework Themes	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	123	121	121	153	154	158	161	158	172	161	162	167	172		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	27	29	26	60	59	59	58	57	59	38	42	45	46		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	2	6	5	3	1	5	4	2	3	2	2	5	6		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	0	1	1	4	2	1	2	2	2	1	2	6	3		>=1	N/A	<1	✔
Number of patients recruited	W	158	238	211	314	234	221	350	431	165	941	1,228	1,180	1,094		>=200	>=171	<171	✔

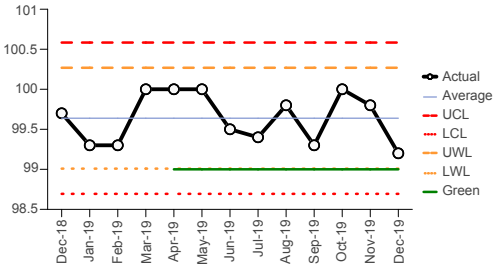
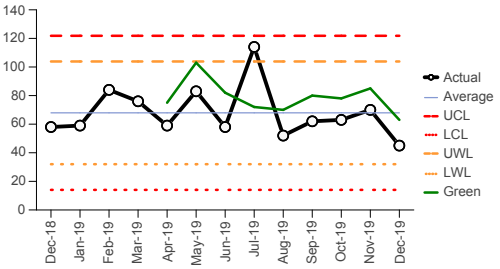
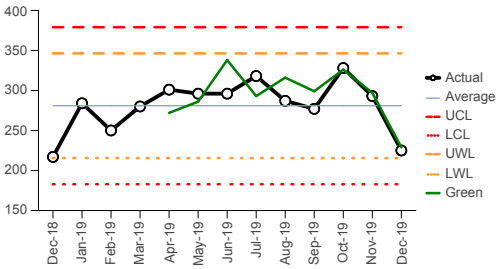
Delivery of Outstanding Care

7.1 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Proprtion of Incidents	**Proportion of Near Miss, No Harm & Minor Harm** D Proportion of Near Miss, No Harm and Minor Harm incidents against all levels recorded. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	99.20 %	R <99 % A N/A G >=99 %		No Action Required
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19. 19/20 aim is to see more than 5% reported than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	45	R <60 A >=60 G >=63		The number of near miss and no harm incidents reported in December 2019 were the lowest totals YTD. This was reflected in the decreased numbers of incidents reported overall. Staff are encouraged to continue to report incidents and the promotion of near miss reporting is actively commended via the Trust's weekly patient safety meeting 'Good Catch' award. Divisions receive weekly reports of all 'Near Miss' incidents reported, to enable prioritisation of reviews and ensure lessons are learned. Progress with improvements is expected to be included in monthly CQSG division governance reports.
Incidents: Increasing Reporting	**Clinical Incidents resulting in No Harm** D Total number of No Harm Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19. 19/20 aim is to see more than 5% reported than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	225	R <218 A >=218 G >=229		The number of near miss and no harm incidents reported in December 2019 were the lowest totals YTD. This was reflected in the decreased numbers of incidents reported overall. Staff are encouraged to continue to report incidents and the promotion of near miss reporting is actively commended via the Trust's weekly patient safety meeting 'Good Catch' award. Divisions receive weekly reports of all 'Near Miss' incidents reported, to enable prioritisation of reviews and ensure lessons are learned. Progress with improvements is expected to be included in monthly CQSG division governance reports.

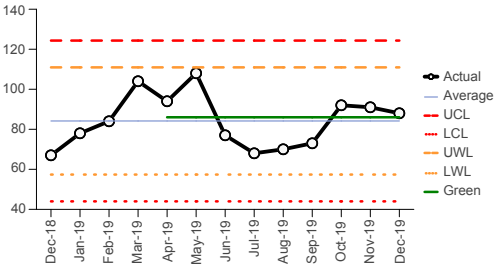
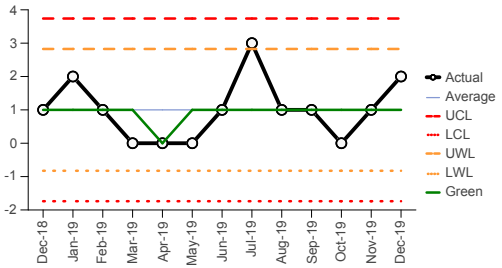
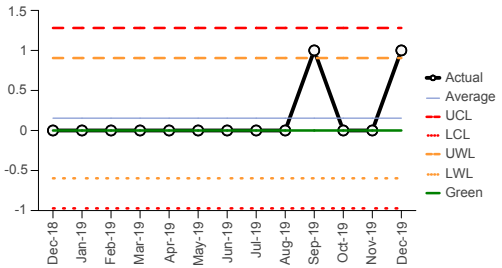
Delivery of Outstanding Care

7.2 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor, non permanent harm** D Total number of Minor Harm Incidents reported. The threshold is based on a reduction for the period Apr 18 - Mar 19. 19/20 aim is to see volume reported less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	88	R >86 A N/A G <=86		Incidents resulting in minor harm are scrutinised by managers to ensure accurate reporting. Whilst the reporting of low level harm incidents remains consistent; there has been a slight decrease compared to the previous 2 months. Divisions receive weekly reports of all 'low Harm ' incidents reported, to enable prioritisation of reviews and ensure lessons are learned. Staff are encouraged to report 'low harm ' incidents as these are considered learning opportunities to review systems and processes. Progress with improvements is expected to be included in monthly CQSG division governance reports.
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** D Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 18 - Mar 19. 19/20 aim for the trust is 11 or less, annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	2	R >1 A N/A G <=1		Two incidents resulting in moderate harm reported in December 2019; both occurring within the Surgical Division. Root Cause Analyses (RCAs) are underway for these and all regulatory requirements have been met, inclusive of Duty of Candour. Note* Incident 39695, whilst reported in December, was confirmed as moderate harm in January 2020. Therefore; this is covered in the January 2020 period in the Trust SIRI Board Report. All moderate harm incidents are discussed at weekly patient safety meeting and minutes/actions are accessible to all Trust staff via the intranet.
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	1	R >0 A N/A G 0		There was 1 incident of severe harm in December 2019; occurring in the Medical Division. This has been reported externally in line with regulatory requirements and an RCA Level 2 is ongoing. All regulatory requirements have been met, inclusive of Duty of Candour. All severe harm incidents are discussed at weekly patient safety meeting and minutes/actions are accessible to all Trust staff via the intranet. Findings and actions for improvements are shared across divisions to ensure trust wide learning. In addition, completed investigation reports are available for staff on the Trust intranet.

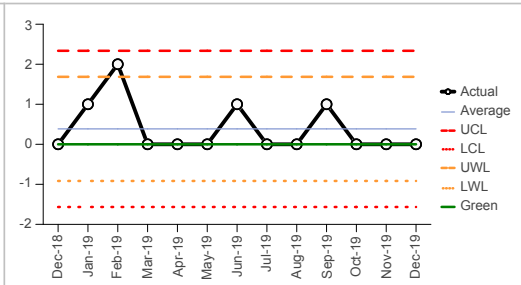
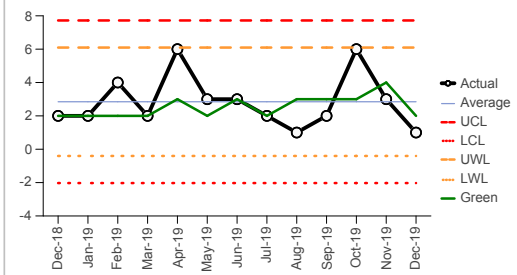
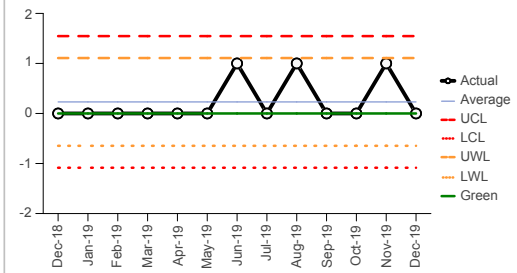
Delivery of Outstanding Care

7.3 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** D Incidents reported resulting in severe harm. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** D Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 20% reduction on the period Apr 18 - Mar 19, on trajectory with WHO global initiative to reduce severe, avoidable medication-associated harm in all countries by 50% by 2022. 19/20 aim is less than 34 annually for the trust. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	1	R >2 A N/A G <=2		In December there was 1 incident associated with non-permanent harm. The patient was given an extra dose of desmopressin due to the prescriber choosing the wrong frequency on the electronic prescribing system. The doctor involved has been asked to undertake a reflection on the error and discuss it with his educational supervisor. The nurses who gave the second dose have also been reminded to check any previous doses prior to administering medicines.
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

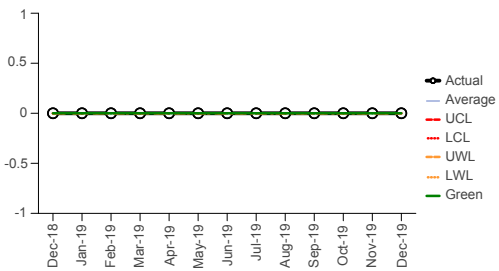
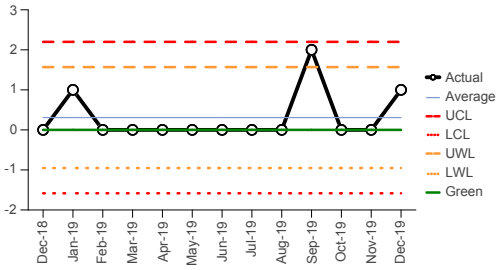
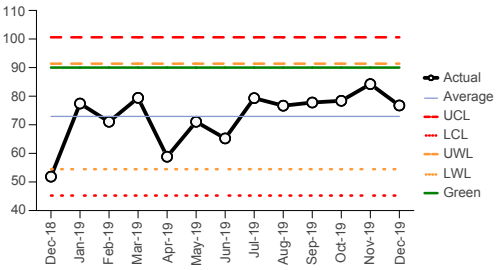
Delivery of Outstanding Care

7.4 - QUALITY - SAFE

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	1	R >0 A N/A G 0		There was 1 never event reported in December 2019, which occurred in the Surgical Division. External reporting requirements have been completed and an RCA Level 2 is underway. All regulatory requirements have been met, inclusive of Duty of Candour. All 'Never Event' incidents are discussed at weekly patient safety meeting and minutes, actions shared on the intranet accessible to all Trust staff. The findings and actions for improvements are shared across divisions to ensure trust wide learning. In addition, completed investigation reports are available for staff on the Trust intranet.
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	76.74 %	R <90 % A N/A G >=90 %		Increased activity over winter period with patients pressenting acutley unwell with possible signs of sepsis. Identification of patients for data from prescription sof IVAB with a number of children not clinically septic but treated as a precaution. Electronic sepsis status to be implemented end of Jan which will help differentiate between possible sepsis/treat as sepsis patients. Ongoing training and education around awareness of sepsis throughout the ED department.

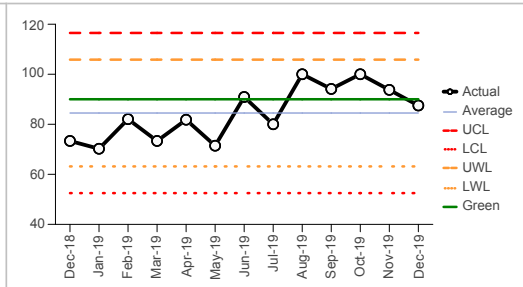
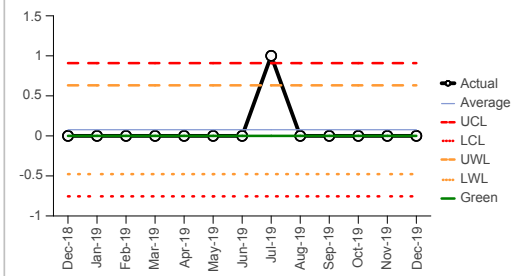
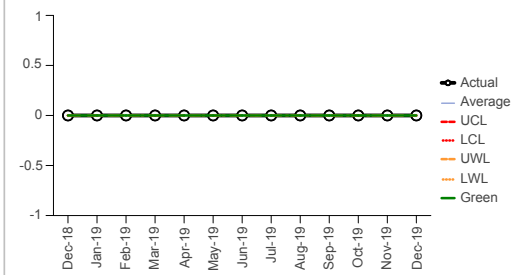
Delivery of Outstanding Care

7.5 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

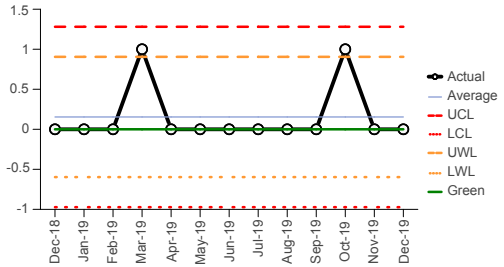
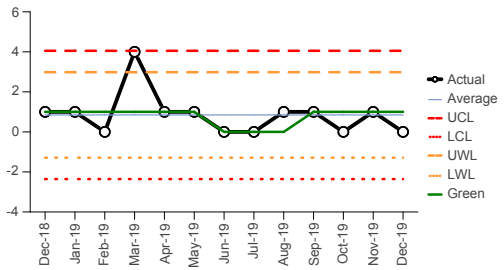
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	87.50 %	R <90 % A N/A G >=90 %		Decrease in percentage due to two patients who received IVAB over 60 mins, times being 69 min and 89 mins. Both patients received sepsis bundle care as part of treatment. Reported as delays but prompt identification, escalation and management provided. Ongoing training and education about sepsis bundle management and prompt administration of IVAB to all staff.
Mortality	**Number of children that have experienced avoidable factors causing death - Internal** W Total number of children that have experienced avoidable factors with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 19/20 is zero. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.6 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - C.difficile** D The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MSSA** D Hospital Acquired Organisms - MSSA . 19/20 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	0	R >1 A N/A G <=1		No Action Required

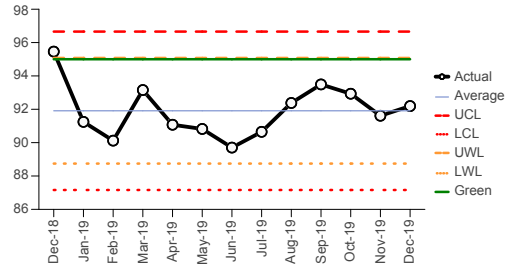
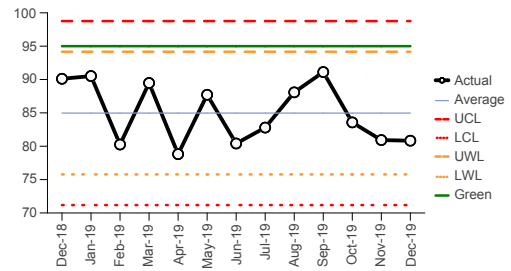
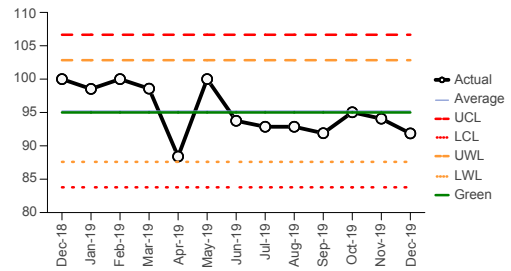
The Best People doing their best Work

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: Overall Percentage Recommended Trust** W Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	92.19 %	R <90 % A >=90 % G >=95 %		During December 92.23% would recommend the Trust. 4.30% would not. There were a total of 2,278 responses 100 would not recommend. 1,807 were extremely likely to recommend, 294 were likely 56 neither likely nor unlikely 21 did not know. Areas for improvement based on not recommended were A&E out of the 474 responses 72 would not recommend. The ambulatory clinic out of 41 responses 11 would not recommend. Ultra sound out of 14 responses 2 would not recommend.
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	80.83 %	R <90 % A >=90 % G >=95 %		ED patient experience coordinator now active and observation audit has commenced. Role description being developed for volunteers and rota created focusing on peak times and utilising Bleep system for response volunteers. Areas identified to target include Reception desk support, supporting families by going to vending machine or shop for refreshments, helping families with siblings, providing water (where applicable) making drinks for staff-going shop/canteen for them, accompanying families to wards on admission and radiology if portering not necessary , preparing cubicles for next attendee
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	91.86 %	R <90 % A >=90 % G >=95 %		Slight decrease in recommends of 2.2% - and 27% reduction in responses which is in line with holiday period.Within Community division it is noted that majority of services receive high % of recommend of up to 100% whilst Liverpool SALT 25% due to only 1 response.Training session plan is to deliver a webinar to reach more department leads within community.

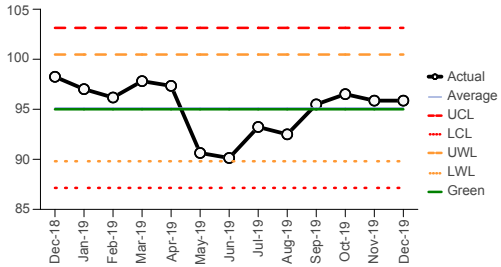
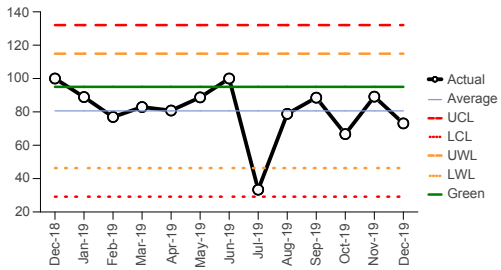
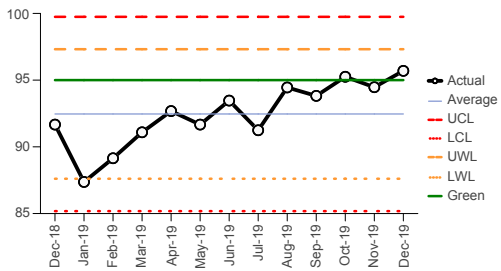
The Best People doing their best Work

8.2 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	95.86 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	73.08 %	R <90 % A >=90 % G >=95 %		Decrease from Nov of 16% - with a 52% decrease in responses which is in line with holiday period Continued theme of car parking and environment as negatives. Current project ongoing with Forum@alderhey to make corridors and waiting areas more welcoming, less clinical and brighter Care and staff attitude remain positive.
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	95.69 %	R <90 % A >=90 % G >=95 %		No Action Required

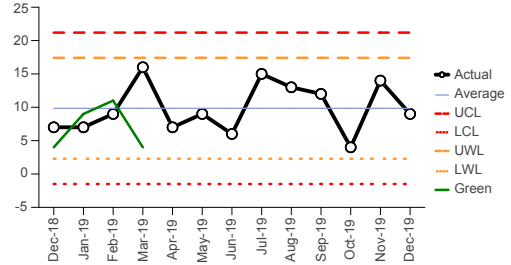
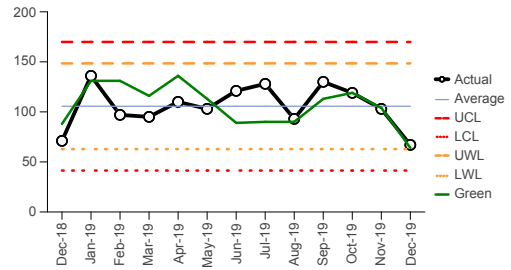
The Best People doing their best Work

8.3 - QUALITY - CARING

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	9	No Threshold		
PALS	**PALS** W Total number of PALS contacts. Threshold is based on a 10% Reduction on 18/19. 19/20 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	67	R >71 A <=71 G <=64		Total numbers of PALS contacts for December were medicine 19, community 21, and surgery 19. December 2018 there was a total of 67 contacts, medicine 30, surgery 27, and community 10. The top themes and trends in all divisions for December 2019 where admin communication mostly in medicine, appointment cancellations OP, waiting times for appointments, A&E waiting times, failure in medical care, attitude of staff, cancelled operation and delayed operation. Further detailed information will be reported through CQSG.

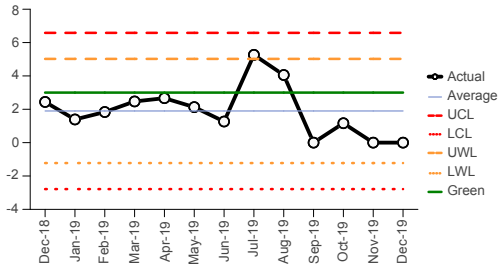
Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

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

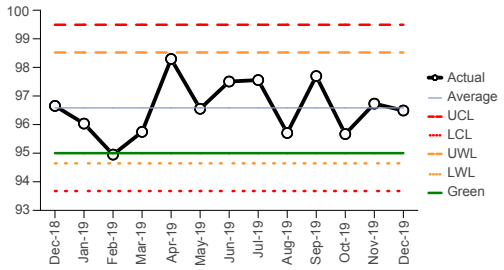
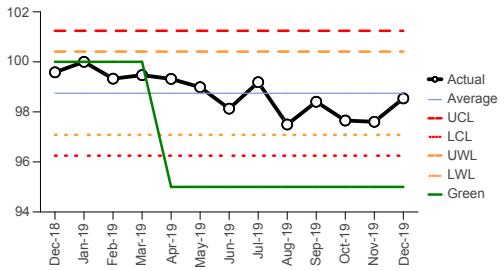
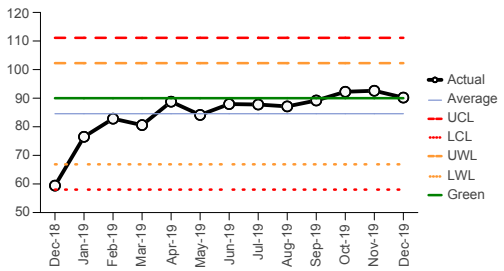
Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	96.49 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 19/20 is 100%. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	98.54 %	R <90 % A >=90 % G >=95 %		Highest percentage recommend since July . Comment analysis identifies communication, lack of introduction and listening skills. From 438 responses 1 child and 5 parent/carers answered no to this question. Comment analysis identifies communication, lack of introduction and listening skills.
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	90.20 %	R <85 % A >=85 % G >=90 %		No Action Required

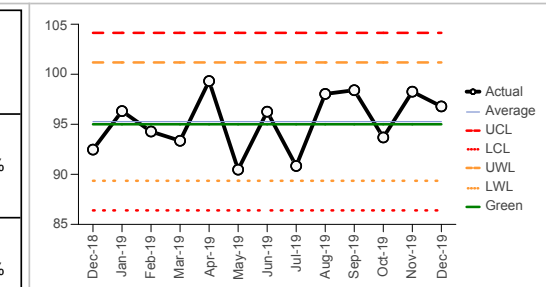
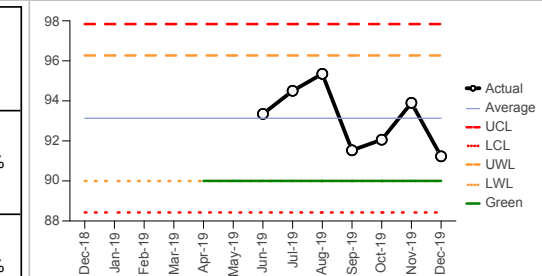
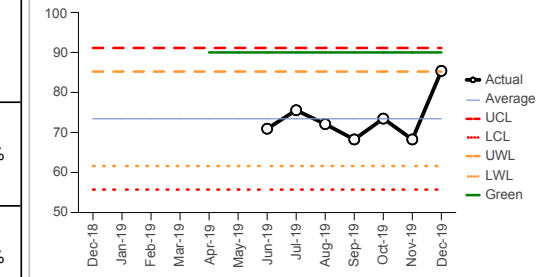
Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	96.78 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	91.23 %	R <85 % A >=85 % G >=90 %		No Action Required
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	85.38 %	R <85 % A >=85 % G >=90 %		17% increase in learning this month. This reflects the changes made to surveys within areas that had been identified as learning not being offered as standard and when learning is delivered by teachers (days after admission taken into account)Further development to be made to incorporate changes to FFT questions this year by working closely with education team.

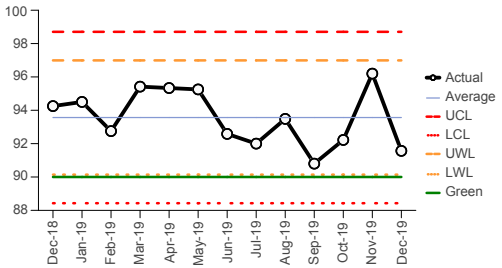
The Best People doing their best Work

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	91.57 %	R <90 % A N/A G >=90 %		No Action Required

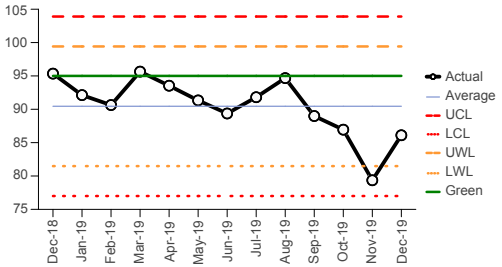
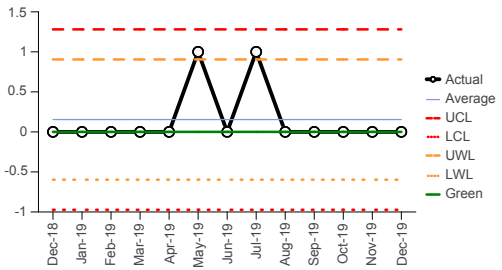
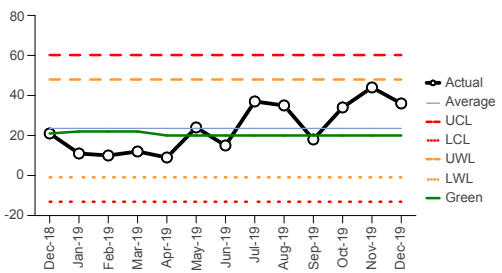
Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

D Drive W Watch P Programme

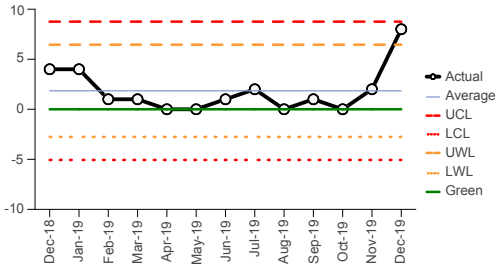
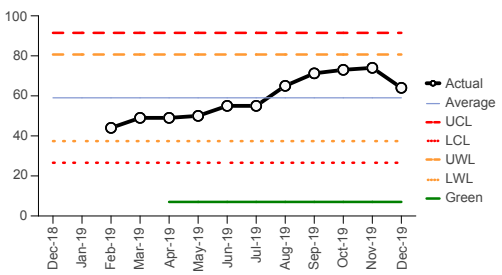
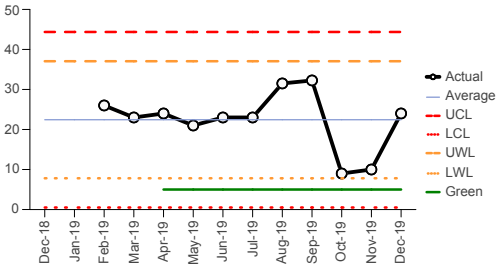
	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	86.10 %	R <95 % A N/A G >=95 %		Although still below the 95% standard, the percentage of patients waiting under four hours in our emergency Department has increased from 79.3% in November to 86.10% in December. This performance standard continues to be our top operational pressure and priority. Improvement huddles and weekly meetings continue to monitor progress against a robust rapid improvement plan, which involves alternative pathways for nonemergency patients.
ED 12 Hr Waits	**ED: Number of patients spending >12 hours from decision to admit to admission** W Number of patients spending >12 hours in A&E from decision to admit to admission. This is a national standard with a zero tolerance threshold. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** D Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 16% based on 18/19 overall performance. This is inline with trajectory from Oct 18 - Mar 19 **Exec Lead:** Adam Bateman **Committee:** RABD	36	R >20 A N/A G <=20		The number of elective patients cancelled on the day reduced by 9 since Nov; however remains higher than anticipated. Unfortunately 5 cancellations were due to consultant unavailability on the 27th December also over the Christmas period there was no available cover for theatre lists at short notice on the day. Other cancellations were primarily due to limited availability of ward/PICU beds. Limited bed availability was mainly associated with the increase in NEL admissions. The division have initiated a review of NEL admissions in an attempt to manage future flow and bed availability.

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

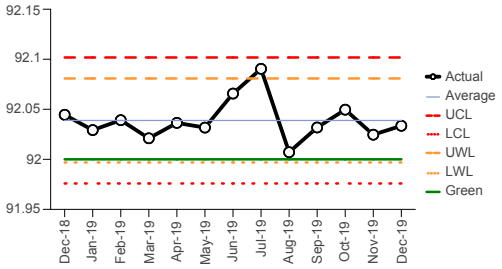
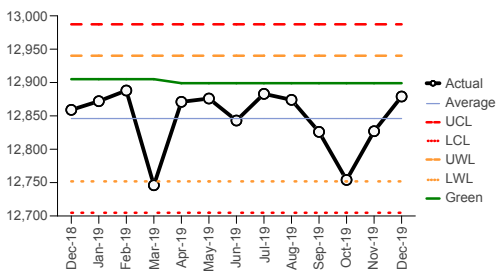
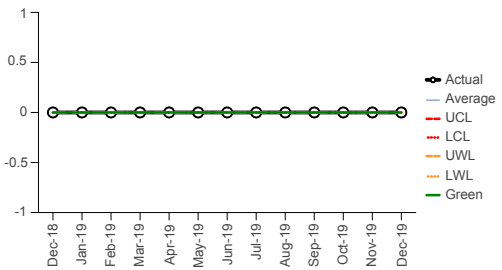
	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	8	R >0 A N/A G 0		We were unable to provide 7 patients with a new date within 28 days of their cancellation. This was an increase of 5 patients from November. Owing to the Christmas period with a reduced number of theatre lists running due to bank holidays we were unable to accommodate the theatre sessions needed to ensure all patients were rescheduled within 28 days. In attempt to ensure this number reduces in January we're monitoring all patients requiring a new theatre date within 28 days at divisional level to ensure robust plans are in place and all options are considered to ensure new dates are provided.
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	64	R >7 A N/A G <=7		Resources have been diverted to Inpatients as we are outsourcing Outpatient documentation. As Outpatinets is now in hand and is running at 2 day turnaround we are working with IM&T and Swiss Post (Outsourcing Company) to set up a process for handling Inpatient Records. The process is progressing rapidly and it is anticipated that the first sample of live records is sent 2/c 13/01/2020 with the majority of backlog sent over a 2 week period and therefore be at a 2 day turnaround by the end of January 2020.
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	24	R >5 A N/A G <=5		Actively engaged with Outsource provider (Swiss Post) and have sent all Outpatient Records off. These have been returned and uploaded and are now available. Wait as at 10/01/2020 is now 2 days. this will continue going forward and the plan is to be at 1 day.

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	92.03 %	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	12879	R >12899 A N/A G <=12899		No Action Required
Waiting Times	**Waiting Greater than 52 weeks** W Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 19/20 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required

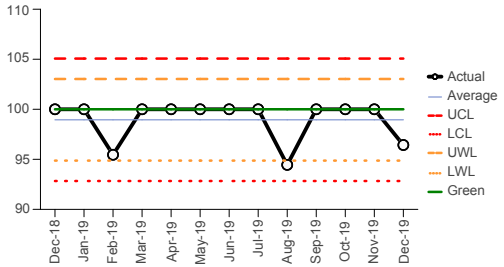
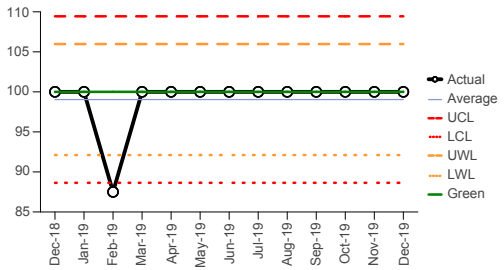
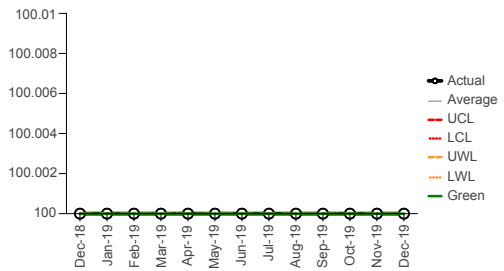
Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

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	96.43 %	R <100 % A N/A G 100 %		Referral was received into Oncology 25/11/2019. Referral was redirected to general surgery 26/11/19. Patient was offered appointment for 2/12/19 which was confirmed by phone. Mum called up to cancel appointment on the day of appointment as she advised the patient was now well. PCO from surgery informed importance of attending appointment in line with referral priority. Mum was offered a further date of 06/12/19 to attend but refused this date also and instead patient was seen 19/12/19 which was 10 days after breach target date.
Cancer RTT	**Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required
Cancer RTT	**All Cancers: 31 day wait until subsequent treatments** W Threshold is set at 100% which a stretch target set higher than national performance. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R <100 % A N/A G 100 %		No Action Required

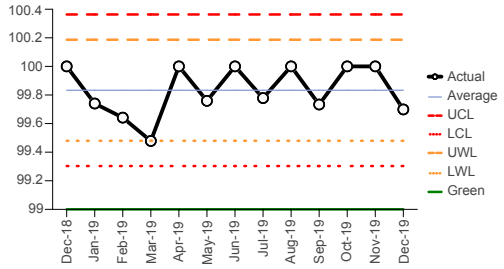
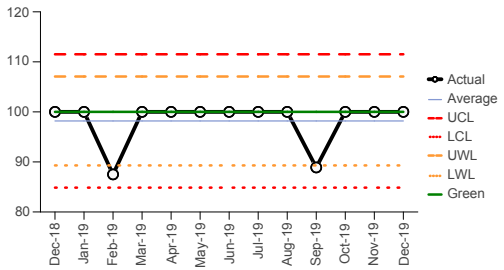
Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

BRILLIANT BASICS

Alder Hey Children's NHS
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	99.70 %	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

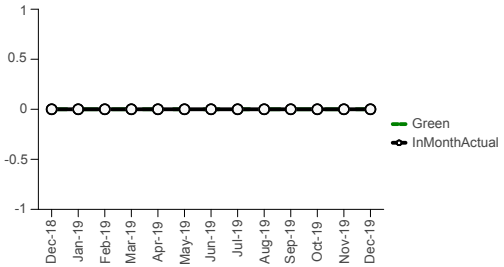
The Best People doing their best Work

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

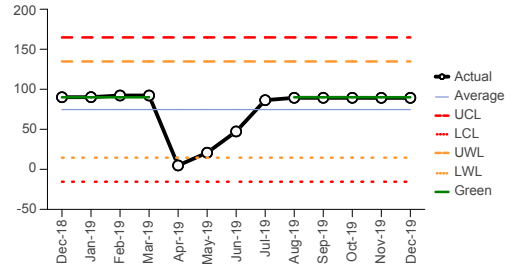
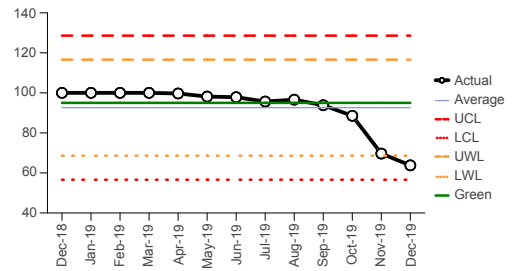
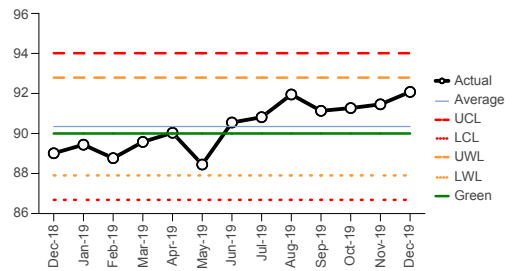
The Best People doing their best Work

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	89.26 %	R <85 % A >=85 % G >=90 %		PDR compliance was 89% at the end of the window. The L&D Team are continuing to chase up any outstanding appraisals.
Appraisal	**Medical Appraisal** W Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	63.78 %	R <90 % A >=90 % G >=95 %		Due to winter pressures there has been an expected drop in appraisal compliance, outstanding appraisals are due to be completed in January/February.
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	92.08 %	R <80 % A >=80 % G >=90 %		No Action Required

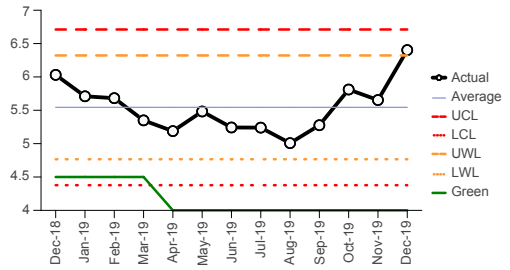
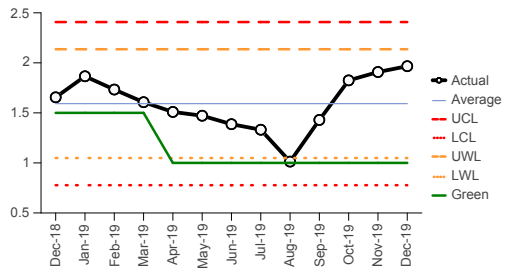
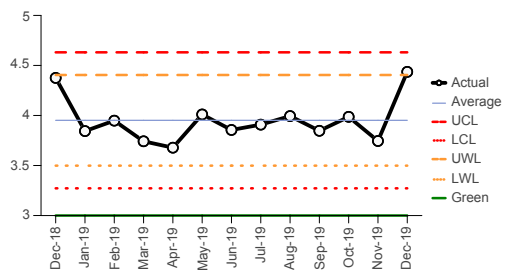
The Best People doing their best Work

15.2 - PEOPLE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

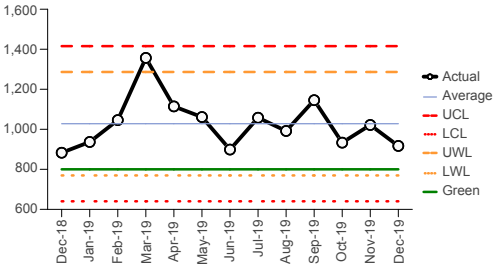
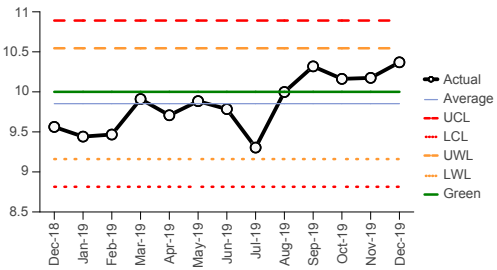
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	6.40 %	R >4.5 % A <=4.5 % G <=4 %		Overall Sickness in December has increased and this remains largely attributable to long term sickness. There however has been an increase in short term sickness which is consistent with sickness absence trends for the same time period in previous years. The Trust continues to invest in preventative interventions to support staff's health and wellbeing and is committed to reducing sickness absence across the Trust.
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	1.97 %	R >1 % A N/A G <=1 %		As above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	4.44 %	R >3 % A N/A G <=3 %		As above

The Best People doing their best Work

15.3 - PEOPLE - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

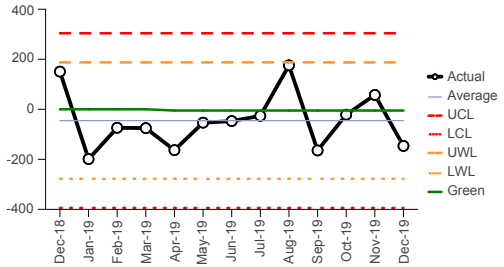
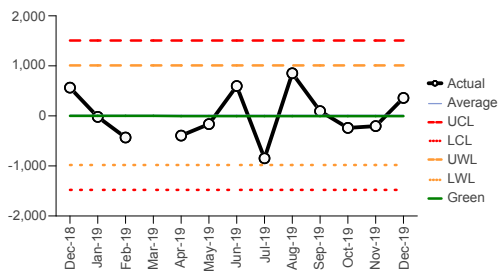
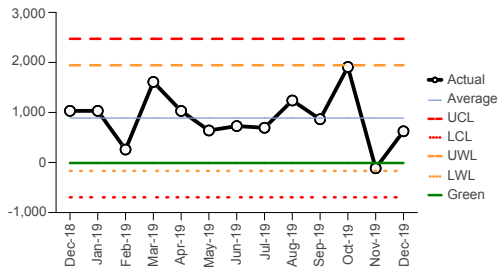
	Description	Performance	Threshold	Trend	Management Action (SMART)
Temporary Spend	**Temporary Spend ('000s)** D Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	916.87	R >960 A <=960 G <=800		Business Partners together with Finance Accountants and Associate COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & DeputyDirectors of HR & Finance.
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	10.37 %	R >11 % A <=11 % G <=10 %		There were 32 leavers in December with the highest number coming from Community and Surgery (11 staff from each), both Additional Professional & Technical and Nursing & Midwifery had 8 leavers, the highest out of the staff groups. The main reson for leaving was voluntary resignation (65%) and 21.8% of leavers in Decembers were retirees.

