BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 7th January 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
PATIENT STORY (1000 – 1015)							
1.	19/20/278	1016	**Apologies**	Chair	To note apologies: Alfie Bass	**N**	For noting
2.	19/20/279	1017	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate.	**R**	For noting
3.	19/20/280	1018	**Minutes of the Previous Meeting**	Chair	To consider and approve the minutes of the meeting held on: **Tuesday 3rd December 2019.**	**D**	Read Minutes
4.	19/20/281	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.	19/20/282	1025	**Key Issues/Reflections and items for information**	All	Board to reflect on key issues & discuss any queries from information items	**N/I**	Verbal
Board Strategic Development							
6.	19/20/283	1040	**Well Led Framework Follow up report**	Erica Saunders On behalf of Cath Hill (AQuA)	To receive and discuss the report following the workshop held on 2nd December 2019	**A**	Read Report
Operational Issues							
7.	19/20/284	1100	**Operational update**	A. Bateman	To provide an overview of operational risks for the previous month.	**A**	Verbal
Delivery of Outstanding Care: Safe, Effective, Caring, Responsive and Well Led							
8.	19/20/285	1115	**Inspiring Quality**	N Murdock	To brief the Board as to the latest developments in Inspiring Quality and in relation to the selection of a quality improvement partner and receive an overview	**A/D**	Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
					of the content of the programme		
9.	**19/20/286**	**1125**	**Corporate Report** **Divisional updates:** - **Medicine** - **Community and Mental Health** - **Surgery** **Executive Report:** - **Quality** - **Performance** - **Finance** - **People**	Execs 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**	To follow
10.	**19/20/287**	**1200**	**Clinical Quality Assurance Committee:** - **Chair's highlight report from the meeting on 18.12.19** - **Minutes from the meeting held on 20.11.19.**	A Marsland	To receive a highlight report of key issues from the November meeting and the approved minutes from November 2019.	**A**	To follow
11.	**19/20/288**	**1203**	**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
12.	**19/20/289**	**1210**	**Quarterly Mortality Report**	N Murdock	To receive the quarter 3 Mortality report	**A**	Read report
13.	**19/20/290**	**1215**	**Safeguarding Annual Report**	J Knowles	To receive the summary of safeguarding activities during financial year of 2018-2019	**A**	Read report
14.	**19/20/291**	**1230**	**Childhood Obesity – Tertiary Service**	Senthil Senniappan	To present a proposal on a Tertiary Service	**A**	Presentation
15.	**19/20/292**	**1245**	**Access to Child & Adolescent Mental Health Services – Improvement Plan**	L Cooper	To provide assurance in relation to these services	**A**	Read report
16.	**19/20/293**	**1255**	**JTAI Children's Mental Health for**	L Cooper	To receive final reports	**N**	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action: Decision(D)/Assurance(A)/Regulatory(R)/Noting(N)		Preparation
			Sefton for Sefton				
17.	**19/20/294**	**1305**	**Alder Hey in the Park Campus Development update** **- Liaison Committee minutes held on 22nd July 2019**	D. Powell	To receive an update on key outstanding issues / risks and plans for mitigation. To receive the July approved minutes.	**A**	Read report
			Lunch (13:05 – 13:35)				
The Best People Doing Their Best Work							
18.	**19/20/295**	**1335**	**People Plan:** **- Freedom to Speak up** **Communications Refresh**	M. Swindell K Turner	To receive the monthly report. To receive an update.	**A**	Read report Presentation
19.	**19/20/296**	**1350**	**Workforce and Organisational Development Committee** - **Chair's highlight report from the meeting on 10.12.19** - **Approved minutes from the previous meeting held on 18.11.19**	C Dove	To receive a highlight report of key issues from the December meeting and the approved minutes from November 2019.	**A**	Read minutes
Game Changing Research and Innovation							
20.	**19/20/297**	**1351**	**Quarterly Digital Update Report**	K Warriner	To receive the quarterly report	**A**	Read report
21.	**19/20/298**	**1401**	**Innovation Committee** - **Chair's highlight report from the meeting on 10.12.19** - **Approved minutes from the previous meeting held on 18.11.19**	S Arora	To receive a highlight report of key issues from the December meeting and the approved minutes from November 2019.	**A**	Read report
Sustainability Through External Partnerships							
22.	**19/20/299**	**1402**	**One Liverpool Plan**	D Jones	To receive an update on progress to date	**N**	Verbal

23.	19/20/301	1412	**Proposed Constitutional Change – Appointed Governors**	E Saunders	To ratify the proposal set before the Council of Governors to amend the Trust's constitution to better reflect current strategic partnerships	**D**	Read Report
Strong Foundations							
24.	19/20/302	1415	**Board Assurance Framework** **Corporate Risk Register**	Executive Leads	To provide assurance on how the risks that threaten the achievement of the trust's strategic and operational plan are being proactively managed.	**A**	Read report To follow
25.	19/20/303	1430	**Change Programme Progress Report**	J. Grinnell/ N Deakin	To receive an update on programme assurance.	**A**	Presentation
26.	19/20/304	1440	**Integrated Governance Committee Report:** - **Chair's highlight report from the meeting held on 29.11.19.** - **Approved Committee minutes from the meeting held on 11.09.19.**	K. Byrne	To receive a highlight report of key issues from the November meeting and the approved September minutes.	**A**	Read report To follow
27.	19/20/305	1451	**Any Other Business**	All	To discuss any further business before the close of the meeting.	**N**	Verbal
28.	19/20/306	1452	**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 February 2020 at 10:00am, Tony Bell Board Room, Institute in the Park.

REGISTER OF TRUST SEAL
The Trust Seal was used in December 2019: - Deed of Variation – Land Exchange Agreement with Liverpool City Council

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

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 3rd December 2019 at 10:00am,**
Tony Bell Board Room, Institute in the Park

Present:	Dame Jo Williams	Chair	(DJW)
	Mrs S Arora	Non-Executive Director	(SA)
	Mrs K Byrne	Non-Executive Director	(KB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Prof F Beveridge	Non-Executive Director	(FB)
	Mr J Grinnell	Director of Finance/Deputy Chief Executive	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Dr N Murdock	Medical Director	(NM)
	Mrs A Marsland	Non-Executive Director	(AM)
	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)
	Mr C Duncan	Director of Surgery	(ChrD)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Director of Strategy	(DJ)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	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)
	Dr F Marston	Non-Executive Director	(FM)
	Mr D Powell	Development Director	(DP)
Agenda item: 255	Valya Weston	Associate Director of Infection, Prevention Control	
	Christopher Parry	Director of Infection, Prevention Control	
	Natalie Deakin	Head of Programme Management	
	Sue Brown	Assoc. Development Director	

Staff Story

Vivienne Crosbie had trained as a Psychologist and secured her first post at Alder Hey Children's NHS Foundation Trust in 2003 as a Clinical Psychologist with the aim to improve services for children with eating disorders. Vivienne spoke of how she had applied for a post at Alder Hey as she wanted to progress her career in a world renowned hospital for children, young people and their families.

In 2007 Vivienne's role was split between inpatients and community. Vivienne later became Clinical Lead for Sefton CAMHS and is now Clinical Lead for Eating Disorders and Crisis Care. Vivienne spoke of the teams she works with and their passion to get services right for children.

The post of Director of Mental Health was introduced in 2015 and Vivienne commented on the leadership and support this role as provided.

Vivienne noted a number of challenges including:

- Providing support for patients accessing multi agency services

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3. Draft Board Minutes Public 031219 v1

- Patients coming through the new hospital into the old Catkin Building for Mental Health Services; the Board noted the current position and that a new building for these services is under construction.

Vivienne described the progress the services have made and for this to continue. On behalf of the Board the Chair thanked Vivienne for taking the time to share experiences with the Trust Board.

19/20/244 Declarations of Interest

There were none to declare.

19/20/245 Minutes of the previous meetings held on Tuesday 5th November 2019

The Board received the above minutes. Kerry Byrne highlighted under item 19/20/230 Audit Committee, the wording was to be changed to reflect that the term 'positive' was in relation to the Acorn Assurance review being undertaken. 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 5th November 2019. Received

19/20/246 Matters Arising and Action Log

19/20/45: Hilda Gwilliams noted 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. The contract was being sourced to determine if there had been any previous agreement in relation to learning updates from the school.

19/20/146: A presentation on pension risks to high earners had been included on the agenda, this item would now be closed.

19/20/38.2: As Sepsis divisional updates are received under the monthly Corporate Report item, this action would now be closed.

19/20/77: Staff would be thanked for the achievements showcased within the Annual report at the Staff Awards event. This action would now be closed.

19/20/172: The Chair had recently visited Whiston Hospital in relation to their achievement of CQC rating of Outstanding and was due to visit Salford Royal next week. This action would now be closed.

19/20/206.1: A quarterly deep dive into progress against delivery had been included under the Change Programme item, this action would now be closed.

19/20/206.2: An update on the Journey to Outstanding had been included under the Change Programme item, this action would now be closed.

19/20/247 Key Issues/Reflections and items for information

On behalf of the Board the Chair congratulated John Grinnell who had won two 2019 Finance Director of Year Awards. John Grinnell had won both Finance Director of a Non Profit Large Organisation (over £100m) award and the overall winner of Finance Director of the Year award.

Louise Shepherd updated the Board from her recent meeting with Sefton leaders and actions required following the recent SEND re-inspection. The Board are aware of the

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current position including long waiting times for ASD/ADHD and the work being completed to quickly improve the services.

Both Louise Shepherd and the Chair reported on a meeting they had attended with representation from CCGs and Liverpool City Council. Lisa Cooper and Dani Jones had been commended at the meeting for their support in relation to the Starting Well strategic theme.

Louise Shepherd and Nicki Murdock reported back from a meeting held in relation to Liverpool Women's NHS Foundation Trust safety risks. Marie Bowles Regional Chief Nurse noted the partnership working between Liverpool Women's and Alder Hey.

Dani Jones noted that the Liverpool Level 1 all-age congenital heart disease partnership had won the Patients' Choice award at Liverpool Heart and Chest Hospital's annual awards. On behalf of the Board, congratulations were passed on to all involved in the CHD partnership.

19/20/248 Operational update

Adam Bateman provided the following update:

Attendances at the Emergency Department continue to increase significantly; daily patient visits are now at an average of around 260 per day. The Board noted many of these patients are not required to be seen by ED. The Board also noted the pressures on the ED team and the social media that was being circulated by the Trust in relation to the high numbers attending ED and the increase in waiting times as a result.

As Bimal Mehta had stood down from the role after three years, Ann Kerr has been appointed as Clinical Director for ED.

Christian Duncan reported on the two pioneering hip surgeries to babies that had taken place at Alder Hey. Training programmes in relation to this are being delivered to Theatre Staff.

A detailed plan had been presented at the Executive team in relation to the oversubscribed multi-storey car park. Included in the plan is a procurement of off-site parking in January 2020.

Resolved:
The Board received the Operational update.

19/20/249 Inspiring Quality Phase 1 – Progress to Date

Nicki Murdock gave a presentation on progress to date against the 10 programmes within Inspiring Quality Phase 1. Phase 1 was a 6 month period that ran from April – October 2019.

The three main purposes of the Phase 1 work were to:

- Create capacity
- Mobilise people
- Communicate change

Phase 2: Embedding Change has commenced and is due to be completed in November 2020 prior to commencing Phase 3.

Resolved:
The Trust Board received a paper and a presentation on Inspiring Quality Phase 1.

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19/20/250 Corporate Report

The Board received the month 7 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.

Patients treated for Sepsis within 60 minutes was an average of 80% with a variable trend that saw an increasing incidence of 100% achievement; enhanced focus will be applied as well as collaboration with the digital team.

Caring

There had been 2 complaints and 36 PALS enquiries, complaints had reduced since last month.

Adam Bateman noted going forward that it would be important to capture lessons learned in complaints and PALS as part of the divisional performance summary.

Action: Associate Chief Nurses

Effective

It was noted the narrative under challenges in relation to one patient in ED waiting 12 hours from decision to admission was incorrect; the correct version of the Corporate Report would be published on the Trust Website within the Trust Board December pack.

Responsive

Turnaround times were consistently good in many areas (especially Pathology) though MRI and CT were now more challenging to deliver. Action plan to address this to be presented at Operational Delivery Board on 28/11/19.

Well Led

Mandatory training is above 90% for fourth consecutive month at 91.6%, an improvement on last month.

Surgery – Christian Duncan

Safe

Sepsis 100% in the last 3 months (only 1 child >60mins in 5 months).

There had been:

- 0 Never Events
- 0 SUI's
- 0 Grade 3/4 Pressure ulcers
- 1 x C diff – Ward 3A

IPC work on 3A and CLABSI is being reported into the Clinical Quality Assurance Committee.

Caring

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There had been 1 complaint and 41 PALS responses. Complaints continued to reduce.

The Board noted there is a programme to increase staffing levels with short-term planning in place.

Effective
Theatre sessions delivered was 668. Both Theatre and Clinic utilisation was at 87%.

Responsive
An increase in cancellations on the day continued for the reporting period.

Well Led
Mandatory training continues to be above 90%.

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

A Youth Worker has commenced in A&E as part of a Violence Reduction Unit pilot initiative. This role is initially part time and funded until 31 March 2020.

Safety huddles within the Community Nursing team have now commenced.

Caring
Launch of 'You're not immune' video created by FRESH CAMHS participation group had taken place at Tate Liverpool.

Effective
Recruitment to the Intensive Support (learning disability) team pilot project was undertaken as part of Transforming Care.

Responsive
Review of CAMHS waiting times to clearly demonstrate time from Referral to Treatment (i.e. First Partnership appointment) with a robust trajectory for improvement and plan in place.

Well Led
Lisa Cooper thanked Kate Warriner and the team for the rollout of new IT equipment to the Community Division.

Executive leads raised items by exception as follows:

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

Caring
Attendances within ED are some of the highest the department had experienced since opening, impacting on children, young people and their family's experience.

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

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Well - Led
In Month 7 the Trust delivered a £0.7k surplus which was £0.2k behind plan.

CIP performance was in line with plan in month although there is still a material gap against the forecast versus target of £1.2m. A financial re-set is being taken through Resources and Business Development Committee to target key areas of improvement.

Resolved:
The Board received and noted the contents of the corporate report for month 7.

19/20/251 Clinical Quality Assurance Committee

Resolved:
The Board received the Chair's highlight report from the last meeting on 20th November and the approved minutes from the meeting held on 16th October 2019.

19/20/252 Serious Incident Report

The Board received and noted the content of the Serious Incident report for October 2019. Hilda Gwilliams stated that during this reporting period there was one new Serious Incident, five investigations were ongoing and three SI's had been closed.

The new incident was in relation to 800 outstanding blood results on Meditech that had not been reported on. The tests are primarily related to immunology and anticoagulation. These tests are not diagnostic, but can support diagnosis. The initial review shows that 774 are negative (i.e. no issues identified). The remaining 26 show a positive result, however the initial assessment suggests they are low risk. A Root Cause Analysis panel is to be arranged.

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

19/20/253 Mental Health Act Report

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

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

A discussion was held in relation to police and detention under the Mental Health Act and use of Alder Hey's Section136 room. Lisa Cooper advised that she and the Chair have a meeting with the Police Commissioner next week and will raise this with relevant officials.

Resolved:
The Board received the Mental Health Act report for the period 01 September 2017 – 31 August 2019. Going forward the next update would be received in May 2020, then annually going forward.

19/20/254 Complaints Quarter 2 Report

The Trust received 37 formal complaints during this period. One complaint from this quarter was subsequently withdrawn from the process at Dad's request after local resolution had been undertaken with service managers from the area.

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Resolved:
The Board received the quarter 2 complaints report.

19/20/255 Infection Prevention and Control Quarter 2 Report
Valya Weston presented the most recent position.

Hand Hygiene for quarter 2 is at 95% compliance. The Board noted the 9 points under additional achievements.

There were 6 concerns under issues for Board attention:

1) There are no rooms in the ICU and Emergency department with adequate ventilation for the isolation of patients with suspected or confirmed airborne transmitted infections and High Consequence Infectious Diseases (HCID). A list of potential solutions was provided and is being worked through.

2) There are continuing issues with risk of *Pseudomonas aeruginosa* contamination in water outlets on PICU and other augmented care areas. This issue is monitored and actioned through the Water Safety Group.

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

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

4) Alder Hey, in conjunction with the Royal Liverpool University Hospital is part of the national network for managing HCID-Airborne Infection patients. Due to the issues with isolation facilities (described above), children with a confirmed diagnosis of a HCID will be transferred to the Royal Isolation Ward but will be cared for by a team of clinical personnel from Alder Hey.

   This process requires that staff who have volunteered for this work need to be trained in the donning and doffing of specialized personal protective equipment for the care of these patients and to protect themselves. This training needs to be repeated every six months in order that staff remain proficient in this process. A list was provided of the staff numbers trained to date.

5) There have been several business continuity incidents in this reporting period; the board noted the current position and progress to date.

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

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trusts. A Trust wide group has been established and will report to the Clinical Quality Assurance Committee.

A discussion was held on the reporting of surgical site infections and its reporting structure. It was noted this is reported into the Infection Prevention and Control Committee, Hilda Gwilliams requested the data is included in the Corporate report.
Action: VW

Resolved:
The Board received the Infection Prevention and Control report for quarter 2.

19/20/256 People Plan

Melissa Swindell presented the report for November highlighting:

- The Staff Survey closed on Friday 29th November 2019 with a response rate of 62%. A breakdown of percentage for each division was given.
- The proposal to implement a centralised Wellbeing Team provided in-house by HR, has been approved by Investment Review Group (IRG). The business case supports the implementation of a team for a period of 18 months.
- Sickness rates for October 2019 showed an increase in month to 5.7%, mainly attributable to an increase in short-term sickness absence.
- A revised version of the staff Temperature Check, a quarterly staff survey, ran in Q1 and Q2. The Workforce and Organisational Development Committee received a presentation of the overall findings from Q1 and Q2, and discussed next steps and feedback.
- To support the medical workforce with mandatory training, it has been agreed to reduce clinical activity on the 3rd January 2020 in order for mandatory training to be completed.

Pensions update

Melissa Swindell delivered an NHS Employers' presentation on the NHS Pension Scheme Tax issues, covering:

- Lifetime allowance overview and limits
- Tapered annual allowance
- National action being taken to address the issues, including a national consultation on the pension scheme, and NHS Employers response to this consultation
- The specific impact that the pensions tax issues have had on Alder Hey service delivery.

The presentation covered the proposed new arrangements for clinicians for the 2019/20 tax year, whereby clinicians using the Scheme Pays option to pay their tax charge for 2019/20 financial year will be fully compensated under new NHS England and NHS Improvement arrangements. The Board had a number of comments regarding the workability of this option. MS confirmed that additional information from NHS England to further explain the implications of this option was expected imminently.

The presentation also outlined a number of local options, which all trusts are encouraged to offer to their staff, including:

- The management of pensionable Clinical Excellence Awards
- The use of multiple contracts of employment. It was noted this option has already been rolled out at other trusts.
- Innovative TOIL arrangements
- Managing pensionable pay
- Establishing new organisations for service delivery

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- Possible arrangements for employees who decide to opt out of the NHS scheme; Alder Hey have adopted a version of these arrangements and a number of other Trusts have already adopted this option.

Melissa Swindell acknowledged that, as the national position on pensions has been moving rapidly, there was not an opportunity to prepare a paper in advance of the meeting, and that it was important to provide the Board with the most up to date position. MS requested Board approval to amend the current Trust policy which supports employees who decide to opt out of the pension, to include those impacted by the Annual Allowance. MS also requested that the Board support a proposal to keep all of the local options open, with a view to trust management and local teams discussing suitability and appropriateness of the options.

Resolved:
The Board received:
a) The People Plan update
b) Approved the request to amend current policy eligibility to include staff affected by the Annual Allowance.
c) Approved the request to allow for all local options to be made available, pending local discussions and management approval.

19/20/257 Workforce and Organisational Development Committee
Resolved:
The Board received and noted the Chair's highlight report from the meeting held on 13th November 2019 and the approved minutes from the meeting held on 19th September 2019.

19/20/258 Fit and Proper Person Test
The Board received an updated version of the Chair's annual declaration report on compliance against FPPR under CQC Regulation 5, setting out positive assurance in relation to the fitness of its Directors. The latest version included both Fiona Marston and Fiona Beveridge.

Resolved:
The Board received the latest version of the FPPR compliance report.

19/20/259 Innovation Committee
Resolved:
The Board received the Chair's highlight report from the meeting held on 18th November and the approved minutes from the meeting held on 9th October 2019.

19/20/260 One Liverpool Plan/Integrated Partnership Board
The latest position had been highlighted by Louise Shepherd as part of her updated under key issues.

19/20/261 Progress report against Strategic Plan to 2021
The Board received the latest version of the above document, it was agreed the report would be circulated as a single document.
Action: JT

Going forward the Strategic Plan would be presented quarterly.

Resolved:
The Board received the progress report against Strategic Plan to 2021

19/20/262 Update on Specialist Trust Group and system governance

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Louise Shepherd and John Grinnell reported back on the Specialist Trust Collaboration Workshop that had been held on 21st November 2019 led by Sir David Dalton, former Chief Executive of Salford Royal NHS Foundation Trust and Pennine Acute Hospital, with regard to group organisational models. Louise Shepherd noted the Trust Boards of the Specialist Trusts are due to meet in February 2020.

Resolved:
The Board noted progress to date in relation the Specialist Trust Group.

19/20/263 Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital

The Board received the Joint Memorandum of Understanding that sets out the framework for collaborative partnership working between Alder Hey Children's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust to jointly establish a new model of care for neonatal services: The Liverpool Neonatal Partnership.

Adam Bateman confirmed that Claire Dove is the Non-Executive Director representative for Alder Hey and there is also NED representation for Liverpool Women's.

Resolved:
The Board received the joint Neonatal Partnership Memorandum of Understanding.

19/20/264 Board Assurance Framework (BAF)

In view of the strategic risk workshop, Erica Saunders presented the current BAF report for information and invited any questions by exception. It was noted that the scoring in relation to the Hospital Environment had increased indicating a worse position, which was not reflected in the narrative against actions and controls. There was a query as to whether this was correct or a possible typographical error; it would be looked into by the Governance Manager.
Action: JP

Resolved:
The Board received the BAF as at end of November.

19/20/265 Change Programme Progress Report

The Board received the latest programme assurance report.

Journey to Outstanding Assurance Report
As requested at the last meeting Natalie Deakin presented progress against the Journey to Outstanding assurance report. Natalie highlighted high level time lines are on track.

Kerry Byrne queried why there had not been a programme on this aspect previously. Hilda Gwilliams advised that the current programme approach pulled together a range of areas under the Delivery of Outstanding Care pillar, which was indicative of the maturity of the Trust's DMO model.

Hilda Gwilliams noted the programme had embedded the 'journey to outstanding' across the Trust.

Change Programme
Natalie Deakin presented an overall update in relation to each of the elements of the change programme: Campus development, Aspetics, Safer, Apprenticeships, Detect, Catering and Best in Acute Care, summarising key achievements and developments delivered to date.

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Resolved:
The Board received:
- The latest programme assurance report
- Journey to Outstanding
- Change Programme

19/20/266 Communications Guide and Calendar 2020

Mark Flannagan presented an overview of the proposed approach to delivering consistent, strong messages about Alder Hey, internally and externally.

The new communications cascade approach to internal communications uses identified channels by which we will keep staff informed on a regular basis.

Slides on the Core Messaging Guide had been included with the paper.

Resolved:
The Board received and noted the communication guide and calendar for 2020.

19/20/267 Alder Hey in the Park Site Development Update
Change Programme: Park, Community, Estates and Facilities

The Trust Board received an update on the Site Development programme.

The planning application for the full reinstatement of the park is due to be approved at the next planning meeting on 10th December 2019.

Construction of the Alder Centre is well underway, construction is on plan and in line with the project delivery programme for handover in March 2020.

To reduce the cost of the Neonatal build an external company had suggested reducing the square footage of the plan. Sue Brown described a number of initiatives the teams are undertaking to do this without any negative effect.

Lisa Cooper requested that the two builds within the community cluster are separated so progress against each is clear.

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

19/20/268 Audit Committee
Resolved:
The Board received the Chair's highlight report from the meeting held on 21st November and the approved minutes from the meeting held on 26th September 2019.

19/20/269 Resource Business Development Committee
Resolved:
The Board received and noted the Chair's highlight report from the meeting held on 27th November 2019 and the approved minutes from the meeting held on 23rd October 2019.

19/20/270 Any Other Business
Christian Duncan

On behalf of the Board the Chair thanked Christian Duncan for his valuable support during his role as Clinical Director of Surgery. The Board wished Christian every success in returning to his main role as a Craniofacial Consultant at Alder Hey.

19/20/271 Review of the meeting

DRAFT

The Chair referred to the strategy session held prior to the Board meeting thanking all members for their involvement. It was agreed a strategy session would be held every quarter in the coming year.

Date and Time of next meeting: Tuesday 7th January 2020 at 10:00 in the Tony Bell Board Room, Institute in the park.

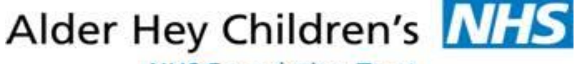
Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following on from the meeting held on the 3.9.19

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.
Action for November 2019							
03.09.19	19/20/146	Board Assurance Framework	The Board discussed the pension risk in association with consultants (high earners) and the impact on services. A quality impact assessment is to be completed.	Christian Duncan/ Lisa Cooper/ Adrian Hughes	05.11.19		05.11.12 An update on this was deferred until the next meeting on 03.12.19 03.12.19: As this item was on the agenda this action would now be closed.
03.09.19	19/20/38.2	Inspiring Quality Progress and Next Steps	***Sepsis Update*** - Divisions to review their compliance against sepsis training and encourage staff/areas outstanding to complete.	Divisions	01.10.19		01.10.19: Update received a further update to be received at the Trust Board meeting on 5th November 2019. 03.12.19: As updates are received within the Corporate Report division section this action would now be closed.
Actions for December 2019							

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

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
28.05.19	19/20/77	Draft Annual Report and Accounts	To arrange a thank you event for achievements within the annual report.	Mark Flannagan	02.07.19		02.07.19: In process 01.10.19 A thank you event to be held at the December Trust Board. 03.12.19: It had been agreed that thank you event would be part of the annual staff awards, this action would now be closed.
01.10.19	19/20/172	Long Term Plan 2019-2024	To map out potential collaborations both locally and internationally	Adrian Hughes Hilda Gwilliams Nicki Murdock	03.12.19		03.12.19: The Chair had recently visited Whiston Hospital in relation to their achievement of CQC rating as Outstanding and was due to visit Salford Hospital next week. This action would now be closed.
05.11.19	19/20/206	Change Programme Progress Report	To provide a quarterly deep dive on progress against delivery	Natalie Deakin	03.12.19		03.12.19: To receive an update under the change programme progress report. 03.12.19 This item was on the agenda, this action would now be closed.
05.11.19	19/20/206	Change Programme Progress Report	To receive an update on progress against the journey to outstanding	Natalie Deakin	03.12.19		03.12.19: To receive an update under the change programme progress report. 03.12.19 This item was on the agenda, this action would now be closed.
Actions for 7th January 2020							
01.10.19	19/20/179	Quarterly Mortality Report	To include details of how far mortality reviews have come over the years	Nicki Murdock	07.01.20		
01.10.19	19/20/179	Quarterly Mortality Report	To review as to whether the Hospital Mortality Review Group should continue the aim of reviewing deaths at 4 months if this wasn't an achievable goal	Nicki Murdock	07.01.20		

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



Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Status							
Overdue							
On Track							
Closed							

Board of Directors

Tuesday 7th January 2020

Paper Title:	**Well-Led Follow-Up Review and Developmental Support 2019/20**
Report of:	**AQuA and MIAA**
Paper Prepared by:	Cath Hill, Director, Advancing Quality Alliance (AQuA)

Purpose of Paper:	Decision Assurance Information Regulation	☐ ■ ☐ ☐
Background Papers and/or supporting information:	Well Led Development Framework, NHSI June 2017 Comprehensive Well Led Review – Report by MIAA/AQuA February 2018	
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	

Well-Led Developmental Support

1. Overview

To support the Trust's forthcoming CQC inspection AQuA/MIAA have competed a follow up review to establish developments at the Trust since the last CQC review. Our findings in this report are based upon the views expressed by Board members and senior staff. We have assumed that the information provided to us are complete, accurate and reliable; we have not independently audited, verified or confirmed their accuracy, completeness or reliability.

A summary of the Trust's 2018 CQC inspection ratings is provided in Figure 1.

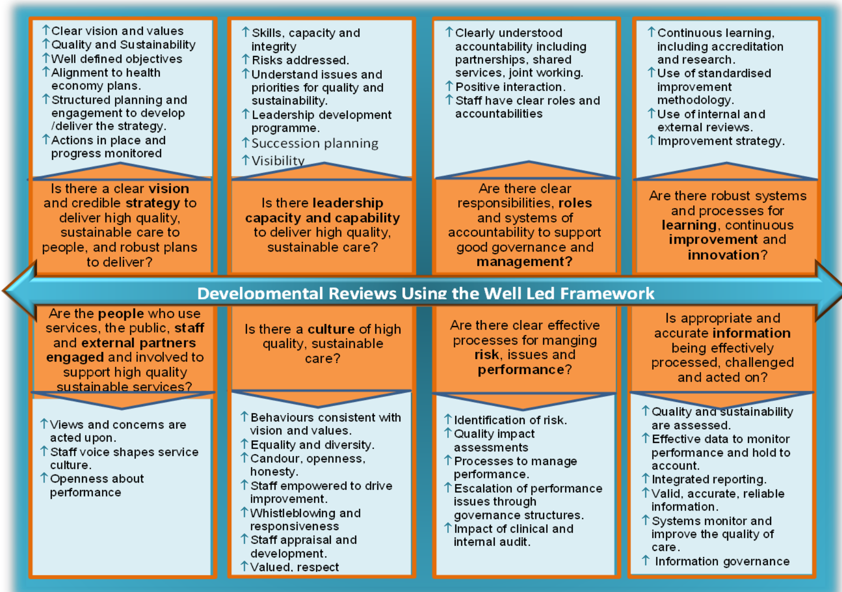
Figure 1 – CQC Ratings

Overall rating for this trust	Good
Are services safe?	Requires improvement
Are services effective?	Good
Are services caring?	Outstanding
Are services responsive?	Good
Are services well-led?	Good

The report which is structured around the Well-Led Key Lines of Enquiry (KLOE) figure 2 aims to describe the Trusts **'Journey since the Last CQC Visit'**

This will to support board members in preparing for CQC interviews.

Figure **2** - Well-Led Framework (As Per NHSI Developmental Review guidance).



For ease of reference, recognising that there are new non-executive members of the Board, Common abbreviations used in this report are provided in Appendix A.

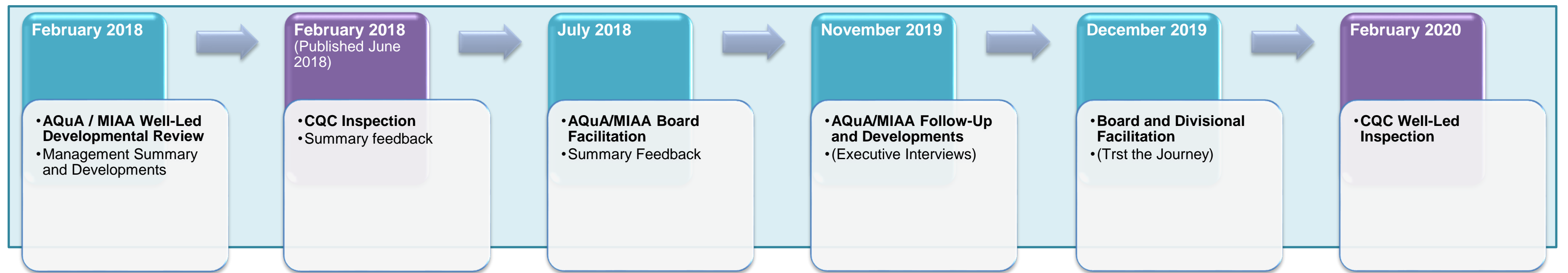
Alder Hey Children's NHS Foundation Trust

Well-Led Follow-Up Review and Developmental Support

2019/20

2. Follow-Up Review

The review captures the Trust's journey since the last CQC assessment:-



The figure below provides an overview structure of the document.

1. A Section for Each of the 8 Key Lines of Enquiry (KLOE)

2. A summary of feedback from the AQUA/ MIAA Well-Led Developmental Review published in February 2018

3. Feedback from the July 2018 AQuA/MIAA Board Development Session

4. Feedback including developments from the CQC inspection published in June 2018.

5. October 2019, follow-up progress and developments.

6. Highlighting The Trust's Outstanding Practice or Services

KLOE 3 Are there clear responsibilities, roles and systems of accountability to support good governance and management?

AQuA/MIAA - Well-Led Review Feb 2018 | AQuA/MIAA - Board Workshop July 2018 | CQC Inspection Feb 2018, Published June 2018

Board | Committees | Divisions | Clinical Partnerships

Outstanding Practice or Services

EXAMPLE ONLY

AQuA Advancing Quality Alliance In Partnership

KLOE 1 Is there leadership capacity and capability to deliver high quality, sustainable care?

AQuA/MIAA - Well-Led Review Feb 2018

The Board's current composition demonstrates an exceptionally good balance of skills, experience, and knowledge. The leadership of the Chief Executive is of particular note in terms of grip, style and the high regard in which she is held. The Chairman is a key asset in enabling the effective operation of a wide and inclusive Board. The non-executive arm of the Board is effective and there is good challenge from the non-executives and between executives. The representation and impact of clinical leadership at the Board table is a developing strength. It enriches the leadership debate and decision-making. The divisional model is a key component of the Trust' leadership arrangements. Those arrangements are progressing well and have delivered outcomes that would not have been possible under the previous structure.

The leadership challenge for the next phase of development will need to address progression in capability below the divisional leaders, embedding risk management, accelerating cross-divisional working, focusing on fewer priorities, and freeing capacity through clarity on decision-making rights and earned autonomy. Visibility of leadership is reasonably strong but this needs some Board attention as there are gaps to reflect and act upon. The nurturing and sustaining of and shadowing is important as they are having significant impact. The stability of the Board is a potential vulnerability given the number of new and interim arrangements and the number of non-executive tenures of appointment coming to an end. Getting the collective narrative right on all of these issues is important, particularly for the wider Trust. Given the wide-ranging nature of the Board it is timely to consider a more structured Board development programme. This should be driven by a skills inventory and include addressing the principle of what it means to be a director. There is a collective sense of the operational and financial challenges but there was a less consistent picture in respect of quality priorities. There is work in progress to sharpen that focus. That work is important to conclude as beyond the Board that lack of consistency was an evident issue.

- ✓ *Chairman facilitates an inclusive board provides a **regional and national profile**.*
- ✓ *Chief Executive **highly regarded** at regional level.*
- ✓ ***Breadth of board experience** with positive relationships.*
- ✓ ***Collective leadership** is being nurtured.*
- ✓ *Strengthening **divisional leadership***

- ↑ *Board **visibility** has been strengthened and well received, but needs to be **sustained.***
- ↑ *As part of the board succession planning, refresh of the **board skills inventory** including diversity.*
- ↑ ***Development programmes**:- to develop executive team effectiveness further; develop clinical leadership; mentoring, coaching, empowerment*
- ↑ *Further clarity on: **clinical leadership roles; earned autonomy** decision making, incentives and ownership.*
- ↑ *Review role and effectiveness of the Executive*

Developments

1.1 The survey results, at Board and Divisional level, generally reflect that **visibility** is a challenge although there is considerable variation in views. The Trust need to ensure that the commitment to the Quality Assurance Rounds is strengthened and sustained (recognising that there are over 50 visits in a rolling programme) as the positive impact was very evident during this review.

1.2 Board Development Recognising the recent changes to executive membership of the board and the forthcoming non-executive changes the following developments are proposed:-

1.2.1 A refresh of the Board skills inventory is timely.

1.2.2 To better understand each other's skills and experience and reassess the effectiveness of working together as a Board. To support this, a more structured, formally adopted Board Development Programme covering team building and strategic challenges, The shared understanding of what it means to be a director in terms of individual and shared accountability, insight beyond the NHS

1.2.3 A capacity assessment. 1.2.4 The Trust's approach to succession planning and talent management needs to be beyond Board level with transparent processes available to the divisions.

1.3 Leadership

1.3.1 The widening of Board and subsequently executive team membership (Core executives and all directors/clinical leaders) has left some lack of clarity of role content, purpose and effectiveness.

1.3.2 The Executive Team should review the membership of this meeting (to maximise the utilisation of this resource) and additionally assess opportunities for executive only discussion.

1.3.3 Clinical leadership development, mentoring and coaching programmes need to be re-introduced (including: ward to board leadership; governance and risk etc). Recognising the changes to the divisional structures, the alignment of clinical leadership needs to be reassessed and linked to the Trust's Leadership and Management Development Strategy.

1.4 Earned Autonomy

The Trust need to develop structures for the achievement of earned autonomy.

AQuA/MIAA - Board Workshop July 2018

KLOE 1: LEADERSHIP

Visibility: Effective Quality Ward Rounds. Important to sustain, communicate, get feedback and monitor where we are on the programme.

Board Development: System leadership and collaboration are key. Clinical Leads need formal support as Board members. Recognised challenge of a new Chair.

Leadership: The modelling of coaching is important - 'Coaching for Quality'.

Earned autonomy: Balance between autonomy and direction is a challenge. Taking responsibility of QI at a local level is necessary. Need to support people with managing risks.

Board Diversity: Programme of mentor support for BME. NHS Leadership Academy Diversity Programme

CQC Inspection Feb 2018, Published June 2018

- ✓ There was an experienced and stable leadership team who were committed to improving services, through learning research and innovation.
- ✓ Leaders at every level prioritised safe, high quality care and had the skills and experience which was maintained through effective development and succession processes.
- ✓ They recognised the training needs for managers at all levels and worked to provide development opportunities for the future of the organisation.
- ✓ The trust had made improvements to the fit and proper person process. The trust had updated their recruitment policy to reflect this and checks for all executives and non-executives had been fully completed.

Developments

- ↑ Consider identifying a specific action to improve the ethnic diversity of the executive board
- ↑ **End of Life Care -** Representation at board level for palliative care services was through the medical director and the lead for mortality but there was no non-executive director lead for palliative or end of life care

Well-Led Developmental Support

2019 Progress			
Executive	**Non-Executive**	**Board Development / Training**	**Fit and Proper Person (FPP)**
2018 – There were a number of acting/interim Executive posts. Since the last review stability across the team has been achieved and maintained. − Newly embedded or substantive team appointments ▪ Director of Strategy ▪ Medical Director ▪ Chief Operating Officer ▪ Chief Digital and Information − Distinctive to many other organisations reviewed, the Trust have board level posts for:-: ▪ Director of Communications ▪ Development Director ▪ Associate Director of Research − This level of stability and structure will support: ○ The ownership and implementation of the 'refreshed strategy'. ○ Robust executive engagement in system level and partnership activity (refer to KLOE 2 and 7). ○ Responsiveness to well-led excellence e.g. innovation.	Overall board membership (exec and NED) demonstrates a broad range of skills and experience relevant for the delivery of the strategy. Since 2018 the team has retained corporate knowledge through − Stable team with 4 non-execs remaining in post since the last review − New Chair (Dame Jo Williams) appointed Feb 19 from within the established NED team − Further to planned turnover, 3 new appointments aligned to the Trust's strategic direction. Specific NED Roles − Anita Marsland – SID, NED lead for Mortality inc. palliative care/end of life. − Ian Quinlan – long-standing Vice Chair, extended by CoG to September 2020 − Kerry Byrne – Audit chair and lead for risk − Claire Dove – workforce committee chair and lead for people agenda and Neonatal partnership with LWH Strong system engagement to bring challenge and develop partnership engagement:- ○ Claire Dove Social Values − The board is balanced in terms of ethnic diversity of the board (response to the last CQC report)	The Trust appointed to the NED vacancies in October 2019. **Following this the Chair is in discussions with AQuA with regard to the design of a board development programme.** Previous well-led development report - The concept of "**collective leadership**" is being nurtured. Executives and non-executives are clear about their roles and function very effectively as a team. **<u>Induction</u>** − All new board directors attend – NHS Providers Board's Programme. (in addition to tailored local induction). − The induction programme was viewed to be comprehensive. <u>Capacity</u> Board capacity is assessed through various mechanisms including individual annual appraisal, assurance committee annual reports to the Board, self-assessment against the Trust's Provider Licence and the Annual Governance Statement, as well as external assurance processes such as review meetings with NHS I/E. **<u>Succession Planning</u>** − L&D Lead recently appointed. − Succession Planning high level Board plan - Nov 19, based on existing 'ready now, ready later' analysis developed by HRD; to be rolled into Divisions	− The Chair approves the annual summary declaration from all directors (Nov 19) − New board level contract include FPP statements. − The Chair approves new board appointments re FPP. − MIAA audit provided substantial assurance

Leadership Framework		Earned Autonomy	Clinical Leadership/Medical Engagement
− Launch of AH new Leadership framework (2019), underpinned by the key elements of the NHS Interim People Plan and the vision for leadership and talent management in the NHS outlined in Developing People, Improving Care, which outlines our plan for leadership development and support 2019-2021 (aligned to the Trust's Inspiring Quality Programme. − Incorporates a Strategic People Plan (Oct 19) which maps to the strategic plan 'our plan'. Delivery is monitored through the Workforce Committee. − Approach is to identify, engage, develop, support and sustain all leaders (includes clinical leadership) and managers in the organisation in a more consistent way that has compassion and inclusivity at its core and promotes a psychologically safe culture in which people feel free to speak up. − Developed a bespoke in-house 3 day Strong Foundations training, in collaboration with the BME, Disability & LGBTQI+ networks, which is for all current and aspiring clinical and non-clinical leaders and managers across the organisation ○ Focussing on Leading Me (self-awareness, self-management and resilience & Inclusive leadership), Leading Others (building trust, psychological safety, feedback, learning, patient and family centred care)and Coaching. ○ The programme draws on the most recent research evidence and local feedback regarding effective leadership and its impact on outcomes for staff, children and families. It aims to build emotional intelligence and equip leaders and managers to create compassionate, safe and trusting working environments in which people can grow, learn, make changes, and feel free to speak up and challenge with both courage and kindness. − Over 200 leaders are booked onto the training in Year 1 (2019-2020) nticipate training all of our 600 leaders and managers within 3 years. (102 trained in last 12 months ie 25% of those eligible, over2) − A STEPping up to Leadership programme based on Strong Foundations for junior doctors to support our future medical leaders. −	− New Leadership faculty, access the range of leadership training offered by the NHS Leadership Academy, − national training programmes for BME staff, or − In-house training such as Cultural Competence training. − 2018 introduced a local Mary Seacole Programme (100% pass rate from first cohort), supported NHS Graduates in their leadership journey, and enabled staff to complete academic leadership modules at universities. − To support and develop the talent community in the North West we are hoping to become the regional host for the Mary Seacole programme. − One of only two Apprenticeship Providers in the Liverpool city region, we deliver Team Leader apprenticeships and utilise our levy to support staff completing Level 5 and Level 7 apprenticeships in Leadership. ○ Completing apprenticeship to masters level, to support succession planning. ○ OFSTED review of provision. − **Focus now is on strengthening our recruitment, appraisal & succession planning processes whilst continuing to develop our diverse talent through training and coaching/mentoring.**	− Alder Hey operates a devolved management model founded upon three clinical Divisions - Medicine, Surgery and Community and Mental Health − This places decision making as close to the patient as possible and to ensure clear responsibility and ownership and local level. − The Divisional structure is a key vehicle for delivery of the line of sight from ward to board. ○ There is clarity regarding responsibilities and decision making powers. ○ Annual plans provide clarity of what is to be delivered. − The ComCell meetings provide a good opportunity to share and address issues openly and at speed – supporting autonomy. − The Trust's Corporate Report has been revised during the year by the Business Intelligence team to place a further focus on Divisional performance metrics and these are now reported out clearly at the Board meeting each month by the Divisional Directors. ○ The report is structured against the CQC's five domains. <u>Divisional Performance Review</u> – − Moved to bi-monthly − Standardised reporting templates use by the divisions, patient centred approach applied, covering each of the key lines of enquiry and aligns to the Trust strategy. − Executives utilise 'live data' on the Business Intelligence Dashboards.	<u>Divisional Clinical Leadership</u> • Divisional clinical leaders attend the Board. • **Divisional clinical leadership is being further strengthened to increase** ownership and the spread of engagement :- − Clinical Information Officers are being appointed to each division. − Safety Leads − Clinical Audit Leads − Quality Lead. − Clinical Effectiveness Lead − Experience Lead. • **AHP voice is being strengthened.** <u>Medical Engagement</u> • **Senior Leadership Doctors Forum (Clinical Cabinet) - Proposal to Board on September 2019, commending December 2019.** • The Trust is moving to a model of taking the committee meetings into the divisions, to increase accessibility for medical colleagues. • Doctors attend the weekly safety huddles. • Junior Doctors Forum in place. − Better supported − Doctors Mess in place. − Doctors represented on the Out of Hours Steering Group. − Health Education England NW visited – more positive response re culture and relationships. − **Development work on rest breaks.** • Divisional level medical engagement is strong and well represented in meetings.

Well-Led Developmental Support

2019 Progress			
Governors	**Visibility**	**Freedom to speak up Guardian**	**Executive Membership meeting**
− Relations with governors have significantly developed since the last review through the introduction of: o Informal lunches with the Chair. o Increased NED attendance at the meetings (what is the exposure and process) o Chair: Lead governor 1:1 − Training(Provided by NHS Providers) o Core skills module (Oct /Nov 18). Repeated for new governors (Oct 19) o NED recruitment module for nominations Cttee members (Dec 18) – in preparation for the planned NED recruitment. o Governor self-evaluation (July 19) − Engagement on – o broader developments such as the Alder Hey campus and how we realise our vision and o role in regeneration in the local area.	− 2018 the Quality Assurance rounds were newly established. The focus is on the 5 CQC domains (Safety, Reliability, Caring, Well Led, and Effective, plus risk) − The process has been extended to community services. − The Quality Assurance round programme has completed one full cycle of all clinical services and teams within the Trust and is part way through the second cycle with a programme mapped out for the remainder of the year. − Two board members (one Executive, one Non-Executive) are assigned to each assurance round, − The process gives individual teams an opportunity to showcase their service, as well as highlight any key risks and actions that are required to mitigate them. − **The programme has continued (but due to a period of NED vacancies) has had less visibility.)** − Exec visibility – programme re-launched using agreed template for feedback; actions and key messages being collated by the Inspiring Quality team using a 'visibility board'	− The Trust has an 'Open Supportive Culture' - Raise it, Change it o There is an open door approach for accessing the senior team and board members. o One of highest reporters of incidents − (FTSU)– Kerry Turner (also leads on Listening into Action (LiA). The FTSU is an active participant in local and national networks − Trust has developed its activities in accordance with best practice guidance from the National Guardian's Office (NGO). − Record our incidences on a database which has restricted access, the format for this database is based on the NGO recommendations; a paper template is used to when meeting staff to capture the information required and to ensure we have a standardised approach to all concerns raised through the FTSU route. − Introduced a debriefing sessions into the Trust, these are monthly meeting for HR Staff side and FTSU to meet to discuss completed staff cases to ensure that we are learning lessons and continuing to build and foster an open culture. − Serious Incident Policy has been updated to include references to the Trust's Just Culture − Modules for the recording of FTSU and Raise it, Change it concerns have been commissioned and built by Uysses ready to go live at the start of 2020 to coincide with a re-launch of the 'Speaking up Safely' communications campaign	− Weekly Exec CommCell – Executives and senior staff review previous week's performance and issues for the current week.

In Partnership

KLOE 2 Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

AQuA/MIAA - Well-Led Review Feb 2018

The strategic intent is collectively and individually held at Board level but the shape of services in the future is not as clearly seen beyond the Board. There is a gap between the Board's perception of the existence of conditions for senior managers and senior clinicians to contribute to the development of strategy. Stakeholder ability to influence strategy is seen as being limited. The principles of working with other organisations to achieve wider system goals underpin strategic intent. There is a good understanding at Board level of how services are performing in relation to quality and actions the Trust is taking to address them. A structured planning process to support strategy development is now being refreshed. It is important that this is sustained with a clear methodology to challenge and engage in determination of the organisation's core strengths and thereby the Trust's role within the system. From this position the full Board needs to be progressively engaged in further detailed analysis of priorities, capacity and skills implications, sign off, and monitoring.

The investment in the creation of "Our Plan" is seen as being timely and of great value. The current strategy refresh s vital and is being well-received. As part of that refresh the Trust should review the support strategies to ensure continued alignment.

- ✓ ***Strategic intent*** collectively and individually held
- ✓ ***Engagement*** on strategy refresh
- ✓ Good examples of ***divisional fit*** into trust strategy
- ✓ *Collective strategic attention on major tasks.*
- ✓ *Collective understanding of the challenges to **achieving the strategy**/ necessity for transformation.*
- ✓ *Live the values*

- ↑ ***Strategic direction:***-*The future shape of services is not as clearly seen beyond the Board. Further Exec engagement is required re international and private patient ambitions.*
- ↑ *Greater **alignment between divisional plans** and support strategies.*
- ↑ *Further develop processes for **monitoring delivery** of the strategy and KPI's.*
- ↑ *Completion of hospital move **post implementation** review.*
- ↑ Development of **workforce planning and capacity analysis**

AQuA/MIAA - Board Workshop July 2018

KLOE 2: VISION AND STRATEGY

Stakeholder engagement: Internally this needs to be made relevant to 'my role'. Develop a strategy and method to build an embedded stakeholder map including mutual gain criteria for relatives, customers i.e. a relationship system.

Governors: NHSP on site bespoke training for governors.

Clinical Cabinet: governance needs refresh and review.

QI: patient voice needs to be better

Developments

2.1 As part of the Trust's strategy refresh, consideration is being given to: exploring options for organisational form; assessing clinical and financial sustainability; developing community and primary care services; alignment with specialist providers; review growth assumptions aligned to funding opportunities, international opportunities, etc. As part of this process the Trust should:

- Ensure external engagement with the strategy including alignment to wider health economy challenges.
- Further executive and senior leadership team engagement awareness is required to ensure full understanding the implications of the Trust's aspirations e.g. the international and private strategic developments (e.g. governance etc).
- Further articulating Alder Hey's ambitions for staff and service carers/users is seen as a requirement for the new strategy.
- Better definition of a narrower set of priorities linked to clear outcomes, from that position delivery of strategy can be better monitored.
- Provide clear KPIs need to support the overarching corporate strategy.
- Review the support strategies (e.g. People and OD Strategy; Integrated Research Strategy, Quality Strategy etc) to ensure continued alignment and establish KPI's for these strategies.
- Refresh divisional business plans aligning to capacity, delivery and outcome requirements.

2.2 As part of the strategic review, the Trust's approach to workforce modelling including: capacity and demand analysis is required.

2.3 The intention to conduct a post implementation review / benefits realisation assessment following the hospital move has been referred to during the course of the review. Converting that commitment into action is important in order to consolidate lessons learned, particularly with regard to planned improvements in, for example, culture, pathways and productivity. It is understood that this is planned to be aligned to the five transformational themes and be conducted early in the new financial year.

CQC Inspection Feb 2018, Published June 2018

- ✓ We rated well-led as good because the trust had a vision for what it wanted to achieve with plans to turn it into action.
- ✓ Staff throughout the trust were aware of the vision and values. / Staff in the majority of areas understood the vision and values.
- ✓ There was a clear statement of vision and values and an overall strategy for the trust but not all services had an underpinning strategy to improve services for example diagnostic imaging services.

Developments

- Ensure that all services have up to date strategies or improvement plans in place.
- Although the trust had an overall strategy which was underpinned by divisional strategies, we found that not all services throughout the trust had an internal strategy to make further improvements. An example of this was in end of life services.
- **End of Life Care -** Although there was a service review in progress with a remit to develop a new model for specialist palliative care but this was in the early stages at the time of our inspection.
- **Diagnostic Imaging -** There was no vision statement on the trust website or in the radiology department specific to the service. We requested this from the trust post inspection but we did not receive any evidence.

AQuA Advancing Quality Alliance *In Partnership* MIAA

Well-Led Developmental Support

2019 Progress		
Strategy	**Involved stakeholders**	**Underpinning Plans**
− The Trust has re-committing to its ambition to provide **'a healthier future for children and young people'** through world leading children's services. Consistency has been retained - the Vision, strategic priorities (agreed in 2011), they should therefore be well understood across the Trust. − Values developed in 2012 following extensive consultation with staff including behavioural framework − There are two strategic aims: **'Doing the Basics Brilliantly' and 'Growing the Future'**.: − Underpinned by **four pillars**: o Delivery of outstanding Care, o The best people doing their best work, o Sustainability through external partnerships and o Game-changing research and innovation − Strategic Plan (2019-2024) 'Our Plan' - approved October 2019. o A structured planning process was applied to support the strategy development. o The strategy identifies ambitions and milestones − Covers the key requirements e.g. Quality, workforce, race equality, sustainability etc. − Alignment to national direction (e.g. ***Long Term Plan***) − The trust has been developing their **Social Values** response the focus being to deliver fairer and better health outcomes in a sustainable way, with fewer environmental and financial resources.	− Engaged with divisions Jan 19. Divisions identified their top 5 priorities aligned to the Long Term Plan. o Divisions completed tactical response (capacity gaps) o Divisional sessions (end Nov) with Execs Broader review of who they will support. o Service level templates shared for completion o Divisions have their own 5 year plans aligned to the Strategic Plan. − Process of 'Big Conversations' with clinicians over the next six months. − Open to all staff - Two 'town hall events' internally, supported by a special edition of Alder Hey Life **Committee review of the draft strategy** − **Joint Board/Governors session** to define the plan June 2019, **Review of draft Sept 19.** − Engaged the Children and Young Peoples Forum – green plan (taking action on climate change.) − Alignment to system plans – worked with Liverpool CCG to develop the children's agenda as part of the ***One Liverpool Plan*** – partnership response – local authority, CCG, etc, addressing determinants of health, promoting the children's agenda – presentation to the Nov 19 Board, Trust involved in the development of this plan − Alignment of system /partners vision. (the executive team are widely engaged in the system agenda - The strategy has enhanced emphasis on strategic partner working (re role in the system).	− Inspiring Quality – Approved − Digital Future - Approved − New People Strategy approved by the Board − Research Strategy re-launched focused on the Starting Well theme **Assure** • Performance reporting – intelligence reports • Weekly patient safety meeting – best practice, time set aside **Workforce Modelling** − Robust workforce planning/modelling is in place for nursing. − Future workforce considerations being factored into Divisional service strategy sessions; 'Challenge Board' process used to identify solutions for specific services where national skills shortages and other issues are threats to sustainability **Post Implementation Review of the New Hospital** **Values** − Respect, Excellence, Innovation, Together, Openness − Appraisal documentation incorporates assessment of values being applied. − **Articulating and enacting values and expected behaviours and using these as a basis to staff recruitment (not yet implemented)., appraisal etc**

Outstanding Practice or Services			
Patient Engagement	**Recognition**		
− As part of the strategy development, engaged the **Children and Young Peoples Forum** − Outcome the Forum's concerns for green credentials. Resulting in the **green plan** (taking action on climate change.)	Cheshire and Merseyside Medicines Optimisation Programme hailed a success by the Healthcare Financial Management Association (HFMA)Dec 19 – National HFMA Awards		

In Partnership

KLOE 3 Are there clear responsibilities, roles and systems of accountability to support good governance and management?

AQuA/MIAA - Well-Led Review Feb 2018

The Board and other levels of governance within the organisation, function and interact appropriately. Observation and interview revealed a unified board. The Board demonstrates corporate leadership and a broadly positive balance between challenge and support. The information flows were seen to support decision-making and the resolution of risks and issues. Some roles on the Board are not clear in terms of responsibility and accountability and there is a variation of view across the Board as to how its time is being spent.

Committees of the Board have had a generally stable, regular operating membership and have been operating within their Terms of Reference. Regular reviews of governance are seen as important and are responded to positively and openly. Committees undertake annual effectiveness reviews. The importance of robust governance is clearly led by the Chief Executive.

There are mechanisms for risk management from divisional and team level through to strategic risk as defined in the Board Assurance Framework. The Annual Governance Statement, and supporting audit arrangements, reflects a robust system of internal control. Governance for working with partners is being kept under review with legal and commercial advice being sought. There was evidence of constructive challenge at Audit Committee. Although Committees function as designed there were a range of issues in respect of meeting etiquette, clarity of attendance, effectiveness, and focus that need attention. The detailed analysis within the full report should support that work. Within that more detailed analysis particular deficiencies are highlighted in respect of research.

- ✓ *Board level, positive balance between* ***challenge, support and clinical inclusion,*** *operating as a unified board.*
- ✓ *Information flows support* ***decision making.***
- ✓ ***Committee effectiveness*** *reviews regularly conducted.*
- ✓ *Ongoing development of* ***governance for partnerships***

- ↑ *Some* ***board roles*** *not clear re* ***responsibility/ accountability.***
- ↑ *Clarity re* ***sub-committee*** *membership, meeting etiquette and divisional ownership.*
- ↑ *Collective sense of* ***focus*** *on a small number of key* ***quality*** *and* ***risk*** *priorities.*
- ↑ *Align to* ***partnership mapping****, governance, legal status and trust role/commitment.*
- ↑ *More divisional ownership of assurance*

AQuA/MIAA - Board Workshop July 2018

KLOE 4: ROLES, SYSTEM ACCOUNTABILITY

Clarity of Board roles: need to give more visibility to this issue e.g. more on website and photographs around the hospital.

Committee Operation: agreed to progress a review of committee structure and ToRs with a view to reducing the number of meetings. Further work on meeting behaviours. Explore options of replacing some meetings e.g. huddles. Information and agendas need to be in a standard format.

Quality and risk: this links to strengthening the leadership of committees and challenging attendance.

QI (Board assurance and engagement): CQAC; accreditation process, Quality Ward Rounds currently provide assurance. Aim is to replicate the Toronto model with a Centre of Excellence Hub, reintroduce divisional stock takes to Board, and strengthen LiA feedback.

CQC Inspection Feb 2018, Published June 2018

Developments

- ↑ Although there were arrangements for governance and performance it was not always clear how some groups reported into the overall trust level governance structure. There was little of evidence of discussion and challenge when required and actions to make improvements had not always been made in a timely way.
- ↑ Consider how all groups feed into executive led committees.
- ↑ There was a governance structure throughout the trust. However, it was not always clear as to how some groups reported in to the executive led committees so that oversight was maintained and performance was challenged when required.

Developments

4.1 Management and operation of sub-committees (further sub-committee specific recommendations are included in **KLOE4** findings):-

a. Attendance at committees and meetings is not well understood. The status of being a member, being invited and observing is blurred.

b. Meeting etiquette is an area for reflection.

c. Meeting effectiveness is variable and, again, was a circumstance that was repeatedly described. This encompassed behaviours and skills as well as a lack of rigour in respect of agenda management, purpose of papers, timeliness of papers being issued and outcomes reached. Cover sheets providing clarity of recommendations and purpose of the paper would help towards addressing this.

d. It is opportune for a reset of the meeting structure, membership and associated behaviours in the context of divisions taking ownership of assurance and how “holding to account” is understood and practiced.

MIAA could share with the Trust approaches for reviewing and reducing the burden of committees.

4.2 The Trust is in the process of mapping external partnerships, these needs to include governance arrangements, objective, legal status, trust’s role and commitment etc.

In Partnership

Well-Led Developmental Support

2019 Progress			
Board	Committees	Divisions	Partnerships
- The functions of the Board are clear and there is clarity as to how those functions will be exercised. The types of strategic decisions that are reserved for the Board, and those that are delegated, are specified in the Reservation of Powers and Scheme of Delegation. Board Operation − Agenda changes - Previously the agenda was at aggregate level - Corporate Report broken down to divisional level to provide context. − Identified 'watch and drive measures' − Divisional leads report to Board (based on CQC Safe, Responsive, Well-Led, Caring, Effective.	Governance Structures − Organograms completed and included in handbook/on intranet as appropriate Committees − The information flows were seen to support decision-making and the resolution of risks and issues. Committees of the Board have had a generally stable, regularly operating membership and have been operating within their Terms of Reference. − Meeting reviews have been introduced to conclude meetings. − Reporting from committees to the board – Chairs report templates are completed to highlight issues and escalation (in addition to minutes) − Committees undertake annual effectiveness reviews. − The Annual Governance Statement, and supporting audit arrangements, reflects a robust system of internal control. − Issues raised by internal and external audit are considered appropriately through the committee structure and acted upon. − Better engagement and participation by the Divisions at the Quality Committee through the requirement for formal reporting against agreed metrics Clinical Quality Assurance Committee - CQAC − This committee is seen as a key element in assuring the Board that quality governance is subject to rigorous challenge. − Agenda has been updated to reflect the domain headings **(agenda remains lengthy)** − Introduction of a cover sheet − **Consistent medical engagement at CQAC to be maintained.**	- Balanced scorecard - QAS feeds to CQAC (QAS feeds issues and actions to divisional performance. - There are mechanisms for risk management from divisional and team level through to strategic risk as defined in the Board Assurance Framework MIAA completed a divisional governance review − Divisional reporting to the Board and CQAC. o Is standardised o Focuses on the KLOE's o This is providing more consistent assurance and improvements to the cascade of information. − **Further refinement is being completed to align the timing of data reviews in committees.** − Divisional Governance Structures:- o Divisional Boards o Divisional Integrated. Clinical Governance Group. o Business Meetings	- Governance for working with partners (joint venture) is being kept under review with legal and commercial advice being sought. - **The Trust has been in the process of mapping external partnerships. These needs to include governance arrangements, objective, legal status, trust's role and commitment etc.** **Clinical Partnerships** – to reduce risk and improve care Liverpool Women's − Achieved approval to develop the Neonatal Intensive Care Unit (NICU) and build our Liverpool Neonatal Partnership with Liverpool Women's Hospital - to provide a single city wide service. Now a single leadership team. − Co-designed the unit (including with parent involvement) − **Work ongoing to enhance joint governance model.** Royal Liverpool − Working with the audit haematology services Royal Manchester Children's Hospital(RMCH), Formalised our partnership with I (RMCH), enabling us to provide the best joined up care for children and young people across the North West (for example in neurosciences and burns) - Medical directors building relations to increase alignment of services. − Neurosciences − Cardiology − Operational Delivery Networks − Cleft Palate and Gait work **Urgent Treatment Centres** − Work with CCG/GPs re the requirements in the centres. **Liverpool Health Partners** − First 100 days to improve outcomes. **Palliative Care** - Developed an integrated model across Alder Hey and Claire House Children's Hospice. - Appointed 2 consultants (job share) in a very difficult to recruit to specialty. - Planning the appointment of a nurse consultant. **Child Friendly Partnership** **Liverpool Heart and Chest Hospital** - Implementation of All Age Cardiac service with LHCH

Outstanding Practice or Services				
Partnership Working	Partnership Working			
Congenital Heart Disease (CHD) achieved Tier 1 (CHD) status (with the Liverpool partnership) for the North, performing 410 operations in 18/19, and successfully tripling the size of our all-age CHD network to support the highest standards of CHD care throughout the North	**International Child Health** improving the health of the world's children, have an established, international paediatric brand with a reputation for excellence, be a proven partner with a track record of international delivery International health partnership − (particularly with low-income countries) − Humanitarian 'mission' operations − Commercial/business development **In summary:-** − Hosted the Department of International Child Health (18 months ago) − Growing commercially − Humanitarian support. − Global education.	**UNICEF Child Friendly City**		

In Partnership

KLOE 4 Is there a culture of high quality, sustainable care?

AQuA/MIAA - Well-Led Review Feb 2018

Vision and values are consistently articulated and understood at the most senior levels and are evident in observed behaviours at the Board. There is a compelling link between the Trust's values and patient centred care. The sense of lived values was a feature of our interviews with senior leaders at the Trust. The approachability of the Board to discuss concerns is regarded positively at divisional level. The Trust has demonstrated a clear commitment to understanding and improving staff survey results and this is reflected in the improved response rates and the introduction of programmes such as Listening into Action. Leaders do live the values and Board discussion reflected this strongly. Staff feedback is encouraged with a range of mechanisms available. There is a lived culture of recognition, support, engagement, respect and celebration with the tone being set by the Board. Transparency and openness is valued. Areas for development included reflecting upon perceptions of limited autonomy or freedom to act; creating a culture that encourages greater ownership; and dealing with behaviours that are not aligned to values.

- ✓ *Well embedded values, with a compelling link to patient-centred care*
- ✓ *People Strategy aim –'by 2020 we will have a fully engaged workforce that is actively driving quality improvement'.*
- ✓ *Approachable Board.*
- ✓ *Staff survey response rate, best in 4 years.*
- ✓ *Social values reporting. Development of E&D foundations.*

- ↑ *Cultural behaviour issues to be addressed as part of developing autonomy and ownership*
- ↑ *Opportunity to improve listening to staff ideas*
- ↑ *Further engagement of clinical staff re Listening into Action.*
- ↑ *Assessment of departmental engagement through triangulation of performance e.g. absence, appraisal rates, staff survey responses,*

Developments

3.1 Aligned to the divisional structure and the increased clinical leadership within the Trust, autonomy is not consistently clear for some wider Board roles and across the organisation. Accountability, mandate, authority to act, permission to act, and permission to fail were all cited as specific issues in respect of certain job roles. There was a real interest in the development of an autonomy framework, particularly, in the divisional setting refer also to KLOE1 (development 1.4). As part of creating the environment for increased autonomy; ownership, escalation and dealing with poor behaviour need to be considered. • Internally there needs to be further clarity regarding what the Trust class as a division and which are classed corporate departments e.g. Research. This aligns to the line management and reporting arrangements.

3.2 There are further opportunities to explore divisional engagement in respect of:- • Understanding the mechanisms to contribute ideas.
• Understanding the wider impact of Listening into Action (LiA), particularly in respect of clinical engagement.

3.3 To further understand and drive improvement in the levels of positivity and pride in recommending Alder Hey as a place to work it may be beneficial to: • Increase Board understanding of cultural differences across the Trust.
- Better understand the effectiveness and consistency of management action increase the triangulation of: Human Resources, Organisational Development performance information at departmental level e.g. Aligning Absence: PDR/appraisals; staff survey response rates and results: sickness: turnover, complaints etc. This would further support issues such as:-
- Earned autonomy **KLOE** 1.4 development.
- The targeted and effective management of performance e.g. achievement of mandatory training targets etc.
- Understanding cultural and behavioural differences across the Trust.

AQuA/MIAA - Board Workshop July 2018

KLOE 3: CULTURE

Autonomy and ownership: Spring clean of systems and process led by Listening in Action and Exec sponsor plus senior person from each Division to work with Kerry Turner. Support services, need to work with Kerry Turner and link QI. Include a review of the Scheme of Delegation.

CQC: Target those teams that are emerging as disengaged via Staff Survey, etc. Divisions to focus on middle managers and create a plan for change.

QI: Appraisals of clinicians to include values and strategy (currently no reference to the Trust). Review of appraisal process to ensure

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- ✓ The trust had an experienced and stable leadership team with the skills and commitment to provide high quality services.
- ✓ Financial pressures were managed so they did not compromise the quality of care delivered.

Outstanding Practice

The hospital had invested in an orthopaedic imaging system (EOS) which is an innovative ultra-low dose x-ray imaging system that scans a patient whilst they were standing upright. Alder Hey Hospital was the first paediatric hospital in the UK to have this scanner. This really benefited children who needed to be imaged frequently. With the orthopaedic imaging system (EOS) the consultants could make more informed diagnoses and create individualised treatment plans for children with musculoskeletal disorders.

We found multi-disciplinary team working with the cardiac team in providing extracorporeal membrane oxygenation was outstanding. Staff supported one another in providing high quality evidence based care.

The community services division worked with colleagues in the trust's acute hospital teams on a 30 day plus length of stay project. The project identified suitable children, who had been admitted as inpatients for longer than 30 days, and brought together a range of acute and community teams, including social care, to provide a wraparound service which enabled children to be discharged out of hospital to home. At the time of the inspection, the service had enabled approximately 46 children, who may otherwise have remained as inpatients, to be discharged.

The physiotherapy team had developed workshops and fitness and exercise groups for children with disabilities within a local gym (from a national chain) to encourage and include children with disabilities in fitness and exercise.

Developments

- ↑ Although staff satisfaction was good in the majority of services, there were areas where this was mixed.
- ↑ The trust had now always reported and serious incidents in a timely way in line with trust policy and national guidance.
- ↑ Ensure that they are fully compliant with the appropriate Lampard recommendations.
- ↑ Although the trust had an up to date policy for the duty of candour which met the requirements of the Health and Social Care Act 2008. Between January 2017 and January 2018, we found that duty of candour had not been applied consistently on all occasions as required.
- ↑ **Critical Care -** The high dependency unit had no system to capture activity and clinical outcomes.
- ↑ **End of Life Care** - Consultant cover for the end of life service was provided by consultants from other speciality areas as well as by the Paediatric Palliative Care consultant. This did not permit the service to fully meet NICE guidance 61 regarding access to a palliative care consultant.

End of Life Care - We were not assured that systems implemented to clearly identify a child's status in terms of the Spectrum of Children's Palliative Care Needs were robust. They relied heavily on the availability of the consultant to complete them.

Well-Led Developmental Support

2019 Progress				
Financially Sustainable		Trust Values		
− In both 2017/18 and 2018/19 - advantage of a number of one off opportunities (eg land sale) which enabled The Trust to overachieve the control total and qualify for the NHSI PSF incentive scheme. − Over the last two financial years we have received circa £48m in additional PSF. This has / will be invested directly into our capital programme, £93m over next 5 years. − This will fund the completion of the high quality Children's Health Park campus including o the building of a new Alder Centre child bereavement centre, o providing a purpose built 22 bedded Neonatal unit, o a new hub for our Neurodevelopmental patients and o a new on site build for our CAMHS tier 4 service. o invest in the replacement of our world class medical equipment o investment into both our IT resilience and our digital advancement strategy.	− The Trusts overall long term sustainability strategy is one of growth and transformation in both core NHS services and also the commercial services such as our Research & Innovation areas which we believe will enable radical transformation in the way healthcare is delivered, creating a sustainable Alder Hey and creating a healthier future for children and young people. **Key developments** − Community & Mental Health o Relocating the Tier 4 unit to the Alder Hey campus which will expand the service. o being at the centre of children's services in the community and to extend our care offering in the community and mental health to children and young adults aged 24. − Medicine o We are developing our Alder Hey 'with' model strengthening a number of partnerships. Much of this work is being undertaken across the paediatric networks as overseen by the STP. − Surgery o The Chronic Heart Disease service has been accredited as the provider for the North West by NHSE, and there are also strong partnerships with Liverpool Heart and Chest hospital in providing an All Age service. o accredited ECMO service o planning expansion in a number of other services including in our Neurosurgical area in treatments for Selective dorsal rhizotomy (SDR), Vein of Galen (VOG) and Deep Brain Simulation (DBS). o There are also strong partnership arrangements in place with Liverpool Women's Hospital in developing a single service neonatal service	1. Respect 2. Excellence 3. Innovation 4. Together 5. Openness	**Mandatory Training** − Robust recording of mandatory training compliance on the Electronic Staff Record (ESR). This improvement was a result of the additional investment with the appointment of a Learning & Development Manager and band 7 post to improve workforce data. − Divisions receive divisional/departmental/individual/topic based data. − ESR is self-service. − Majority of training can be accessed online − Trust is >90% Safeguarding − Introduction of a sepsis e-learning system on ESR. ↑ **Trust overall compliance is >90% for mandatory training** ↑ **Mandatory training TNA and denominators approved by the Education Governance Committee** **Equality & Diversity (E&D)** − Reference in the strategic plan to the Trust's ambitions - Workforce Race Equality Standard and the Workforce Disability Equality Standard − 3 active staff networks:- o LGBTQIA+ o BAME o Disability − Trust took part in Liverpool Pride (2019) for the first time. − Trust Board recruitment in 2019 has demonstrated an improvement in diversity − Different ways to engage - Launched a 'reciprocal mentoring programme' pairing senior managers and executives with an equal relationship for shared learning (4-5 pairings in place). − Active membership in the Cheshire & Mersey E&D network. − NED Champion supporting the approach to EDI in 19/20 − Examples of outstanding responsiveness e.g. reasonable adjustments Be Kind' Phlebotomy Clinic – For learning disabilities / autism. − NHS Rainbow badges launched 2000 staff - Pride week in March	**Local staff survey** – Quarterly temperature checks. **National Staff Survey**– reformed the approach to ensure it is about Alder Hey. A more focused campaign approach is applied to encourage staff response rate. Focus on staff groups, weekly meetings and week by week messaging. REFER also to KLOE 7) − Regarding the staff survey comparators, the Trust is benchmarked as a 'specialist trust' as oppose to a diverse acute, community and specialist provider.for 2019, this has been changed to Combined Acute and Community providers − 2018 survey 60% response rate an increase of 8% from 2017 - (The Trusts highest response rate). − 2018 – There were improvements across over 75% of questions; 72% of staff said they would recommend the Trust as a place to work to their friends and family. − Responses are analysed by divisions, teams etc. All departments are encouraged to engage with staff to understand the actions required to drive improvement. The position is collated into a divisional plan and subsequently a corporate action plan. − Local divisional developments following the last survey – − Surgery – wellness and wellbeing led to ownership of mental health first aid lit. − Medicine – visible leadership 'open door sessions' and structured walkabouts. − Community – IT issues – IT upgrades to enable agility and support delivery. **Staff Resilience** − Revisit staff resilience training and managing conflict. − Established a Staff Advisory and Liaison Service SALS (2019) this is to provide all staff with a place to raise concerns in a safe place, this is supported by members the FTSU team. Empowering Staff re **Health & Wellbeing** o Health & Wellbeing Group o Time to change pledge through MIND (50 signed up) o Reward and Recognition Group

Lampard Review	Duty of Candour	Serious Incidents	Raising concerns	Schwartz Rounds	Just Culture
– The Trust has introduced a rolling programme of DBS checks (Oct 19.) Issue addressed related to the renewal of DBS checks, which is now agreed with the Unions.	– Now fully implemented (2018) − National guidance applied. − Speak to the child and family directly and write to the family. − Monitored by CCG – monthly report. − Report to the Board. − If an investigation is undertaken, the families are informed (irrespective of the outcome).	− Trust is a good reported (evidence) − Following investigation, all recommendations are logged and monitored until complete. Changes in practice are captured and communicated. − Closed loop technology to improve safety WBIT, MILK ↑ **Improvements are required to learning** (see also KLOE 8)	– **clearer sign posting.** ↑ **We are working towards replacing the Bullying and Harassment Policy and the Grievance Policy with an overarching Resolution Policy** − training staff in mediation skills and the use of facilitated conversations to ensure we can support the principles of early resolution as issues arise.	Have been re-introduced (Aug 19) they provide a structured forum where staff of all levels come together regularly to discuss the emotional and social aspects of working in healthcare. Example topics include:- - Patents I will never forget. - Why the best isn't good enough.	**Bullying** – - joint working group with JCNC launched to test against social partnership forum. Zero tolerance – updated policy implemented and training roll out commenced - Zero tolerance - stated aim of the Board to eradicate bullying throughout the organisation

Top Quality Issues	Nurse Staffing	Key Indicators	Experience	Recognition
− Failure to scan paper medical records on a timely basis. − Not embracing transformation and changing clinical roles to address staffing pressures e.g. Staffing levels – nursing	To ensure full nurse staffing levels, the Trust 'recruit to a local pool'. The Trust recruit to nurse staffing establishment + 40 WTE to provide maternity and sickness cover. To maintain this position an international	• Inspiring Quality (refer to KLOE 8) • No grade 4 pressure ulcers – 3 years. • No MRSA or C.Diff • MSSA reducing each year. • Access delays Mental Health, ASD, ADHS outsourcing the backlog.	• In response to patent feedback, play specialists are in place. The role has been expanded to plan and distraction therapy. • Atrium – programme of activities and performances e.g. carol services are	A lived culture of recognition, support, engagement respect and celebration. • Monthly star award(nominated by staff) – voucher and certificate provided. • Annual gala awards February – based on the Trust's values.

Well-Led Developmental Support

and some clinical specialist fields e.g. Paediatric Radiology. – Staff morale due to external issues e.g. Brexit impact on research and drugs etc.	recruitment campaign is being initiated in Nov/Dec 19. There is a challenge recruiting enough staff to provide mental health experience.	• **Sepsis** – ○ Paediatric Early Warning Scores (PEWS) to detect Sepsis. ○ The Trust has participated on the national group to develop a paediatrics sepsis tool for diagnosis and treatment. ○ The Trust is the leading paediatric performer. ○ Improvements e.g. communications, electronic alert system, changes to antibiotic prescribing, agreed protocols = Qtr 2 19/20 in-patient 'green'. – This approach and outcomes are being shared with other organisations. ○ Challenges in Emergency Department - further changes to Meditech required.	now filmed to ensure availability on TV for children on wards. • Children missing pets – dog taken to wards.	• Recognition of long service – lunch ad vouchers. • Support retirement – gift. • For 3 years the Trust have had a 'Fab Staff week' • At divisional level services have introduced staff Fab Day e.g. community services.

Cross Divisional Working	Ward Accreditation	Perfect Ward	

• Tuesday Morning weekly informal meeting (3 divisions / 9 at the Top - meet 45 minutes)
• Focus on set topics to establish progress and interface. This has embed relationships and driven improvements across a range of projects e.g.
  • SAFER Project – includes complex care teams.
  • Outpatients improvements
  • CUR
  • HDU Clinical Care Model
  • Acute Response Team
  • Hospital Manager of the week.
	– Well established system.
	– Unannounced reviews.
	– Structured on the KLOE's
	– Regularity subject to the ward's grading.
	– Wards rated gold, silver, bronze.
	– Significantly improved the standards of care. E.g. 2 improved in 2019 from bronze to gold.
	– Departmental accreditations also follow this process. E.g. community – stars with staff.
		- Monthly Review
		- Captures live data – real time reporting
		- Quality, safety, hand hygiene, medication etc.	

Outstanding Practice or Services

Experience & Outcomes	Safety	Training – Patient Safety	Caring / Patient Experience / Safety	Patient Safety	
– **3D printing** for pre-operative planning, team factors and family communication – – Alder Hey Innovation in Partnership with 3D Life prints has established an additive manufacturing facility in the Innovation Hub. – This comprises 6x3D printers, 3D scanners and dedicated biomedical engineers to create models to enhance healthcare delivery. – Currently these include: ○ 1) Scanning and archiving dental moulds to reduce storage space. ○ 2) Creation of complex anatomical representations of difficult surgical cases, to improve the pre-operative planning process, communication within teams and to enhance understanding with families. ○ 3) Creation of 3d printed cutting guides to increase accuracy of intra operative interventions ○ 4) Construction of rapid prototypes of medical devices. – A key factor of our process is that the teams are hosted on site and the biomedical engineers attend MDT meetings to facilitate case selection and to ensure the models are produced in close partnership with clinicians.	– Hy-genie is a passive monitoring system that allows hospitals to continuously detect usage of **hand hygiene** stations. – The platform provides real-time insight into hand hygiene behaviour, ultimately helping to improve compliance in hospitals. – This product is being developed with support from local venture capitalists and technology firms.	– VIRTI - Is an immersive, mixed reality healthcare demonstration and assessment experience. – Virti will increase engagement in training and provide objective assessment. – Enhance the quality of skill acquisition and **improve patient safety**	– Lactate sensor - Building on a unique patented platform technology Alder Hey Innovation are working with LJMU to develop a non-invasive blood monitoring application. – The technology detects biomarkers in the blood would enable blood to be tested without the use of painful needles, or the removal of blood from a child, which with our tiny patients is in precious short supply. – The technology would also significantly **reduce infection risk** in infants in intensive care, and provide a continual feed of data to clinicians support continual monitoring and more **responsive healthcare** – In response to patient feedback, a robot has been developed to allow longer term in-patients to see school friends. – Ward based chefs to educate in nutrition and to meet patient requests. – Introduced Case Management Team (in the last 12 months) to support the pathway for patients with complex needs e.g. autism patients.	– 3D printed medication - Alder Hey is leading research to create custom 3D printed pills that combine accurate dosing with custom shapes and surface compositions to improve compliance.	
– Consultant orthopaedic surgeon at Alder Hey Children's Hospital in Liverpool Alf Bass has been named top doctor at the **WellChild Awards** (Sept 2018). – Mr Bass who specialises in the care of children with neuromuscular conditions including cerebral palsy was nominated for his award for his role in leading the development of surgery in this field, enabling children with severe mobility and neurodevelopmental needs to manage their pain and to improve their mobility. – This work included the creation of one of the main Gait Labs in the UK, which allows a range of professionals to study the movement of children and has radically redesigned the whole service at Alder Hey shifting the emphasis from surgery to rehabilitation.	**Centre of Clinical Excellence** – The Trust was awarded **Centre of Clinical Excellence** status by Muscular Dystrophy UK, The awards recognise excellence across a range of criteria, including the care received by patients, and help to drive up the standards of clinical support for people with muscle-wasting conditions. – **Rob Burley, Director of Campaigns, Care and Support at Muscular Dystrophy UK, said:** "We would like to congratulate Alder Hey, which has deservedly been awarded Centre of Clinical Excellence status. Alder Hey provides a comprehensive service for people with muscle-wasting conditions and promotes best practice, ensuring patients have access to the best possible healthcare near where they live. Improved clinical care means faster access to treatments and potential cures.		– Nurse led pre-assessment triage across all services. – 'Be Kind' **Phlebotomy Clinic –** For learning disabilities / autism. The clinic has been established to support equality and diversity recognising that reasonable adjustments have been introduced. – Therapy staff completing '**Care Aims**' - agreed expected outcomes with patients – – significant results of focused achievement of patient centred outcomes – Lengths of treatment shortened. – Increased satisfaction. – Process being extended to Community Paediatricians.	**Safety, Quality & Experience** – Transfer of the Northern Ireland perinatal / paediatric post mortem service to Alder Hey. Unanimous positive feedback from clinicians and parents. – Dramatic improvement to bereaved families experience. – "I can only imagine how challenging this change has been – well done – safety, quality and experience in action" – Consultancy Director Women's and Children's Southern Healthcare Trust.	

KLOE 5 Is appropriate and accurate information being effectively processed challenged and acted on?

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The award of Global Digital Exemplar funding is a reflection of the Trust's vision to be totally digital by 2020. The funding has provided the Trust with an opportunity to increase the pace of their digital developments. Finance information is presented and robustly challenged throughout the organisation. The Board have a broadly positive view of the type and level of performance information that they receive and how that information enables them to hold management to account. Assurance over the robustness and timeliness of data is generally positive but it is not an entirely consistent response. There is work in train reviewing metrics with key areas including quality, finance, HR and performance. Taking stock of practices in other trusts has been a component of this work. Further opportunities include developing a measurement for improvement approach in accordance with current NHSI recommended practice; clarifying the quality and finance issues that go to respective committees; and improving communication and engagement.

- ✓ *Awarded **GDE funding** 'totally digital by 2020'*
- ✓ ***Financial information** robustly challenged.*
- ✓ *Board positive re **performance information received.***
- ✓ *Ongoing work to **review the metrics.***
- ✓ ***Cyber security** responsiveness*

- ↑ *Development of **measurement for improvement** reporting.*
- ↑ *Clarity re sub-committee **reporting of quality and financial issues***
- ↑ *Clarity re sub-committee, **scrutiny and assurance expected re financial recovery.***
- ↑ ***GDE** – provides an opportunity to **reduce unwarranted clinical variation,** through adoption of clear clinical pathways.*
- ↑ *Meditech required a lot of **data validation,** decreasing the value of the BI portal. Challenges with the effective operation of Meditech.*

Developments

6.1 It was evident that the current Board and committee reporting focus was on measurement for assurance. The BI team's presentation to the quality committee, on quality metrics proposed measurement for assurance metrics. There are real opportunities in developing a measurement for improvement approach in accordance with current NHSI recommended practice:

- measurement for assurance means information is compared with target levels of performance (along with a red-amber-green rating), historic own performance and external benchmarks (where available and helpful).
- measurement for improvement means that data is presented using appropriate statistical methods to enable tracking of processes, balancing measures and
- outcomes over time, paying attention to variation rather than simply comparing against targets and thresholds at particular times.
- To support the implementation of this, 'Measurement for Improvement' training is recommended for Board and senior staff, AQuA could support this process.

6.2 Further clarity regarding committee roles is required in respect of the:

- quality and finance issues that go to CQAC and RABD.
- level of scrutiny and assurance that is expected of each of the committees of the Board in respect of financial recovery.

AQuA/MIAA - Board Workshop July 2018

KLOE 5: INFORMATION

Committee scrutiny and assurance: New report, improved mapping, portal, capability and IT use reflec how the Trust has moved on. Need to further refine SMART, being action and priority focused, and holding to account. More focus on data connected to quality outcomes is taking place in committees and exec meetings

QI: Need to balance strategy versus operational KPIs Development programme on how we all use information (do middle managers use it systematically?). What is out target model and how d we achieve accessibility and consistency?

CQC Inspection Feb 2018, Published June 2018

Developments

- ↑ Services did collect and manage information well but it was not always clear how this information was being used to make improvements.
- ↑ **Community -** The service collected, managed and used information to support all its activities, using secure electronic systems with security safeguards. However, as not all services within the community division had access to all of the systems, there was a risk that staff did not always have access to all information about their patient.

AQuA Advancing Quality Alliance *In Partnership*

Well-Led Developmental Support

2019 Progress				
Data Quality (DQ)		**Information Systems**	**Digital Strategy**	**Global Digital Excellence (GDE)**
– Data Quality Steering Group (DQSG) provides assurance on DQ – The group meets monthly and membership includes Operational, Clinical, IT & Informatics support. – The agenda includes review of national and local performance, review of improvement actions and plan and review of DQ Audit plan. – DQSG key responsibilities * Provide visible senior leadership for the management and accountability of DQ.* Use national DQ standards guidance and framework to continually review the quality of data recorded across the Trust.* Ensure that data recording is standardised across all systems (SOPs and Training Manuals), * Finalise and disseminate action plans to address identified DQ weaknesses and issues.* Monitoring of performance via 'DQ Dashboards' to monitor an agreed set of data, to include Trust performance in relation to the externally submitted data (SUS National DQ Dashboards, Commissioner DQ reports)* Review and monitor a monthly risk report, which identifies risks relating to poor data quality, agreeing appropriate remedial action. * Support and monitor the annual DQ audit schedule * Finalise policies and procedures which support the collection, recording and reporting of DQ.* Actively promote and facilitate DQ improvement within clinical, professional and administrative teams.* Develop a communication plan for DQ.* Ensure that the DQSG maintains links with other relevant groups, committees and boards, e.g. the Audit Committee, sharing knowledge in relation to DQ.* Ensure that appropriate guidance and advice is available to all.	There are robust Data Quality monitoring processes embedded in all departments within the Trust and these processes are overseen by the – Data Quality team role includes, ○ investigation and review, make recommendation and action (feedback and training and support) ○ external and Commissioner monitoring reports, liaising with Informatics ○ delivering the annual DQ Audit plan to focus on key DQ issues. This is all monitored at Data quality Steering Group. ○ Other teams have dedicated DQ roles e.g. Booking and Scheduling - DQ /Audit post. – The external reporting of AH data shows: ○ performance above the national performance (SUS National DQ Dashboards, ○ nationally reported Data Quality Maturity Index DQMI Score of 94.8 currently (National Average: 87) (June 2019 performance: ranked 194 from 482 Trust submissions). ○ Performance with regards to the CAMHs data has also seen improvement due to focused DQ improvement work undertaken over the last 12 months with a DQI 86.8 score of June 2019 performance: ranked 67 from 200 Trust submissions)	Continued development of Data Quality dashboards 2 key areas for 2018/19 DQ improvement work focused on: – Waiting List management – CAMHs data – included user training and development of support material (User Guides) and implementation of a framework for monitoring performance (dashboards and reports) – Development of annual DQ Audit Plan and data quality processes – Ongoing actions for improvement included strengthening the audit process within departments for key data entry points; review of the matrix of monitoring reports to monitor and review data quality; aligning training resources to provide refresher training; establishing an escalation process for managing frequent data quality errors; – establishing a priority list for system fixes and system enhancements with Trust software supplier; – The Trust has representation on the EPR System development user groups (Statutory Changes Peer Group and Community Wide Scheduling Peer group) to influence developments.	– **Digital Futures** sets out the digital ambitions and strategy for the Trust over the next five years. – Our ambition is to create an ethos of **'Outstanding Digital Excellence'**. At the heart of this vision is our 'north star' focus on **creating the best experience and outcomes** for Children, Young People and - Families, and Staff. Through this we will strive to: • **Provide the best possible digital and technology services** to support, enable and drive clinical excellence, digital quality improvement, outcomes and patient safety • **Deliver Information Technology basics well**, championing a 'Digital First' approach across Alder Hey, supported by excellent, proactive, customer focused services • **Unleash innovation and research** to harness digital technology in order to create opportunities to adopt and evaluate digital innovations throughout the world's first 'Living Trust' • **Maximise local, national and international partnerships** to bring in expertise and new advances in pursuit of a shared vision.	- Alder Hey was one of sixteen Trusts who were identified as part of the Global Digital Exemplar Programme in 2016. This has enabled AH to digitise clinical pathways, improve integration and spear head regional interoperability developments - Whole hospital 'efforts' in improving safety and culture - Every clinical pathway has been reviewed as part of the programme. Final year of GDE funding – As part of the **GDE** Programme, the Trust is developing a set of standardised clinical documentation within MEDITECH (The Trust's EPR system). – These are then customised to reflect workflows, protocols and standards within each clinical team. These are referred to as "specialty packages", a key component of this work is the development of reports to track, monitor and improve the quality of care delivered to patients. – As part of the GDE journey the Trust are applying (DEC 19) for 'International Digital Maturity Standard' HIMSS. The Trust is applying for level 6 accreditation (there are 7 levels. If awarded, the Trust will be the first children's hospital in Europe to achieve the standard. The standard will demonstrate safety in the Trusts digital processes. – GDE work is providing a blueprint to share learning e.g. the introduction of specialty packages e.g. sepsis; clinical decision support in burns.

Measurement for Improvement	Cyber	Meditech	Performance
– Achievement of HIMSS level 6 accreditation in December 2019;first paediatric trust to have achieved this and only 4th NHS organisation nationally- significant assurance provided in terms of patient safety as part of this accreditation	- The Trust has undertaken external audits, to assess cyber security. - The Trust will be applying for Cyber Essential + accreditation. - The cyber tool and dashboard is proactively managed. - Dedicated Cyber post in place. - As part of the ambition to be the safest Children's Trust, the Trust is in the process of applying for CareCert accreditation. - Quarterly reporting the Board on Digital and cyber. - Cyber / data security toolkit (DSPT) – good progress made	- GDE funding has helped the Trust gain leverage with Meditech. - They now operate as a strategic partner. - Adopting the next generation of EPR. - Communications have vastly improved – Meditech has set up its UK HQ in Liverpool – which has helped engagement. - System is very reliable.	- Live performance reporting supporting patient flow and activity, allowing drill down to patient level re waiting lists:- ○ A&E ○ Radiology ○ Out Patients - Utilises Power BI dashboards.

Outstanding Practice or Services					
Paediatric Intensive Care Unit has its medical devices integrated with the ICU EPR enabling **safe care** for our children and young people	**Community teams have extensive use of a community EPR, integrated** with other community services and General Practice	**integrated approach to clinical imaging** with many 'Other Ologies' integrated into our PACS system	**Orthopaedic surgeons are a global exemplar of good practice** as the first to run **nationwide clinical research** studies completely online	**There are core building blocks including an integrated Electronic Patient Record and an Electronic Document Management System.** These systems are the foundations which are allowing the Trust to digitise customised clinical pathways to fit the workflows and pathways in place at Alder Hey with individual clinical teams thus enabling **improvements to quality, patient safety and efficiency**	The Trust has led the 'Share2Care' programme across Cheshire and Mersey to share patient records. This is **impacting on supporting multi organisational clinical decision making**. The Trust hosts the team.

KLOE 6 Are there clear effective processes for managing risk, issues and performance?

AQuA/MIAA - Well-Led Review Feb 2018			AQuA/MIAA - Board Workshop July 2018	CQC Inspection Feb 2018, Published June 2018
Leaders are able to describe the key risks that relate to their areas of work and the Board has a collective sense of the strategic risks that may affect delivery of strategy. A risk review was undertaken in 2017 and has resulted in a range of actions being agreed which are being overseen by the Integrated Governance Committee (IGC). This has strengthened director ownership of escalated risks and divisional understanding. Performance management is seen as a corporate strength with good Business Intelligence and an Integrated Corporate Report available in real time. Integrated performance reports are in place for all three divisions. Metrics will be recast with the clinical teams for introduction in April of this year. Another major development of note is the Clinical Intelligence Portal that will bring team-focused information all into one site to create a benchmark, to streamline and enable decision-making. The Board's responsiveness to performance and quality issues was evident with sepsis being a notable example. The track record on financial delivery is good and the strength of financial leadership and engagement was evident throughout the review. The shared responsibility approach to CIP is a reflection of that position. Areas for development include the importance of sustaining the focus upon embedding risk arrangements, narrowing the focus down upon a smaller number of risks, developing the concept of a risk appetite and strengthening outcome focused data at divisional level.		✓ *Board have a collective sense of* ***strategic risk*** ✓ *There is a strengthened director* ***ownership of escalated risks and divisional understanding.*** ✓ ***Business intelligence and integrated corporate*** *report are available in real time.* ✓ *The Board have evidenced* ***responsiveness to quality issues.*** ✓ *Solid financial performance* ✓ Systematic programme of clinical & internal ↑ ***BAF and underpinning risk register*** *not fully embedded. Validation of* ***divisional risks ongoing.*** ↑ ***Lack of alignment of risk recording processes and inconsistency.*** ↑ *Opportunity to develop* ***risk appetite.*** ↑ *Review of divisional performance management approach inc.* ***bi-monthly meetings and more outcome focused*** *reporting.* ↑ ***Opportunity to triangulate themes*** *and shared learning.*	**KLOE 6: RISK AND PERFORMANCE** **WL Risk Issues:** BAF/Risk Register is more embedded but needs slimming down and to become action-focused. Accepted development needs on recording of risks and this is being reviewed. Risk appetite is an aspect to explore. **Div Perf Mgt:** Ownership needs strengthening. **CQC risk issues**: There needs to be a collective focus on the Trust's top three risks and to stop over processing. Improvement will come from being action-focused, clearly defining how we describe	↑ The trust had systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. However, we found that there were a number of risks that did not have an action identified to mitigate the risk and a number of overdue actions across all risk registers. There were also a number of risks that did not have identified controls as outlined in the risk management strategy. ↑ Risks and serious incidents were not always dealt with in a timely way to eliminate and reduce them and a number of risks did not have an action identified to mitigate the risk. ↑ **End of Life Care -** • The service had systems for identifying risks but plans to reduce them were unclear. The risk register had only one risk for end of life which did not have any actions identified and recorded to mitigate the risk until during the inspection. ↑ **Out Patients -** Not all the risks from the outpatient improvement project were up to date or had associated actions. ↑ **Diagnostic Imaging** - There were arrangements for identifying, recording and managing risks, issues and mitigating actions but they were not always robust. We found one risk on the register which had been there since February 2016 without action.
Developments	5.1 The Board Assurance Framework (BAF) and underpinning risk registers are in place but they are not fully embedded. Work is in train to validate all divisional risks and this remains a challenge. The integration of the BAF into the work of the committees was not easily visible with very little engagement and debate. Overall, the processes supporting the identification, understanding, monitoring and addressing of risks need a sustained focus to become more effective. • To support a more focused review of the BAF at committee level, provide the delegated risks only. • To support a collective narrative of risks and provide a clear understanding of the top organisational risks, a summary position of the top risks should be provided with the BAF. • To ensure consistency of risk scoring, include the impact and likelihood definitions on BAF documentation. Failure to refer back to the definitions commonly results in inconsistencies in risk ratings. • Developing the concept of a risk appetite may be a helpful mechanism to engage leaders in collectively understanding risk and signal the Board's level of acceptance across its strategic risks.	5.2 Despite the strengths of the performance management systems there remains a substantial variation of views: • The bi-monthly, divisional performance meetings using the IPR framework, were viewed to be too short for some divisions. Linked to the earned autonomy (**KLOE1** development 1.4) and the different stages of divisional maturity, a rebalanced process could be considered. • At divisional level in respect of the type and level of performance information that they receive. • Strengthening of outcome focused data would be beneficial to monitoring the quality of care provided. • Refer also to **KLOE 3** development 3.3,		

2019 Progress							
Committee	**Top *Risks***			**Policies**	**Performance**	**Audit**	**Performance Highlights**
Integrated Governance Cttee (ICG) (meets bi-monthly) - Reviews Risk Registers – Divisional, corporate and Board Assurance Framework (BAF) - Deep dives are conducted into BAF risks (e.g. workforce, IM&T)	**Boards need a collective understanding of the top risks –need to agree the top risks (use the risk register and BAF and summarise the top 3)** - *(Common issue in organisations - Board not able to consistently describe risks*)	Corporate Risk Register – Revised the Corporate Risk Register – reported to the Board. – The Corporate Risk Register, which contains all operational risks of 15 and above is also scrutinised by the IGC and on a quarterly basis by the Board alongside the Board Assurance Framework, which is cross referenced with the CRR from the perspective of strategic risks. Divisional Risks ↑ Deputy Chief Exec led a review of divisional risks (Sept 19) ↑ Review of divisional risks at the Divisional Performance Meetings ↑ Risk Manager completes monthly validation of the divisional and departmental risk registers. ↑ Risk registers are updated via monthly validation meetings and discussed at divisional risk and governance group; ↑ they reported on a bi-monthly basis to the Integrated Governance Committee	*Exec Comcell* – – Weekly 30 minute review of the organisations performance over the past week & challenges for the future - Representatives from the 3 divisions and the executive team. - Current focus is on:- Sepsis; Emergency Dept., Elective lists, Outpatients, Outcomes, FLU. - Also updates on serious incidents, estates, IT and successes. - Executives & divisional leadership working together – this is developing a robust open and proactive culture.	– The Trust has a register of policies in place. – A proactive approach is being applied to managing policy reviews. – Weekly actions are in place. – Local guidelines are under the same review process.	**Previous report –** - Performance management is seen as a corporate strength with good Business Intelligence and an Integrated Corporate Report available in real time. - Integrated performance reports are in place for all three divisions. These contain expected metrics across four domains and is considered at Divisional Board meetings with executive attendance. - The Clinical Intelligence Portal provides team - focused information all into one site to create a benchmark, to streamline enable decision-making. ***Operational performance committee*** **-** Divisional Performance Reviews – process updated by COO to ensure comprehensive discussion across all area including risk and governance; all EDs now attend Overarching issues are discussed at the monthly Operational Delivery Board and solutions explored and agreed.	- There are systematic programmes of clinical and internal audit. - The Trust utilise internal audit well, in terms of risk focused reviews and early engagement in projects.	Trust has achieved - a 25% reduction in hospital acquired MSSA in 18/19 - are in our 3rd year of zero Grade 4 pressure ulcers - In 2018/19 the Trust had no cancelled operations for 'staffing unavailable' and a 69% - reduction in children experiencing cancelled operations - an 18.6% reduction in medication incidents since 2014/15 - full delivery of the national cancer, referral-to-treatment and diagnostic standards Our Emergency Department was in the top 15 in the UK for meeting the 4 hour standard in 18/19

Outstanding Practice or Services				
Asthma Mapping – to manage activity				
– Asthma Mapping - Alder Hey are tackling the Respiratory Consultants challenge of "How do we **reduce the attendance at A&E** of patients having acute asthma attacks?" – Using multiple diverse sources and care giver data Alder Hey is working with multiple agencies and using smart analytics to identify causes and implement patient interventions to reduce asthma attacks. – This is just one of a multiple of project focused on asthma treatment and compliance in children and young people.				

KLOE 7 Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

AQuA/MIAA - Well-Led Review Feb 2018

There are many good examples of service user engagement ncluding the development of the Trust's Quality Strategy. Marketing and communication has strengthened its leadership and a new plan has been presented to the RABD Committee. Sustained efforts have been made to engage governors with more to do to ensure their governance responsibilities are ulfilled and the Trust secure as much value as they can from hem. In particular, the responsibility to hold the organisation to account through the non-executives is a challenge. There are a ange of mechanisms for staff and service engagement. The divisions do see that there is a significant improvement pportunity in service user and patient engagement including generating better information on the patient experience. Relationships with partners and commissioners revealed a onsiderable range of positive views in terms of the strength of the leadership, innovation and the quality of care at Alder Hey. But there was a strength of view that trust, collaboration, flexibility and compromise were not always allmarks of relationships with partners.

- ✓ *Multi-layered service user engagement including panels.*
- ✓ *Relationships with primary care are a key part of the strategy.*
- ✓ Marketing and Communications Plan supports wider engagement.
- ✓ Inclusivity of Governors.
- ✓ A range of approaches are applied to achieve for clinical and staff engagement.

- ↑ *Wider stakeholder engagement required re strategy.*
- ↑ *Governors are not fully operating in a way that fulfils their role.*
- ↑ *Stakeholder engagement plan under development. There was strength of view that trust, collaboration, flexibility and compromise were not always hallmarks of relationships with partners.*
- ↑ *Trust's quality plan for implementation of a clinical cabinet was not yet implemented.*

Developments

7.1 To support the ongoing development of Governor relationships and effectiveness,

- Continued engagement and invite of governors to Board and Board Assurance Committees
- MIAA could support the Trust:-

There may be value in a workshop session to take stock of:

- Use of sub-groups Information sharing mechanisms
- Reminder of key responsibilities
- Practical coaching on how to hold to account and how to represents interests of respective constituencies. Leading to the development of a Governor Development Programme.

7.2 A Stakeholder engagement plan under development which should be considered with the mapping of external partnership (**KLOE4**). . The board may wish to reflect on this feedback in developing the plan. Relationships with partners and commissioners revealed a considerable range of positive views in terms of the strength of the leadership, innovation and the quality of care at Alder Hey. But there was strength of view that trust, collaboration, flexibility and compromise were not always hallmarks of relationships with partners.

7.3 The Trust's quality plan for the formation of a Clinical Cabinet has yet to be implemented.

AQuA/MIAA - Board Workshop July 2018

KLOE 7: ENGAGEMENT

Stakeholder engagement: Internally this needs to be made relevant to 'my role'. Develop a strategy and method to build an embedded stakeholder map including mutual gain criteria for relatives, customers i.e. a relationship system.

Governors: NHSP on site bespoke training for governors.

Clinical Cabinet: governance needs refresh and review.

QI: patient voice needs to be better incorporated.

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- ✓ The trust proactively engaged and involved staff and had processes in place to ensure that the voice of staff was heard and acted on.
- ✓ There was effective engagement with patients and those who used services in the majority of areas.

Developments

- ↑ **End of Life Care -** • There was limited engagement with patients, staff and the public to manage end of life care services. There were no specific patient surveys for the service.
- ↑ **Out Patients** - The trust did not engage well with patients, staff, the public and local organisations to plan and manage appropriate services, or collaborate with partner organisations effectively. Whilst the BME and Disability engagement groups had recently been formed, there were no patient or parent groups directly feeding into the work of the outpatient department. There was also no formal benchmarking of service provision against other providers.

Well-Led Developmental Support

A Communications engagement	System Engagement	Board Meetings	Staff and Volunteers	Visibility	Service User/Carer
-:- Daily - Weekly - Monthly – Annually approach has been adopted. – Communications Calendar (Dec 2019 Board) Covering internal and external engagement. – A 'Core Message Guide' (developed through focus groups and listening to staff) will be issued in Dec 2019 covering – who we are; describing the Trust in 25, 50 words; vision, values etc. – **The Trust are moving to a communications editorial group for all communications this will ensure; engagement of advocates; Alder Hey language is used; the service is represented i.e. child friendly.** – **Planned update of the websites has commenced.** – **The Trust implementing a programme of new signage to engage better with the core service users, this will be integrated with the Alder Hey App.**	– Chief Exec Chairs the 'Children's Transformation Board – robust partnership with our local community partners through our collaborative Children's Transformation programme. – Hosted the Conference on the Wider Determinants of Child Health – Work with Liverpool Health Partners on the 'Starting Well Theme' – **Planning a climate change summit with the Council (aligned to the Green Policy)** – **Engaging with the Children's Commission on joint work.** **<u>NED System Engagement</u>** – Anita Marsland – Sefton TP chair, chair of Reader organisation in Liverpool – Claire Dove – Social Value local and national,, Neonatal partnership	**<u>Patient and staff stories</u>** are presented at each Board meeting. Board meetings are open meetings.	**<u>Clinical Cabinet</u>** - Proposal to Board on September 2019. Roles now advertised. - **Refer to KLOE 1 re Medical engagement (inc Junior doctors forum)** **<u>Staff Engagement</u>** – New staff magazine 'Alder Hey Life' (approx. Oct 2018). Issued 3-4 times p.a. (moving to quarterly). Editorial board includes representatives from across the hospital. – Strategy Engagement – Two 'town hall events' internally, supported by a special edition of Alder Hey Life – Town hall events (open to all staff) are led by the Chief Executive, supported by the executive team – held in the hospital and the community. Cover issues e.g. safety & quality, case studies etc. – '**Latest from Louise'** team brief led by the Chief Executive, the day after the board. ○ Nominated divisional representatives are required to attend Team Brief to provide consistency of attendance and messaging. This was to strengthen the cascade of communication. – Weekly blogs from Louise, providing updates and celebrating success. – Twitter accounts are open to all departments. **<u>Governor Meetings</u>** Relations with governors have significantly developed since the last review through the introduction of: – Informal lunches with the Chair. – Increased NED attendance at the meetings (what is the exposure and process) – Chair: Lead governor 1:1	- Louise's **Open Door Sessions** - The service user voice is heard at the start of each Board meeting. - Quality Assurance Rounds – walk around. - Process in place for Escalating concerns anonymously. - Listening Into Action (LiA)– to improve employee engagement – listening to staff and unblocking obstacles. - The divisional autonomy and engagement is more embedded which has resulted in a reduced need for the LiA structure. Issues are identified locally and resolved. - Staff awards gala – star awards - **Staff Fab** week and divisional level Fab Days e.g. Community Based staff	**<u>Children and Young Peoples Forum</u>** (significant strength at the Trust) – Strategy and consultation with staff and partners, weekly strategy session in atrium developed with families and patients - identified what was important to them – resulting in the **<u>Green Policy (</u>**taking action on climate change) – An innovative approach was applied at the AGM - Forum members delivered the financial outturn. – NEDs have attended PLACE assessments with the Children's and Young People's Panel (assessing ward cleanliness etc) **<u>CAMHS Forum</u>** **<u>ASD Patient Forums</u>** **Re-launched Alder Hey children and young people's forum, rebranded as The Forum, highly active locally and nationally including engagement with CEO of the NHS**. **<u>Engagement of the complainant</u>** in the resolution e.g. Neonatal Unit redesign. FRESH – people who accessed mental health services formed a group, regionally and now nationally known. 'Inspiring Quality' Every Service Improvement or change should include users of the service on the group.