The Best People doing their best Work

16.1 - FINANCE - WELL LED

Alder Hey Children's 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	-147	R <-20% A >=-20% G >=-5%		The M9 CIP performance across the Trust showed an under achievement of (£0.147m) The full year CIP target is £6m. The forecast outturn for CIP delivery is £5.0m, a forecast CIP under performance of £1.0m representing a risk to CIP delivery for the full year. The key area of under delivery is within the medicine division (£0.5m) and corporate areas (£0.5m). As part of the trusts recovery plan for 2019/20 achievement of recurrent CIP will be a key focus.
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	358	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Capital Expenditure In Month Variance (£'000s)** W Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	624	R <-10% A >=-10% G >=-5%		No Action Required

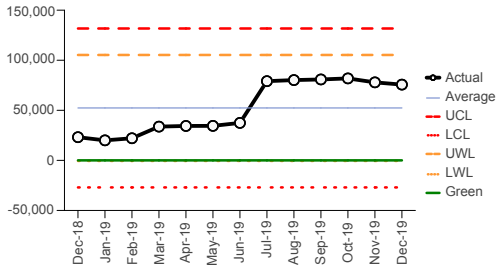
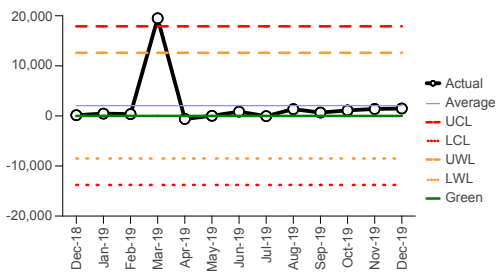
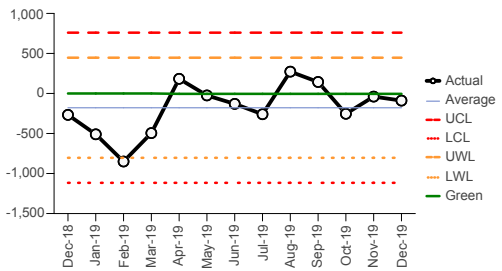
The Best People doing their best Work

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	75,657	R <-20% A >=-20% G >=-5%		No Action Required
Finance	**Income In Month Variance (£'000s)** W Variance from income plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,479	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	-89	R <-20% A >=-20% G >=-5%		No Action Required

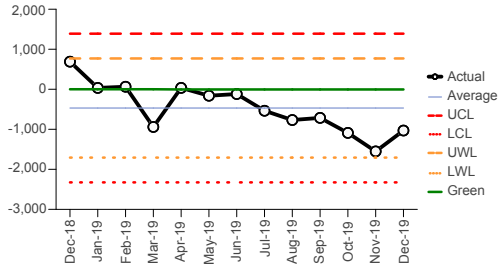
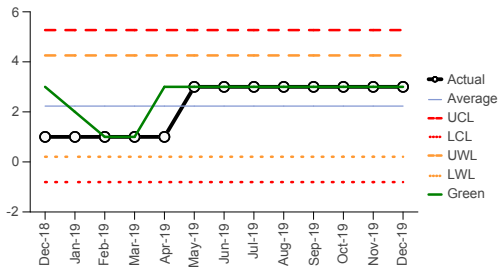
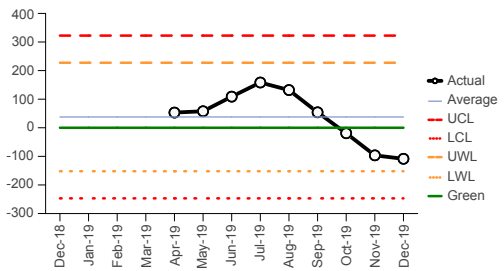
The Best People doing their best Work

16.3 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

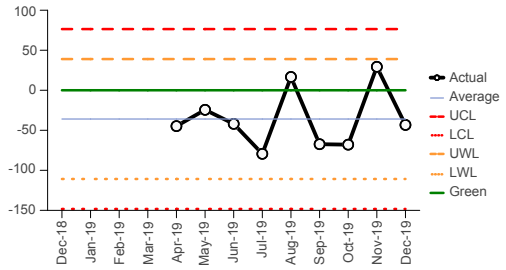
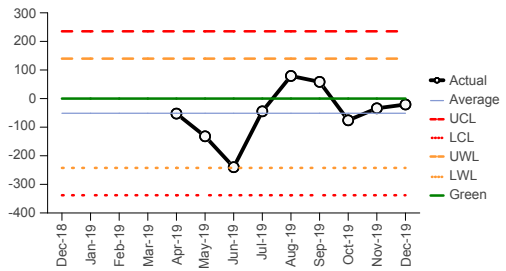
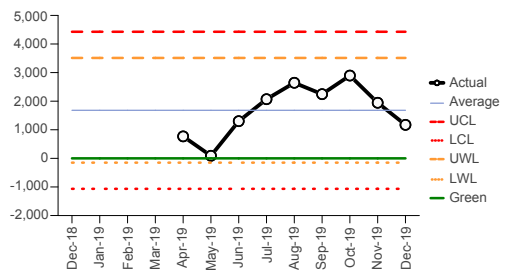
	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** W Variance from non pay plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-1,031	R <-20% A >=-20% G >=-5%		Non pay for month 9 exceeded budget by £1m. Of this £0.4m was offset by income and the remainder related to the delivery of clinical activity.
Finance	**NHSI Use of Resources** W NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	3	R >3 A N/A G <=3		No Action Required
Finance	**AvP: IP - Non-Elective** W Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-108.58	R <0 A N/A G >=0		Significant adverse variances in A&E (69 spells) and general paeds (41 spells).

The Best People doing their best Work

16.4 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-43.31	R <0 A N/A G >=0		Significant adverse variances in sleep studies (30 spells) and ENT (11 spells).
Finance	**AvP: Daycase Activity vs Plan** W Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-20.71	R <0 A N/A G >=0		Significant adverse variance in dentistry (46 seplls).
Finance	**AvP: Outpatient Activity vs Plan** W Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1172.01	R <0 A N/A G >=0		No Action Required

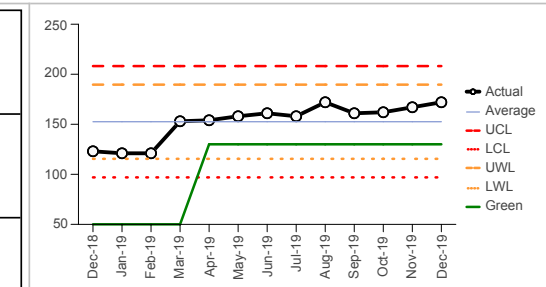
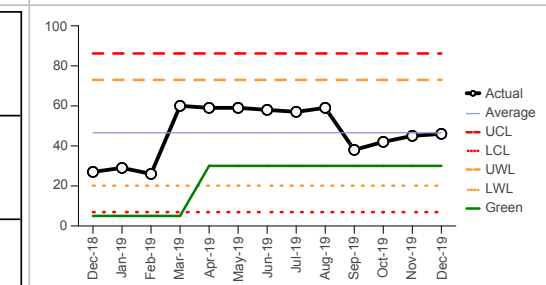
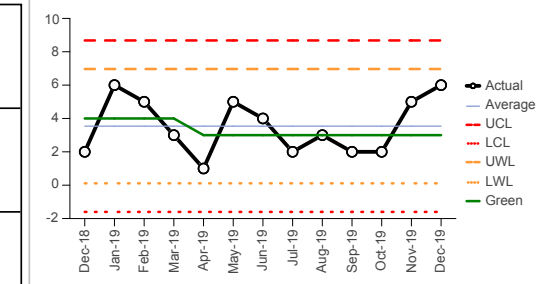
Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of Open Studies - Academic** W Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	172	R <111 A >=111 G >=130		No Action Required
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	46	R <21 A >=21 G >=30		No Action Required
Clinical Research	**Number of New Studies Opened - Academic** W Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	6	R <2 A >=2 G >=3		No Action Required

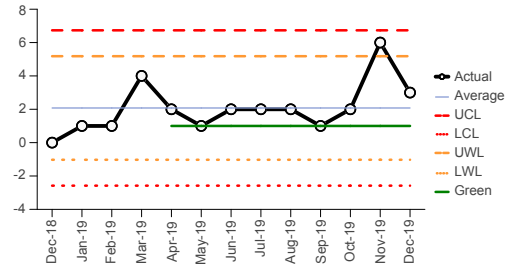
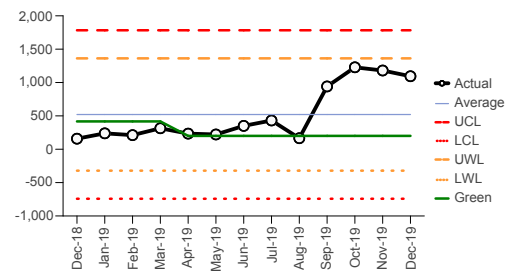
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

GROW THE FUTURE

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

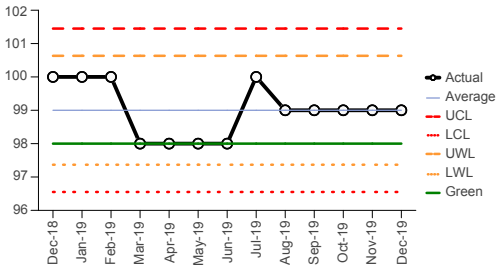
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	3	R <1 A N/A G >=1		No Action Required
Clinical Research	**Number of patients recruited** W Number of patients recruited to NIHR portfolio studies in month. **Exec Lead:** Matthew Peak **Committee:** REIC	1094	R <171 A >=171 G >=200		No Action Required

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

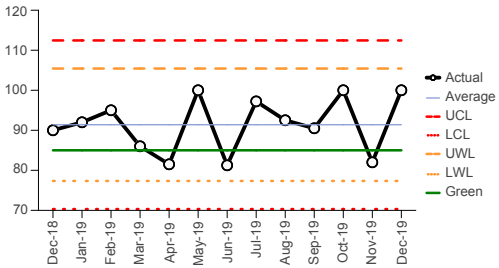
The Best People doing their best Work

19.1 - FACILITIES - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** W Auditing for Domestic Services, aim is to ensure National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Nicki Murdock **Committee:** CQAC	100 %	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	2	20	20	No Threshold
Clinical Incidents resulting in No Harm	D	30	70	115	No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	12	22	43	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	2	No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	1	0	0 / N/A / >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0 / N/A / >0
Medication errors resulting in harm	D	0	1	0	No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0 / N/A / >0
Pressure Ulcers (Category 4)	W	0	0	0	0 / N/A / >0
Never Events	W	0	0	1	0 / N/A / >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		100.0%	60.0%	>=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	No Threshold

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	1	2	6	No Threshold
PALS	W	21	19	18	No Threshold

EFFECTIVE

		COMMUNITY	MEDICINE	SURGERY	RAG
% Readmissions to PICU within 48 hrs	W			0.0%	<=3 % / N/A / >3 %
ED: 95% Treated within 4 Hours	D		86.1%		>=95 % / N/A / <95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0 / N/A / >0

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	1	35	No Threshold		
28 Day Breaches	W	0	0	8	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		94.6%	97.6%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		97.7%	99.1%	>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge	D P		92.7%	88.7%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		92.7%	99.3%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		90.4%	91.7%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		81.6%	87.7%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	74.3%	94.2%	94.2%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,371	3,420	8,088	No Threshold		
Waiting Greater than 52 weeks	W	0	0	0	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		96.4%		100 %	N/A	<100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W		100.0%		100 %	N/A	<100 %
All Cancers: 31 day wait until subsequent treatments	W		100.0%		100 %	N/A	<100 %
Diagnostics: % Completed Within 6 Weeks	W		99.7%	100.0%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		100.0%		100 %	N/A	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	-9	494	159	No Threshold
Income In Month Variance (£'000s)	W	26	869	565	No Threshold
Pay In Month Variance (£'000s)	W	-30	-12	-37	No Threshold
Non Pay In Month Variance (£'000s)	W	-6	-363	-369	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
AvP: IP - Non-Elective	W		-127	19	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	-39	-4	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		21	-44	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	312	-71	403	>=0	N/A	<0
PDR	W	90.1%	87.8%	93.3%	>=90 %	>=80 %	<85 %
Medical Appraisal	W	51.5%	65.1%	65.2%	>=95 %	>=90 %	<90 %
Mandatory Training	W	94.1%	91.6%	91.1%	>=90 %	>=80 %	<80 %
Sickness	D	5.5%	6.0%	7.3%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.9%	2.2%	2.2%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.6%	3.8%	5.1%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	120	224	471	No Threshold		
Staff Turnover	D	11.7%	9.4%	10.9%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	96.7%	90.7%	91.7%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Zero for the following: Clinical Incidents Resulting In Moderate, Semi permanent Harm; Never Events; Cat 3 and 4 Pressure Ulcers; Hospital-acquired Infections For MRSA and C Difficile.	**Highlight** ▪ 100%: Inpatients treated for Sepsis within 60 mins. ▪ Improved cleanliness score to 98.3%. ▪ Zero never events, hospital-acquired infections (MRSA, C. difficile) for over 12 months. **Challenges** ▪ Against a target of 90%, an improvement, but still under-delivery with 76.7% of patients in ED treated for Sepsis within 60 mins.
CARING	2 complaints and 19 PALS responses.	**Highlight** ▪ Third consecutive month of no more than two complaints. **Challenges** ▪ New quality team will help to overcome challenge of responding to complaints in a timely fashion.
EFFECTIVE	Although still below the 95% standard, the percentage of patients waiting under four hours in our emergency Department has increased from 79.36% in November to 84.87% in December. This performance standard continues to be our top operational pressure and priority. An ED action plan continues to make progress, which along with recommendations from the following will bring about sustainable positive change over time: workforce plan; enhanced ways of working; redirecting of appropriate patients to primary care and General Paediatrics clinics. Additional ED slots from both physiotherapy and dermatology teams. Comfort and safety grounds in ED waiting room. Tactical command huddles three times a week.	**Highlight** ▪ Was Not Brought rate remains below 12% (for fourth month). ▪ Scanning outsourcing continues. ▪ Coding comorbidity average remains above 4.4 for 7th consecutive month. **Challenges** ▪ ED performance (see to the left). ▪ Clinical Utilisation decreased to 80.9% - Task and Finish Group to focus on over next 2 months.
RESPONSIVE	Turnaround times consistently good in many areas (especially Pathology) though concern over MRI, CT. Action plan to address this was presented at Operational Delivery Board on 28/11/19 and involves recruitment of additional radiologists as well as Outsourcing presented at Divisional Board on 21/01/2020.	**Highlight** ▪ RTT target consistently achieved for over 12 months though acknowledge that some areas still require focus. ▪ Diagnostic target consistently achieved for over 12 months. **Challenges** ▪ MR- See to left
WELL LED	Shift fill rate above 90% for 12 consecutive months. Temporary spend reduced for third consecutive month. Reduced out of date risk register reviews to zero by end of December.	**Highlight** ▪ Mandatory training is above 90% for 7th consecutive month. **Challenges** ▪ Medical workforce poor on some mandatory training metrics.

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	21	20	36	30	19	29	20	36	11	20	16	25	20		No Threshold
Clinical Incidents resulting in No Harm (D)	69	98	89	89	103	88	78	105	76	70	87	73	70		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	16	35	24	37	38	25	23	21	9	19	21	16	22		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	0	0	0	0	0	0	0	0	1	0	0	1	0		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	0	0	0	1		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	1	1	0	0	0	1	0	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	0	0	2	1	4	3	0	1	0	0	3	0	1		No Threshold
Medication Errors (Incidents)	29	31	31	34	51	40	24	37	32	21	30	20	22		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	0	0	1	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
Acute readmissions of patients with long term conditions within 28 days	3	3	3	2	2	3	3	4	4	1	8	5	3		No Threshold
Never Events (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	81.0%	74.2%		63.2%	100.0%	66.7%	85.7%	83.3%	100.0%	87.5%	100.0%	90.0%	100.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	0	0	1	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	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI	2	2	6	1	0	0	2	1	1	2	1	3	1		No Threshold
Hospital Acquired Organisms - MSSA (D)	0	0	0	1	0	0	0	0	1	0	0	0	0		No Threshold
Cleanliness Scores	94.1%	97.1%	97.1%	98.6%	97.2%	98.3%	91.8%	96.4%	98.5%	98.6%	97.9%	97.4%	98.3%		>=90 % >=80 % <80 %
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.					99.5%	99.5%	99.7%	100.0%	99.5%	99.6%	99.7%	99.7%	100.0%		>=95 % N/A <95 %
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.					65.6%	55.0%	55.0%	58.9%	58.9%	58.9%	58.9%	58.5%	58.5%		>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine within 30 minutes	41.0%	50.0%	63.0%	62.0%	63.0%	54.0%	63.0%	52.5%	52.5%	62.0%	59.0%	50.0%	62.0%		>=90 % >=80 % <90 %
Pharmacy - Dispensing for Out Patients - Complex within 60 minutes	89.0%	91.0%	67.0%	95.0%	60.0%	75.0%	100.0%	87.5%	87.5%	63.0%	100.0%	92.0%	89.0%		>=90 % >=80 % <90 %

CARING

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Complaints (W)	5	4	2	4	2	1	3	2	4	7	0	1	2		No Threshold
PALS (W)	27	47	37	23	40	34	38	40	33	39	39	37	19		No Threshold

EFFECTIVE

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Referrals Received (Total)	1,755	2,041	1,939	2,186	2,023	2,118	1,968	2,204	1,706	1,774	2,090	1,912	1,802		No Threshold
ED: 95% Treated within 4 Hours (D)	95.3%	92.1%	90.6%	95.6%	93.5%	91.3%	89.4%	91.8%	94.7%	89.0%	86.9%	79.4%	86.1%		>=95 % N/A <95 %
ED: Percentage Left without being seen (W)	3.5%	4.5%	5.5%	3.4%	3.9%	5.2%	6.8%	4.9%	3.6%	6.2%	5.9%	9.3%	7.0%		<=5 % N/A >5 %
ED: Number of patients spending >12 hours from decision to admit to admission (W)	0	0	0	0	0	1	0	1	0	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised (W)	86.7%	84.5%	83.4%	83.6%	81.8%	83.3%	82.9%	83.6%	86.2%	80.2%	83.9%	79.3%	78.9%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	0	4	2	0	1	1	1	2	5	2	3	4	1		No Threshold

Medicine

D Drive W Watch P Programme

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG		
28 Day Breaches W	0	0	1	0	0	0	0	0	0	0	0	1	0		0	N/A	>0
Clinic Session Utilisation D P	82.4%	81.3%	86.8%	87.4%	85.5%	85.3%	84.8%	85.7%	81.6%	85.3%	84.7%	85.8%	80.9%		>=90 %	>=80 %	<85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	29	29	58	32	64	62	62	40	43	39	38	42	26		No Threshold		
OP Appointments Cancelled by Hospital %	15.5%	15.2%	15.2%	13.5%	17.1%	17.9%	16.0%	14.6%	16.1%	13.0%	15.1%	13.9%	15.2%		<=5 %	N/A	>10 %
Was Not Brought Rate W P	13.1%	11.5%	11.8%	9.6%	10.8%	10.7%	9.9%	11.0%	12.1%	9.7%	9.4%	9.6%	11.5%		<=12 %	<=14 %	>14 %
Was Not Brought Rate (New Appts) W	16.3%	14.1%	13.7%	10.6%	13.6%	13.6%	10.1%	13.3%	14.7%	11.0%	12.6%	11.7%	14.0%		<=10 %	<=12 %	>12 %
Was Not Brought Rate (Followup Appts) W	12.1%	10.7%	11.2%	9.3%	10.0%	9.7%	9.9%	10.2%	11.2%	9.3%	8.5%	9.0%	10.7%		<=14 %	<=16 %	>16 %
Coding average comorbidities	3.76	3.75	4.01	3.93	4.39	4.37	4.40	4.49	4.66	4.43	4.69	4.69	4.79		No Threshold		

RESPONSIVE

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG		
Convenience and Choice: Slot Availability	91.4%	91.5%	87.5%	78.0%	63.1%	66.8%	64.5%	64.7%	72.9%	74.9%	84.7%	85.6%	82.7%		>=96 %	N/A	<96 %
IP Survey: % Received information enabling choices about their care W	94.1%	93.3%	89.7%	94.2%	98.6%	94.8%	97.9%	97.4%	95.4%	99.0%	93.8%	96.1%	94.6%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect W	100.0%	100.0%	100.0%	99.4%	99.3%	98.6%	97.9%	99.5%	97.0%	99.0%	97.2%	96.6%	97.7%		>=95 %	>=90 %	<90 %
IP Survey: % Know their planned date of discharge D P	55.9%	68.7%	75.0%	76.0%	85.0%	82.1%	82.8%	84.1%	83.8%	89.0%	87.7%	87.1%	92.7%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care W	91.2%	98.5%	92.2%	92.9%	98.6%	91.5%	95.8%	88.4%	97.0%	98.4%	97.6%	98.3%	92.7%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play D							92.7%	94.7%	94.4%	93.8%	88.6%	91.0%	90.4%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning D							69.4%	86.2%	75.1%	68.1%	72.0%	68.1%	81.6%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks W	92.7%	92.9%	92.5%	93.9%	94.6%	94.3%	94.7%	94.3%	93.5%	92.9%	93.5%	93.9%	94.2%		>=92 %	>=90 %	<90 %
Waiting List Size W	3,295	3,686	3,398	3,355	3,434	3,771	3,565	3,762	3,501	3,195	3,213	3,332	3,420		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	13	18	22	15	7	5	5	7	11	9	10	18	1		No Threshold		
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals W	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%	96.4%		100 %	N/A	<100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients. W	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
All Cancers: 31 day wait until subsequent treatments W	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
Diagnostics: % Completed Within 6 Weeks W	100.0%	99.7%	100.0%	99.6%	100.0%	100.0%	100.0%	99.8%	100.0%	99.7%	100.0%	100.0%	99.7%		>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers) W	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%		100 %	N/A	<100 %
Pathology - % Turnaround times for urgent requests < 1 hr	89.5%	89.9%	89.4%	90.8%	92.4%	91.0%	92.7%	93.4%	90.8%	91.7%	91.5%	90.9%	89.8%		>=90 %	>=85 %	<90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	99.9%	100.0%	99.9%	99.9%	100.0%	100.0%	100.0%		>=90 %	>=85 %	<90 %
Imaging - % Report Turnaround times GP referrals < 24 hrs	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=95 %	>=90 %	<95 %
Imaging - % Reporting Turnaround Times - ED	83.0%	93.0%	88.0%	92.0%	75.0%	83.0%	94.0%	86.0%	96.0%	94.0%	100.0%	92.0%	82.0%		>=90 %	>=85 %	<90 %
Imaging - % Reporting Turnaround Times - Inpatients	80.0%	88.0%	82.0%	86.0%	84.0%	84.0%	88.0%	92.0%	82.0%	87.0%	91.0%	85.0%	81.0%		>=90 %	>=85 %	<90 %
Imaging - % Reporting Turnaround Times - Outpatients	87.0%	82.0%	92.0%	85.0%	88.0%	86.0%	96.0%	92.0%	93.0%	94.0%	87.0%	87.0%	92.0%		>=85 %	N/A	<85 %
Imaging - Waiting Times - MRI % under 6 weeks	71.0%	69.0%	78.0%	66.0%	67.0%	64.0%	63.0%	73.0%	78.0%	76.0%	92.0%	89.0%	82.0%		>=95 %	>=90 %	<95 %
Imaging - Waiting Times - CT % under 1 week	73.0%	89.0%	82.0%	89.0%	81.0%	82.0%	85.0%	87.0%	88.0%	84.0%	84.0%	80.0%	89.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Plain Film % under 24 hours	91.0%	92.0%	91.0%	92.0%	91.0%	92.0%	92.0%	92.0%	91.0%	92.0%	89.0%	89.0%	90.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Ultrasound % under 2 weeks	88.0%	84.0%	86.0%	81.0%	85.0%	78.0%	90.0%	86.0%	89.0%	88.0%	86.0%	87.0%	88.0%		>=90 %	>=85 %	<90 %
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	100.0%	92.0%	88.0%	81.0%	100.0%	60.0%	78.0%	68.0%	68.0%	100.0%	82.0%	83.0%	79.0%		>=95 %	>=90 %	<95 %

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

D Drive W Watch P Programme

WELL LED

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	72	-430	-242		-140	-302	-215	-308	946	-8	199	66	494		No Threshold
Income In Month Variance (£'000s)	W	25	50	418	416	-225	-298	86	79	676	-53	595	678	869		No Threshold
Pay In Month Variance (£'000s)	W	-126	-212	-217	-244	-51	98	37	-79	291	129	126	162	-12		No Threshold
AvP: IP - Non-Elective	W					17	20	89	111	67	3	-33	-73	-127		>=0 N/A <0
AvP: IP Elective vs Plan	W					-30	-26	-30	-56	-1	-36	-41	-5	-39		>=0 N/A <0
AvP: OP New						-32.10	-56.48	34.41	118.12	176.81	201.81	-45.52	40.78	23.30		>=0 N/A <0
AvP: OP FollowUp						-271.82	-492.12	-331.98	-200.73	-30.19	-94.57	-215.01	-20.03	-134.69		>=0 N/A <0
AvP: Daycase Activity vs Plan	W					-6	-119	-154	-65	100	39	-37	-61	21		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W					-176	-586	-232	-47	264	119	-118	112	-71		>=0 N/A <0
PDR	W	89.2%	89.2%	89.2%	89.2%	2.8%	14.1%	37.4%	83.8%	87.8%	87.8%	87.8%	87.8%	87.8%		>=90 % >=85 % <85 %
Medical Appraisal	W						98.4%	97.6%	93.7%	93.7%	92.1%	88.1%	69.8%	65.1%		>=95 % >=90 % <90 %
Mandatory Training	W	90.0%	91.0%	90.1%	90.7%	90.7%	89.7%	92.0%	91.2%	91.9%	91.4%	91.6%	91.8%	91.6%		>=90 % >=85 % <80 %
Sickness	D	5.2%	4.6%	4.4%	4.8%	4.5%	4.7%	4.6%	5.3%	5.0%	5.3%	5.2%	5.6%	6.0%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.9%	1.8%	1.9%	2.0%	1.6%	1.4%	1.1%	1.6%	1.2%	1.6%	1.3%	2.1%	2.2%		<=1 % N/A >1 %
Long Term Sickness	D	3.3%	2.8%	2.5%	2.8%	2.9%	3.3%	3.4%	3.8%	3.8%	3.7%	3.9%	3.4%	3.8%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	175	219	297	326	270	271	263	247	282	300	284	247	224		No Threshold
Staff Turnover	D	7.8%	7.8%	7.7%	8.0%	8.0%	8.5%	8.8%	8.9%	9.8%	10.6%	9.8%	9.8%	9.4%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	97.2%	96.0%	97.0%	103.2%	100.2%	101.0%	97.5%	97.8%	98.8%	102.9%	99.3%	97.2%	90.7%		>=90 % >=85 % <90 %

Surgery Division

SAFE	• One never event –Wrong site surgery Tooth extraction • Sepsis 60% in Dec 3/5 exceptions were clinically reviewed and accepted • No Grade 3/4 Pressure ulcers • No incidents resulting in sever or permanent harm • No SUI's	**Highlight** • Medication errors reducing from 53 to 27 with no errors resulting in harm • **98%** cleanliness scores • No hospital acquired infections **Challenges** • 6 never events in 18 months –learning to be cascaded
CARING	• Further reduction in PALS from 35 > 17 • 6 formal complaint received as experienced in November	**Highlight** • ECMO Regional Network event • Patient information leaflets 100% up-to-date • 95.7% friends and family test would recommend **Challenges** • Ongoing complex formal complaints
EFFECTIVE	• Reduction in theatre utilisation to 83.27% below YDT average 88% • Clinic Utilisation 81.37%, reduced from 85% and below YDT average 88% • 7 Patients not rebooked within 28 days • Theatre sessions delivered 563, despite Christmas Holiday (mean 112.6, range 53-145)	**Highlight** • **298 CCAD** cases in first 9 months (412 in rolling 12 months) • 28 patients re-booked within 28 days • Maintained elective program while Trust experienced winter pressures **Challenges** • Reduction in theatre and clinic utilisation • Cancelled ops remain an challenge owing to non-elective admissions and bed availability

RESPONSIVE	• RTT 98.96% (national target 92%)
	• Reduction in the number of patents admitted for +21 day. 15 >10
	• IP survey, all metrics >95% accept from learning
		Highlight
		• Continuing to exceed national waiting time targets
		  ○ No 52 week breaches this year to date
		  ○ Continue to achieve 100% for seeing all patient requiring diagnostic tests within 6 weeks since May 2019
		Challenges
		• Rescheduling patients cancelled on the day of their admission within 28 days

WELL LED	• Mandatory training – 91%
	• Sickness – 7.4 (Short term 2.4% and Long Term 5%)
	• Finance:
	  ○ Reduction in temporary spend
	  ○ Yearend forecast improved by 100k but remains 0.7 mil overspent against budget
		Highlight
		• Staff Survey: 666 responses, 58% *(53% and 44% in previous 2 years)*
		• Appointment to Divisional Research Lead and Divisional CCIO roles
		Challenges
		• Increase sickness rates both short and long term

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss (D)	30	28	40	34	28	30	20	59	27	28	42	32	20		No Threshold
Clinical Incidents resulting in No Harm (D)	99	140	104	139	143	142	163	140	137	130	143	142	115		No Threshold
Clinical Incidents resulting in minor, non permanent harm (D)	35	32	34	43	38	67	37	33	39	28	46	53	43		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm (D)	1	2	1	0	0	0	1	2	0	1	0	0	2		No Threshold
Clinical Incidents resulting in severe, permanent harm (D)	0	0	0	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death (D)	0	0	1	0	0	0	0	0	0	1	0	0	0		0 N/A >0
Medication errors resulting in harm (D)	2	2	2	1	2	0	3	1	1	1	3	3	0		No Threshold
Medication Errors (Incidents)	36	38	41	44	38	57	49	28	45	24	41	55	27		No Threshold
Pressure Ulcers (Category 3) (W)	0	0	0	0	0	0	1	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4) (W)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Never Events (W)	0	1	0	0	0	0	0	0	0	2	0	0	1		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients (D P)	66.7%	62.5%		90.9%	75.0%	75.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%	60.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)	0	0	0	0	0	0	1	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	1	0	0	0	0	0	0	1	0	0		0 N/A >0
Hospital Acquired Organisms - MSSA (D)	1	1	0	3	1	1	0	0	0	1	0	1	0		No Threshold
Cleanliness Scores	98.0%	97.3%	97.2%	98.0%	98.2%	97.7%		97.0%	97.2%	97.7%	97.9%	97.6%	98.0%		>=90 % >=80 % <80 %

CARING

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Complaints (W)	0	2	2	6	1	2	2	8	7	4	1	6	6		No Threshold
PALS (W)	26	39	26	30	33	31	26	42	21	48	39	34	18		No Threshold