<u>Staff Survey</u>		
<u>National Survey</u> – Reformed the approach to ensure it is about Alder Hey. – A more focused campaign approach is applied to encourage staff response rate. Focus on staff groups, weekly meetings and week by week messaging. – Trust has made significant improvements in our Staff Survey scores over the last five years. – In 2017, we were recognised by the Association of UK University Hospitals as the most improved Trust in the country for our Staff Survey results, – Analysis of the 2018 data demonstrated that over 75% of questions were scored more positively that the previous year. – In 2018, 72% of our staff said they would recommend the organisation as a place to work, an increase on 8% from the previous year, and the 2019/20 Q1 Temperature Check reported a score of 73% for this question. – Responses regarding line management have also improved, with staff reporting better support, feeling more valued and getting recognition for their work. – There has been a recognition from staff of the great work that has been ongoing regarding wellbeing, reward and recognition, and the new leadership programmes, However, we know that focused effort needs to be sustained on supporting wellbeing, with a particular focus on mental wellbeing and work related stress, hence the adoption of the national Time to Change programme; the work we have been doing on 'zero tolerance' needs to continue, as well as supporting staff with leadership skills at all levels. – We also need to ensure that we continue to support our staff Networks to improve the experience of our disabled, BAME and LGBT+ staff. – Listening into action following the survey continues to be focused on reward and recognition, wellbeing, locally driven improvements	<u>Divisional Action Planning</u> Each division presented their results to the divisional boards – Identifying key themes – Surgery ○ Engaged with the heads of service, matrons etc. ○ Captured improvements in the divisional annual plan. ○ Key improvements – Wellbeing including mental health and quality of appraisals – actions were aligned actions to the Trust developments e.g. 'Time to Change'; MIND programme etc. – Community ○ Presented to team meeting level ○ Completed a template for divisional actions. ○ IT issue has been identified but was supported by significant investment. Staff Fab day to support wellbeing. ○ Raising concerns was addressed through - Working with the FTSUP Guardians to improve the openness culture – Medicine ○ Grouped responses by staff group. ○ 'Big Conversations' were conducted with the medical teams. ○ Time to do work tools.	<u>Local Survey</u> – 2019/20 Q1 - introduction of a new way of gathering staff feedback, through a quarterly 'Temperature Check', specifically designed by the Associate Director of OD, who is also a Consultant Clinical Psychologist, a unique post to Alder Hey. – The survey, sample of staff (circa 25% per qtr) contains questions which map to the national Staff Survey engagement questions, and also questions which focus on psychological safety. – Q1 data trend of improvement compared to the 2018 staff survey results. The responses to the psychological safety questions, which asked staff about team relationships, inclusion/difference, speaking up, asking for help and respect, saw strengths in asking for help, inclusion/difference and respect. The areas which scored slightly lower, and we will be looking into further, will be around the themes of team support and culture.

Well-Led Developmental Support

Freedom to Speak Up	Alder Hey Children's Charity	Strategic engagement and partnerships
– The Trust has an 'Open Supportive Culture' - Raise it, Change it o There is an open door approach for accessing the senior team and board members. o One of highest reporters of incidents – (FTSU)– Kerry Turner (also leads on Listening into Action (LiA). The FTSU is an active participant in local and national networks – Trust has developed its activities in accordance with best practice guidance from the National Guardian's Office (NGO). – Record our incidences on a database which has restricted access, the format for this database is based on the NGO recommendations; a paper template is used to when meeting staff to capture the information required and to ensure we have a standardised approach to all concerns raised through the FTSU route. Introduced a debriefing sessions into the Trust, these are monthly meeting for HR Staff side and FTSU to meet to discuss completed staff cases to ensure that we are learning lessons and continuing to build and foster an open culture.	- Relations with the charity have transformed and significant investment agreed to support innovation as well as research and patient experience	**Refer to KLOE 3 Roles and systems – Clinical Partnerships and Liverpool Health Partners, system leadership**
–		
– Sweeney Collaborative – **Schwartz Rounds** – Refer to KLOE 4 – **Patient Shadowing Programme** – Student doctors following the patient journey as art of their induction. The Trust are looking to expand this to other areas. – Point of care partner – Family and patient centred care partner – **Goal based outcomes** – Links to the quality improvement initiative.		

Outstanding Practice or Services					
Information for patients and families	**Engagement & Experience**	**Engagement & Outcomes**	**Patient home simulator**	**Festival of Innovation**	**Wellbeing The Woodland Walk**
– AAiVA - The **Ask Oli chatbot** is the first real-world use of AI technology to improve **patient experience** within a hospital setting. – Working with our partner STFC Hartree, we have developed an accessible 24/7 virtual assistant for validated information at point of need for patients and families. – Ask Oli provides relevant responses to questions on general information about a visit to Alder Hey during the hospital visit or whilst at home. – With the help of staff and patients, Oli continues to learn and broaden his knowledge and as well as general hospital he currently covers in growing toenails, fractures, attending fracture clinic, preparing for operations, having an anaesthetic and more. – In development our clinical teams are teaching him about specific medical conditions too. It has answered over 15000 questions so far and we have secured our first contract to replicate this program in another local hospital.	– **Alder Play** - Alder Hey's **patient experience** platform App includes virtual tours, augmented reality characters, patient stories, gaming and virtual stickers to help Familiarise, Distract and Reward the Children and their families visiting the hospital. – It is deployed and in use in the hospital and our Innovation team are engaged training staff and rolling it out across departments building user engagement and feedback. – Working with staff, patients and their families, ensures the AlderPlay platform continues to develop and meet all the real world needs, supporting the patient's entire journey through our hospital.	– **HBA1C App** - Children and young adults with diabetes quite often don't understand the damaging consequences of sustained high glucose levels stored in the blood (technically known as HbA1c levels in haemoglobin). Essentially, high levels of sugar in the blood can lead to damage to blood vessels, over time creating serious complications in adulthood, including amputations, blindness and so on. – Clinicians at Alder Hey are working with the Innovation Team to develop child friendly digital solutions to actively encourage HbA1c monitoring, including an app with gamification elements to **encourage engagement** and understanding among children and young adults with this sensitive issue.	Patient home simulator - Within the Innovation hub we have created an environment to test the use of technology in a home setting. This allows for more rapid iterative development of technologies designed to be used in the home.	Patient and Staff engagement is a key part of the Innovation process and critical for innovation culture development. **Activities for engagement** include pop up sessions in the atrium, Innovation introduction presentations and detailed needs /challenge workshops at a ward, department and divisional level. The annual **Festival of Innovation** also engages staff, patients and their families in fun interactive technology demonstrations and workshops. In 2019 we had over 450 people attend our Festival and it will be part of a region wide innovation week in 2020. Inspiring the whole hospital in innovation and empowering them to solve their needs with the latest innovative technologies.	Wellbeing The Woodland Walk has transformed a corner of Springfield Park into a fully accessible walkway that will encourage visitors to benefit from the natural environment which can boost their **health and wellbeing**. The highlight of the walk includes a trail made up of 15 activity stations which encourage visitors to interact with, care for and learn about the natural environment. Five local primary schools have now been trained as Forest School Leaders and use the venue on a weekly basis to develop social and emotional intelligence, confidence, practical and creative skills and team building in their primary school classes. Recently, a school from Guernsey used the Forest School for enrichment purposes; there has been a family forest fun day and promotion of the benefits of outdoor play and learning on an informal basis. In October, the CAMHS team will be using the Forest School to **support patients** in a therapeutic outdoor environment.
Awards					
– A team of nurses who created a tool to help healthcare professionals communicate with people unable to speak has won the **Andrew Parker Student Nurse category of the RCNi Nurse Awards 2019.** The award was sponsored by the Royal College of Nursing Inspired by a mum's story of how her daughter was unable to communicate with healthcare professionals, the learning disability nursing students began teaching Makaton, a form of sign language, in workshops they delivered to their peers. The team decided to create a communication tool for healthcare professionals to use in practice. They printed, cut out, laminated and cut out again 300 sets of Makaton signs and symbols to provide to the new cohort of students about to start at Edge Hill University. They then threaded each set onto a metal ring that can be attached to a lanyard.					

AQuA Advancing Quality Alliance *In Partnership*

KLOE 8 Are there robust systems and processes for learning, continuous improvement and innovation?

AQuA/MIAA - Well-Led Review Feb 2018

- ✓ Innovation – open, adaptable approach to innovation, with appointment of an innovation partner and strategic alliance with Liverpool University. Encouraging engagement through pitching events.
- ✓ Research – Core to the strategic vision. 95% academic research, robust national profile.
- ✓ Learning – Utilising Human Factors training
- ✓ Quality Improvement – AQuA membership to support QI plans, invested in clinical engagement to embed plans

Innovation is an absolute strength at the Trust and the academic strategic alliances are well established and underpin this position. Research is also core to the Trust's vision and the Trust has a strong culture of promoting research and being visible on the research platform. Quality improvement plans have been committed to with discussions at Board and investment in clinical lead time. In terms of development this section of the review has highlighted deficiencies in the leadership, governance, integration, direction and role of the research directorate. More specifically, a clearer performance framework, accountable leadership, and clarity of message around funding would move things forward. One area that has been very much strengthened in the new NHSI Well Led guidance aligned with CQC's assessment relates to the effective application of quality improvement (QI). Consistent with the majority of other health organisations, there are opportunities to develop the application of QI including: alignment to the delivery of the Quality Strategy; developing a structured approach to QI training; developing a standardised local methodology for QI; and, applying QI methodology to the delivery of the CIP programme. The Trust's membership of AQuA will be beneficial in developing a more structured approach to the delivery of quality improvement.

- ↑ Overarching strategy for research, education, innovation needs to be reset supported by re-establishing the sub-committee arrangements.
- ↑ Deficiencies in research leadership, governance, integration, direction and clarity of role.
- ↑ Further development of the quality strategy aligned to quality priorities and plans. Supported by the GDE developments. Consistent understanding of quality improvement

Developments

8.1 The intent of the Trust's quality improvement ambitions would benefit from a clearer Quality Strategy, providing transparent Quality Improvement aspirations and approach for achievement. The 'Thoughts on developing the Trust's Quality Improvement Plan', provide a good starting point for this. Key further development opportunities include:-

- Clarifying the distinction between what the Trust mean by:-
- 'Quality' (refer to the Institute of Medicine's definition, testing the Trust's quality aims and KPI's against this; and ,
- 'Quality Improvement' (***"There is no single definition of quality improvement. However, a number of definitions describe it as a systematic approach that uses specific techniques to improve quality."*** Quality improvement made simple. Health Foundation, 2013).
- Developing a structured approach to quality improvement training for all staff (initiated with an introduction to improvement); *refer to 'Developing a Quality Improvement Culture and the dosing formula.*
- Board understanding of performance in terms of variation (refer to Information developments **KLOE 6**, development 6.1 above).
- Use of a locally determined standardised improvement methodology embedded across the organisation to improve the quality, efficiency and productivity of services.
- Establishing clear leadership roles, responsibilities and reporting lines for quality improvement e.g. the role and priorities of the Co-Director of Clinical Effectiveness and Transformation'.
- The Clinical Quality Steering Group complete Root Cause Analysis and share the results with divisional membership. The Director of Nursing is considering extending this to a wider quarterly half day session. AQuA membership could be utilised to advise and support this development.

8.2 NHSI has recently issues a number of documents supporting this approach: Developing People Improving Care, Building Capacity and Capability for Improvement. Consistent with other organisations, it is recommended that the Trust take a quality improvement approach to their cost improvement programme i.e. to maximise clinical leadership and align initiatives to quality developments aligned to cost reduction.

8.3 An overarching strategy for research, education, innovation and development needs to be reset which will provide an opportunity to review the leadership, governance, committee and reporting requirements.

It may be a timely opportunity for a review of the Strategy for Research, Innovation and Education strategy. There needs to be clarity regarding commercial growth and support of internal transformation etc. This would furthermore inform where the three workstreams fit within the organisation.

8.4 Research - A specific review is recommended into the strategy and strategic direction for research (including the viability of commercial aspirations

AQuA/MIAA - Board Workshop July 2018

KLOE 8: LEARNING, IMPROVEMENT, INNOVATION

Strategy: Research and Innovation has a timeline for review and development including creating internal opportunities . This will include alignment to QI.

Timing of research needs to match ambition. Flexible enough to react (horizon scanning).

CQC Inspection Feb 2018, Published June 2018

- ✓ They promoted training and research.
- ✓ There was a strong focus on continuous improvement and learning at all levels in the organisation.
- ✓ Innovation was supported and celebrated across all services. They used innovation well.
- ✓ There was a proactive approach to seeking out and embedding new models of care through research.
- ✓ Ensure that complaint responses are managed in line with the trust policy.
- ✓ The trust was committed to improving services when things go well and when they go wrong.

Outstanding

The dental clinic demonstrated a number of innovations which included the wide awake club for children with autism to receive care at quieter times, and acclimatisation sessions for patients' with learning disabilities. The clinic included a nurse who was a learning disability champion, and staff had received training in interacting with children with individual needs. Staff within the clinic had been nominated for an award for how the deal with children with individual needs.

The trust was involved in a number of innovative programmes. These included producing 3D models of parts of the anatomy following scans of children. This allowed medical staff to have a clearer outline of the children's condition before any procedures were undertaken and meant that children who had to undergo surgery were potentially in theatre for shorter periods of time. The trust had also developed a virtual reality programme of a heart.

An interactive application was launched in November 2017 which featured gaming and augmented reality. This was designed to provide entertainment but also distraction for the patient whilst undergoing procedures in the hospital. Young patients were able to select their own avatar to explore the hospital before they arrived.

The trust had an innovation laboratory were staff and patients were encouraged to put forward ideas to help improve patient care. These were then taken forward by the trust.

Well-Led Developmental Support

2019 Progress

Research		Innovation	Education
The Trust has recruit the highest number of children and young people to research studies; over 44,000 since the inception of the National Institute for Health Research (NIHR) Clinical Research Network (CRN) - wide-ranging core research strengths including respiratory, rheumatology, neurosciences, infectious diseases, clinical pharmacology (paediatric), medicines formulation research and paediatric surgeries. In partnership with the University of Liverpool, the NIHR Alder Hey Clinical Research Facility for Experimental Medicine offers children and young people the opportunity to take part in life-changing research trials – New team introduced at director and divisional level. – Exec Lead – Claire Liddy – Director of Research – Jo Blair – General Manager Jason Taylor ○ Development of Clinical Academic Posts – Research Management Board (commencing Nov 19). – Corporate Strategy (approved Sept 2019) has a clear focus on research ○ Aligned draft Research strategy which provides clearer objectives (October 2019) **Jointly sponsored (Alder Hey and Liverpool University) application for a NIHR funded post – Research Professor Children's Orthopaedics.**	**Research Institute (opened Jan 2019)** Our children and young people's health campus houses a dedicated Research, Education and Innovation (RE&I) Institute, which is home to our partnership with four Universities (University of Liverpool, Edge Hill University, Liverpool John Moores University and University of Central Lancashire) and the National Institute for Health Research (NIHR) **The health campus will grow to encompass specialist mental health, neurodevelopmental and bereavement services, all within a parkland setting dedicated to inspiring and supporting children's health and well-being.** – Academic Research – Higher Education (Medical School) – Clinical Research Facility (trials)	– Board approved Innovation Strategy 2019 – Innovation Business Plan – implemented – AH is the only trust in the country that has a 'Bat Cave', (i.e. Innovation Hub), pioneering leading innovations globally – Dedicated database and reporting system. – Every submitter is communicated with regarding the stage of their submission and contacted directly to progress their project. – methodology: Engage, Triage, Validate, Active. – Each stage has its own specific activities and criteria and consistent selection criteria. The bespoke system also enables reporting of the number of projects at any time including status, departments and individual. – The learnings from the projects and details from the needs workshops are fed back in to numerous departmental and operational meetings and multi department project teams are set up to work together improving and solving the identified needs together.	– Director of Medical Education is in post. – Education Governance Cttee, reports into Workforce and OD. – Four of the Trust's consultants are Clinical Chairs at Liverpool University. Support team have oversight of programmes. GMC survey re Junior Doctors. Health Education NW reviewed services October 19 – positive feedback. Nurse Education – Practice educators on all wards (introduced in the last 12 months) - Consistent education of nurses on wards; compliance with mandatory training; support newly qualified re preceptorship; share good practice. This has helped recruitment and retention. **Gaps** – **Issue re Cardiology Trainees – working with Manchester to address gaps and new roles.**

Benchmarking	Quality Improvement	Learning		
– Engagement re GIRFT – e.g. Radiology, Orthopaedics, appendectomy. The Trust are leading on determining the Paediatric GIRFT requirements and trialling the processes. One of the Trust's consultants Simon Kenny is the National Lead. – GIRFT results have supported the teams to change practice Radiology extended roles. – Spinal GIRFT – positive results. – Respond to - National Confidential Enquiry into Patient Outcomes (NCPOD) contribute. – TARN – Trauma audit registration and benchmarking. – Gaps – – **The Trust is not receiving oversight of audit outcomes.** – **Some set audits not completed.**	– To ensure full clinical commitment across all disciplines, the '**Inspiring Quality Strategy'** was deferred until the substantive appointment of the Medical Director (commences Jan 19). – **Inspiring Quality** = Brilliant Basics, Human Factors, Training staff re change. The Trust recognises that empowering staff to deliver safe, high quality, reliable care can provide a step change in improvement results. – The Trust is developing an organisation wide approach to QI to train and empower staff engagement. – Every Service Improvement or change should include users of the service on the group. – IQ partner appointed to disseminate QI structure / capacity through the organisation - **A supplier will be appointed in December to commence in Jan 2020.**	**Staff focus groups – learning from major cases** Learning from Alfie – – During the course of the case, regular open sessions were held for staff. – Open letter issued by the Chair/Chief Exec to provide the Trust's position. – Helplines, links to the police etc arranged. – Debriefings offered to all teams. – Workshops completed with NHSE and Great Ormond St – to capture national and local learning. – Revisited national policy including legal approach. – Revisit staff resilience training and managing conflict. – Additional staff support in ITU and HDU.	– Established a Staff Advisory and Liaison Service (2019) – Introduced a debriefing sessions into the Trust, these are monthly meeting for HR Staff side and FTSU to meet to discuss completed staff cases to ensure that we are learning lessons and continuing to build and foster an open culture. External Sharing The Trust is currently involved in a range of worldwide shared learning. E.g. A partnership to share experience and learning - Small Hospital in China. Four cohorts have been received in the Trust. Clinicians are giving lectures at the hospital. Refer t the Education Business Links award below. **Internal Shared Learning** – **There is not sufficiently robust dissemination re learning from safety issues, root cause etc. Internal communications needs to increase to two weeks.**	**Learning from incidents .** Learning is communicated and shared through a number of communications mechanisms. ○ Safety Alerts ○ Patient Safety Meetings ○ Screen Savers ○ Medication Safety Newsletters. ○ RCA Bulletins. ○ Safety Board ○ Integrated Governance and cascade. ○ RCA across divisions and lessons learnt. Example of improvements following a RCA– ○ Process for booking follow-ups, providing additional information to ensure prioritisation of appointments. ○ Flow – 7 changes to the flow and bed management meeting – impact a significant reduction in on the day cancellations due to beds. Huddle boards - A&E, Out patients and management short focused meetings and learning Comcell - Weekly review of the organisation performance over the past week & challenges for the future - also captures incidents and actions Ward Accreditation refer to KLOE 4

Outstanding Practice or Services

Partnership - Screening Solution	Partnership – Mobility Solution	Pre-operative planning
– **SHINE** - Alder Hey, University of Liverpool, LJMU and Arthritis UK have collaboratively developed a new technology to detect dysplasia of the hips in new born babies. – The technology is currently being trialled and it is anticipated that this innovative solution could lead to significant improvements in the accuracy of screening, reducing the need for unnecessary treatment for babies that are currently misdiagnosed, and avoiding the cost and distress of full diagnostic testing for those that don't need it. – We have plans to develop the technology further to support future commercialisation	– **MOVE** is a partnership between Alder Hey and the University of Liverpool – focused on the future of inclusive childhood mobility for disabled children. – The partnership is looking at developing a power chair which enables disabled children to enjoy childhood to the full, and which optimises their development, socialisation and engagement with life generally. – The MOVE power chair will be an Intelligent and customisable device allowing flexibility for parents and therapists, as well as being affordable and maintainable for families and carers.	– **Headspace** - Alder Hey and the University of York have collaboratively developed a 3D morphable model (3DMM) of the human head based on a 1500 patients. – The model is one of the largest samples for a head model in the world. It also includes the full cranium which is unique, other models only include face. – The technology is being further developed to support innovation in both pre-operative planning and post-operative assessment of craniofacial surgery at Alder Hey.

Accreditation	Awards
– **Anaesthesia Clinical Services Accreditation** (ACSA) awarded by the Royal College of Anaesthetics – **Quality Network for Impatient CAHMS –** awarded to the Deni Jones Unit. – **JACIE (Oncology –** autologous Transplant Programme) First time accreditation for an Oncology Department. – **UCAs accreditation for the Pathology Department**	– **Graphite Pencil award for Digital Design** 2018 - Winner of this prestigious design award for work on Alder Play and featured on the Apple App store as App of the day. https://www.dandad.org/awards/professional/2018/digital-design/26773/alder-play/ – The **Education Business Links Award**, (Feb 2019) that the Academy team won, was a result of them offering innovative training and successful education partnerships in Greater China. – Two clinical academics, Professor Calum Semple and Dr Christine Cole, have received awards Dec 2019 from **The Liverpool Commonwealth Association** (LCA) for their service to the Ebola Crisis 2014-2016, and survivor healthcare in Sierra Leone. Research into assessing the country's capacity to conduct research to treat this terrible disease. The team published a seminal paper describing Post Ebola Syndrome. – **British Heart Foundation Healthcare Hero Award 2019** - The award highlights both Mr Ram Dhannapuneni work as an expert Consultant Cardiac Surgeon and his extensive charitable fundraising activities. He has already raised over £60,000 for charities both here and abroad, and dedicates his time and expertise as a lead surgeon for Healing Little Hearts charity in performing hundreds of free heart surgeries, teaching and training in several developing countries.

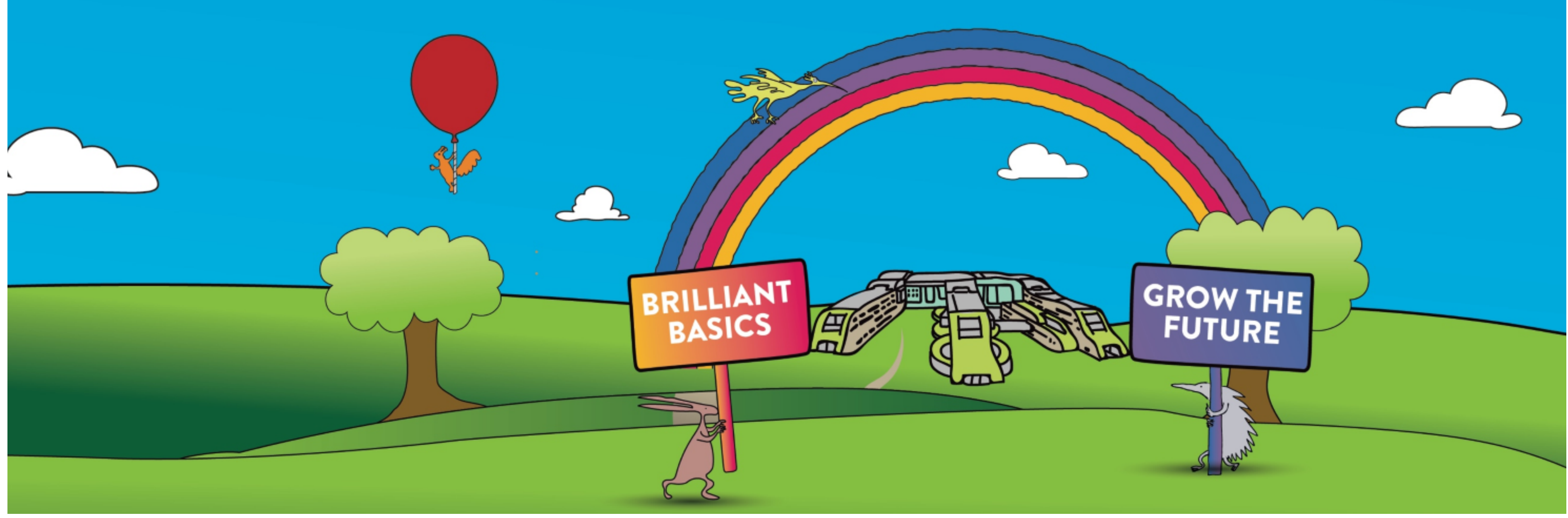
Abbreviations

The Terms used within the report (plus additional NHS Terms to support interview)

Ref.		Ref.		Ref.	
AGM	Annual General Meeting	**FPP**	Fit and Proper Person	**OD**	Organisational Development
AH	Alder Hay Children's NHS FT	**FTSU**	Freedom to Speak Up	**Ofsted**	Office for Standards in Education, Children's Services and Skills
AHSN	Academic Health Science Network	**GDE**	Global Digital Exemplar	**PBR**	Payment By Results
AQuA	Advancing Quality Alliance	**GIRFT**	Getting It Right First Time	**PEWS**	Paediatric Early Warning Score
BAF	Board Assurance Framework	**GMC**	General Medical Council	**PLACE**	Patient –Led Assessment of the Care Environment
BMAE	Black, Asian, minority ethnic	**HDU**	High Dependency Unit	**PSF**	Provider Sustainability Fund
CAMHS	Child and Adolescent Mental Health Services	**HIMSS**	Hospital Information and Management Systems Society	**QI**	Quality Improvement
CCG	Clinical Commissioning Group	**HR**	Human Resources	**QIA**	Quality Impact Assessment
CE	Chief Executive	**IGC**	Integrated Governance Committee	**RE&I**	Research, Education and Innovation
CIP	Cost Improvement Programme	**IPR**	Integrated Performance Report	**RMCH**	Royal Manchester Children's Hospital
CoG	Council of Governors	**ITU/ICU**	Intensive Therapy Unit/ Intensive Care Unit	**RTT**	Referral to Treatment
CRN	Clinical Research Network	**KLOE**	Key Lines of Enquiry (Used in CQC assessments)	**SALS**	Staff Advisory Liaison Service.
CRR	Corporate Risk Register	**LGBTQ**	Lesbian, Gay, Bisexual, Transgender and Questioning.	**SID**	Senior Independent Director
CQC	Care Quality Commission	**LiA**	Listening into Action	**SOP**	Standard Operating Procedure
CQAC	Clinical Quality Assurance Committee	**LJMU**	Liverpool John Moores University	**STFC**	Science and Technology Facilities Council
CYP	Children and young Persons	**MDT**	Multi-Disciplinary Team	**STP**	Strategic Transformation Partnership
DD	Divisional Director	**MIAA**	Mersey Internal Audit Agency – Trust's Internal Auditors	**SUS**	Secondary Uses Service
DoF	Director of Finance	MRSA	Methicillin-resistant staphylococcus aureus	**Trust**	Alder Hey Children's NHS FT
DoN	Director of Nursing	**MSSA**	Methicillin-sensitive Staphylococcus aureus	**WLI**	Waiting List Initiative
DQ	Data Quality	**NCEPO**	National Confidential Enquiry into Patient Outcomes		
DQMI	Data Quality Maturity Index	**NED**	Non-Executive Director		
DQSG	Data Quality Steering Group	**NIHR**	National Institute for Health Research		
EA	External Audit	**NGO**	National Guardians Office		
ED	Executive Director	**NHSE**	National Health Service England		
EMT	Executive Management Team	**NHSI**	National Health Service Improvement		
EPR	Electronic Patient Record				
ESR	Electronic Staff Record				

In Partnership

TRUST BOARD Report November 2019



How Did We Do?

Executive Summary **Month: November** **Year: 2019**

Delivery of Outstanding Care

Safe

- Highest recorded figure of the year for children treated for sepsis in ED and receiving antibiotics within an hour (84%). Continued high delivery of antibiotics within 60 minutes across in patient wards.
- One reported moderate incident – Grade 3 pressure ulcer. Initially unable to categorise however continued review and now categorised. 72 hour review undertaken, RCA commenced and Duty of Candour undertaken.
- 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.

Highlight

- Continued high reporting of clinical incidents resulting in near miss and no harm.
- Antibiotic administered within 60 minutes for children with suspicion of sepsis.
- Reduction in medication errors resulting in harm.
- No never events.

Challenges

- Increase in number of reported incidents resulting in minor none permanent harm in past 2 months however reporting culture within the Trust remains high with trajectory of high incident reporting with low harm continued.
- Device related pressure ulcer; Tissue Viability team reviewing products and guidance for staff and parents / carers.

The Best People Doing their Best Work

Caring

- Reduced number of PALS concerns raised in month. Increased number of formal complaints increased however particularly low number the previous month therefore reduced aggregate number. 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 3 months. OPD and Community continue to receive high recommendations from our families.

Challenges

- 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. Comprehensive action plan in place which includes safe, caring and compassionate measures such as additional Health Care Assistants working in the waiting area to undertake Comfort Rounds.

Delivery of Outstanding Care

Effective

We have faced exceptional pressures in the Emergency Department due to unprecedented volumes of patients attending. The increase in volume is driven largely by sharp increases, above predicted, in flu and cold presentations. 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). We are liaising with NHSE for additional investment and with Mersey Care for additional capacity in the community.

Cancelled operations are high as we accommodate an increase in emergency cases. We are re-setting our bed model predictor and have introduced a weekly scheduling meeting to better schedule planned operations and reduce those cancelled on the day.

Scanning turnaround times for outpatient records have improved following outsourcing. We are working on configurations to permit this to happen for inpatient records. We expect to fully resolve delays to scanning in January 2020.

Highlight

- Low number of readmissions to PICU within 48 hrs.

Challenges

- ED waiting times.
- Scanning turnaround times.
- On the day elective cancellations.

Delivery of Outstanding Care

Responsive

We are delivering outstanding performance in relation to national standards for planned care and cancer care. At specialty level, there are, nonetheless, challenges in some clinical specialties. We are in dialogue with Sefton CCG about investment in learning disability pathways. In CAMHS we have an improvement plan to deliver the 92% waiting time standard by June 2020.

Highlight

- % of patients who know is in charge of their care and planned date of discharge.
- Time to treatment for planned care.
- Access to cancer care.
- Access to planned care.

Challenges

- % involved in learning.
- Waiting times for ASD, ADHD and CAMHS.

The Best People Doing their Best Work

Well Led

In Month 8 we delivered a £0.18k surplus which was £0.2k behind the plan. This means we are now £0.3m behind our year to date plan. It is important that we recover this position by the end of Q3 in order to secure our PSF income.

Activity levels remained high in month in Outpatients and A&E which both exceeded their plan. Elective activity was 2% behind plan Non Elective was 6% behind plan.

Pay was in line with the plan for the month. Temporary staffing expenditure continues to be high at £0.9m in the month.

Non pay remains an area of concern and is overspent year to date by £3.7m. Action plans to address have been requested from divisions.

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 £77.9m which is significantly higher than plan driven mainly by capital slippage.

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

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

Sickness levels are constant at 5.7%. There is work underway to support specific teams where sickness levels are high.

Highlight

- Activity Levels in OP.
- Mandatory Training.

Challenges

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

Game Changing Research and Innovation

Research and Development

Research and Development	Highlight
• Divisional Performance Review with Execs. • Interviews for the position of Associate Divisional Research Director. • Presentation of Research Incentivisation Pilot Plan to Ops Board.	• Ratification of Research Incentivisation Pilot Plan. **Challenges** • Level of staffing to support and deliver research activity.

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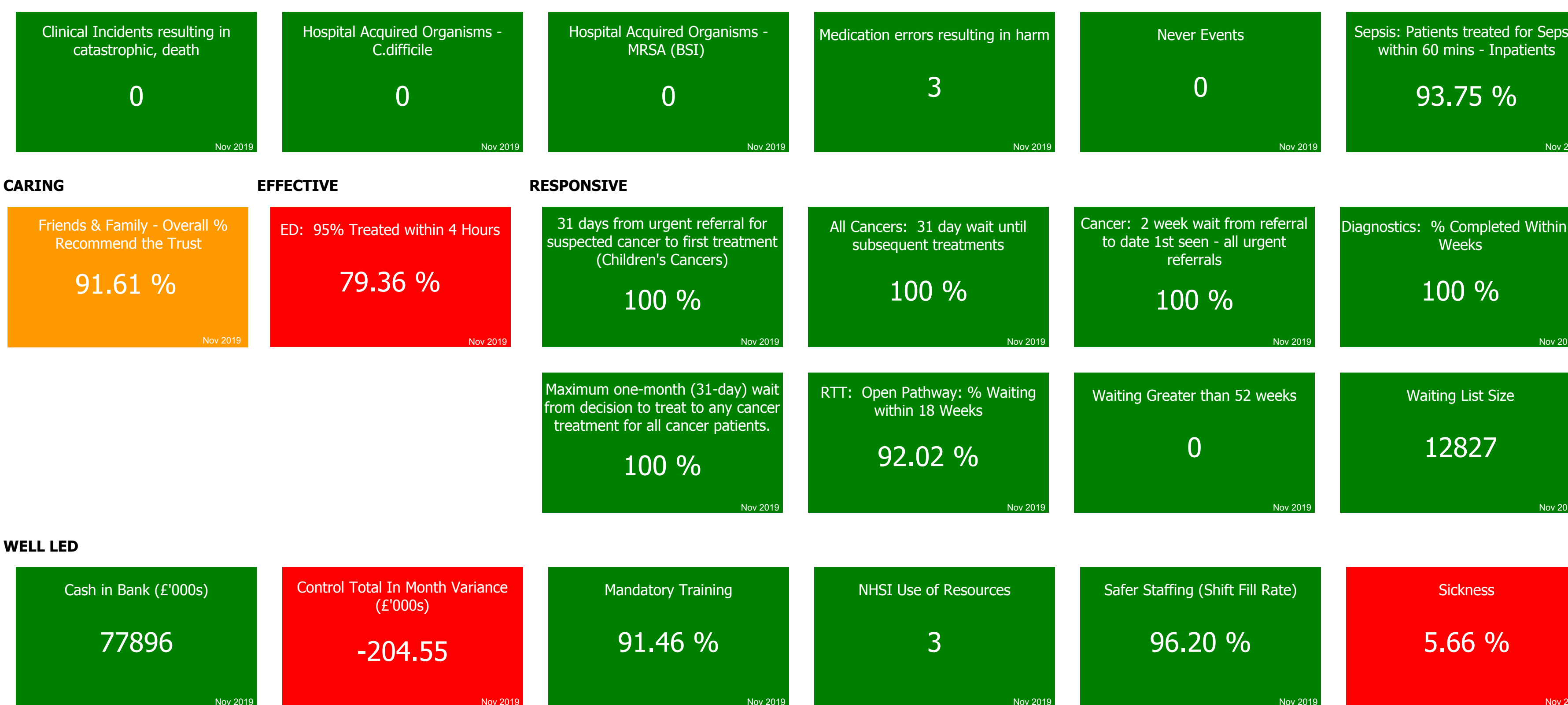
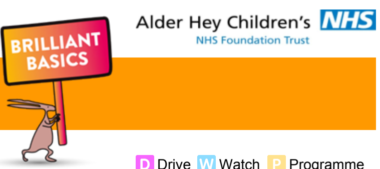
Alder Hey Children's NHS
NHS Foundation Trust

Leading Metrics



Delivery of Outstanding Care

SAFE



D Drive W Watch P Programme

Indicator	Type	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG (Green)	RAG (Amber)	RAG (Red)	Comments Available
Clinical Incidents resulting in Near Miss	D	79	58	59	83	76	58	83	57	113	52	62	60	74		>=85	>=81	<81	✔
Clinical Incidents resulting in No Harm	D	286	217	284	251	280	302	296	298	319	285	277	329	287		>=297	>=283	<283	✔
Clinical Incidents resulting in minor, non permanent harm	D	94	67	78	84	104	94	108	76	68	72	73	93	93		<=86	N/A	>86	✔
Clinical Incidents resulting in moderate, semi permanent harm	D	1	1	2	1	0	0	0	1	3	1	1	0	1		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	1	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	D	0	0	1	2	0	0	0	1	0	0	1	0	0		0	N/A	>0	✔
Medication errors resulting in harm	D	6	2	2	4	2	6	3	3	2	1	2	6	3		<=4	N/A	>4	✔
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	1	0	1	0	0	1		0	N/A	>0	✔
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Never Events	W	0	0	1	0	0	0	0	0	0	0	2	0	0		0	N/A	>0	✔
Sepsis: Patients treated for Sepsis - A&E	D P	57.6%	51.9%	77.4%	71.1%	79.4%	58.8%	71.1%	65.2%	79.3%	76.7%	77.8%	78.4%	84.2%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	76.2%	73.3%	70.2%	82.1%	73.3%	81.8%	71.4%	90.9%	80.0%	100.0%	94.1%	100.0%	93.8%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	W	0	0	0	0	0	0	0	0	1	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	1	0	0	0	0	0	0	1	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	D	0	1	1	0	4	1	1	0	0	1	1	0	1		<=1	N/A	>1	✔

The Best People doing their best Work

CARING

D Drive W Watch P Programme

Indicator	Type	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	D	80.6%	90.1%	90.5%	80.3%	89.5%	78.8%	87.7%	80.4%	82.8%	88.1%	91.1%	83.6%	80.9%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	D	100.0%	100.0%	98.5%	100.0%	98.6%	88.4%	100.0%	93.8%	92.9%	92.9%	91.9%	95.0%	94.1%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	D	97.9%	98.2%	97.0%	96.2%	97.8%	97.3%	90.6%	90.1%	93.2%	92.5%	95.5%	96.5%	95.9%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	D	97.5%	100.0%	88.9%	76.9%	82.9%	80.8%	88.7%	100.0%	33.3%	78.8%	88.5%	66.7%	89.1%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	D P	91.4%	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 % >=90 % <90 %	✔
Complaints	W	5	7	7	9	16	7	9	6	15	13	12	4	14		No Threshold	
PALS	W	115	71	136	97	95	110	103	121	128	93	130	119	103		<=104 <=115 >115	✔

Delivery of Outstanding Care

EFFECTIVE

BRILLIANT BASICS

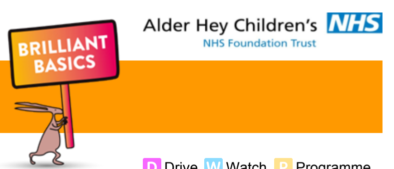
Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG			Comments Available
% Readmissions to PICU within 48 hrs	W	1.1%	2.4%	1.4%	1.8%	2.5%	2.7%	2.1%	1.3%	5.3%	5.4%	0.0%	1.2%	0.0%		<=3 %	N/A	>3 %	✔
ED: 95% Treated within 4 Hours	D	93.8%	95.3%	92.1%	90.6%	95.6%	93.5%	91.3%	89.4%	91.8%	94.7%	89.0%	86.9%	79.4%		>=95 %	N/A	<95 %	✔
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	0	1	0	1	0	0	0	0		0	N/A	>0	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	D	38	21	11	10	12	9	24	15	37	35	18	34	44		<=20	N/A	>20	
28 Day Breaches	W	6	6	4	1	1	0	0	1	2	0	1	0	2		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		<=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		<=5	N/A	>5	✔

Delivery of Outstanding Care

RESPONSIVE

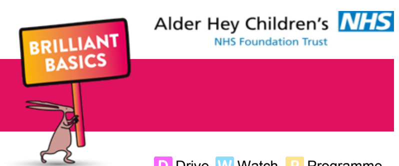


D Drive W Watch P Programme

Indicator	Type	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG			Comments Available
IP Survey: % Received information enabling choices about their care	W	95.1%	96.7%	96.0%	94.9%	95.7%	98.3%	96.6%	97.5%	97.6%	95.7%	97.7%	95.7%	96.7%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Treated with respect	W	100.0%	99.6%	100.0%	99.3%	99.5%	99.3%	99.0%	98.1%	99.2%	97.5%	98.4%	97.7%	97.6%		100 %	>=95 %	<95 %	✔
IP Survey: % Know their planned date of discharge	D P	69.0%	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 %	>=85 %	<85 %	✔
IP Survey: % Know who is in charge of their care	W	92.2%	92.5%	96.3%	94.3%	93.4%	99.3%	90.5%	96.3%	90.8%	98.0%	98.4%	93.7%	98.3%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Patients involved in Play	D								93.3%	94.5%	95.3%	91.5%	92.1%	93.9%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Patients involved in Learning	D								70.9%	75.6%	72.1%	68.3%	73.5%	68.3%		>=90 %	>=85 %	<85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	W	92.1%	92.0%	92.0%	92.0%	92.0%	92.0%	92.0%	92.1%	92.1%	92.0%	92.0%	92.0%	92.0%		>=92 %	>=90 %	<90 %	✔
Waiting List Size	W	12,934	12,859	12,872	12,888	12,746	12,871	12,876	12,843	12,883	12,874	12,826	12,754	12,827		<=12899	N/A	>12899	✔
Waiting Greater than 52 weeks	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	87.5%	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%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%		100 %	N/A	<100 %	✔
Diagnostics: % Completed Within 6 Weeks	W	99.3%	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 %	N/A	<99 %	✔
PFI: PPM%		99.0%	100.0%	100.0%	100.0%	98.0%	98.0%	98.0%	98.0%	100.0%	99.0%	99.0%	99.0%	99.0%		>=98 %	N/A	<98 %	✔

The Best People doing their best Work

WELL LED

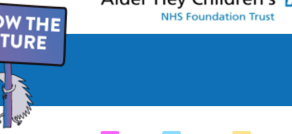


D Drive W Watch P Programme

Metric	Type	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG (Green)	RAG (Amber)	RAG (Red)	Comments Available
CIP In Month Variance (£'000s)	W	-285	151	-199	-74	-75	-163	-54	-47	-26	176	-165	-22	57		>=-5%	>=-20%	<-20%	✔
Control Total In Month Variance (£'000s)	W	-48	564	-21	-433		-394	-165	596	-848	852	94	-240	-205		>=-5%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	W	1,041	1,032	1,032	259	1,610	1,030	640	728	694	1,239	865	1,909	-115		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	W	17,580	23,136	19,983	22,068	33,699	34,361	34,449	37,415	79,086	80,174	80,807	81,847	77,896		>=-5%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	W	684	142	456	355	19,495	-612	21	846	-52	1,348	666	1,103	1,367		>=-5%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	W	-74	-267	-510	-850	-495	183	-25	-130	-260	273	143	-254	-39		>=-5%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	W	-659	689	34	63	-942	34	-161	-119	-537	-769	-715	-1,090	-1,552		>=-5%	>=-20%	<-20%	✔
NHSI Use of Resources	W	1	1	1	1	1	1	3	3	3	3	3	3	3		<=3	N/A	>3	✔
AvP: IP - Non-Elective	W						53	58	109	158	132	54	-18	-97		>=0	N/A	<0	✔
AvP: IP Elective vs Plan	W						-45	-24	-42	-76	17	-67	-66	29		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan	W						-53	-132	-241	-45	79	58	-77	-34		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan	W						768	90	1,300	2,069	2,646	2,246	2,872	1,906		>=0	N/A	<0	✔
PDR	W	90.1%	90.1%	90.1%	92.2%	92.2%	4.8%	20.7%	47.3%	86.4%	89.3%	89.3%	89.3%	89.3%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal	W	100.0%	100.0%	100.0%	100.0%	100.0%	99.7%	98.1%	97.8%	95.7%	96.6%	93.8%	88.5%	69.7%		>=95 %	>=90 %	<90 %	✔
Mandatory Training	W	89.7%	89.0%	89.4%	88.8%	89.6%	90.0%	88.4%	90.5%	90.8%	91.9%	91.1%	91.3%	91.5%		>=90 %	>=80 %	<80 %	✔
Sickness	D	5.6%	6.0%	5.7%	5.7%	5.3%	5.2%	5.5%	5.2%	5.2%	4.9%	5.2%	5.8%	5.7%		<=4 %	<=4.5 %	>4.5 %	✔
Short Term Sickness	D	1.6%	1.7%	1.9%	1.7%	1.6%	1.5%	1.5%	1.4%	1.3%	1.0%	1.4%	1.8%	1.9%		<=1 %	N/A	>1 %	✔
Long Term Sickness	D	3.9%	4.4%	3.8%	3.9%	3.7%	3.7%	4.0%	3.8%	3.9%	3.9%	3.8%	3.9%	3.7%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	D	971	883	937	1,046	1,357	1,114	1,061	899	1,058	992	1,145	933	1,021		<=800	<=960	>960	✔
Staff Turnover	D	10.2%	9.6%	9.4%	9.5%	9.9%	9.7%	9.9%	9.8%	9.3%	10.0%	10.3%	10.1%	10.1%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	W	95.3%	94.2%	94.5%	92.8%	95.4%	95.3%	95.2%	92.6%	92.0%	93.5%	90.8%	92.2%	96.2%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	W	90.0%	90.0%	92.0%	95.0%	86.0%	81.5%	100.0%	81.2%	97.2%	92.5%	90.5%	100.0%	82.0%		>=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



D Drive W Watch P Programme

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	W	136	123	121	121	153	154	158	161	158	172	161	162	167		>=130	>=111	<111	✔
Number of Open Studies - Commercial	W	28	27	29	26	60	59	59	58	57	59	38	42	45		>=30	>=21	<21	✔
Number of New Studies Opened - Academic	W	8	2	6	5	3	1	5	4	2	3	2	2	5		>=3	>=2	<2	✔
Number of New Studies Opened - Commercial	W	0	0	1	1	4	2	1	2	2	2	1	2	6		>=1	N/A	<1	✔
Number of patients recruited	W	296	158	238	211	314	234	221	350	431	165	941	1,228	1,180		>=200	>=171	<171	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Increasing Reporting	**Clinical Incidents resulting in Near Miss** D Total number of Near Miss Incidents reported. The threshold is based on increasing on last year for the period Apr 18 - Mar 19. 19/20 aim is to see more than 5% reported than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	74	R <81 A >=81 G >=85	Nov-18 to Nov-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	The Division continue to receive weekly report for all near miss incidents . These reports enable monitoring and immediate learning . The revised Incident policy has a clear focus on the importance of 'near miss' reporting and this is available for all staff across the Trust via the intranet. In addition the divisions have been provided with the last 12 months stats around near miss reporting, including evidence of compliance levels around recommendations, lessons learned and actions for improvement to increase focus.
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 Murdoch **Committee:** CQAC	287	R <283 A >=283 G >=297	Nov-18 to Nov-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	Divisions receive weekly reports of all 'No Harm' incidents reported to enable prioritisation of reviews and ensure lessons are learned, actions for improvement are implemented and feedback to staff (to minimise risk) and reporters. Staffs are encouraged to report 'No harm' incidents as these are considered learning opportunities to review systems and processes to minimise risk of more serious harm. These reports enable monitoring of trends and actions for improvement to be implemented. Progress with improvements is expected to be included in monthly CQSG division governance reports.
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 Murdoch **Committee:** CQAC	93	R >86 A N/A G <=86	Nov-18 to Nov-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	Divisions receive weekly reports of all 'low Harm' incidents reported to enable prioritisation of reviews and ensure lessons are learned, actions for improvement are implemented and feedback to staff (to minimise risk) and reporters. Staffs are encouraged to report 'low harm' incidents as these are considered learning opportunities to review systems and processes to minimise risk of more serious harm. These reports enable monitoring of trends and actions for improvement to be implemented. Progress with improvements is expected to be included in monthly CQSG division governance reports.

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

D Drive W Watch P Programme

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

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Medication Errors	**Medication errors resulting in harm** D 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 Murdoch **Committee:** CQAC	3	R A G	>4 N/A <=4	Actual, Average, UCL, LCL, UWL, LWL, Green; Nov-18 to Nov-19	No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** W Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	1	R A G	>0 N/A 0	Actual, Average, UCL, LCL, UWL, LWL, Green; Nov-18 to Nov-19	This was initially reported as unstageable in August 2019 but has now been classified as a category 3 medical device related pressure ulcer. The patient was an inpatient on Oncology and was discharged home with special support splint. 5 days later the patient attended daycase for treatment and parents reported the pressure ulcer. An RCA has commenced to investigate. The wound is now healing well.
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** W Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0	Actual, Average, UCL, LCL, UWL, LWL, Green; Nov-18 to Nov-19	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)
Never Events	**Never Events** W Never Events. The threshold is based on this event never occuring. 19/20 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R	>0		No Action Required
			A	N/A		
			G	0		
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	84.21 %	R	<90 %		Increase in percentage treated in under 60 mins. No change in data collection, increased number of patients needing high level care (in part due to flu). Positive upward trend even with the increased winter pressures. Good work by the clinicians and nurses in ED.
			A	N/A		
			G	>=90 %		
Sepsis	**Sepsis: Patients treated for Sepsis within 60 mins - Inpatients** D P Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 19/20 aim is 90%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	93.75 %	R	<90 %		No Action Required
			A	N/A		
			G	>=90 %		

Delivery of Outstanding Care

7.5 - QUALITY - SAFE

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Mortality	**No of children that have suffered avoidable death - Internal** W Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 19/20 is zero. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** D The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - C.difficile** D The threshold is based on this event never occuring. 19/20 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required

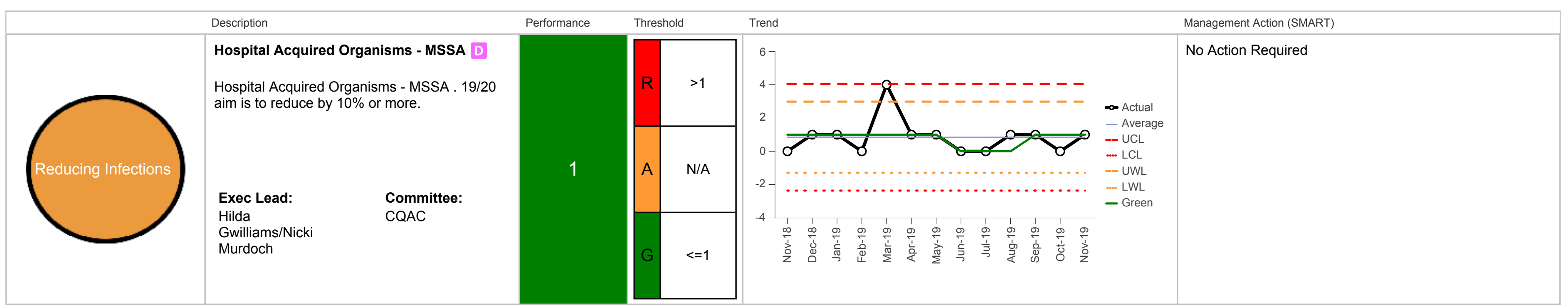
Delivery of Outstanding Care

7.6 - QUALITY - SAFE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme



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

The Best People doing their best Work

8.1 - QUALITY - CARING

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family A&E - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	80.92 %	R <90 % A >=90 % G >=95 %		Funding received from NHS England to recruit a Volunteer Coordinator to support the Trusts winter pressures. A&E has been identified as the area to implement the volunteer response programme. An observation audit is to be carried out during December/ January to identify areas were a volunteer could support staff and our CYP and their families.
Friends & Family	**Friends & Family Community - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	94.07 %	R <90 % A >=90 % G >=95 %		Community responses have continued to dramatically increase since SMS was launched in July. Further training has been scheduled for the Divisional lead/ community Head of Quality for the use of the FFT system in order to act on the actions that have been automatically generated by Iquvia system that collects the FFT feedback.
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	95.86 %	R <90 % A >=90 % G >=95 %		No Action Required

The Best People doing their best Work

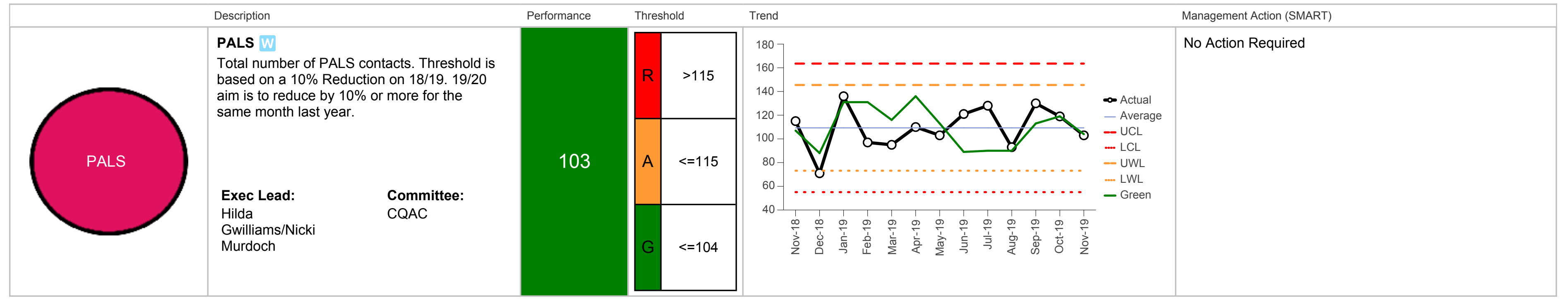
8.2 - QUALITY - CARING

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** D Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	89.13 %	R <90 % A >=90 % G >=95 %		On comparison within the Service we can identify that the environment of Liverpool CAMHS is the predominant trend with only 43.48 % recommending the Trust in this service compared to 81.82 % at Sefton CAMHS. Signage to Catkin building and waiting area also identified. Comments regarding staff attitude and care received were all positive.
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** D P Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	94.47 %	R <90 % A >=90 % G >=95 %		Concierge staff and volunteers have started a new programme and will be supporting outpatients with late arrivals for clinic appointments. A system has been set up that will give families a direct line to ring if they are running late, volunteers will then let the clinics consultants know
Complaints	**Complaints** W Total complaints received. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	14	No Threshold		

8.3 - QUALITY - CARING

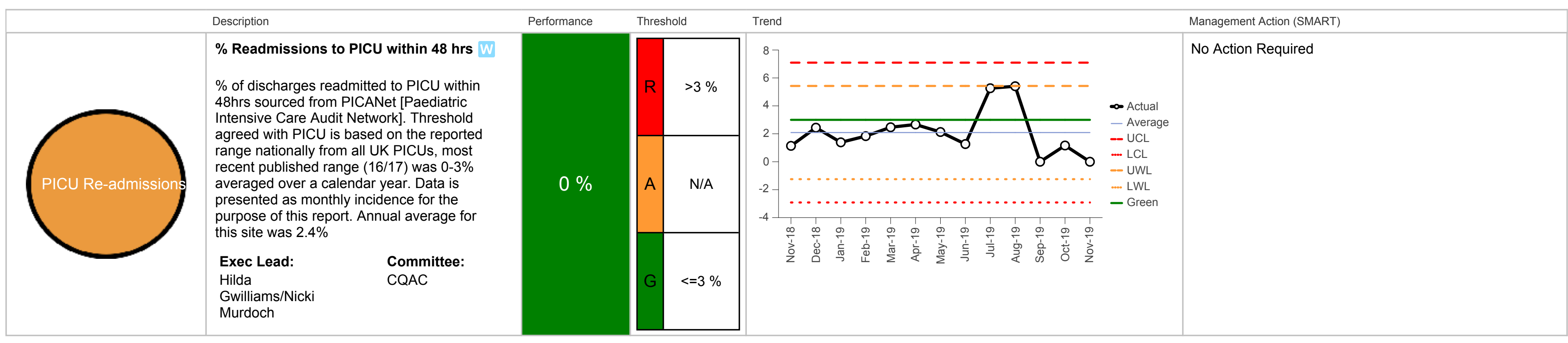
D Drive W Watch P Programme



	Description	Performance	Threshold		Trend	Management Action (SMART)
PALS	**PALS** W Total number of PALS contacts. Threshold is based on a 10% Reduction on 18/19. 19/20 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	103	R	>115		No Action Required
			A	<=115		
			G	<=104		

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE



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

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** W Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	96.73 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** W Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 19/20 is 100%. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	97.60 %	R <95 % A >=95 % G 100 %		During October Medicine had 28 actions raised with 10 directly around respect/communication. The theme for Medicine continues around staff attitude and communication. From 211 surveys completed 205 said they were treated with respect. Surgery had 22 new actions raised with 9 from respect question .336 out of 343 answered yes to treat with respect. Most negative feedback from EDU and MDU. Training with medical students/junior doctors identified with an action to implement at induction. Bedside play sessions with Liverpool AC to commence to improve communication/engagement with children/yp
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** D P Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	92.59 %	R <85 % A >=85 % G >=90 %		No Action Required

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

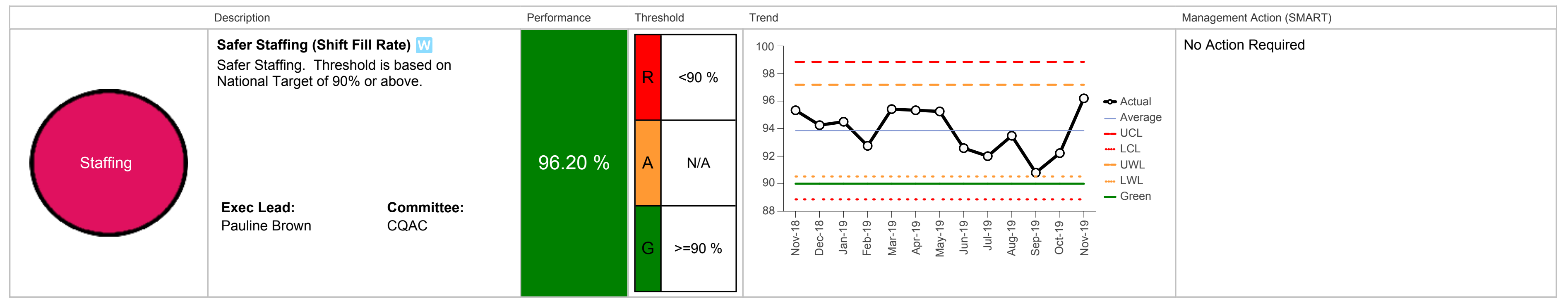
D Drive W Watch P Programme

	Description	Performance	Threshold		Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** W % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 19/20 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	98.26 %	R <90 % A >=90 % G >=95 %		No Action Required
Inpatient Survey: Play	**IP Survey: % Patients involved in Play** D % of children / families that report engaging in play. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	93.90 %	R <85 % A >=85 % G >=90 %		No Action Required
Inpatient Survey: Learning	**IP Survey: % Patients involved in Learning** D % of children / families that report engaging in learning. Thresholds are based on previously defined local targets. The 19/20 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Nicki Murdoch **Committee:** CQAC	68.26 %	R <85 % A >=85 % G >=90 %		It has been highlighted that the school headmaster from Springfield does not have a direct reporting line manager this will be investigated further. We are scoping the questions that are asked to see if they are relevant

The Best People doing their best Work

11.1 - QUALITY - WELL LED

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	96.20 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** D Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	79.36 %	R <95 % A N/A G >=95 %		At 79.36%, waiting times in the Emergency Department continue to be challenging and is our top operational pressure and priority. There are improvement huddles and weekly meetings held between staff and a senior manager. We are focused on alternative pathways for non-emergency patients. We have expanded the criteria for patients that can be seen by a GP and have agreed to pilot patients accessing local walk-in-centres from the department. Additional Emergency Access Clinics, staffed by General Paediatrician consultants, are now in place for non-emergency 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	44	R >20 A N/A G <=20		Owing to increasing emergency demand affecting theatre and bed availability unfortunately the division experienced an increase in the number of patients being cancelled on the day of their planned procedure. Plans are in place to review the elective and non-elective demand for remaining winter moths to re-consider the number of elective patients scheduled pre-day. The number of cancelled procedures per month remains below the number cancelled this time last year.