EFFECTIVE

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Readmissions to PICU within 48 hrs (D)	2	1	2	2	2	2	1	5	3	0	1	0	0		No Threshold
% Readmissions to PICU within 48 hrs (W)	2.4%	1.4%	1.8%	2.5%	2.7%	2.1%	1.3%	5.3%	4.1%	0.0%	1.2%	0.0%	0.0%		<=3 % N/A >3 %
Referrals Received (Total)	2,842	3,671	3,797	4,017	3,752	4,081	3,775	4,156	3,304	3,549	3,823	3,279	2,790		No Threshold
Theatre Utilisation - % of Session Utilised (W)	86.3%	89.7%	89.4%	90.4%	89.7%	90.0%	88.6%	89.4%	90.8%	88.3%	86.9%	85.6%	83.6%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons (D)	21	7	8	12	8	23	14	35	30	16	31	40	35		No Threshold
28 Day Breaches (W)	4	4	0	1	0	0	1	2	0	1	0	1	8		0 N/A >0
Clinic Session Utilisation (D P)	82.4%	83.8%	85.1%	88.6%	87.9%	87.3%	87.2%	89.0%	87.1%	86.5%	87.0%	84.9%	81.4%		>=90 % >=80 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice	48	55	74	58	53	41	40	43	37	29	70	57	11		No Threshold
OP Appointments Cancelled by Hospital %	13.2%	13.8%	14.1%	13.6%	13.3%	12.9%	12.7%	11.9%	12.0%	11.9%	12.6%	12.2%	13.0%		<=5 % <=10 % >10 %
Was Not Brought Rate (W P)	13.1%	12.7%	11.7%	10.6%	11.8%	11.1%	9.6%	9.7%	10.4%	9.7%	9.7%	10.9%	12.3%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts) (W)	14.9%	12.3%	11.7%	10.8%	11.4%	10.8%	10.5%	10.2%	11.6%	10.1%	10.1%	11.4%	11.9%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) (W)	12.3%	12.9%	11.7%	10.5%	12.0%	11.2%	9.2%	9.5%	10.0%	9.6%	9.5%	10.7%	12.5%		<=14 % <=16 % >16 %
Coding average comorbidities	4.00	3.96	4.13	3.92	4.09	4.24	4.15	4.12	4.25	4.06	4.15	4.15	4.24		No Threshold
CCAD Cases	31	33	39	42	30	36	31	43	35	38	35	27	23		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Convenience and Choice: Slot Availability		80.4%	82.6%	90.6%	87.0%	80.0%	76.5%	90.0%	89.7%	82.0%	90.5%	96.9%	99.0%	98.7%		>=96 % N/A <96 %
IP Survey: % Received information enabling choices about their care	W	98.5%	97.7%	98.3%	96.8%	98.0%	97.9%	97.2%	97.7%	95.9%	97.1%	96.8%	97.2%	97.6%		>=95 % >=90 % <90 %
IP Survey: % Treated with respect	W	99.3%	100.0%	98.9%	99.5%	99.3%	99.3%	98.3%	99.0%	97.8%	98.1%	98.0%	98.2%	99.1%		>=95 % >=90 % <90 %
IP Survey: % Know their planned date of discharge	D P	62.0%	81.3%	87.8%	83.8%	92.4%	85.6%	91.3%	90.1%	89.0%	89.3%	95.0%	96.1%	88.7%		>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care	W	93.4%	95.0%	95.6%	93.7%	100.0%	89.7%	96.5%	92.4%	98.6%	98.4%	91.3%	98.2%	99.3%		>=95 % >=90 % <90 %
IP Survey: % Patients involved in Play	D							93.8%	94.4%	95.9%	90.3%	94.2%	95.7%	91.7%		>=90 % >=85 % <85 %
IP Survey: % Patients involved in Learning	D							72.1%	68.9%	70.4%	68.4%	74.3%	68.4%	87.7%		>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	93.7%	93.1%	94.0%	94.0%	93.6%	94.0%	94.0%	93.8%	94.1%	94.5%	93.8%	93.7%	94.2%		>=92 % >=90 % <90 %
Waiting List Size	W	8,320	7,923	8,221	8,129	8,165	7,712	7,939	7,765	8,266	8,519	8,319	8,157	8,088		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%	89.5%	92.3%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-253	-240	-470		-405	-63	282	-525	455	531	-399	-59	159		No Threshold
Income In Month Variance (£'000s)	W	47	-56	208	364	-372	159	370	53	775	771	266	580	565		No Threshold
Pay In Month Variance (£'000s)	W	-2	-30	-407	-274	23	-7	-34	-165	-117	-116	-286	-213	-37		No Threshold
AvP: IP - Non-Elective	W					36	37	20	48	65	51	14	-23	19		>=0 N/A <0
AvP: IP Elective vs Plan	W					-15	2	-11	-25	17	-31	-28	29	-4		>=0 N/A <0
AvP: OP New						-208.97	-305.45	-341.11	-235.53	-169.56	-326.33	-187.46	-318.84	-243.44		>=0 N/A <0
AvP: OP FollowUp						450.69	290.90	923.71	1,083.55	1,399.07	1,316.96	1,717.97	802.38	644.95		>=0 N/A <0
AvP: Daycase Activity vs Plan	W					-46	-14	-86	17	-23	18	-42	25	-44		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W					379	52	642	982	1,596	1,134	1,860	655	403		>=0 N/A <0
PDR	W	90.0%	90.0%	96.6%	96.6%	11.6%	42.7%	74.4%	93.8%	93.3%	93.3%	93.3%	93.3%	93.3%		>=90 % >=85 % <85 %
Medical Appraisal	W						97.6%	97.6%	97.0%	98.2%	94.5%	89.6%	67.7%	65.2%		>=95 % >=90 % <90 %
Mandatory Training	W	88.0%	90.0%	88.4%	89.4%	88.8%	87.3%	88.6%	89.3%	90.3%	90.6%	90.3%	89.9%	91.1%		>=90 % >=85 % <80 %
Sickness	D	6.4%	6.2%	6.4%	5.2%	5.2%	6.2%	6.6%	6.4%	5.7%	5.9%	6.4%	6.0%	7.3%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.9%	2.1%	2.0%	1.6%	1.5%	1.7%	1.6%	1.6%	1.1%	1.6%	1.9%	1.7%	2.2%		<=1 % N/A >1 %
Long Term Sickness	D	4.5%	4.1%	4.4%	3.6%	3.7%	4.5%	5.0%	4.8%	4.6%	4.4%	4.4%	4.2%	5.1%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	484	474	564	591	515	505	461	527	513	613	513	577	471		No Threshold
Staff Turnover	D	9.8%	9.7%	9.9%	10.3%	10.5%	11.0%	11.3%	9.9%	10.6%	10.5%	10.5%	10.4%	10.9%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	91.9%	93.3%	89.3%	89.4%	91.9%	91.0%	89.1%	89.4%	92.5%	86.1%	89.6%	95.5%	91.7%		>=90 % >=85 % <90 %

Community & Mental Health Division		
SAFE	Flu immunisation clinic in outpatients commenced to support children & young people with complex needs who miss the universal flu vaccination programme in primary care are protected by offering them vaccinations as they attend Outpatients at Alder Hey.	**Highlight** • No never events • No severe or moderate incidents of harm • Zero pressure ulcers grade 3 or 4 • Reduction in 'no harm' incidents (restrictive interventions & seclusions) on the Dewi Jones Unit due to improvements in young person's health **Challenges** • Provision of Tissue Viability Support to community based staff • Ongoing challenges arranging training updates for staff in community locations
CARING	Teams are regularly recording compliments on Ulysses which means we are able to highlight this across the Division	**Highlight** • Reduction in both PALs and complaints for month of December **Challenges** • Improvements being sought to Catkin building estate to improve patient safety and experience.
EFFECTIVE	'Journey to the Stars' Silver awards achieved by Dewi Jones Unit, Sefton CAMHS and Outpatients	**Highlight** • Digital bid approved with NHSx for £350k improvement in our Specialist Mental Health Services to support digital communication between providers and children and young people (booking appointments) **Challenges** • Continued improvements in recording and reporting on paired outcome measures in our Specialist Mental Health Services to demonstrate impact of services
RESPONSIVE	Crisis Care team actively involved in supporting the Emergency Department in managing children & young people experiencing mental ill health during Winter.	**Highlight** • Improvement in Eating Disorder waiting times compliance with national standard of 100% of children & young people seen within one week for an urgent appointment. Continued improvement is expected as service recruits to additional posts. • Ongoing improvements for waiting times in Specialist Mental Health Services, including reduction of over 100 patients on Choice waiting list and improvement in RTT% to achieve first milestone of 50%. • Waiting times continue to reduce for Sefton SALT with longest wait 30 weeks on plan to achieve agreed 18 week trajectory (31 March 2020)

		Challenges • Increase in waiting times for Liverpool SALT to 21 weeks – improvement plan developed • Improvements in waiting times for Liverpool ASD and ADHD on course to meet planned trajectory. Lack of commissioned pathways in Sefton an improvement proposal submitted.
WELL LED	At the end of December, all risks on the Divisional risk register had been reviewed. The Division has achieved its required financial performance at the end of Month 9 (£78k+ year to date position) and full delivery of 19/20 CIP	**Highlight** • Mandatory training is at 94.1% • Sickness has reduced for third consecutive month (remains above trust target but this is decreasing) • Staff survey closed with 66% response rate • PDR rate remains above 90% • Appointment of Divisional Research Lead (Dr Nadia Ranceva) **Challenges** • Turnover remains above trust target, presentations to divisional board to discuss trends and consider improvements. • 75% of services with mandatory training under 90% are based in Sefton, training sessions required in community locations.

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	4	3	3	3	6	15	7	5	7	8	1	6	2		No Threshold
Clinical Incidents resulting in No Harm	D	31	38	41	41	48	54	41	53	57	68	85	63	30		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	4	4	6	6	6	2	7	8	7	6	11	10	12		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	0	0	1	0	0	0	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Medication Errors (Incidents)		4	10	9	5	12	6	3	6	5	9	11	8	9		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Pressure Ulcers (Category 3 and above)		0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Cleanliness Scores			100.0%					99.5%			98.9%					No Threshold
CCNS: Advanced Care Plan for children with life limiting condition		0	0	0	0	10	10	10	10	9	8	8	7			No Threshold
CCNS: Supported early discharges from hospital care						100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		No Threshold
CCNS: Prescriptions		0	0	0	0	12	24	17	21	32	28	25	21			No Threshold

CARING

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Complaints	W	2	1	4	6	4	4	1	4	2	1	3	5	1		No Threshold
PALS	W	11	36	29	33	30	30	43	37	28	38	37	21	21		No Threshold

EFFECTIVE

		Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Referrals Received (Total)		773	909	969	1,086	918	1,064	918	1,019	622	818	1,097	934	781		No Threshold
Clinic Session Utilisation	D P	78.7%	79.3%	81.1%	87.5%	83.5%	83.3%	83.7%	82.5%	82.6%	82.6%	83.1%	83.9%	80.0%		>=90 % >=85 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice		8	8	18	16	20	14	14	8	7	14	20	19	11		No Threshold
OP Appointments Cancelled by Hospital %		23.6%	18.4%	21.4%	22.7%	20.2%	17.1%	18.8%	16.0%	11.1%	12.6%	13.9%	12.7%	12.7%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	W	9.9%	13.9%	10.8%	10.0%	11.0%	12.2%	9.7%	11.3%	9.5%	8.6%	8.9%	11.3%	11.3%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	14.4%	14.0%	12.7%	11.4%	13.7%	13.0%	12.7%	12.3%	13.6%	11.7%	10.5%	10.4%	13.2%		<=14 % <=16 % >16 %
Was Not Brought Rate (New Appts) - Community Paediatrics		13.0%	17.8%	14.9%	13.3%	12.7%	16.5%	12.0%	14.1%	9.6%	10.5%	10.1%	13.5%	13.4%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts) - Community Paediatrics		11.4%	11.6%	10.4%	6.9%	12.8%	10.4%	10.7%	8.7%	9.9%	9.6%	9.8%	8.9%	11.2%		<=14 % <=16 % >16 %
CAMHS: % CHOICE Was Not Brought Rate		11.5%	17.6%	12.6%	14.9%	16.7%	14.0%	13.5%	19.1%	21.0%	10.4%	13.7%	13.8%	16.7%		<=10 % <=12 % >12 %
CAMHS: % All Other Was Not Brought Rate		16.1%	15.6%	13.9%	13.6%	14.3%	14.6%	13.6%	14.3%	16.4%	14.0%	11.1%	11.8%	15.1%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		100.0%	95.9%	88.8%	118.9%	115.7%	100.0%	91.4%	98.2%	86.2%	84.8%	65.9%	71.0%	77.9%		No Threshold
CAMHS: Tier 4 DJU Bed Days		217	207	173	237	212	202	161	182	155	148	113	119	139		No Threshold
Coding average comorbidities			2.00	1.50	6.00	4.00	2.50	3.00	3.00	5.50	5.00	4.00	1.00			No Threshold
CCNS: Number of commissioned packages		0	0	0	0	10	10	10	10	10	10	10	10	10		No Threshold

RESPONSIVE

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

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Community

D Drive W Watch P Programme

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
CAMHS: Referrals Received	297	332	351	402	325	345	309	326	185	289	418	342	258		No Threshold
CAMHS: Referrals Accepted By The Service	183	203	210	232	190	218	172	175	125	161	251	176	150		No Threshold
CAMHS: % Referrals Accepted By The Service	61.6%	61.1%	59.8%	57.7%	58.5%	63.2%	55.7%	53.7%	67.6%	55.7%	60.0%	51.5%	58.1%		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	78.3%	82.7%	78.3%	74.2%	75.2%	74.9%	73.9%	76.4%	71.6%	70.8%	76.1%	76.8%	74.3%		>=92 % >=90 % <90 %
Waiting List Size W	1,162	1,263	1,269	1,262	1,272	1,393	1,339	1,356	1,107	1,112	1,222	1,338	1,371		No Threshold
Waiting Greater than 52 weeks W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
CAMHS: Crisis / Duty Call Activity	277	325	344	425	343	337	343	315	266	294	471	384	250		No Threshold
CAMHS: RTT (First Partnership) % waiting within 18 weeks W					63.6%	66.0%	61.1%	54.7%	49.6%	46.2%	48.9%	49.6%	49.0%		>=92 % >=90 % <90 %
ASD: Completed Pathways	25	64	69	77	68	63	84	45	74	78	86	75	36		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)	48.0%	37.5%	40.6%	58.4%	60.3%	30.2%	25.0%	13.3%	28.4%	32.1%	54.7%	50.7%	52.8%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%) P			100.0%	86.7%	57.1%	66.7%	62.5%	72.7%	54.5%	71.4%	72.2%	83.3%	87.5%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%) P					50.0%	50.0%		66.7%	0.0%		0.0%	100.0%	100.0%		No Threshold
CCNS: Number of Referrals W					138	163	156	147	149	133	129	168	105		No Threshold
CCNS: Number of Contacts D					886	919	894	921	893	913	951	1,094	847		No Threshold

WELL LED

	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s) W	115	-38	14		-66	75	-12	-13	27	92	-36	22	-9		No Threshold
Income In Month Variance (£'000s) W	265	87	61	336	-111	177	36	-47	57	43	74	34	26		No Threshold
Pay In Month Variance (£'000s) W	-2	-151	-57	-307	181	-69	-64	2	-4	51	-43	15	-30		No Threshold
AvP: OP New					-1.48	-11.08	-5.63	28.14	-3.08	114.22	192.67	181.19	118.32		>=0 N/A <0
AvP: OP FollowUp					5.13	84.99	343.17	291.03	136.10	260.13	271.48	408.78	192.82		>=0 N/A <0
AvP: Outpatient Activity vs Plan W					4	76	341	322	136	381	468	591	312		>=0 N/A <0
PDR W	93.0%	93.7%	93.7%	93.7%	1.4%	10.8%	48.6%	87.1%	90.1%	90.1%	90.1%	90.1%	90.1%		>=90 % >=85 % <85 %
Medical Appraisal W						100.0%	100.0%	97.0%	100.0%	97.0%	84.8%	78.8%	51.5%		>=95 % >=90 % <90 %
Mandatory Training W	90.9%	88.3%	89.2%	90.3%	92.2%	89.2%	90.2%	92.0%	93.2%	92.9%	92.7%	93.5%	94.1%		>=90 % >=85 % <80 %
Sickness D	7.6%	7.9%	7.5%	7.4%	6.7%	6.4%	4.9%	4.3%	4.4%	4.2%	5.9%	5.7%	5.5%		<=4 % <=4.5 % >4.5 %
Short Term Sickness D	1.6%	1.7%	1.5%	1.8%	1.4%	1.6%	1.2%	0.9%	0.8%	1.1%	2.4%	2.1%	1.9%		<=1 % N/A >1 %
Long Term Sickness D	6.0%	6.2%	6.0%	5.6%	5.3%	4.8%	3.7%	3.4%	3.6%	3.1%	3.6%	3.6%	3.6%		<=3 % N/A >3 %
Temporary Spend ('000s) D	144	179	106	367	198	226	96	158	122	143	42	104	120		No Threshold
Staff Turnover D	12.9%	12.2%	11.9%	12.8%	11.8%	11.7%	9.9%	10.1%	10.2%	10.6%	10.5%	11.2%	11.7%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate) W	99.0%	97.0%	100.0%	106.0%	100.0%	102.0%	97.0%	87.0%	87.3%	91.2%	87.6%	100.3%	96.7%		>=90 % >=85 % <90 %

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Financial Dashboard -M9 2019/20

How Did We Do?

Executive Summary **Month: 9** **Year: 2019**

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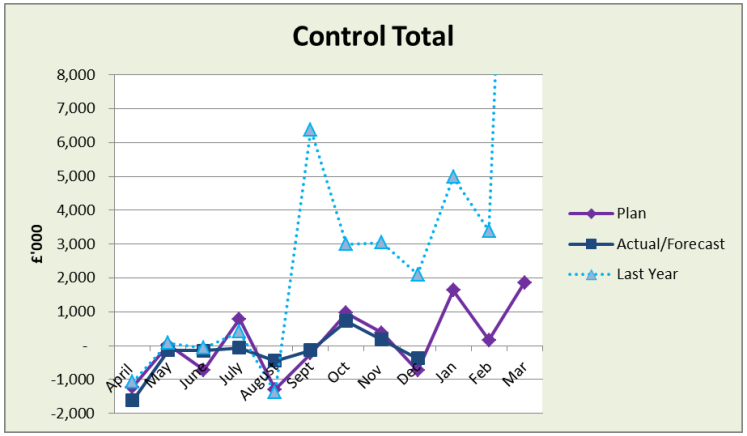
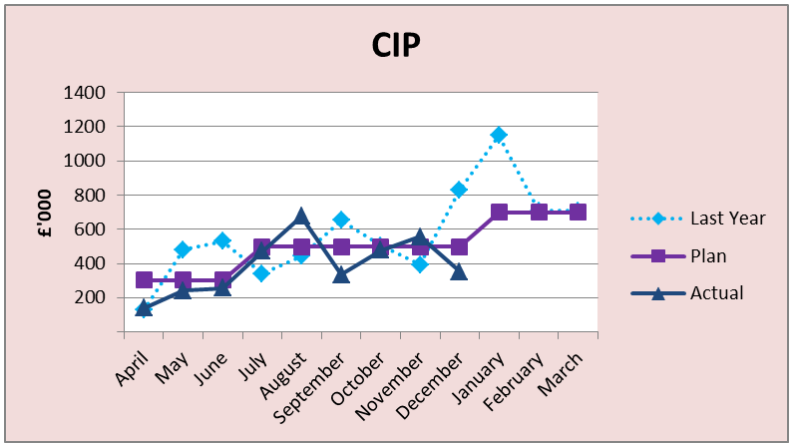
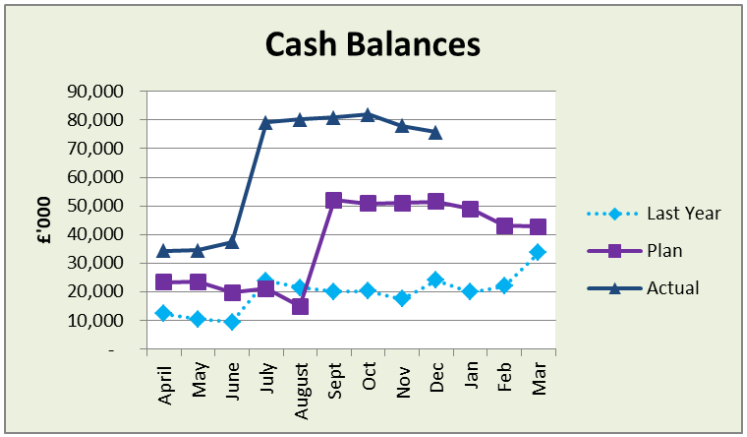
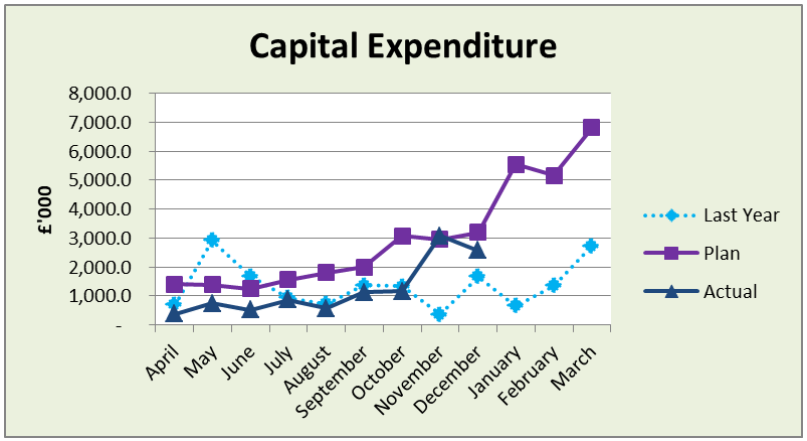
Control Total in month	CIP Forecast for year	Use of Resources	Control Total Forecast
£0.37m	£6m	3	(£0.3m)
Achieved	Achieved	Achieved	Not Achieved

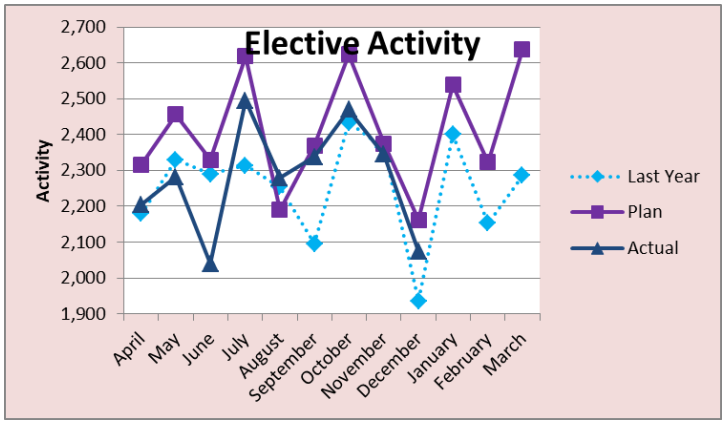


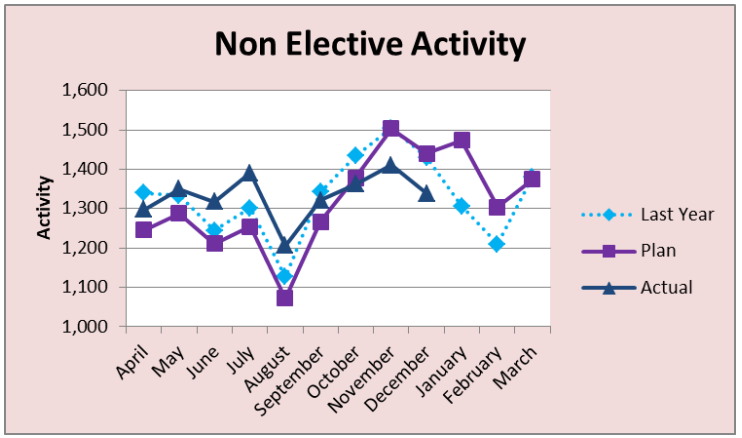


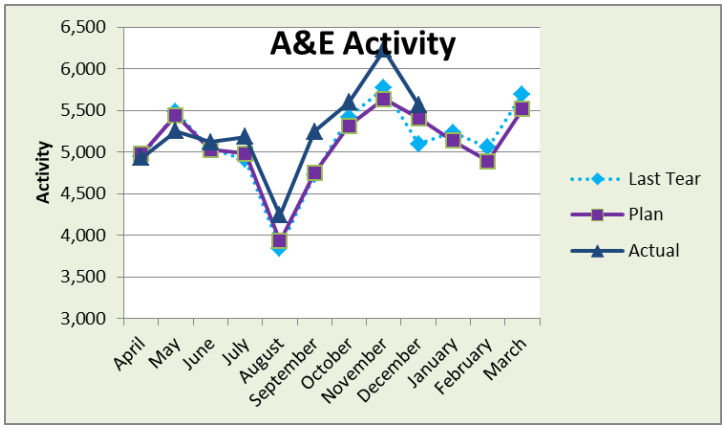


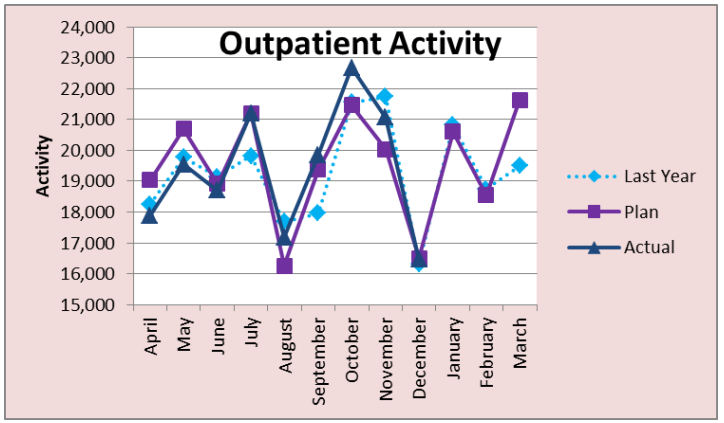


Elective Activity in Month	Non Elective Activity in Month	Outpatient Activity in Month	A&E Activity In Month
2,074	1,338	16,455	5,565
Not Achieved	Not Achieved	Not Achieved	Achieved









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BOARD OF DIRECTORS

Tuesday 4th February 2020

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

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1. Purpose of the report

The purpose of this report is to provide the Board with an overview of the current serious incident management position. The report includes learning from serious incidents, 'Never Events' closed since the last reporting period (November 2019) and the immediate learning from serious incidents declared in this reporting period (December 2019).

2. Background:

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

3. Summary of Serious Incidents and Never Events

The cumulative total of serious incidents including Never Events over the 12 month period was **6**.

There were **3** serious incident reported during December 2019 and **1** 'Never Event. There were no serious safeguarding incidents reported. Duty of candour was applied in all four cases, in line with regulation 20. All 72 hour reviews were completed within Trust policy timeframes and submitted to Liverpool Clinical Commissioning Group (CCG).

Appendix 1 provides an overview of immediate lessons learned, immediate actions for improvement and ongoing actions, to minimise risk of recurrence of the same or similar incidents recurring for new serious incidents and the 'Never Event incident reported during this period.

Appendix 2 provides an overview of the completed investigations during this reporting period

There was one moderate Harm incident reported during this period "extraversion injury' and the investigation is in progress at time of reporting.

Note: All investigations are complaint with the 60 day's timeframe or completed within the agreed extension period

Appendix 1

	New SIRI investigations				
StEIS reference	Incident	Duty of Candour in line with regulation 20	Immediate lessons	Immediate actions	Further action to be taken
2019/28203	Sub-optimal care of the deteriorating patient. Escalation delay	completed/compliant	Need for escalation to Registrar to be made aware of patient's on going PEWS score by SHO or nursing staff. Senior medical review as per PEWS policy. Patient transferred to Critical Care earlier. Robust, concise patient documentation from nursing and medical staff. Full documentation of PEWS and recorded in a timely manner.	Safety notice – Importance of following PEWS policy.	Level 2 Investigation underway
2019/20741	Patient underwent an unnecessary MRI under General Anaesthetic (GA)	Completed/compliant	When a discrepancy on the ordering of investigations is discovered it should be escalated immediately to the Service Manager who would arrange a clinical review of all patients seen during the clinic. This will ensure that all investigations have been correctly ordered. It is good practice to ensure that clinical staff do not view more than one patient record via Meditech at any one time The Consultant will undergo	Clinical Director circulated a Trust wide Safety Alert to reiterating that staff are only to only view one patient record at any one time on Meditech Clinical Director has informed the Consultant of the incident and requested a written statement. The Consultant works part time and is currently abroad.	Consultant to undergo clinical systems training at next visit Discuss incident and propose standard operating procedure at Surgical Division Integrated Governance and Board. Level 1 investigation underway

			standard clinical systems training on each visit		
StEIS 2019/26251	'Never Event' Incorrect tooth extraction	Completed/compliant	The importance of following procedures for tooth extraction	Safety alert sent out to all Theatre staff to highlight incident, and raise staff & clinicians awareness of potential for wrong site surgery in oral surgery.	Level 2 investigation underway

Appendix 2

Completed SIRI investigations in reporting period					
StEIS reference	Incident	Duty of Candour in line with regulation 20	lessons learned	Recommendations	Further action to be taken
StEIS 2019/20632	Death of a patient awaiting cardiac surgery	completed/compliant	Poor communication between teams can result in poor experience and increased anxiety for parents Should special investigations be cancelled (CT scan) the primary cardiology Consultant for the patient should be informed to prevent delays in the interstage care pathway Should a child from RMCH who is on the cardiac surgical waiting list clinically deteriorate, this should be escalated through a formal process to the surgical planning meeting and JCC when appropriate Should a cardiac surgery operation be cancelled, if aspirin medication has been stopped this should be restarted.	Formal apology to the family for the communication failings identified through this investigation. To provide feedback to the family and staff involved in the incident, including a copy of the report. To inform the primary Consultant if a specialist investigation is cancelled and escalate to JCC. The children on the cardiac surgery waiting list and the categories are reviewed weekly Formal method to escalate if there is a deterioration in a child's clinical condition from RMCH to JCC Clear guidance on alteration of aspirin	To provide feedback to the family including copy of report and offer of meeting to discuss findings. To provide feedback to the staff involved in the incident, including a copy of the report. To ensure there is a process in place. Feedback to radiology departments at AHCH and RMCH Weekly update to be provided to lead cardiologist regarding patients going over recommended time for surgery. Development of formal escalation process if there is a deterioration in a child's clinical condition whilst on the cardiac surgical waiting list Weekly update to be provided to lead cardiologist regarding patients going over recommended time for surgery.

			The cardiac surgery waiting list should be reviewed weekly regarding the category of patients listed to inform the cardiac surgical planning meeting. Patients going over their recommended timing (category) for surgery should be reported to the lead cardiologist to allow for clinical oversight.	medication when children due for cardiac surgery are cancelled Discuss the case discussed at cardiac QAQI All children on the waiting list with either a PDA stent or BT shunt reviewed to assess surgical priority Local policy of stopping Aspirin prior to surgery reviewed and amended for cancelled operations	Formal process to escalate if there is a deterioration in a child's clinical condition whilst on the cardiac surgical waiting list To develop an SOP regarding aspirin guidance when on the cardiac surgery waiting list
2019/20104	Loss of vision in the right eye of a patient following the identification of widespread retinal haemorrhages and surgery for extraction of cataract	completed/compliant	Significant retinal haemorrhages of this pattern and extent following paediatric cataract surgery is previously unreported. Frameworks are in place to allow appropriate evaluation of evidence if problems occur and this should start with an incident report. Referral to Rainbow team with significant retinal haemorrhage is appropriate Protocols for the recording of the administration of medicines must be followed	To provide feedback to the child, family and staff involved in the incident. To further evaluate the role of antibiotics in this procedure and report proposed changes to CEDG as necessary Trust wide communication highlighting the importance of clear documentation within the patient electronic record of any drug prepared and / or administered to a patient as per section 11 of the Medicines Management Code and	The family will receive the report and an invitation to formally discuss the findings of the report. To further evaluate the role of antibiotics in this procedure and report proposed changes to CEDG as necessary Trust wide communication highlighting the importance of clear documentation within the patient electronic record of any drug prepared and / or administered to a patient as per section 11 of the Medicines Management Code and relevant

			Record keeping and communication with professional teams must always be in line with professional bodies' standards and Trust policies.	relevant professional bodies protocols. An audit of the recording and documentation of drug preparation and administration in theatre to identify any training needs; training will then be provided as necessary. Disseminate the report with the team involved to address the action plan and ensure shared learning. In addition shared the findings and lessons learned Trust wide. The RCA investigation team recommends that the ophthalmology department ensures the instructions for administration of eye drops on the ward is very clear and that consistent information is given to the nursing team and parents and documented in the medical record. Refer to paediatrics for general overview of causes of unilateral retinal haemorrhages.	professional bodies protocols. An audit of the recording and documentation of drug preparation and administration in theatre to identify any training needs; provide training as necessary. An audit of the instructions for administration of eye drops from the surgical team to the ward to identify any training needs; provide training as necessary. The report is to be shared with the team involved and Trust wide within 1 month of completion of the report. Refer to paediatrics for general paediatric overview of causes of unilateral retinal haemorrhages

2019/20741	Never Event Wrong route administration of medication	completed/compliant	Bags of epidural infusate should not be brought into theatre until the point that they are needed for use and should not be left in proximity to other bags of fluid. All infusions should be checked again after preparation at the point of connection to the patient with another practitioner. These checks should be signed for on the epidural prescription by both parties.	Formal apology to the patient and their family for the shortcomings identified through this investigation. To provide feedback to the child, family, including a copy of the report and offer of a meeting to discuss the findings. To provide feedback to the staff involved in the incident, including a copy of the report. Issue a safety alert to all theatre staff to highlight the risk and actions to prevent recurrence Develop a Standard Operating Procedure (SOP) for the commencement of local anaesthetic infusions in the operating theatre, with particular attention to the handling of the local anaesthetic solution once it has been	To provide feedback to the child, family and staff involved in the incident. To provide feedback to the staff involved in the incident, including a copy of the report. To raise awareness of risk in the theatre department To raise awareness of risk in the theatre department To be communicated that epidural pump and all associated consumables to be present at the place of preparation of the infusion before the bag of infusate is issued. This practice will be audited via the observational audits of the anaesthetic support staff. Investigate the use of reservoir bags with specific non-compatible ISO 18250 connectors

				removed from the drug cupboard/fridge located in the recovery room and the procedure for checking the infusion at the point of connection to the patient. The SOP will form the basis for revised teaching on epidural infusions as part of the department induction and also continuous professional development (CPD) programme for all anaesthetists and Operating Department Practitioners (ODP's). A new international standard for reservoir connectors (ISO 18250) has recently been published but as yet products are not available. Using such non-compatible connectors would make this accident (almost) impossible. When such products (reservoir bags with specific connectors) come to market we should consider	

				moving over exclusively to their use. *NB* The use of the NrFit neuro-axial connector at the connection to the patient would NOT have prevented this error.	

END

Alder Hey Children's NHS
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BOARD OF DIRECTORS

Tuesday 4th February 2020

Paper Title:	**Clinical Quality Assurance Committee Assurance Report**
Date of meeting:	15th January 2020 - Summary 18th December 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 15th January 2020 along with the approved minutes from the 18th December 2019 meeting.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None
Associated risk (s)	Include risk(s) reference, title of risk, and current risk score.

1. Introduction

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

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

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

- Programme Delivery Update
- Inspiring Quality monitoring assurance update
- Children with Medical Complexities
- Sepsis Update
- DETECT Update
- Quarter 3 DIPC Report
- GIRFT Update – Ophthalmology
- Board Assurance Framework
- Corporate Report – Quality Metrics
- ExeConnect – executive visibility programme
- Clinical Claims Report – CQAC ratified policy
- RM7 Claims Management Policy – CQAC ratified policy
- Dissemination and Implementation of National Guidance Policy

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

None.

4. Positive highlights of note

- A positive updated was provided regarding DETECT
- CQAC received a positive Inspiring Quality monitoring assurance update
- CQAC received a positive ExecConnect – executive visibility programme update.

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS
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Joint Clinical Quality Assurance Committee & Clinical Quality Steering Group
Minutes of the last meeting held on Wednesday 18th December 2019
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Shalni Arora	Non Executive Director
	Catrin Barker	Chief Pharmacist
	Adam Bateman	Chief Operating Officer
	Pauline Brown	Director of Nursing
	Denise Boyle	Associate Chief Nurse - Surgical Division
	Lisa Cooper	Divisional Director for Community Division
	Mark Flannagan	Director of Communications and Marketing
	John Grinnell	Director of Finance/Deputy Chief Executive
	Christian Duncan	Divisional Director, Surgical Division
	Rachel Greer	Associate Chief of Operations, Community Division
	Adrian Hughes	Divisional Director, Medicine Division
	Dani Jones	Director of Strategy
	Julie Knowles	Assistant Director for Safeguarding/Clinical Director for Statutory Services
	Nicki Murdock	Medical Director
	Matthew Peak	Director of Research
	Tony Rigby	Deputy Director of Risk & Governance
	Erica Saunders	Director of Corporate Affairs
	Melissa Swindell	Director of HR & OD
	Cathy Umbers	Associate Director of Nursing & Governance
	Kate Warriner	Chief Digital & Information Officer

In attendance:

Agenda item:		
19/20/133	Lachlan Stark	Head of Planning & Performance
	Ellie Johnson	Project Manager
	Lesley Taylor	Outpatient Matron
	Sharon Charlton	Outpatient Service Manager
19/20/138	Andy McColl	Chief Operating Officer, Medicine Division
19/20/140	Roland Partridge	General Surgeon
	Valya Weston	Head of Service/Associate Director
19/20/144	Jenny Williams	Improvement Manager
	Julie Creevy	Executive Assistant (Minutes)

19/20/134 Apologies:

Hilda Gwilliams	Chief Nurse
Anne Hyson	Head of Quality – Corporate Services
Jill Preece	Governance Manager
Sarah Stephenson	Head of Quality – Community Division Division
Cathy Wardell	Associate Chief Nurse – Medicine Division

19/20/135 Declarations of Interest
None declared.

AM welcomed all to the second joint Clinical Quality Assurance Committee & Clinical Quality Steering Group meeting.

19/20/136 Minutes of the previous meeting held on 20th November 2019

Resolved: Committee approved the minutes of the Clinical Quality Assurance Committee meeting held on 20th November 2019.

19/20/137 Matters Arising and Action Log

Action Log

Patient Information Leaflets - PB confirmed that progress had been made in relation to Patient Information Leaflets, with 85% in date leaflets for Medicine Division, 92% for Surgery Division and 100% for Community Division. AM stated that she was delighted to receive positive update.

19.20.74 – Quarter 1 DIPC - NM stated that she is in negotiations/discussion with regards to DIPC, and that the future plan would be to redraft the DIPC report, NM stated that she envisaged a conclusion by February 2020.

19.20.77 - Bleeps Improvement Programme Update

KW updated the committee regarding the improvement programme relating to the use of bleeps throughout the Trust. IT team had undertaken focussed work regarding non emergency bleeps, where a number of bleeps had been connecting to the wrong network. A number of short term, and long term actions are due to be completed by the end of January 2020. Actions included training and monitoring/tracking, with focussed work on the wireless network. Significant investment had been made this year on new technology. IM&T team are considering the longer term plan. NM stated that the IM&T team had been extremely responsive to date, and that the junior doctors felt assured of the current position.

19.20.88 – Best in Outstanding Care - CQAC agreed that this item could be removed from action log, as this item is included on the agenda.

19.20.88 Nutrition Steering Group, committee noted that this item had been actioned and could be removed from the action log.

Quality Improvement Progress Reports

19/20/138 Inspiring Quality monitoring/assurance update

Best in Outpatient care update

LS, EJ, LT and SC presented Best in Outpatient care update, which included an update regarding independent assurance report detailing key outcomes, latest improvements for brilliant booking, improvement update, digital outpatient improvement update, – key issues as follows:-

- Committee noted that the programme ratings were all green.
- Increase of % of visitors likely to recommend OPD – 94% as at November 2019.
- Increase Clinicians satisfaction within OPD (measured every 4 months), - 85% as at November 2019.
- Increase clinic utilisation – 86% as at November 2019.
- Reduce WNB rate – 12% as at October 2019.
- Reduction in DNC list – 503 as at November 2019.
- Full service review had taken place within Phlebotomoy, with introduction of

clinical work stream, new equipment had been provided, relocation into new rooms, result in decrease in incidents, improved staff health and wellbeing.

- Discussion took place regarding digital offer and progress, NM stated that feedback indicated that patients did not want to miss school when attending appointments, NM queried whether it was the teams intention for outpatient appointments to be offered during the evening. Team confirmed that feedback needed to be mapped out with regards to clinician input, in order to agree potential solutions, whilst linking in with schools.
- Discussion took place regarding blood tests, and whether blood tests had to be completed on site, or whether domiciliary visits could be improved. CB stated the importance of access to medicines and clarity for staff on what GP's can and can't prescribe.
- Discussion took place regarding whether thought is required regarding 'virtual ED, and whether support could be offered via telephone consultation.

PB stated that the presentation was extremely welcomed, and the quality/ performance to date was extremely good, and stated that the presentation articulated shared learning for colleagues.

AM asked whether the team required any support from the committee – no further support was required.

AM thanked the team for significant sustained improvements to date.

CQAC received Best in Outpatient Care update and noted the significant improvements made to date regarding Outpatients Brilliant booking, and Digital outpatients.

19/20/139 Delivery of Outstanding Care

Safe

SAFER Update

AB & AM presented the SAFER update - key issues as follows:-

- Cancelled operations – Baseline 17/18: 321 (27 per month)
- Average (2019/20 thus far): 22 per month
- 2018/19 - Cancelled operations – no ward bed 71 2019/20 - 31
- 14% reduction of cancelled operations on the day
- 70% reduction in no available ward bed
- Cancellations remained high due to emergency activity this year, short term actions had taken place, with additional daily trauma lists introduced.
- 'Do you know your planned date of discharge' – Baseline for 17/18: 59.5%, Target: 95% (Trust target), average (2019/20 thus far): 88.2%
- Discharges before 12PM & Discharges after 3PM, Baseline (17/18): 18.3%, Target: 30%, Average (2019/20 thus far): 24%
- Improved position was noted with regards to progress made in relation to complex patient's length of stay.
- Complex patients (length of stay >30 days) – 2017/18: 36,813, 2018/19: 24,781, 2019/20 (M6) 2,847.
- Next steps included focus on Continuity of principles: Ward 3A, and Ward 4A, with full SAFER principles in Ward 1C, followed by Review of EDD data, shift into Business as usual, and followed by project closure in May/June 2020.

JG asked whether any other radical approaches could be adopted with regards to early discharge. A McColl stated that working with Ward 1C would be key to improving the current figures.

AH queried whether there is any potential to incorporate automated EDD – KW agreed to review this.

Action: KW to review automated EDD

KW queried whether additional support is required for Ward 1C staff, in order to provide creative and holistic support to colleagues on Ward 1C.

AH stated that the Trust demonstrated exemplar provision with regards to weekend discharges, and queried what would be the most appropriate forum to share information/report. All agreed that CQAC would be most appropriate forum to receive report. JG stated that this would also be followed up via discussion at Programme Board, with a fundamental shift once the programme ends. All agreed that sufficient time would be appropriate for discussion at Programme Board, with regular report to CQAC thereafter.

Action: Programme Board and CQAC to receive regular update as appropriate.

AM thanked AM & AB for update.

19.20.140 *Update on Progress from Central Lines Review Group*

RP & VW presented the Update on Progress from Central Lines Review Group and detailed issues regarding problems with long lines placed for patients, with majority of issues relating to Community issues – line type, no central point of referral/lack of a database. CQAC noted that good progress had been made. RP stated that S Melville is leading on long lines and process is working well, with further scope for improvement.

- IV passport is in advanced stage of development .
- Central point of referral – RP stated that complex cases are discussed on a Monday afternoon, and cases are captured as appropriate.
- Aim is to market the IVA team on the intranet, to enable resource hub.
- Funding is required in order to grow and enrich the IV team.
- Investment in training in order to upskill IV team.
- Consider expansion of provision to peripheral hospital.
- Invest in equipment.

PB stated that she welcomed the request and approach for outreach provision. MP alluded to the fundamental lack of data.
AB stated that there is a clear need for the Model of Care to be escalated and proposed that this should be shared at Investment Review Group in order to obtain appropriate support to enable progress. LC asked for nursing resource to be included for the Community Division.
LC queried whether the IV passport would be shared with Children & Young People Forum, VW confirmed that she is content to share at C&YP Forum, and that she would liaise with LC once the evaluation had been completed.
AB agreed to follow up request regarding ensuring management support is provided, in order to present to Investment Review Group.

Action: AB to support in order to present to Investment Review Group.

VW to liaise with LC once evaluation is complete.

AM thanked RP & VW for update.

19.20/141 *Incident Management Policy* – CU presented the Incident Management Policy, which had been previously approved by CQSG. The policy had been rewritten to provide further clarity regarding objectives, roles and responsibilities, with particular emphasis on learning. An appendix had been included to provide further clarity. CQAC & CQSG all agreed that the policy was very clear and concise and were in agreement to ratify the policy.

Resolved: Committee ratified Incident Management Policy.

Effective

19.20/142 ***CQSG Key issues Report***

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

- *Bi-annual Transfusion Report* – POC stated that the Bi annual Transfusion Report had been received at CQSG, with most items detailed within the report, on plan for delivery. Issue raised at Transfusion meeting which related to issue regarding Liverpool Women's Hospital – with no acknowledgement received from Liverpool Women's Hospital since 10th June 2019. TS had tried unsuccessfully to engage with colleagues from Liverpool Women's Hospital, in order to improve the level of engagement with LWH, with limited success. NM stated that this needed to be escalated to C Dewhurst, Jo Minford and Jennifer Deeney. POC agreed to liaise/feedback as appropriate.

  Action: POC to feedback to above colleagues in order to expedite improved engagement from LWH.

  AM, on behalf of CQAC thanked CQSG for continued support.

19/20/143 Divisional Reports

Surgery Division Report – DB presented key issues report, key issues as follows:-

- 266 incidents during October 2019, 155 no harm, 64 minor harm, 46 near misses. Themes regarding medication errors, main themes wrong dose and wrong dose prescribed, and documentation errors. Duplication IV & oral paracetamol prescribed. Duplication of drug 10mg and 40 mg noticed before administration. DB stated that the prescribers had been met with and reflections completed. A 10x error had been detected before reaching patient, related to nurse who had programmed pump 10 x less over 4 hours, resulting in less medication received, nurse had reflected on incident, and unit had received a safety alert.
- 1 complaint had been received in October 2019.
- Family & Friends enabling choices – ongoing work is progressing with regards to respect and expected Date of Discharge.
- Ward Accreditation – Division had 2 wards achieving Gold status, with remaining wards at Silver.
- Risks – 7 during October 2019, 4 presently renewed and reported through to Information Governance Committee, risks are shared with Associate Chief Nurses and COO's for each of the Divisions. Associate Chief Nurse for Surgery and COO for Surgery meet with risk owners within surgery

division on a monthly basis.

- Hand hygiene – 94%, CPE screening 89%, - 3 CLABSI cases within 3A, PICU and 1C, with all cases involved in RCA panels, which 2 had no lapses in care, with the remaining case, currently being finalised. PB stated that her understanding was that this case was unavoidable.
- KW referred to roll out of medicine verification and stated that it would be useful to understand how IM&T could support surgical wards. KW would review how best to provide support to wards. CB stated that culture needed to change, with regards to manufacturers and regulators of medicines, ensuring that barcodes are on every bottle, and not just on the box.

Community Division update - LC presented Community Division update, key issues as follows:-

- 131 incidents during October 2019, 47 of these incidents related to a patient who presented a safety risk on Dewi Jones Unit.
- No never events were reported during October 2019.
- Grade 3 pressure ulcer – completed action plan in place, discussed at Information Governance Committee.
- Bid had been presented to Investment Review Group, on track to progress.
- 4 complaints had been received during October 2019, with month on month decrease.
- Ward Accreditation – Outpatients had received Silver status.
- Risks had been reviewed and updated as appropriate, with any new risks having a risk assessment. Quality update is circulated to community staff following Community Governance meeting.
- PB stated that as a result of pressure ulcer reporting, this had resulted in increased reporting for pressure ulcers, which was an increase in reporting, and not an increase in the number of incidents.

Medicine Division Report – AH presented the Medicine Division update, key issues as follows:-

- 153 incidents within the Division, with majority resulting in no harm, with 25 resulting in harm.
- 35 Medication errors, incidents are reviewed on a monthly basis at Medication Safety Group meeting, themes regarding admission/transfer/discharge and sample issues.
- 6 new risks within the Division, 5 risks had been previously closed.
- Specific ongoing work is taking place regarding TPN.
- AH referred to ongoing issue regarding long term sickness of consultant and referred to ongoing issues regarding medical workforce, AH stated that the Consultant is due to return from long term sick leave, and that there had been a positive visit by a junior doctor who had recently visited the Trust from London. AH stated that he is and that he is hopeful for a significant workforce improvement within palliative care.

On behalf of CQSG POC expressed his thanks to Divisions for extensive work that goes into the production of the Divisional reports, which ensured that CQSG receive comprehensive update report.

AM stated that this was also echoed by CQAC, who formally acknowledged continued support received from CQSG members.

Committee received and noted Divisional update reports.

19/20/144 GIRFT Update – JW presented the GIRFT update, which detailed background to GIRFT, GIRFT methodology, unwarranted variations identified, GIRFT at Alder Hey – opportunities, challenges and proposed timetable for CQAC, key issues as follows:-

- GIRFT at Alder Hey, - Ophthalmology, Surgery, ENT, Dentistry and Radiology
- Early 2020 – Dermatology, Plastic Surgery, Burns and Hand surgery.
- Not yet live – Cranial Neurosurgery, Critical Care & CAMHS.
- General emerging themes regarding Access to services, follow up rates, skill mix, workforce, service development, coding, capacity, readmission, pathway, audits, follow up rates.
- Challenges regarding data collection, paediatrics versus adult, Tertiary versus Secondary Acute versus Community, Cohorting of patients, not all relevant to Alder Hey.
- Opportunities to link with review and design pathways of care, opportunities to collect more data, in order to aligning information with GIRFT, in order to receive 360 view. Opportunities to utilise existing data and ensure greater depth of involvement. Retrospective review of clinical areas, completed already in order to maximise opportunity.
- Committee agreed it would be beneficial to receive a desk top review of Ophthalmology at January CQAC 2020 meeting and a deep dive into separate topics thereafter at future meetings. AM questioned what information had been disseminated to teams following GIRFT review.

Action: CQAC to receive desk top review report on Ophthalmology at January 2020 meeting.

CQAC received and noted GIRFT report.

19/20/145 Well Led

Journey to Outstanding – Insight Report

ES presented the Journey to Outstanding Insight report in order to ensure that Committee members are regularly sighted on report, ES requested any comments be shared with E Morgan or K Edwardson.

Committee agreed that they would receive quarterly update regarding Insight report.

Action: CQAC to receive update at March 2020 meeting.

- ES reported that ¾ of the mock inspections had taken place, process had been really helpful for all involved. MP stated that progress is being made with regards to reconnecting research.
- All issues or risks identified had solutions in place.
- Strategy roll out – roll out in Community scheduled for 19th December 2019. Medicine Division - early January, Surgery Division - early January, by the end of December each service would have a service plan for each clinical service.
- Comms on plan.
- Mandatory training – study day is planned on 3rd January 2020, NM & PB had supported study day session on 3rd January 2020.
- The Trust had received a HSJ award together with Hill Dickinson with regards to consent.

  AM thanked ES for comprehensive update.

19/20/146 **Board Assurance Framework**

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

- ES stated that a workshop had previously been held, and team are in the process of undertaking revisions, revised framework would then be circulated electronically to Executive Team. Planning Team session was held on 17th December 2019.

Committee received and noted Board Assurance Framework.

19/20/147 **Drugs & Therapeutics Report** – CB presented the Q2 Drugs & Therapeutics Report - key issues as follows:-

- Current and recently closed medicines management risks were highlighted.
- CQUIN medicines optimisation activity was fully compliant in Q2 against all five triggers. The Cheshire and Merseyside Hospital Chief Pharmacists Medicines Optimisation Group have won a HFMA award related to switching of biosimilar medications.
- The Pharmacy team are refining management of controlled drug waste, and have new registers in place which prompt the recording of CD waste in the correct manner.
- Activity regarding non medical prescribing (NMP) – NMPs are predominantly nursing staff; the Trust now has its first paramedic NMP. CB met with P Brown with regards to the NMP strategy going forward. Discussions reflected the need to establish a NMP oversight committee (to report into Medicines Management and Optimisation Committee (MMOC)).
- TPN errors - a separate group has been established to develop an action plan to address PN errors and assocated risks. A NMP Pharmacist for PN has been appointed; a video on how to set PN up has been produced and the PN policy has been reviewed and updated.
- More recent work around error avoidance has been linked to bar coded verification of medicines. This will be reflected in the Q3 report.
- One of the Medication Safety Officer (MSO) posts in the Trust has been vacant for 5 months. Post now appointed to with candidate to commence 2nd January 2020. A separate business case to expand the MSO team has been prepared.

KW informed the committee's that the Trust had recently received HIMMs accreditation assessment, and that the Trust is the first paediatric Trust in North and nationally to achieve this. KW stated that outcomes and safety measures would be of interest.
CQAC received and noted the Drugs & Therapeutics Report.

19/20/148 Corporate Report – Quality Metrics

PB stated that the Sepsis trajectory highlighted significant inpatient ward compliance, 100% compliance in October 2019.

19/20/149 Clinical Audit Plan Report

LE presented the Clinical Audit Plan Report, - key issues as follows:-
LE confirmed that the Cinical Audit Plan was progressing well.
LE stated that during January 2020 there is a need to review/forward look at local audits plans for the forthcoming 12 months.

- LE advised that the way in which audits are escalated had changed, and are escalated to Clinical Directors/audit leads, with improved support. LE stated that the intention is to have monthly sessions with colleagues, and that she is keen to involve Research Division going forward.

Action: AM & POC to agree future reporting schedule and POC update LE thereafter.

AM supported the need for leads for each of the Divisions in order for colleagues to be focused on priorities for the organisation.

CQAC received & noted the Clinical Audit Plan report.

19/20/150 Safeguarding Annual Report

AM stated that the committee had demonstrated the importance of safeguarding throughout the Trust and welcomed Safeguarding Annual Report.

JK presented the Safeguarding Annual Report, which detailed Summary of Safeguarding Activity, Governance, Incidents, effectiveness, responsiveness, current challenges, vision for service improvement, staff development and key Successes – key issues as follows:-

- Safeguarding Training – 90% compliance achieved throughout 2018/19
- Spot light sessions including FII, Domestic Violence, SUDiC.
- Reviewed Safeguarding Mandatory Training strategy commencing in January 2020 to reflect intercollegiate Guidance and requirement to include Adult Safeguarding Training, Prevent & LAC.
- 86 safeguarding related incidents reported across the Trust over the past 12 month period.
- Responsive – Allegations Management – 14 cases referred under allegations process.
- 2 cases where concerns were fully substantiated.
- Well led – clear leadership structure in place, learning from serious case reviews, and identification of risks.
- Leading the way in staff development – two safeguarding nurses had completed the Forensic and Medical Examinations in Rape and Sexual Assault Course (FMERSER).
- Appointment of Psychologist within SARC.
- Appointment of Physician Associate for Statutory Services.

Current challenges

- Regarding unpredictable nature of Safeguarding with demands on both Operational and strategic level. Nursing team are taking most referrals across the organisation last year 3,500 referrals by end of September, team anticipate around 4,000 referrals, safeguarding team would like to see a decrease in referrals in the future.
- Implementing actions from recent inspections – Professional Curiosity, Managerial Oversight/Supervision – staff awareness of MCA & DoLs
- Impact of Limited FME availability on the SARC service.
- Meeting tight Statutory time scales for CiC medical assessment versus high WNB rate.
- External pressures with no additional resources – i.e. Quality Assurance demands.

Vision for Service improvement

- Strengthen capacity to meet increased service demands.
- To further enhance understanding of the wider safeguarding agenda across the organisaton i.e. Adults, PREVENT, Contextual safeguarding, Professional Curiosity.

- To review the safeguarding supervision framework.
- Work with Innovation team on how artificial intelligence can enhance research within safeguarding.
- Create opportunities to influence statutory services national agenda.
- Ensure safeguarding is integrated within areas of service expansion, specifically resource.
- Work towards centralisation of the LAC service and review of commissioning arrangements.
- Key successes included: successfully safeguarding children, young people and vulnerable adults, achieving significant assurance from commissioners, safeguarding training compliance achieved and being maintained, presenting at national conferences, resilience and innovation – contextual safeguarding; working with partner agencies to reduce violent crime.

Committee received and noted the Safeguarding Annual Report for 2018/19.

AM thanked JK for informative update, and stated that all are extremely proud of the Safeguarding services provided, and that she conveyed her apologies that unfortunately not all Committee members were in attendance to receive update.

CQAC agreed that they would receive a quarterly Safeguarding update to ensure that the CQAC are sighted on initiatives.

AM stated that should a discussion take place regarding safeguarding, that she would be keen to be involved in discussions. LC agreed to include AM in any such discussions.

Review of meeting
Committee reviewed the content of the meeting, and agreed content was Informative.

19/20/151 Any Other Business
Committee noted that it was CD's last meeting, in his role of Divisional Director for Surgery. On behalf of CQAC AM thanked CD for his continued support, dedication and commitment. CD in turn thanked AM for support, CD confirmed that AB had been briefed in preparation of his new role.

AM stated that she would like to meet with Alfie Bass, who commences in post as Divisional Director for Surgery in the New Year.

Action: Meeting to be diarised with AM & AB

18/19/152 Date and Time of Next meeting
Wednesday 15th January 2020, Tony Bell Boardroom, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

4th February 2020

Paper Title:	**Alder Hey People Plan Update**
Report of:	**Human Resources & Organisational Development**
Paper Prepared by:	**Deputy 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

Introduction

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

Our People Plan Pillars

Staff Advice and Liaison Service (SALS)

As part of the development of the Staff Advice & Liaison Service (SALS), a Listening into Action 'Big Conversation' is taking place on 11th February 2020 to understand the needs our workforce and develop a system of support that is right for staff. The system will combine the best of the staff support currently on offer in the organisation with a number of new elements to bring about the consistency and ease of access that would make staff support at Alder Hey outstanding. Further updates will be shared with the Board at future meetings.

Financial Wellbeing

As part of the focus on Health and Wellbeing the HR team are developing the Trust's financial wellbeing offering. We are aware that staff across the Trust have various financial

priorities and that personal finances can be complex. We are endeavouring to provide support to staff to understand the impact of loans and investments and understand the total rewards package on offer including the NHS Pension Scheme. We are proposing a number of initiatives and are working in partnership with our payroll and pension colleagues to provide staff with the support and guidance they need to be financially well. Further updates will be shared at future meetings as the offering develops.

The Strong Foundation Programme continues, and the feedback from participants remains positive; Cohort 6 is now live and additional dates are being planned to meet demand. Work progresses on developing the pathways so that leaders can access conversations regarding their development, which is a core element of the Leadership Strategy.

The leadership team, working with Dr Urmi Das, Clinical Director in Medicine, have piloted a version of the Strong Foundations Programme with a range of doctors in training (ST6 and 7) from across the region. The feedback has been very positive, and there is interest from the GMC about this approach, which we will be discussing with them.

Library & Knowledge Service

Health Education England (HEE) released the new Quality and Improvement Outcomes Framework for NHS funded Library and Knowledge Services in England in 2019, a streamlined framework focused on improved services to support the wider learning needs of all Trust staff. A self-evaluation of our services will be submitted to HEE in June 2020, and further updates will be provided in due course.

In partnership with the research and innovation teams, the Library and Knowledge Service have supported a project to collate all of the research publications published by Alder Hey staff. The data will be shared with each division and utilised for future research projects.

Medical Education

A number of new appointments have been made within the Medical Education team; Dr Gavin Cleary has been appointed as the Director of Medical Education and Dr Clare

Halfhide has been appointed as the Postgraduate Clinical Tutor. We are also in the process of recruiting to the post of Clinical Sub-Dean.

The Annual Assessment Visit report has been received from Health Education England North West and the Medical Education team and colleagues are in the process of preparing an action in response, which must be submitted by the end of March 2020.

In the academic year 2020- 2021 The University of Liverpool we will be increasing the number of students. The ENT team will have 40 students per placement and we will be incorporating psychiatry in the paediatric placement. The team are working with both specialties to ensure that programmes are successful.

The trust has hosted 3 workshops for SAS doctors in partnership with Health Education England North West which have been well attended and received by our medical colleagues. To date the sessions have focused on;

- Assertive communication for Doctors
- Leadership and Management in the NHS for SAS Doctors
- Stress management for SAS Doctors/ Effective Conflict Management for SAS Doctors

Appraisal and Revalidation

As part of the ongoing focus and commitment to the development of medical staff, the Medical Education team have reviewed the appraisal and revalidation process with the aim of improving compliance figures in 2020-21. A two year programme has been developed to transfer the appraisal window to April to September in line with the rest of the organisation.

Apprenticeships

There are currently 86 learners in the Trust registered as apprentices, 11 of which have been employed with us directly as apprentices. The 3rd – 7th February 2020 is National Apprentice Week and we have a range of promotional activities planned both internally and externally to support the **'Look beyond'** campaign. The Apprenticeship team will be hosting information sessions in the atrium for staff and working with the divisions and HR team to identify apprenticeship opportunities as part of our future workforce development

International Nurse Recruitment

On 28th February 2020 the first 25 of our international nurse recruits will be arriving from India. A project group has been established to provide a programme of induction and support for our new nurses when they arrive including pastoral support to obtain bank accounts, national insurance numbers and signposting for accommodation. We have also

developed a programme of mentoring support for our new recruits. All of our new nurses have been provided with a support package that includes first 3 months accommodation, education and training support to complete OSCE qualification and financial support for the first month. The remaining recruits are due to join us in early spring.

Step into Work programme

The Trust has secured funding from Health Education England to support our Step into Work programme. We have committed to offer 30 placements throughout the next 12 months to unemployed people across quarterly cohorts. The programme will be promoted amongst local minority groups to promote equality, diversion and inclusion across the organisation.

Step into Work is a 10 week pre-employment programme, supporting local unemployed people back into work with full pastoral support. At the end of cohort learner are given the opportunity to apply for all internal vacancies and also join our bank. The first cohort of learners commence in post on 17th February 2020.

Summary of formal Employment Relations Activity – December 2019

Following the release of Baroness Dido Harding's guidance and recommendations related to people practices in May 2019, the HR team have identified a number of actions including regular reporting of employee relations activity to board. A full overview is provided quarterly and summary view is provided monthly to provide assurance and oversight.

In December there were a total of 16 cases, with the majority of these within the Division of Surgical Care.

Division	B&H	Investigation	Disciplinary	Grievance	Org. Change	Employment Tribunal	Total
Surgery	3	3	0	1	0	1	8
Medicine	0	0	0	1	0	0	1
Community	0	0	2	0	2	0	4
Corporate	0	2	0	0	1	0	3
Total	**3**	**5**	**2**	**2**	**4**	**1**	**16**

Workforce KPI's – December 2019

- PDR: **89.3%**
- Mandatory Training: **92.1%**
- Sickness: **6.4%** of which;
    - **2.9%** Short term (1.9% in November)
    - **4.5%** Long term (3.7% in November)

Sickness has increased in December. A review of sickness data highlights that there was a 46% increase in absences recorded as cough, colds and flu in December compared to November and a 10% increase in gastrointestinal absences across the Trust. The HR team are working with managers to support the management of sickness across the Trust, and particularly in those hotspot areas.

NHS
Health Education England

North West Office
Postgraduate Medicine and Dentistry
Regatta Place
Brunswick Business Park
Summers Road
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L3 4BL

E: martin.smith@hee.nhs.uk
T: 0151 479 2588

Ms Louise Shepherd
Director of Medical Education
Alder Hey Children's NHS Foundation Trust
By email to: louise.shepherd@alderhey.nhs.uk

13 January 2020

Dear Louise,

Re: Educational Quality Monitoring Review 3 October 2019

On behalf of the panel for the above review, please accept our appreciation for the support of the Trust in carrying out a successful and productive review. We have attached our report which we hope you will find a fair, supportive and helpful summary of the review.

Our reviews are focused solely on areas of risk to education and training, our reports often focus on details of concerns, where we have seen or heard evidence suggesting areas for improvement. While we have reported what we heard on the day, we appreciate that in many cases you will wish to investigate and audit to confirm our conclusions or provide further details. In order to support the Trust in prioritising improvements, our report includes some requirements which we have risk-rated using our Intensive Support Framework (ISF) scores. Intensive Support Framework Guide - June 18.pdf These risk scores reflect the progress made against actions and we will regularly review the scores in the light of evidence from actions you have taken. We will keep your education team updated regularly with any changes to scores - and please do keep us informed through your Associate Dean of any progress made.

We have also included several examples of good educational practice or areas we heard have been improved. We would like the North West to be the best place to train by far, and we are extremely grateful to those individuals and teams who work hard to promote, inspire and improve medical education. We thank all those educators and educational leads who are helping to ensure a future medical workforce fit to deliver excellent healthcare for the patients of tomorrow.

We have provided an action plan template, which we would ask you to complete and return to quality.nw@hee.nhs.uk before 30 March 2020. Please return the completed Word document, as we cannot process PDFs or versions which have been amended.

We would also welcome any feedback you might have about the report or action plan: please send this to quality.nw@hee.nhs.uk

If you have any questions, please do not hesitate to contact us through your Quality Support Manager martin.smith@hee.nhs.uk or your Associate Dean Aruna.Hodgson@hee.nhs.uk

NHS
Health Education England

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Yours sincerely,

Dr Andy Watson
Deputy Dean (Quality)

cc

Dr Adrian Hughes	Co-Medical Director
Dr Christian Duncan	Co-Medical Director
Dr Gavin Cleary	Director of Medical Education
Helen Blackburn	Medical Education & Revalidation Manager
Mr Robin Benstead	GMC
Mr Richard Tubman	GMC
Ms Lyndsey Dodd	GMC
Dr Aruna Hodgson	Associate Dean
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Prof Pramod Luthra	Associate Dean
Dr Tamsin Dunn	Head of School in Emergency Medicine
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Helen Duff	Quality Manager
Martin Smith	Quality Support Manager
Leanne Moore	Quality Coordinator
Jyoti Vithlani	Lay Member Representative

NHS
Health Education England

Quality Outcome Report

Local office name:	**Health Education England – North West**
Organisation:	**Alder Hey Children's Hospital NHS Foundation Trust**
Placements reviewed:	**Postgraduate medical trainees at all grades working in paediatrics, paediatric cardiology, emergency medicine and plastic surgery.**
Date of Review:	**3 October 2019**

Date of report:	**13 January 2020**
Author:	**Martin Smith**
Job title:	**Quality Support Manager**

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Review context

Background

Our monitoring process:	HEE monitors the risks to educational quality within our placements. Where we see significant, increasing or sustained risks we will intervene appropriately, through the requirements included in this report. Our reviews include both exploratory and supportive elements. We look for evidence that the Education Provider has effective quality control mechanisms of its own, by looking for concerns and good practice. HEE's role in this is not to alert the Provider to issues, but to check the Trust's awareness of issues and subsequent actions taken. This report includes requirements to support the Provider in developing its own quality control mechanisms. Further support is available through your Associate Dean and Quality Support Manager.
Reason for review:	See "Background and Introduction" section.
No. of learners met:	24 (paediatrics) + 9 (other specialties)
No. of supervisors / mentors met:	14 (paediatrics) + 9 (other specialties)
Other staff members met:	CEO, MD, DME, GoSW and others.
Duration of review:	9 hours
Intelligence sources seen prior to review:	CQC reports; earlier reviews and action plans; specialty reports; GMC survey results 2013-2019; regional QSG reports; local intelligence from our educators' network.

Panel members

Name	Job title	Role
Dr Andy Watson	Deputy Dean	Review Panel Chair
Dr Roisin Haslett	Deputy Dean	Review Panel
Professor Pramod Luthra	Associate Dean	Review Panel
Dr Aruna Hodgson	Associate Dean	Review Panel
Dr Tamsin Dunn	Head of School	Review Panel
Robin Benstead	GMC	Review Panel
Dr Richard Tubman	GMC	Review Panel
Jyoti Vithlani	Lay Representative	Review Panel Quality Assurance
Martin Smith	Quality Support Manager	Notes
Leanne Moore	Quality Coordinator	Notes

Executive summary

Background and Summary

We select the learners to meet based on risk, from the evidence available to us. In this case, we asked to meet doctors working in paediatrics, for whom we have concerns under GMC enhanced monitoring. The focus of these concerns is around induction and handover, and we can provide some detail in this report on the nature of these concerns, and how they are linked. We also asked to meet trainees and educators working in paediatric cardiology, in plastic surgery and in emergency medicine, as in each case recent GMC Survey results have raised concerns.

Monitoring by risk ensures that our focus is necessarily on areas which may need improvement; we recognise that there were a number of trainees we did **not** need to meet. In these cases, we are assured by the evidence that education is working well. For those we did ask to meet, trainee and educator groups were extremely well attended, and we commend the DME, MEM and all those who had worked hard to organise this review.

The panel were made very welcome by the Chief Executive, Directors of HR, Organisational Development (OD) and Clinical Medicine and DME and Clinical Tutor. The DME presented a comprehensive summary of the issues, history and the vision of education and training, and highlighted the many educational partnerships the Trust had established and maintained.

We heard one immediate safety concern on the day which we have formally raised with the Trust and to which the Trust has robustly and comprehensively responded. We will also refer to some patient safety issues which, although we heard no evidence of an immediate risk to patients, there is a potential for risk which we wanted to bring to the Trust's attention.

GMC enhanced monitoring currently applies to Alder Hey, as monitoring highlighted significant issues surrounding induction and handover. This report provides some detail regarding induction and handover, which we hope will be useful to the Trust in identifying continued improvements in these areas. For both these indicators, paediatrics trainees reported a gradual improvement to processes, but there is still some work to be done to ensure all trainees have a comprehensive induction prior to starting, and that handover is a clearly understood robust process that supports patients and provides learning opportunities for trainees. We have included requirements below to support the continuation of this work. The panel recognises small improvements in both handover and induction, but we have no evidence at this time that improvements will be sustained, so we cannot recommend enhanced monitoring is removed at this time.

Learning environment and culture

This is a Trust with a unique role and with unique challenges. Paediatrics educators described the transition to new premises in 2016 as a big move entailing big changes. It was made clear to the panel that the organisation of work, either through processes or electronic systems, is one of the key concerns for this Trust.

Most of the trainees we met described a supportive, friendly trust: we have included some examples of educators working hard to protect trainees from intensive rotas, but also of strained working relationships. For emergency medicine trainees, we heard that they did not feel entirely part of the

team they worked in. We also heard an example of a trainee who did not feel supported while performing a lumbar puncture on a child.

The Trust described plans to implement an electronic patient record system, and to build robust patient management systems around this. Whilst we heard that this was still in the planning stages, trainees spoke with optimism about their involvement. Our interviews suggest that there is still work to be done to improve handover and induction, and we hope that the systems and processes under development will encourage improved management of information and clearer terminology. We have included examples where systems had not worked as expected and while the response was normally rapid enough to prevent the risk of harm, watertight processes will further minimise the need for further interventions.

Trainees recognised that learning opportunities, such as interesting cases, were available, and often prolific, but access was limited whenever there were gaps in the rota. The panel heard from trainees that teaching was variable in quality across specialties, including paediatrics, but that educators were not aware of this when we discussed it with them.

To provide an example: a concern emerged regarding protocols; paediatrics trainees described some departments (cardiology was given as one example) in which protocols were not available to trainees unless someone with access was willing to print them. In some cases (such as endocrinology) we heard that the protocols were unfamiliar, lacked effective version control and would need to be discussed with a consultant if working on-call or providing cover.

The Trust has also recognised a poor morale amongst trainees since 2016-17, in part attributable to the lack of a space for doctors to rest and recover. We heard of plans to provide a doctor's mess in the hospital treehouse in order to help address this. We heard that there was apathy amongst trainees regarding IT systems; emerging from old computers, inconsistent ways of working in different departments and heard Meditech described as inefficient.

We heard of developments from the Future Models of Care Group – extended consultant presence at evenings; admission thresholds to avoid patients falling between named consultants; a new Acute Care team; new education development posts; an escalation policy in event of unexpected rota gaps.

Two thirds of the emergency medicine trainees we met recommended their placements: the rest cited the work-life balance they experienced as the reason why they could not recommend to other trainees. We heard trainees describe a variable approach to the learning opportunities, but that things worked well when they went to plan. They described a supportive department, but we heard that they never fully felt part of the team.

The plastic surgery and otolaryngology trainees we met expressed satisfaction with their placements and a few minor issues notwithstanding, we are satisfied that these placements meet the required educational standards.

We met paediatric cardiology trainees as part of our review but have limited what we have reported to avoid identifying trainees with the comments we heard. The Deputy Dean for Hospital and Community Care will raise the issue within the school of medicine, and we have included a requirement below as we have concerns regarding the experience of trainees in paediatric cardiology placements, and about the sustainability of the programme.

When asked, in a blind test, to rate their placements out of five, most tier 1 paediatrics trainees gave 3 points. All tier 3 paediatrics trainees gave four out of five for their generalist experience, whilst their view of specialist learning was more variable: 3 gave five points, 4 gave four points and 3 gave three points.

Educational Governance and Leadership

We have reassuring evidence of improving educational governance from our review and have therefore reduced the risk level of our concern from Intensive Support Framework level 3 to 2. This report includes examples of improved local governance and engagement with educational quality, as well as a developing educational governance framework in the organisation.

We were pleased to hear that our 2018 report acted as a catalyst to enable the voice of education to be heard at all levels of the Trust.

We heard from the Trust about collaborative action plans across short, medium and long terms. College tutors from each speciality report to the Medical Education Board, which reports to the Educational Governance Committee, as does the Junior Doctor Forum (chaired by the GoSW) and the Out of Hours (OOH) Committee which responds to rota challenges. The Educational Governance Committee reports through the Workforce Organisational Development Committee to the Trust Board.

We heard from the Trust that attendance data for induction, teaching and mandatory training had been collected and these were included as metrics for the Medical Education Board as educational performance indicators.

When we asked how trainees were encouraged to attend the HEE review, we heard that the message had been sent out through consultants, through email and through the WhatsApp group used for secure internal communications.

Supporting and Empowering Learners

None of the trainees we met raised concerns about trainees or patients not being treated with fairness, dignity and respect on this occasion.

In our Round Table discussion, we heard that the Alder Centre supplies staff counselling and support; support through the Lead Employer; clinical psychologist in the OD development role. The Trust highlighted a strong freedom-to-speak-up ethos and was developing the Staff Advice and Liaison Service to help support this.

Trainees were involved in the Future Models of Care Group and had contributed towards the plans for improving handover and patient management.

We have provided some examples of good support for trainees returning to work following a break; but the examples we cite for flexible working suggest some work remains to be done in this area.

Supporting and Empowering Educators

Several of the developments proposed by the Trust were dependant on an educationally-engaged consultant workforce. When we asked whether this engagement was in place, we heard that it was

beginning to form, as consultants were becoming aware that a well-trained trainee workforce would be beneficial to the Trust – if trainees were able to manage handover themselves, for example. We have, however, set a requirement to complete the review of educator job-planning to further support this engagement.

Educators have a 360-degree appraisal every three years, with education a standard part of the appraisal documentation. We had a consistent response from educators when we asked how their educational appraisal worked.