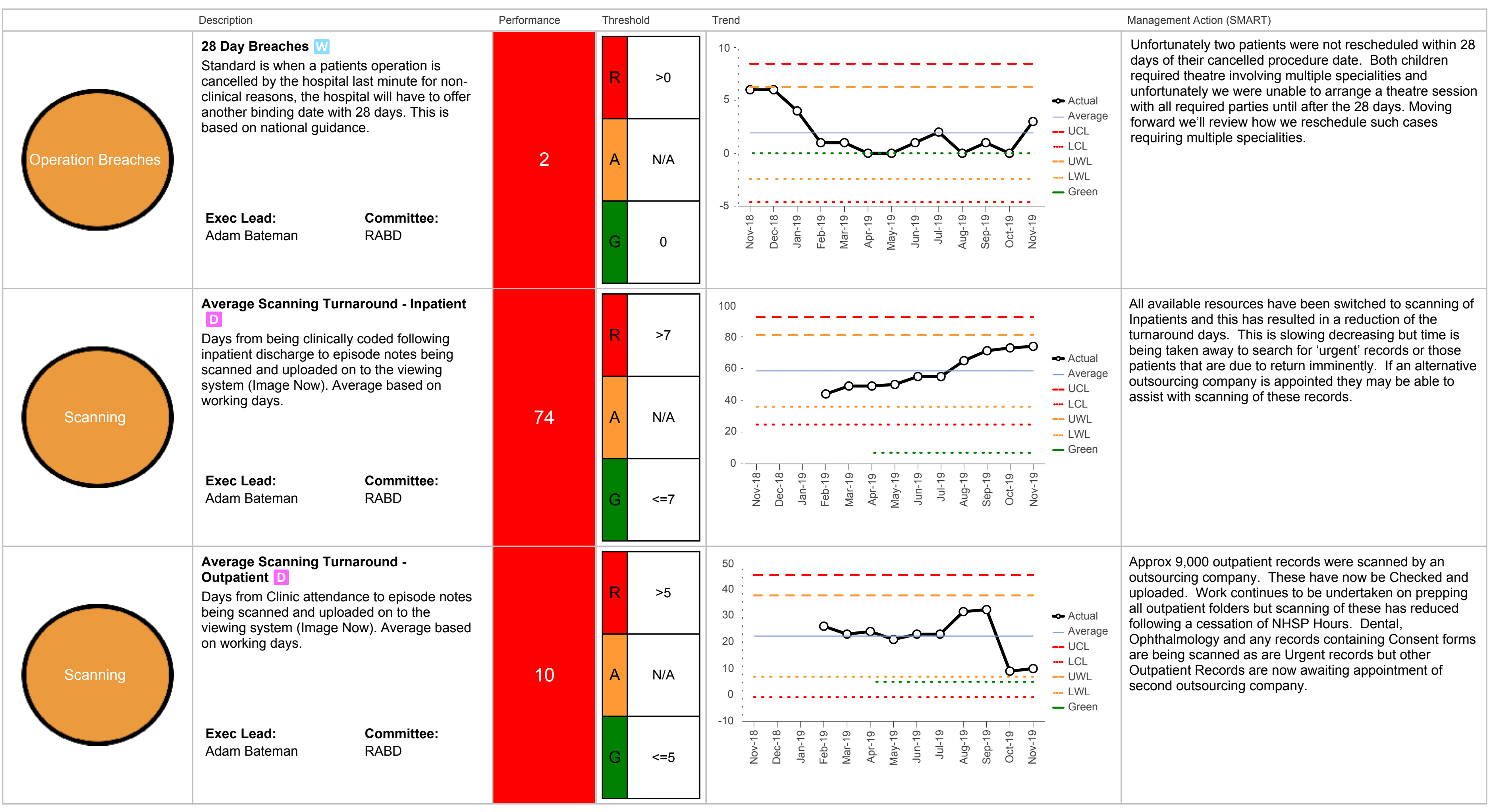
Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme



	Description	Performance	Threshold		Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** W Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	2	R A G	>0 N/A 0		Unfortunately two patients were not rescheduled within 28 days of their cancelled procedure date. Both children required theatre involving multiple specialities and unfortunately we were unable to arrange a theatre session with all required parties until after the 28 days. Moving forward we'll review how we reschedule such cases requiring multiple specialities.
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	74	R A G	>7 N/A <=7		All available resources have been switched to scanning of Inpatients and this has resulted in a reduction of the turnaround days. This is slowing decreasing but time is being taken away to search for 'urgent' records or those patients that are due to return imminently. If an alternative outsourcing company is appointed they may be able to assist with scanning of these records.
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	10	R A G	>5 N/A <=5		Approx 9,000 outpatient records were scanned by an outsourcing company. These have now be Checked and uploaded. Work continues to be undertaken on prepping all outpatient folders but scanning of these has reduced following a cessation of NHSP Hours. Dental, Ophthalmology and any records containing Consent forms are being scanned as are Urgent records but other Outpatient Records are now awaiting appointment of second outsourcing company.

13.1 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** W 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	92.02 %	R <90 % A >=90 % G >=92 %	Chart (Nov-18 to Nov-19): Actual, Average, UCL, LCL, UWL, LWL, Green	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	12827	R >12899 A N/A G <=12899	Chart (Nov-18 to Nov-19): Actual, Average, UCL, LCL, UWL, LWL, Green	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	Chart (Nov-18 to Nov-19): Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

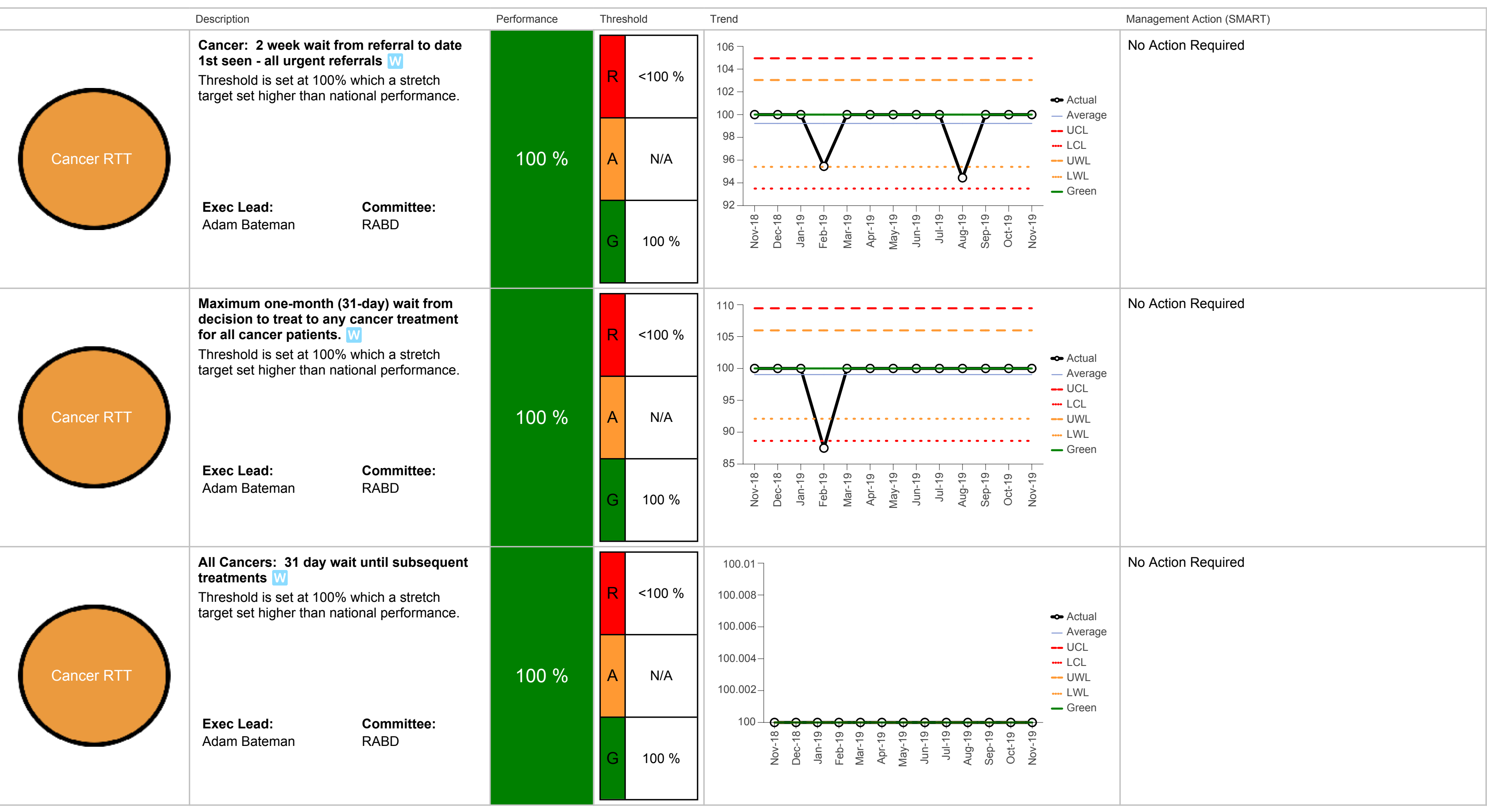
Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

Alder Hey Children's 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	100 %	R	<100 %		No Action Required
			A	N/A		
			G	100 %		
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 %		No Action Required
			A	N/A		
			G	100 %		
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 %		No Action Required
			A	N/A		
			G	100 %		

Delivery of Outstanding Care

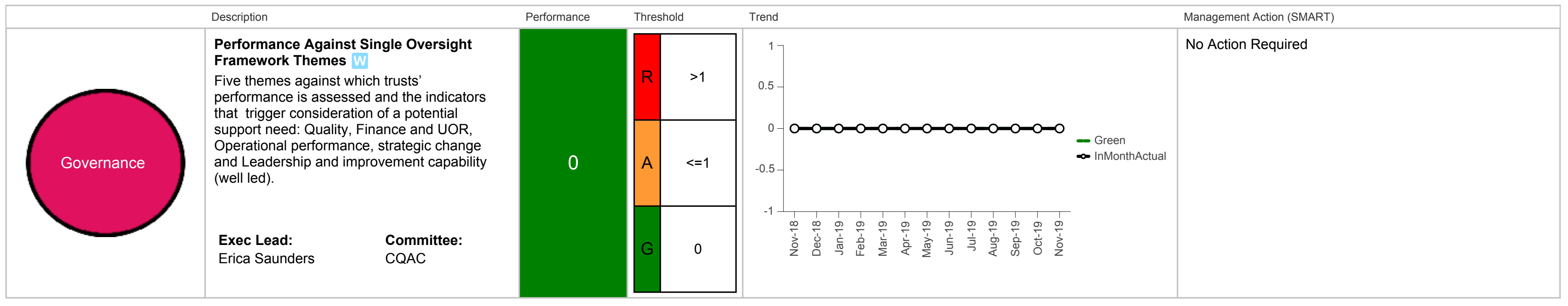
13.3 - PERFORMANCE - RESPONSIVE

D Drive W Watch P Programme

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

14.1 - PERFORMANCE - WELL LED

D Drive W Watch P Programme



	Description	Performance	Threshold		Trend	Management Action (SMART)
Governance	**Performance Against Single Oversight Framework Themes** W 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		No Action Required
			A	<=1		
			G	0		

The Best People doing their best Work

15.1 - PEOPLE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** W 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	69.66 %	R <90 % A >=90 % G >=95 %		There are 95 appraisals out of date, they are to be completed in January.
Training	**Mandatory Training** W This is a Trust target that measures all required training including Resuscitation. **Exec Lead:** Melissa Swindell **Committee:** WOD	91.46 %	R <80 % A >=80 % G >=90 %		No Action Required

Chart legends: Actual, Average, UCL, LCL, UWL, LWL, Green. X-axis: Nov-18, Dec-18, Jan-19, Feb-19, Mar-19, Apr-19, May-19, Jun-19, Jul-19, Aug-19, Sep-19, Oct-19, Nov-19.

The Best People doing their best Work

15.2 - PEOPLE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** D % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.67 %	R >4.5 % A <=4.5 % G <=4 %	Actual, Average, UCL, LCL, UWL, LWL, Green (Nov-18 to Nov-19)	Sickness continues to sit around 1.5% above the Trust target. Action plans are in place for areas with significant absence. In addition a full review of all absences is being undertaken with individual action plans in place. Our top 3 reasons for absence are still Anxiety/Depression, Other musculoskeletal problems and Gastrointestinal problems.
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	1.92 %	R >1 % A N/A G <=1 %	Actual, Average, UCL, LCL, UWL, LWL, Green (Nov-18 to Nov-19)	See above
Sickness	**Long Term Sickness** D % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	3.74 %	R >3 % A N/A G <=3 %	Actual, Average, UCL, LCL, UWL, LWL, Green (Nov-18 to Nov-19)	See above

The Best People doing their best Work

15.3 - PEOPLE - WELL LED

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	1021.47	R A G	>960 <=960 <=800		Business Partners together with Finance Accountants and Ass COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & Deputy Directors of HR & Finance.
Staff Turnover	**Staff Turnover** D Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	10.13 %	R A G	>11 % <=11 % <=10 %		Turnover remains slightly above the Trust target for the 3rd month. the Division of Surgery had the most leavers in November (37.5%) with the majority of leavers being Nurses (41.67%). 17 of the 24 (70.83%) leavers this month gave voluntary resignation as their reason for leaving.

The Best People doing their best Work

16.1 - FINANCE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**CIP In Month Variance (£'000s)** W 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	57	R A G	<-20% >=-20% >=-5%		No Action Required
Finance	**Control Total In Month Variance (£'000s)** W Variance from Control Total plan. Variation between months is usual and the threshold of -5% to - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-205	R A G	<-20% >=-20% >=-5%		The control total delivered in November was behind plan by £0.2m. Year to date the control total is behind plan by £0.3m. The Trust needs to overachieve in December to reach the quarter 3 plan and therefore secure its PSF funding.
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	-115	R A G	<-10% >=-10% >=-5%		No Action Required

16.2 - FINANCE - WELL LED

D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Cash in Bank (£'000s)** W 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	77,896	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	1,367	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	-39	R <-20% A >=-20% G >=-5%		No Action Required

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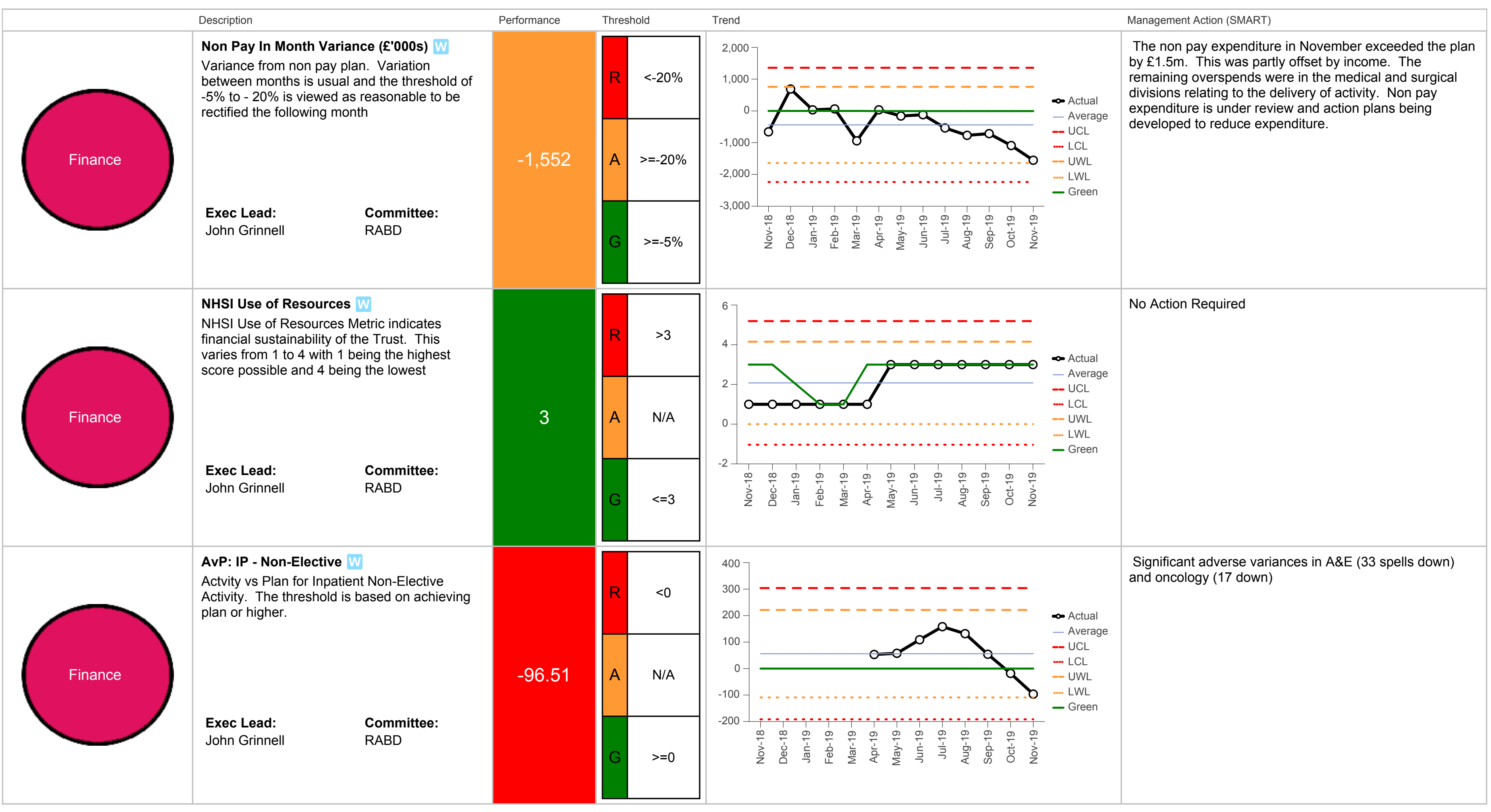
16.3 - FINANCE - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

BRILLIANT BASICS

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	-1,552	R <-20% A >=-20% G >=-5%		The non pay expenditure in November exceeded the plan by £1.5m. This was partly offset by income. The remaining overspends were in the medical and surgical divisions relating to the delivery of activity. Non pay expenditure is under review and action plans being developed to reduce expenditure.
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	-96.51	R <0 A N/A G >=0		Significant adverse variances in A&E (33 spells down) and oncology (17 down)

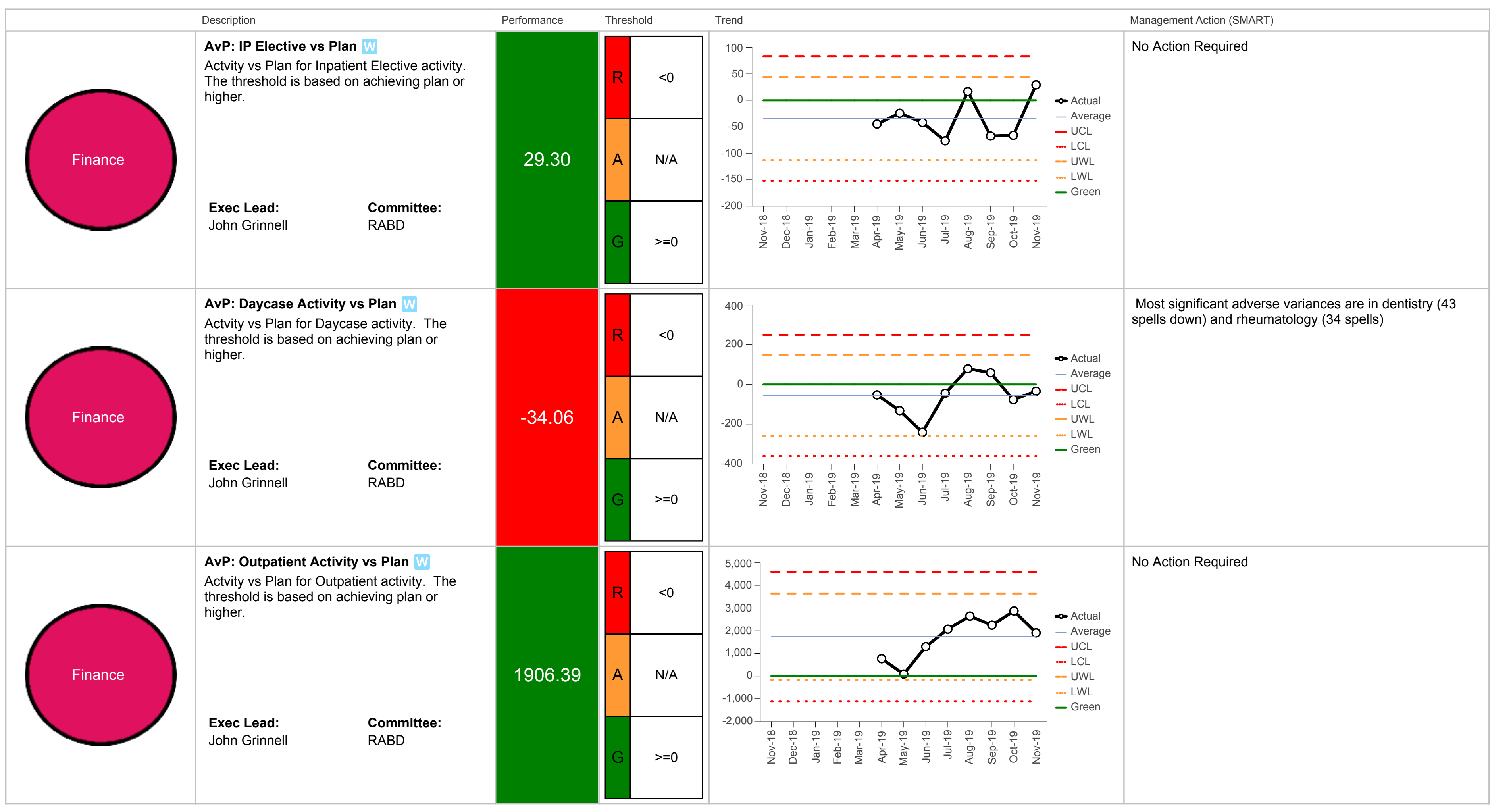
The Best People doing their best Work

16.4 - FINANCE - WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

D Drive W Watch P Programme



	Description		Performance	Threshold		Trend	Management Action (SMART)
Finance	**AvP: IP Elective vs Plan** W Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell	**Committee:** RABD	29.30	R A G	<0 N/A >=0		No Action Required
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	-34.06	R A G	<0 N/A >=0		Most significant adverse variances are in dentistry (43 spells down) and rheumatology (34 spells)
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	1906.39	R A G	<0 N/A >=0		No Action Required

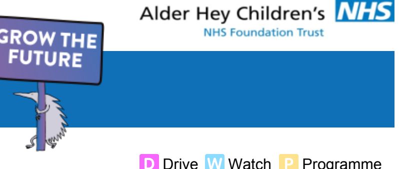
17.1 - RESEARCH & DEVELOPMENT - WELL LED

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	167	R A G	<111 >=111 >=130	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green (Nov-18 to Nov-19)	No Action Required
Clinical Research	**Number of Open Studies - Commercial** W Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	45	R A G	<21 >=21 >=30	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green (Nov-18 to Nov-19)	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	5	R A G	<2 >=2 >=3	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green (Nov-18 to Nov-19)	No Action Required

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED



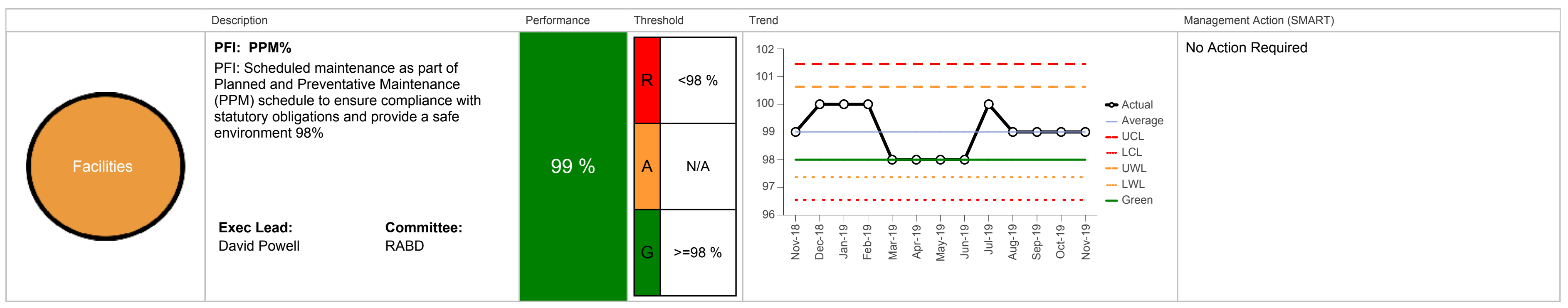
D Drive W Watch P Programme

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** W Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	6	R <1 A N/A G >=1	Chart: Nov-18 to Nov-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	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	1180	R <171 A >=171 G >=200	Chart: Nov-18 to Nov-19 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required

Delivery of Outstanding Care

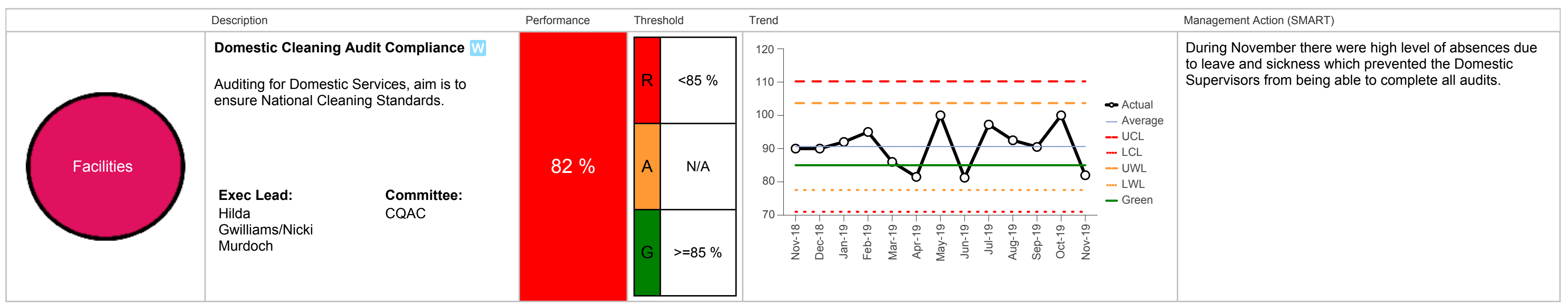
18.1 - FACILITIES - RESPONSIVE

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 %		No Action Required
			A	N/A		
			G	>=98 %		

19.1 - FACILITIES - WELL LED



	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 Murdoch **Committee:** CQAC	82 %	R	<85 %		During November there were high level of absences due to leave and sickness which prevented the Domestic Supervisors from being able to complete all audits.
			A	N/A		
			G	>=85 %		

All Divisions

D Drive W Watch P Programme

SAFE

		COMMUNITY	MEDICINE	SURGERY	RAG		
Clinical Incidents resulting in Near Miss	D	6	25	36	No Threshold		
Clinical Incidents resulting in No Harm	D	63	73	139	No Threshold		
Clinical Incidents resulting in minor, non permanent harm	D	11	16	54	No Threshold		
Clinical Incidents resulting in moderate, semi permanent harm	D	0	1	0	No Threshold		
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	N/A	>0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	0	N/A	>0
Medication errors resulting in harm	D	0	0	3	No Threshold		
Pressure Ulcers (Category 3)	W	0	1	0	0	N/A	>0
Pressure Ulcers (Category 4)	W	0	0	0	0	N/A	>0
Never Events	W	0	0	0	0	N/A	>0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P		90.0%	100.0%	>=90 %	N/A	<90 %
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	N/A	>0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	N/A	>0
Hospital Acquired Organisms - MSSA	D	0	0	1	No Threshold		

CARING

		COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	W	5	1	6	No Threshold
PALS	W	20	38	34	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		79.4%		>=95 %	N/A	<95 %

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
ED: Number of patients spending >12 hours from decision to admit to admission	W		0		0	N/A	>0
On the day Elective Cancelled Operations for Non Clinical Reasons	D	0	5	39	No Threshold		
28 Day Breaches	W	0	1	1	0	N/A	>0

RESPONSIVE

		COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care	W		96.1%	97.2%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W		96.6%	98.2%	100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge	D P		87.1%	96.1%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W		98.3%	98.2%	>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D		91.0%	95.7%	>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D		68.1%	68.4%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	76.8%	93.9%	93.7%	>=92 %	>=90 %	<90 %
Waiting List Size	W	1,338	3,332	8,157	No Threshold		
Waiting Greater than 52 weeks	W	0	0	0	0	N/A	>0
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W		100.0%		100 %	>=95 %	<100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W		100.0%		100 %	>=95 %	<100 %
All Cancers: 31 day wait until subsequent treatments	W		100.0%		100 %	>=95 %	<100 %
Diagnostics: % Completed Within 6 Weeks	W		100.0%	100.0%	>=99 %	N/A	<99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W		100.0%		100 %	>=95 %	<100 %

WELL LED

		COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	W	22	66	-59	No Threshold
Income In Month Variance (£'000s)	W	34	678	580	No Threshold

All Divisions

D Drive W Watch P Programme

		COMMUNITY	MEDICINE	SURGERY	RAG		
Pay In Month Variance (£'000s)	W	15	162	-213	No Threshold		
Non Pay In Month Variance (£'000s)	W	-27	-774	-427	No Threshold		
AvP: IP - Non-Elective	W		-72	-24	>=0	N/A	<0
AvP: IP Elective vs Plan	W	0	-6	30	>=0	N/A	<0
AvP: Daycase Activity vs Plan	W		-61	25	>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W	576	114	634	>=0	N/A	<0
PDR	W	90.1%	87.8%	93.3%	>=90 %	>=80 %	<85 %
Medical Appraisal	W	78.8%	69.8%	67.7%	>=95 %	>=90 %	<90 %
Mandatory Training	W	93.5%	91.8%	89.9%	>=90 %	>=80 %	<80 %
Sickness	D	5.5%	5.3%	6.3%	<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	2.0%	2.0%	1.8%	<=1 %	N/A	>1 %
Long Term Sickness	D	3.5%	3.2%	4.5%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	104	247	577	No Threshold		
Staff Turnover	D	11.2%	9.9%	10.5%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	100.3%	97.2%	95.5%	>=90 %	>=80 %	<90 %

Medicine Division

SAFE	Zero for the following: Clinical Incidents Resulting In Moderate, Semi permanent Harm; Clinical Incidents Resulting In Severe, Permanent Harm; Never Events; Hospital-acquired Infections For MRSA and C Difficile.	**Highlight** ▪ 90%: Inpatients treated for Sepsis within 60 mins – ▪ 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 84.21% (78.38% last month) of patients in ED treated for Sepsis within 60 mins. ▪ Category 3 Pressure Ulcer.
CARING	1 complaint and 38 PALS responses.	**Highlight** ▪ Second consecutive month of no more than one complaint. **Challenges** ▪ New quality team will help to overcome challenge of responding to complaints in a timely fashion.
EFFECTIVE	Unprecedented demand (both in terms of numbers of attendees and acuity) has meant that the ED Standard continues to be a challenge and has deteriorated further since previous month. 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 every morning. Clinical Utilisation remains above 85% and has improved upon the previous month.	**Highlight** ▪ Was Not Brought rate remains below 12% (for third month). ▪ Scanning outsourcing continues. ▪ Coding comorbidity average remains above 4.4 for 6th consecutive month. **Challenges** ▪ ED performance (see to the left).
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.	**Highlight** ▪ 12th consecutive month to achieve RTT target though acknowledge that some areas still require focus. ▪ Diagnostic target consistently achieved for over 12 months. ▪ Percentage of patients '*knowing who is in charge of their care*' above 97% for 4th consecutive month. **Challenges** ▪ Consistent underachievement of MR and CT radiology targets, though these are more stringent local Alder Hey targets.
WELL LED	Shift fill rate above 99% for 12 consecutive months. Temporary spend reduced from previous month. Collected effort to reduce out of date risk register reviews (from 55.6% to 16.1% currently, and reducing further each week).	**Highlight** ▪ Mandatory training is above 90% for fourth consecutive month at 91.8%, an improvement on last month. **Challenges** ▪ Medical workforce poor on some mandatory training metrics.

Alder Hey Children's NHS Foundation Trust

Medicine

D Drive W Watch P Programme

SAFE

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	28	21	20	36	30	19	29	20	36	11	20	16	25		No Threshold
Clinical Incidents resulting in No Harm	D	107	69	98	89	89	103	88	78	105	76	70	87	73		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	29	16	35	24	37	38	25	23	21	9	19	21	16		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	1	0	0	0	0	0	0	0	0	1	0	0	1		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	1	1	0	0	0	1	0	0	0	0	0		0 N/A >0
Medication errors resulting in harm	D	3	0	0	2	1	4	3	0	1	0	0	3	0		No Threshold
Medication Errors (Incidents)		46	29	31	31	34	51	40	24	37	32	21	30	21		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	0	0	1	0	0	1		0 N/A >0
Pressure Ulcers (Category 4)	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Acute readmissions of patients with long term conditions within 28 days		6	3	3	3	2	2	3	3	4	4	1	8	5		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	90.0%	81.0%	74.2%		63.2%	100.0%	66.7%	85.7%	83.3%	100.0%	87.5%	100.0%	90.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)		0	0	0	0	0	0	0	0	0	1	0	0	1		0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	D	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - CLABSI		0	2	2	6	1	0	0	2	1	1	2	1	3		No Threshold
Hospital Acquired Organisms - MSSA	D	0	0	0	0	1	0	0	0	0	1	0	0	0		No Threshold
Cleanliness Scores		96.3%	94.1%	97.1%	97.1%	98.6%	97.2%	98.3%	91.8%	96.4%	98.5%	98.6%	97.9%	97.4%		>=90 % >=80 % <80 %
Pharmacy - ASU (Aseptic Service Unit) Environmental Monitoring to include ranking within the region.							100	100	100	100	100	100	100	100		No Threshold
Pharmacy - NPP (Near Patient Pharmacy) Medicines Reconciliation, percentage completed.							65.6%	55.0%	55.0%	58.9%	58.9%	58.9%	58.9%	58.5%		>=50 % N/A <50 %
Pharmacy - Dispensing for Out Patients - Routine		55.0%	41.0%	50.0%	63.0%	62.0%	63.0%	54.0%	63.0%	52.5%	52.5%	62.0%	59.0%	50.0%		>=90 % >=80 % <90 %
Pharmacy - Dispensing for Out Patients - Complex		94.0%	89.0%	91.0%	67.0%	95.0%	60.0%	75.0%	100.0%	87.5%	87.5%	63.0%	100.0%	92.0%		>=90 % >=80 % <90 %

CARING

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Complaints	W	1	5	4	2	4	2	1	3	2	4	7	0	1		No Threshold
PALS	W	26	27	47	37	23	40	34	38	41	33	35	37	38		No Threshold

EFFECTIVE

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Referrals Received (Total)		1,985	1,755	2,041	1,939	2,186	2,023	2,118	1,967	2,202	1,701	1,772	2,086	1,890		No Threshold
ED: 95% Treated within 4 Hours	D	93.8%	95.3%	92.1%	90.6%	95.6%	93.5%	91.3%	89.4%	91.8%	94.7%	89.0%	86.9%	79.4%		>=95 % N/A <95 %
ED: Number of patients spending >12 hours from decision to admit to admission	W	0	0	0	0	0	0	1	0	1	0	0	0	0		0 N/A >0
Theatre Utilisation - % of Session Utilised	W	81.2%	86.7%	84.5%	83.4%	83.6%	81.8%	83.3%	82.9%	83.6%	85.7%	80.2%	83.8%	79.3%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	4	0	4	2	0	1	1	1	2	5	2	3	5		No Threshold
28 Day Breaches	W	1	0	0	1	0	0	0	0	0	0	0	0	1		0 N/A >0
Clinic Session Utilisation	D P	86.4%	82.7%	81.8%	87.2%	87.5%	85.9%	85.8%	85.2%	85.9%	82.1%	85.6%	85.1%	86.1%		>=90 % >=80 % <85 %

Medicine

D Drive W Watch P Programme

Measure	Flag	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Hospital Initiated Clinic Cancellations < 6 weeks notice		36	29	29	58	32	64	62	62	40	43	39	38	42		No Threshold
OP Appointments Cancelled by Hospital %		15.0%	16.3%	16.1%	16.1%	14.3%	18.4%	19.4%	17.5%	16.0%	17.8%	14.3%	16.9%	15.6%		<=5 % / <=10 % / >10 %
Was Not Brought Rate	W P	11.9%	14.2%	12.6%	12.9%	10.5%	12.2%	12.2%	11.5%	12.7%	14.1%	11.3%	11.3%	11.6%		<=12 % / <=14 % / >14 %
Was Not Brought Rate (New Appts)	W	13.7%	16.8%	14.5%	14.1%	11.0%	14.2%	14.4%	10.6%	14.0%	15.4%	11.4%	13.3%	12.7%		<=10 % / <=12 % / >12 %
Was Not Brought Rate (Followup Appts)	W	11.2%	13.3%	11.9%	12.5%	10.3%	11.5%	11.3%	11.9%	12.2%	13.6%	11.2%	10.6%	11.2%		<=14 % / <=16 % / >16 %
Coding average comorbidities		3.50	3.75	3.75	4.00	3.92	4.38	4.37	4.40	4.49	4.66	4.43	4.68	4.69		No Threshold

RESPONSIVE

Measure	Flag	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Convenience and Choice: Slot Availability		92.1%	91.4%	91.5%	87.5%	78.0%	63.1%	66.8%	64.5%	64.7%	72.9%	74.9%	84.7%	85.6%		>=96 % / N/A / <96 %
IP Survey: % Received information enabling choices about their care	W	94.1%	94.1%	93.3%	89.7%	94.2%	98.6%	94.8%	97.9%	97.4%	95.4%	99.0%	93.8%	96.1%		>=95 % / >=90 % / <90 %
IP Survey: % Treated with respect	W	100.0%	100.0%	100.0%	100.0%	99.4%	99.3%	98.6%	97.9%	99.5%	97.0%	99.0%	97.2%	96.6%		100 % / N/A / <95 %
IP Survey: % Know their planned date of discharge	D P	60.8%	55.9%	68.7%	75.0%	76.0%	85.0%	82.1%	82.8%	84.1%	83.8%	89.0%	87.7%	87.1%		>=90 % / >=85 % / <85 %
IP Survey: % Know who is in charge of their care	W	88.2%	91.2%	98.5%	92.2%	92.9%	98.6%	91.5%	95.8%	88.4%	97.0%	98.4%	97.6%	98.3%		>=95 % / >=90 % / <90 %
IP Survey: % Patients involved in Play	D								92.7%	94.7%	94.4%	93.8%	88.6%	91.0%		>=90 % / >=85 % / <85 %
IP Survey: % Patients involved in Learning	D								69.4%	86.2%	75.1%	68.1%	72.0%	68.1%		>=90 % / >=85 % / <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	91.5%	92.7%	92.9%	92.5%	93.9%	94.6%	94.3%	94.7%	94.3%	93.5%	92.9%	93.5%	93.9%		>=92 % / >=90 % / <90 %
Waiting List Size	W	3,365	3,295	3,686	3,398	3,355	3,434	3,771	3,565	3,762	3,501	3,195	3,213	3,332		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		6	13	18	22	15	7	5	5	7	11	9	10	18		No Threshold
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	W	100.0%	100.0%	100.0%	95.5%	100.0%	100.0%	100.0%	100.0%	100.0%	94.4%	100.0%	100.0%	100.0%		100 % / N/A / <100 %
Maximum one-month (31-day) wait from decision to treat to any cancer treatment for all cancer patients.	W	100.0%	100.0%	100.0%	87.5%	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	99.3%	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 % / N/A / <99 %
31 days from urgent referral for suspected cancer to first treatment (Children's Cancers)	W	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%		100 % / N/A / <100 %
Pathology - % Turnaround times for urgent requests < 1 hr		89.3%	89.5%	89.9%	89.4%	90.8%	92.4%	91.0%	92.7%	93.4%	90.8%	91.7%	91.5%	90.9%		>=90 % / >=85 % / <90 %
Pathology - % Turnaround times for non-urgent requests < 24hrs		100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	99.9%	100.0%	99.9%	99.9%	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%	99.0%	100.0%	100.0%	100.0%	100.0%		>=95 % / >=90 % / <95 %
Imaging - % Reporting Turnaround Times - ED		78.0%	83.0%	93.0%	88.0%	92.0%	75.0%	83.0%	94.0%	86.0%	96.0%	94.0%	100.0%	92.0%		>=90 % / >=85 % / <90 %
Imaging - % Reporting Turnaround Times - Inpatients		75.0%	80.0%	88.0%	82.0%	86.0%	84.0%	84.0%	88.0%	92.0%	82.0%	87.0%	91.0%	85.0%		>=90 % / >=85 % / <90 %
Imaging - % Reporting Turnaround Times - Outpatients		85.0%	87.0%	82.0%	92.0%	85.0%	88.0%	86.0%	96.0%	92.0%	93.0%	94.0%	87.0%	87.0%		>=85 % / N/A / <85 %
Imaging - Waiting Times - MRI % under 6 weeks		66.0%	71.0%	69.0%	78.0%	66.0%	67.0%	64.0%	63.0%	73.0%	78.0%	76.0%	92.0%	89.0%		>=95 % / >=90 % / <95 %
Imaging - Waiting Times - CT % under 1 week		89.0%	73.0%	89.0%	82.0%	89.0%	81.0%	82.0%	85.0%	87.0%	88.0%	84.0%	84.0%	80.0%		>=90 % / >=85 % / <90 %
Imaging - Waiting Times - Plain Film % under 24 hours		91.0%	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 % / >=85 % / <90 %
Imaging - Waiting Times - Ultrasound % under 2 weeks		90.0%	88.0%	84.0%	86.0%	81.0%	85.0%	78.0%	90.0%	86.0%	89.0%	88.0%	86.0%	87.0%		>=90 % / >=85 % / <90 %
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks		100.0%	100.0%	92.0%	88.0%	81.0%	100.0%	60.0%	78.0%	68.0%	68.0%	100.0%	82.0%	83.0%		>=95 % / >=90 % / <95 %

Medicine

D Drive W Watch P Programme

WELL LED

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	23	72	-430	-242		-140	-302	-215	-308	946	-8	199	66		No Threshold
Income In Month Variance (£'000s)	W	581	25	50	418	416	-225	-298	86	79	676	-53	595	678		No Threshold
Pay In Month Variance (£'000s)	W	-37	-126	-212	-217	-244	-51	98	37	-79	291	129	126	162		No Threshold
AvP: IP - Non-Elective	W						17	20	89	111	67	3	-33	-72		>=0 N/A <0
AvP: IP Elective vs Plan	W						-30	-26	-30	-56	-1	-36	-41	-6		>=0 N/A <0
AvP: OP New							-32.10	-56.48	35.41	118.12	177.81	201.81	-44.52	41.78		>=0 N/A <0
AvP: OP FollowUp							-271.82	-487.12	-332.98	-200.73	-29.19	-87.57	-217.01	-17.03		>=0 N/A <0
AvP: Daycase Activity vs Plan	W						-6	-119	-154	-65	100	39	-37	-61		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W						-176	-581	-232	-47	266	126	-119	114		>=0 N/A <0
PDR	W	89.2%	89.2%	89.2%	89.2%	89.2%	2.8%	14.1%	37.4%	83.8%	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%		>=95 % >=90 % <90 %
Mandatory Training	W	90.4%	90.0%	91.0%	90.1%	90.7%	90.7%	89.7%	92.0%	91.2%	91.9%	91.4%	91.6%	91.8%		>=90 % >=85 % <80 %
Sickness	D	4.7%	5.1%	4.6%	4.5%	4.9%	4.4%	4.6%	4.4%	5.1%	4.7%	4.9%	4.9%	5.3%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.8%	1.8%	1.9%	1.9%	2.0%	1.6%	1.4%	1.1%	1.6%	1.2%	1.6%	1.3%	2.0%		<=1 % N/A >1 %
Long Term Sickness	D	2.9%	3.3%	2.7%	2.6%	2.9%	2.8%	3.1%	3.3%	3.5%	3.5%	3.3%	3.6%	3.2%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	242	175	219	297	326	270	271	263	247	282	300	284	247		No Threshold
Staff Turnover	D	9.3%	8.2%	8.1%	7.9%	8.6%	8.4%	8.8%	9.2%	9.3%	10.3%	11.0%	10.2%	9.9%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	97.5%	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 % >=85 % <90 %

Surgical Care Division

SAFE	• No Never Events • No SUI's • No Grade 3/4 Pressure ulcers • 1x MSSA	**Highlight** • **Sepsis 100%** in the last 4 months (only 1 child >60 mins in 6 months) • **98%** cleanliness scores **Challenges** • Increase in incidents relating to medication errors
CARING	• 34 PALS, slightly reduction compared to October (39) • 6 formal complaints received, which is in line with July – Sept average	**Highlight** • Achieved first paediatric hip replacement at Alder Hey, only few centres provide service nationally **Challenges** • Complexity of complaints with one involving the ombudsman • Nurse staffing levels 4A / 3A
EFFECTIVE	• Theatre sessions delivered 555 (mean 139, range 130-146) • Theatre utilisation 85% • Clinic Utilisation 85%	**Highlight** • Achieved 146 theatre sessions in one week • Clinic utilisation now consistently > 85% **Challenges** • Increase in cancelled ops owing to non-elective admissions and bed availability • Responsive elective scheduling in line with winter pressures
RESPONSIVE	• RTT 93.7% (national target 92%) • IP survey, 5% improvement in number of patients who know who is in charge of their care, 96.2% total • IP survey, 92% of patients know their estimated date of discharge • Continue to achieve 100% for seeing all patient requiring diagnostic tests within 6 weeks since May 2019	**Highlight** • No 52 week breaches this year to date • Reduced overall waiting list by 200 patients accumulative **Challenges** • Rescheduling patients cancelled on the day of their admission within 28 days

WELL LED	• Mandatory training – 90%
	• Sickness - 6.3% (Short term 1.7% and Long Term 4.6%)
	• Finance:
	  ○ Forecast full delivery of CIP
	  ○ Shortfall against budget of £0.8 Mil
		Highlight
		• Focus on reducing long term sickness
		Challenges
		• Divisional risks greater than 15
		• Financial balance within budget

Alder Hey Children's NHS Foundation Trust

Surgery

D Drive W Watch P Programme

SAFE

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	41	30	28	39	34	27	30	19	58	27	28	39	36		No Threshold
Clinical Incidents resulting in No Harm	D	130	99	140	105	139	144	142	165	141	135	130	145	139		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	43	35	32	34	43	38	67	36	33	41	28	47	54		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	1	2	1	0	0	0	1	2	0	1	0	0		No Threshold
Clinical Incidents resulting in severe, permanent harm	D	0	0	0	0	0	0	0	0	0	0	1	0	0		0 N/A >0
Clinical Incidents resulting in catastrophic, death	D	0	0	0	1	0	0	0	0	0	0	1	0	0		0 N/A >0
Medication errors resulting in harm	D	3	2	2	2	1	2	0	3	1	1	1	3	3		No Threshold
Medication Errors (Incidents)		42	36	38	41	44	38	57	49	29	45	24	41	53		No Threshold
Pressure Ulcers (Category 3)	W	0	0	0	0	0	0	0	1	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	0	1	0	0	0	0	0	0	0	2	0	0		0 N/A >0
Sepsis: Patients treated for Sepsis within 60 mins - Inpatients	D P	63.6%	66.7%	62.5%		90.9%	75.0%	75.0%	100.0%	75.0%	100.0%	100.0%	100.0%	100.0%		>=90 % >=80 % <90 %
Pressure Ulcers (Category 3 and above)		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	0	1	0	0	0	0	0	0	1	0		0 N/A >0
Hospital Acquired Organisms - MSSA	D	0	1	1	0	3	1	1	0	0	0	1	0	1		No Threshold
Cleanliness Scores		95.2%	98.0%	97.3%	97.2%	98.0%	98.2%	97.7%		97.0%	97.2%	97.7%	97.9%	97.6%		>=90 % >=80 % <80 %

CARING

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Complaints	W	2	0	2	2	6	1	2	2	8	7	4	1	6		No Threshold
PALS	W	41	26	39	26	30	33	31	26	42	21	48	39	34		No Threshold

EFFECTIVE

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Readmissions to PICU within 48 hrs	D	1	2	1	2	2	2	2	1	5	4	0	1	0		No Threshold
% Readmissions to PICU within 48 hrs	W	1.1%	2.4%	1.4%	1.8%	2.5%	2.7%	2.1%	1.3%	5.3%	5.4%	0.0%	1.2%	0.0%		<=3 % N/A >3 %
Referrals Received (Total)		3,808	2,842	3,667	3,796	4,017	3,752	4,079	3,773	4,145	3,285	3,539	3,808	3,251		No Threshold
Theatre Utilisation - % of Session Utilised	W	88.6%	86.3%	89.7%	89.4%	90.4%	89.7%	90.0%	88.6%	89.6%	90.8%	88.0%	86.8%	85.3%		>=90 % >=80 % <80 %
On the day Elective Cancelled Operations for Non Clinical Reasons	D	34	21	7	8	12	8	23	14	35	30	16	31	39		No Threshold
28 Day Breaches	W	5	6	4	0	1	0	0	1	2	0	1	0	1		0 N/A >0
Clinic Session Utilisation	D P	84.1%	82.4%	83.8%	85.0%	88.6%	87.9%	87.3%	87.1%	89.2%	87.2%	86.5%	86.9%	84.9%		>=90 % >=80 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice		37	48	55	74	58	53	41	40	43	37	29	70	57		No Threshold
OP Appointments Cancelled by Hospital %		12.9%	13.6%	14.3%	14.6%	14.0%	13.8%	13.3%	13.2%	12.3%	12.5%	12.3%	13.0%	12.7%		<=5 % <=10 % >10 %
Was Not Brought Rate	W P	11.3%	13.3%	13.0%	11.9%	10.8%	12.1%	11.4%	9.8%	9.9%	10.7%	10.0%	10.3%	11.3%		<=12 % <=14 % >14 %
Was Not Brought Rate (New Appts)	W	12.2%	15.3%	12.7%	12.0%	11.1%	11.7%	11.3%	10.9%	10.5%	12.0%	10.5%	10.7%	12.0%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	11.0%	12.4%	13.2%	11.9%	10.6%	12.2%	11.4%	9.4%	9.6%	10.2%	9.8%	10.1%	11.1%		<=14 % <=16 % >16 %
Coding average comorbidities		3.56	3.99	3.96	4.12	3.92	4.08	4.24	4.15	4.12	4.25	4.05	4.14	4.08		No Threshold
CCAD Cases		30	31	33	39	42	30	36	31	43	35	39	35	27		No Threshold

Surgery

D Drive W Watch P Programme

RESPONSIVE

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG		
Convenience and Choice: Slot Availability		88.3%	80.4%	82.6%	90.6%	87.0%	80.0%	76.5%	90.0%	89.7%	82.0%	90.5%	96.9%	99.0%		>=96 %	N/A	<96 %
IP Survey: % Received information enabling choices about their care	W	95.6%	98.5%	97.7%	98.3%	96.8%	98.0%	97.9%	97.2%	97.7%	95.9%	97.1%	96.8%	97.2%		>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect	W	100.0%	99.3%	100.0%	98.9%	99.5%	99.3%	99.3%	98.3%	99.0%	97.8%	98.1%	98.0%	98.2%		100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge	D P	73.2%	62.0%	81.3%	87.8%	83.8%	92.4%	85.6%	91.3%	90.1%	89.0%	89.3%	95.0%	96.1%		>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care	W	94.3%	93.4%	95.0%	95.6%	93.7%	100.0%	89.7%	96.5%	92.4%	98.6%	98.4%	91.3%	98.2%		>=95 %	>=90 %	<90 %
IP Survey: % Patients involved in Play	D								93.8%	94.4%	95.9%	90.3%	94.2%	95.7%		>=90 %	>=85 %	<85 %
IP Survey: % Patients involved in Learning	D								72.1%	68.9%	70.4%	68.4%	74.3%	68.4%		>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	W	94.1%	93.7%	93.1%	94.0%	94.0%	93.6%	94.0%	94.0%	93.8%	94.1%	94.5%	93.8%	93.7%		>=92 %	>=90 %	<90 %
Waiting List Size	W	8,400	8,320	7,923	8,221	8,129	8,165	7,712	7,939	7,765	8,266	8,519	8,319	8,157		No Threshold		
Waiting Greater than 52 weeks	W	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0
Diagnostics: % Completed Within 6 Weeks	W	100.0%	100.0%	100.0%	89.5%	92.3%	100.0%	91.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 %	N/A	<99 %

WELL LED

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG		
Control Total In Month Variance (£'000s)	W	-209	-253	-240	-470		-405	-63	282	-525	455	531	-399	-59		No Threshold		
Income In Month Variance (£'000s)	W	131	47	-56	208	364	-372	159	370	53	775	771	266	580		No Threshold		
Pay In Month Variance (£'000s)	W	57	-2	-30	-407	-274	23	-7	-34	-165	-117	-116	-286	-213		No Threshold		
AvP: IP - Non-Elective	W						36	37	20	48	65	51	15	-24		>=0	N/A	<0
AvP: IP Elective vs Plan	W						-15	2	-11	-22	17	-31	-26	30		>=0	N/A	<0
AvP: OP New							-207.97	-305.45	-341.11	-235.53	-169.56	-326.33	-190.46	-318.84		>=0	N/A	<0
AvP: OP FollowUp							449.69	285.90	923.71	1,083.55	1,399.07	1,311.96	1,705.97	781.38		>=0	N/A	<0
AvP: Daycase Activity vs Plan	W						-46	-14	-87	17	-23	18	-43	25		>=0	N/A	<0
AvP: Outpatient Activity vs Plan	W						379	47	642	982	1,596	1,129	1,844	634		>=0	N/A	<0
PDR	W	90.0%	90.0%	90.0%	96.6%	96.6%	11.6%	42.7%	74.4%	93.8%	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%		>=95 %	>=90 %	<90 %
Mandatory Training	W	87.8%	88.0%	90.0%	88.4%	89.4%	88.8%	87.3%	88.6%	89.3%	90.3%	90.6%	90.3%	89.9%		>=90 %	>=85 %	<80 %
Sickness	D	6.0%	6.4%	6.2%	6.4%	5.2%	5.2%	6.2%	6.6%	6.4%	5.6%	5.9%	6.5%	6.3%		<=4 %	<=4.5 %	>4.5 %
Short Term Sickness	D	1.6%	1.9%	2.1%	2.0%	1.6%	1.5%	1.7%	1.6%	1.6%	1.1%	1.5%	1.9%	1.8%		<=1 %	N/A	>1 %
Long Term Sickness	D	4.4%	4.5%	4.1%	4.4%	3.6%	3.7%	4.5%	5.0%	4.8%	4.5%	4.4%	4.5%	4.5%		<=3 %	N/A	>3 %
Temporary Spend ('000s)	D	485	484	474	564	591	515	505	461	527	513	613	513	577		No Threshold		
Staff Turnover	D	10.6%	9.8%	9.7%	9.9%	10.3%	10.5%	11.0%	11.3%	9.9%	10.6%	10.5%	10.5%	10.5%		<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	W	93.6%	91.9%	93.3%	89.3%	89.4%	91.9%	91.0%	89.1%	89.4%	92.5%	86.1%	89.6%	95.5%		>=90 %	>=85 %	<90 %

Community & Mental Health Division

SAFE	Safer staffing figures for previous months reports reviewed for Dewi Jones Unit and confirmed at 100%	**Highlight** • Zero moderate or severe harms • Zero never events • Zero pressure ulcers grade 3 or 4 • Reduction in medication incidents compared to previous month **Challenges** • Provision of Tissue Viability Support to community based staff
CARING	Services from the division attended a Sefton Parent Carer Event and provided advice, support and information to Parents of Children & Young people with SEND. Positive feedback received from Parent Carer forum regarding attendance and positive feedback from parents.	**Highlight** • Continued reduction in PALS (20). This represents a 50% reduction compared to November 2018. • Increase in FFT scores for Mental Health Services with positive comments relating to staff and care provided. **Challenges** • Whilst FFT scores for Mental Health Services have increased this month analysis shows that the environment at Liverpool CAMHS (Catkin Building) is the main theme. This is being addressed with estates and facilities and highlighted to executive team.
EFFECTIVE	The complex care team continued to support a reduction in the number of children who are in hospital over 21 days as well as reducing the number of children who have their discharge delayed for non-medical reasons.	**Highlight** • Rollout of laptops for staff across community sites & improvements in network connectivity. • Community staff undertook NASEN training to improve understanding of contribution to Education Health Care Plans (EHCPs) **Challenges** • Locally held paper records not included in Trust wide scanning outsourcing.
RESPONSIVE	CAMHS RTT % continues to improve and a detailed improvement plan is in place to achieve 92% RTT by 30 June 2020	**Highlight** • Staff survey 62% • Flu vaccination rate increased to 49% • Continued decrease in Sefton SALT waiting times who remain on track to reach 18 weeks by end March 2020 **Challenges** • EDYS waiting time compliance is at 71.4%. All new posts recruited to which will positively impact on waiting times (part of national targets) • ASD & 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	Quarter 2 divisional assurance meetings completed and process embedded within the division.	**Highlight** • Mandatory training compliance is at 93.5% • PDR rates remain above 90% **Challenges** • Staff sickness remains above trust target but has reduced since previous month • Staff turnover is above trust target at 11.2%. There is an active recruitment plan ongoing for areas with high turnover and over establishment to certain services e.g. CAMHS

Alder Hey Children's NHS
NHS Foundation Trust

Community

D Drive W Watch P Programme

SAFE

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Clinical Incidents resulting in Near Miss	D	6	4	3	3	3	6	15	7	5	7	8	1	6		No Threshold
Clinical Incidents resulting in No Harm	D	37	31	38	41	41	48	54	41	53	57	68	85	63		No Threshold
Clinical Incidents resulting in minor, non permanent harm	D	5	4	4	6	6	6	2	7	8	7	6	11	11		No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	D	0	0	0	0	0	0	0	0	1	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)		6	4	10	9	5	12	6	3	6	5	9	11	8		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	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%		No Threshold
CCNS: Prescriptions		0	0	0	0	0	12	24	17	21	32	28	25	21		No Threshold

CARING

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Complaints	W	2	2	1	4	6	4	4	1	4	2	1	3	5		No Threshold
PALS	W	41	11	36	29	33	30	30	43	37	28	38	37	20		No Threshold

EFFECTIVE

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Referrals Received (Total)		1,065	772	910	969	1,085	918	1,060	916	1,017	621	814	1,093	925		No Threshold
Clinic Session Utilisation	D P	81.9%	78.7%	79.3%	81.1%	87.2%	83.5%	83.3%	83.6%	82.7%	82.5%	82.4%	83.1%	83.2%		>=90 % >=85 % <85 %
Hospital Initiated Clinic Cancellations < 6 weeks notice		21	8	8	18	16	20	14	14	8	7	14	20	19		No Threshold
OP Appointments Cancelled by Hospital %		24.2%	25.6%	20.0%	23.5%	24.8%	22.0%	18.4%	21.0%	18.1%	12.6%	14.7%	16.5%	15.1%		<=5 % <=10 % >10 %
Was Not Brought Rate (New Appts)	W	10.8%	11.9%	17.1%	13.2%	12.4%	12.7%	15.1%	11.1%	14.8%	13.7%	10.5%	10.8%	13.3%		<=10 % <=12 % >12 %
Was Not Brought Rate (Followup Appts)	W	14.5%	15.2%	14.4%	13.5%	12.2%	14.5%	13.5%	13.1%	13.3%	15.0%	12.4%	11.0%	11.9%		<=14 % <=16 % >16 %
CAMHS: % Patient Active Caseloads With 2 Or More Contacts							17.8%	28.6%	34.5%	39.3%	41.8%	44.4%	46.5%	48.0%		No Threshold
CAMHS: % CHOICE Was Not Brought Rate		6.9%	12.3%	19.4%	16.3%	15.4%	17.1%	16.0%	13.3%	21.8%	23.0%	10.5%	13.0%	13.4%		<=10 % <=12 % >12 %
CAMHS: % All Other Was Not Brought Rate		14.1%	14.7%	14.7%	13.4%	12.1%	14.1%	13.7%	12.8%	13.2%	14.5%	12.2%	10.9%	12.0%		<=14 % <=16 % >16 %
CAMHS: Tier 4 DJU % Bed Occupancy At Midday		104.3%	100.0%	95.9%	88.8%	118.9%	115.7%	100.0%	91.4%	98.2%	86.2%	84.8%	65.9%	71.0%		No Threshold
CAMHS: Tier 4 DJU Bed Days		220	217	207	173	237	212	202	161	182	155	148	113	119		No Threshold
Coding average comorbidities		2.67		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	0	10	10	10	10	10	10	10	10		No Threshold

Alder Hey Children's NHS Foundation Trust

Community

D Drive W Watch P Programme

RESPONSIVE

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
CAMHS: Tier 4 Admissions To DJU		2			2	2			2	1			1			No Threshold
CAMHS: Referrals Received		410	297	332	351	402	325	345	309	326	185	288	418	342		No Threshold
CAMHS: Referrals Accepted By The Service		267	183	203	210	232	190	218	172	175	125	160	251	176		No Threshold
CAMHS: % Referrals Accepted By The Service		65.1%	61.6%	61.1%	59.8%	57.7%	58.5%	63.2%	55.7%	53.7%	67.6%	55.6%	60.0%	51.5%		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	78.8%	78.3%	82.7%	78.3%	74.2%	75.2%	74.9%	73.9%	76.4%	71.6%	70.8%	76.1%	76.8%		>=92 % >=90 % <90 %
Waiting List Size	W	1,169	1,162	1,263	1,269	1,262	1,272	1,393	1,339	1,356	1,107	1,112	1,222	1,338		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		447	277	325	344	425	343	337	343	315	266	294	471	384		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%		>=92 % >=90 % <90 %
ASD: Completed Pathways		45	25	63	67	77	67	63	84	45	72	77	83	53		No Threshold
ASD: Completed Pathway Compliance (% within 18wks)		64.4%	48.0%	36.5%	40.3%	58.4%	61.2%	30.2%	25.0%	13.3%	27.8%	31.2%	54.2%	41.5%		>=92 % >=90 % <90 %
EDYS: Routine Completed Pathways per Month (Seen in 4 wks) (as 95%)	P			83.3%	100.0%	86.7%	57.1%	66.7%	62.5%	72.7%	54.5%	71.4%	72.2%	71.4%		No Threshold
EDYS: Urgent Completed Pathways per Month (Seen in 1 wk) (as 95%)	P			50.0%			50.0%	50.0%		66.7%	0.0%		0.0%	100.0%		No Threshold
CCNS: Number of Referrals	W						138	163	156	147	149	132	129	168		No Threshold
CCNS: Number of Contacts	D						886	919	894	921	893	913	951	1,058		No Threshold

WELL LED

		Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	W	-69	115	-38	14		-66	75	-12	-13	27	92	-36	22		No Threshold
Income In Month Variance (£'000s)	W	21	265	87	61	336	-111	177	36	-47	57	43	74	34		No Threshold
Pay In Month Variance (£'000s)	W	-15	-2	-151	-57	-307	181	-69	-64	2	-4	51	-43	15		No Threshold
AvP: OP New							-1.48	-11.08	-5.63	28.14	-3.08	113.22	192.67	182.19		>=0 N/A <0
AvP: OP FollowUp							5.13	84.99	343.17	291.03	137.10	260.13	267.48	392.78		>=0 N/A <0
AvP: Outpatient Activity vs Plan	W						4	76	341	322	137	380	464	576		>=0 N/A <0
PDR	W	93.0%	93.0%	93.7%	93.7%	93.7%	1.4%	10.8%	48.6%	87.1%	90.1%	90.1%	90.1%	90.1%		>=90 % >=85 % <85 %
Medical Appraisal	W							100.0%	100.0%	97.0%	100.0%	97.0%	84.8%	78.8%		>=95 % >=90 % <90 %
Mandatory Training	W	91.4%	90.9%	88.3%	89.2%	90.3%	92.2%	89.2%	90.2%	92.0%	93.2%	92.9%	92.7%	93.5%		>=90 % >=85 % <80 %
Sickness	D	6.6%	7.6%	7.9%	7.5%	7.4%	6.7%	6.4%	4.9%	4.3%	4.4%	4.2%	6.0%	5.5%		<=4 % <=4.5 % >4.5 %
Short Term Sickness	D	1.8%	1.6%	1.7%	1.5%	1.8%	1.4%	1.6%	1.2%	0.9%	0.8%	1.1%	2.4%	2.0%		<=1 % N/A >1 %
Long Term Sickness	D	4.8%	6.0%	6.2%	6.0%	5.6%	5.3%	4.8%	3.7%	3.4%	3.6%	3.1%	3.6%	3.5%		<=3 % N/A >3 %
Temporary Spend ('000s)	D	169	144	179	106	367	198	226	96	158	122	143	42	104		No Threshold
Staff Turnover	D	12.8%	12.9%	12.2%	11.9%	12.8%	11.8%	11.7%	9.9%	10.1%	10.2%	10.6%	10.5%	11.2%		<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	W	99.0%	99.0%	97.0%	100.0%	106.0%	100.0%	102.0%	97.0%	87.0%	87.3%	91.2%	87.6%	100.3%		>=90 % >=85 % <90 %

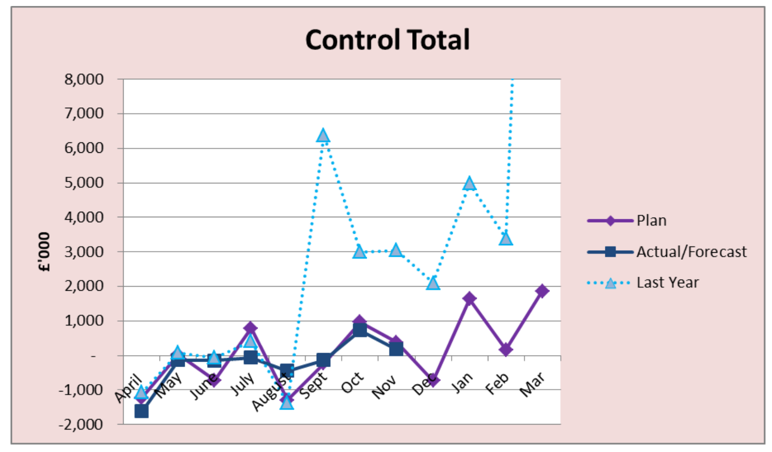
NHS
Alder Hey Children's
NHS Foundation Trust
Financial Dashboard
-M8 2019/20
BRILLIANT BASICS
GROW THE FUTURE

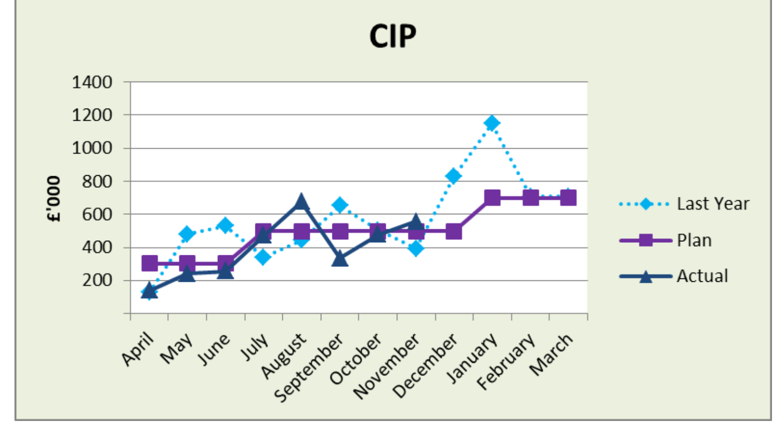
How Did We Do?

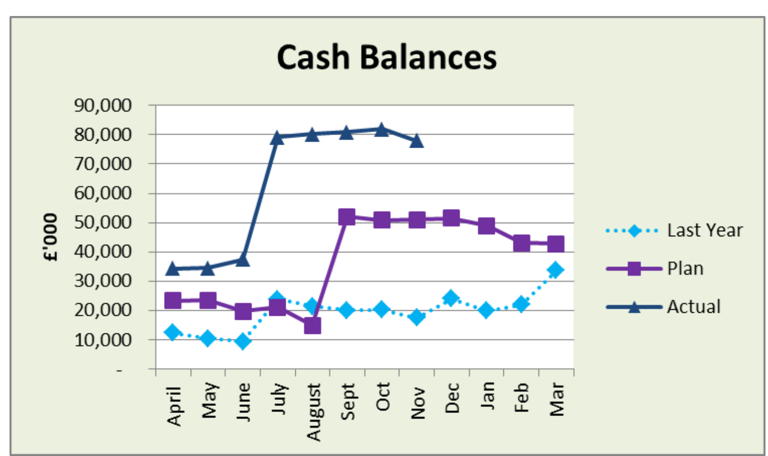
Executive Summary Month: 8 Year: 2019

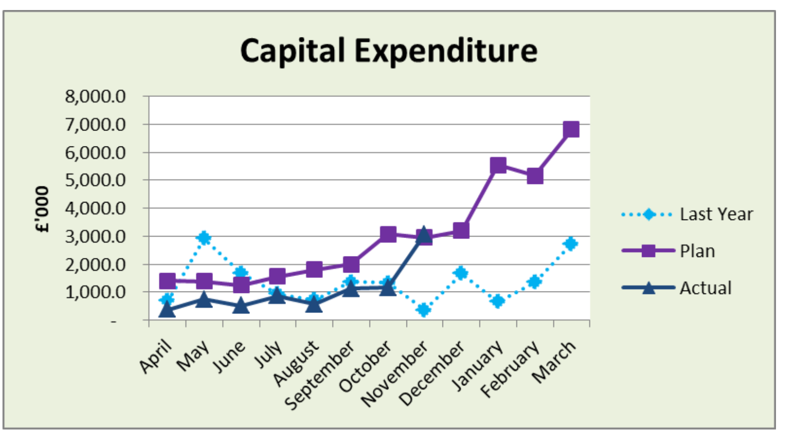
Alder Hey Children's NHS Foundation Trust

Control Total in month	CIP Forecast for year	Use of Resources	Control Total Forecast
£0.18m	£6m	3	(£0.9m)
Not Achieved	On Plan	On Plan	Not Achieved





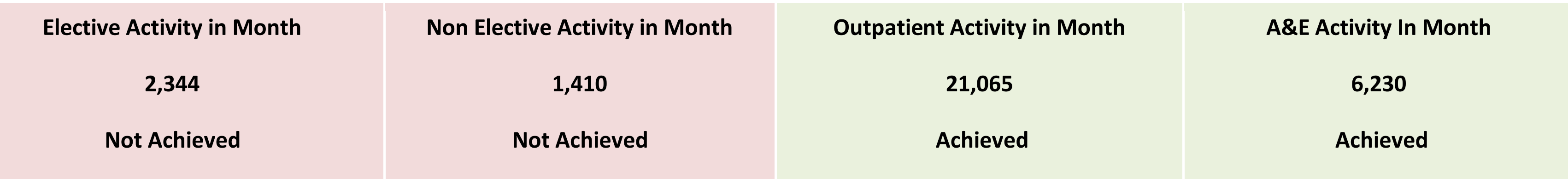




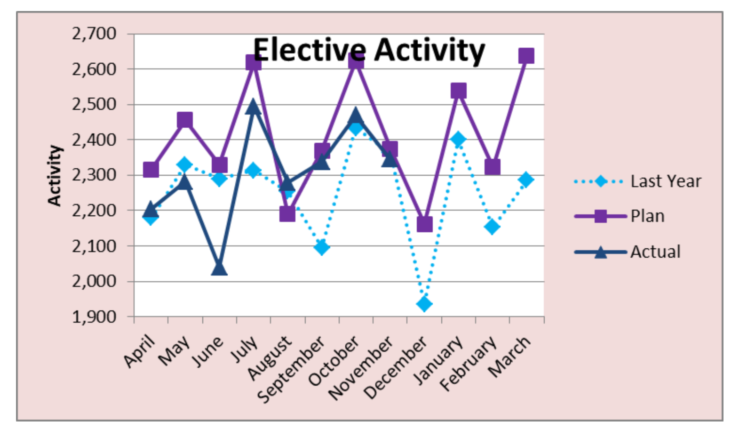
How Did We Do?

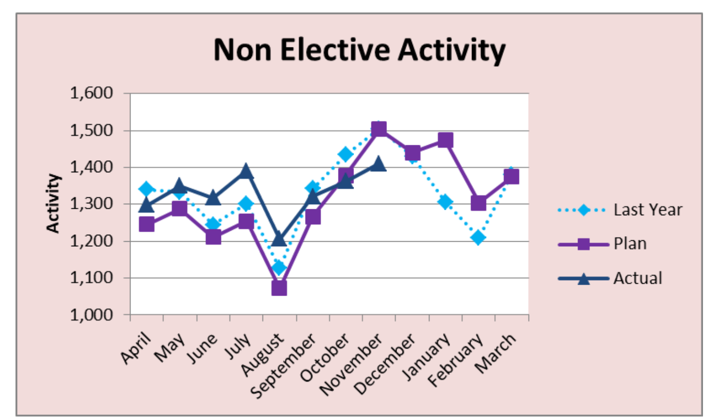
Executive Summary **Month: 8** **Year: 2019**

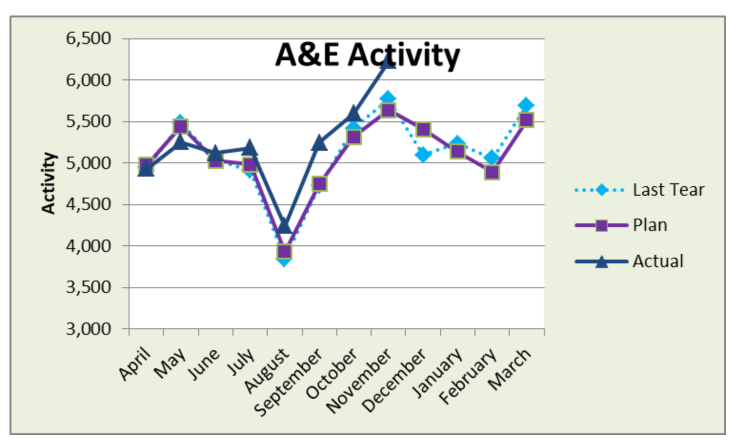
Alder Hey Children's NHS Foundation Trust

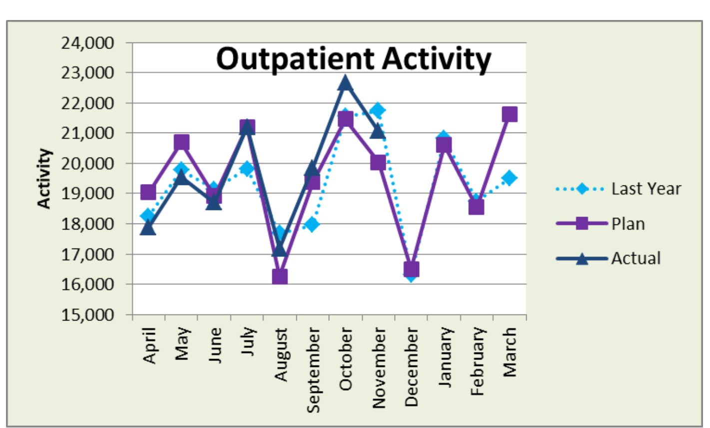


Elective Activity in Month	Non Elective Activity in Month	Outpatient Activity in Month	A&E Activity In Month
2,344	1,410	21,065	6,230
Not Achieved	Not Achieved	Achieved	Achieved









BOARD OF DIRECTORS

Tuesday 7th January 2020

Paper Title:	**CQAC**
Date of meeting:	18th December 2019 – Summary 20th November – 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 18th December 2019 along with the approved minutes from the 20th 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
Associated risk (s)	Include risk(s) reference, title of risk, and current risk score.

1. Introduction

CQAC 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)

- Inspiring Quality monitoring update – Best in Outpatient Care
- SAFER update
- Update on Progress from Central Lines Review Group
- Incident Management Policy – CQAC ratified policy
- CQSG Key issues report
- Divisional Report
- GIRFT update
- Journey to outstanding update & Insight Report
- Board Assurance Framework
- Drugs & Therapeutics Report
- Clinical Audit Plan
- Safeguarding Annual Report

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

None

4. Positive highlights of note

- A positive update was provided regarding Best in Outpatient Care.
- The Committee received a positive update from Central Lines Review Group.
- Committee received Annual Safeguarding report and noted the Quality aspects within the report relating to Safeguarding service.

5. Issues for other committees

None

6. Recommendations

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

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 20th November 2019
10.00 am, Large Lecture Theatre, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Dame Jo Williams	Chair of Alder Hey NHS Foundation Trust
	Adam Bateman	Chief Operating Officer
	Christian Duncan	Divisional Director, Surgical Division
	Rachel Greer	Associate Chief of Operations, Community Division
	Hilda Gwilliams	Chief Nurse
	Adrian Hughes	Divisional Director, Medicine Division
	Dani Jones	Director of Strategy
	Jill Preece	Governance Manager
	Tony Rigby	Deputy Director of Risk & Governance
	Sarah Stephenson	Head of Quality – Community Division Division
	Melissa Swindell	Director of HR & OD
	Andrew Williams	Clinical Lead, Sefton Specialist, CAMHS
	Simon Hooker	Governor
In attendance:		
Agenda item:		
19/20/123	Jacqui Allen	Senior Nurse Quality
	Julie Creevy	Executive Assistant (Minutes)
19/20/124	**Apologies:**	
	Shalni Arora	Non Executive Director
	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
	Anne Hyson	Head of Quality – Corporate Services
	Nicki Murdock	Medical Director
	Erica Saunders	Director of Corporate Affairs
	Cathy Umbers	Associate Director of Nursing & Governance
	Cathy Wardell	Associate Chief Nurse – Medicine Division
	Kate Warriner	Chief Digital & Information Officer
	Will Weston	Associate Chief of Operations, Medicine

19/20/125 Declarations of Interest
None declared.
AM welcomed Simon Hooker, Governor to the meeting.

19/20/126 Minutes of the previous meeting held on 16th October 2019
Resolved:

19/20/127 Matters Arising and Action Log
Action Log

19.20.47 – Patient Information Leaflets – 'Triumvirates to ensure divisional plans are in place and monitored via local governance processes and include on QAR's and performance reports' – HG confirmed that each division had been provided with data packs. Agreement had been made at Executive Team for Divisional Directors to disseminate within each of their Divisions, HG confirmed that an update would be provided by Divisional Directors at the weekly Well led meeting.
CQAC agreed that this item would be closed and removed from the action log.

Action: HG agreed that ACN's would provide assurance report to ensure CQAC are sighted on issue at December 2019 meeting.

19.20.59 – 'CQAC to receive Ward accreditation position statement in October 2019 – this item is included on the CQAC agenda and would be removed from the action log.

19.20.73 – 'Palliative Care Update' - this item is included on the CQAC agenda and would be removed from the action log.

19.20.74 – 'Quarter 1 DIPC Report – offline discussion to be held' HG stated that there was an interim arrangement for Valya Weston to present DIPC updates to CQAC, however HG stated that the updates should be provided by the medical lead, HG stated that NM had met with medical colleague, however a further discussion is required during December to finalise presenting future DIPC reports.

Action: NM to undertake follow up discussion with medical colleague

19.20.77 – Resus update – HG stated that an update had been received from Kate Warriner. CQAC noted that an Action plan is in place to resolve issues by the end of November/early December. Action plan included locking down some of the devices and streamlining of some of the wireless configuration. This was for non-emergency bleeps only. MS stated that bleep issue had been raised by Junior Doctors and that the Action plan had been submitted to Health Education England. AB stated that the Resus bleep update does not just reflect resus, it relates to the full bleep system across the Trust, and that both he and KW would present an update report to December CQAC/CQSG meeting.

Action: CQAC to receive report at December 2019

19.20.88 – 'CQAC to receive Briefing paper regarding Best in Outstanding Care in December' – Committee noted that this is on plan to receive update at December 2019 meeting.

19.20.88 – 'CQAC to receive update regarding ASD' – this item to be removed from the action log as this item is included on the agenda.

19.20.90 – 'CQC briefing/Board session to be arranged to support Board members' - CQAC noted that 1 NED session had taken place. CQAC agreed that this item could be closed and removed from the action log.

19.20.91 – 'Nutrition – Dame Jo to consider NED Championing within the Nutrition Steering Group'– Dame Jo confirmed that Fiona Marston, newly

appointed NED had agreed to be involved in attending and Championing Nutrition Steering Group.

Action: LC to ensure Nutrition Steering Group dates are shared with Fiona Marston.

Quality Improvement Progress Reports

19/20/128 **Programme Assurance Update**

In the absence of ND, HG provided a programme assurance update, key issues as follows:-

Detailed in the high level summary - Sepsis had seen an improved position. Resulting in sustained achievement of 100% performance in delivering Sepsis treatment for inpatients within 60 minutes over a 10 week period. Trends had been evident regarding inpatients and were being monitored through the weekly Com cell.
Focus on ED, with the ED team focussing on technology. Department are working extremely hard to achieve milestones and standards, with ED department treating largest number of patients on 24th November (252), with the busiest period to date being week commencing 18th November 2019. AM asked how the staff within ED were coping with increase in patients, AB confirmed that staff are accepting a high number of patients and are dealing very well with challenges placed upon them. CQAC noted the dedication and commitment of staff during this extremely busy period and that staff are doing extremely well in difficult circumstances.

HG stated that the Business Case for ED had previously been shared in a number of forums, and that the Executive Team are committed to working with the ED team, plan is for AB to submit Business Case to Investment Review Group.

Dame Jo questioned whether the Winter Plan is working well, AB stated that staffing arrangement/plans are in place, which is satisfactory, however this was challenging for staff.

CD stated that the Surgical Division had witnessed some cancellations, and that there is a need to concentrate on scheduled patients. CD stated that the theatre run rate equated to 134-136 sessions per week, as compared to previous year when the Surgical Division could not get beyond 100 sessions per week. CQAC noted that there is a recruitment drive currently taking place in India led by Pauline Brown & Phil O'Connor to recruit nurses. CD stated that there are currently pressures on the Cardiac service.

AM queried the underlying issues with regards to challenges in ED – AB confirmed that there are a significant number of primary care patients triaged as green, RSV/respiratory cases. AB confirmed that the Trust is working with partners to attempt to alleviate pressures faced within ED.

CQAC noted that the ED Action Plan is due to be presented to Operational Delivery Board on 28th November 2019.

Best In Outpatient Care – CQAC noted that this project was now green.

AB stated that he would like to acknowledge the work of the SAFER group, which had resulted in positive results for service delivery for families resulting in half of the discharges taken place before midday.

AM requested on behalf of CQAC for thanks to be expressed to staff ED staff.

Action: Comms/AB to relay CQAC thanks to ED team

Dame Jo questioned when data would be available regarding Inspiring Quality. AB stated that the team are working with partner to support, and that progress would be made, resulting in each division having a baseline.
AB stated that he would follow up this issue via a discussion with NM.

Action: AB to follow up with NM, in order to progress.

Inspiring Quality monitoring/assurance Update

- ***Models of Care update***

  AH presented Models of Care Update – key issues as follows:-

  - Team are working on 5 work streams which had evolved following discussion regarding the need for improved working regarding general paeds and critical care, with significant progress made.
  - HDU model – model had been through Trust processes, resulting in recruitment of 3 excellent HDU candidates for general paeds, with a special interest, with all 3 due to commence in post within the next 3 month period. One candidate CK had already commenced in post, with the other 2 candidates having impressive skill sets. CQAC noted that this was an improvement journey, with the aim for 7 day cover in daytime envisaged approximately in 12 months' time, resulting in a further 12 month period for 7 day cover in its entirety. AH stated that there would be a transition element of PICU consultants on HDU moving out and the new team moving in. CQAC noted that this showed tremendous potential to improve partnership working, with significant opportunities regionally. HG stated that she was delighted to see achievement and improvements made to date which was extremely welcomed.
  - Positive progress had been made in terms of the Paediatric Assessment Unit (PAU), model had been agreed on 4C, occupy 8 bedded areas, creation of 12 assessment bed/chairs, Business Case is due to be presented to Investment Review Group in 2 weeks' time. Recruitment required regarding senior ANP cover model and nursing cover – timescale for completion March 2020.
  - Pathways and thresholds, correct roll out is required, with a planned relaunch during January 2020 ensuring robust escalation process.
  - Outreach work HDU – on plan with staff expected to be in place by April 2020.
  - Out of hours consultant cover – pilot model commenced in September 2019, however it became evident that this was unsustainable, with support required during the day. G Smith is currently working on establishing a Business Case to increase middle grade support.
  - Team are reviewing support for overnight provision, and reviewing a new approach to ascertain what requirements are needed. AH stated that this would involve expansion of the team.

  AH formally acknowledged project support received.

AM stated that the positive update was well received. Dame Jo stated that she was interested in the process, AH stated that it had been based on evidence regarding incidents/standards and included a workshop approach.

AM thanked AH for update.

- ***Update on Patient shadowing project***

  AB stated that the Patient Shadowing presentation that had been shared at the Board of Directors meeting on 1st October 2019 was included in the meeting pack for information purposes. Patient shadowing had been built into strong foundations. In 2020 the team would be able to report update on outcomes regarding patient experience.

  AM stated that Non Executive Directors are keen to be involved in this Patient shadowing initiative. TR agreed that he would follow this up and would liaise with NED's as appropriate.

  Action: TR to include and involve NED's regarding Patient Shadowing Project**.**

  HG queried whether a report is produced regarding shadowing for students and sought clarity on whether CQAC should review. AB stated that he would follow up regarding delivery and progress in order to evaluate.

  Action: AB & TR to liaise with W Calvert to obtain appropriate report for CQAC to review.

  CQAC received Programme update and noted achievements to date.

19/20/129 Delivery of Outstanding Care

Safe

Ward Accreditation Update

J Allen presented the Ward Accreditation update, key issues as follows:-

- Ward Accreditation process was re-established in October 2017, which initiatively focussed on inpatient wards, and was subsequently expanded. In total 57 assessments had taken place to date throughout Inpatients, Day case and Outpatients. CAMHS-Sefton and CAMHS Liverpool had been through assessment process once. 15 Wards/departments had been through the assessment process a minimum of 3 times and the Dewi Jones Unit and Clinical Research Facility had been through the assessment period twice. Ward Accreditation visits are unannounced.
- JA requested that she would like to see more involvement from parents, carers and patients to include going forward.
- 3 wards had achieved Gold, (Surgical Day Unit, Burns Unit and Ward 3C), 2 wards had achieved this status on previous inspections, with positive feedback received from parents.

- Further work required regarding the need for staff to fully understand 'Duty of Candour' and ensuring that the language/terminology used within the Risk register is easily understandable for all staff.
- Concerns regarding ward 4A who on first inspection achieved bronze statues, and had now achieved silver – significant work on medicine management had taken place, and extremely positive feedback from parents.
- Discussion took place regarding Burns Unit & Surgical team who had achieved Gold twice, and discussed how this should be celebrated for the teams, to enable achievements to be fully acknowledged throughout the Trust.

CQAC agreed that it would be positive for the above teams to be presented with certificate from a member of the Board of Directors, to included Governors to acknowledge achievement.

Action: agreed to take offline to agree most appropriate forum to present staff with Ward accreditation awards.

DJ queried whether there were any emerging themes following the Ward accreditation process. JA stated that the criteria in categories was regarding handing hygiene audits, cleanliness audits, mandatory training compliance, compliance from safeguarding. DJ questioned whether there is a mechanism in place regarding learning, following the assessment process and that there was an opportunity for a GAP analysis.

HG questioned how this is shared at Clinical Quality Steering Group, and requested whether a report could be generated detailing SAFE themes for Associate Chief Nurses to review and follow up.

HG queried whether there was any learning that could be shared following the Burns accreditation process, in order to share across divisions. HG agreed to follow this up offline with J Allen. J Allen confirmed that copies are sent to Nurse Leadership Team and are published on the intranet, with Action plans and reports shared with Chief Operating officers within each of the divisions, Associate Chief Nurses and Heads of Quality for Divisions JA stated that she intended to follow up with communciations team with regards to creating a ward accreditation newsletter.

CQAC received and noted the Ward Accreditation Update report, presented by J Allen.

Effective

CQSG Key issues Report

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

- HG stated that there had been a significant increase in demand regarding interpretation and translation services. Video feedback had been trialled, with positive feedback received from patients, families and staff. End of year projections for cost on interpretation and translation services equated to £200,000. HG stated that a small working group would be established in order to review options. HG stated that a number of Trusts had joined a NHS service to provide interpretation/translation services, with Trusts having to pay a joining fee, together with annual costs. MS queried

whether there was a digital solution available, HG confirmed that once the small group had been set up that they would continue to review available options.

- Clinical Audit Plan - HG stated that she had met with team on a number of Occasions.

Action: Clinical Audit Plan update to be shared at December 2019 meeting.

Dame Jo requested that it would be helpful for updates could be included within the action log for CQSG, to ensure that the committee are aware if actions are complete/on plan.

Action: PoC to ensure that the CQSG is fully reviewed, refreshed, and updated with update included regarding status of actions within the action log.

Discussion took place regarding training and training data. MS stated the importance of consulting with 'subject matter experts' being in attendance at appropriate forum/meetings. MS stated that there is robust system in place regarding training and data, and that her team are proactively reviewing training compliance, CQAC noted that this continued to be work in progress.

Action: - MS to feedback to PoC with regards to ensuring subject matter expert is included in discussions as appropriate at CQSG

HG queried whether there is a Trust Group to share concerns at – i.e. a 'Fix it Group' MS stated that there is an Education Governance Committee who meet on a bi monthly basis, however there isn't a group specifically to raise issues at. MS confirmed that D Shaw works alongside the 'subject matters' on an individual basis.

AH stated the importance of communication to staff with regards to communicating to staff once an investigation had taken place.

MS stated that it is of vital importance for the subject matter expert to understand the process in order to reflect the current position. MS stated that communications are scheduled later this week with regards to mandatory training, and that information regarding 'dispelling myths' could be included within this communication to staff.

CQAC received and noted CQSG key issues report.

Palliative Care Report including Escalation Process update Report

AH provided Palliative Care Report update, AH articulated the challenges experienced within Palliative Care Team with regards to single handed provision of Palliative care, with an unmanageable caseload for single handed consultant, with expected sickness to continue until March/April 2020. Consultant has been, and continued to be well supported whilst away on sick leave. CQAC noted that nationally these posts are hard to recruit to, and that there is insufficient trainees to train. AH confirmed that progress had been made regarding leadership for the service. Significant progress had been made with nursing team which had been challenging, 8A Nursing lead post would provide significant impact. Locum consultant post had been advertised, also interest received from junior colleague to further support.

CQAC noted that additional resources are required to support additional 2 PA's. Interest colleagues are not fully accreditated palliative care consultants, however they could become accredited. A joint partnership paper is being scoped/developed with Claire House, which would fully detail the clinical model, with the aim to become an exemplar model. AH stated the importance of fully accessing appropriate funding opportunities, with regards to any match funding, or any funds available to hospices, with the need to review nursing model with developing the model to work across Alder Hey and Claire House.

AM expressed concern regarding the current risk, and sought clarity on timescales to show an improved position. AH confirmed that nursing element is on plan, and that the Trust are likely to have 2 new consultant in post in 3-4 months time.

Dame Jo highlighted the importance of finessing communications to ensure that the Trust is attracting colleagues to work at Alder Hey.

CD expressed element of caution, and referred to challenges, and a lack of agreement from different clinicians, in terms of communicating with families, which remained a challenge, with the need to formulise relationships with families in order to ensure that families are not given mixed messages and that new colleagues need to be fully supported.

Complex care – There is a need to develop Complex care model, with opportunity to co alless to ensure 'Outstanding/best in world offer'.

CQAC received and noted Palliative Care update.

Well Led

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

- Feedback received from MIAA colleagues regarding framework and connection. Ongoing work is taking place, led by ES in order to review connections.
  AM queried when ES programme of work is scheduled to conclude – HG stated that a meeting is scheduled w/c 25th November 2019, and following that meeting ES will have clarity regarding timescales.
  Dame Jo stated the importance of RABD fully scrutinising the outstanding Red risks within the BAF report at the next RABD meeting, CQAC noted that this is reviewed routinely at RABD meeting.

  CQAC received and noted Board Assurance Framework.

Best in Mental Health Services report
AW presented Best in Mental Health Services report which provided an overview of 5 improvement priorities within Comprehensive Mental Health Strategy, to deliver improvements in mental health services to meet the needs of the children and young people, and be recognised as a national leader in CAMHS. Update provided details on Dewi Jones Unit, Eating Disorder Services, Booking & Scheduling, Mental Health in Liverpool and Crisis Care work streams, detailing what has been delivered and next steps:-

Additional developments as follows:-

- A model for the alternative care of young people with learning difficulties and complex neurodevelopmental presentations has been proposed and a project set up with interim funding from Transforming Care.
- This project is being set up with key stakeholders including the three local CCGs and 2 Local Authorities.
- The CYP work-stream of the Mental Health Programme Board (Cheshire and Merseyside health & Care Partnership) is finalizing a proposal to reform and extend how inpatient services work to avoid inappropriate hospital admissions while providing more intensive support in the community **(April 2020).**

CQAC received and noted the Best in Mental Health Service report.

Neurodevelopmental Services Update - Rachel Greer presented Neurodevelopmental Paediatrics Update and Improvement Plan which included an update on ASD. Following update at Board of Directors meeting on 2nd July 2019, the team set out Trust ambition to deliver single service provided across CCG areas, paper was extremely comprehensive and provided an update on actions, with actions monitored externally through SEND performance group and Strategic Board, together with local Alder Hey SEND group. CQAC noted that a number of actions had now been completed within the action plan. The team are working with external provider. Appointed formally though procurement process, with ongoing work with regards to new pathways for ADHD. CQAC noted that agreements made to date, was not a ‘quick fix’, but is part of a commitment to SEND Strategic Group, - Pathway is December 2020 – currently on plan for Liverpool. Commissioners are reviewing.

CQAC received and noted the report and updates to be agreed improvements as progress towards the delivery of safe, effective and evidence based a neurodevelopmental paediatric services which meets the needs of children, young people and families.

Corporate Report – Quality Metrics

HG presented Corporate Report – Quality metrics, key issues as follows:-

- Feedback relating to Families and Friends who would recommend Alder Hey – ED feedback had improved, Action plan is in place and is being monitored widely.
- Inpatients showed an improved position
- Mental Health Services – had shown a significant improved position, last 3 months previously 33% to 88%.
- Choice/respect – Focus remains on school element with regards to measuring targets/learning elements. AM queried what the lack of progress related to, HG queried that a dialogue is required with head teacher of school.

Discussion took place regarding information shared at CQAC and the need to not duplicate elements of information, HG agreed that there is a need to AM, HG to discussion information flow to CQAC in order to ensure appropriate synchronisation.

Action: Offline discussion with AM & HG regarding information flow/timing of information received in order for CQAC to provide assurance to Board in a timely way.

19/20/130 7DS audit service programme

AH presented the 7DS audit service programme, key issues as follows:-

- The audit was undertaken by the clinical audit team, who reviewed a cohort of patients admitted as an emergency during September 2019 whose length of stay exceeded 14 hours. It was decided that the audit concentrated on the following 4 specialties - general paediatrics (43 patients), paediatric surgery (18 patients), plastics (17 patients) and trauma and orthopedics (9 patients). CQAC noted that the Trust is making good progress. Steering Group had been developed with representation at Divisonal level, Clincial Director level, Heads of Quality, senior managers and I.T. representatives. CQAC noted that additional audit resources is required to enable the clinical audit team to continue facilitating the audit as a rolling programme.
- AH requested that there is a need for the 7DS audit programme to be included within the Delivery Management Office programme, to ensure appropriate dedicated programme support is provided, as there is insufficient capacity of programme support at present.
- In terms of frequency of daily assessments by a consultant or a delegated clinician - during weekdays 77% of patients received a daily review by a consultant and 57% at weekends
- Progress had been made against standard 2, with full compliance maintained for standards 5 and 6.
- The data for standard 8 refered to PICU and HDU admissions only. Patients admitted to High Dependency Unit on ward 4A would be included in the next audit, requested clarity on standard 8.
- The analysis undertaken by the 7 day service web site tool indicated that 95% of patients received twice daily reviews whilst in critical care – this included HDU and PICU. It appears that this includes occasions when the review was delegated to another member of the clinical team (not a consultant).
- Clarification is required prior to the next audit regarding the delegation and documentation of consultant reviews and how this is recorded in the health records.
- The implementation of electronic 'Standard Documentation' has had a positive effect on the data collection for the audit. Additional changes to mandatory fields within Meditech have not yet been implemented, this will certainly further improve data quality. A review of use of Badger is required to improve the accuracy of audit findings in PICU.

  Action: AH to request whether the 7DS Programme could be included within the transformation programme in Quarter 4.

CQAC received, noted and accepted the 7DS audit service programme.

Review of meeting

CQAC reviewed the content of the meeting, and agreed that the content was good. CQAC welcomed strong presentations from Jacqui Allen, Adam Bateman & Andrew Williams. HG stated that she welcomed feedback

regarding alignment of data receipt in order to provide committee assurance to Board, and that this would be followed up with Information Analysts.

19/20/131 Any Other Business

- TR sought exec representation for M Flanagan's shadowing event on the afternoon of 20th November 2019, as MF could not attend at short notice.

Action: Ascertain if Exec could attend in MF's absence.

- AH sought clarity regarding Haematology and the most appropriate forum for Haematology to report into. AH shared with the committee impending crisis in the Haematology Services, which had been compounded with maternity leave and sick leave within the team. Dialogue had commenced with colleagues from Manchester, with further discussion planned on 22nd November at Partnership Board. Issue is included on the Risk register, the risk will not change, unless Manchester are unable to support Alder Hey. Critical point was noted during mid December 2019, with no consultant cover for a 3 week period, with Manchester aware of this position. CQAC noted that there is a need to develop long term sustainable plan with Manchester.

  HG stated that CQAC would be the most appropriate committee to review the briefing paper. HG agreed that she would include this item on Exec agenda for further discussion.

  Action: HG to include on Exec agenda for further discussion.

- HG stated that she had received a letter from Chief Nurse at Liverpool CCG with regards to Clinical Quality & Performance meetings and that following changes in the wider system – NHSE/NHSEI had agreed that they did not want to hold 2 separate meetings. In response to this letter HG had written to CCG Chief Nurse raising concern with regards to this approach, and a response is awaited. HG confirmed that she would provide an update in due course once a response had been received from CCG.

18/19/132 Date and Time of Next meeting

Joint CQAC & CQSG meeting - 10.00 am – Wednesday 18th December 2019, Tony Bell Boardroom, Institute in the Park.

BOARD OF DIRECTORS

Tuesday 7th January 2020

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

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1. Background:

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

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

In November 2014 a statutory Duty of Candour was introduced for all Secondary care providers registered with CQC in England as set out in Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. In April 2015 this became law for all providers and the CQC guidance requires Trusts to achieve a verbal Duty of Candour for moderate harm and above incidents within 10 working days. This should be followed up with a written Duty of Candour in a suitable timeframe.

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

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

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

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

Current position

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

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

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

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

Table 3 shows that the Trust had one moderate harm incident during this reporting period and provides a progress update on the incident investigation.

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

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

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

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

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2019/23494	24/10/2019	Medicine	800 outstanding blood results found on Meditech that had not been reported on. The bloods are primarily related to immunology and anticoagulation. These bloods are not diagnostic, but can support diagnosis.	Darren Powell, Clinical Director for Laboratory Medicine	RCA panel held 18/12/2019, the RCA report is being written.	Yes - The report is due for submission to the CCG and CQC 22/01/2020.	Not applicable – no harm known to have been caused at this stage.

			The initial review shows that 774 are negative (i.e. no issues identified). The remaining 26 show a positive result, however the initial assessment suggests they are low risk.				

Lessons learned/Action following 72 hour review:

1. Insufficient reconciliation process in place for bloods related to immunology and anticoagulation. A monthly review has now been initiated.
2. Deficits identified for notifying clinicians of outstanding results. In this case, the positive results have been shared with the relevant clinicians via individual letters for their clinical review. The longer-term plan is for an electronic notification process to be devised.

StEIS 2019/21208	26/09/2019	Surgery	**Never Event (retained swab):** The patient underwent an adenotonsillectomy. The Consultant ENT Surgeon inserted a post nasal swab and has stated this was part of their routine practice. The patient was extubated, and moved to the recovery area. The nurse raised concern that a swab was missing. At this point, the Surgeon recalled that he had not removed the post nasal swab and requested the anaesthetist to deepen the anaesthetic. The patient's mouth was then opened with an anaesthetic laryngoscope to retrieve the swab. The patient did not need to be re-intubated.	**Nursing lead:** Paula Clements, Theatre Matron **Medical lead:** Costas Healy, Consultant	The final RCA report was completed and sent to the CCG and CQC 19/12/2019.	Yes - The report was due for submission to the CCG and CQC 19/12/2019.	Compliant

Lessons learned/actions following RCA investigation: Additional training requirements

1. All Surgeons and Medical staff who work in theatres to attend NatSSIP's 5 steps to safer surgery training and also attend Human Factors training with regular updates.