The Panel note an improving sense of faculty, with many specialty educators meeting to discuss educational matters and an improved awareness that this was happening. The educators we spoke to felt that they were generally well supported, although some were still awaiting the educational job-planning process, and those in paediatric cardiology described limited time for education because of the pressures of the service they provided. We have continued a previous requirement to continue this job-planning work.

Developing and Implementing Curricula and Assessments

Paediatrics trainees working at tier 1 described plentiful learning opportunities, particularly for those working on-call or in community-based roles.

We heard from emergency medicine trainees that they were confident about meeting the requirements of their curriculum from their placements. Paediatrics trainees had opportunity to cover their CBDs but reported observations to be harder to arrange. Paediatrics supervisors had variable enthusiasm for WPBAs: some recognised their value and others felt they were a tick-box exercise. Surgery educators reported work under way to improve educator awareness and delivery of foundation competences within their placements.

Educators in plastic surgery and ENT were aware of the opportunities provided by the number of cases involving cleft palates and maxillofacial work and wanted to do more to ensure trainees could access these opportunities. We heard that educators felt that the recent increase in the number of trainees on the rota was improving access to such opportunities.

We heard that ST2 and ST3 grade trainees in emergency medicine were paired with each other to support their gathering of portfolio evidence. From emergency medicine educators, we heard that trainees' responsibility to gather portfolio evidence promptly was made clear on induction to the department, and that they should seek help from their educational supervisor if they needed it.

Sustaining the workforce

From the Trust's presentation, the panel heard of a multi-professional approach at the bedside, in research and in teaching.

We heard that a Trust representative had travelled to Boston to look at how extended rotas are used, as this was seen as a way to support senior and junior staff. Specialist ANPs were in place in many

areas, and the Trust were looking to further integrate members of the multi-professional team to ensure a more robust future workforce.

From emergency medicine trainees we heard that ANPs were very supportive to trainees as they were able to mix medications and process discharges. We heard that trainees thought that an ANP or another doctor at night would help the rearrangement of shifts to attend teaching or other learning opportunities.

Findings and conclusions

Trust Induction
The panel heard examples of accommodations made to help prepare trainees for work: trainees transferring from other deaneries were given three days to acclimatise before providing cross-cover or ward work. We heard that in respiratory medicine, returning trainees would spend their first day back with the leading consultant. We heard one example of a trainee starting out-of-sync to the rest of the cohort who started the placement on-call. This trainee did not have an induction until the day after their on-call shift.

We heard from tier 3 paediatrics trainees that they received a timetable, 48 hours before induction, and a request to complete a training module before starting – and there was time in the induction to complete the module as well. Trainees welcomed the inclusion of transfusion training and informed the panel that the Meditech induction was helpful.

Plastic surgery trainees described their Trust induction as useful and interesting. Their educators described encouraging trainees to read the handbook provided and contribute to updates as necessary. Paediatric cardiology trainees had a similar view, describing team building sessions and adding that the rota coordinator is a trainee on the programme and so will never start a trainee on a night shift until they are two weeks into the placement. We heard that current trainees will modify their work for this fortnight to give trainees time to get settled and familiar with their surroundings.

Emergency medicine trainees reported all having a Trust induction, which they described as above average: they were introduced to key people and were shown an online handbook which they described as useful.

Departmental Induction
Paediatric cardiology trainees described a departmental induction which included a full walk-around of the unit, a guidebook written by previous trainees, consultant mobile numbers (with permission), protocols stored on the intranet, all supported by helpful nursing staff.

One trainee described a double-induction for both emergency medicine and their departmental specialty, which was flexibly delivered to prevent the trainee working more than their contracted hours.

Culture and Working Relationships
Paediatrics trainees described all staff as supportive and gave examples of staff rallying around when parents or patients showed challenging behaviour. Tier 1 trainees described nursing staff as efficient and supportive and registrars as particularly helpful.

We heard some isolated examples of behaviours which did not encourage good working relationships: one described “getting flak” from consultants when asking to join the theatre list. Another described fraught relationships when the referral pathway for a patient was uncertain.

Emergency medicine trainees were treated with respect, but some did not feel that they were fully part of the team – more just passing through. We also heard that educators would coach trainees on managing

conversations with patients. However, we heard an example from a trainee of consultants openly discussing trainees in the department. In the example provided, we heard that a trainee called in sick, followed by comments by a consultant, audible by other staff, that the trainee was not too sick to post on social media the previous day.

From trainees working in paediatric cardiology, we heard about good working relationships with medical on-call teams guided by senior nurses.

Rota Management
Tier 3 paediatrics trainees reported that additional junior doctors and locums had been scheduled for weekends.

We asked paediatrics educators how trainees would go about influencing the rota for a key educational event. The response was that the names of trainees arriving for the next rotation was often delayed, so the Trust would have to take some steps to ensure the appropriate provision of service. We heard that supervisors worked hard to protect new starters and encourage clinic and teaching attendance. Some paediatrics educators observed that the process for arranging swaps should be formalised and clarified. We heard from educators that trainees may not have fully understood the process for arranging swaps.

Emergency medicine supervisors confirmed that numbers were low, including consultant numbers which we heard counted ten at the time of the visit rather than the sixteen planned for. We heard that, despite a supportive and flexible rota coordinator, sickness could not always be covered.

From supervisors working in plastic surgery, we heard that the number of trauma patients had doubled since 2015, when their rota extended to include Whiston and Chester, but the number of trainees had not changed. They recalled that the Trust had needed to recruit doctors from abroad when one of the ST trainees became unwell. Surgery educators felt that the busy rota prevented them from providing feedback to trainees as often as they would like.

Learning Experiences
From emergency medicine educators, we heard that supervisors were assigned the learning opportunities and resources which they could then distribute to trainees. Educators described identifying trainees who worked well in the department and assigning more challenging tasks like leading the resuscitation team under supervision, managing nerve blocks or reviewing other patients.

Emergency medicine trainees reported plentiful opportunities for learning that workload often prevented them from accessing. The panel heard that these trainees were able to attend clinics and follow their patients through the treatment system using an electronic record. We heard that they were encouraged to ask questions of the follow-up patients they met.

We heard that paediatrics tier 1 trainees appreciate the work of the phlebotomy team in picking up most of the blood work. These trainees also mentioned learning a lot from the specialty trainees in the Trust.

Tier 3 paediatrics trainees perceived the amount of specialty training was low compared to the amount of generalist training. This issue has been raised within the paediatrics School Board.

The Panel heard that in surgery, local teaching is delivered fortnightly and every Friday is designated a teaching day. We heard from surgery educators that there is no inter-professional teaching or opportunity for shared learning.

Plastic surgery educators described a very busy department and had discussed the choices with trainees: inclusion on the theatre timetable plus on-call duties, or inclusion on the clinic timetable plus on-call duties.

Clinical Supervision / Bedside Teaching / Feedback

Tier 1 paediatrics trainees reported being well supervised during their out-of-hours work. De-briefing sessions had been arranged to ensure trainees received supervisor feedback following out-of-hours work.

Paediatrics trainees working in dermatology cited proactive support from their supervisors.

We heard from emergency medicine trainees that they did not feel as well supported at nights as they did during the day.

Tier 1 trainees reported little feedback at this early stage of their placements but expected robust and detailed feedback in their mid-placement meetings. They did, however, highlight the support and feedback they received from registrars and nursing staff.

Emergency medicine trainees reported receiving constructive criticism from their consultants, including on a case-by-case basis. We heard that they would have liked more feedback about their work within the emergency medicine team.

Clinical Governance and Incident Reporting
All the trainees we met described confidence in openly raising concerns and felt that they would be heard and action taken.

Trainees reported a lead consultant available in emergency medicine should concerns emerge.

From emergency medicine trainees we heard that issues arising from critical incidents are regularly discussed in the departmental mortality and morbidity meetings, but that trainees were unable to attend these. The panel were left uncertain about how shared learning would be disseminated. Educators described conversations and huddles if issues emerge within the department; outside the department, information is sent via email.

The panel heard that pharmacists would attend departmental meetings to discuss the shared learning to be made from prescribing errors. In rheumatology, these meetings took place each week.

We heard from consultants in plastic surgery that trainees were encouraged to do a piece of reflective work which could later be discussed with the supervisor.

Local Teaching
In general, paediatrics trainees praised their local teaching. Diabetes and endocrinology teaching was said to be very good by trainees who had attended.

We heard that teaching in cardiology was driven by a particular consultant; the panel did not record this consultant's name but we are grateful for the leadership demonstrated in driving teaching.

From emergency medicine trainees we heard that ad hoc teaching takes place for 10 minutes before handover every day. Trainees also described GP teaching in emergency medicine every week for an hour, which was open to all trainees if available. ST trainees in emergency medicine reported no formal local teaching, exception for some simulation which the trainees found useful.

Simulation
Paediatrics trainees highlighted simulation days in emergency medicine, but these were only available to those working on a certain shift.

We heard from emergency medicine educators that they try to deliver 2 simulation sessions each month, including some for nurses, but that this would be interrupted by any absence on the consultant rota.

The panel heard from educators that there was little on-site simulation available to plastic surgery trainees, and some available for those working in ENT.

Study Leave
Paediatrics trainees reported applying for study leave without any problem. We heard a reported example from some trainees that one trainee was expected to cover the night shift the day before their exam, despite the Trust policy to prioritise time off in such circumstances. Exploring further, the panel heard that several trainees would take the exam at the same time and allowing all trainees to take the preceding day off was perceived as unrealistic. The panel acknowledged the reasons but was concerned that one trainee was at a disadvantage as far as exams were concerned.

Educational Governance
Educators in emergency medicine described meetings to discuss end-of-placement survey findings as well as the GMC survey. The panel heard about action plans being discussed and then implemented. The Panel heard that supervisors working in surgery had been recently made aware of the GMC survey results through the school.

Educators in ENT described weekly meetings to discuss overall trainee progress, which trainees were frequently involved in.

Paediatric cardiology supervisors reported regular meetings to discuss the GMC survey.

Emergency medicine trainees were also unable to provide any information about the representatives or the work of the trainee forum.

Trainees reported having been introduced to the GoSW on induction. The group of emergency medicine trainees agreed that exception reporting appeared to involve a lot of work, and they felt that this put many trainees off logging an exception. None of these trainees reported logging an exception, despite telling us that they rarely felt able to leave on time.

Educational Supervision
We heard from emergency medicine trainees that most were introduced to their educational supervisors in the first week of their placements. All reported having a personal development plan following their initial meeting and the meetings were said to be easy to schedule.

From surgery educators, we heard that they would assess trainee confidence and theatre time to judge the level of supervision to provide.

Equality and Diversity
All trainees we met described being treated fairly, and with dignity and respect.

We heard emergency medicine educators described aiming to be role models for compassion, including examples of demonstrating respect for religious beliefs during end of life care, empathy with the many children and carers facing disabilities and the use of translation services to communicate with patients who did not speak English. In the latter example, we heard that trainees were involved to learn about addressing language differences in a clinical setting. They described a need to improve services for patients with hearing impairments, but that this had been escalated and was being addressed. Plastic surgery educators confirmed that language services were standard practice at the hospital and effectively delivered.

From paediatrics supervisors, we heard an example of a paediatrics trainee with impaired hearing, who was provided with an adapted bleep unit on joining the Trust.

Support for Trainees
We heard from paediatrics supervisors that the Trust had a return to training (RTT) policy, with an RTT champion working to alert supervisors and help orient trainees by assigning daytime on-call work to include direct supervision from a consultant.

Supervisors in paediatrics highlighted ways of checking trainee health and wellbeing, and that handover (if attended) and ward rounds will usually give consultants a good sense of the trainees who might need additional support. We heard that senior nurses or consultants were often asked to monitor and support trainees, without the specific detail of the issue being discussed with them.

Educators in ENT recognised the need for close supervision of trainees, especially when very young patients were involved, and recognised the need to encourage more complex procedures under supervision. We heard examples of issues picked up quickly by educators and shared with the Training Programme Director. Supervisors met each week with an agenda including any trainees needing support, with a larger scale meeting at the end of each placement.

From emergency medicine educators, we heard that trainees could call the medical support team at nights, but we also heard about a trainee left very upset having had to administer a lumbar puncture without the support expected from this team. The consultants we interviewed reported being aware of this concern and had provided support for the trainee following the event and encouraged a report to the GoSW.

Emergency medicine educators demonstrated awareness of trainees who required additional support in their placements. We heard that they looked out for trainees frequently staying after their shift, and those who were demonstrating a lack of engagement or experiencing difficulty with a technical task. We heard that staff nurses on nights had raised concerns about a trainee with educational supervisors, who discussed options with other consultants, then supported the trainee through adaptations to the placement. Educators also heard about information from other Trusts but described this as “on the grapevine” and highlighted the potential value of a formal Trust-to-Trust handover for trainees requiring professional support.

Flexible Working

We heard from a trainee working LTFT that it had been very difficult getting their work schedule organised – a catch 22 required the work schedule to be signed off by the ES before the trainee had met their ES. It took a week before this trainee was able to get their LTFT work schedule signed off.

Most trainees received their work schedules two weeks in advance of starting: one reported a helpful arrangement in which they were not given any on-call work for two weeks to help them acclimatize to the UK. Educators described an arrangement with a LTFT trainee who was unable to work a particular night session.

The Panel heard that LTFT trainees were not always assigned a supervisor as rapidly as their full-time colleagues.

Resources

We heard reports of intermittent wi-fi signal throughout the hospital. In one example, the panel heard of a trainee missing seven bleeps to attend a neonatal patient. In another example, a bleep did not reach a trainee, who reported being initially blamed for not responding. Although this trainee was excused eventually, this concern is not conducive to healthy working relationships. We also heard that bleep problems may have limited educational opportunities as supervisors highlighted the use of non-urgent bleeps to convey information about training or interesting cases.

Trainees mentioned that the paediatrics ePortfolio ideally needs Google Chrome installed, but that this browser is not available within Alder Hey.

Paediatrics trainees raised the issue of car parking: it was generally felt that for those trainees working in the community, car parking at Alder Hey should be free.

Educators in paediatric cardiology reported not having a place to sleep in their department. We heard that a number of rooms had been suggested but none of these had met regulations.

Supporting Educators

Educators in emergency medicine felt supported by the Trust but were concerned for the future of their specialty: they highlighted the eighteen trainees currently in the department of which only two had aspirations to be an emergency medicine consultant.

Educator Selection
We heard that there were only two accredited educational supervisors working in cardiology and one of these was currently on maternity leave, with the other left to supervise all five trainees in the department. Whilst both consultants are now working in the Trust, trainees were uncertain whether they would be each be assigned trainees.

From emergency medicine supervisors, we heard that each consultant is trained as a supervisor within six months of starting. Royal College Educational Supervisor training is provided, and educators are not assigned any trainees until this is completed. We heard that similar arrangements were in place for consultants working in surgery.

Educator Development
We heard that the Royal College of Paediatrics had recently delivered “Effective Educational Supervisors” training at the Trust.

Paediatric cardiology educators described being well supported in attending in-house or external training but felt reluctant to do so because of the impact this would have on the department.

Educator appraisal
Some appraisers were present in the group of paediatrics supervisors we met. From them, we heard that educational appraisal is embedded in the general medical appraisal. If appraisers held concerns, they would raise them with the DME, the panel heard.

All the consultants we met reported having an appraisal annually which included reflection on their work as educators and were appreciative of the support they had from the Trust in this area.

Faculty
From emergency medicine consultants, we heard that consultants would discuss the allocation of trainees at the start of the placement, and carefully allocated those trainees needing additional professional support to the consultant best placed to provide that support. We heard that they would meet each day for 10 minutes before lunch to discuss current trainee needs. Educators were not aware of any forum or meeting with educators from other departments.

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that are worthy of wider dissemination, deliver the very highest standards of education and training or are innovative solutions to previously identified issues worthy of wider consideration.

Learning environment / Prof. group / Dept. / Team	Good practice
Trust-wide	We heard of a process for supporting educators who may be having difficulties with the role.

Patient / learner safety concerns

Any concerns listed will be monitored by the organisation. It is the organisation's responsibility to investigate / resolve.

Were any patient/learner safety concerns raised at this review?	Yes

The safety concerns outlined in red have been shared with the Trust and a detailed action plan has been received.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_01	*Paediatrics*	*Postgraduate trainee*
		Risk Category: 2
The Trust must ensure that the paging system used by trainees is effective in delivering urgent messages to trainees.		
	1. We heard from trainees that there were two forms of pager available, and some trainees carried both whilst others only had one. We heard that the newer version of the pager would not convey pages to the trainees in certain parts of the hospital, and trainees would only discover they had been paged sometime later, often too late to respond. 2. We noted this issue during previous visits and included it in our report. 3. Trainees reported that the crash bleep was now run using the older bleep system to ensure it had reach in all parts of the hospital. 4. Some trainees had an older, reachable bleep whilst others held the newer, less accessible format. We heard that some trainees were told they could not have one of the older bleeps. 5. We heard of an issue with a new-born patient; the trainee missed seven bleeps as they were out of the range of the signal. 6. With two systems at play, trainees were uncertain of the protocol covering paging. 7. This issue affected trainee's relationships with other teams, as they reported sometimes being held to account for bleeps they had not received. 8. We heard from doctors working in surgery that their issues with paging had now been resolved.	

The following non-immediate patient safety risks were identified during the visit which we would ask the Trust to investigate and address as appropriate.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_02	*Paediatrics*	*Postgraduate trainee*
		Risk Category: 1
The Trust must ensure that trainees are not working beyond their competence in writing out repeat prescriptions for patients never met.		
	9. We heard from paediatrics trainees working in neurology and other specialties that they are expected to sign repeat prescriptions, for patients that they had not met, frequently for medication they were not familiar with. 10. More senior trainees were comfortable with this: indeed, it was viewed as an efficiency for patients needing medications, but the tier 1 trainees we spoke to expressed some discomfort at having to do this, as they were processing prescriptions based on consultant letters. When we asked	

	why the repeat prescriptions could not go through a GP, we heard that this went against Trust policy. 11. Consultants in paediatrics highlight weekly script meetings with a pharmacist in rheumatology and had not had any medication errors since these meetings began. We heard from the same group that oncology had a formal process to ensure all prescribing was safe.

Educational requirements

Compulsory requirements are set where HEE have found that GMC / HEE standards are not being met.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_03	*Paediatrics / all trainees*	*Postgraduate trainees*
		Risk Category: 2

The Trust must continue the work being carried out to improve induction, ensuring that

a) All inductions cover key information trainees need to work safely;

b) All inductions provide access to the key systems trainees need to do their jobs;

c) All trainees, including those working nights, receive a full induction before starting.

d) All surgical trainees providing cross-cover for other specialties receive an appropriate induction to the department they are working in.

Summary of findings	12. We heard examples of paediatrics trainees arriving to work at their department without the department being informed of their arrival. We heard a number of examples of accommodation made for trainees starting out-of-hours, but also heard from several of the trainees that they did not have an induction prior to starting. In one case a trainee gave an example of starting nights in emergency medicine without an induction and admitted to getting lost because they were not familiar with the geography of the hospital. 13. Not all trainees knew where to find the incident reporting form used by the Trust. 14. We heard that tier 1 paediatrics trainees did not cover on-call arrangements or handover as part of their inductions. 15. We heard variable reports of departmental induction: a comprehensive handbook was provided in some departments (like cardiology) but most did not supply one. Some paediatrics trainees reported a tour of the department but in some areas, this did not take place. 16. Trainees working in neurology reported still not having been introduced to consultants at the time of this review. In respiratory medicine, we heard trainees were supplied a written document but would have preferred a more interactive introduction which covered where to go and who to see. 17. Trainees in renal medicine reported a handbook, including meeting timetable and an introduction to the consultants, but, as noted elsewhere, added that the addition of guidelines for unusual medicines would have been helpful. 18. We heard examples of paediatrics trainees arriving to work at their department without the department being informed of their arrival. We heard a number of examples of accommodation made for trainees starting out-of-hours, but also heard from several of the trainees that they

did not have an induction prior to starting. In one case a trainee gave an example of starting nights in emergency medicine without an induction and admitted to getting lost because they were not familiar with the geography of the hospital.

19. Not all trainees knew where to find the incident reporting form used by the Trust.
20. We heard that tier 1 paediatrics trainees did not cover on-call arrangements or handover as part of their inductions.
21. We heard variable reports of departmental induction: a comprehensive handbook was provided in some departments (like cardiology) but most did not supply one. Some paediatrics trainees reported a tour of the department but in some areas, this did not take place.
22. Trainees working in neurology reported still not having been introduced to consultants at the time of this review. In respiratory medicine, we heard trainees were supplied a written document but would have preferred a more interactive introduction which covered where to go and who to see.
23. Trainees in renal medicine reported a handbook, including meeting timetable and an introduction to the consultants, but, as noted elsewhere, added that the addition of guidelines for unusual medicines would have been helpful.
24. In emergency medicine trainees reported feeling equipped for work, with an effective departmental rota, an introduction to the support available for trainees, including supervisory arrangements and accessible and user-friendly rotas.
25. Paediatrics trainees working in cardiology and gastroenterology described delays in obtaining the handover lists on starting, two weeks in one case.
26. Paediatrics trainees informed the panel that there are two patient management systems in use, and while all reported getting access to the Meditech system, not everyone was given access to the Badger system used in ICU. We also heard that these trainees did not have access to the Badger training. Whilst trainees were always able to access Badger through someone else's password, this is a potential information governance risk.
27. Paediatrics trainees reported having blood product training as part of their induction, but they were not provided with access to the blood ordering system. We heard one trainee explain that it took them a month to arrange appropriate access. A plastic surgery trainee was not aware of how to order blood and had to ask a foundation trainee.
28. The panel felt some of the terminology used was confusing – "ward handover" for example a better description than "second on".
29. Plastic surgery trainees described the induction as split between IT and clinical work and did not cover key aspects of clinical work: trainees described following up with nurses to find out how some clinical aspects worked.
30. The panel heard from plastic surgery trainees who were uncertain and lacked confidence in the management of emergencies and escalation protocols when providing cross-cover for ENT.
31. The Panel note the Trust policy not to have trainees providing ENT cross-cover but point out that the rota has them providing this cover for other organisations, such as the Royal Liverpool Hospital.
32. Plastic surgery trainees described the job-plans they received six weeks prior to ENT placement as the best the trainees had ever seen.

	33. Emergency medicine trainees reported starting without having the induction to prescribing which others had received, and another reported that the induction team had no record of them and so they did not receive a computer login prior to starting their placements. Other trainees reported having to attend the induction in their own time and had not yet received the hours back in lieu.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_04	*All*	*Postgraduate trainees*
		Risk Category: 1
The Trust must review the storage and content of protocols and guidelines so that all are available to trainees in a consistent and accessible location.		
Summary of findings	34. We heard that each department stored its protocols differently and trainees were not always provided with access to these. Some protocols were stored on the K Drive, others on the intranet and in various different sections. 35. Paediatrics trainees described the K drive as the depository for some protocols, which trainees by default did not have access to. One trainee described pursuing IT for access, a process which was said to take several weeks and required permission at a very high level. 36. Educators were clear that protocols had to be stored safely in order to prevent unauthorised changes, but the panel would point out that read-only access would achieve this and allow trainees to review the protocols they needed. 37. This issue was compounded by the prescribing of unfamiliar medication, which has been mentioned elsewhere. 38. In respiratory medicine, trainees perceived guidelines as critical resources for handover. 39. We heard from trainees who had worked in gastroenterology that there were multiple copies of the guidelines and they were not certain which should be followed. 40. We heard from the paediatrics supervisors that the Trust quality team were working towards a consistent and effective store of protocols. We heard them describe the current issue created by people creating copies and workarounds for various protocols. The Guideline Committee can only process so many guidelines at a time, and people have adapted locally stored guidelines while they are waiting.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_05	*All*	*Postgraduate trainees*
		Risk Category: 1
The Trust must ensure that rotas are responsive to the needs of trainees.		
Summary of findings	41. We heard from tier 1 paediatrics trainees that they had some difficulty in accessing their annual leave: it was explained that there were logistical	

	issues and trainees were meant to arrange their own swaps, but reported that they had not been made aware of this guidance. 42. Another paediatrics trainee, who had arranged to work LTFT, described regularly being assigned work on non-working days, which then had to be rearranged at a considerable cost in terms of time. 43. The panel appreciate the need to balance service delivery with the needs of individuals, both as employees and trainees.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_06	*Emergency Medicine*	*Postgraduate trainees*
		Risk Category: 1
The Trust must ensure that trainees in emergency medicine work in an environment that allows access to the available learning opportunities.		
Summary of findings	44. We heard that half of the departmental teaching programme in emergency medicine had been cancelled because of staff shortages. 45. The same group highlighted the increased likelihood of sick leave for those working with children as part of the reason for staff shortages. 46. We heard trainees describe conditions as relentless when someone calls in sick, and as this is such a frequent occurrence, trainees were too tired to enjoy their days off work, having to recharge their batteries rather than enjoying life outside work. 47. Trainees described a shift pattern of four days working 1300 – 2300, then a block of nights, which they described as leaving them feeling exhausted and more likely to make mistakes.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_07	*Paediatrics*	*Postgraduate trainees*
		Risk Category: 3
The Trust must continue working to improve handover so that the process encourages appropriate patient management and opportunities for learning.		
Summary of findings	48. We heard of complex arrangements around a dual handover (one for general cases/the take and another for tertiary patients) which ideally required separate rooms that were not always available. The "2nd on" handover sometimes overran, impacting on the HDU round scheduled to start 30 minutes later. 49. The panel acknowledge that handover has changed recently: all interviewees reported some improvement, although trainees noted that consultant input remains variable. We heard that consultants were always present at the generalist handover but their attendance at the second, specialist handover was variable. 50. Paediatrics educators described a lot of work during 2019, including detailed audits, and a number of measures intended to improve handover, including an improved structure based around consultant input.	

	51. We heard that the handover process is paper based. Trainees reported the Meditech system incorporated patient information but did not yet include a list of assigned patients. 52. The panel heard from paediatrics trainees that there was no consistent place for handover documentation, although trainees added that this was being addressed. 53. We heard that long-term patients were not covered by the handover, so that trainees starting their placements did not have information about a considerable portion of patients. 54. Paediatrics trainees reported that the 1700 handover is not always well attended and sometimes no-one turns up because there is nothing to discuss. Some felt that this was a wasted learning opportunity. 55. We heard that there was generally a consultant presence at handover, but that learning opportunities were not always exploited and more often than not, business handovers were taking place. 56. Trainees took a considerable time explaining the handover arrangements to the panel. We heard that the processes were developed by previous trainees and the current cohort expressed frustration regarding the process. Some trainees remembered the Trust had a handover team but no-one was able to tell us whether this team still existed. Some thought the process was confusing, with dual arrangements, different practices and methods of recording in different departments and nursing staff uncertain how to escalate concerns. Despite this, we heard that there is a handover book. 57. Handover is related to other patient management systems. One paediatric trainee made a pertinent comment that trainees were always able to find patients they are looking for, but handover did not cover all patients. Trainees did not expect to know about every patient but did expect to know who was sick, which room they were in, which nurse was assigned, and which jobs needed to be done. 58. For those trainees who had worked there, the model of handover used in HDU was described as effective without being onerous. 59. We heard from paediatrics tier 3 trainees that matrons were not present at handover, and this would have been useful.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_08	*Paediatric cardiology*	*Postgraduate trainees*
		Risk Category: 2
The Trust must support improvements to paediatric cardiology placements so that trainees have time to learn and consultants have time to teach.		
Summary of findings	60. Paediatric cardiology educators reported experiencing issues promoting learning in such a busy department. They acknowledged the small rota and the responsibility towards the on-call rota but recognised that this was limiting trainees' experience to working on wards or the on-call rota at night. 61. They described paediatric cardiology trainees who would have to spend all day working hands-on with patients who were becoming disenfranchised with the specialty. 62. We heard that educators were aware of concerns amongst trainees about the introduction of a residential rota and expressed their own concerns that such a rota would require twice as many trainees to run safely and sustainably.	

	63. Educators expressed concerns at the sustainability of the programme, highlighting the risk presented by the number of retirements expected in the consultant body over the next few years. 64. Paediatric cardiology educators referred to increasing numbers of referrals and perceived the medical on-call teams would refer patients on to cardiology without fully examining them. 65. Educators referred to a background of a national shortage of paediatric cardiology trainees. The educators were aware that the paediatric cardiology trainees were all considering leaving their specialty. 66. The educators praised the work of the ANPs and felt that they would benefit if they had more of them. 67. This concern is rated at level 2 to reflect the significance of the GMC Survey results in 2019.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_09	*All*	*Postgraduate trainees*
		Risk Category: 1
The Trust must continue working to ensure that trainees know how to record clinical incidents and receive necessary support and feedback if they do so.		
Summary of findings	68. Trainees in paediatrics described the incident form available on the intranet but added that this was not included in induction and one trainee mentioned having to ask a ward sister where to find the form. 69. We heard one group of educators describe the incident reporting tool as lacking usability. 70. One trainee who had been involved in reporting an incident described support from the ward sister. Others who were named in incident reports that they had not completed mentioned that they would only find out at the last minute that they were involved.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_10	*All*	*Educators*
		Risk Category: 2
The Trust must continue working to ensure that all educators are provided with a job-plan that allows time to supervise trainees and engage them in educational activities.		
Summary of findings	71. We heard that handover was not part of job-planning yet, but paediatrics supervisors informed the panel that this was a work in progress. Some supervisors felt that handover did not need to be included in job plans as it should be considered part of direct clinical care. 72. From emergency medicine supervisors, we heard that each consultant is trained as a supervisor within six months of starting. Royal College Educational Supervisor training is provided and educators are not assigned any trainees until this is completed.	

	73. Paediatric cardiology educators described their job plans as intense and they sometimes found it difficult finding the time they needed for education, despite feeling supported by the Trust and their TPD. 74. We already hold this concern at level 2.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_11	*All*	*Postgraduate trainees*
		Risk Category: 1
The Trust must ensure that enough computers are available for trainees to access, and these are fit for the purpose intended.		
Summary of findings	75. Paediatrics trainees referred to considerable lost time due to faulty computers and printers. 76. Emergency medicine trainees described not having enough computers available and gave an example of three computers failing in their department, in the week prior to our review, yet to be replaced. We heard that there was always someone waiting to get on a working computer once available. 77. Access to the online resources is further compounded by the issues we heard about wi-fi. The panel heard from several groups of trainees that there were areas of the hospital in which the wi-fi signal was less than effective. We heard that the crash bleep was not affected but that the local team bleeps, reliant on the mobile signal, had malfunctioned, and trainees reported that they frequently could not be located. 78. We heard that the signal did not work in the Institute in the Park, where offices, lecture theatres and the library were located. Trainees did not know exactly which areas of the hospital had a strong signal and which areas were affected.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20191003_12	*All*	*Postgraduate trainees*
		Risk Category: 2
The Trust must ensure that trainees are able to access regional teaching, and that attendance is monitored so that educators are aware of the number of trainees able to attend each session.		
Summary of findings	79. Paediatrics tier 1 trainees described their regional teaching programme as much improved recently, although their rota only allows them to attend one regional teaching session every six months. Trainees praised the STEP teaching programme, although this was said to be hard to get to sometimes. 80. Tier 3 paediatrics trainees perceived regional teaching as needing improvements: they referred to a lack of consultant support, and a perceived difficulty for Alder Hey trainees to attend, despite it being based at the hospital. 81. We heard from emergency medicine trainees that it was difficult for them to attend regional teaching, as there were not enough people available on the rota to fill the gap.	

	82. We asked supervisors why trainees were finding it difficult to attend regional teaching, but they seemed unaware of the issue, despite their monitoring of teaching attendance. We heard that there is a rota for teaching, with the day rotating each week so as not to disadvantage those working LTFT.

Acknowledgements

We would like to thank the Trust education, quality and senior leadership teams for their support in organising this review and for their continued engagement with HEE. The rooms were well set out, and all visitors felt welcomed and well catered for. The Trust kept us informed about a potential scheduling clash on the day of the review, and the education team worked hard to ensure representative numbers of trainees were present for the interviews.

Sign off and next steps

Report sign off

Outcome report completed by *(name)*:	Martin Smith
Chair's signature:	Dr Andy Watson
Date signed:	
HEE authorised signature:	Dr Andrew Watson
Date signed:	10 January 2020
Date submitted to organisation:	13 January 2020

Organisation staff to whom report is to be sent

Job title	Name
Chief Executive	Louise Shepherd
Medical Director	Dr Nicki Murdock
Director of Medical Education	Dr Gavin Cleary
Medical Education Manager	Helen Blackburn

Action plan to be completed by the Trust

To be returned to:	Martin.smith@hee.nhs.uk
To be returned to HEE by *(date)*:	30 March 2020

To be completed by *(name)*:	

Appendix 1: HEE Quality Framework Domains & Standards

Domain 1 - Learning environment and culture

1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.
1.2. The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.
1.3. There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), evidence based practice (EBP) and research and innovation (R&I).
1.4. There are opportunities for learners to engage in reflective practice with service users, applying learning from both positive and negative experiences and outcomes.
1.5. The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge services.
1.6. The learning environment maximises inter-professional learning opportunities.

Domain 2 – Educational governance and leadership

2.1 The educational governance arrangements measure performance against the quality standards and actively respond's when standards are not being met.
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.
2.3 The educational leadership promotes team-working and a multi-professional approach to education and training, where appropriate.
2.4 Education and training opportunities are based on principles of equality and diversity.
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

Domain 3 – Supporting and empowering learners

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards and / or learning outcomes.
3.3 Learners feel they are valued members of the healthcare team within which they are placed.
3.4 Learners receive an appropriate and timely induction into the learning environment.
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

Domain 4 – Supporting and empowering educators

4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.
4.2 Educators are familiar with the curricula of the learners they are educating.
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.
4.4 Formally recognised educators are appropriately supported to undertake their roles.
4.5 Educators are supported to undertake formative and summative assessments of learners as required.

Domain 5 – Developing and implementing curricula and assessments

5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

Domain 6 – Developing a sustainable workforce

6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

Appendix 2: HEE Intensive Support Framework

Our monitoring is based around risk, and we use several sources, including the GMC Surveys, CQC and QSG reports and our own monitoring visits, to determine an estimated risk score. We provide a risk score with each requirement and will track and monitor the risk to see whether the actions taken are successful. We will amend the risk scores where we see evidence of changes (both positive and negative) and will always inform you of any changes.

Rating	Threshold
0	No evidence that HEE standards are not met
1	HEE standards not met, but action plan in place and provider consistently working to resolve.
2	HEE standards not met, and sustainable improvements not at pace, despite action plan.
3	Placements well below HEE standards, and sustained improvements not at pace, despite action plan.
4	Placements well below standards; serious risk to trainee or patient safety; escalation has not resolved the concern.

Appendix 3: Abbreviations Used

ACAT	Acute care assessment tool
ACCS	Acute care common stem
AHP	Allied health professional
ALS	Advanced life support
AMU	Acute medical unit
ANLS	Advanced neonatal life support
ANP	Advanced nursing practitioner
AP	Assistant practitioner
APLS	Advanced paediatric life support
ARCP	Annual review of competence and progression
BLS	Basic life support
CAMHS	Child and adolescent mental health services
CCG	Clinical commissioning group

CCT	Certificate of completion of training
CfWI	Centre for workforce intelligence
CI	Clinical incident
CMT	Core medical training / trainee
CPD	Continuing professional development
CQC	Care Quality Commission
CPT	Core psychiatry training / trainee
CST	Core surgical training / trainee
CT	Core trainee
D&E	Diabetes and endocrinology
DGH	District general hospital
DME	Director of medical education
E&D	Equality and diversity

ENT	Ear, nose and throat (otolaryngology)
EOLC	End of life care
EPR	Electronic patient record
ESR	Electronic staff record
EWTD	European working time directive
F1	Foundation year 1
F2	Foundation year 2
FFT	Friends and family test
FOI	Freedom of information
GDC	General Dental Council
GMC	General Medical Council
GoSW	Guardian of safe working
GPhC	General Pharmaceutical Council
GPST	General practice specialist trainee
HCA	Health care assistant
HEE	Health Education England
HEE NW	Health Education England in the Northwest
HEI	Higher education institution
ICAT	Intensive care assessment tool
ICP	Integrated care pathway
ICU	Intensive care unit
IG	Information governance
IT	Information technology
JDAT	Junior doctors advisory team
KPI	Key performance indicator
LAS	Locum appointment for service
LAT	Locum appointment for training
LETB	Local education and training boards
LTFT	Less than full time
LWAB	Local workforce action board
MAU	Medical assessment unit
MD	Medical director
MH	Mental health

NETS	National education and training survey
NHSE	NHS Employers
NHSI	NHS Innovation and Improvement
NICE	National Institute for Health and Care Excellence
NMC	Nursing and midwifery council
O&G	Obstetrics and gynaecology
OOH	Out of hours
OOP	Out of programme
OT	Occupational therapist
PA	Physician associate
PG	Postgraduate
PHE	Public Health England
PICU	Paediatric intensive care unit
QA	Quality assurance
QC	Quality control
QI	Quality improvement
QSG	Quality surveillance group
RC	Royal college
RCA	Root cause analysis
RMN	Registered mental health nurse
RO	Responsible officer
SHO	OBSOLETE: Senior House Officer
SLA	Service level agreement
SPA	Supporting professional activities
ST	Specialist trainee
STP	Sustainability and transformation plan
SUI	Serious untoward incident
T&O	Trauma and orthopaedic
TTA / TTO	To take away / out (medication on discharge)
UG	Undergraduate
WPBA	Workplace-based assessments
WTE	Whole time equivalent

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Wednesday 29th January 2020

Paper Title:	**Research Management Board Committee Assurance Report from the January 2020 meeting**
Date of meeting:	29th January 2020
Report of:	Professor Matthew Peak
Paper Prepared by:	Professor Matthew Peak

Purpose of Paper:	Decision ☐ Assurance ☐ Information ■ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Research Management Board Committee meeting held on 29th January 2020 along with the approved minutes from the 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:	

1. Introduction

The Research Management Board 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/finance/workforce including delivery, governance, clinical risk management, workforce and information governance, research & development; and the regulatory standards of quality and safety with respect to clinical research.