2. HALT Tool Training for all Surgeons and Medical staff who work in theatres, reinforcing its use. 3. Refresh/communicate to all staff the correct process for checking of swabs, needles and instruments.							
StEIS 2019/20741	19/09/2019	Surgery	**Never Event (wrong route administration of medication):** The patient's epidural catheter was connected to an epidural giving set which had inadvertently been connected to and primed with a bag of gelofusine rather than the intended chirocaine and clonidine epidural solution. The pump was stopped immediately on identification. At this time, 0.9mls had been administered. 0.25-0.3 mls was aspirated from the filter and 0.1 mls was aspirated from the epidural catheter and hub. This left approximately 0.5-0.6 mls in the epidural catheter and epidural space. The decision was made to not utilise the epidural catheter for the remainder of the case and it was re-sited at the end of the case one space below the original site. No harm is known to have been caused to the patient .	**Medical lead:** Harvey Livingstone, Consultant Paediatric Anaesthetist **Allied Health Professional lead:** Neil Wallis, Clinical Lead, Theatres	The final RCA report was completed and sent to the CCG and CQC 13/12/2019.	Yes - The report was due for submission to the CCG and CQC 13/12/2019.	Compliant
Lessons learned/actions following RCA investigation: 1. 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. New							

2. 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. Action: 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 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).							
StEIS 2019/20632	18/09/2019	Surgery	**<u>Unexpected death:</u>** A patient under the care of the cardiac team for shunt dependent circulation, sadly passed away prior to their scheduled surgery taking place. Initial case review highlighted potential areas requiring further investigation in terms of the patient's pathway.	**Medical lead:** Andrew Riordan, Consultant in Infectious Diseases **Allied Health Professional lead:** Alan Bridge, Clinical Lead, Theatres	The RCA panel meeting is being arranged.	Yes – An extension has been granted to the 06/01/2020 due to the work pressures of the lead.	Compliant
Lessons learned/Action following 72 hour review: 1. To ensure all patients who breech the waiting time are incident reported and action taken to address. 2. To ascertain why there was a communication issues following the death of the child **3.** List the case for review at the cardiac QAQI 4. To review all children on the list with either a PDA stent or BT shunt and review the surgical priority listing 5. To review the local policy of stopping Aspirin prior to surgery although this will need more discussion and maybe a case by case basis rather than a blanket stop all. 6. To review the cardiac elective list and ensure all category 3 or above patients are prioritised for surgery							
StEIS 2019/20104	12/09/2019	Surgery	**<u>Patient found to have retinal haemorrhages post-cataract surgery:</u>** The patient was referred to the ophthalmology service on the 7th February 2019 and was triaged by the consultant as urgent. The patient attended the cataract clinic on the 19th	**Service lead:** Judith Gray, Head of Optical Services **Medical lead:** Adam Donne, Consultant ENT Surgeon	The final RCA report has been written and is in the first quality check stage; the report from the external specialist ophthalmologist is being written.	Yes – An extension has been granted to the 06/01/2020 to allow for the completion and receipt of the external specialist report.	Compliant

			February 2019 whereby he was diagnosed with bilateral congenital cataracts and was listed for left eye cataract extraction on the 26th February 2019. The patient was admitted overnight and was reviewed in the cataract clinic on the 27th February 2019 and discharged. The patient was reviewed routinely thereafter and the left eye was noted to be making positive progress. The patient was readmitted for surgery on the right eye on the 12th March 2019. The procedure was uncomplicated and patient was admitted overnight and was reviewed in the cataract clinic on the 13th March 2019 and discharged. The patient had a further clinic appointment on the 15th March 2019 and subsequent review on Friday 22nd March 2019. During this review, widespread retinal haemorrhages in the right fundus were identified that were not present at the reviews on the 13th and 15th March. Initial investigations were				

			undertaken to consider non-accidental injury (NAI) including a safeguarding referral and a skeletal survey. The findings concluded that there were no abnormalities and no external signs of injury. Following a further clinic appointment on the 29th May 2019, it was found that the patient has significant optic atrophy in the right eye and that the optic nerve has sustained a significant insult in relation to trauma, circulation or toxicity. At this moment in time the cause of the retinal haemorrhages and optic atrophy is unknown.				
Lessons learned/Action following 72 hour review: Gentamicin will not be used for cataract surgery for the time being as a precautionary measure.							

Table 3 Moderate harm incidents

Reference Number	Date investigation started	Division	Incident Description	RCA Lead Investigator	Progress	60 working day compliance (or within agreed extension)	Duty of Candour applied
39162	25/11/2019	Medicine	**Category 3 Pressure Ulcer:** Confirmation of category 3	Rachel Duncan, Matron for Cancer Services	An After Action Review has been completed and is in the final quality check stage.	Yes – The final report is due out 24/02/2020.	Compliant

			pressure ulcer to the patient's left heel 25/11/2019.				

Lessons learned/Action following 72 hour review:

1. Whilst standard skin care advice was verbally provided, no written information was provided to the parents to support this. Written information has since been produced.
2. Enhanced training for the staff group involved.

Table 3 Closed SIRIs:

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

END

BOARD OF DIRECTORS

Tuesday 7th January 2020

Paper Title:	**Q2 Mortality Report 2019/2020**
Report of:	**Nicki Murdock**
Paper Prepared by:	Julie Grice/Karl Edwardson

Purpose of Paper:	Decision Assurance Information Regulation	☐ ☒ ☐ ☐
Background Papers and/or supporting information:	N/A	
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	

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY

Medical Director's Mortality Report

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

Section two is the Quarter 1 Mortality report which includes a review of statistical analysis in PICU and Cardiac Surgery, followed by more detailed analysis of the place of death, teams involved and specifics about expected v observed deaths.

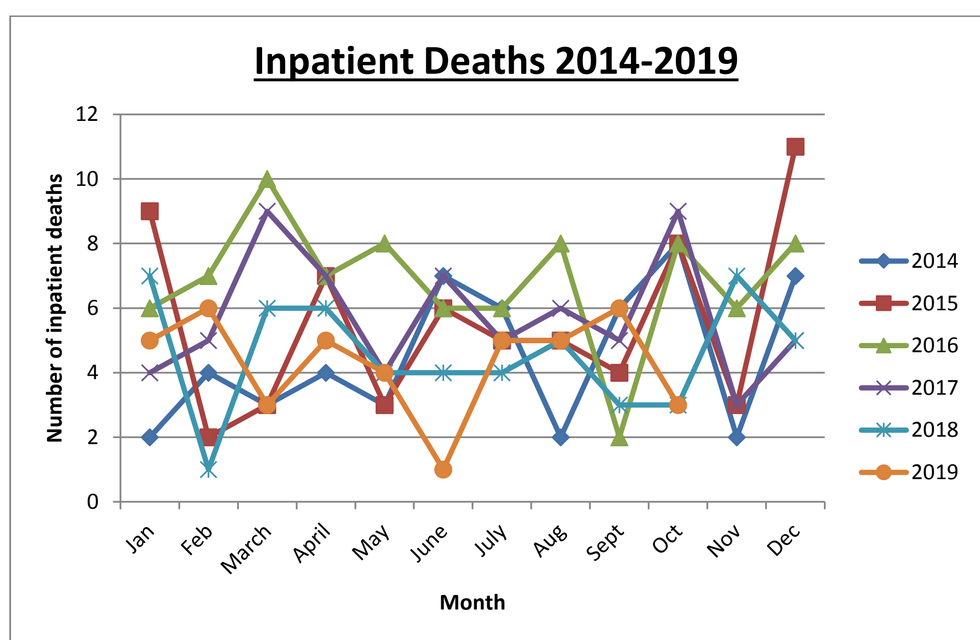
Section 1: Report from the Hospital Mortality Review Group (HMRG)

Number of deaths (Jan. 2019 – Dec. 2019)	44
Number of deaths reviewed	28
Departmental/Service Group mortality reviews within 2 months (standard)	33/41 (80%)
HMRG Primary Reviews within 4 months (standard)	22/28 (79%)
HMRG Primary Reviews within 6 months	16/19 (84%)

The HMRG performance target of 4 months has improved from the last report to 79%, when there was a drop in performance due to the introduction of extended forms meeting the new national requirements. Following the introduction, we had a small backlog but the group has worked hard and reviews are now being completed in a timely manner.
The 6-month figure still remains very good with only 3 cases preventing completion.
The group continues to work extremely well, although there is still a very limited pool of reviewers, which puts pressure on the target. The meetings are well attended and time available is maximised to ensure thorough discussion.
Some of the cases have been extremely complex and challenging requiring multiple discussions and in some cases more information.
The links between our neighbouring DGH's, hospices and Liverpool Women's' continue to develop ensuring the mortality process continues to improve and the learning is shared across the region.

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

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



Outputs of the mortality review process for hospital deaths for 2019

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2-month timescale	HMRG Reviews within 4-month timescale	HMRG Reviews within 6-month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable		RCA/72 Hour Review	Learning Disability
							Internal	External		
Jan	5	5	5	1	5	2	1		1	
Feb	6	4	6	2	4	1		1	3	1
March	3	3	3	1	3					1
April	5	4	3	3	4	1		1		
May	4	3	3	3		1			1	3
June	2*	2	1	2		1		1	1	1
July	5	5	5	3		3				
August	5	2	3	4						2
Sept	6		4						1	
Oct	3									
Nov										
Dec										

- Includes 1 death in Emergency Department

Potentially Modifiable factors and Actions

Over the period of this report, there has been 1 potentially avoidable death, due to there being preventable external factors. The case related to a child that fell out of a first floor window suffering a catastrophic head injury. Despite maximal care, from all necessary teams in the Trust, there was nothing that could be done to reverse the damage to the brain.

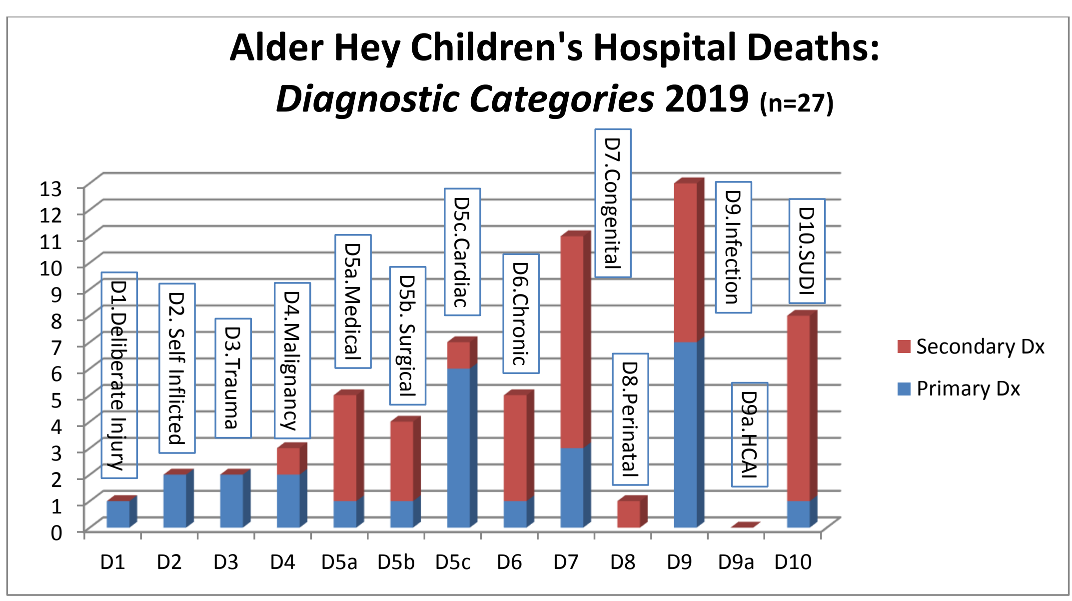
Learning Disabilities

The output table of the mortality process above records the children who were identified as having learning disabilities who have been reviewed in 2019. Currently, of the 28 children reviewed 8 were identified as having learning disabilities. The HMRG policy states that the death register is reviewed every month for any patients who are recorded to have any learning disabilities and reported to the LeDeR database as soon as identified. The HMRG review also identifies in the recurrent theme if there is any learning disability identified. On the Hospital mortality group is the learning disability nurse consultant who does not always attend the meetings but is available for advice or to raise any concerns. There have not been any concerning issues identified.

Family

The bereavement team provide support to the family for a considerable time period (if wanted) and we are improving the feedback that the HMRG receives from them so improving the families input .The family will be informed via a letter (as advised by the new guidance) that a mortality review is undertaken for every child that dies in Alder Hey and given an opportunity to feedback or rise any concerns. The responsible clinician usually offers to meet with the family around 6 weeks and this is recorded in the HMRG review as to whether this has been offered. The work with the bereavement team is ongoing as this is an area that can always be improved as it is vital that the family are heard but it has to be done in a way that is sensitive to the family's needs and wishes.
If there is any investigation or concern raised that the Trust informs the family according to its Duty of Candour.

Primary Diagnostic Categories

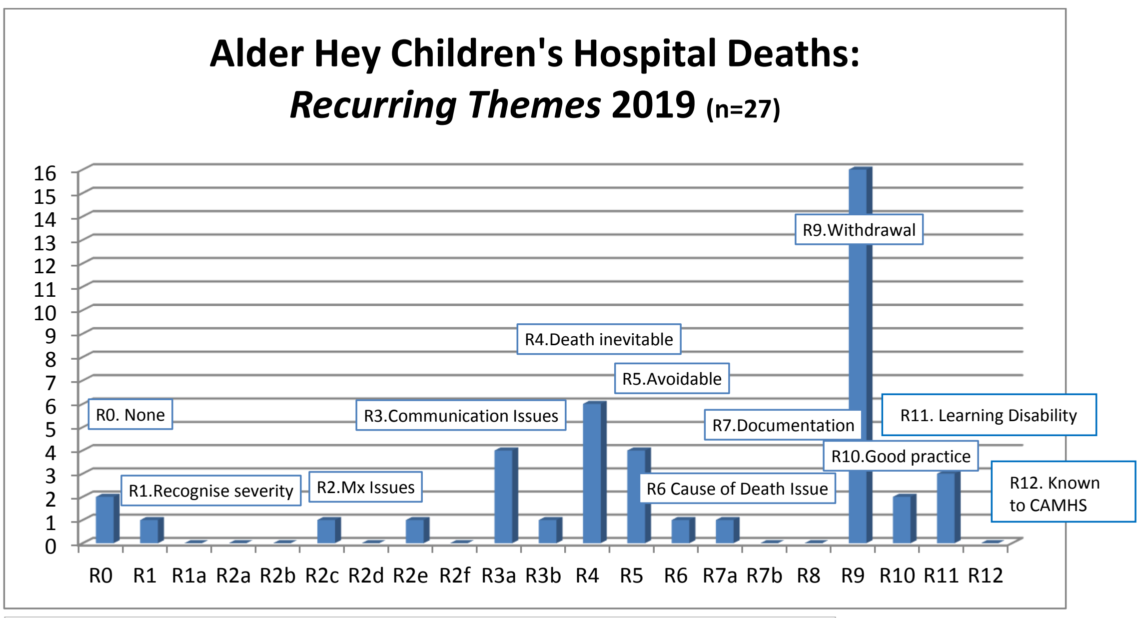


Diagnostic/Disease Categories (based on CEMACH categories - ref. *Arch Dis Child* 2011;96:922-6 + 927-31)

D1.	Deliberately inflicted injury, abuse or neglect
D2.	Suicide or deliberate self-inflicted harm
D3.	Trauma & other external factors – *excludes deliberate self-inflicted harm (D2)*
D4.	Malignancy
D5.	Acute Medical or Surgical condition – subcategory D5a. Medical D5b. Surgical D5c. Cardiac
D6.	Chronic medical condition
D7.	Chromosomal, genetic and congenital anomalies
D8.	Perinatal / Neonatal event
D9.	Infection / Sepsis (proven or clinical) – subcategory D9a. Healthcare-associated infection (home or away)
D10.	Sudden unexplained, unexpected death / SUDI / SUDC – *excludes SUDE (D5*

The most common diagnostic category is infection at 26 % but with no hospital acquired infections recorded. Second highest is the category of cardiac conditions with 22%. The cardiac cases, are not surprising due to the number of patients that come to Alder Hey, for full assessment and potential operation. Some of these children have inoperable conditions after they are evaluated.

The main secondary diagnostic category with 26% is sudden unexplained death, followed by medical and congenital causes. This category covers any child death that was not expected so covers a wide spectrum.



Recurring Themes

R0.	No RT
R1.	Failure to recognise severity of illness – subcategories: R1a. Failure to ask for Senior/Consultant review
R2.	Possible management issues – subcategories: R2a. before Arrival R2b. Delay in Transfer R2c. in Alder Hey R2d. Delay in supporting services or accessing supporting service R2e. Difference of opinion re: Rx – Patients & families R2f. Difference of opinion re: Rx – Clinical teams
R3.	Communication issues – R3a. Patients & families R3b. Clinical teams
R4.	Death inevitable before admission
R5.	Potentially avoidable death – subcategories: R5a. Alder Hey R5b. Medical R5c. External
R6.	Cause(s) of death issue – subcategories: R6a. Incomplete or inaccurate Death Certificate R6b. Should have had a post-mortem R6c. Not agreed R6d. Failure to discuss with the HM Coroner
R7.	Documentation – subcategories R7a. Recording R7b. Filing
R8.	Failure of follow-up
R9.	Withdrawal
R10.	Example of Good Practice

The commonest theme is the withdrawal of care in 59% of cases which show the intensive care team are providing the best possible care until they feel all treatment options are futile, then with the full agreement of the family withdrawing intensive care, whilst ensuring the child is comfortable.

The next commonest theme is that death is inevitable prior to admission, this occurred in 22% of cases. This is when even when the AHCH teams provide optimal care there is nothing than can be done to prevent death. This may not be apparent prior to transfer and may require investigations to be taken in AHCH to complete a full assessment and then discuss all treatment options or lack of.

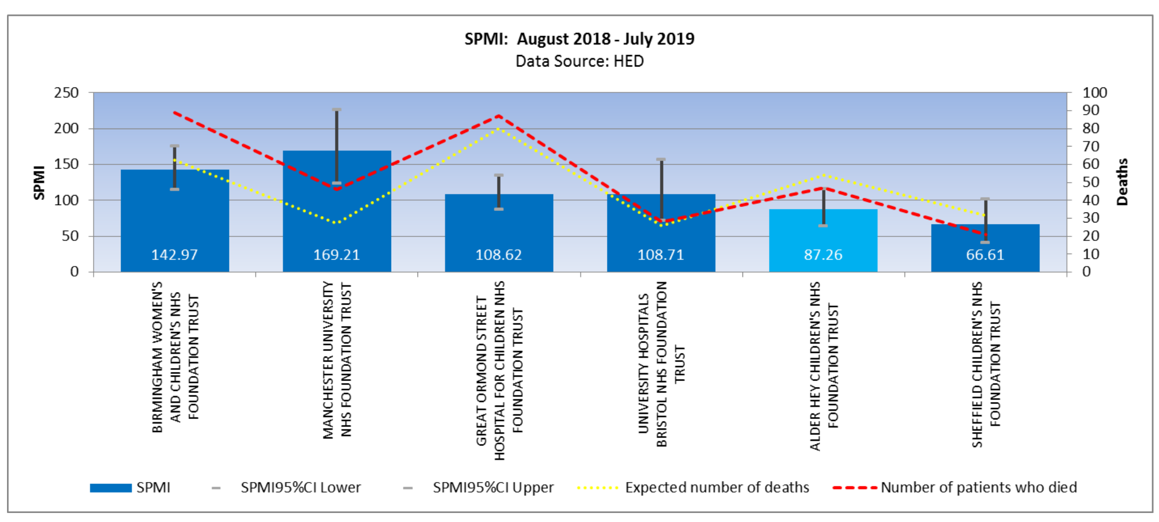
There are no worrying recurrent themes that are becoming apparent and the two main recurrent themes are consistent in the figures.

Section 2: Quarter 2 Mortality Report: July 2019 – September 2019

External Benchmarking

-Standardised Paediatric Mortality Index (SPMI); – HED

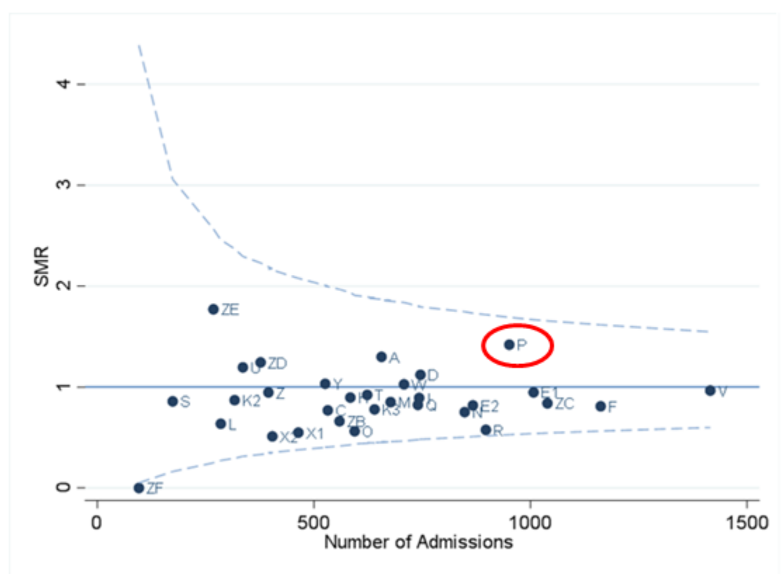
HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates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



The chart shows that Alder Hey has a lower mortality level than the average NHS performance with 47 deaths against 53.9 expected deaths.

-PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other children's trusts. In the most recent PICANet report (2018 Annual Report of the Paediatric Intensive Care Audit Network January 2015-December 2017), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions.
The chart below is taken from PICANet's most recent report, and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.

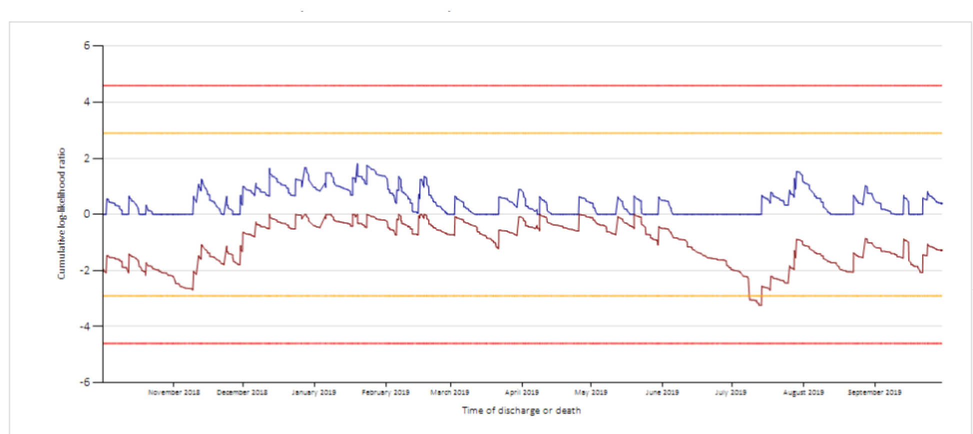


The funnel plot above shows Alder Hey at point 'P'. The SMR for Alder Hey is within the control limits of the funnel plot, suggesting mortality is under control.

Statistical analysis of mortality:

a) RSPRT (Risk-adjusted resetting probability ratio test)

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM3 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'.

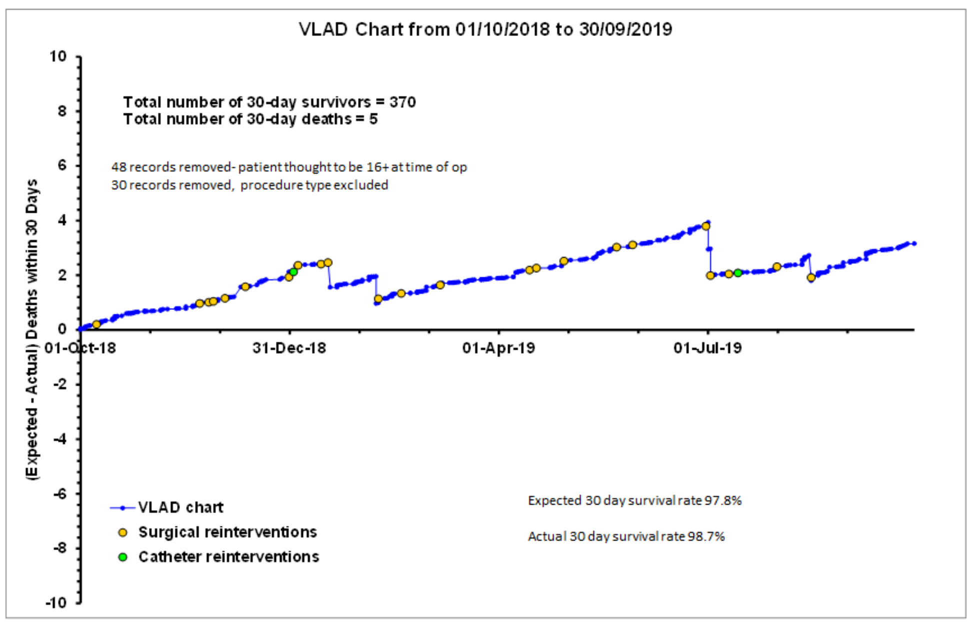


Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero.This data is nationally validated because it is generated by PICANet. The above RSPRT chart indicates that we have been in "Safe Zone" between November 2018 and September 2019. In July 2019 the RSPRT trend-line moved below the so-called 'safe zone' indicating continued decrease in the PIM3-predicted mortality rate for the PICU. This represented far better actual mortality than that predicted by PIM3 All PICU deaths + RSPRT trends are discussed in the following month and monitored regularly.

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

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

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

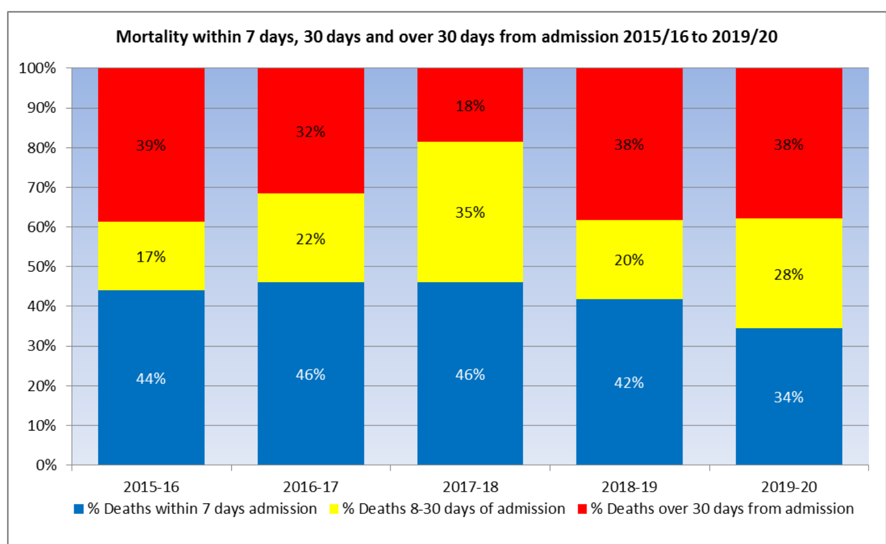


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from October 2018 to September 2019. The survival rate at 30 days was 98.7% against an expected rate of 97.8%.

Real time monitoring of mortality

Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below the chart shows mortality broken down by the time from admission to death, mortality within 7 days, 30 days and over 30 days from admission.



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 42-46% of deaths occur within this time frame. In the current financial year (April – September) 34% occurred within 7 days of admission, 28% occurred within 8-30 days from admission, and 38% deaths occurred over 30 days from admission.

Conclusion

The HMRG is functioning well although there have been a number of challenging cases resulting in a few not yet fully completed. The process continues to adapt according to the national guidelines and there will need to be a number of changes over the next few months to ensure we meet the national requirements particularly focusing on the bereavement team work. Our process is robust but needs to provide the data required to input into the national database. We need to strive to engage clinicians both internally and externally and the links with the CDOP process have changed following the guidelines. We continue to review every in-patient death in HMRG and the majority of deaths have at least one departmental group review in addition.
The process has evolved over the last 5 years or so and the percentage completed within the 4 months has raised rapidly. The review process has developed and the communication within and outside of the organisation improved. The group has expanded to include a greater variety of people with differing roles who help to ensure the review process is more robust.
There is clearly ongoing work to continue to improve the process and increase engagement and communication across the Trust. Learning from deaths is the key goal and we are now trying to ensure that this occurs across the organisation and with time spreads out across the region.

References

SPMI - The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. **Pg 7**

Benchmarking - As previously reported Alder Hey benchmarks externally for PICU (http://www.picanet.org.uk/documentation.html), congenital cardiac disease http://nicor4.nicor.org.uk and oncology. **Pg 7**

PICU SMR - The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate. **Pg 8**

PRAiS and VLAD charts - The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.
The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance. **Pg 10**

BOARD OF DIRECTORS

Tuesday 7th January 2020

Paper Title:	**Safeguarding Annual Report**
Report of:	**Hilda Gwilliams, Chief Nurse**
Paper Prepared by:	Julie Knowles, Assisting Director of Safeguarding
Purpose of Paper:	Decision ☐ Assurance ✓ Information ☐ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ✓ To approve ☐
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ✓ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	

Alder Hey Children's NHS
NHS Foundation Trust

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST

Safeguarding Service

Annual Report

2018/19

Report Authors Julie Knowles
Assistant Director of Safeguarding & Service Group Lead for Statutory Services
Catherine Creed Named Nurse for Children, Young People and Adults

Completion Date

Submission Date to Board 18th December 2019 (CQAC)

Executive Summary

In keeping with all NHS organisations, Alder Hey has a statutory duty to make arrangements to effectively safeguard and promote the welfare of children and adults accessing services.

The safeguarding team are based within the new Rainbow Centre, which is situated on the ground floor near the Emergency Department and provides a 'hub' for the co-ordination of the safeguarding service across the whole Trust.

Key achievements of 2018–2019 include:

- Work in collaboration with the CCG to further develop the health assessment pathway for new into care children.
- To continue working in collaboration with the safeguarding CCG service in the development of Key Performance Indicators that are measurable and reflect the safeguarding / LAC service delivery model provided by a tertiary children's hospital with a specialist safeguarding service in order to achieve compliance.
- To work with NHS England Specialist Commissioners in developing a bespoke service for historic sexual abuse.
- To collaborate closely with the executive team to develop policies that will better support staff in the management of parents displaying challenging and aggressive behaviours.
- To review and develop systems to better capture activity data, including FII cases.
- Further development of the Safeguarding children/adult training strategy to take account of the changing needs of the workforce, to include specialist topics pertinent to a Tertiary setting and ensure full compliance with the Intercollegiate guidance.
- Creation of an Induction Booklet for new clinical staff and will be used for new Trainee's working within the safeguarding unit.

Priorities for the forthcoming year:

Safeguarding

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

- To review the safeguarding supervision framework to ensure all specialist services are adequately supported.
- 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 i.e. Apprentice program, Sefton Community services
- Formulate an options appraisal to meet safeguarding mandatory training demands
- Work towards centralisation of the LAC service
- Review of Commissioning arrangements to take account of continued increase in clinic requests
- Commissioned service for conversions
- Consider use of skill mix to improve service delivery
- Implementation of LAC training strategy

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Introduction

This Safeguarding Children annual report aims to assure the Board that Alder Hey is fully compliant with its statutory duty to safeguard and promote the welfare of children and adults in need of protection accessing services within the organisation. The report will detail all safeguarding activities within and relating to Alder Hey Children's NHS Foundation Trust (referred to throughout this report as Alder Hey) during the financial year of 2018 - 2019. It is designed to highlight key issues, working arrangements and recent developments.

The Rainbow Centre is situated on the ground floor near the Emergency Department and provides a 'hub' for the co-ordination of the safeguarding service across the whole of Alder Hey. The facilities include office space, a video interview suite and dedicated meeting rooms, as well as two dedicated examination suites, which provide a calm, sympathetic environment where children who are suspected of being abused can be medically examined and interviewed,
The report will utilise the CQC reporting framework (Safe, Effective, Responsive, Caring, and Well Led) to provide an overview of day to day safeguarding activity and demonstrate the breadth and complexity of the work being undertaken.

The Governance Framework will be explained together with the commissioning arrangements that are in place to monitor the quality of service delivery.

Multi Agency Safeguarding Arrangements (MASA) in England has a statutory responsibility for the review of all child deaths (Working Together 2018). As an acute Tertiary Paediatric Trust, we provide a substantial contribution to the child death review function and have a dedicated specialist nurse to support service provision. A summary of activity relating to this function is included within the report.

Learning from significant safeguarding incidents that may contribute towards a child's death is a core function of the MASA and as such the safeguarding service within Alder Hey provides a substantial contribution towards this process.

A further function of the service is to ensure Alder Hey achieves the required compliance level for mandatory safeguarding training. The data provided within the report support the

continued effort by the team to achieve and maintain the necessary standards whilst also delivering additional training opportunities to further enrich learning across the organisation.

The report will conclude with identification of key priorities for the forthcoming year.
Key legislative and national guidance relating to safeguarding will be summarised within the appendices.

SAFE

1.1 Service Structure

Alder Hey Safeguarding Team

The Chief Nurse provides executive leadership for safeguarding across the organisation. The Assistant Director of Safeguarding (Julie Knowles) also undertakes the role of Clinical Director for Statutory Services, which includes Safeguarding, Looked After Children (LAC), Special Educational Needs (SEN) and the Adoption Service.

The Named Nurse post (Catherine Creed) has a particularly focus on delivering the adult safeguarding agenda. In conjunction with the Trust Named Doctor (Dr. Madeleine Pipon), they take the safeguarding operational lead role across Alder Hey, providing expert advice and support for fellow professionals and other agencies.

The safeguarding nursing team is an integral part of Alder Hey's Safeguarding Service, providing support to the Rainbow Doctors involved in child protection investigations. They also receive a significant number of generic safeguarding referrals from across Alder Hey in relation to other child protection issues which do not require a 'rainbow medical examination' but there remain safeguarding issues. These may include: parental substance misuse, parental mental health concerns, domestic abuse, chronic neglect, deliberate self-harm, non-attendance or discharge issues. The specialist Safeguarding Professionals will attend multi-agency meetings including strategy meetings, professional meetings, pre discharge meetings, child protection case conferences and attendance at Court hearings.

The safeguarding nursing team provide supervision to nursing and allied professional groups on aspects of safeguarding and provide support should they be required to produce a Court report or in attendance at Court. The team also deliver safeguarding mandatory training across the organisation.

Alder Hey is commissioned to provide the Safeguarding Designated Doctor role for Knowsley, Liverpool, Sefton and Halton CCGs and the LAC Designated Doctor role across the North Mersey area.

There is provision of a dedicated 24/7 child protection service to examine and advise on the medical aspects of suspected or actual child abuse. This includes physical and sexual abuse, presenting in the community, or hospital A&E, outpatients or inpatients. The safeguarding team are generally referred to as the 'Rainbow Team', which relates to the name given to the dedicated examination facilities, 'The Rainbow Centre'.

The Safeguarding team includes:

- 1.3 WTE Consultants available for Child Protection work during any 24 hour period;
- 1.3 WTE Middle Grade Doctors available for Child Protection each day during core working hours and as part of the on-call rota during the weekends;
- 2.0 Sessions Named Doctor for Safeguarding;
- 1.0 WTE Assistant Director of Safeguarding plus 1 PA Clinical Director for Statutory Services;
- 1.0 WTE Named Nurse for Safeguarding Children, young people and adults;
- 2.8 WTE (B7) Safeguarding Nurse Specialists
- 0.6 WTE (B7) Child Death Review / Safeguarding Nurse Specialist
- 0.8 WTE (B6) Looked After Children Nurse Specialist
- 0.6WTE (B7) Clinical Psychologist
- 1.0 WTE (B6/7) Physician Associate
- 2.6 WTE Health Care Assistant
- 2 WTE Admin Support.

The Safeguarding Team follows the good practice principles highlighted in the National Service Framework for Children (2004), Working Together to Safeguard Children document (2018), the Children Act (1989, 2004) and The Care Act (2014) and aims to promote child and adult centred care, whilst helping and supporting families through the child protection process. The team also support the safeguarding of vulnerable adults whilst recognising the Mental Capacity Act (2005) and the need to 'Make Safeguarding Personal'

The Rainbow Centre offers a multi-agency approach to the treatment of abused children with close liaison between Police, Children's Social Care and hospital-based personnel. The facility includes two dedicated examination suites, a video interview suite and dedicated meeting rooms.

Alder Hey has a large catchment area and provides secondary health care for the boroughs of Liverpool, Knowsley and Sefton. It is also a tertiary referral centre for specialist services with a specialist Paediatric Intensive Care Unit which receives patients from the local and regional areas, e.g. North Wales, Merseyside and Cheshire, and across the wider North West. The Safeguarding Team works closely with Burns and Plastics, Critical Care, Orthopaedics, Paediatric Surgery, Neurosurgery, Ophthalmology, Radiology, CAMHS and Medical Photography colleagues in the management of some of the most complex child protection investigations within the region.

By arrangement with those CCG's, Police and Children's Services, any children requiring medical examination, are referred as per protocol to the Rainbow Centre at Alder Hey, to be seen by a member of the specialist child protection on call team. This includes a first on call specialist trainee/specialty doctor/physician associate and second on call consultant. Children are admitted to hospital by the team as required.

For those children who are inpatients and concerns of possible abuse are raised, the Consultant with responsibility for the child will follow the relevant Alder Hey Safeguarding procedure and make a referral to the Consultant on call for the Rainbow Service.

The Rainbow Team provides the Paediatric input for joint examinations with Forensic Medical Examiners (FME) for examination of children with suspected sexual abuse. A Consultant takes the role of Forensic Lead for the children's Sexual Assault Referral Centre (SARC), located within the Rainbow Centre, to ensure that high standards are maintained and that existing staff have regular training updates.
The Rainbow Team are also required to attend multi agency meetings to discuss findings of medical assessments, produce confidential medical / Court reports and respond to information requests from both partner agencies and the LSCB in relation to the Serious Case Review Process or other LSCB functions, such as audit and performance management.

1.2 Summary of Safeguarding Activity during 2018 - 2019

Appendix I provides an overview of the operational safeguarding activity during the past year and includes a full breakdown of referrals to the specialist safeguarding service (Rainbow Centre), the number of referrals to the Safeguarding Nursing Team, number of strategy / professional meetings held at Alder Hey together with the number of Police video interviews undertaken. This information is also shared with the Clinical Commissioning Service as part of the key performance indicators.

- Data shows there were 566 contacts made to the Rainbow Centre during the 2018/19 reporting period, regarding children and young people who may require a medical assessment relating to physical or sexual harm. This is a slight decrease from the previous year (591).
- For those cases where the clinical management decision was to undertake medical assessments, the data shows a slight reduction (410) than the previous year (432).

- The data demonstrates that 72% of the contacts made to the Rainbow Centre will go on to have a full medical assessment. For those cases where a medical assessment was not indicated advice will be provided to the referrer or signposting to the relevant service.
- During 2018/19 there were 285 Physical examinations undertaken and 125 forensic examinations. The slight decrease in forensic examinations from the previous year (129) is disappointing and suggests that despite the multi-agency focus on child sexual exploitation, the number of referrals for forensic examinations remains lower than would be expected.
- Liverpool continues to make a large portion of the referrals for medical assessments within the Rainbow Centre (154), followed by Knowsley (74), Sefton (72), St. Helens (67), and Wirral (26). However, it is acknowledged that Alder Hey only provide a SARC service to Wirral as all physical abuse cases are seen locally. There were 17 out of areas referrals to the Rainbow Medical Team, which is a slight increase from the previous year (15); this cohort of patients often constitute some of the most complex safeguarding cases managed by Alder Hey and include traumatic head injuries, significant burns and fractures.
- Meditech referrals to the safeguarding nursing team continue to increase (3443). This 8% increase from 2017 /18 (3185) builds on the picture of a continued rise in activity (2016/17, 1976). Overall, activity has doubled since 2015 (1721). If the referral rate continues to rise at an average rate of 1000 per quarter, it is anticipated that the referrals will likely total over 4000 for 2019. This would demonstrate a further 16% increase in activity over the past year and would demonstrate a 132% increase in referrals being managed by the safeguarding nursing team since 2015. Most referrals to the safeguarding nursing team are received from the wards (2023) and ED (1242). There were 120 referrals received from the outpatient departments during 2018, which is a slight increase from the previous year 104. However the data for January to September 2019 demonstrates a significant increase in referrals (210), which is suggestive of increase safeguarding awareness from staff working in these areas.
- Children requiring an 'Achieving Best Evidence' (ABE) interview attend the Rainbow Video Interview Suite; during 2018/19, 133 interviews were undertaken, which was a slight decrease from the previous year (145).
- Where possible Professional / Strategy meetings are held onsite, as this has a significantly positive impact on medical representation being achieved. There were 482 meetings held within 2018 /19, which demonstrates a dramatic increase in the number of multi-agency meetings attended by the safeguarding service from the

previous year (277). However, due to the limitations in data collection systems, this figure remains an under representation as it does not include the significant contribution made to multi-agency partnership collaboration by the wider Alder Hey Teams.

- Meditech nursing referrals are only one source of activity. Other requests for support, advice information and other actions such as LSCB CIG (critical incident group) requests may come via the safeguarding email account or via telephone. Equally many of requests are via telephone calls; during one month (July 2018) there were 721 telephone calls to the Rainbow reception (597) and the safeguarding duty desk (124).
- 197 children attended Alder Hey's Emergency Department (ED) as a result of a dog bite injury during 2018, which is a 7% increase from the previous year (184) and a 22% increase since 2015 and 2016 (162 static figure). A bespoke template has been created by the ED department which ensures consideration of a safeguarding referral is made for each child presenting to the ED with an injury from an animal attack. This is used in conjunction with the safeguarding team dog bite standard operating procedure.
- The named nurse provides continual support to critical care staff based on the High Dependency Unit, providing an annual update of Deprivation of Liberty Safeguard in May 2018, for a long term adult patient. This involves local authority staff visiting the young adult and her responsible adult to ascertain current health needs, assess mental capacity and consent for continued delivery of care. This process was updated May 2019

1.3 Policies & Procedures

Safeguarding Children Policy and Procedures

The Safeguarding Children Policy and associated Procedures were reviewed in line with the annual review process as recommended within the CCG quality assurance process and to reflect changes in National Guidance (HM Gov. 2018).

The policy was presented to the trust Clinical Quality Steering Committee (CQSC) on Tuesday 9th October 2018 to note the review and changes made formally and Re ratify the Policy and the procedures were re ratified in June 2019.

Safeguarding Adult Policy

The Safeguarding Adult Policy was reviewed in line with the CCG quality assurance process and Re ratified by the CQSC in October 2018.

MCA and DoLS Policy

The MCA and DoLS policy was first issued in January 2017 and will be due for a formal 3 yearly trust review in January 2020 or earlier to ensure it is reflective of any changes to legislation around DoLS provision. The Policy has had an annual policy review and re ratified by CQPG in October 2018. The policy is inclusive of Birmingham City Council v D&Another (2016) EWCOP8 New Judgement re 16/17yr olds)"

Domestic Abuse and Violence Policy

Domestic Abuse and Violence Policy, which is inclusive of NICE guidance was ratified at the Workforce and Organisational Development Committee on 19th April 2017. The policy underwent an annual review in October 2018

Prevent Policy

The Prevent Policy was reviewed in March 2018 as part of the trust internal 3 yearly review with a refresh of the Equality Impact (EI) Assessment. Ratification was gained at the April Clinical Quality Steering Group.

Looked After Children (LAC) Policy

The LAC Policy and associated SOPs were updated and ratified by CQSC in May 2019.

Safeguarding Supervision Procedures (Contained with the Safeguarding Procedures)

The Trust has a Clinical Supervision Policy that cross references with the Safeguarding Supervision Guidance, which sits within the safeguarding children procedures (Ratified via CQPG in June 2019).

1.4 Training

The Safeguarding Team provides mandatory safeguarding training for both clinical and non-clinical staff in accordance with the Royal College of Paediatrics and Child Health (RCPCH) standards, Royal College of Nursing (RCN), General Medical Council (GMC), Nursing & Midwifery Council (NMC) and The Working Together document (HM Gov. 2018).

The Safeguarding Training Strategy is based on the RCPCH and RCN Intercollegiate Documents, which provides a framework to indicate the level of safeguarding training required for individual staff groups. Currently to achieve compliance with safeguarding training, Alder Hey staff are offered opportunities for blended learning. However, the revised national guidance (Intercollegiate Jan. 2019) suggests specialist trusts such as Alder Hey should be accessing additional mandatory training, which would include more in-depth safeguarding children knowledge, safeguarding adults and Looked After Children. At the time of completing the AR a safeguarding training options appraisal is being considered by the executive team.

Alder Hey training figures for safeguarding mandatory training have met the 90% compliance target set by the CCG throughout the whole year. In addition, the safeguarding team has delivered additional internal targeted training, with topics reflecting Multi Agency 'Spotlight on' events.

To ensure maintaining full compliance is sustainable, the safeguarding trainer liaises closely with the learning and development manager and receives regular reports identifying all staff that are within 90 days of becoming non-compliant.

1.5 Governance

Governance Structure

Appendix II provides an overview of the safeguarding governance structure adopted by the Safeguarding Service within Alder Hey.

The Chief Nurse as the executive lead for safeguarding meets with the Assistant Director of Safeguarding on a regular basis. These meetings ensure the Board are fully up to date with all Safeguarding issues relating to Alder Hey.

The Assistant Director of Safeguarding produces quarterly reports which are presented to the Community Divisional Governance meeting. Key issues from this report are subsequently reported up to the Divisional Board and subsequently to the Executive Board by the Divisional Director or Chief Nurse as necessary.

The Safeguarding Team meet on a weekly basis to discuss and quality assure Child Protection cases being managed within Alder Hey. In addition, there is a formal peer review process with the Radiology Department on a quarterly basis. Arrangements for six monthly joint peer review with the Safeguarding Service from Manchester Children's Hospital ensures there is a consistent approach to the medical safeguarding investigation process by the two specialist tertiary services within the North West.

In relation to the children's SARC, there are bi-monthly Peer review case discussion meetings with the Rainbow clinical team and the Forensic Medical Examiners (FMEs).

Any procedural issues identified within the various case discussion processes are subsequently taken to the 'Rainbow Management meeting', which provides a forum for discussion of such issues with partner agencies. This meeting is chaired by the Named Doctor and is attended by partner agencies from Social Care and the Police from all the boroughs covered by the service. The meetings are also attended by the lead Forensic Medical Examiner.

The Safeguarding Governance meetings provide a conduit for effective information sharing within the organisation both strategically and operationally. Key information from the LSCB Strategic Boards and sub-groups services by Alder Hey are shared. Equally, internal

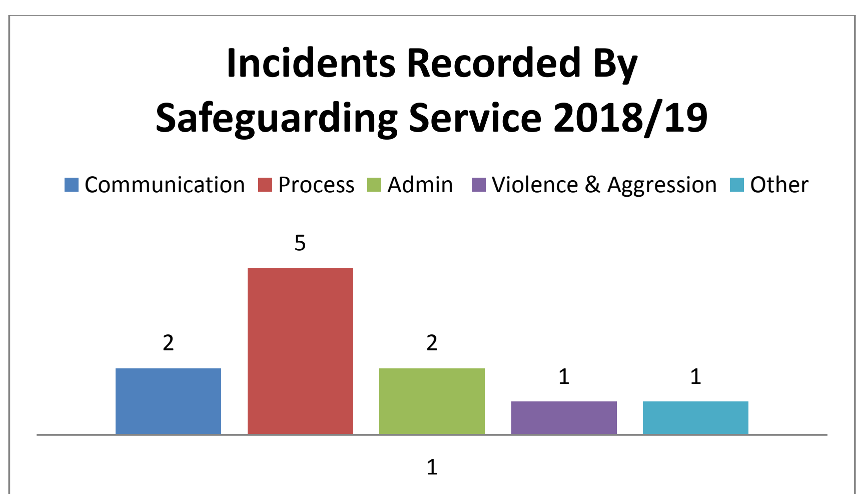
matters are addressed within this forum and progress of the Operational Safeguarding Work Plan is monitored.

There is a network of Safeguarding Champions who meet on a bi-monthly basis; the meetings are facilitated by the safeguarding nurse specialists and ensure effective information sharing and clinical supervision at an operational level is achieved.

The Safeguarding Team works in close collaboration with a number of specialist internal departments and other health agencies, such as partner NHS Trusts, GPs and Community Health Practitioners.

Incidents

There were eleven incident forms completed by the safeguarding service, the details of which can be found in Appendix (III).

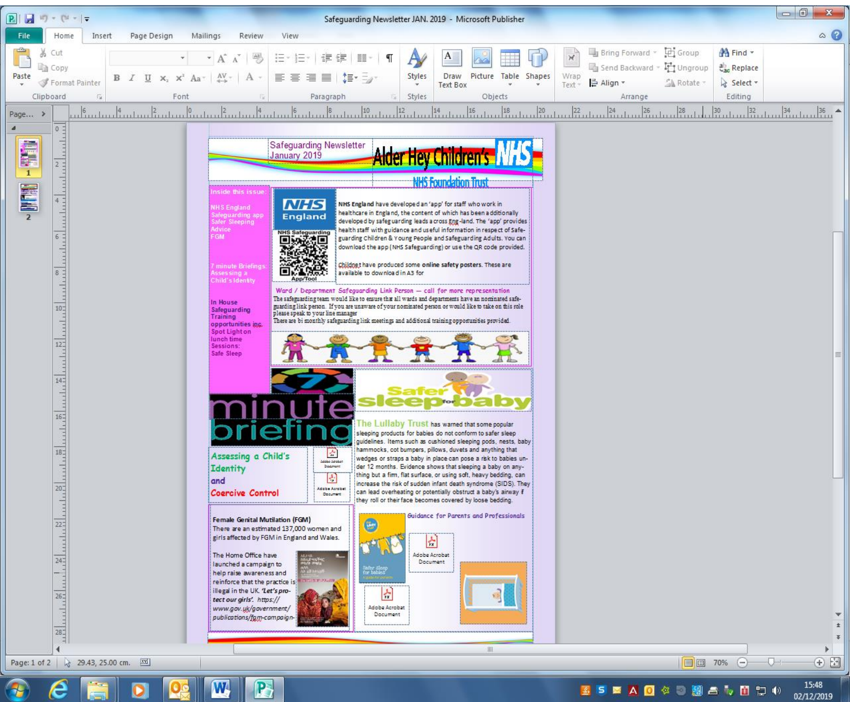


One of the incidents recorded as 'other', related to the use of "sleepyhead" sleep systems, which had been donated to the trust and were routinely being used by wards for babies. As per Pan Merseyside safe sleep (6 steps) campaign, supported by Public Health England, these pods/nests are not advised to be used for babies, as there is a risk they can cause babies to overheat and as such increase the risk of Sudden Infant Death Syndrome (SIDS).

- The AD for safeguarding contacted Alder Hey Charitable funds to inform them that the pods were being recalled. The Charitable Funds manager agreed to write to the

company who provided the items to advise of Health and Safety risk associated with the item.

- There was also an email request to Communications to request a network notice was created to recall all pods and request they are returned immediately to Charitable funds.
- Safe Sleep screensavers were circulated across the Trust.
- The January 2019 Safeguarding Newsletter, included the Lullaby Trust Safe Sleep messages



Complaints

There were two formal complaints related to the Safeguarding Service, the details of which are listed below together with the learning and outcomes.

- Ref:- SO04496

Summary of Complaint

2 part complaint

1. Parent complaining that safeguarding nurse amended minutes of professional meeting without agreement of the named Social Worker.

2. Parent reported a mobile recording device had been removed from the ward

Actions Included:
Nurse involved in the incident provided a statement re. Rational for amending minutes
Change in Practice:
Emphasised the importance of clear communication within a MDT to understand who 'owns' minutes and agree clear actions to be undertaken.

- Ref:- SO04974

Summary of complaint

Miscommunication between clinicians led to child's extended stay in hospital

Actions Included:
Doctor involved in complaint has reflected on issues raised and apologised for increased stress caused to the family due to his decision making.
Change in Practice:
Emphasised Importance of following agreed pathways

Recruitment and Vetting Arrangements

All job advertisements and job descriptions contain information relating to Alder Hey's role in safeguarding children and the expectation placed on all candidates applying to work within the organisation.

The HR department also take responsibility to ensuring HR department staff have attended safer recruitment training and this is then cascaded within their internal training programme. Three yearly DBS checks and/or the use of the DBS update service will be implemented at Alder Hey commencing 1st June 2019.

EFFECTIVE

2.1 Statutory Services Commissioning Arrangements

Clinical Commissioning Groups (CCGs) are the NHS commissioning organisations that operate under the legislative framework as set out under the Health and Social Care Act 2012 and came into being from April 2013. They are responsible for some of the commissioning responsibilities that were previously undertaken by Primary Care Trusts in England prior to 2013. CCGs equally have a range of statutory duties which include safeguarding children.

Each provider has safeguarding Key Performance Indicators (KPIs) and an audit tool built into the contract with the CCG. The information returned by the providers is scrutinised by the safeguarding service and discussed as part of the Contract Performance/Quality Contract Meetings.
Over the past twelve months Alder Hey has submitted the Quarterly safeguarding quality indicators and supporting evidence as required.

Key Performance Indicators (KPI)

The safeguarding quality indicators and supporting evidence were submitted to the commissioners for each quarter within the agreed timescales. The Trust received a rating of 'Significant Assurance' for safeguarding and children throughout the 2018 / 2019 reporting period. A summary of compliance and the overall rag rating for 2018-19 is described below, together with the improved assurance rating from 2015 to date.
The full 2018 / 2019 feedback report is available in Appendix IV.

Organisation	Q1 (2018/19) Assurance rating			Q2 (2018/19) Assurance rating			Q3 (2018/19) Assurance rating			Q4 (2018/19) Assurance rating		
	C	A	T	C	A	T	C	A	T	C	A	T
Training			↔			↔			↔			↔
Gov P&P			↔			↔			↔			↔
Multi Agency			↑			↔			↔			↔
Supervision			↔			↔			↑			↔

Audit Tool			↔			↔			↔			↔
LAC			↔			↔			↔			↔
Overall			↔			↔			↔			↔

Key: C-Children. A-Adult. T-Trajectory.

Q4 Overall Assurance Rating 2018 - 19

Safeguarding Adults:

Safeguarding Children:

Q4 Overall Assurance Rating 2017 - 18

Safeguarding Adults:

Safeguarding Children:

Q4 Overall Assurance Rating 2016 - 17

Safeguarding Adults:

Safeguarding Children:

Q4 Overall Assurance Rating 2015 - 16

Safeguarding Adults:

Safeguarding Children:

Specialist Commissioning Arrangements for Children's Sexual Assault Referral Centre (SARC)

Commissioning responsibility for all SARCs within the North West sit with NHS England, Specialist Commissioning (Health & Justice) and KPIs are submitted on a quarterly basis. Compliance against each standard is discussed within a quarterly contract meeting.

Forensic Examinations are undertaken by a Rainbow Doctor (Community Developmental Paediatrician) and a Forensic Medical Examiner (FME). Liverpool Community Health (LCH) had previously been commissioned to manage the FMEs; however, since April 2017 management has transferred to Central Manchester Foundation Trust (CMFT). As previously reported the availability of FMEs continues to be of concern and has been raised within the NHSE contract meetings. CMFT are sighted on this problem and are providing alternative arrangements where there are gaps in the FME rota.

One of the safeguarding nurses has completed the forensic training course (FMERSA) and another is currently in training and due to complete in December 2019. It is anticipated that the service model will be amended to incorporate the increased nursing skills, which should have a positive impact on the current challenges. At the time of writing this report the Forensic Lead is completing a service delivery options appraisal.

The Children's SARC received funding to provide 22.5 hrs per week Psychological support and were successful in recruiting to a joint post working between T3 CAMHS and the SARC.

The SARC Psychologist post provides highly specialised assessment and therapeutic interventions to children, young people and their parents/carers who access the Paediatric SARC. In addition the post provides training and consultation to staff that input in to the Paediatric SARC and other professionals across a range of external agencies including: primary care, social care, education, and third sector organisations.

2.2 Multi-Agency Representation

Local Safeguarding Children's Boards (LSCB) have statutory responsibilities under Section 11 of the Children Act (2004). The Children and Social Care Act (2017) replaced LSCBs with new Multi Agency Safeguarding Arrangements (MASA); led by the three named statutory safeguarding partners; local authorities, chief officers of police and health (clinical

commissioning groups). All agencies have a shared and equal duty for new safeguarding arrangements and promote the welfare of children.

Alder Hey has retained a seat at Sefton's Main Board and is represented by the AD for Safeguarding. Following publication of the revised MASA arrangements Liverpool Local Safeguarding Partnership (LSCP) have extended an invitation to some health providers to attend their LSCP Forum, which includes Alder Hey. The Director of Nursing and the AD for Safeguarding will share representation.

Alder Hey is represented on the following multiagency groups:

- Merseyside safeguarding Provider Network (first meeting 18 May 2017);
- Multi Agency Child Exploitation;
- LPool & Sefton Audit Group Sefton LSCB;
- SUDiC Implementation Group;
- Child Death Overview Panel;
- Sefton New Models of Practice T&F Group;
- CHANNEL (Prevent statutory duty)

2.3 AUDIT

Safeguarding Audits

The Safeguarding Team developed a robust audit plan for 2018/19 which was monitored and updated following monthly team meetings. This assisted in ensuring regular updates were provided

LSCP/Multi Agency Audit

Sefton Multi-Agency Audit – Child Sexual Abuse in the Family Environment

Main findings

1. The voices of child victims of sexual abuse within the family environment were largely absent
2. There was a lack of professional curiosity in many of the cases
3. It was not clear why, in many of the cases, that a strategy meeting was not held
4. Information sharing and coordination between agencies was inadequate
5. In some of the cases, the original allegations of sexual abuse were lost and attention had turned to other matters

6. Although only six cases were audited, this was a worrying snapshot of practice and an unconvincing exercise that allegations of child sexual abuse in the family environment are being dealt with as robustly as they should

The evidence of the audit indicated that there is a whole scale partnership lack of awareness, understanding and identifying and responding to CSAFE. Alder Hey responded to the request to review current processes and provided a position statement in regard of CSAFE awareness.

Alder Hey Specific Audits

- Audit of intimate images stored on external media device (DVD) at the Paediatric SARC in Rainbow Alder Hey
- Audit of medical investigation into suspected inflicted bruising in children
- Survey Monkey Audit to measure compliance with sec. 11 standards, which was piloted within the ED
- Audit of staff adherence to safeguarding adults inpatient assessment tool for patients over 18 years

  Alder Hey Safeguarding Adults policy and Safeguarding Procedures advise that any adult who is an inpatient at Alder Hey for 48 hours or more should have a safeguarding adult assessment completed on Meditech. At Alder Hey NHS Foundation Trust we have a duty to protect all vulnerable individuals in its care; this includes adults as well as children/young people

  In conclusion further training and highlighting to staff of their responsibilities in regard of vulnerable adults has commenced. Safeguarding adults training is now part of mandatory training from January 2020
- Looked After Quality Assurance Audit

  As part of a measure to improve quality in the initial health assessments, there is a continuing audit. Assessments are measured against an audit tool which is based on the National tariff 2014-15

  The audit concluded that quality of IHA has improved from last year. The audit demonstrated the bare minimum needed for quality assurance but did not indicate

the level of improvement especially with the implications of the health issues identified. The number of reports to be reissued by the LAC Dr and Nurse is likely to increase, as they will be returned from the beginning of March 2019 if the health plan only has 1 word for an issue.

2.4 Safeguarding Newsletter

A quarterly newsletter is produced and cascaded to all staff through Communications team, as well as being available on the safeguarding intranet page.

The information shared includes 'hot topics' within safeguarding children and adults, learning from serious case reviews, training dates and news from local safeguarding boards pertinent to Alder Hey.

RESPONSIVE

3.1 Looked After Children

Alder Hey plays an integral role within the pathway for children who become Looked After (LAC), as we are commissioned to undertake an Initial Health Assessment (IHA) on all children who are new into care. In collaboration with the CCG, Alder Hey continues to work tirelessly to improve the quality of the assessments being undertaken and ensure a robust health screening process puts in place action plans to meet any identified health deficits. Guidance for the IHAs has been produced that reflects some recent changes in practice and gives clear guidance to professionals when completing IHAs which results in a better quality report. In addition, competencies in the clinical assessment of looked after children and adoption for specialist trainees in the Department of Developmental Paediatrics at Alder Hey has been produced.

The Safeguarding / LAC team continue to improve the health assessment pathway for children entering the care system. The patient journey from child protection assessment, undertaken within the Rainbow Centre to assessment of children new into care has been modified to reduce duplication and improve patient experience.
IHAs are required to be completed within twenty working days of a child entering the care system. However, the pathway is reliant on collaborative working between Children's Services and various health providers to ensure timescales are effectively achieved. The 'Was Not Brought' (WNB) rate for children attending IHA clinics remains an ongoing challenge and is reported within the quarterly key performance indicators.
However, as a consequence of the poor attendance, the Department of Developmental Paediatricians is regularly asked to provide additional clinics at very short notice, which increases the demands on an already stretched service.

All initial health assessments are quality assured by senior clinical members of the LAC team and the Specialist Nurse. Strict criteria for quality have been agreed in all areas of the report to ensure a holistic overview of the child or young person is captured. The forms are pre-populated with any pertinent information available from social care and the online community record in order to capture immunisation history, birth and past health history.
Listening to and capturing the voice of the child and young person is continuing to influence our approach to the assessment and underpin effective health action plans, which will have a positive effect on the health outcomes of CIC.

Our understanding of the medical conditions which might affect children who are looked after is also increasing and leading to further enhancements of service provision.

Guidelines supporting testing for blood borne infection have been devised in conjunction with the lead consultant and nurse from the Department of Infectious Diseases and Immunology. In addition, guidelines reflecting nationally agreed protocols support clinical decision making regarding the investigation and treatment of Unaccompanied Asylum Seeking young people. The Level Four competencies agreed at intercollegiate level for clinicians undertaking this work is followed and our Lead Doctor for Looked after Children at Alder Hey is working closely with colleagues at a regional level to ensure consistency is achieved.

Alder Hey has devised pathways for reducing medicalisation, for example if a permanence medical is requested we look carefully at the information available and the length of time between initial health assessment and request for permanence medical. In some cases children do not have to attend for a second medical if there has been a short time space between IHA and request and we have all the required information. This is decided on a case by case basis by the medical advisor for the area taking into account the best interests of the child/young person.

All members of the LAC team are passionate about the health and well-being of looked after children and continue to strive for improvements in all areas of work at Alder Hey.

3.2 Child Death Review Process

Chapter 5 of Working Together to Safeguard Children (2018) has set out procedures to be followed by Multi-agency partners when a child dies.
There are two inter-related processes for reviewing child deaths.

- A rapid response by a group of key professionals who come together for the purpose of inquiring into and evaluating each unexpected death of a child;

and

- An overview of all child deaths (under 18 years) in the LSCB area undertaken by a Child Death Overview Panel.

The Merseyside Sudden Unexpected Death in Childhood (SUDiC) protocol deals with the rapid response component that is the immediate evaluation of the circumstances surrounding a child's death.

The Merseyside SUDiC Protocol is also utilised for cases where a child suffers an Acute Life Threatening Event (ALTE) if professionals involved in the case deem it to be appropriate, reasonable and proportionate. For this purpose the definition of an ALTE is:

Any sudden/unexpected collapse of an infant or child (0 up to 18 years) requiring some form of active intervention/resuscitation and subsequent intensive care / high dependency unit admission and it remains unexplained.

Using the SUDiC protocol for children fitting the ALTE criteria ensures effective early multi agency action, which underpins the 'Golden Hour' principle of securing significant material that would otherwise be lost to the Police investigation whilst also considering any wider safeguarding factors. All of which are undertaken with sensitivity, following the five common principles of the Pan Merseyside SUDiC / ALTE Protocol, especially when having contact with family members.

Alder Hey employs a Child Death Review (CDR) Specialist Nurse to lead on the reviews of both expected and unexpected deaths of any child or young person. The CDR specialist nurse is part of the wider Safeguarding Nursing Team based within the Rainbow Centre but has specific responsibilities for notifying external agencies of any child deaths that occur within Alder Hey.

A large part of CDR Specialist Nurse's role is to ensure Alder Hey staff are aware how to initiate the SUDiC / ALTE Protocol. She provides regular face-to-face, drop-in 'spot light on' sessions to teach and guide clinical staff. Equally, level 2/3 Safeguarding Training also incorporates information about the SUDiC/ALTE Protocol.

The CDR Specialist Nurse attends SUDiC / ALTE strategy meeting and completes reports for external agencies within established timeframes. In our locality the Pan Merseyside CDOP currently compromises of 5 local authorities including Wirral, Liverpool, St Helens, Sefton and Knowsley.

The CDR Specialist Nurse also attends the CDOP multiagency panel meetings/reviews, CDOP Business Meetings and SUDiC Implementation Group meetings. She represents Alder Hey at the Pan Merseyside Safe Sleep Group and contributes actively to Alder Hey's Mortality Review Group (HMRG).

The notification process via paediatric liaison and hospital/hospice staff continues to function extremely well. If a child dies at Alder Hey, a death notification is sent via Meditech to the Paediatric Liaison Nurses, who complete appropriate documentation (referred to as an 'A form'). Community Teams and the CDOP Manager become aware, thus generating a Sentinel system request to the Child Death Review Specialist Nurse. Within 15 working days the necessary documentation is completed and the form submitted. The Pan Mersey

CDOP has continued to use the Sentinel database system for the collection of information relating to the CDOP process.

Child Death Report Figures 2018-2019

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
Alder Hey Deaths	6	6	3	8	6	4	4	11	6	4	6	3
ALTE	0	1	0	1	2	1	0	0	0	2	1	2
SUDiC	1	1	0	3	3	1	3	2	2	2	1	2
Total Deaths	7	6	6	17	8	4	7	13	8	6	6	5

	Apr 18	May 18	Jun 18	Jul 18	Aug 18	Sep 18	Oct 18	Nov 18	Dec 18	Jan 19	Feb 19	Mar 19
B Forms Merseyside requests	4	3	4	9	9	4	11	8	7	4	5	5
B Form Merseyside complete	4	2	4	9	9	4	5	8	8	2	10	6
B Form Out of Area requests	2	2	1	3	3	2	1	7	1	6	1	0
B Form Out of area complete	2	2	1	1	2	4	1	9	1	3	4	3

Hospital Mortality Review Group (HMRG)

The Assistant Director for Safeguarding and the CDR Specialist Nurse attend Alder Hey's bi-monthly Hospital Mortality Review Group (HMRG). At the HMRG meeting Clinical staff from all specialties across Alder Hey discusses and categorise each death that has occurred, utilising a standard template to assist in the categorisation process.

The Chair of the HMRG has been working with external partner agencies to implement the reporting requirements set out within recently published, Child Death Review: Statutory and Operational Guidance (0ct 2018). This publication has been developed to assist in addressing a continual rise in the National paediatric mortality rates over the last 25yrs.

This guidance sets out the full process that follows the death of a child who is normally resident in England. It builds on the statutory requirements for child death review's set out in Chapter 5 of *Working Together* (2018) and clarifies how individual professionals and organizations' across all sectors involved in the child death reviews should contribute to the process.

The guidance aims to:

- improve the experience of bereaved families, and professionals involved in caring for children
- ensure that information from the child death review process is systematically captured in every case to enable learning to prevent future deaths

The process set out in the document runs from the moment of a child's death to the completion of the review by the Child Death Overview Panel (CDOP) or any equivalent arrangements put in place by child death review partners. This includes the immediate actions that should be taken after a child's death; the local review of a child's death by those who interacted with the child during life, and with the investigation after the child's death; through to the final stage of the child death review process which is the statutory review arranged by child death review partners.

The process is designed to capture the expertise and thoughts of all individuals who have interacted with the case in order to identify changes that could save the lives of children.

The reporting templates utilised by the HMRG has been revised and include "a Child Death Review Analysis Form", which once completed, is submitted directly into the Merseyside Child Death Overview Panel (CDOP).

The Merseyside CDOP has been set up by Child Death Review (CDR) partners, the Merseyside CCGs and Mersey side Council to review the deaths of children under the requirement of the Children Act, 2004 and Working Together to Safeguard Children 2018.

The purpose of the Merseyside CDOP is to undertake a review of all child deaths (excluding both those babies who are still born and planned terminations of pregnancy carried out within the law) up to the age of 18 years, normally resident in Knowsley, Liverpool, Sefton, St Helens and Wirral, irrespective of their place of death. Merseyside CDOP will adhere to the statutory guidance: Child Death Review Statutory and Operational Guidance (England) 2018

3.3 Fabricated or Induced Illness Protocol (FII)

Fabricated and induced illness is one of the most complex forms of child abuse. As a tertiary specialist centre, Alder Hey receive numerous referrals from both Primary and Secondary care providers relating to children and young people whose clinical presentation does not appear to follow the usual organic medical pathways. As such, the number of concerns relating to possible FII continues to grow and is sourced from a number of specialities.

Alder Hey follows guidance outlined within the Pan-Merseyside FII protocol, which includes the consideration of 'challenge' by health professionals where appropriate. This element is aimed to ensure that in circumstances where FII is suspected, a Lead Consultant is identified to offer the index family a comprehensive overview of all clinical findings from each medical speciality.

The Named Doctor/Nurse for Safeguarding and the Associate Director for Safeguarding take the lead role in managing all internal FII concerns and have on occasions played a key role in supporting professionals from partner agencies in their investigation of possible FII incidents. Reported concerns cover a broad spectrum, some of which have resulted in full multi-agency Child Protection investigations and others have been successfully managed within a containment strategy formulated by Alder Hey's Safeguarding Team.
Colleagues from Great Ormond Street Hospital have been recently working with the Royal College of Paediatrics to update the FII guidance and are going to promote the move towards utilising 'Perplexing Presentations' as a term of phrase, rather than FII. The revised guidance will also include a greater emphasis on incorporation of 'challenge' within the agreed pathway.

3.4 Safeguarding Adults

As a tertiary centre for specialist treatment including Cardiology and Neurology, young adults with complex health needs can remain under the care of Alder Hey, whilst safe and appropriate transient into adult services is identified. The safeguarding team ensure staff treating young adults are aware of changes to the law once someone becomes eighteen years and that due consideration is given to the MCA (2005) once young people turn sixteen years. The safeguarding team support colleagues to consider consent for eighteen years

and over patients, as well support when concern for safety, well being and risk is identified for this cohort of patients

A small audit completed in April 2019 looked at adult attendance between January and March 2019. The audit identified 113 adults between 18-23 years had attended in the time period, 21 were admitted onto a ward for between 1-12 days. The audit concluded that although staff followed general principles of safeguarding, they were not informing the Named Nurse for Safeguarding and just 40% had an adult inpatient risk assessment completed. This would identify who the 'responsible adult' is, able to consent, should the young adult not have capacity, any court orders in place and identify safeguarding risk

Following the audit specific training was delivered in relation to safeguarding adults and mental capacity act, awareness further raised within quarterly safeguarding newsletter and link nurses/practitioners provided with an update.

Although infrequent, the identification of safeguarding risk or a disclosure from an adult inpatient, the safeguarding team offer support to the individual and staff during any referrals to adult social care.

Domestic Abuse support has continued to be strengthened with the appointment of a safeguarding specialist nurse with experience within adult safeguarding. Her knowledge of Multi Agency Risk Assessment Conferences (MARAC) and risk assessment tools has ensured that parents who disclose they living in a coercive and controlling environment can be signposted to community support, alongside child protection procedures

In addition we have supported managers, whose staff have disclosed domestic abuse, working to formulate a risk assessment and supportive environment that enables them to remain in work and speak with Independent Domestic Violence Advisors (IDVA) whilst away from an abusive partner

PREVENT compliance has been maintained for 2018/19. Training is delivered via e-learning, with additional face to face dates offered where accessibility and learning styles may not be met online

The named nurse for safeguarding sits on Liverpool's CHANNEL panel. Adult and child cases where there may be evidence or concerns that an individual holds extremist views, may pose a risk to themselves, organisations or general public care they are risk assessed and monitored through review with a multi -agency panel.

3.5 Supervision

As part of the Safeguarding work plan for 2018/19 improvements in recording of supervision was identified as one of the key objectives. A series of supervision templates were subsequently developed to capture the following forms of supervision

- Reactive
- Planned
- Group

Where indicated, the supervision template is copied directly onto the child's electronic records.

The safeguarding duty nurse provides reactive supervision to staff across the trust where there is an urgent safeguarding need identified; working alongside the frontline staff to formulate a plan to reduce any immediate risk and plan for long term safety of the child or vulnerable adult

Senior ward staff who have long term inpatients who are Looked After/Child In Care or have a Child Protection Plan, meet with a member of the safeguarding nurses on a monthly basis to ensure ongoing safeguarding risk is managed and staff can reflect in a safe space when cases have been emotive or challenging.

The safeguarding specialist nurses currently hold a weekly drop in session within Rainbow Centre, where staff can bring cases to discuss and be supported to formulate a plan to contain or escalate to social care should information necessitate further safeguarding.

The safeguarding specialist nurses receive monthly supervision and managerial oversight by dip sampling cases to ensure a consistence approach and a high standard of work is maintained within the team.

The SARC psychologist meets quarterly with the administrative team and health care assistants to provide time for reflective within a safe space of cases that may have been difficult emotionally.

A priority for 2019 /20, is to further strengthen the safeguarding supervision offer across the trust. We have identified that CAMHS, Community specialist teams and Community therapists as a cohort of staff requiring a strengthened safeguarding supervision offer due to level of vulnerability within their caseloads.

3.6 Allegations of Abuse Against Staff

The Designated HR Officer for the management of allegations within the organisation and the assistant Director of Safeguarding lead on the incidents which are investigated following the MASA procedures.

During 2018 - 2019 there were fourteen concerns investigated under the allegations against a professional protocol. There were two of the cases where concerns were fully substantiated:

- Information was received from another trust which raised concerns regarding the suitability of a volunteer to continue volunteering at Alder Hey. The investigation process identified vulnerabilities in the individual's mental health and it was suggested they were not currently suitable to volunteer at the trust and the individual's contract was terminated.
- A concern was raised that a security guard had worked outside the remit for which they were employed when supporting a vulnerable patient. The incident was reported to the individual's employer and the LADO process followed. The investigation processes established that no harm had come to the patient but it was considered the security guard would not be suitable to work with vulnerable children, young people or adults.

Case example from one of the twelve cases not proven:

Allegation made by an in-patient alleging via social media to be in a relationship with an Alder Hey staff member. The Trust procedures for managing allegations was triggered and a full investigation undertaken. The allegation was found to be completely unfounded (when interviewed by the Police, the patient denied posting the message and alleged her social media account must have been hacked). The staff member was provided with support throughout the investigation process and a supportive debrief process was initiated for the staff member on completion of the investigation. The professionalism the staff member maintained throughout the process was to be commended.

CARING

4.1 Hearing the Voice of the Child

Children and Young People's Feedback

Friends and Family cards are utilised to collect service users' feedback

What was good about your visit?

Staff lovely

Toys

Nice staff

Welcomed by staff

Sharon was kind and explained everything

Staff were amazing to my little girl

The nurse was supportive and I wouldn't of done it

Made me feel comfortable

How could we have improved?

PlayStation

Chocolate biscuits and a cat

Nothing but stuff for older kids

You can't improve

Maybe a PlayStation to take their minds off what is happening

WELL LED

5.1 Identified Risks

Risk Register				
What is the risk	**New risk, update on risk, risk for escalation or closure?**	**Current Risk score and target score**	**Are all actions up to date?**	**Learning/Change of practice**
Challenges within the safeguarding nursing team to meet the increased demands	New Risk	9	yes	Risk remains open whilst agreement for additional resources are being negotiated
Challenges in covering the Rainbow Rota due to reduced medical availability	New Risk	9	yes	Risk now closed as new group of trainees have commenced plus additional resource from trainee undertaking spin rotation and recruitment of a Physician Associate
Clinicians are not able to attend strategy meetings that are held off site	New Risk	6	yes	Risk now closed as spider telephone has been purchased to enable dial in facility

5.2 Learning from Significant Safeguarding Investigations

'Working Together to Safeguard Children' (HM Gov. 2018) is national statutory guidance which gives Local Safeguarding Children Boards a responsibility to develop a Learning and Improvement Framework. This framework sets out responsibilities for "professionals and organisations involved in safeguarding children to reflect on the quality of their services and learn from both their own practice and that of others". The framework also sets out the various processes for reflecting on cases where children have died or been seriously harmed and how learning from these cases should be shared.

As described earlier, Alder Hey has a large catchment area and provides secondary health care for the boroughs of Liverpool, Knowsley and South Sefton. It is also a tertiary referral centre for specialist services with a specialist Paediatric Intensive Care Unit which receives patients from the local and regional areas, e.g. North Wales, Merseyside and Cheshire, and across the wider North West. Within the provision of this highly specialist service, Alder Hey manages some of the most serious and complex child protection investigations across the Country. As a consequence of this, the organisation is required to contribute to Serious Case Reviews (SCR) and other multi-agency Practice Learning Reviews (PLR) initiated both locally and from surrounding Local Authorities.

During 2018-2019 the safeguarding team were requested to provide information on thirteen cases, which were being considered by various LSCB Serious Incident Groups (SIG) across the Region for the possibility of the case meeting the threshold to undertake a SCR. This was a slight reduction from the previous year (15).

Seven of the cases were felt to meet the threshold for undertaking a SCR. Whilst a further two cases were not felt to meet the required threshold, it was thought that some learning could be identified, therefore 'Practice Learning Reviews' were undertaken by the relevant LSCBs.
Alder Hey safeguarding service is required to contribute to both the SCR and the PLR process, which includes providing detailed 'Internal Management' reports of Alder Hey's involvement with the child and their family and attendance at panel meetings to analyse multi-agency partnership working and identify any learning.

Summaries of the SCRs & PLRs undertaken in 2018/19 have been summarised below;

	Consideration for SCR	SCR	PLR
Liverpool	6	2	2
Sefton	3	1	0
Knowsley	0	0	0
Out of Area	4	4	0
Total	13	7	2

5.3 Service Challenges

- The unpredictable nature of Safeguarding with demands at both Operational and Strategic level
- Delivering a reactionary service with limited resources
- Impact of Limited FME availability
- High WNB rate within the Statutory Clinics
- Meeting Statutory time scales – Fast turnaround – timescale 20 days from beginning to end.
- Quality assurance demands
- External pressures with no additional resource – i.e. No. of KPI's
- Increased complexity of service requirement
- The Commissioning arrangements, for meeting with prospective adoptive parents are unclear.
- Due to clinical demand, non-urgent work streams cannot be prioritised – training/QA/reform of policy

5.4 Vision for Service Improvement

- Strengthen capacity to meet increased service demands
- To further embed understanding of the wider safeguarding agenda across the organisation i.e. Adults, PREVENT, Contextual Safeguarding, Professional Curiosity
- To review the safeguarding supervision framework to ensure all specialist services are adequately supported.

- 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 i.e. Apprentice program, Sefton Community services
- Formulate an options appraisal to meet safeguarding mandatory training demands
- Work towards centralisation of the LAC service
- Review of Commissioning arrangements to take account of continued increase in statutory clinic requests
- Commissioned service for conversions
- Consider use of skill mix to improve service delivery
- Implementation of LAC training strategy

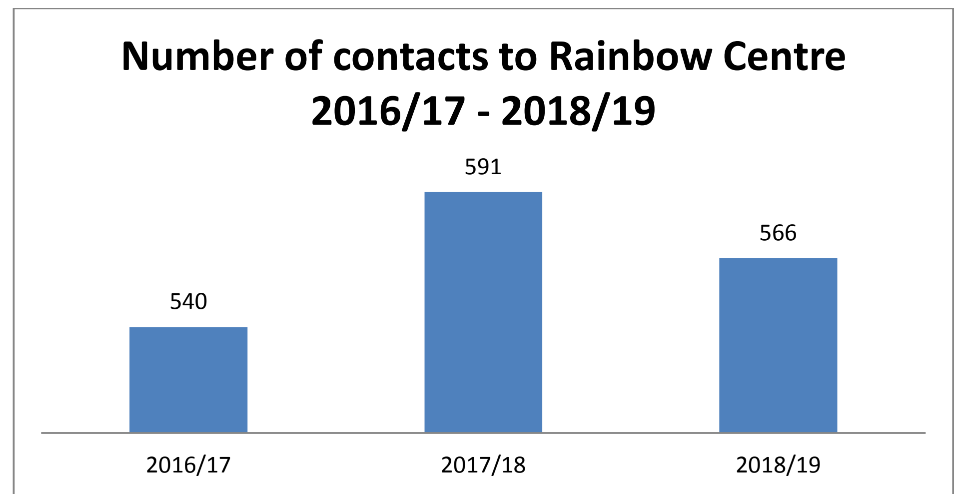
5.5 Executive Oversight

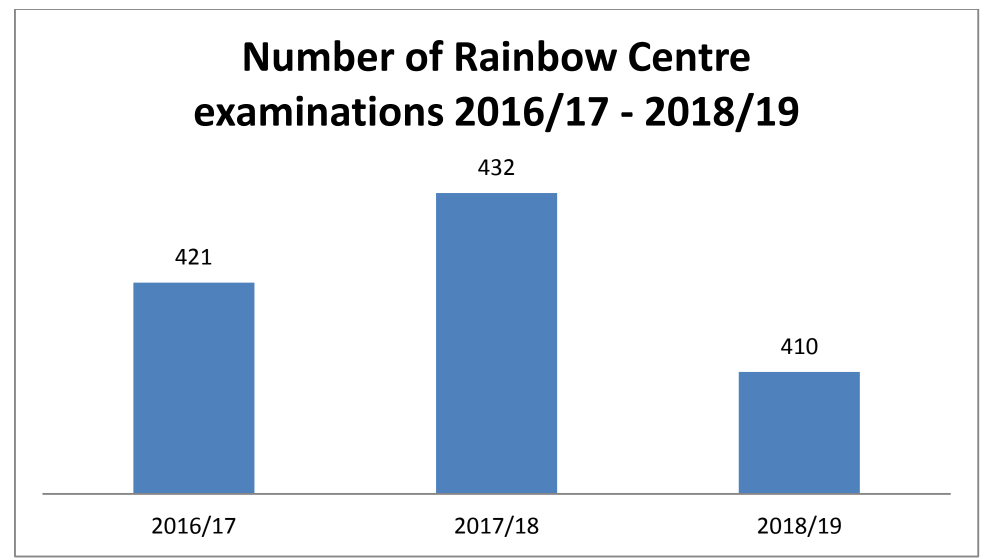
In November 2017, the Alder Hey Executives, Heads of Quality and Divisional Leads undertook a Quality Visit to the Rainbow Centre to review the Safeguarding and LAC Services. This process was repeated in July 2019 and as part of the visit a presentation was given by the Statutory Services team members to provide an overview of service delivery.

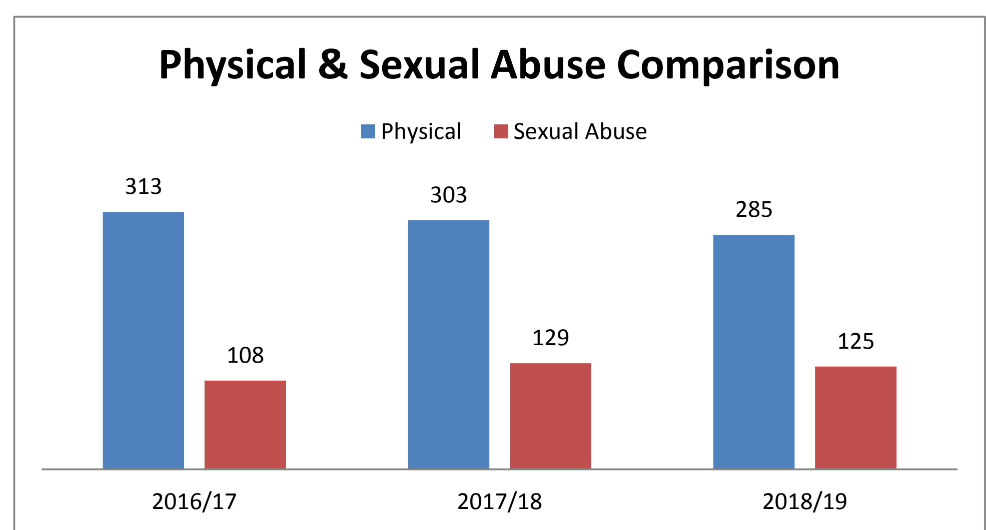
5.6 What makes us Proud?

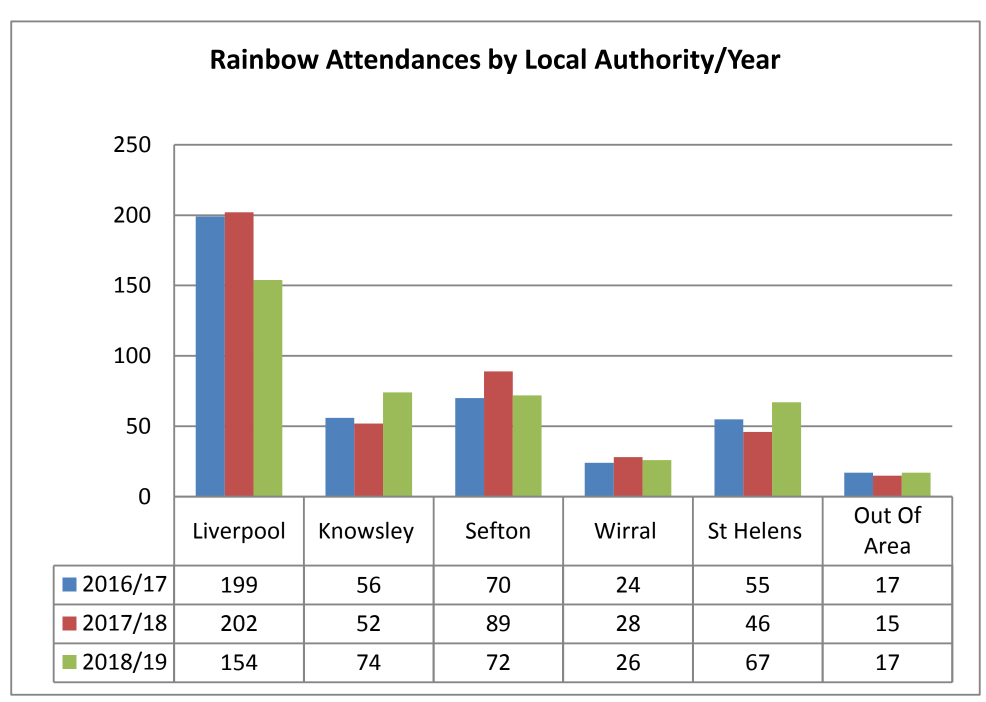
- Successfully Safeguarding our children, young people and vulnerable adults
- Achieving significant assurance from the commissioners
- Safeguarding- training compliance achieved and being maintained.
- Presenting at National Conferences
- Our team - Staffing improvement/ different skill mix.

Appendix I



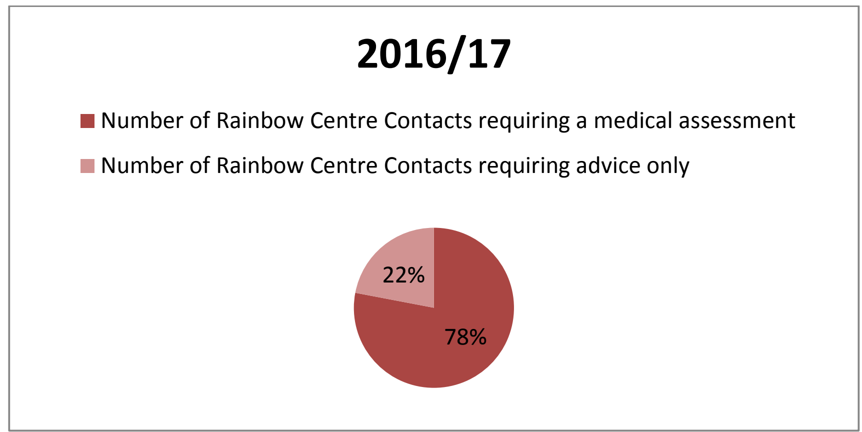


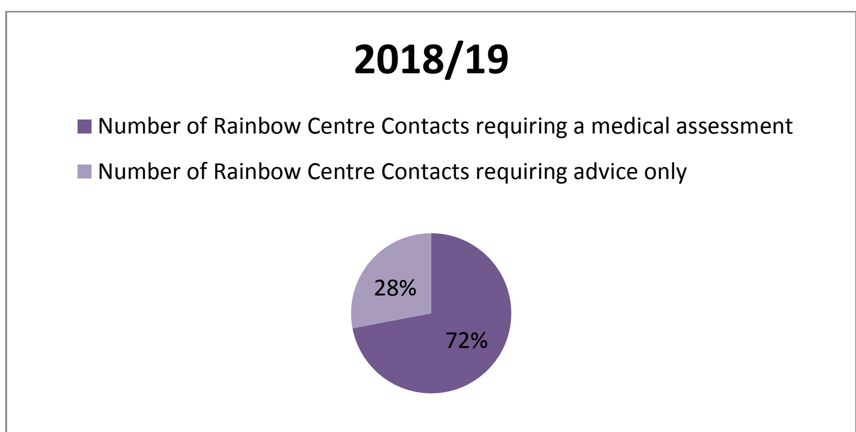


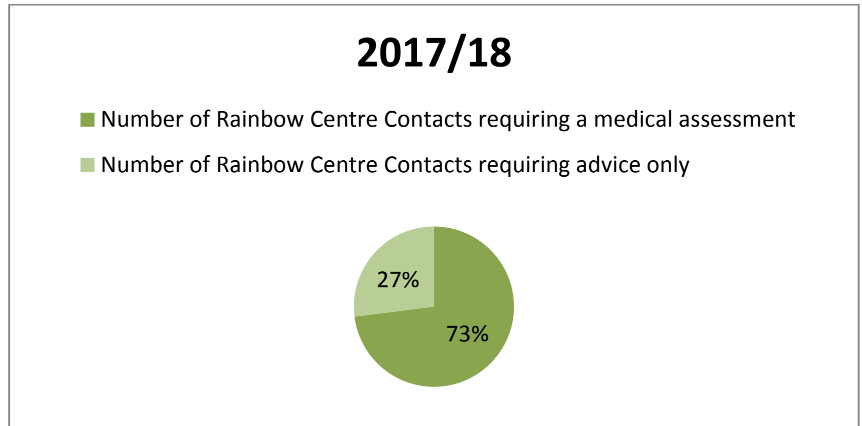


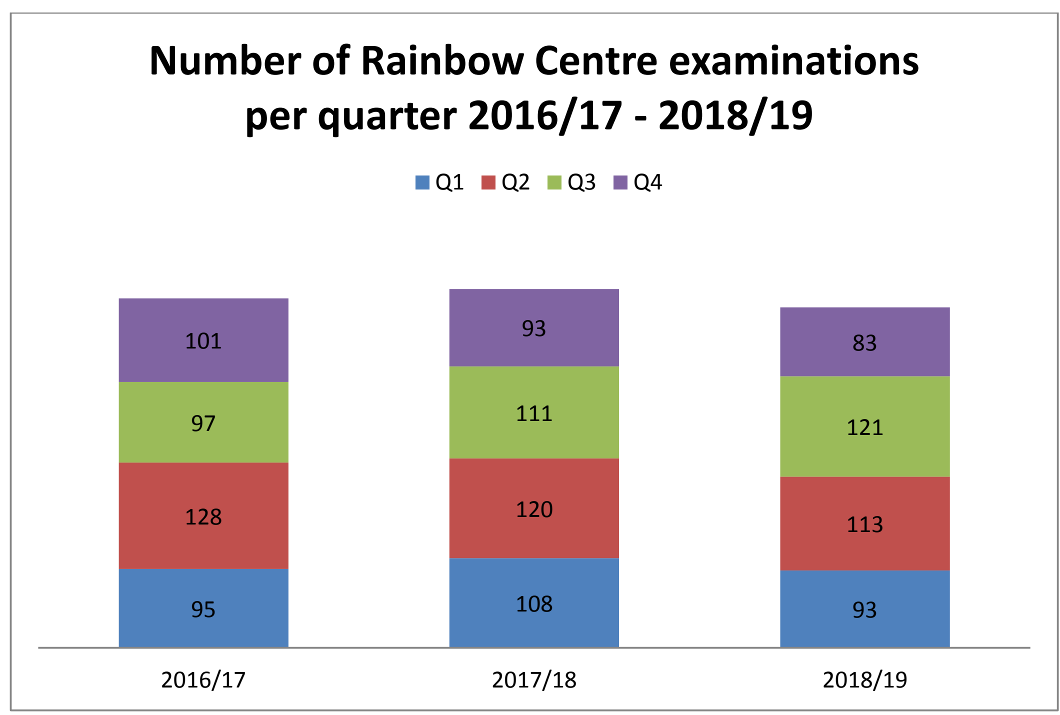
	Liverpool	Knowsley	Sefton	Wirral	St Helens	Out Of Area
2016/17	199	56	70	24	55	17
2017/18	202	52	89	28	46	15
2018/19	154	74	72	26	67	17

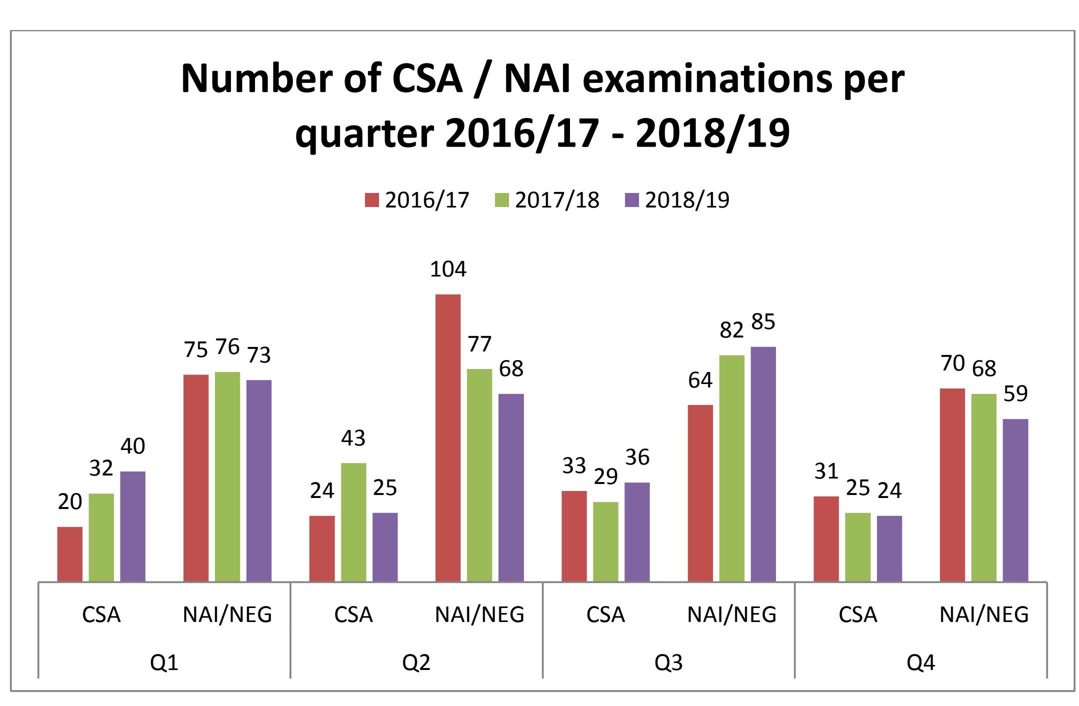
Percetange of Rainbow contact requiring examination or advice only

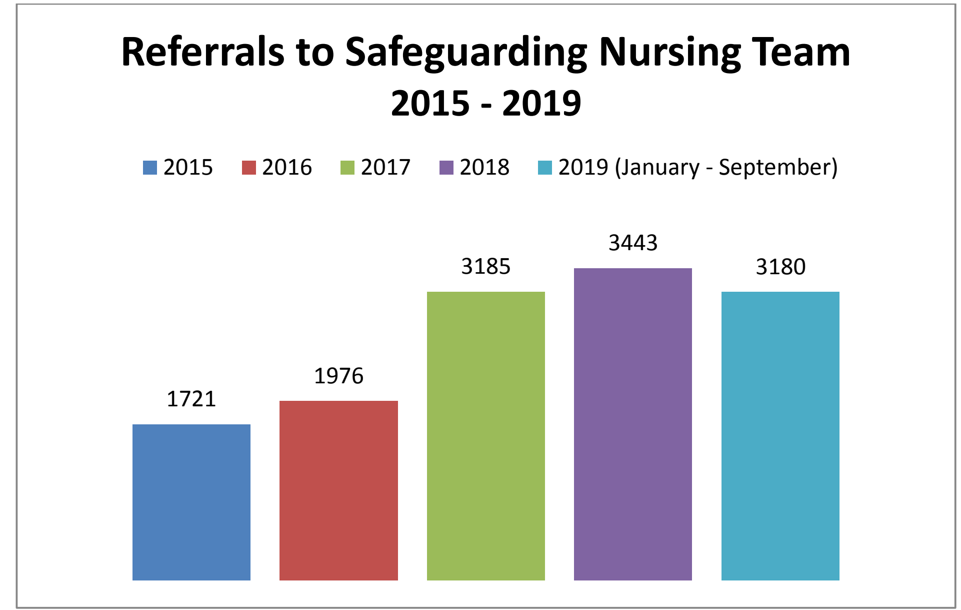


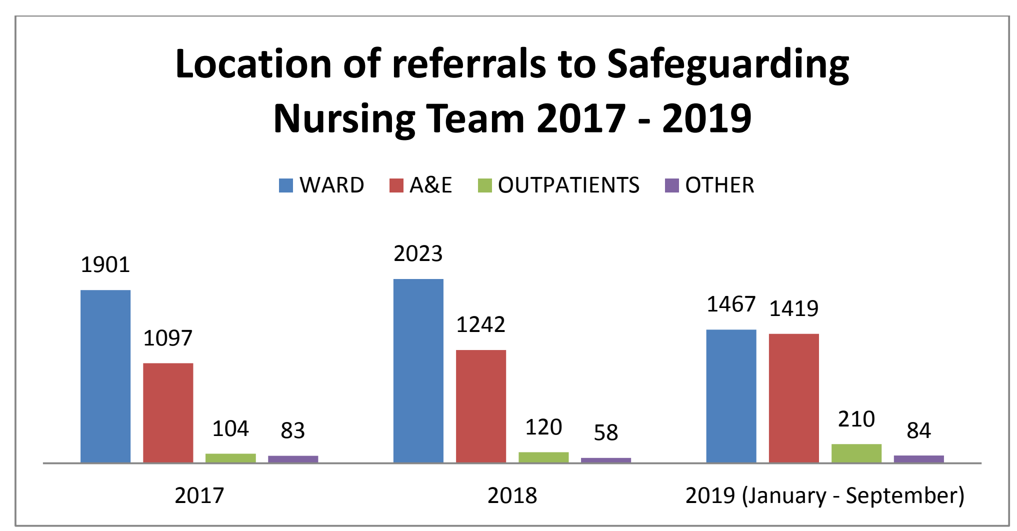


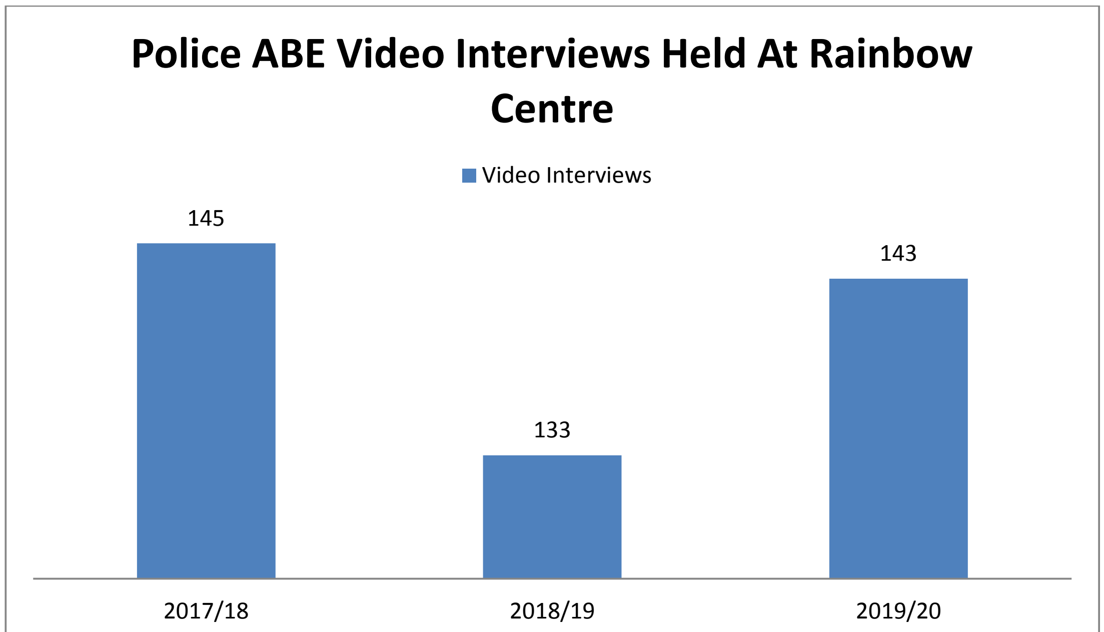



Number of Rainbow Centre examinations per quarter 2016/17 - 2018/19
Q1
Q2
Q3
Q4
101
97
128
95
93
111
120
108
83
121
113
93
2016/17
2017/18
2018/19


Number of CSA / NAI examinations per quarter 2016/17 - 2018/19
2016/17
2017/18
2018/19
20
32
40
75
76
73
24
43
25
104
77
68
33
29
36
64
82
85
31
25
24
70
68
59
CSA
NAI/NEG
CSA
NAI/NEG
CSA
NAI/NEG
CSA
NAI/NEG
Q1
Q2
Q3
Q4


Referrals to Safeguarding Nursing Team 2015 - 2019
2015
2016
2017
2018
2019 (January - September)
1721
1976
3185
3443
3180


Location of referrals to Safeguarding Nursing Team 2017 - 2019
WARD
A&E
OUTPATIENTS
OTHER
1901
1097
104
83
2023
1242
120
58
1467
1419
210
84
2017
2018
2019 (January - September)


Police ABE Video Interviews Held At Rainbow Centre
Video Interviews
145
133
143
2017/18
2018/19
2019/20

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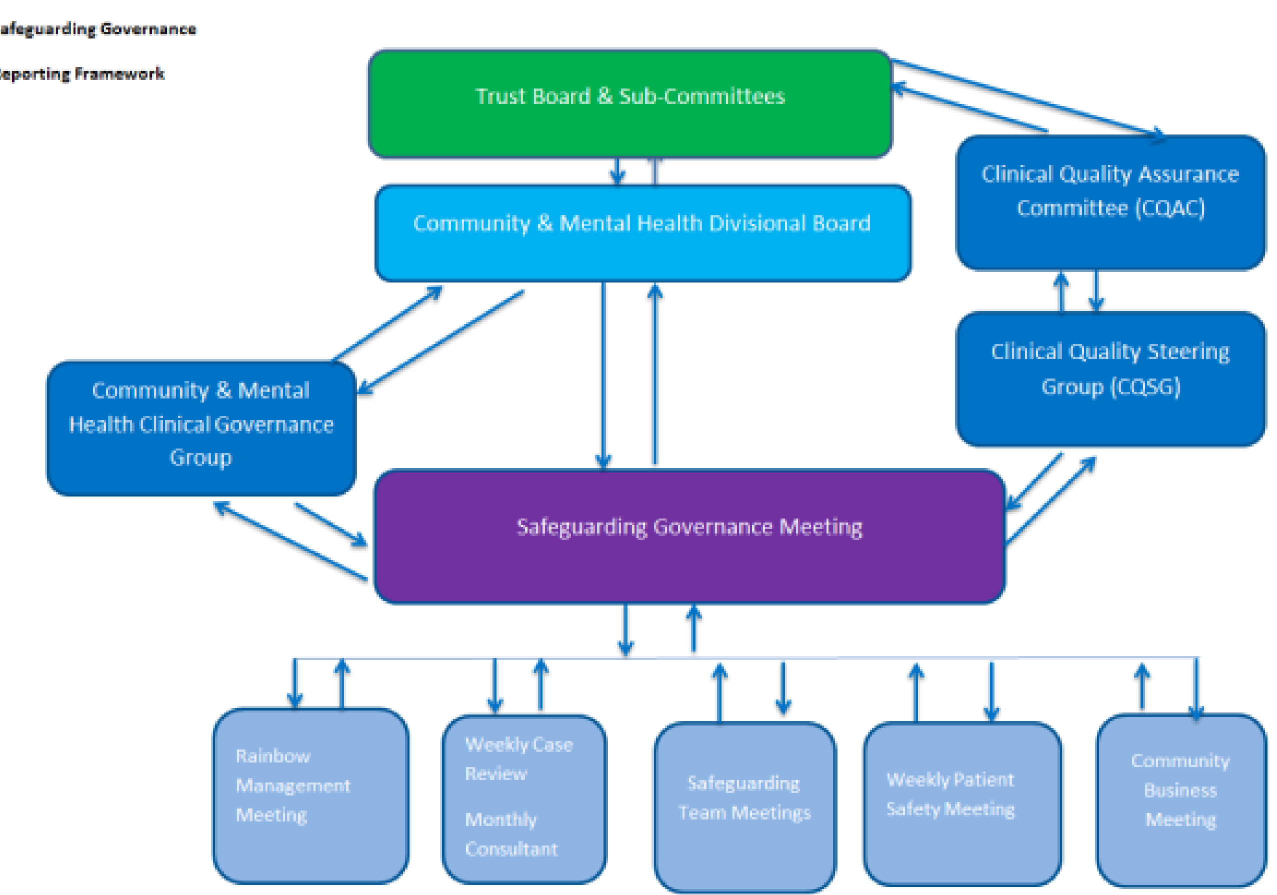
Appendix II



Safeguarding Governance Structure

Appendix III

Incidents Completed by the Safeguarding Service (11)

Date	Incident Number	Details of Incident	Feedback / Learning
23.05.2018	29335	school nurse order was submitted on 23/05/18 and was submitted to the school nurse liaison team in Ormskirk - the order contained incorrect clinical safeguarding training Information relating to another patient. The information did not contain any identifiable patient demographics. Alder Hey was notified of this via the Ormskirk school nurse liaison team on 04/06/18. The information has now been sent on the correct patient.	Importance of checking all patient information is correct is reinforced within safeguarding training
28.06.2018	29892	Automated letter generated in Medisec via Meditech for Comm. Paeds and RBow have been deleted by an admin person – Numerous patients involved	Pathway coordinator has raised an issue that letters not relating to safeguarding were appearing on her worklist She had sought advice how to manage the situation whilst an IT solution was found but inadvertently deleted letters instead of redirecting to the correct department. Informed by transcription that letters were successfully retrieved.
29.06.2018	29872	Voicemail left on my mobile 29/6/18 at 18:48 by a GP (name given but no phone number or place of work) referring a 6yr old child (name given but no other details) out of hours to Rainbow for assessment of whether a discrete skin lesion on the arm was non-accidental or sunburn. The GP stated she had asked the family to attend and she was going off her shift. The child had been sent home with Mum and no mention was made of single Point of Referral	Situation escalated to named GPs in all areas regarding appropriate referral processes
30.08.2018	30881	The resuscitation grab bag requires a 05.09.18 full stock check including replacement of out of date stock on the 28th of each month. Bag has been checked daily but had not been opened. Advised staff member what is required, replacement stock is available on level 2 store cupboard by the tree house - code 2222.	Band 5 Staff Nurse I have investigated this issue and been informed by staff within the department they were not previously made aware it was their responsibility to open the grab bags and check by the contents and that this role was undertaken by a member of the rhesus team. I have emailed the Rhesus team to request departmental staff training on checking the bags is facilitated asap
30.09.2018	31533	Telephone call received from parent	Complainant known to have mental

		very abusive concerning staff. insisted that I contacted Merseyside Police to arrest (Community Matron) she also demanded that she wanted palliative care consultant to visit her today as she had a poorly sick child. Mother said she was going to sue Alder Hey and Resp Consultant. Mother would not give me details of child's surname.	health problems. Situation escalated to social care and child adequately safeguarded. Staff member provided with support
23.10.2018	31937	Child brought to Rainbow SARC for examination accompanied by mother, maternal grandfather and maternal uncle. There was very poor communication from the Social Worker who did not share with Clinical staff their intention to invoke a Police Protection Order and have the child removed to foster care once the medical examination was complete. Police turned up to the department unannounced causing distress to the family. Staff within RBow should have received prior notice of social cares intention to request a PPO in order to manage any potential risk.	Incident escalated to Manager Nurse Consultant For Safeguard within Children's Social Care. I advised her re. poor communication and attitude of social care staff member having a detrimental effect on the patient experience within the RBow centre. The Manager to escalate to the social worker's manager and accepts there was missed opportunities to communicate with RBow clinical staff. Communication notice will be sent to Social Care staff to emphasise the importance of including RBow in strategy meetings.
30.10.2018	32049	Patient A was required to attend radiology for repeat skeletal survey. Requested RBow to assist as per Nat. guidelines we are required to have an independent paediatric trained staff member present. The RBow team unfortunately did not have anybody free, therefore the only option was to re book the appointment	Appointments must not be cancelled due to revised guidance. Where possible RBow HCA to support skeletal survey/ Radiology to escalate to management need to obtain additional staff resource
21.11.2018	32477	"Sleepyhead" sleep systems/nests/pods and wards are using these for babies. As per Pan Merseyside safe sleep (6 steps) campaign, public health England these pods/nests are not advised to be used for babies. These can cause babies to overheat and increases the risk of Sudden Infant Death Syndrome (SIDS). There are British standards for cot mattresses there are no such standards for pods/nests etc. We have rolled out the 6 steps to safer sleep across the trust and these pods go against the message. There have been deaths within Merseyside attributed to the use of these systems. Staff have reported that during a baby event outside of the trust - parents were overheard saying "these are used by Alder Hey". I do not feel we should be promoting the use of	Decision made to recall all sleepy head pods. AD for safeguarding contacted lullaby trust and charitable funds to inform them that pods were being recalled. Charitable funds manager agreed to write to company who provided the items to advise H&S risk associated with item. Email to Comms to request a network notice was created to recall all pods and request they are returned immediately to Charitable funds. Request made to Comms to provide safe sleep information as screensavers. Request made to Director of Nursing for Child Death Review nurse to attend the Senior Nurse forum to provide information re. safe sleep

		these	
27.12.2018	32979	Patient attended for follow up skeletal survey (NAI) as instructed by social care. Radiology had not been informed that the follow survey had been booked. In addition, there wasn't a nurse available from Rainbow to assist the examination This information was then passed to social care and family who attended Radiology on the agreed date / time.	case reviewed and can confirm Radiographer both first and second skeletal survey booked via MEDITECH system. Consultant who made booking has also confirmed she spoke directly with Radiology as per RCR guidelines. and agreed date / time of second skeletal survey.
08.02.2019	33766	Forensic medical examination was completed Friday 08/02/19 by FME and paediatrician. The following samples were taken - urine pregnancy test, and Chlamydia /GC PCR Swab. The samples were left in the Rainbow department on the 08/02/19 and only delivered to the lab on Monday 11/02/19 when the samples were discovered.	Spoke to clinical staff Staff Nurse involved in error and it was confirmed to be human error Clinical staff member was aware of usual expected practice for the transporting of samples to the lab. I made enquiries with ED regarding the use of their pod system and they confirmed they would be happy for Rainbow staff to access their system if required.
31.03.2019	34652	Patient had not returned to ward at JG - 1400. Staff nurse went to rainbow to see where patient was as no communication to the ward. Staff nurse told that patient had left with social worker. When discussed with Rainbow consultant on call, he stated that he advised for patient and social worker to return to the ward. This was not done. Social worker under the impression that because rainbow discharged the patient would be discharged home. This was not the case. Discussions with careline and general paediatrician on call in relation to safety of child and needing a medical review today to formally discharge the patient. Social workers have agreed to book a taxi, inform the family and bring them back to the ward for safety advice.	Trust Risk Manager - Safety Alert 08/05/19 - disseminated to Trust staff (attached).