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

Copy of the agenda attached

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

a. Challenges with financial systems resulting in out-of-sequence invoicing for commercial research and activity which impacts on overall financial position for 2019/20
b. Preparation for CRF renewal and resources for increasing capacity in Clinical Research Facility (CRF) to meet demand
c. Lack of clarity regarding integration (or possible duplication) of research processes within Alder Hey and Liverpool Health Partners (SPARK)
d. Potential for demand to exceed available capacity and resource to set up and deliver the research portfolio, including within CRF

4. Positive highlights of note

- Contribution of Associate Directors of Research from each Division
- Structure and content of meeting more focused and aligned to Trust strategic pillars
- Single point of access for research (Alder Hey Research Review Committee) ratified
- Positive feedback from NIHR on CRF annual report
- Excellent performance within Division for mandatory training and staff survey
- Positive initial feedback from Dept of Health and Social Care audit of NIHR research finances
- Exceeding targets for recruitment into clinical research studies
- 50% increase in number of commercial research studies compared to previous quarter

5. Issues for other committees

Liverpool Health Partners – Operations Executive Group (see 3c)
Operational Delivery Board (see 3b & 3d)

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

Research Management Board
Thursday 31st October 2019 1500-1630,
Small Meeting Room, 2nd Floor, Institute in the Park

Present:

Professor Matthew Peak (Chair)	Director of Research
Rebecca Hamilton Cook	Industry Partnership Manager
Louise Bracken	Senior Research Pharmacist
Jason Taylor	CRD Associate Chief of Operations
Jo Blair	Clinical Lead for Research
Calum Semple	Representative of the University of Liverpool Honorary Professors
Christian Hendrich	Clinical Academic (with CRF Thematic Leadership)
Richard Kirk	Research Governance and Quality Lead
Matthew Bickerstaff	NIHR Alder Hey CRF Operational Manager
James Wilcox	Senior Finance Lead
Bernie Carter	Director of Children's Nursing Research Unit
Adam Bateman	Chief Operating Officer
Nicki Murdoch	Medical Director
Sarah Marshall	Senior HR Lead
Barry Pizer	NIHR CRN Speciality Lead for Paediatric and Cancer

Apologies:

Kevin Southern	Senior Clinical Academic
Shivaram Avula	Representative of University of Liverpool Honorary Professors

Agenda Item	Topic	Action
19/20/1	**Welcome and Apologies**	
	MP welcomed all to the first Research Management Board (RMB) meeting and apologies were noted as above.	
19/20/2	**Declarations of Interest**	
	MP advised the agenda set for this meeting has been based on the Trust/Corporate template, and added that feedback on this from attendees would be welcomed.	

19/20/3	**Terms of Reference**	
	The Terms of Reference for the Research Management Board were circulated with the agenda prior to this meeting. MP informed the group that the TOR was approved by the Trust Board. A main focus of RMB items will be research implementation and partnerships. MP advised reporting from RMB may change going forward as governance arrangements for research and innovation are under discussion. NM highlighted that the TOR has a single reference (through membership) to the University of Liverpool and did not refer to the other three Universities resident in the institute (Edge Hill, LJMU and UCLAN). MP highlighted that plans for a Research Partnership Board, to include all four HEIs, had stalled as some HEI senior representatives had expressed preference for a single partnership group which covers research and innovation. MP invited comments on the TOR.	
19/20/4	**Research Strategy and Delivery**	
	JT presented an update to the RMB outlining the Clinical Research Division's (CRD) strategy and objectives and progress in achieving these. Key points included increased stability in CRD through staffing, process and new improvement projects. In addition, activity supporting growth including funding from the charity, new research management and delivery posts and new commercial initiatives were all underway and would be fully described in items later in the agenda.	
19/20/5	**Clinical Research Facility Update**	
	MB, CRF Operational Manager, provided an update. MP advised that this is an important example of a successful partnership, between Alder Hey and the University of Liverpool. NM asked if more additional space is required to conduct Research, MP informed the group that the CRF renewal based on successful partnerships is a more pressing issue at present and is to be presented at Liverpool Health Partners (LHP) Board. Occupancy within the CRF is reported to the NIHR. MP added this may become a challenge moving forward. CS highlighted the use of space in other areas to carry out CRF outreach work. Promoting research knowledge amongst staff- as part of the above discussions the relative lack of staff awareness of research was highlighted, the group discussed how this could be included in annual revalidation, training for new consultants and new research programs.	Progress with CRF renewal planning to be reported at next RMB (MB)
19/20/6	**Research and Innovation Alignment**	
	MP provided an update on high level plans for integrated governance between research and innovation covering areas such as partnerships, communications, risk management, regulatory frameworks and quality assurance.	

19/20/7	**Charity Investment**	
	JB provided an update on the recent investment from Alder Hey Charity. Research PAs (or equivalent) for NHS healthcare professionals will be advertised (HR agreement pending) by the end of the calendar year. A part of the award process will be to ensure that research time can be included in individual or clinical team job plans. In addition, the UoL honorary professors/associate professors have been provided with one PA each, funded by the Alder Hey Charity. Further information on progress to be provided at the next meeting. MP has developed a proposal for peer-review of research applications to the Alder Hey Charity General Purpose Fund. AB offered congratulations to the team on this progress.	Update on selection of research PAs and protected time at next RMB (JB)
19/20/8	**Income Distribution/Financial Position**	
	RHC presented the business case for the Trust to adopt a new process for commercial research income distribution to ensure that all departments participating in research were recognised appropriately through a consistent and transparent means of passing through costs. She outlined the principles of this approach and the rationale for running a pilot of this process with the neuromuscular portfolio. MP raised that whilst this represented a good opportunity for growth there is a significant clinical and financial risk (reflected in the risk register) that this programme is heavily dependent on a single investigator. The group discussed the issues and AB proposed that a plan was taken to November's Operational and Strategic Management Board for review. All attendees agreed with this plan.	Income distribution model to be taken to next Operations Board (JT).
19/20/9	**LHP Spark**	
	JT presented an overview to the group. JT presented the LHP SPARK initiative (a LHP joint research office with 13 partners) and the division of responsibilities between the central SPARK office and the Trust in managing clinical research. JT highlighted that participation in the SPARK initiative requires an increasing level of resource from Alder Hey to carry out the necessary alignment between systems before this would become business as usual. This needs to be balanced with internal investment in research infrastructure for safety, quality and productivity. MP advised this will be monitored going forward and reported to RMB.	Report on SPARK alignment at the next RMB (JT).

19/20/10	**Staff Engagement and Support**	
	JB presented an update on the plan for improving staff engagement and support through enhanced communications (a dedicated website, screensavers, print, events) and the appointment of three Associate Divisional Research Directors to provide leadership for the integration of research within the three other clinical divisions.	
19/20/11	**HR Update**	
	SM provided an update based on the Trust HR metrics. SM added that she has designed a programme of training for the Division's team leaders and managers (with input from JT) from both HR and other departments to strengthen the skills base in this team. This programme will begin in the new year and consist of 10 half days. MP thanks SM for her ongoing support.	
19/20/12	**Performance Update**	
	JT presented an update on the current KPIs used within the Trust and indicated that though these were useful they didn't fully capture the activity within the Division and its impact. Therefore new measures would be developed for future use.	New Performance Measures to be developed for use within AH (JT).
19/20/13	**Governance Update**	
	Presented by RK.	
19/20/14	**Risk Register Update**	
	JT presented- risk register to be regularly reviewed at this meeting.	
19/20/15	**AOB**	
	None noted. MP thanked all attendees for their time and inputs. Feedback from all is welcome.	
	Date, time and venue of the next meeting- Wednesday 29th January 2020 10-11.30am	

Alder Hey Children's NHS
NHS Foundation Trust

Action Log

Ref	Item	Actions	Owner	Due	Status	Update
Meeting held 31.10.2019						
19/20/5	CRF	Progress with CRF renewal planning to be reported at next RMB.	MB	Next meeting	On Track	
19/20/7	Charity Investment	Update on selection of research PAs and protected time at next RMB	JB	Next Meeting	On track	
19/20/8	Income Distribution/Financial Position	Income distribution model to be taken to next Operations Board.	JT	Next meeting	On track	
19/20/9	LHP Spark	Report on SPARK alignment at the next RMB.	JT	Next meeting	On track	
19/20/12	Performance update	New Performance Measures to be developed for use within AH.	JT	Next meeting	On track	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 4 February 2020

Paper Title:	**Board Assurance Framework (January)**
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

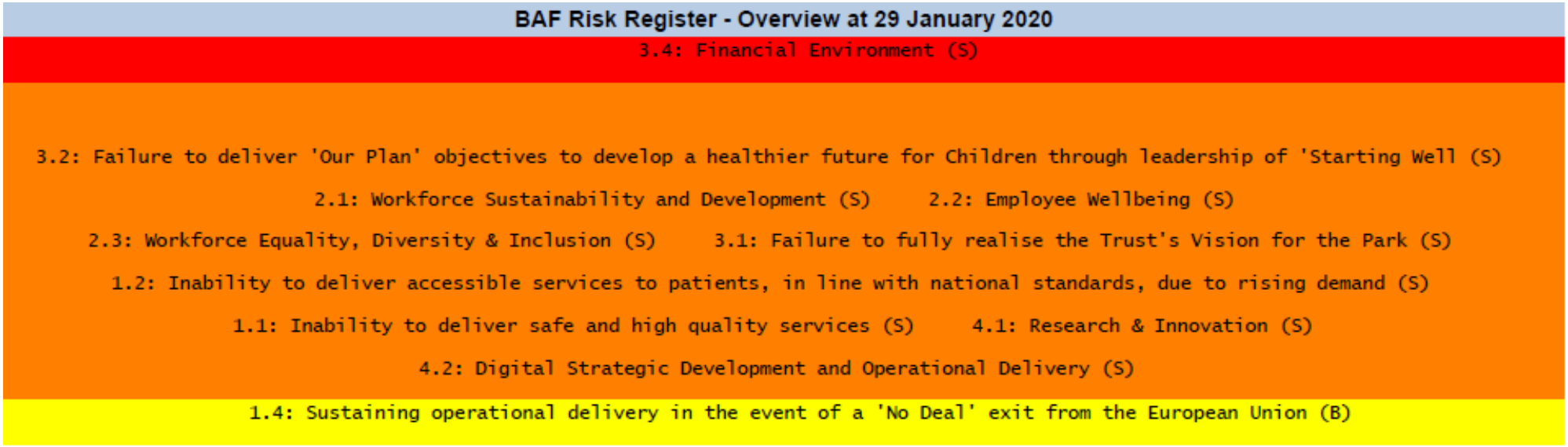
This report is a summary of the current Board Assurance Framework (BAF) for review and discussion. The purpose of the report is to provide the Board with assurance on how strategic risks that threaten the achievement of the trust's strategic plans and long term objectives are being proactively managed,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

2. Review of the BAF

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

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

BAF Risk Register - Overview at 29 January 2020



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

3. Summary of BAF - at 29 January 2020

The diagram below shows that the majority of risks remained static in-month with the exception of risk 1.4 Sustaining operational delivery in the event of a 'No Deal' exit from the European Union.

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
		Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care					
1.1 HG	**Inability to deliver safe and high quality services**	3-3	2-2	STATIC	STATIC
1.2 AB	**Inability to deliver accessible services to patients, in line with national standards, due to rising demand**	3-3	3-2	STATIC	STATIC
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**	3-2	3-1	STATIC	**IMPROVED**
STRATEGIC PILLAR: The Best People Doing Their Best Work					
2.1 MS	**Workforce Sustainability and Development**	4-3	4-2	**INCREASED**	STATIC
2.2 MS	**Employee Wellbeing**	3-4	3-3	**INCREASED**	STATIC
2.3 MS	**Workforce Equality, Diversity & Inclusion**	3-4	3-2	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	**Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships**	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 & Innovation**	3-3	3-2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Operational Delivery**	4-3	4-2	**IMPROVED**	STATIC

8. Changes since 7 January 2020 Board meeting

External risks

- ***Risk of failure to deliver 'Our Plan' objectives to develop a healthier future for Children through leadership of 'Starting Well' and Women and Children's system partnerships (DJ)***
  Risk reviewed. No change to score in month. Updates to key actions and progress included.

- ***Workforce Equality, Diversity & Inclusion (MS)***
  Risk Reviewed, actions reviewed and timescales revised.

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***
  11 month transition period underway within which plans will be developed and finalised in readiness for full exit on 31st Dec 2020.

Internal risks:

- ***Inability to deliver accessible services to patients, in line with national standards, due to rising demand (AB)***
  Risk reviewed - no change to score in-month. All actions remain on track.

- ***Inability to deliver safe and high quality services (HG)***
  Risk reviewed - no change to score in-month. All actions remain on track.

- ***Financial Environment (JG)***
  Month 9 performance shows an improvement against plan and a corresponding reduction n gap to control of £1.9m. Divisions are focussing on further measures to reduce the gap and a particular focus is on improving corporate services position. Focus is also on agreeing year end commissioner contracts.

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

- ***Digital Strategic Development and Operational Delivery (KW)***
  BAF reviewed. Good progress in relation to risk areas. Plans in place for 2020 delivery.

- ***Workforce Sustainability and Development (MS)***
  Risk reviewed and actions updated. All actions on track.

- ***Employee Wellbeing (MS)***
  Risk reviewed, all actions on track.

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

Erica Saunders
Director of Corporate Affairs
4 February 2020

Appendix A. Links between BAF and high scored risks – as at 29 January 2020

BAF Risk	Strategic Aim	Related Corporate Risk
1.1 Inability to deliver safe and high quality services	Delivery of **outstanding care**	(1921) Delay in patient care if a bleep call fails (1984) Delays in children being able access Cardiac treatment (delayed stepdown from critical care meaning that this capacity is not available for other patients). (1270) Delays in diagnosis of ADHD and ASD (NICE CG128) – Sefton (1131) Potential for incorrect treatment and management for patients in the Community and Mental Health Division
1.2 Achievement of national and local mandatory & compliance standards		(1524) Young people over 16 years age are unable to access adult specific ADHD services which includes prescribing and review of medication.
1.4 Sustainable operational delivery in the event of a 'No Deal' exit from EU		None
2.1 Workforce Sustainability & Capability	**The best people** doing their best work	(1984) Delays in children being able access Cardiac treatment (delayed stepdown from critical care meaning that this capacity is not available for other patients). (1270) Delays in diagnosis of ADHD and ASD (NICE CG128) - Sefton
2.2 Staff Engagement		None
2.3 Workforce Equality, Diversity & Inclusion		None
3.1 Failure to fully realise the Trust's vision for the Park	Sustainability through **external partnerships**	None
3.2 Service sustainability, growth and the Trust's role in a sustainable local health economy		None
3.4 Financial Environment		None
4.1 Research, Education & Innovation	Game-changing **research and innovation**	None
4.2 Digital Strategic Development and Operational Delivery		None

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

BAF 1.1	Strategic Objective: Delivery Of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led		Link to Corporate risk/s: 1921, 1984, 1270, 1270, 1921, 1270, 1270, 1921, 1921, 1921, 1921, 1131		
Exec Lead: Hilda Gwilliams	Type: Internal, Known	Current IxL: 3x3	Target IxL: 2x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. International recruitment in line with UK Guidance	29/02/2020	Confirmation received that the expected 25 new staff members have completed necessary checks and will be joining the trust w/c 17 February 2020. Surgical ward managers and matrons have collectively reviewed all JDs and aligned staff to most appropriate areas. The trust has received information from spec. com. in relation to increased neonatal workforce financial envelope (COO in discussion to identify early recruitment numbers).

Alignment of workforce plans across the system	30/06/2020	Discussions taking place to address demand surges and associated pressures
3. Confirm EHU graduate numbers qualifying in April 2020 and allocate to medical areas.	16/03/2020	Discussions underway with Medical Division ward managers focussed on the next intake of EHU graduates (April 2020)

Executive Leads Assessment
January 2020 - Hilda Gwilliams Risk revised following Board Workshop in line with 'Our Plan' to 2024. Confirmation of international recruitment completed and additional highly skilled nursing recruits joining the Trust in February 2020.
November 2019 - Hilda Gwilliams Risk reviewed, no change to score in-month. Additional mitigations in place until international workforce commence in January 2020.
October 2019 - Philip O'Connor Risk Reviewed, no change to score in-month. Actions updated to reflect KLOE delivery groups established and meeting bi-weekly.

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. 5 year workforce plan, model of care and investment case for the urgent and emergency care	30/11/2020	Draft business case submitted to Executive Directors and to be finalised by 30/1/2020. Additional resilience required for Winter 2020-21 Letter sent to CCG highlighting the need for investment in paediatric urgent care system
2. Increase in capacity and new pathways of care in community paediatrics for ASD & ADHD diagnostics	30/06/2020	Alternative service provision models e.g. pathways within ASD/ADHD assessment processes Use of external provision (third party provider) to support diagnosis of ASD. Recruitment commenced for Speech & Language, Neuro developmental Practitioner and Clinical Psychology

4.Completion of detailed actions for specialties with a Challenged Action Board	31/12/2020	Challenge Action Boards reviewed at Operational Delivery Board and Executive Directors Meeting to monitor and support progress
3. Additional workforce capacity in Specialist Mental Health Services and new pathways	30/06/2020	Recruitment commenced for additional practitioners in Specialist Mental Health Services New CBT group treatment session designed
Strategic and tactical command now established to support ED	31/03/2020	

Executive Leads Assessment

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

November 2019 - Erica Saunders
Risk score increased to reflect pressures from extremely high emergency attendances and a number of theatre cancellations on the day of planned surgery.

October 2019 - Erica Saunders
Risk reviewed. No change to score in-month and all actions remain on track for delivery of mandatory targets. ED remains a fragile area due to an increase in attendances of 11% during September 2019 reducing performance to 88.9%. An action plan for resilience and staff well-being is in place with results expected mid-November 2019.

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: 3x2	Target IxL: 3x1	Trend: IMPROVED

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

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

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

Executive Leads Assessment
January 2020 - Lachlan Stark 11 month transition period underway within which plans will be developed and finalised in readiness for full exit on the 31st Dec 2020.
December 2019 - John Grinnell Risk reviewed in line with 31 January 2020 scheduled exit. Business to remain 'as is' given 12 month transition period. Business continuity plans to remain in place ready for resurrection if required.
November 2019 - Lachlan Stark Risk review undertaken today. NHSE Webinars paused pending outcome of election. maintained risk levels due to lack of clarity despite extensive work locally and nationally regarding supply chain. Current exit scheduled to 31 Jan 2020.

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 and Development		
Related CQC Themes: Safe, Effective, Responsive, Well Led		Link to Corporate risk/s: 1270, 1984, 1270, 1984, 1270, 1270, 1270		
Exec Lead: Melissa Swindell	Type: Internal, Known	Current IxL: 4x3	Target IxL: 4x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Continue with regular reporting of data target hotspot areas and staff groups review methodology of accessing training	31/03/2020	good work progresses - over 90% mandatory training across the trust with some hotspot areas still in development.
2. Action plan developed in conjunction with NHSI to support the reduction of sickness absence across the organisation. This includes the introduction of a pilot wellbeing team to support the management of sickness absence. Target is 4% absence rates across the organisation.	31/03/2020	Wellbeing Team Leader appointed, recruitment to the full team in January 2020
3. Development of a methodology to roll-out across the organisation. Plan for a workforce summit in June/July 2019	31/03/2020	progress delayed. Under review for a roll out for business planning for 2020/21
4. Succession planning to be completed for the Executive Team. To be rolled out to the Divisional senior management teams in January 2020	31/03/2020	In progress

Executive Leads Assessment

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

November 2019 - Sharon Owen Risk reviewed actions remain on track, risk rating remains the same.
October 2019 - Melissa Swindell Risk reviewed, actions updated.
September 2019 - Melissa Swindell Risk reviewed, all actions remain on track, risk score remains the same

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
1. Develop a proposal to implement a SALS service	31/03/2020	Proposal in development
2. Appoint to the wellbeing team	31/03/2020	Team Leader appointed; team to be appointed Jan 2020
3. Detailed action plan in response to 2018 HEE visit. Use of £60k welfare monies to re-purpose a new JD mess. JD Forum refreshed	29/02/2020	JD mess agreed, will be fully in place February 2020

Executive Leads Assessment

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

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

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

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: 3x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
2. Work with the BME and Disability Networks to develop specific action plans to improve experience.	31/03/2020	time to change plan implemented oct 19
1. Work with Community Engagement expert to develop actions to work with local community	31/03/2020	scoping expertise from C&M NHS resources

Executive Leads Assessment

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

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

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

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Agree detailed plan for Phase 1 Park works	24/01/2020	Consultation process in train
2. Agree Park management approach with LCC	29/02/2020	Outline process agreed with LCC
1. Complete cost assessment and scheme rationalisation	09/03/2020	Cluster schemes prepared for market test
3. Agree plan for bringing forward Park clearance	10/02/2020	Plan agreed at November Board
Create single line of accountability into Development Team	10/02/2020	

Executive Leads Assessment

February 2020 - David Powell
Review in advance of February Board

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

November 2019 - David Powell
Review in advance of December Board

Board Assurance Framework 2019-20

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

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

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
1. Strengthening the paediatric workforce	31/03/2020	6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'. In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements.
2. Develop Sefton and Knowsley plans for C&YP - align with One Liverpool where possible/appropriate	30/04/2020	Progressing with both areas;Alder Hey membership of the new Sefton Paediatrics Partnership Board and the Knowsley programme of Children & Young people's improvement sponsored by Knowsley Council and Knowsley CCG
3.Collaboration with LCCG and system leaders to develop 28/02/2019 next stage of One Liverpool; develop the programme of work for C&YP / Starting Well - Children's transformation partnership to take a leadership role	30/04/2020	Alder Hey leading the "Starting Well" theme for One Liverpool on behalf of the Liverpool system and agreed through the January 20 Provider Alliance.
4.Continue to develop joint partnership hosting arrangements for existing and pending ODNs with RMCH	30/04/2020	Work progressing to design joint arrangements in partnership; agenda item for North West Paediatric Partnership Board in March 2020

5. Develop Business Model to support centralisation agenda and Starting Well	01/06/2020	
6. Develop Operational and Business Model to support International and Private Patients	01/06/2020	

Executive Leads Assessment
January 2020 - Dani Jones Refresh of risk title, descriptor and actions following Our Plan and subsequent risk review with Trust Board. Risk score reviewed and no change in month.
November 2019 - Dani Jones Risk reviewed - no change to score in month. Additional evidence attached to controls and new actions added.
October 2019 - Dani Jones Risk reviewed: score remains as per previous month. Evidence attached to controls.

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. Affordability of Capital Plans
3. Cost of Winter escalating
4. Long Term Plan shows £3m shortfall

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
3. Five Year capital plan	31/03/2020	Board agreed revised 5 year programme which recognises potential shortfalls in years 3-5 and initial mitigation. Programme to be further assessed as we finalise our LTP.
1. Tracking actions from Sustainability Delivery Group	31/03/2020	Recovery work overseen by the Group has shown significant progress with forecast gap to control reducing to £1.9m with further improvement workstreams planned for Q4.
2. Develop fully worked up CIP programme - £1.5m gap	31/03/2020	Latest recovery programme has improved CIP trajectories with objective in Q4 to bridge any identified gaps.
4. Cost of Winter	28/02/2020	Revised winter impact has been completed which reduces investment levels to c.£1m which has been incorporated into revised forecast. Discussions ongoing across the system regarding potential funding.
5.Long Term Financial Plan	28/02/2020	Constructive conversations and workplan underway with NHSI pricing Team with regards to a long term solution to tariff pressures we face. Meeting in February with NHSI and the pricing team to explore whether any transitional support may be available.

Executive Leads Assessment

January 2020 - John Grinnell
Divisional forecast demonstrating £2.5m shortfall against plan despite CIP projections. Winter pressures are offsetting some improvements which is becoming the biggest risk to our delivery. Contract position is showing a nett underperformance so risk profile lower. Actions in Q4 include recovery action plans and a stretch target for each Divisional area. Focus is now turning to bridging our gap in our 20/21 plan. Key elements will be our escalation of the impact of tariff on our ability to meet plan and also us focussing on key transformational schemes that will drive efficiencies. Capital plan remains a concern given reduced funding available and control of the capital budget lines which are showing pressure.

November 2019 - John Grinnell
Latest forecast is a £2.4m deficit from control total. Corporate and Divisional recovery schemes being focussed on. Increased risk relating to winter

pressures and financial performance that have yet to be fully scoped.
October 2019 - John Grinnell Risk reviewed - no change to score in-month. Half yearly forecast still showing £2.8m gap. Some progress being made on recovery actions to bridge however, further step-up required. Further assessment to be undertaken at M7.
September 2019 - John Grinnell Sustainability recovery group continues to meet weekly with an action focus on closing £3.4m gap. Significant progress being made through the targeted recovery plan
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.

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 & Innovation		
Related CQC Themes: Responsive, Well Led		Link to Corporate risk/s: No Risks Linked		
Exec Lead: Claire Liddy	Type: Internal, Known	Current IxL: 3x3	Target IxL: 3x2	Trend: STATIC

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

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

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

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

Executive Leads Assessment
January 2020 - Claire Liddy Updated and reviewed as risk static
November 2019 - Claire Liddy Updated and reviewed. Risk static
October 2019 - Claire Liddy Updated and reviewed

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: 4x2	Target IxL: 3x2	Trend: STATIC

Risk Description

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

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

Gaps in Controls / Assurance

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

Actions required to reduce risk to target rating	Timescale	Latest Progress on Actions
Implementation of cyber actions including managed service and cyber accreditation	31/03/2020	Cyber action plan in place, cyber lead in post, plans for cyber essentials for March 2020
Integration with divisions, clinical leadership strengthened, clarity and ownership of plans	31/03/2020	Divisional CCIOs in post, Divisional IT leads in place, clear strategy and priorities through digital futures
Testing and commissioning of secondary data centre	28/02/2020	Discussions and plans progressing well with Dell and CCC, dependent on CCC handover in Feb.

Executive Leads Assessment

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

December 2019 - Kate Warriner
BAF risk reviewed, score reduced due to significant progress against plans made in 2019. Strategic risks in relation to cyber security and delivery of transformation at scale and pace remain.

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th February 2019

Paper Title:	**Integrated Governance Committee**
Date of meeting:	22nd January 2020 – meeting summary 29th November 2019 – Approved Minutes
Report of:	Kerry Byrne, Committee Chair
Paper Prepared by:	Cathy Umbers, Associate Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Integrated Governance Committee meeting held on 22nd January 2020, along with the approved minutes from the 29th November 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 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 overseeing the design and effective operation of risk management systems and processes across the Trust, including the management of the Corporate Risk Register (CRR) and Board Assurance Framework (BAF).

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

- The Corporate Risk Register
- The Board Assurance Framework
- The Divisions Risk registers
- The Corporate Functions risk registers
- The Change Programme risk register

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

There are currently **5 high risks** on the corporate risk register

- **Risk reference 1131 (16) : "Potential for incorrect treatment and management for patients in the Community and Mental Health Division"**

✓ Scanning progress reports received weekly for CAMHS.
✓ Regular item on the Weekly Management Meetings.
✓ Trust wide task and finish group with Divisional representation.
✓ Agreed process for archiving notes, space and SOP for retrieval

- **Risk reference 1270 (16): Delays in diagnosis of ADHD and ASD (NICE CG128) – Sefton**.

✓ Waiting times reviewed as a regular item on the Weekly Management meetings.
✓ All vacancies are filled for ASD team for Liverpool pathway.
✓ Monthly reports structure agreed with Clinical Commissioning Group (CCG) for on-going monitoring.
✓ Data available via Alder Hey patient administration system (Meditech).
✓ Meditech monitoring for Liverpool pathway available to support control of waiting times.
✓ Additional non recurring investment awarded by Liverpool CCG to help reduce waiting times.

- Additional non recurrent funding provided by Sefton CCG to enable additional staffing resource to support introduction of named pharmacist working within the ADHD. team to assist in monitoring and overview of prescribing. Assessing children as part of medication reviews to ensure optimum prescribing practice and reducing the risk of preventable reviews which can add further pressures on the service.

- **Risk reference 1524 (16): Young people over 16 years age are unable to access adult specific ADHD services which includes prescribing and review of medication.**

✓ Commissioning leads identified with each of the serving Clinical Commissioning Groups (CCG).
✓ Quarterly project progress reports to divisional board meeting (Liverpool).
✓ Trust Transition Policy in place (C62 - Transition to Adult Services).
✓ ADHD medication care pathway in place.

- ✓ Formal contract withdrawal notice on the care provision to adults receiving ADHD specific medications and care ceasing from 1 April 2019.
- ✓ CCG have made arrangements of adult service provision by Merseycare.
- ✓ Formally agreed process for transitioning adults with ADHD to CWP (adult facility). Liverpool cohort project team in place.
- ✓ Joint CWP/ Alder Hey Transition SOP in place.

- **Risk reference 1984 (15): Delays in children being able access Cardiac treatment, and delayed step downs from critical care meaning that this capacity is not available for other patients.–**

- ✓ 1C (cardiology) patient flow group review capacity issues and identify any children who can be safety nursed in other areas of the trust.
  Daily review on the ward round all the children who need a bed on the cardiac unit and make informed decisions of priority.
- ✓ Daily huddle to review bed availability and prioritise any emergency cases.
- ✓ Weekly list planning meeting - to look ahead to the next week and anticipate any issues and manage case mix of cases as appropriate.

- **Risk reference 1921 (15): Response to emergency bleep testing is sub-optimal in some areas**

- ✓ Bleeps are tested at 10:00 hours daily, for response from bleep holders.
- ✓ SOP in place, which states that if, no response escalation to manager to assure bleep holder available.
- ✓ Quarterly reports re compliance to Resus Committee from Facilities.
  Walkie-talkie systems available for staff should the emergency bleep system go down.
- ✓ Other means of contacting required clinicians, including non-emergency bleeps, mobile phone and Wi-Fi calling (Avaya system).
- ✓ Update on recent board to board with PFI partners and agreed next steps.

4. Positive highlights of note

- Good feedback from teams on progress with managing risks across the Trust.
- Twenty-six high risks reduced since 1st November 2019.

5. Issues for other committees

None noted

6. Recommendations

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

END

NHS
Alder Hey Children's
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE
29th November 2019
Time: 12:00-14:00
Venue: Institute in the Park, Tony Bell Boardroom

Present:

Mrs K Byrne	Non-Executive Director **(Chair)**	(KB)
Mr A Bateman	Chief of Operations	(AB)
Mrs E Saunders	Director of Corporate Affairs	(ES)
Mrs M Swindell	Director of HR & OD	(MS)
Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Mrs P Brown	Director of Nursing	(PB)
Mr A Williams	Director of Community	(AW)
Mr A Hughes	Director of Medicine	(AH)
Mr J Grinnell	Director of Finance	(JG)
Mrs N Murdock	Medical Director	(NM)
Mrs E Hughes	Assoc. Chief Innovation Officer	(EH)

In Attendance Other:

Mrs J Keward	Infection Control Nurse	(JK)
Mr D Haughton	Project Manager Development Directorate	(DH)
Ms Lesley Calder	Minute Taker	(LC)

In Attendance:

Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mrs C Fox	Programme Director for Digital	(CF)
Mrs S Brown	Senior Project Manager	(SB)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mr J Taylor	General Manager – Innovation	(JT)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Mrs J Fitzpatrick	Information Governance Manager	(JF)
Mr S Atkinson	Interim Associate Director of Estates	(SA)
Mr P Sanderson	Head of Pharmacy	(PS)
Mrs S Stephenson	Head of Quality for Community	(SS)

Apologies:

Mrs C Liddy	Deputy Director of Finance	(CL)
Mrs L Cooper	Divisional Director of Community	(LC)
Mr D Powell	Director of Development Directorate	(DP)
Mrs S Brown	Senior Project Manager	(SB)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mr M Flannagan	Director of Communications	(MF)
Mrs R Greer	Assoc. Chief of Op (Community)	(RG)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mrs J Preece	Governance Manager	(JP)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mrs V Weston	Assoc. Dir. of Infection Prevention	(VW)
Mrs C Barker	Chief Pharmacist	(CB)
Mrs S Brown	Senior Project Manager	(SB)
Ms L Fearnehough	Head of Technical Services	(LF)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
	2.	**Chair's introduction**	The Chair asked for CU to update the Risk Management Report Template to include an "actions update" section to cover any outstanding actions in a division / service. KB will then deal separately with any actions that don't fall easily into any of the reports. The Chair advised the committee that the (CQC) Care Quality Commission will be visiting the Trust in early 2020. The Chair updated the Committee on a detailed review of the CRR that the Executive Team is currently undertaking. CU has meetings scheduled with each of the Execs over the next few weeks following which there may be updates required to the risks that make up the CRR. The aim of the review is to ensure that the risks are scored consistently and in line with the agreed scoring mechanism. The Chair also highlighted that there has been some slippage in the completion of risk reviews, including action updates and action plans. The Chair requested that all attendees ensure that the risks for their area are fully brought up to date by 31 December 2019 and that they email CU to confirm that this has been done. The Chair advised that, in future, we will be focussing on seeking assurance that all areas are proactively identifying risks and recording them on their risk registers and that some of the larger areas - such as the divisions - where there are many risks owners need to think about their processes to ensure this happens	Risk Management Report Template update to include an actions update section Risks on risk register ensure as up to date as possible and email CU to confirm completion.	CU All	22nd Jan 20 31 Dec 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			effectively. Finally, new cover sheets for each report have been introduced for this meeting. For the next meeting can you please ensure that only the relevant strategic objectives for your division/corporate function are ticked.	New cover sheet tick which strategic objective relevant to division/corp function	All	22nd Jan 20
19/20/79	**2.1**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 11th Sept 2019. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	The Committee reviewed each of the outstanding actions and updates have been included in the Actions Log at the end of the minutes.			
19/20/80	**2.4**	**Corporate Risk Register Review report**	Cathy Umbers (CU) presented the CRR (High Risks). **Summary** This report is taken from the Ulysses Risk Register module reported information, on 20th November 2019, and is inclusive of all high risks on the register from 1st Sept to 31st Oct 2019. There are currently **28 high risks** on the register. **Risks overdue review** Risk no 1169 risk rating 20 – "Fragile medical workforce within haematology service" **Risk no 1251 risk rating 16** – "Lack of Consultant cover for palliative care" **Risk no 1306 risk rating 16** – "Junior doctor shortages in Division of surgery" **Risk no 1866 risk rating 16** – "May cause patient harm due to unnecessary variability in care, due to out of date guidelines being			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			consulted or failure to access guidance" **Risk no 1909 risk rating 15** – "Information for parents, children and young people may not be clinically updated and reviewed and therefore providing incorrect information" **<u>Actions overdue completion</u>** **Risk no 1388 risk rating 16** – Overdue action reference 7872, 7322 **Risk no 1668 risk rating 15** – Overdue actions reference 8355 **Risk no 964 risk rating 15** – Initial risk rating same as current with 7 controls identified. **Risk no 1169 risk rating 20** - initial risk rating same as current **Risk no 654 risk rating** - increased from 12 to 16 **Risk no 799 risk rating 16** - initial risk rating same as current **Risk no 1921 risk rating 15** – overdue action **Risk no 1919 risk rating 15** - initial risk rating same as current **Risk no 1588 risk rating 15** - initial risk rating same as current **Risk no 1961 risk rating 15** - No gaps identified. **Risk no1984 risk rating 15** - initial risk rating same as current. No gaps identified. **Risk no 2016 risk rating 20** - initial risk rating same as current. Overdue action 8884. **<u>New high risks identified = 4</u>** **Risk 2016** Current risk rating 20 (IV Therapy and Vascular Access) – Unsustainable vascular access service across the Trust – Current risk rating 20. **Risk 1965** Current risk rating 15 (Surgical Division) – Risk of patients lost to follow-up following discharge (Ward 1C)			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk 1984 Current risk rating 15 (Surgical Division) - Delays in children being able to access cardiac treatment, and delayed stepdown from critical care meaning that this capacity is not available for other patients (Ward 1C) **Risk 2003** Current risk rating 15 (Strategic Estates Development) - Risk to completion of demolition project **Risks reduced/closed** There were no high risks closed during this reporting period **Risks increased** **Risk 1904** – Ability to fill nursing rotas effectively on Ward 4A – Increased from 12 to 16. **Risk reduced** 1 high risk reduced during this period (risk reference 1866) (reduced from a 16 to 15). CU advised the Executive team have reviewed all high risks and will be actively working with the risk managers to ensure the risks are appropriately scored, in line with controls, gaps and associated actions. Risk owners and managers are expected to ensure actions are SMART in line with guidance and that they will address the gaps to support risk mitigation, in addition to including progress updates with actions, each time the risks are reviewed. CU further advised if any committee members need additional support this can be arranged add hoc, in addition to the planned monthly validation meetings. **Resolved** that: the Committee NOTED the contents of the paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			(high risks are discussed in detail in the individual division / service risk reports).			
19/20/81	**2.5**	**Board Assurance Framework (BAF)**	Erica Saunders (ES) presented the Board Assurance Framework. ES advised that the Board would be holding a workshop ahead of the December meeting next week to discuss and agree revised BAF risks to reflect the refreshed strategic plan. . **Resolved** that: the Committee NOTED the contents of the paper			
19/20/82		**BAF Deep Dive Report**	Dani Jones (DJ) presented the BAF 3.2 risk. Risk 3.2 Service sustainability, growth & Trust's role in a sustainable local health economy. DJ advised there is risk of failure to deliver BAU and maximise growth opportunities due to NHS financial environment and constraints on internal infrastructure. There is risk of failure to develop external opportunities for partnership and to proactively establish the Trust's role in development of a sustainable local health economy and also a risk of failing to play our part in reducing unwarranted variation in Children & Young People's services across Liverpool and beyond. DJ advised that failing to mitigate this risk would be severe. 'Our Plan' to 2024 will be delivered through a clear strategic plan for the Trust; 'One Liverpool' is a system plan with a focus on Starting Well. Through the Divisional Performance Management Framework we can ensure processes in the Trust are effective and accreditations through National Review process of e.g. quality surveillance team.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Ensure compliance with standards will be met in areas such as All-age, CHD and Neonatal. Compare gap and risk analysis against national service specifications and ensure partnership arrangements with key partners including RMCH memorandum of understanding (MOU). DJ advised the Trust measures how we are making an impact through Board and Divisional reporting, system alignment of plans (One Liverpool and Our Plan went to Trust Board Oct 19), business cases such as the Neonatal Business Case having been approved, formalised MOU's in place with key partners (e.g. RMCH), and assurance and progress against (QST) Quality Surveillance Team and (SDIPs) Service Development Improvement Plans. DJ advised of a range of actions to achieve the target risk, including - the Trust needs to strengthen the paediatric workforce i.e. 7 day service assessments & follow on actions; ensure joint partnership and hosting arrangements for Operational Delivery Networks across the Mersey footprint; develop a programme plan for 'One Liverpool' and 'Starting Well' theme; develop Sefton & Knowsley plans for Children and young people and align with One Liverpool. This external risk compares with others in the health economy. DJ commissioned an independent anonymous review of this risk by MIAA across their client base in September 2019. The theme of the risk is virtually the same within every other Trust and our themes and controls are comparable with other trusts. Our risk rating is comparable in terms of scores, typically ranging from 10 to 20 – impact tends to be 4 or 5 of the Matrix, with reduction of scores being dependent on reduction of likelihood. The Trust current risk rating is 12 and target risk rating is 8; this independent assessment			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			gives a lot of reassurance that we have correctly identified the risk and are logging it in the right way. The Chair thanked DJ for the detailed presentation of this risk.			
	3.	**Risk Register Management Reviews**				
Item no	**Item**	**Key Point Discussions**		**Action**	**Owner**	**Time Scale**
19/20/83	**3.0**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. • Total number of risks = 58 • Number of new risks identified since the last reporting period = 7 (1964, 1965, 1981, 1984, 1986, 1989, 1994) • Number of risks closed and removed from the risk register = 8 (1193, 1425, 1474, 1597, 1747, 1789, 1853, 1873) • Number of risks with an overdue review date = 13 • Number of risks with no agreed action plan = 10 • Number of risks with changed risk scores = 3 (1 increased, 2 decreased) • Number of high/extreme risks escalated to the Executive Team = 7 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = The risk profile is broadly similar to previous reporting period, with majority of risks falling within the Moderate Risk category. The number of High Risks has increased from 4 to 6, with two risks having a			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		higher risk score and escalated into this category. **<u>High risks with a score of 15+</u>** **Risk no 1715 risk rating (25)**: **Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease**. (Increased risk score from 10 to 25) **Risk no 1306 risk rating (16)**: **Concerns around junior doctor shortages in surgery.** AM advised that there are plans to look at the rotas to see where gaps are. AM advised this risk in the medium term is still high. Development of a long term strategy for the division which the Medical Director is involved in. AM advised we had a successful recruitment of trainees whom will start in post in Feb 20. **Risk no 1904 risk rating (16)**: **Availability of trained nurses on Ward 4A.** (Increased risk score from 12 to 16). We don't have sufficient numbers of qualified nurses on ward 4C. There are 6 nurses on long term sickness and maternity leave and we are looking at actions to mitigate this risk. To cover some of the gaps we are taking staff from other areas however due to the fragile workforce we are struggling all round. PB advised there is a new intake of nurses starting soon so risk will be reduced to 12. **Risk no 964 risk rating (15)**: **The process for planning and scheduling of elective lists is not robust enough to prevent errors occurring.** AM advised that due to the Digital Team progress has been made. A pilot started on 21st Aug 19 and with IT support to roll this out it takes away the risk of manual error. The pilot will be for 6-8 weeks and once the pilot is finished we can work on taking this forward and roll it out to the Trust.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1588 risk rating (15): **Inadequate Ventilation system on Critical care Manusa cubicle.** Critical care doesn't have a fully isolated cubicle. The solution is for Estates and Building Services to resolve however we are assisting GD to progress this as fast as possible. AM advised if we had an infectious patient in PICU the patient would be put in a cubicle and the rest of patients would be moved. AB advised the Trust has a long term plan but unsure how long will it take to complete as this risk needs to be mitigated. To be discussed further at executive meeting. CU asked "has risk no 1881 Gain access by tailgating or using door release button under reception desk (ICU) been completed?". AM advised two members of staff have now been recruited so there are 2x staff per day weekdays and 1x staff covering over the weekend. GD advised the whole waiting area is being updated and a new reception desk is being installed over Christmas period. AM to provide an update at the next meeting. KB advised that going forward Risk Owners will need to include in their RM reports when a risk is expected to be reduced based on completion of actions identified to mitigate. KB to ask for this to be included in forthcoming reports. **Risk no 1965 risk rating (15)**: **Risk of patients lost to follow up following discharge (specifically on Ward 1C).** Actions in place to mitigate. **<u>Risks scores increased</u>** **Risk no 1904 increased from 12 to 16 (see above)**	Risk 1881 provide an update at next IGC meeting Include when a risk will reduce in RM reports.	AM CU	22nd Jan 19 22nd Jan 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			New risks **Risk no 1965 risk rating 15:** Risk of patients lost to follow up following discharge (specifically on Ward1C). (see above) **Risk no 1984 risk rating 15:** Delays in children being able access Cardiac treatment, and delayed step downs from critical care meaning that this capacity is not available for other patients. **Risk no 1964 risk rating 12:** Images stored outside the patient record are not available to staff for patient care, or to health records for access requests. Clinical images are also at risk of being lost if not correctly filed on an approved Trust system. **Risk no 1981 risk rating 6:** Public perception of cleanliness of hospital environment, risk of insects within patient wounds/ invasive devices (Ward 3A)**.** **Risk no 1986 risk rating 6:** Risk of security to medications (eye drops) in Ophthalmology department. **Risk no 1989 risk rating 6:** Identification of different management of patients transferred from other providers than we would provide here in Audiology. **Risk no 1994 risk rating 15:** Unable to contact the cardiology consultant on call particularly in emergency situation AM advised the Surgery Division have fallen slightly behind on the review of the overdue risks for October 19; actions are either overdue or out of date. We do have assurance that risks are being			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			identified. AM advised that Risk Managers are coming to meetings on 9th & 11th December 2019 to thoroughly discuss their risks. AM advised that the Surgery Division risk register is in a good position however on-going work to complete. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/84	**3.1**	**Medicine Division**	Adrian Hughes (AH) presented the risk management report for Medicine. • Total number of risks = 98 • Number of new risks identified since the last reporting period = 18 (1967, 1968, 1969, 1970, 1972, 1974, 1975, 1976, 1977, 1979, 1980, 1990, 1998, 1999, 2000, 2001, 2002, 2004) • Number of risks closed and removed from the risk register = 7 (1602, 1822, 1891, 1960, 1969, 1977, 907) • Number of risks with an overdue review date = 51 • Number of risks with no agreed action plan = 8 (1990, 1970, 1972, 2028, 941, 599, 1998, 1302) • Number of risks with changed risk scores = 17 (6 increased, 11 decreased) • Number of high/extreme risks escalated to the Executive Team = 3 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **High risks** **Risk no 884 risk rating 16 "Failure of RO Plant supporting**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Haemodialysis" Current controls: Internal workarounds and testing of water quality by clinical team, weekly checks from IFM and meetings with Interserve and Renal Team to provide assurance regarding delivery of operational plan. CW advised there are good controls in place and the division are working with the execs and the unit to mitigate. Patients who are not able to have dialysis we have been able to defer to Manchester and controls are in place however this is a serious Trust risk due to patient involvement. GD Building Services advised there are 2 new units being installed. Work starts on 2nd Dec 2019 and will be finished in Jan 2020. **Risk no 1169 risk rating 20 "Fragile Medical Workforce within the Haematology Service".** Current controls: 2 x Advanced Nurse Practitioner (ANPs) in place to support ANP gaps. Recruitment of 2 Locum Consultants. Actions being taken: ANP training programme in place - 2 staff on the course and job planning for Haematology. This is an issue with recruitment of Haematology Consultants and there has been unexpected sick leave of consultants in the service which will continue until Jan 2020. However, there is a consultant who is going to relocate to Liverpool to take up a post within the service. Even with a team of 4 consultants there is still a risk. The service is managing but risk is not necessarily mitigated however there is sustainability from Haematology service in Manchester. Risk discussed in detail. AH agreed to review risk and revise the wording. JG advised this risk title needs rewording as it does not state what the risk actually is. **Risk no 1787 Risk rating 15 "Error in the prescribing, preparation, administration and monitoring of Parental Nutrition (PN)"** Controls include the PN Policy, Alaris GP pumps have had	Risk no 1169 reword title of the risk to reflect the issue of recruitment	AH	22nd Jan 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			profiles added to help prevent mix up of rates, template prescriptions contain information to guide prescribers in the prescribing of PN. Actions being taken include: Non-medical prescribers (dieticians and pharmacists) to be appointed to support prescribing and the development of a Trust Nutrition Team, different coloured light protective bags to be introduced for PN within the Trust, prescribing of PN through the Meditech system will be pursued. Risk reviewed and actions updated following meeting 14/06/19. No change in risk score yet). However likely to be reduced with mitigations in place. **New risks** Risk no 1980 **(risk score 16) General Paediatrics - Ability to fill rotas of Junior doctors (middle grades) cover between the hours of 09:00 and 16:00, (due to shortage of middle grade doctors).** AH advised there are not enough middle grade junior doctors coming on rotation via Mersey Deanery. A business case has been put together and we will recruit via recruitment agencies. Once the post has been advertised should be filled in 3-6 months. Risk no 1967 **(risk score 8) Diabetes - Loss of Diabetes training room** - will stop the team being able to start insulin pump therapy for children with type 1 diabetes. Potentially leading to unstable diabetes and associated long term complications. Risk no 1968 **(risk score 12)** Diabetes - The training room is used for commencing children and young people on insulin pump therapy (requiring several attendances in a short period of time). **Loss of this facility will result in the cessation of new pump starts.**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1972 (risk score12) Diabetes – Unable to attend international state of the art conferences and seminars due to lack of funding, that could potentially impact on patient care **Risk no 1974 (risk score 12) Diabetes** - Patient safety is at risk due to poor? mobile phone reception within the hospital and also at nurses homes whilst on call. **Risk no 1975 (risk score 12)** Diabetes - Incorrect dose advice being advised to patients resulting in harm. **Risk no 1976 (risk score – not noted)** Diabetes - Exhaustion and stress (due to increase in on call commitments). **Risk no 1999 (risk score 12)** Allergy Service - There is an 18week+ wait within the Allergy Service for new patients. **Risk no 2000 (risk score 12)** Dietetics - Limited staffing to provide service for Dietetics within cardiology **Risk no 2001 (risk score 12)** Diabetes - Inability to provide staff training to ward staff, this may lead to patients on the ward receiving inadequate care and risking their health **Risk no 1969 (risk score 10)** Cancer – Principal Investigator (PI) retired April 2019. Sponsor will close study if no PI for Myechild Study. Unable to recruit if AML patient presents as contract and substantial amendment partially signed. Gemtuzimab Ozogamicin only available as part of trial so patient will not receive as standard care and would have to go to another Principle Treatment Centre to enrol on trial.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1970 (risk score12) EEG - The current service heavily relies on the existing band 7 clinical physiologist to support this large increasing workload. The services have to stop when this physiologist is on annual leave or cancelled at short notice when off sick. Also, when theatre (SDR or other monitoring procedures) or Norcess (both Commissioned) work occurs, we have to cancel other procedures which are routinely carried out in the dept. This delays treatment all round and often causes our activity to breach. **Risk no 1977 (risk score 10)** Pharmacy - Requirement to store intra-thecal medications in an alternative cold store with other products – this is outside Trust policy. **Risk no 1979 (risk score 12)** Palliative Care - Due to the age of the pumps there is a risk of fluid ingress. If this happens it cannot be predicted how the pump will function. **Risk no 1990 (risk score 12)** Oncology - Named consultants are not always aware of admission, hence blood results and interventions are not flagged to them. **Risk no 1998 (risk score 12)** Therapy Services - The current and planned workload for physiotherapy staff delivering assessment and rehabilitation of SDR patients is beyond sustainable capacity and likely to result in stress and absence of staff. **Risk 2002 (risk score 9)** Pharmacy - Delay to invoice processing for homecare medicines and inability to expand the homecare medicines portfolio			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 2004 (risk score 9) Oncology - An incorrect SA surface area could be calculated potentially resulting in a lower dose of chemotherapy being prescribed. If this is not noticed by the prescriber and oncology pharmacist at verification then a lower dose of chemotherapy would be administered. **Closed risks** (1602,1822,1891,1960,1969,1977,907) **Risks overdue review** AH advised that there are 51 risks overdue review which is a significant increase for this reporting period. There have been some staffing challenges which are being addressed and it is expected the position will improve before the next reporting period. KB advised divisions to assure themselves that all risks are on the register and support staff in this regard. **Risks with a changed risk score** AH advised that there are 17 risks with a changed risk score and that the division are in the process of looking at the risks. AH advised that there is still a lot of work to complete in the Medicine Division, however is confident the Division is showing assurance of effective management of risk. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/85	**3.2**	**Community Division**	Andrew Williams (AW) presented the risk management report for			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Community. • Total number of risks = 43 • Number of new risks identified since the last reporting period = 5 (1988, 1987, 1963, 1995, 1997) • Number of risks closed and removed from the risk register = 9 (1466, 1570, 1691, 1713, 1757, 1767, 1804, 1886, 898) • Number of risks with an overdue review date = 3 • Number of risks with no agreed action plan = 4 • Number of risks with changed risk scores = 2 (decreased 1922, 714) • Number of high/extreme risks escalated to the Executive Team = 3 (1524, 902, 1270) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **New risks** **Risk no 1988 risk rating 12 – Risk to service delivery of phlebotomy service and stress on other nursing staff with phlebotomy skills as a result of multiple staff with recommended adjustments in place.** Support being provided by HR partner to ensure sickness policy is followed. Action for HR to liaise with Team Prevent (Occupational Health) regarding frequency of adjustments to phlebotomy duties. AW advised there are staffing issues which is creating challenges to cover the service. **Risk no 1987 risk rating 12 – Risk of being unable to progress with electronic solution for requesting of blood tests from local GP's.** Local clinical guideline for Phlebotomy in place, additional			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			label printer in place. Further actions to be agreed. **Risk no 1963 risk rating 8 - Risk that the Trust will not be able to offer a Specialist Respiratory Physiotherapy Service Liverpool in the community.** Controls include writing to families of patients in North Sefton regarding where to go for support in the absence of a therapist. Recruited Respiratory Physiotherapist in Liverpool is prioritising patients to be seen. Meeting to be held at Divisional Level to agree next steps **Risk no 1995 risk rating 12 - Vulnerable children at risk of harm due to sexualised and aggressive nature of behaviours.** (Dewi Jones Unit). Controls include 3:1 staffing for the patient and use of Mental Health Act to enable utilisation of restrictive practices when required. Action to continue negotiations with NHSE regarding future arrangements for this patient. AW advised this period has been challenging for the service and there is a sense that patients get delayed being moved to other services. Dewi Jones is supporting staff as best as they can. **Risk no 1997 risk rating 12 - Appointments for children requiring a forensic assessment may be delayed or children may be required to travel out of area to have a timely appointment.** (Rainbow Centre). AW advised that the forensic appointments are out of the area and it's not ideal sending patient out of the area for appointments. **High Risks** **Risk no 1524 risk rating 16 - Risk of staff practising outside sphere of competency due to reduced capacity to transition patients (ADHD) to adult services.** To meet with transition leads			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			to discuss this risk and consider how the Transition Policy should be inclusive of a process when adult services are not in a position to either accept referrals as no service exists, or where an adult service exists and significant waits are evident. CU asked "is there any additional support that can be provided to these paediatricians?". AW advised that a long term solution would be a different level of Consultants in Adult Services with expertise in ADHD. AB advised the difficulty is the long waits for adult services and the oversight of delivery of the service for young adults. Risk title to be reviewed as discussions indicate that the risk is not that which is stated. **Risk no 1270 risk rating 16 - Waiting time for ASD and ADHD assessment.** A detailed service specific action plan has been developed to assist the division in its oversight of actions completed, actions on-going and newly identified actions to assist in mitigating the risk. Commence a prescription audit measuring against ADHD recommended medication regimes **Risk no 902 risk rating 16 - Inadequate connectivity in community sites and outreach venues for clinicians to view patient records electronically.** Paper notes still provided to clinicians working in community to enable them to see patients safely without access to the main system. Roll out of mobile devices for staff in CAMHS and Community Paediatrics to enable access to systems in a mobile environment. AW advised there is a lot of work being completed and the new IT system is working very well. Once the 365 software comes in connectivity will improve. There are a number of complexities e.g. desktops/laptops/mobile phones. Majority of deployment has been issued but we do have some troubleshooting. This should all be rolled out by IT end of December 2019.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risks 1524 and 1270 relate to Neurodevelopmental and ADHD. The risks relate to appropriate staff on transition to adult services. The adult service is inadequate and the Trust is looking to the CCG who provide this service. For a long term plan the division is looking at having patients 0-25 years old, not aged 18 which it currently is. Risk 1270 AW advised there has been problems with monitoring this pathway which is ongoing and no agencies are involved. **Action 18/19/124 – Risk no 1131 risk rating 12 – process for scanning and archiving clinical notes within Community**. AB advised it's the timeliness of scanning that is the issue and the division is working with the Trust wide Task & Finish group. There is a scanning specialist working internally and they will meet with the Community Division to look at bringing this risk down. The division doesn't have a lot of scanning just the backlog and this will be remedied. KB advised from a committee perspective you are providing assurances and it sounds like there is good understanding of the risks within the team. "Is the trust being funded for 16+ patients?" AW advised the services is not funded for the Neurodevelopmental patients they should be placed elsewhere but as previously mentioned there are long waits for adult services. AW advised the committee that the Division are confident they are effectively managing the risks for Community, however additional scrutiny of all risks with particular focus on high risks will be undertaken.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
19/20/86	**3.3**	**Research Division**	Jason Taylor (JT) presented the risk management report for the Research Division. • Total number of risks =13 • Number of new risks identified since the last reporting period = 9 • Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 3 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **New risks** **Risk no 2005 risk score 4 - Failure to conduct a scheduled research patient visit**. Staff shortages can increase likelihood of a scheduled research visit not being conducted. **Risk no 2007 risk score 3 - Unauthorised access to research departments**. Clinical research space is at risk of access to unauthorised visitors. **Risk no 2008 risk score 3 - Staff performing research related activity without being named on the research delegation log**. Staff participating in research need to be listed in the delegation log to demonstrate they are adequately skilled to perform delegated tasks.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 2009 risk score 8 - Insufficient resources available to support the delivery of research portfolio. Commitments are made to participate in research studies without full assessment of strategic and operational fit. **Risk no 2010 risk score 8 - Staffing funded by Clinical Research Network (CRN) don't match requirements of research portfolio**. Funding allocation from the Clinical Research Network (CRN) has had insufficient oversight. **Risk no 2011 risk score 9 - Confidential patient identifiable information and/or sensitive clinical trial data in paper form accessed by unauthorised personnel.** Access to Clinical Research Division in the Institute in the Park is not restricted to authorised personnel. JT advised that there is an action plan in place and all paper records are kept securely in one of research rooms with huge glass barriers. **Risk no 2012 risk score 6 - Unauthorised individuals access confidential patient information and/or clinical trials data.** Electronic confidential patient identifiable information and/or sensitive clinical trial data can be accessed by unauthorised personnel. **Risk no 2013 risk score 8 - Externally employed research staff communicating with and/or accessing the data of Alder Hey patients for the purposes of research without Trust assurance of relevant Human Resource checks being in place**. Externally employed research staff could communicate with or access the data of Alder Hey patients without confirmation of the relevant Human Resource checks being in place.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 2014 risk score 9 - An external monitor could access the Electronic Health Record of a patient that is not enrolled on a research study. User access to our electronic health records cannot be restricted to individual clinical research participants. JT advised there is a lot more on-going work within the division around risks. Managers and staff are engaged in risk management training to support the service. There are good systems and action plans in place for this reporting period. KB advised that clinical research have done a great job reviewing their risks and all their staff are engaged. JT advised clinical research is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/87	**3.4**	**Infection Control Service**	Jo Keward (JK) presented the risk management report for Infection Prevention and Control. • Total number of risks = 6 • Number of new risks identified since the last reporting period = 1 • Number of risks closed and removed from the risk register = 2 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team =			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			1 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risks</u>** **Risk no 2016 risk score 20 - (Limited line service across the Trust from January 2020.)** has been added due to delay in recruitment. JK advised that 2 members of the vascular access service are leaving. There are delays in the recruitment process and until posts filled there is only 1 staff member in the line service. Some lines need a specialised skill to insert. Medical staff can cover if necessary. **Risk no 1919 risk score 15 - Failure to reach to risk 80% compliance with Staff influenza vaccination.** JK advised that vaccination is slightly higher than last year. Current compliance is 60.8% of frontline staff have been vaccinated. To achieve levels as last year IPC would need to vaccinate another 400 staff by Feb 2020. There is additional work within Community to complete as staff in the division are below 50% compliance. JK advised we have seen more patient flu cases coming into the Trust and some of these patients have already been vaccinated. These patients will be tested to understand why they have contracted the flu. Another communication will be sent out to offer vaccinations. There are 2 areas to this risk. Risk of failing to reach high compliance of staff vaccinations which increases likelihood of patients being infected and there is also the risk to meet CQUIN. JK to look at how the risk is described as the risk only covers hitting the 80% compliance.	Risk no 1919 to look at how risk is described as 2 areas to the risk failure to reach compliance figures and increased likelihood of patients being infected.	JK	22nd Jan 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			<u>On-going risks</u> **Risk no 654 risk score 16 - Staff acquiring airborne hospital acquired Infections whilst delivering patient care.** Failure to ensure an adequate seal whilst wearing the respirator could lead to staff being exposed to infectious particles. Fit testing for FFP3 respirators ensures that there is an adequate seal and the most appropriate mask is used. All staff undertaking aerosol generating procedures or caring for patients under airborne isolation must be fit tested as all staff are not fit tested at present. JK advised that the machines were ordered 4 weeks ago and expect delivery imminently. This should help mitigate the risk. **<u>Closed risks</u>** **Risk 1578** (Risk of HAI due to gaps in staff knowledge about Infection prevention & Control) has been closed as risk 637 is a duplicate of this risk. We have therefore merged the two and closed this one off. **Risk 1593** (A patient can acquire a HCAI due to inadequate deep cleaning process) has been closed as we have now acquired a second UV machine for cleaning therefore mitigating the risk adequately. KB advised that the details of controls in place for high risks need to be included in IPC risk management reports going forward. JK advised IPC are satisfied with management of risks on the register. **Resolved** that: the Committee NOTED the contents of the paper	Add details of controls in place and actions for high risks to risk report	JK	22nd Jan 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/88	**3.5**	**Facilities**	Mark Devereaux (MD) presented the risk management report for Facilities. • 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 score = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 MD advised there are no changes since last reporting period and 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			
19/20/89	**3.6**	**IM&T & Part 2 Global Digital Excellence**	Cathy Fox (CF) presented the risk management report for IM&T. • Total number of risks = 20 (IM&T and 6 GDE) • Number of new risks identified since the last reporting period = 1 • Number of risks closed and removed from the risk register = 4 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk score = 1 • Number of high/extreme risks escalated to the Executive Team =			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			4 (947, 1187, 1668, 1961) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risk with a score of 15+</u>** **Risk no 947 risk rating 16 – "Lack of resilience in Meditech EPR with no secondary data centre in place.** Meditech 6 resilience will be implemented by the end of 2019 and Meditech Expanse resilience in partnership with CCC implemented in line with go live of system in 2020. **Risk no 1187 risk rating 16 – "Server infrastructure no longer replicated to a secondary site."** Risk reported on the BAF. A proposal has been presented by Dell Technology to address the lack of resiliency within the existing infrastructure on 09/0719. This provided the Trust with 3 solutions, associated costs and benefits/ risks. This will be going to Executives for approval. **Risk no 1668 risk rating 15 - Test results not picked up when clinicians away from office**. Risk Exec Lead changed to Medical Director to lead and influence the process. **Risk no 1961 risk rating 15 – Cyber Security** – Board approval required to proceed with the IT Resilience and Cyber Security proposal. CF advised that IT risk management report is the same as last reporting period. There is a significant amount of work taking place within IT and this will be on-going until March 2020. KB asked could IT include detail of the work that is being completed for high risks	Add details of controls in place and	CF	22nd Jan 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			(i.e. the existing controls and actions) within their report. CF advised that IM&T have improved greatly and have had a thorough review of the risk register and are comfortable with their current position. **Resolved** that: the Committee NOTED the contents of the paper	actions for high risks to risk report		
19/20/90	**3.7**	**Human Resources**	The risk management report for Human Resources is as follows: • Total number of risks = 9 • Number of new risks identified since the last reporting period = 1 (581) • 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 (201) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention IGC = 0 **New risks** **Risk no 581 risk rating 10 - There is a possibility that staff could order, prescribe, collect or administer blood products incorrectly**. N.B. In this reporting period this risk has been reassigned to HR and thus appearing on the HR risk register, however this is a clinical risk and will be correctly reassigned to the appropriate owner, to ensure the effective management of this risk. **High risks**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 201 risk rating 16 - Risk of being unable to meet staffing duty rota requirements in line with best practice standards. The risk is staff ill-health, wellbeing issues above the Trust target of 4%. Human Resources have no overdue and no risks without agreed action plans and are satisfied at this point with the risks on the register. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/91	**3.8**	**Finance**	John Grinnell (JG) presented the risk management report for Finance. • Total number of risks = 4 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 JG advised the committee that the Finance department have no overdue and no risks without agreed action plans and are 100% compliant at this point with the risks on the register. **Resolved** that: the Committee NOTED the contents of the paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/92	**3.9**	**Building Services & Estates**	Graeme Dixon (GD) presented the risk management report for Building Services. • Total number of risks = 11 • Number of new risks identified since the last reporting period = 2 • 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 (decreased) • Number of high/extreme risks escalated to the Executive Team = 3 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risks with a score of 15+</u>** **Risk no 1388 risk rating 20 – "Pipe corrosion"** SA & JG awaiting response from letter regarding corroded pipes, expected today 29th Nov 2019. KB advised that pressure needs to be kept on Project Co and further board to board meetings are to be arranged by Finance Director's PA - A Graham (AG). **Risk no 825 risk rating 15 – "Internal balconies".** Feasibility study undertaken by contractors on the 26th April 19. Stuart Atkinson (SA), Interim Associate Director of Estates advised he has concerns of what is in place in the CHP building at present in terms of risk. Full length glass is a solution, however very expensive. Any changes will not happen quickly as the landlords need to agree any decisions the Trust makes. GD advised that SPV have advised the handrails cannot be removed however the independent Architect advised the handrails could be removed. A	Arrange another meeting with Project Co	AG	22nd Jan 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			further discussion is needed to address this issue to progress a decision. JG advised the Trust needs to find a route to a conclusion as we need to mitigate this risk. SA will provide an update at the next IGC Meeting. **<u>On-going risks</u>** **Risk no 1958 risk score 12 – Defect in the roof of HDU/PICU building leading to water ingress into the critical care unit.** GD advised that Project Co will begin to repair the skylights. The work is to commence March 2020. GD advised all risks are within review date and Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/93	**3.10**	**Development Directorate**	David Houghton (DH) presented the risk management report Development Directorate. • Total number of risks = 17 • Number of new risks identified since the last reporting period = 1 (2003) • Number of risks closed and removed from the risk register = 3 (1952, 1258, 845) • 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 (1241, 2003) • Changes in the risk profile or categories of risk being reported			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			that need to be brought to the attention of IGC = 0 **<u>High risks</u>** **Risk no1241 risk rating was 16 – "Lack of Capital Funding for the Park."** Gaps in Controls: The original capital allocated was based on delivery of the Park in 2017. We are now planning to hand back the park to LCC in 2022 with inflation currently running between 30% & 40%. DH advised that funding is a key challenge and Development Directorate are currently looking at alternative designs to meet budget. **<u>New risks</u>** **Risk no 2003 risk rating 15 – Risk to completion of demolition project**. Existing buildings scheduled for demolition could not be demolished and site development would be affected; reputational damage. No agreement in place to mitigate risk but development directorate is exploring options. DH advised that the Development Directorate risks continue to reduce as progress is made, risks have been reduced within this reporting period, and the Directorate are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/94	**3.11**	**Health & Safety**	The risk management report for Health & Safety was presented 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 = 1 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **High risk** **Risk no 799 risk rating 16 – "Failure to control contractors on site (CHP) & Retained Estate"**. MS advised that H&S are still waiting on the report from MIAA. Once there is a solution this risk can either be closed or decrease the risk score. GD advised that the control of contractors policy went to the H&S Committee meeting. This is now in good shape and the risk will now be reduced however not able to implement at this time. There are a few quick changes to make and go through policy in more detail before being submitted to WOD. **Update on realised risks** **Risk no 809 risk rating 12 – "Welfare Regulations – Retained Estate"** Installation of speed bumps from Catkin Car Park up to Ambulance Bay authorised by Facilities/Estates. Waiting date of installation. Temporary car park works undertaken.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Ongoing welfare issues on retained estate specifically with regard to lighting, external grounds. On completion of these works the risk score will be revisited with a view to reducing. **Risk no 1386 risk rating 12 – "Lift Entrapment – CHP"** Near miss incident (patient entrapment) – Design of lift car hatch to roof makes it extremely difficult to pass vital medical equipment into the lift in the event of entrapment. Funding approved by Investment Review Group for modifications to lift car. Date of works to be advised via SPV/BST. On completion of these works – risk will be reviewed with a view to closing the risk. Health & Safety are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/95	**3.12**	**Business Preparedness & Emergency Planning**	Elaine Menarry (EM) presented the risk management report for Business Preparedness & Emergency Planning. • Total number of risks = 12 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 2 (1585) • 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 (1435) • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		that need to be brought to the attention of IGC = 0 **<u>Changed risk score (increased)</u>** **Risk no 1435 risk rating from 8 to 12 - Risk of delays or errors during major incident response if an electronic major incident booking in system isn't available via Meditech.** The Emergency Dept currently have a paper based system for booking in major incident patients. A SOP is available and supporting and depts. are aware of this. However, as it is a paper based system, other receiving depts. e.g. pathology, radiology, theatres and pharmacy depend on information from Meditech to be able to respond effectively. A working group is now in place which meets weekly to implement an electronic major incident booking as urgent priority. A mock Meditech major incident booking system has been developed and funding is required for additional IT equipment in the Emergency Dept to support an electronic response. A quotation is currently being finalised at approximately £10,000 and the mock system will need to be trialled prior to purchasing this additional equipment. This risk has been increased to reflect the urgency of completing this project. In addition, this risk will also be transferred to the Medicine Division. **<u>Closed risks</u>** **Risk no 1585 Risk of out of date business continuity plans if they aren't monitored within the Divisional Programme.** Business Continuity review dates are monitored by the EPRR Divisional Assurance links and reported to each Emergency Preparedness Group. **<u>Incidents/Exercise</u>**			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Live exercise - Generator Test (Exercise Black Start) took place on 29th Oct 19. A full report on the learning and associated actions from the generator test is to be submitted to the Emergency Preparedness Group on 27th Nov 19. Incident - IM&T incident users unable to log on and access local data. The incident identified that some users are still saving to the C: drive and IM&T are ensuring all users have access to the H: drive and are continuing to advise staff not to store information on C: drive Incident - Further water ingress incident in CHP site and research institute. Building Services Team are monitoring CHP programme of repairs. For the Research Institute, the root drain has been temporarily replaced until final design filter is in place. EM advised all risks are within review date and Business Preparedness & Emergency Planning is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/96	**3.13**	**Information Governance**	Jo Fitzpatrick (JF) presented the risk management report for Information Governance. • Total number of risks = 8 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 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			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1753 risk rating 6 - the risk score relating to DSPT compliance has been lowered from 9 to 6 as more capacity within IT has been created, via the appointment of an interim cyber security lead who will support the actions required for meeting elements including Information Asset Management. **Risk no 1892 risk rating 12** - IG Training compliance needs to be at 95% for toolkit compliance. Additional training methods are available from the Intranet, as well as scheduled face to face sessions; managers across all Divisions need to ensure that their staff are up-to-date with this mandatory training. JF advised the Committee good progress has been made with managing the IG risks and IG and are satisfied with progress made to date. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/97	**3.14**	**Medicines Management & Pharmacy**	Paul Sanderson (PS) presented the risk management report for Medicines Management & Pharmacy. • Total number of risks = 14 • Number of new risks identified since the last reporting period = 2 (2002, 1977) • Number of risks closed and removed from the risk register = 0 (1471, 1589, 1344, 1191) • Number of risks with an overdue review date = 3 (1209, 1510, 2002) • Number of risks with no agreed action plan = 2 • Number of overdue actions across all risks = 5/23			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• 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 IGC = 1 (1924 national incident related to supply of parenteral nutrition for home patients current score 10) **Overdue risks** **Risk no 1209 risk rating 12 – "**Move to preparation of chemotherapy worksheets/labels and stock control" **Risk no 1510 risk rating 9 – "**Pharmacy Outpatient Service does not meet patient needs potentially compromising patient care" **New risks** **Risk no 2002 risk rating 9 -** Delay to invoice processing for homecare medicines & inability to expand the homecare medicines portfolio. **Risk no 1977 risk rating 5 -** Requirement to store intra-thecal medications in an alternative cold store with other products - outside policy. PS advised the intra-thecal fridge is broken and a new one has been ordered. **Risks with Financial implications** **Risk no 1924 risk rating 10 -** Parental Nutrition treatment not available - resulting in admission to hospital.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			High risks **Risks no 1787 risk rating 15 – "Error in the prescribing, preparing and administration of parenteral nutrition."** A wider meeting of all stakeholders has been organised to re-visit and reassess the risk and mitigations. PS advised that the TPN risk review meeting held on 25th Nov 19 and was attended by gastro, Neonatology, pharmacy & dietetics. Reviewed overall process and agreed to set up a TPN Steering Group. This risk will be reviewed on Tuesday 3rd Dec 19 and an update will be provided at the next IGC meeting. PS advised the Committee, Medicines Management & Pharmacy recognise that while ongoing work is required, good progress made to date. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/98	**3.15**	**Marketing & Communications**	The risk management report for Marketing & Communications was presented as follows. • Total number of risks = 3 (806, 807, 808) • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 3 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
19/20/99	**3.16**	**Innovation**	Emma Hughes (EH) presented the risk management report for Innovation Dept. • Total number of risks = 2 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 EH advised in the next reporting period governance for Innovation will be in a better structured place however at present there are no risk overdue review and are satisfied with management of risks. KB asked "do you take the Innovation risk register through the innovation Board meeting?". EH advised "yes the risk register is taken through the Innovation Board meeting to discuss risks." **Resolved** that: the Committee NOTED the contents of the paper			
19/20/100	**3.17**	**Change Programme**	Natalie Deakin (ND) presented the risk management report for the Change Programme.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Total number of risks = 26 • 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 = 5 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **Risks showing as 12+** **Risk no 1653 risk score 12** - Demographics. Incorrect demographics could fail the project to realise all benefits. **Risk no 1912 risk no 12** - If the patient remains under the care of the incorrect attending Consultant, there is a risk that alerts (High PEWS 6-9, Critical PEWS 10+ or new sepsis concern) would be sent to the wrong clinician and so missed and delay action by the responsible clinician. Potential risk for lack of clarity amongst clinical teams about which Consultant holds overall responsibility for individual patients and receiving escalation alerts, as well as who in the team should carry an iPod to receive these alerts. **Risk no 1320 risk score 12** - Medical Capacity. Due to potential increase in medical review for sepsis patients may divert resources from non-sepsis patients			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Risk no 1329 risk score 12 - Meditech and Information collection. Due to the information required and how it is recorded on Meditech V6 there may be challenges exporting the data for review KB asked the committee "do the divisions and project leads feel it works better having the Change Programme risks reported to IGC via a separate report from Natalie rather than (as previously) in their individual reports?" JG advised yes this works better and as the projects team are well placed for any challenges. ND advised that as this is the first report that she has submitted to IGC she will need to look at the risks in detail outside of the meeting to ensure that there is no duplication of reporting. For example, for Facilities there will be duplication of reporting today however it is business as usual risks for Facilities. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/101		**Password Policy**	Cathy Fox (CF) presented the Password Policy to the meeting. CF advised the policy outlines that weak passwords have proven to represent a critical risk to the organisations defence against cyber breaches or targeted attacks; despite any investment in firewalls, anti-virus or other security controls. The policy outlines passwords containing 12 characters which won't need changing and the view is this is safer than constantly changing passwords. KB asked why there was now no requirement for the passwords to be complex (as well as 12 characters). CF advised that she would confirm this. Elvina White (EW) has suggested the Password Policy is referred to as a subordinate information security policy within the Trust's	Confirm if the password policy requires complexity in addition to 12 characters	CF	22 Jan 20

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Overarching Information Security Policy – RM42 (page 11). CF advised the policy had been to Operational Board for approval and is been submitted to the IGC meeting for ratification. **Resolved** that: the Committee RATIFIED the contents of the paper			
		Meeting Effectiveness Review	KB advised the committee that the Working Group that is being set up to look at further developing risk management and risk reporting has not yet organised its' first meeting. Updates will be provided to each IGC meeting as appropriate.			

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
Chairs Intro	Risk management principle – Risk Owners	Risk Owners to check for any such risk and update. IM&T and Finance particularly to identify any such risks allocated to them and liaise with the relevant risk owner.	All	All future Meetings	29th Nov 2019	Don't allocate risks to finance or IT, only allocate the action.
Chairs Intro	Risk Management Principle – Risk description.	All risks need to have sufficient detail of what actual risk is so that those outside the department can understand the implications (particularly for example when reports are extracted for Board).	All	All future Meetings	29th Nov 19	Descriptions of risks have now improved.
18/19/125	Risk no 1593 – A patient can acquire a HCAI due to inadequate deep cleaning process. Lease company has agreed to lease the Trust 3 new UV machines.	Still awaiting the machines. Provide an update at the next IGC meeting.	V Weston/J Keward	29th Nov 19	29th Nov 19	
19/20/10b	Risk 1858 – Security and fire risk controls. There are a number of risks that are tied together with the Institute risk 1858, risk 1746.	Clarity is needed around the actions and breakdown of the risks to follow up if any of problems were part of the cost of the Institute. To provide an update at the next IGC Meeting.	S Brown	29th Nov19	29th Nov 19	Risk has been closed as it contained multiple risks which have been separated into individual risks which are easier to report on. Action to completion
19/20/45a	Risk no 1412 risk rating 9 Contracts with Universities to support RE phase 11 are not yet signed.	To provide an update to next IGC Meeting.	S Brown	29th Nov 19	29th Nov 19	EHU and UCLAN leases are both in place. LJMU are still to exchange their lease but it has been signed by both parties and with the legal teams.
18/19/86	Risk no 799 – Failure to control	MS to speak to GD outside of	M Swindell	29th Nov 19	29th Nov 19	GD advised Building

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
	contractors (CHP) & Retained Estate.	meeting and update next IGC Meeting.				Services has been managing the contractors and there have been no further issues.
19/20/11	Risk 1840 – Regularly delivering COSHH compliance training.	H&S intranet page to incorporate a dedicated area to access generic COSHH risk assessments and Safety Data Sheets. Waiting to be uploaded to intranet page.	A Kinsella	29th Nov19	29th Nov19	The COSHH risk assessment and Safety Data Sheets have been uploaded but we continue to work on the page.
19/20/74	Risks 1753 & 1893 DSPT moving these risks to IT.	JF to talk to ES about moving these risks and will update next IGC Meeting	J Fitzpatrick	29th Nov 19	29th Nov 19	Following discussions with CU at the Risk validation meeting, it was agreed that as these risks present a risk to data protection and security, they should stay with IG.
19/20/52	Risk no 1400 risk rating 4 – Acorn: Governance for Acorn Partnership not in place	JT to provide an update to the position of risk at next IGC meeting,	E Hughes	29th Nov19	29th Nov19	Acorn update has gone to audit committee and Innovation Board. An action plan is in place to close existing contract with Acorn. If we continue with them it will be under a new agreement, terms and governance. Risk has been closed.

INTEGRATED GOVERNANCE COMMITTEE

ACTION LIST OUTSTANDING

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
Chairs Intro	New front cover sheet	Tick only the strategic objective(s) relevant to your division/corporate function	All	22nd Jan 19		
Chairs Intro	Risk management report template	Add section on report template for "update of outstanding action(s)"	CU	22nd Jan 19		
Chairs Intro	Risk register – Divisions and Corporate Functions	Review the risks on your risk register ensure they are as up to date as possible and email CU to confirm completion.	All	31St December 19		
18/19/124	Risk no 1131 - Process for scanning and archiving clinical notes within Community Division. Scanning turnaround times for outpatient records have reduced from 32 days in September to 9 days in October. However, scanning turnaround times remain too long for inpatient records.	To provide an update at the next IGC Meeting.	A Bateman	29th Nov 19		The Trust is going to extend the outsourcing of outpatient records with the internal records switching their focus to the inpatient backlog.
19/20/83	Risk no 1881 (risk rating 12) No reception staff, parents will attempt to gain access by either tailgating or using the door release button under the desk.	Work is being completed over the Christmas period. To provide an update at next IGC meeting.	A McColl	22nd Jan 20		See Section 3.0 for current position. Building services item
19/20/83	Risk Management Reports	Report template to be updated to include when a high risk will reduce in score based on the planned actions to mitigate	CU	22nd Jan 20		
19/20/54	Should there be a BAF Report on Pensions & Tax?	MS to add a risk for Pensions & Tax to the BAF	M Swindell	22nd Jan 20		Report going to Board 3rd Jan 20.

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
						MS to provide an update to IGC Jan 20.
19/20/74	Risk 1893 Information Asset Management Tool. Need to discuss this area with IT as there is no funding available for tools which will not prevent Information Asset Management from moving forward.	Speak to IT about funding available for tools and will report back to next IGC.	J Fitzpatrick	29th Nov 19		JF provided detail previously, however suggests that this is revisited along with the function as part of that review following my departure.
19/20/84	Risk no 1169 Fragile Medical Workforce within Haematology Service	Reword title of the risk as it's a recruitment issue rather than fragile workforce	A Hughes	22nd Jan 20		
19/20/87	Risk no 1919 – Failure to reach to 80% compliance with staff influenza vaccination.	To look at how the risk is described as there are 2 areas to this risk. Failure to reach CQUIN compliance figures and the increased likelihood of patients being infected.	V Weston/J Keward	22nd Jan 20		
19/20/87	N/A – risk report	Add details of controls in place and actions for high risks to risk report	V Weston/J Keward	22nd Jan 20		
19/20/89	N/A – risk report	Add details of controls in place and actions for high risks to risk report	CF	22nd Jan 20		
19/20/92	Risk no 1388 - Corroded pipework	Arrange another meeting with Project Co. LC to speak to AG	LC	22nd Jan 20	5th Dec 2019	This will be on the agenda at the Exec to Exec

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
						meeting Jan 2020.
19/20/101	N/a Password policy	Confirm if the password policy requires complexity in addition to 12 characters.	CF	22 Jan 2020		

Alder Hey Children's NHS
NHS Foundation Trust

Register of Company Shareholdings
As at 31st December 2019

Changes made since last reporting period:

Changes highlighted in blue

1. New Companies formed with Alder Hey as Shareholder

There have been no new companies formed with Alder Hey as a shareholder since the last report and no significant changes to be reported on for this period.

Full Master Company Register as at 31st December 2019:

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Alder Hey Ventures LTD	27.06.17	David Powell	100% wholly owned subsidiary	10837212	AH	Commercial No employees	Commercial, innovation, product development and exploit IP	Confirmation statement: 12.07. YE: 30.06.18 Accounts due: 27.03.19	'Active' Not used Not consolidated
Alder Hey Living Hospital LTD	24.04.17	John Grinnell Erica Saunders David Powell	50% JV with Alder Hey Children's Charity AH significant control	10835638	AH Charity	Commercial No employees	App development and commercialisation	Confirmation statement: 23.04.19 YE: 31.03.19 Accounts filed: 21.01.2020	'Active' used Equity investment materiality
Asthma Buddy Ltd	18/05/2017	No	30.10%	10188710	Boundary Street, Liverpool	Commercial	Peer to Peer support for information on Asthma	Managed through 3rd party	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
							App development and commercialisation		
Doctors Hours Ltd	18/05/2017	No	30.10%	10188794	Boundary Street, Liverpool	Commercial	Junior doctors hours monitoring App development and commercialisation	Managed through 3rd party	Active
Bloom Revalidation Ltd	18/05/2017	No	30.10%	10189548	Boundary Street, Liverpool	Commercial	Nurse revalidation App development and commercialisation	Managed through 3rd party	Active
Digital Audiology Technologies Ltd	18/05/2017	No	30.10%	10189060	Boundary Street, Liverpool	Commercial	Digitised gaming hearing test App development and commercialisation	Managed through 3rd party	Active
Fresh Wellness Ltd	30/06/2017	No	30.10%	10259396	Boundary Street, Liverpool	Commercial	Mental health support app App development and commercialisation	Managed through 3rd party	Active
Conquer Kids	27/04/2017	No	30.00%	10746202	Boundary	Commercial	App development	Managed through	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Phobia Ltd					Street, Liverpool		and commercialisation	3rd party	
Blood Sense Ltd	27/04/2017	No	30.00%	10746341	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Physiopal Digital Ltd	27/06/2018	No	30.00% - person with significant control	10838856	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Remedy Medpass Ltd	27/04/2018	No	30.00%	10746292	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Sample Tracker Ltd	27/04/2018	No	30.00%	10746420	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Reel Medical Technology Ltd	27/04/2018	No	30.00%	10746455	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Acorn Partners Ltd	18/05/2018	No	27.5%	10188842	Boundary Street, Liverpool	Commercial	Managing company for partnership	Managed through 3rd party	Active
Kids COPD Monitoring Ltd	14/12/2017	No	40.1%	11112790	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Pik Kit Ltd	15/12/2017	No	40.1%	11112815	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Kids Medicine Compliance Ltd	15/12/2017	No	40.1%	11112938	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Hand Hygenie Solutions Ltd	09/11/2017	No	30%	11055776	Boundary Street, Liverpool	Commercial	Hand compliance sensor system	Managed through 3rd party	Active
Cofoundary Enterprise 36	15/12/2017	No	0%	11112857	Boundary Street, Liverpool	Commercial	Sensor based alternative to spirometry	Managed through 3rd party	Active

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th February 2019

Paper Title:	**Audit Committee Assurance Report from the January 2020 meeting**
Date of meeting:	16th January 2020
Report of:	Kerry Byrne, Non-Executive Director
Paper Prepared by:	Julie Tsao, Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Audit Committee meeting held on 16th January 2020 along with the approved minutes from the meeting held on 21st November 2019.
Action/Decision Required:	To note ■ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ☐ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ■
Resource Impact:	None

1. Introduction

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

Under its terms of reference, the Committee shall review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

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

- Internal Audit Progress Report
- Report on the follow up of previously agreed actions
- Draft Internal Audit Plan 2020/21
- Board Assurance Framework - Benchmarking statistics
- Anti-Fraud Progress Report
- E&Y Technical Update Report
- E&Y External Audit Planning report
- Unusual or new accounting transactions within the current audit year
- Outcome from the Audit Committee Effectiveness Review
- Board Assurance Framework
- Next steps for External Audit Contract

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

The Committee asked that, following changes to a number of the shareholdings in companies relating to the innovation programme, an updated shareholdings list is provided to Board.

4. Positive highlights of note

MIAA advised the Committee of the clearance of outstanding recommendations in the following audit reports – Discharge Planning, Cyber Security, Activity Data and Did Not Attend KPIs. There are now no outstanding audit issues in these areas.

5. Issues for other committees

The following items are to be notified to other committees:

CQAC	Recommendations from the effectiveness review of the Audit Committee:

	• The Clinical Audit Team should provide to the Audit Committee at the start of the year their Annual Work Programme and the end of the year a summary of the results from completing the work programme including the implementation status of recommendations made. Throughout the year CQAC should consider whether any significant findings should be reported to Audit Committee. • CQAC should seek the input of Audit Committee in commissioning the Clinical Audit Annual Work Programme and include within its' Annual Report a section on its' oversight of Clinical Audit providing assurance as to its' effectiveness
Innovation Committee	IC is asked to oversee the implementation of the recommendations raised by KPMG in their recent report on the ACORN partnership and provide regular updates to Audit Committee

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th February 2020

Paper Title:	**Resource and Business Development Committee Assurance Report**
Date of meeting:	22 January 2020 – Summary 27 November 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 22 January 2020 along with the approved minutes from the 27 November 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)

- **Update on current Tariff situation**
- **Finance Report including updates on M9, Operational Plans & Budgets and Financial Recovery Plan**
- **Marketing & Communication update**
- **Digital update**
- **Medical Records Transformation Plan**
- **Corporate Report**
- **Procurement Monitoring update**
- **ERDF Project update**

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

- Children's Tariff changes £5m downside. The Trust has activated a national piece of work through the Children's Hospitals Alliance, plus discussions are ongoing with the Director of Pricing at NHS I/E.
- Capital Campus budgets and over spend & delay including potential risk of non-sign-off by Clinical on T4 design.

4. Positive highlights of note

- HIMMS Level 6 achieved – first Pediatric Trust and first Trust in North
- Improving Control Total forecast from £(2.6)m to £(1.9)m deficit
- Procurement Collaboration opportunity through Specialist Trusts

5. Issues for other committees

- H&S Committee to ensure review of security and SOPs are adequate.

6. Recommendations

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

Audit Committee

Draft Minutes of the meeting held on **Thursday 21st November 2019**

Tony Bell Board Room, Institute in the park

Present:	Mrs K Byrne (Chair)	Non-Executive Director	(KB)
	Mrs. A. Marsland	Non-Executive Director	(AM)
In Attendance:	Mr G Baines	Assistant Director, MIAA	(GB)
	Ms K Stott	Senior Audit Manager, MIAA	(KS)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Mrs R Lea	Associate Director of Finance	(RL)
	Mrs C Liddy	Director of Operational Finance	(CL)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator *(minutes)*	(JT)
Observer:	Ms K Jenkinson	Interim Accountant	(KJ)
	Mr S Hooker	Public Governor	(SH)
Agenda item:	Mrs S Charlton	Outpatients Service Manager	(SC)
Apologies:	Mr J Grinnell	Director of Finance	(JG)

19/20/48 Minutes of the previous meeting held on 26th September 2019

Resolved:
Subject to a small number of typos to be corrected outside of the meeting Audit Committee approved the minutes from their last meeting held on 26th September 2019.

19/20/49 Matters Arising and Action List

All actions are incorporated into agenda items except the following:

19/20/07 Draft Counter Fraud Annual Report 2019/20: A proposal on the identification of fraud risks within Ulysses to enable compliance with the annual self-assessment was awaited from MIAA. Virginia Martin will provide an update to the January 2020 meeting.
Action: VM

19/20/36 Follow Up Audits: Following a request from Claire Liddy MIAA confirmed follow up of actions from the Materials Management audit would be performed on an annual basis instead of quarterly. The next update would be received at the April 2020 Audit Committee. It was agreed this action would now be closed.

19/20/36 Follow Up Audits: It was confirmed that the outstanding actions from the PFI Contract Monitoring and Consultant Job Planning audits are followed up as part of MIAA's regular review of agreed actions and therefore specific actions in relation to these are not required. It was agreed that these actions would be closed.

19/20/37 Anti-Fraud Progress Report Quarter 2: It was confirmed that anti-fraud recommendations would be included as part of the MIAA follow up process, therefore this action would now be closed.

19/20/37 Anti-Fraud Progress Report Quarter 2: Claire Liddy requested anti-fraud guidance sessions are also provided to HR and IT (in addition to those existing for Finance and Procurement) and these are included as part of the 2020/21 MIAA anti-fraud plan of work. MIAA were asked to consider if any other areas should also be included. This action would now be closed.

19/20/37 Anti-Fraud Progress Report Quarter 2: Introduction of an eLearning module for fraud awareness. An update on the revised induction process and how the anti-fraud awareness session is delivered to staff throughout the Trust is to be received at the January Audit Committee.

19/20/40 Audit Committee Effectiveness Review: The Chair thanked the committee for responding to the committee effectiveness questionnaire. A paper on the findings would be presented at the January Audit Committee.

19/20/44 Losses & Special Payments. Information is awaited from the H&S team to confirm whether the electric shock previously reported to committee was avoidable.

19/20/50 Progress Report, MIAA

Audit Committee received an update on the one audit that had been finalised:

Cost Improvement Plan – Substantial Assurance

The review identified that the Trust has robust systems and processes in place relating to CIP / QIA and it was confirmed that controls are established and operating effectively. Four issues had been rated from low to moderate.

Gary Baines referred to a number of reviews that would be delayed; these included Safeguarding and Non-Clinical Claims.

The Chair confirmed that MIAA had provided a list of the timings of the remaining audits (relating to Action 19/20/35 which can now be closed). The Chair reminded the committee that internal audit and management had been asked to ensure that the audit reports are spread more evenly throughout the year rather than being back-ended, and to that end, that all audit fieldwork be completed by the end of January each year to ensure all reports are finalised prior to year-end. Whilst MIAA confirmed that all fieldwork was on track to complete by the end of January (with the agreed exceptions of Assurance Framework / Risk Management and Data Protection and Security Toolkit) it was noted that 8 audit reports are now due for presentation to the January and April audit committees (with only 1 audit report provided to each of the September and November meetings).

The Chair asked for details on the process for deferrals. Both MIAA and the Executives agreed to ensure deferrals are only permitted in exceptional circumstances.

The Committee asked whether the internal audit planning process could be undertaken earlier so that the Draft Internal Audit Report was presented to the January meeting each year enabling fieldwork to commence immediately in April each year. MIIA welcomed this approach.

50.1 Action: MIAA to present the Draft Internal Audit Plan to the January meeting each year.
50. 2 Action: JT to update the Work Programme to reflect presentation of the Draft Internal Audit Plan to the January meeting (rather than April).

To assist in monitoring of audit progress and delays the Chair asked MIAA to include the dates of the various stages of the audit (fieldwork, issue of draft report, receipt of management responses, issue of final report) in their Progress Report. KPIs currently exist except for "receipt of management responses" and the Chair asked management to agree the KPI for this.
50.3 Action: ES/CL to suggest the "receipt of management responses" KPI for inclusion in reporting from 2020/21

The Committee discussed the presence and use of contingency days in the audit plan and advised that these were not generally to be used for "scope creep" or overruns on existing audits as was the case with Control of Contractors audit. The Committee asked MIAA to specify the number of contingency days in the Audit Plan (along with the days for all audits) and this is included in the Quarterly Progress Report. The Committee would like to receive suggestions for use of the contingency days in advance of their use.
50.4 Action: MIAA to specify the number of days allocated to Contingency in the Audit Plan, advise the Committee of any requests for use of the contingency days and report on the usage via the Progress Report.

The Chair advised the Committee that MIAA had shared their "post audit questionnaire" and confirmed that very few were completed by auditees. The Chair had discussed this with management prior to the meeting and provided a template questionnaire for management to look at and work with MIAA to develop a more Alder Hey specific questionnaire. The aim is then to launch this for 2020/21 and encourage completion by auditees.
50.5 Action: ES & CL to develop an Alder Hey internal audit questionnaire in conjunction with MIAA for introduction in 2020/21.

The Chair noted that the reporting of KPIs and receipt of questionnaires can help the Committee review the effectiveness of internal audit, as is one of the suggested actions in the draft findings from the self-assessment of audit committee recently undertaken and to be reported in January 2020. A further draft finding is that the effectiveness of External Audit is also regularly reviewed by the Committee. Management were asked to suggest an approach to undertaking this, perhaps similar to that of Internal Audit which can be used following the external audit process for 2019/20 accounts.
50.6 Action:ES/CL to suggest a mechanism to review the effectiveness of External Audit for 2019/20 accounts.

The Chair noted the summary of responses provided by management for each of the audit findings hadn't been included in this report as usual and asked that it is reintroduced going forward.
50.3 Action: MIAA

Resolved:
Audit Committee received an update on Internal Audit progress report.

19/20/51 Follow Up Audits

Audit Committee received the above report noting progress against the 50 overdue recommendations. Revised deadlines have been agreed for PFI Contract Monitoring and Consultant Job Planning. As the Consultant Job Planning is an annual process it was agreed an update on the follow up audit should be in sync with the process.

Going forward MIAA were asked to include a summary table showing the percentage of recommendations implemented, partly implemented or not implements and also for the individual recommendations followed up, details of who they had spoken to for the follow up process, a summary of information received and a clear description of the information outstanding.
Action: MIAA

Resolved:
Audit Committee received the Follow Up Audit report noting actions to receive assurance against progress.

19/20/52 External Audit Plans and Fees

Resolved:
Meetings are in the diary to agree external audit plans and fees, this will be presented to the January Audit Committee.

19/20/53 E&Y Technical update report

Resolved:
As the quarter 2 report had been re-circulated in error it was agreed the quarter 3 report would be circulated after the meeting.
Action: JT

19/20/54 Wavier Activity Report

6 approved waivers were received for the reporting period 1st April – 31st October 2019. The committee noted the low number of wavers and that they had been reducing over the last three years.

Going forward it was requested to include details of why the waiver was needed such as where services are only available from a single provider.
Action: Steve Begley

19/20/55 No Child Unaccounted for Campaign

Sharon Charlton updated the committee on the two projects within Outpatients and progress since the last update was received at Audit Committee on 23rd May 2019. (Relates to Action 19/20/20).

No Child Unaccounted For

Concerns had previously been raised around non-completion of EPPF forms, this meant that there was no record of the next part of the patient's pathway. A number of initiatives had been implemented including extending the completion deadline to 48 hours. This had seen the number of non-completion of EPPF forms and has been reduced to 6%. Support was being provided to any re-offending clinicians.

EPPF forms were introduced as part of Meditech 6. Claire Liddy noted the Trust are unable to be paid for patients that do not have a completed EPPF form or cashed up.

The number of EPPF forms completed is reported weekly at Exec Comcell meetings and any areas that are under performing in relation to completion are discussed at the weekly performance group.

The Innovation Department are working with the Business Intelligence team on a solution with NHS Digital to help predict possible WNB.

Was Not Brought (W.N.B)
A clinic report is available at each session for the clinician that highlights previous WNB and Safeguarding Alerts.

The number of appointments that are wasted through WNB is displayed around the department to provide a visual reminder to patients and their families.

Kath Stott agreed to include this update within the Follow up Audit report.

On behalf of the Audit Committee the Chair thanked Sharon Charlton for providing a comprehensive update on progress to date.

Resolved:
The Audit Committee noted the positive improvement since the May update.

19/20/56 Board Assurance Framework (BAF)
The BAF is presented to Trust Board, sub committees and is reviewed and updated by the Executive Lead on a monthly basis.

A review of the Ulysses system has been completed to link the corporate risks with the respective BAF but this is currently not able to be shown in the BAF report due to technical issues with Ulysses which are being looked into.

ES advised that a strategic workshop looking at risks on the BAF in light of the refreshed Strategic Plan, is to be held at the beginning of the Trust Board on 3rd December 2019.

Resolved:
Audit Committee received and noted the contents of the BAF including the ongoing scrutiny of all strategic risks by the relevant assurance committee.

19/20/46 Any Other Business
No other business was reported.

19/20/47 Meeting Review
No items required forwarding to any of the other committees.

Date and Time of next meeting: Thursday 16th January 2019, at 14:00, Tony Bell Board Room, Institute in the Park.

Resources and Business Development Committee
Minutes of the meeting held on: Wednesday 27th November 2019 at 9:30pm in Tony Bell Boardroom, Institute in the Park

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

19/20/115 **Apologies**
The Chair noted the apologies received from Claire Liddy, Melissa Swindell, Hilda Gwilliams, Nicki Murdock, Sue Brown & Natalie Deakin.

19/20/116 **Minutes from the meeting held on 23rd October 2019**
Resolved:
The minutes from the meeting held on the 23rd October were approved.

19/20/117 **Declarations of Interest**
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There were no declarations of interest.

19/20/118 **Matters Arising and Action log**
There were no matters arising. The Action Log was updated.

19/20/119 **Update of Tariff**
JG gave a verbal update on the current situation with Tariff. Centrally the work on establishing a new tariff has been paused for 20/21; following this announcement agreement has been reached by the core members of the Children's Alliance to commission a formal piece of work whilst central work is paused. A workshop with Alliance members and external support is due to be held on 6th December and will be updated at the next RABD.
ACTION: Update to be brought to next RABD following workshop event (JG)

Update on External Partnerships
DJ presented an update on the External Partnerships; a follow-on piece on commercial partnerships has been proposed to be brought to a future RABD.

CD welcomed the presentation however asked whether we have enough clarity on the outcomes we are aiming to achieve for each of the partnerships as it is important we are clear on impact and also which may be of a higher priority. IQ added that he would welcome this as his concern was there could be too many partnership streams for us to manage well at any time. DJ welcomes the question and confirmed that she will be doing a piece of work across each of the partnerships to clearly define the outcome. She did add that whilst this is key we also need to recognise how important it is that Alder Hey is at the table for what are essentially the system discussions about the future and we shouldn't underestimate the progress that has been made in the last 12 months. Some of the networks and partnerships are also mandated. A lot of this work will have benefits for Alder Hey but more importantly the wider system. AB noted that in doing the impact assessment it is important that we are very clear on the what this means for the children we serve. IQ thanks DJ for the hard work and progress made over the last 12 months and the committee agreed that a further discussion would take place focussed on the impact at a future meeting. It was also agreed that a similar discussion should take on commercial partnerships.
ACTION: To look at potential impact of each partnership in totality (DJ)
ACTION: To bring back a similar assessment of commercial partnership (JG)

19/20/120 **Proposed International Educational Projects**
CK presented an update on proposed international education projects.
Clinical Observer programme - CK asked for direction in relation to the level of fees to be levied if AH were to undertake the Clinical Observer programme.
Chengdu project - costs to be circulated outside the meeting; advice being sought within Chinese business community around fees.

CD noted surprise that there is no business model for these projects and what is the impact back for Alder Hey; do these costs include all administration; what will the impacts be if we begin to take staff out of frontline care when we struggle at times to fulfil our contract and care for the children in our care; CK responded that part of our strategy is to improve health care for children across the world. Work is done remotely, but some visiting is required from a cultural view. CD noted that reputational risk is with Alder Hey whether other hospitals take part or not. DP & CD discussed the validity of the original paper to Board 2-3 years ago and whether this is an update albeit without full figures for review by RABD. IQ noted that 3 years is a long time within the NHS. JG noted that there has been a plan in the past and this presentation is an update to that; there has previously been a strategy review which has not been brought back to RABD, but that effectively suggests that an academy vision is the way forward. JG to bring this back to RABD with an impact assessment for discussion.. MF suggested that the brand is potentially being undervalued particularly in China where there is a high level of regard for Alder Hey. CD suggested working with the Universities and utilising their external campuses & knowledge. RL clarified the situation regarding current income from the Clinical Observers project. CD noted that the Committee need to look at figures and make judgements to ensure decisions are right for Alder Hey. IQ asked whether this is to be brought back and whether a decision to be made on fee levels for Clinical Observer project – JG to progress the fee levels outside the meeting however recognised the need for us to regroup on the overall academy and strategy.
ACTION: Strategy review to be brought back to future RABD (MS/JG)

19/20/121 **Proposed Write-offs**

AC gave an update on the value of current write-offs that have been proposed to a value of £439.54. The majority are small amounts which are uneconomic to pursue with two larger debts against a company gone into administration. Approval was given to proceed with these.

ACTION: Write-offs to the value reported to be carried out (AC)

19/20/122 **Finance Report**

AC gave an update on the current financial position. The year to date is in deficit by £1.8m and behind plan overall by £0.1m. Cash is higher than plan largely due to slippage on the capital programme. The forecast year end position is £2.7m behind plan. All divisions and corporate departments have been asked to submit their top 3 improvement plans to close the gap.

IQ questioned the amount of overspend within Facilities in one month; AC noted that there is an unachieved CIP along with overspends particularly in catering and portering; there have also been some changes and a slight improvement in catering although improvements are not as quick as originally planned. CD asked whether we have a really clear programme to ensure the restaurant can break even and does this need re-evaluating given current progress. AB noted that the Catering management have been tasked to bring back a full review which needs to be programmed into the committee schedule. DP suggested surveying staff as to their views; DJ suggested wrapping that around a whole "staff benefits" as it is important to understand what the users of the service want and different points in the day. This survey could include the offer in the Institute which remains unresolved. AC added that there has been a proposal to improve facilities in the Institute at a cost with a small return. JG suggested bringing the Catering item to RABD in early 2020 which he would ask HG to lead on. CK noted that there are other uses for the space proposed for Institute improvements that the building could benefit from.

In terms of the overall position JG noted that there is still a shortfall on forecast and future projections need to show their plans for this; also winter pressures are now beginning to impact and the elective programme needs to be managed alongside the emergency cases.

As an overall comment IQ suggested it might be timely to look back on our investments over the last few years as he would like to see how the cost base has increased against turnover especially against some of the efficiency assumptions that were made in the business case for the new building. His concern was that unless we can improve our margins going forward are financial sustainability will be challenged. rise in staffing while the hospital is not greatly increasing turnover. JG noted that the Executive Team have committed to bringing something back to Board in the New Year which would provide a valid review against the original business case & modelling for the new hospital

ACTION: Catering review to be brought back to January RABD (MD/HG)

ACTION: Historic look back on financial performance of AH to support longer term planning to come back to the committee early in the New Year (JG/CL)

19/20/123 **PFI Contract Monitoring & Update on Key Risks**

GD gave an update on the PFI contract monitoring.

PFI performance has been generally good with almost 99% compliance in October.

Water Ingress - Project Co have employed an external contractor to survey the roof with the first report due by Christmas.
Pipes – non-destructive testing has begun, with an initial report provided. Further updates are expected imminently.
Energy – Energy usage has been 8% below monthly target for October. Project Co have agreed to an options appraisal to look at alternative fuel sources and have an investment fund available alongside a proposed Energy Performance Contract which is currently being considered by the Trust.
Green roof reinstatement is in progress, with replanting of grass to take place in Spring 2020. DP suggested getting the contractor to commit to a schedule; SA responded that this is requested weekly and was due to be signed off by their board last week.
Water temperatures still not fully met; looking to employ member of staff for monitoring; formal water safety report now provided; no positive results reported. AB feeling more assured than previously. IQ asked if there was an easy answer to the problems; GD noted that the pipework is very complex and the problems are not easily resolvable.
Deductions for August are still in dispute – discussions to be held in the next two weeks to resolve.
Skylights – no further leaks have been noted; temporary covers are currently in place for winter before permanent fixes are due to be fitted in April 2020
Theatre temperatures - still an ongoing issue, the problem is due to be raised at next liaison meeting. Mitigations are in place but staff asked to log incidents.
JG asked whether feasibility study has been completed around Isolation unit ventilation; GD responded that has not yet been undertaken but there is a solution which is awaiting their final costs and he will report back when he has a firm position.

19/20/124 Top 5 Risks/Key Priority Areas for 2019/20

RABD received the latest updates on the areas below:

CIP
Current forecast outturn is £4.7m against a plan of £6m, an under delivery of £1.3m. Two areas driving this position are Medicine & non-clinical areas. Medicine division have presented a revised forecast outturn position and it is anticipated some of the revised forecast will contribute towards CIP delivery. A plan is needed for the Corporate areas as to how their CIP targets will be met. In terms of future CIP Commissioner landscape is changing and income generation CIP will be more challenging so there is a need to find alternative ways to deliver and reduce not run-rates. IQ suggested looking at different pools for making savings rather than business development & growth.

Capital
DP gave an update on the Capital programme. Some concerns over asbestos in the old buildings which is increasing costs. The Alder Centre is showing as a £200k overspend and discussions are ongoing with the charity as to whether they will support this. The preferred bidder has been appointed for the Park reinstatement works. Community Cluster costs are projected to exceed budget but mitigation plans are underway for this. The project is currently behind schedule. Capital Finance – Following the submission of the LTP which included the loss of PSF funding and a deficit I&E position for the next two years this has a direct impact on cash and the capital programme and it will be necessary for £13m to be deferred beyond year 5. Two options were proposed – KW asked for an impact assessment; IQ asked that any reduction on IT expenditure does not impact on

resilience; MF asked whether Staff Welfare funding includes the existing commitments. JG noted that our prime objective is to improve our financial forecast which would allow these areas to be re-instated however under Option 2 these are the investments that are not committed. The Committee agreed that we should not look to unpick those schemes that are already underway or form a legal obligation however as we progress with this work we will need to have a better understanding of the impact of not progressing the areas that would need to be deferred or removed from the programme.
ACTION: Impact assessment needs to be undertaken before decision made

19/20/125 **Programme Assurance**
JG gave a brief update. CD noted that the discussion on the International work and the Academy should have framed the earlier discussion on International observer-ships

19/20/126 **Marketing and Communications Activity Report**
MF gave a brief update on the Marketing & Communications activity over the last month, including digital activity statistics.

19/20/127 **Board Assurance Framework (BAF)**
ES gave an update and noted that there will be a strategic risks session prior to Trust Board in December. JG noted that he is re-looking at the Hospital Environment risk profile given there has been some progress made in mitigating risks.

19/20/128 **Corporate Report**
AB noted a correction to the Corporate Report around a particular metric in relation to 12 hour waits; an updated report was reissued.

AB gave an update on the current performance; November is proving to be challenging with some of the busiest ever days & weeks. Colleagues from other departments are supporting ED staff by seeing patients; GP support has also been given from PC24; a daily meeting is being held every morning to support staff & monitor staffing levels, AB noted that there is a need to increase staffing levels; this is a cost pressure but is a safety need. IQ asked why this was happening; AB suggested it is following previously accurate patterns & trends along with flu & asthma admissions coupled with families feeling assured coming to AH when perhaps other routes and services are more appropriate.. CD noted that there has previously been a piece of work around branding external clinics as Alder Hey to extend that sense of safety. AB replied that there is work ongoing with PC24 and a proposal is being put together for the CCG to seek funding for this; DJ noted that a wider alternative strategy for Alder Hey is being worked on. AB noted that Critical Care is also facing pressures with times when Alder Hey has been at maximum capacity but noted that we are not isolated in reaching these capacity levels across the region & nationally. He also noted that staff have been amazing and incredibly supportive during these extremely busy times. AB also noted that there have been other improvements in metrics with the benefits of changes in delivery now showing positive impacts.

19/20/129 **Energy Update**
There has been a 20% overall reduction in energy usage over last 4 years, however overall spend has increased due to higher energy prices. CD asked whether an environmental strategy has been commenced and that alternative energy sources need to be explored. MF noted that this is now being looked at and a proposed Green Plan is to be brought to Board in March.

19/20/130 **Digital Update**

KW gave a brief update on Digital including that the first meeting of the Digital Oversight Collaborative has met. A new service model is being implemented which is progressing well and more proactive support is being given to clinical areas. Resilience equipment is now onsite and configuration is on target for implementation by end of 2019. The Trust a HIMSS assessment scheduled in December, several risks are being managed in advance of the visit. Speciality packages delivery is progressing well. In summary 2019 has been about strengthening a number of basics and making great progress, with 2020 being about mobilisation and implementing future strategy. Departmentally there has been a journey of radically changing some ways of working and this is proving positive with good feedback from divisions and front line teams.

19/20/131 **Any Other Business**

IQ asked that papers be submitted within the deadlines – if not submitted on time, they will not be discussed at the meeting.

19/20/132 **Board Assurance Review**

The Board Assurance Summary was discussed and completed for submission to the next Trust Board in December.

Date and Time of Next Meeting: Wednesday 11th December 2019, 09:30, Tony Bell Board Room, Institute in the Park.