Alder Hey Children's NHS
NHS Foundation Trust

Appendix IV

Alder Hey Children Hospital
Quarterly Analysis Report
Quarter 4 Financial Year 2018-19

RAG Rating Key:

(Green)	Significant (Green) – evidence to validate a 'significant' rating assessed submission of evidence e.g. policy, procedures, documents, audits where processes, policies and systems meet fully compliant criteria, to mitigate a corporate or strategic risk.
(Amber)	Reasonable (Amber) – Reasonable ratings in the context of assurance on controls are clear documented processes and systems which are evidenced by receipt and oversight through internal governance systems (e.g. Clinical Governance Committee minutes received by the Board). For example using an action plan e.g. Subject to progress through a formal committee for and approval as mitigating a corporate or strategic risk.
(Red)	Limited (Red) – Limited assurance is usually gained from draft plans, strategies and policies are yet to go through formal ratification, risk assessment or dissemination. These tend to be control documents which spell out what will happen, when things will happen and what resources are needed but do not carry any weight due to the lack of sign off.

Safeguarding Training *(Children , Adults, MCA / DoLS, Prevent, Physical Intervention)*	**Safeguarding Adults:** (Green) Q4 2018/19 Compliance threshold has been achieved for Safeguarding Adult Level's 1, 2, 3, & 4 and MCA/DoLS training for the fifth consecutive quarter (Q4 2017/18 & Q1 & Q2 & Q3 & Q4 2018/19). **Safeguarding Children:** (Green) Although the ESR figures for Level 2 and Level 3 Safeguarding Children have not reached the required threshold for compliance it has been reported that the Safeguarding Team hold records of staff who have been trained within the last quarter that have not yet been loaded onto ESR that reflect that compliance has been achieved.

Safeguarding Training Cont.	Safeguarding Training	RAG	Additional Comments
	Safeguarding Children Level 1	92.8%	Q4 2018/19 Compliance threshold achieved
	Safeguarding Children Level 2	87.2%	Assurance has been given that the training compliance threshold has in fact been reached however the training figures have not yet been uploaded onto the ESR system.
	Safeguarding Children Level 3	87.5%	Assurance has been given that the training compliance threshold has in fact been reached however the training figures have not yet been uploaded onto the ESR system.
	Safeguarding Children Level 4 **MH/LD/Community**	100%	Q4 2018/19 Compliance threshold achieved
	Prevent Basic Awareness	92.8%	Q4 2018/19 Compliance threshold achieved
	Prevent Health Wrap	87.5%	Assurance has been given that the training compliance threshold has in fact been reached however the training figures have not yet been uploaded onto the ESR system.
	Safeguarding Adults Level 1	92.8%	Q4 2018/19 Compliance threshold achieved
	Safeguarding Adults Level 2	90.7%	Q4 2018/19 Compliance threshold achieved
	Safeguarding Adults Level 3	100%	Q4 2018/19 Compliance threshold achieved
	Safeguarding Adult Level 4	100%	Q4 2018/19 Compliance threshold achieved
	MCA / DoLS	92.2%	Q4 2018/19 Compliance threshold achieved
Governance (Policies SI's)	**Safeguarding Adults & Children :** All Children & Adults policies were submitted as part of the quality schedule during Q2 2017/18. They include relevant legislation and national guidance. • M3 Safeguarding Children Policy & Procedures **V8 2018-21** • M2 Safeguarding Adult Policy **V4 2018 - 2021** • M70 Domestic Abuse and Violence Policy		

	V1 2017- 2020 • Management of Allegations Procedures included in Policy **M3 V8 2018-20** • RM19 Prevent Policy **V2 2018-2021** • M69 Mental Capacity Act and Deprivation of Liberty Policy **V2.1 2018-2021**
Multi agency engagement	**Safeguarding Adults**: Multi agency engagement compliance thresholds have been achieved for Q4 2018/19. **Safeguarding Children:** There is clear evidence of multi-agency working. The metrics for multi-agency engagement have been achieved with the exception of attendance at one case conference however it is reported that a report was submitted in lieu of the relevant member of staff being able to attend. The conversion rate for safeguarding referrals has increased to 40% to single assessment, 45% to early help and the remaining 15% were no further action.
Safeguarding Supervision	**Safeguarding Adults:** Safeguarding adult supervision compliance thresholds achieved for Q4 2018/19 **Safeguarding Children**: All of the safeguarding children supervision metrics have been achieved. The CAMHS data set has again been included within the return. CAMHS02 metric for the number of referrals into CAMHs subject to plans (CP, CIC and CE) who go on to receive a service / treatment has not been achieved for Liverpool. South Sefton and Southport and Formby CCG's. Additional narrative has been sought for this metric.
Commissioning Standards 2016.17 Action Plan Q2 onwards	**Safeguarding Adults and Children:** The commissioning standards action plan has been submitted.
MCA/DoLS *(requests for authorisations,)*	**Comments:** 1 long term adult patient residing at AHCH has an authorised DoLS in place which requires renewal May 2019.

IMCAs (*and outcomes)*	
CIC/LAC	**Safeguarding Children:** Reasonable assurance remains for Quarter 4 with similar trends and narratives seen across all metrics and applicable to all CCGs. However, it has been a challenge this quarter for Liverpool and Sefton CCGs to review the KPI's due to AHCH data integrity issues, with additional data issues noted on a small number of metrics relevant to Knowsley CCG. Both Liverpool and Sefton CCGs requested the Trust resubmit KPI template on two occasions due to the original submission appearing incorrect. Whilst the third submission was an improvement in terms of quantative data, the lack of revised narrative has impacted on clarity. The CCGs recognise that there has been a change in personnel completing the KPI submission however data integrity issues have served to limit, to some degree, the CCGs consideration of assurance. CiC self-audit resubmitted with additional evidence provided. Whist it is positive to note a revised CiC Policy this remains in draft therefore associated standards remain rated Amber. Again a number of SOPs have been provided; this does present clearly to commissioners the Trust's vision to support a culture that recognises the needs of Children in Care, but the impact of such can only be demonstrated fully via robust audit and review processes. Training and Supervision offer appears to be continually evolving with the safeguarding/CiC team looking to implement a revised programme of training, inclusive of CiC training that demonstrates compliance with Intercollegiate Document for Looked After Children (March 2015), across the Trust starting Quarter 1 2019/20. Compliance with Initial Health Assessment (IHA) KPIs remains below threshold for all CCG areas with a slight downward trajectory noted for Liverpool CCG, whilst compliance for Sefton and Knowsley CCGs has seen an improvement. As always the CCGs recognise the impact of cancellation/WNB on both performance and requests for additional resource acknowledging the limited influence the Trust has on these factors. Data integrity issues have given rise to the need for additional discussions to ensure the Trust has implemented appropriate mitigation when considering compliance in context of current service offer. Quality Assurance of IHAs requires additional review; this is in terms of 100% compliance rating against data that appears incorrect when reviewing full suite of metrics, triangulation with community providers and recent business meeting discussions. All CCGs recognise the significant increase in request for services associated with children in care, particularly the request for Adoption

Medicals and Adult Health Clearances. Robust discussions are required between relevant Local Authorities, Children's Commissioners within CCGs and the Trust to consider the expectations on the current commission in light of continual increased demand. Supportive discussions between the AHCH safeguarding/CiC team and CCGs Designated professionals have further highlighted a requirement to reconsider the existing service model, alongside clinician job plans, to facilitate the on-going development of a continuously improving, good quality provision.

Other work flows: Lampard

Independent inquiry into child sexual abuse IICSA - *(Formerly Goddard)*

Quarterly Analysis

Organisation	Q1 (2018/19) Assurance rating			Q2 (2018/19) Assurance rating			Q3 (2018/19) Assurance rating			Q4 (2018/19) Assurance rating		
	C	A	T	C	A	T	C	A	T	C	A	T
Training			↔			↔			↔			↔
Gov P&P			↔			↔			↔			↔
Multi Agency			↑			↔			↔			↔
Supervision			↔			↔			↑			↔
Audit Tool			↔			↔			↔			↔
LAC			↔			↔			↔			↔
Overall			↔			↔			↔			↔

Key: C-Children. A-Adult. T-Trajectory.

Overall Assurance

Safeguarding Adults:

Safeguarding Children:

Rationale

An overall rating of significant assurance has been applied for Safeguarding Children and Adult.

From Q1 2019 a revised set of safeguarding KPI's has been introduced for all Liverpool CCG commissioned services. The KPI's have been agreed with the Trust and the CCG will also undertake an on-site Safeguarding Assurance Visit within the reporting year.

Actions to be taken forward

Safeguarding Children & Adults:

	Name	**Date**
Designated Nurse Children	Esther Golby	8.5.19
Designated Nurse Children CIC/LAC	Carlene Baines	31.5.19
Designated Nurse Adults	Carmel Hale	9.5.19
MCA DoLS Co-ordinator	Carmel Hale	9.5.19
Head of Safeguarding QA	Helen Smith	3.6.19

BOARD OF DIRECTORS

Tuesday 07 January 2020

Paper Title:	**Access to Specialist Mental Health Services Improvement Plan**
Report of:	**Lisa Cooper, Director Community & Mental Health Division**
Paper Prepared by:	**Rachel Greer, Associate Chief Operating Officer** **Kate Holian, General Manager**
Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ☐ Sustainability through **external partnerships** ☐ Game-changing **research and innovation** ☐ **Strong Foundations** ☐
Resource Impact:	None identified at present

1. Introduction

The purpose of this paper is:

- To provide an update to Trust Board on current access times for Specialist Mental Health Services (Liverpool & Sefton)
- Seek approval of an agreed standard for the measurement of access times and improvement plan to achieve these

2. Background

Alder Hey currently provides Specialist Mental Health Services (CAMHS) to children and young people living in Liverpool and Sefton as part of a wider partnership of mental health support offered including third sector organisations. However, increasingly children and young people are presenting with a wide range of complexities including undiagnosed neurodevelopmental problems, social and family difficulties and multiple adverse childhood experiences (ACEs), which have resulted in increased demand for Alder Hey CAMHS and led to an increase access times for assessment and treatment. Whilst access to CAMHS is a long standing national challenge due to increasing demand, acuity of problems and increased co-morbidity in presentation, as a lead provider of mental health services for children and young people Alder Hey is committed to improving access to CAMHS and developing a comprehensive, equitable offer for children and young irrespective of where they live or access education.

The current access system used within CAMHS is the Choice and Partnership Approach (CAPA). This is a clinical system which is used to ensure that children and young people access appropriate care and support. The aim of CAPA is to provide services to young people that are user-friendly, designed around their needs, accessible, safe and effective.

CAPA relies upon the principles of “Choice” and “Partnership” and works as follows:

- New young people who are referred to the service and their families are invited to an initial “Choice” appointment’. This appointment is a face to face appointment aimed at identifying what they want help with and reaching a shared understanding of the problems. From there a range of alternatives open to them can be offered, including other services, strategies they can use to help themselves, and any appropriate specialist CAMHS interventions.

- If the young person and family then choose to be seen for further appointments within the service, they are invited to book a “Partnership” appointment here the young person and families will work in partnership with the CAMHS professional to access specialist/therapeutic care and support.

Whilst Alder Hey uses the CAPA model within CAMHS there are no nationally agreed access times for CAMHS which has led locally to a variation in how long

children and young people currently wait for “Choice” and “Partnership” appointments across Liverpool and Sefton.

This paper proposes 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
- No average waits to be reported

3. Current Access Times

The current access times for CAMHS at Alder Hey are as follows (20 December 2019):

Choice	Liverpool	Sefton
Number of young people waiting for Choice	260	76
% of young people assessed within 6 weeks of referral (Choice)	28.5%	67.1%
Waiting times (weeks)	0-29	0-21
Partnership	**Liverpool**	**Sefton**
Number of young people waiting for Partnership	498	219
% of young people assessed within 18 weeks of referral (Partnership)	47.8%	59.4%
Waiting times (weeks)	0-63	0-60

4. Improvement plan

The proposed phased target plan for achieving the 92% referral to treatment target is as follows:

Measure	Staged Target 31 December 2019	Staged Target 31 March 2020	Final Target 30 June 2020
% referral to Choice within 6 weeks	50%	92%	92%
% overall pathway wait within 18 weeks (referral to partnership)	50%	75%	92%

Number of young people waiting over 52 weeks	0	0	0

To support compliance with the above access times both Liverpool and Sefton CAMHS have in place improvement plans which include the following:

- Increased staffing (over establishment) to reduce the impact of staff absence and turnover
- Implementation of evidence-based group interventions targeted at the specific needs of children and young people waiting for an appointment
- Increase in numbers of Choice and Partnership appointments being offered
- Reviewed all staff job plans to identify additional capacity
- Improved matching of children and young people to staff based on needs and skill
- Strengthening of the consultation model provided into the Local Authority and schools to provide improved management of cases at the point of referral
- Improvements in multi-agency care planning to support discharge/ transition of children and young people who no longer require CAMHS
- Robust Clinical Lead and Assistant Clinical Lead oversight of caseload management
- Review of all children and young people on current waiting list to ensure management of any identified risks, provision of interim support and allocation of appointments based on clinical need

5. Governance and Monitoring Arrangements

The agreed individual service improvement plans are designed to deliver safe, effective and evidence based Specialist Mental Health services within a maximum 18 week overall pathway for all children and young people referred to the services.

The agreed actions were developed using the current data available to the Community & Mental Health Division and are made with a number of key assumptions:

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

The action plan was agreed at the CAMHS business meeting and is monitored on a weekly basis within the division and bi-weekly through Operational Delivery Group. In addition, waiting times are reported through CCG contract monitoring processes and to relevant Liverpool and Sefton mental health partnership boards.

6. Next Steps

The Trust Board is asked to note the contents of this report and approve the agreed standard for the measurement of access times for Specialist Mental Health Services at Alder Hey.

BOARD OF DIRECTORS

Tuesday 07 January 2020
Part 1

Paper Title:	Joint Targeted Area Inspection Children's Mental Health (Sefton)
Report of:	Lisa Cooper Divisional Director Community & Mental Health Division
Paper Prepared by:	Lisa Cooper Divisional Director Community & Mental Health Division

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	N/A
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 currently identified

1. Report Purpose

The purpose of this paper is to provide to the Trust Board:

- The outcome of the Joint Targeted Area Inspection of Children's Mental Health in Sefton
- Provide assurance of actions taken in relation to recommendations regarding Alder Hey Children's NHS Foundation Trust.

2. Background

In 2016, Joint Targeted Area Inspections (JTAIs) were introduced and are short, focused inspections carried out on a multi-agency basis. The inspections are led by Ofsted and involve HMI Constabulary and Fire & Rescue Services; Care Quality Commission and Her Majesty's Inspectorate of Probation. The inspections are themed and have previously included Child Sexual Exploitation, Domestic Abuse, Neglect and Child Sexual Abuse.

From 23 – 27 September 2019, a JTAI regarding children's mental health in Sefton was undertaken. The inspection examined how local services respond to children living with mental ill health, including:

- Local authorities
- Schools
- Police
- Youth offending teams
- Health professionals

The inspection included the following areas:

- Evaluation of 'front door' services and how agencies are identifying and responding to children with mental ill health
- Deep dive inspection of how agencies assess and support the mental health of children aged 10 to 15 years old who are subject to child in need or child protection plans, or are a looked-after child
- The effectiveness of the support offered to individual children and of the multi-agency leadership and management of this work, including the new multi-agency safeguarding arrangements

The final letter regarding the outcome of the inspection was published on 18 December 2019 and can be found Here

3. Actions Identified for the Trust

As a result of the inspection the following actions were identified for the Trust:

- Access to Alder Hey Specialist Child and Adolescent Mental Health Services (waiting times) with a recognition that the partnership (CCG/LA) are aware of this and have not taken action
- Access to appropriate safeguarding supervision for mental health staff
- Lack of awareness across services of Crisis Care and Single Point of Access
- Provision of Speech and Language Therapy to Youth Offending Services
- Safeguarding practice and consistency across staff in identifying young people at risk
- Positive Behavioural Support (PBS) training for A&E staff
- Voice of child not being included in assessments and referrals
- Sharing of information with 0-19 services
- Lack of formal meetings between safeguarding and A&E staff

A number of good practice areas were highlighted for Alder Hey including: Camhelions group, looked after children health assessments, sharing information with agencies, commitment of staff to children and young people, child and adolescent mental health service offered to looked after children.

As a result of the inspection an internal action plan has been completed **(Appendix 1)** which has been submitted to Sefton CCGs. This will be included in a multi-agency action plan for submission to Ofsted by March 2020 via the Local Authority. The Trust's internal action plan 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.

5. Next Steps

The Trust Board are asked to note the contents of this report and to be assured that the Trust has in place an action plan to address the recommendations from the JTAI into children's mental health in Sefton.

Appendix One: Trust internal action plan following JTAI into children's mental health in Sefton

Number	Recommendation	Actions required	Impact	Lead	Completion Date	Progress
1	Waiting times for Specialist mental health services need to improve.	Develop and implement improvement plan to support timely access to specialist mental health services	Children & young people will access the appropriate specialist mental health service according to their needs within 18 week pathway	Service Leads CAMHS	30 June 2020	Improvement plan in place (Trust Board January 2020)
2	Ensure Ormskirk Hospital Emergency Department is aware of referral to on call psychiatry and Crisis Team cover.	Communicate arrangements and current offer of 24 hour on call psychiatry for Sefton and Liverpool to Ormskirk Hospital ED	Children and young people will be supported to access appropriate Crisis Care and support	Crisis Care Lead	01 October 2019	Completed Regular updates provided to Ormskirk Hospital
3	Alder Hey ED staff will have received training and will report as being competent in positive behaviour management techniques	Practice educator employed within ED to support training within	This will support staff in competency development of management	Service Lead A&E	September 2019	Completed

	when caring for children with extreme challenging behaviour.	service Positive Behaviour Support has been added to the mandatory training day	of children with extreme, challenging behaviour. To support staff in ED to feel in skilled and competent in managing presentations of mental health difficulties in the ED environment.	Service Lead A&E	31 January 2020	TBC
4	Speech and Language Therapy needs for children & young people known to the Youth Offending Team will be assessed and communication needs appropriately met.	SALT and Sefton YOT service to scope service offer for appropriate SALT intervention (not currently commissioned)	Young People known to YOT can access appropriate SALT support	Head of Speech & Language Therapy	31 March 2020	Meeting with YOT arranged for January 2020
6	Routine information-sharing between Alder Hey children's hospital and the 0–19 public health nursing service to "Go Live"	System and processes in place and "Go live" planned for 01 October 2019	Appropriate information is shared from Alder Hey to 0-19 services	Assistant Director Safeguarding	01 October 2019	Complete

7	Bi-monthly meetings will be reinstated between Alder Hey safeguarding team and ED.	Meetings will be scheduled on a bi-monthly basis. Information shared and actions recorded	Improved communication and information sharing between ED and safeguarding team which will ensure children & young people will be safeguarded	Assistant Director Safeguarding & Safeguarding Lead ED	24 October 2019	Complete
8	A dedicated risk assessment tool will be introduced in ED at the Ormskirk site which identifies children who may have poor mental health who self –harm (not an Alder Hey action).	Crisis Care lead to share Alder Hey self-harm assessment pathway with ODGH colleagues	To assist with identification of children & young people who present to Ormskirk ED with mental health difficulties	Crisis Care Lead	November 2019	Complete
9	The quality of safeguarding assessment will be consistent by ensuring staff are developed to demonstrate professional curiosity and voice of the child is included.	Safeguarding team to undertake a quarterly audit of ED staff recognition and adherence of	Evidence of the lived experience for children and young people who attend ED. Data to show	Assistant Director Safeguarding	Quarterly audits	Part of Trust audit plan and on track

		safeguarding procedures. This includes voice of the child and professional curiosity	impact of safeguarding training and where there may be gaps in professional knowledge or daily practice			
10	Improve the consistency of safeguarding practice in specialist mental health services.	Safeguarding improvement plan in place across Alder Hey Specialist mental health services since September 2019 which includes the recruitment of a Safeguarding Specialist post across mental health services	Children and young people accessing mental health services will be safeguarded and all safeguarding risk will be shared with necessary partner agencies Staff will be supported to challenge and escalate where there may be a discrepancy of professional opinion	Assistant Director Safeguarding & Service Leads CAMHS	31 March 2020	Recruitment to post underway Safeguarding supervision model commenced December 2019 Relevant policies/procedures updated to reflect CAMHS

BOARD OF DIRECTORS

7th January 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

The People Plan sets out the vision to create a healthy, psychologically safe, improvement-focused, compassionate, inclusive and learning culture to enable the delivery of outstanding care to our children and families. Key to the development and sustainability of such a culture are healthy, well supported staff who feel safe, connected to each other and valued for their unique role in the delivery of care at Alder Hey.

Whilst we currently have a range of support for our staff (including the Alder Centre, Psychological Services, HR & OD teams, Occupational Health) there is not consistency for all parts of the organisation coupled with a range of difficulties for some in seeking support depending on their role in the organisation and what it is they might need help with.

A proposal to develop a Staff Advice & Liaison Service (SALS) was approved at the Workforce and OD Committee in December 2019. This will be an enhanced staff support system to provide advice, guidance and support on a range of domestic and work related issues to complement the support systems already available. 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.

Pilot of a centralised 'wellbeing team'

Recruitment has begun into the core roles for the centralised Wellbeing team with the Band 7 lead role now appointed to. During January 2020 the HR team, in partnership with staff side colleagues and managers across the organisation, will develop a detailed structure and process to ensure we are providing the right support for our employees' psychological, physical and emotional wellbeing.

Star Awards

Nominations for the annual star awards closed on 6th December 2019; the Awards Evening will be held on Friday 7th February 2020. There were 294 nominations, with 28 teams/ individuals shortlisted across the following categories;

- Delivery of Outstanding Care
- Best People Doing Their Best Work in the Best Place
- Delivering Game Changing Innovation
- Delivering Game Changing Research
- Growing Sustainably Through Great Partnerships
- Strong Foundations
- Living Our Values
- Volunteer of the Year
- CEO and Chair Special Recognition Award

Strong Foundations

Three 'Strong Foundations' programmes have been delivered in 2019, with 10 more cohorts in place for 2020, supporting the leadership development of over 200 people across the organisation. As the programme progresses the team are developing the programme to ensure we meet the requirements of our staff and support the development of strong leaders across the organisation.

Talent management and succession planning

As we move into 2020 the HR and OD team will be developing the Trust's approach to talent management and succession planning in conjunction with our commitment to leadership development and a culture of learning. It has been identified that we have an aging demographic, and due to national issues including the reduced number of junior doctors and trained nurses in the pipeline the focus of the next 12 months will be identifying and developing our future talent.

Apprenticeships

There are currently 86 learners in the Trust registered as apprentices, 11 of which have been employed with us directly as apprentices. Discussions with City of Liverpool College have taken place to explore potential partnership opportunities. The team are preparing for an imminent Ofsted inspection of the Trust's internal provision.

Staff Network development and support

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

Staff Survey

The annual Staff Survey response period closed on the 29th of November 2019. Following on from last year's success in increasing our completion rate to 60%, we were keen to continue our year on year improvement and were aiming for an increase on this; the final response rate was 62%. This was over 140 more staff than completed the survey last year, from several different staff groups. As per the table below, the last 5 years have seen our completion rates increase from 35% to 62% which is a significant achievement.

2015	2016	2017	2018	2019
35%	39%	54%	60%	62%

As with previous years it is vitally important that we utilise the Staff Survey feedback to discuss ways to improve staff experience within the Trust and make important changes within the organisation to show that we are listening and acting upon staff feedback. We are currently exploring a number of different formats for presenting the results data back to divisions and departments to support them in having 'Big Conversations' with their areas which will help them to identify how they can improve as an area over the next 12 months.

Civility and Bullying and Harassment task and finish group

In response to ongoing feedback from staff survey, temperature checks and Listening into Action feedback a multidisciplinary team of HR and OD colleagues, staff side representatives and Freedom to Speak up Champions has been established to focus on the Trusts approach to supporting and promoting a culture of civility in the workplace and preventing the occurrence of bullying and harassment with the first meeting held of 31st October 2019.

Investigation & Disciplinary Review

Following Baroness Dido Harding's national recommendations into the review of practices relating to investigations and disciplinary cultures and practices, Alder Hey HR and staff side have agreed to the separation of the investigation process from the Disciplinary Policy with a view to incorporating this into its own policy and support framework. The focus is to ensure appropriate safeguards for an individual's dignity, health and wellbeing following on from when an issue is reported.

Summary of formal Employment Relations Activity – November 2019

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

Workforce KPI's – November 2019

- PDR: 89.3%
- Mandatory Training: 91.5%
- Sickness: 5.7% of which;
    - 1.9% Short term (1.8% in October)
    - 3.7% Long term (3.9% in October)

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

Title	**Liaison Committee Meeting Minutes**	
Date / time	Monday 22 July 2019, 1400hrs	
Location	Executive Meeting Room, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool L12 2AP	
Present	**Trust:**	David Powell (Development Director) **DP** Stuart Atkinson (Trust Associate Director of Estates) **SA** Rachel Lea (Trust Associate Director of Development) **RL** Graeme Dixon (Head of Building Services) **GD**
	Project Co Directors:	Alan Travis (Laing O'Rourke, Explore Investments) **AT** Neil Woodburn (John Laing Investments Ltd) **NW** Tristan Meredith (Interserve Developments) **TM**
	Other Project Co Attendees:	Andrew Saunders (Project Co Representative) **AJS** Carl Roberts (Interserve FM) **CR**
Apologies	Louise Shepherd (Trust CEO) **LS** John Grinnell (Trust Deputy CEO & Finance Director) **JG** Claire Liddy (Trust Representative) **CL** Andy Pearson (John Laing Investments Ltd) **AP**	

Item	**Discussion**	**Action**
1.0	**Quorum** – the meeting was quorate as defined within clause 12.1 of the PA.	**Note**
2.0	**Previous Minutes dated 16 April 2019** – The previous minutes were accepted as an accurate record of the meeting. **Action 3.2** – A meeting is to be arranged to discuss the current Energy Performance Contract ('EPC') proposal. The EPC has been added to the agenda of the next meeting of the Liaison Committee. **Action 3.4** – Project Co have reviewed the existing pipework corrosion mitigation strategy. The document remains live.	 **DP / AJS** **Note**

	Action 3.5 – AJS, GD & RL met on 14 May 2019 to discuss and review the Liaison Committee Terms of Reference ('TOR'). Project Co issued a draft TOR on 26 June 2019, at the time of meeting the Trust had not provided any comments.	**Note**
3.0	**Draft Terms of Reference**	
3.1 3.2 3.3 3.4	The draft TOR issued by Project Co on 26 June 2019 was approved by the members of the Liaison Committee. It was agreed that meetings would now take place quarterly. The Trust agreed to confirm Trust membership, this would allow Section 2 of the ToR to be updated. Once membership has been confirmed a final copy of the ToR would be circulated to committee members. A general discussion took place around Future Liaison Committee reporting requirements, focusing on improvements and a consolidated (Trust & Project Co) view. SA agreed to share a template report which could be used as the basis for future, related, joint discussions. Committee members briefly reviewed the existing "Partnership Charter". Attendees agreed that the document had been drafted at a point in time to deal with specific matters and that key contributors "were doing most of this now". Notwithstanding this, it was acknowledged that AJS & SA should revisit the survey element to see if this could be developed further to add value to future meetings of the Liaison Committee.	**Note** **RL** **SA** **AJS / SA**
4.0	**Key Issues / Hot Topics**	
4.1 4.2	Energy Performance Contract ('EPC') AJS updated Committee members as to the status of the EPC and advised Project Co would issue a formal proposal to the Trust in due course. Following issue of the proposal, a meeting is to be diarised to discuss the mechanics of the contract and also the underlying commercial arrangements. In terms of a general update on energy, AJS and GD confirmed that energy efficiency remained below the contractual target, GD agreed to provide Trust colleagues with further information in this regard. IFM's work around energy efficiency was ongoing through their energy bureau, regular updates would continue to be delivered to the Energy Efficiency Committee. Rainwater ingress AJS advised that the planned remedial works to roof light 1 (HDU) would commence on 24 July 2019 and subject to access would be completed by calendar month end. Committee members agreed that the alteration and / or dismantle of the protective canopies must be a managed event.	**AJS** **GD** **Note**

4.3	Theatre temperatures GD informed attendees that the issues being experienced with theatre temperatures were not related to the theatre plant, further investigative work was now underway working back to the energy centre.	**Note**
4.4	Water temperatures CR delivered a high-level update on progress with improving water temperatures through IFM's water team. CR advised that water temperatures have improved, and it was confirmed that IFM's analysis of the associated data was ongoing – CR referred to printouts / graphs from the building management system to support the key messages.	 **Note** **Note**
5.0	**Any Other Business**	
5.1	Attendees discussed the need for future meetings of the Liaison Committee to be more strategic. Committee members agreed that the forum should not be utilised as a project update.	**Note**
6.0	**Next Meeting**	
6.1	10 December 2019; 1230hrs – Executive Meeting Room	**Note**

ALDER HEY CHILDREN'S HEALTH PARK

MEETING OF THE LIAISON COMMITTEE

AGENDA – 10 December 2019; 1230HRS

1. **Quorum**
2. **Previous Meeting Minutes**
   - **2.1 Accuracy & Approval**
   - **2.2 Actions**
3. **Draft Terms of Reference**
4. **Key Issues / Hot Topics**
   - a) **Follow up to the Executive to Executive meeting; 15 October 2019**
   - b) **Energy Performance Contract ('EPC')**
5. **Any Other Business**
6. **Next Meeting**

Board of Directors
7th January 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.

Board of Trust Directors Report

Campus Development report on the Programme for Delivery

7th January 2020

1. Introduction

The delivery of the overall vision for the campus has sustained a number of delays, which has inevitably delayed the reinstatement of the park which we are legally bound to deliver under the land exchange agreement.

Delays have occurred due to extended negotiations on the price of construction for purpose built new accommodation and changes to the original design in order to restrict cost to the financial envelopes available. As the projects have many interdependencies the knock on effect has been a delay to a number of projects.

The development team is now in a position to confidently reset the programme for delivery of the campus over the next 3 years. This update paper to the Trust Board provides the current status of each major project including a financial update against the capital plan, the risks currently associated with the project and the actions/next steps to be taken.

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	20,522	Out to market test-value engineering list to be finalised
C Cluster Dewi			
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	**51,674**	
Revised Budget	45,615	51,674	
Under/(Over) Budget	**-39**	**6,059**	

4. 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. Programme of works has been agreed and will commence prep works and engagement with local groups and community in January 2020 completing in Mid July 2020.	Nil at present time	Regular project meetings on a monthly basis with groundworks to ensure programme delivers on time and budget.

Alder Centre

Current status	Risks	Actions/next steps
Construction currently is in a 3 week delay due to adverse weather conditions in the Autumn. Occupation towards the end of April is still on track as a 4 week commissioning period was included which could be reduced. The Charity has agreed to fund the deficit of £204k which will cover the landscape and furniture/fittings shortfall in funding. Fixtures/fittings have been ordered. Loose furniture in the process of being selected with stakeholder involvement.	Landscaping and external perimeter wall construction will not be delivered in line with occupation dates. New service model structure currently not agreed and worked up across the Alder Centre Unit. (Current Manager vacancy)	Price and dates to be agreed with contactor in January 2020 and construction programme for delivery to be agreed. Ensure the Division address the vacancy /cover and service model is fully developed and agreed prior to occupation of the new building.

Acquired Buildings Occupation (neighbouring sites)

Current Status	Risks	Action/next steps
410 Prescot Road- currently in the process of being purchased for £425k.	Resistance from staff to	Director led group being set up to

Some minor refurbishment works are currently being costed and will be covered from the allocated budget. Expected completion on acquiring the building is end of January 2020, with works instructed/commencing in February and occupation in June 2020. **Knotty Ash Nursing Home**- currently in the process of being purchased for £1.050M, the allocated budget will allow for C. £875k refurb works to be completed. Mersey Design Architects are currently working up potential internal redesign of the building for consideration in meeting our needs. Expected completion on acquiring the building is end of January 2020, with works instructed/commencing end of February and occupation in July/August 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 Eaten Road and will be seeking to discuss commercial deals that could be completed over the next 3-5 years with current occupiers/owners.	move to either location. Medical records storage exceeds the space available. Refurbishment works not delivered to planned timetable. Capital cost may be beyond future capital available.	agree all relocation of staff/services and manage the change process appropriately. IM&T currently working up a programme for digitisation of all stored records. Tendering of works to commence in January 2020 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 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 to work up a contingency plan.

Alder Hey Children's NHS
NHS Foundation Trust

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. 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. Capacity lab will also be linking directly with Groundworks in delivering phase 1 of the park. 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.	Funding required is not delivered through the partnership approach. LCC do not agree to a future Community Interest Company for Sustainability.	Weekly review of the programme and progress with Capacity Lab, with weekly presence on site. Maintain regular discussion and meeting with LCC Lead for leisure services

Infrastructure works & commissioning

Current status	Risks	Actions
Masterplan of Infrastructure works is currently being prepared, planning	Nil at present time.	Ensure timely process

application to be submitted in April and out for tender in May 2020.		/programme is adhered to.

Clinical Hub and Dewi Jones Construction

Current status	Risks	Actions
Planning permission was granted by Liverpool, City Council planning committee in November 2019. Currently we are coming towards the end of the Pre-Contract Service Agreement (PCSA) which is currently in delay of 4 weeks. The PCSA will be completed by the end of January 2020 with a detailed cost of the project. Current construction costs are estimated as C. £14.7m which is £1.7m over the available budget. Agreement from Galliford Try to utilise our procurement system for the major purchase items which will allow transparency and assurance on market testing. If this is within the financial envelope available for the project it's anticipated a contract would be signed early February and work commences on Construction mid-March. 2020	Final PCSA cost of project exceeds the allocated budget. Delay to full contract agreement.	List of value engineering options to be completed, this could translate into some reduction in space (shell and core only). Continue with weekly meetings with Galliford Try. Board approval prior to final contract signature/sign off.

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 and is ready for tendering covering; • Technical • Clinical • Architectural • Innovation The outstanding element to be agreed is the approach from the PFI perspective (we have received their feasibility study) and our approach to procurement which will depend on any agreement with the PFI. 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. Discussions with Phillips with regards to encompassing new and innovative design to the unit, continues via meetings and dialogue.	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. Planning permission fails to be achieved within the timescale of the overall programme delivery.	Division of Surgery to take a revised and final Business Case to the Trust board for approval in February 2020. Currently we are looking at some options for reducing the anticipated cost in providing 24 cots spaces and supporting services, by looking at what space could be utilised on ward 1C and integrated with a new build. This would have a knock on effect to EDU, potential design and costs are currently being looked at by Gilling Dodd (Architects working on LWH build) and the reconfiguration of beds/cots by the Service Lead/Surgical Division. Concurrently run dual processes throughout the design process. 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 • 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 Eaten road current offering.	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.

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.

5. Trust Board of Directors

The Trust Board of Directors are requested to receive and acknowledge the update provided and agree to reset of the programme so future progress can be monitored accurately over the next three years. The development team would like to present the report in a meaningful format in the future and propose that this format be acceptable to the Trust Board encompassing a RAG rating for each project against the planned timetable in future reports.

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
13th November 2019

Present:	Ms C Dove	Non-Executive Director (Chair)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Mr I Quinlan	Non-Executive Director	(IQ)
In Attendance:	Mrs P Brown	Director of Nursing (Deputy for Chief Nurse)	(PB)
	Mrs K Turner	Trust LiA Lead (Part Attendance)	(KT)
	Mr A Bateman	Chief Operating Officer (Part Attendance)	(AB)
	Mrs G Thomas	Apprenticeship Delivery Manager	(GT)
	Mrs S Owen	Deputy Director of HR&OD	(SO)
	Ms A Chew	Associate Finance Director	(AC)
	Mrs J Potier	Associate Director of OD	(JP)
	Ms E White	Care Pathways, Policies & Guidance (Part Attendance)	(EW)
	Ms Z Connor	HR Business Partner	(ZC)
	Mr D Shaw	Learning & Development Manager	(DS)
	Ms N Deakin	Change Programme Manager	(ND)
	Mrs P Brown	Director of Nursing	(PB)
Apologies:	Mrs H Gwilliams	Chief Nurse	(HG)
	Ms L Cooper	Director of Children & Young People - CAMHS	(LC)
	Mrs N Murdock	Medical Director	(NM)
	Mr N Davies	HR Business Partner	(ND)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
19/85 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 19th September 2019 and they were approved as an accurate record.			
19/86 **Matters Arising, Actions**	**The Committee considered the following under matters arising, any actions not mentioned will be progressed as part of today's agenda or brought back to a future meeting:** **19/51 Modern Slavery** The Committee noted this links in with procurement processes (action 15/08 & 16/02), CD/MKS to progress government processes. **17/13 & 19/68 Equality Objectives**			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	MKS advised that following a conversation with CD a new approach is to be progressed for EDI. **19/69 Nurse Associate Recruitment** Develop a wider plan – MKS confirmed this gave more questions than answers and will be brought back to February 2020 Committee. **19/74 HEE Inspection** Preparation for visit. This will be noted as complete on the action log.			
19/86 **Programme Assurance ‘The Best People Doing Their Work’**	**Programme Assurance Framework – August 2019** The Committee received a regular summary prepared by the External Programme Assessor and Assurance Team. The purpose of this assurance framework is to ensure the monitoring of robust processes for progression. All papers supporting Programme Assurance for the work stream ‘The Best People Doing Their Best Work’ is recorded as read prior to the meeting. ND gave a brief summary of the current dashboard – the Improving Portering Services project appears to be at a standstill with no evidence uploaded since January 2019, with catering project displaying a very good standard of governance and all benefits/metrics showing positive trends. E-rostering project is a new addition to this month’s report with plans for Medical Workforce, Wellbeing and Equality, Diversity and inclusion PIDS due to be presented at Programme Board in the coming weeks given their initial sign off. MKS referred to the Portering Project and advised that significant movement had taken place with this project. Both the Trust and Trade Unions have collectively put proposals to Porters, with both being rejected. Following discussion by the Committee MKS advised that it is hoped to implement one of the proposals for a 3 month trial after Xmas, with proposed implementation in 1st April. NT acknowledged that it was difficult to upload Programme Assurance as no organisational change taking place and noted transformational change will still need monitoring. E-rostering – it was noted that there is a delay in receiving a response from NHS England in relation to the bid. The Committee **noted** the comments made.			
19/87 **Progress Against the People Strategy**	**Marketing & Community Activity Report** The Committee received the Marketing & Communications Activity report prepared by the Director of Marketing & Communications. MF advised that we are adopting a clearer *Communications* Cascade process to deliver through pre-identified and timely channels information of value to staff. Core to this will be ensuring all staff have the opportunity to			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	be informed of progress towards Our Plan, through a process of sharing information via regular briefings. MF advised of a process he is reviewing to support the preservation of artefacts from the old Alder Hey building. The Committee **noted** the progress made.			
19/88	**Mandatory Training** The Committee received a report prepared by the Learning & Development Manager. The report provides an update on the current and recent mandatory training compliance trends and areas of focus at the Trust. The purpose of the report is to provide assurance to the Committee. The report is noted as read. DS advised that the Trusts overall Mandatory Training compliance has been consistently above the 90% target now for the last 5 months, remaining relatively consistent at 91% compliant. DS outlined the subjects where compliance does not meet the 90% (Manual Handling and Information Governance) and also pockets of staff where compliance is particularly low (Estates has seen some improvements) and advised that Learning and Development and HR are working together to support these areas with meeting the required targets/compliance. DS outlined planned actions/actions taken to support compliance and referenced the quality/accessibility processes in development. Reporting processes for Sepsis is taking place and should appear in Mandatory Training reports from the end of November (as we work towards Trust compliance with this topic). Divisional/Departmental Managers as well as Subject Matter Experts continue to receive monthly reports of their mandatory training compliance down to individual names and compliance rates. The Comms team are on board to inform the Trust on developments and requirements. The Committee discussed the reasoning behind the 90% target set (i.e. to cover sickness etc.) and MKS recognised that we are measured against what you say you are planning to do but acknowledged that the national target is set at 95%. MKS advised that the Trust is in the best position we have ever been in in relation to compliance statistics and DS has put an action plan in place to improve any residual areas. CD asked what the compliance rates are for digital training? MKS advised that it is at 80%, with only a small cohort of people. The Committee acknowledged that ongoing innovation and monitoring is required. The Committee noted the progress made.			
19/89	**Staff Survey** The Committee received a report prepared by the Associate Director of Organisational Development. The purpose of the report is to inform the Committee of the progress made			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	to support an increase in completion rates along with the plans put in place to support feedback processes and improve staff experience within the Trust. The report is noted as read. JP advised that response rates had reached 48% on the date of the Committee with 2.5 weeks before the survey closes. Following last year's success in increasing our completion rate to 60%, the Trust is keen to continue its year on year improvement and is now aiming for a completion rate of 65% from the 2019 Staff Survey. JP outlined the key points of the strategy this year to improve response rates i.e. opportunities to win voucher rewards; Fab Staff week focus on Staff Survey gaining feedback from staff about why they do or don't complete the survey; themed posters – highlighting key concepts such as confidentiality; regular updates utilising digital marketing; communications directly with divisional and departmental managers briefing them on how they can help support completions; encouraging participation, particularly with teams and services who typically don't have access to regular technology etc. KT advised they have focussed on hotspots throughout the Trust. JP outlined the discussions that have taken place with senior management and the Divisions to progress/consider the feedback received from the Staff Survey. The **noted** the information received.			
19/90	**Apprenticeships Plan** The Committee received a presentation prepared by the Apprenticeship Manager. The purpose of the report is to outline a framework for the future plan to support apprenticeship workforce at the Trust. GT acknowledged measures are required to monitor outcomes. GT outlined the key issues affecting the population and the impact this has had on the labour market and at the Trust i.e. minority groups are under-represented; an aging workforce – under 25 year olds are the lowest cohort; high level of nursing vacancies – as well as high attrition rates for students during training and 12 months post qualification; low proportion of HCAs with relevant maths and English to progress. GT outlined what we are doing to engage and see an increase to the numbers of apprenticeships at the Trust. Particular attention/observation/suggestions was brought to the following in relation to increased numbers: • Annex 21 – GT advised that she has a meeting with Pharmacy with reference to an issue around minimum wage. MKS confirmed the Trust has commitment to pay under annex 21 and would never knowingly let staff go below the minimum wage. SO to check B2 salary to make sure it doesn't fall under minimum wage. • To support being an employer of choice, CD advised that we need to ensure staff are aware of the whole package in place for staff, i.e. holidays, flexible working			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• Following earlier reference to data that shows that there has been a 7% fall in the number of 16 to 19 years over the last 15 years, CD – suggested extending the offer to the older generation of workforce as not everyone can afford to retire. PB acknowledged paediatric work does tend to attract the older generation back into the workforce. • Recruitment – GT advised to target BME the Trust should consider using positive action. CD thanked GT for the framework and requested apprenticeships be brought back to a future Committee to update on how the framework has been embedded into practices at the Trust. The Committee **noted** the progress made.	Update on Apprenticeship framework	GT	TBC
19/91	**Education Governance – HEE visit update** The Committee received a report prepared by Medical Education & Revalidation Manager. The purpose of the report is to update the Committee on the outcome of the visit by Health Education England on 3rd October to assess the progress that has been made against the action plan that was submitted on 20th February 2019. The report is noted as read. MKS acknowledged this was a significant piece of work and it was hoped the outcome would be that HEE would be satisfied enough to enable GMC to remove the Trust from the register. The report outlines both the positive and negative aspects of the challenges the Trust faced. HB advised that that the visit was well attended by trainees and the trainees were asked to rate Alder Hey with the majority giving scores of 4 or 5, HEE have recognised how far the Trust has come. The main area of concern raised at the meeting was over the 'erratic' bleep system, with the outcome being that the Trust has been issued with a patient safety notice. An action plan must be returned to HEE by 30th October. CD requested an update in at December's meeting. The Committee noted the progress made.	Update on Action Plan to HEE	HB	February 2020
19/92	**Temp Check Report Analysis Q1 & Q2 (April-September 2019)** The Committee received an analysis prepared by Associate Director of Organisational Development and the Learning & Development Manager. The purpose of the report is to introduce the new quarterly temperature check (previously monthly) to enable the production of more meaningful data, correlated with questions raised under the headings 'staff engagement' and 'psychological safety culture' from the Staff Survey of 2018. JP acknowledged that there is no national measure to refer to. The Committee discussed the reasoning behind the outcomes of the data and how the data can be utilised to offer support to teams, with a more proactive approach/early intervention. A number of observations were raised:			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• If someone makes a mistake, it can be open to interpretation; you can respond how you like. Wondering if it's punitive i.e. whatever it means to you. • Measuring process – use one team from the Divisions • Psychological survey – review terminology MKS advised this1/4ly report will be regular report to board. It will enable more analysis to be undertaken and with the responses informed by staff, will support change at the Trust. The Committee **noted** the content of the analysis and progress made.			
19/93	**Sickness Business Case** The Committee received a business case prepared HR Business Partner that had previously been approved by the Investment Review Group (IRG). SO advised that sickness levels have been consistently above Trust target of 4% over the past 12 months and continues to have an impact on operational delivery. Feedback from managers suggest that the administration processes for supporting absence is a significant challenge as it is time consuming and prevents them from being able to support staff in the most appropriate and timely manner. The Sickness Business Case is noted as read. The HR team were asked to consider a number of options to support sickness absence. The purpose of the business case is to inform the Committee of the proposal to establish a centralised sickness absence team in-house at the Trust. As part of this fixed term model, all sickness absence will be reported by member of staff to a central team on the first day of absence. SO outlined the financial implications of recruiting 4 members of staff with the aim of reducing the overall length of sickness and base line cost of sickness. CD asked the Committee for feedback on the proposals, particular attention was brought to: • Should more investment go into the Occupational Health facility, as some lengthy waits? SO advised that will be addressed also with Occupational Health through the contract management discussions. • The challenge from the Trust was to try a different approach to sickness as some managers are struggling with managing/controlling increased sickness (i.e. ward managers with large groups of staff). • Green light has been received to recruit, between now and recruitment, decisions to be made on processes (ensuring the appropriate/supported questions are asked – devising a script – systematic approach). • Target areas with high levels of sickness to pilot to make more manageable • Gateways roll-out comms. • With dedicated resource in place – it is part of the plan to focus on long term sick also.	Update on the		

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	CD requested an update next quarter The Committee approved/noted the development of sickness business case.	development of the new sickness process	SO/ZC	April 2020
19/94	**Pay Report** The Committee received the report outlining the options for spot salaries. Discussion had taken place outside of the Committee with Staff Side and the HR Business Partner to progress to conclusion. The HR Business Partner sought approval of the recommended option 1 (for those staff on spot salaries whose salary is below the equivalent top of the respective pay scales to receive a 1.1% increase in line with AfC award in April 2019). The Committee **approved** the recommendation.			
19/95 **Key Workforce Risks – Review Of top Workforce Risks action planning against most significant risks**	**BAF Assurance Framework – October 2019** The Committee received a regular (BAF) report under the Strategic Objective 'The Best People Doing Their Best Work'. The report is noted as read. The Committee discussed the 3 risks and noted there was no change in the risk score. It was agreed that the workforce sustainability risk needs a review prior to the next Trust Board, along with a risk relating to pensions – particularly for clinical staff. The Committee **noted** the content of the report.	Review workforce sustainability risk, prior to next Trust Board	MKS	December 2019
19/96	**Key Workforce Risks KPIs – October 2019** The Committee received a regular report prepared by the Deputy Director of HR concerning the key risks relating to workforce monitoring for October 2019. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. The report is noted as read. Key headlines are: SO outlined the detail in the report. Particular attention was brought to the staffing section, temporary spend – a group meets fortnightly with the aim to constantly monitor/reduce this spend. Noted that HR are progressing a piece of work to support reduction of premium spend on locum payments for doctors, conversations are taking place within the divisions to review temp spend and identify possible way of reduction. The Committee **noted** the content of the report.			
19/97	**Workforce Risk Report October 2019** The Committee received the Human Resources Risk Register prepared by the Deputy Director of HR. The purpose of the report is to outline the internal monitoring processes for risks and the actions taken to reduce the risk. Key headlines are:			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Risk Title – There is a possibility that staff could order, prescribe, collect or administer blood products incorrectly. The Transfusion team have a concern about the reporting of training on ESR. The action taken to reduce the risk is that a meeting has been held between ESR and L&D and the Transfusion teams and initial actions agreed for Transfusion team create a matrix of requirements and for ESR lead to send Transfusion team a current staff list to help with this process. MKS advised that the HR team are happy to develop the risk for training purposes, but we cannot be held responsible for a clinical risk, this is to be reassigned to Transfusion team for monitoring. The Committee noted the content of the report.			
19/99 **Sub Committee Minutes**	The Committee received the minutes for the following for information. • JCNC – 31.07.19, 27.08.2019 & 3.10.2019 The Committee **noted** the content.			
19/100 **Legislation, terms & conditions, employment policie4s/EIAs – review & ratification/approval.**	The Committee received the following policies and Equality Assessments for formal ratification/approval • **Display Screen Equipment** • **Health & Safety Policy** MKS advised that both had previously been approved at the Health & Safety Committee. A few general/legislative updates had been made. The Committee **ratified** and **approved** the policies and equality assessments.			
19/101 Board Assurance	The Board Assurance Summary was discussed and completed for submission to the next Trust Board in December 2019.			
19/102 AOB	**Pension Scheme** MKS advised that a piece of work is taking place to develop plans to support impact following changes made by the government to annual and lifetime allowances. A paper will be taken to the December Board.			
Date of Next Meeting	**Rescheduled to Tuesday 10th December 2019, 10am-12noon, Room 5, Mezzanine.**			

Action List

Minute Reference	Action	Who	When	Status
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Noted on 19/09/2019 that DMO support is in place for this ongoing action.	ND MKS		Ongoing Ongoing
19/35	Apprenticeships – Produce a plan to develop how we move forward with apprenticeship/workforce. Noted on 26/06/2019 this item deferred until September 2019. Noted on 19/09/2019 this item has been deferred.	MKS/GT	November 2019	Complete
People Strategy Overview & Progress Against Strategic Aims				
	Modern Slavery			
19/51	Liaise with Head of Procurement to progress processes, noted on 19.11.2019 that this is linked to 15/08 & 16/02, government process to be progressed.	MKS/CD	Ongoing	Ongoing
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CD	Ongoing	Ongoing
	Equality & Diversity			
17/13 19/68	• Equality Objectives Plan for 2018-2021 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee • WRES/WDES Updated Plan	HA HA/SM HA	1/4ly Update 6 monthly Review	Ongoing Ongoing
	Education Governance Update			
18/38	• To be a regular item on the Committee Agenda.	HB	Ongoing	Ongoing
19/74	• Prep LS & MKS prior to HEE Inspection visit	HB		Complete
19/91	• Update on HEE action Plan	HB	TBC	
	Nurse Associate Recruitment			
19/69	Develop a wider plan	Vikki Hughes	February 2020	
	Marketing & Communication			
19/71	Discuss temperature check in more detail	MF & MKS	November 2019	Complete
	Mandatory Training & CQC			
19/73	To be standard agenda items going forward	MKS/JF	October 2019	Ongoing

	Sickness Absence			
19/77	Plan to manage sickness to be brought to a future meeting.	SO	November 2019	Complete
19/93	Update on progress of embedded new process.	SO	April 2020	
	Apprenticeship			
19/90	Update on framework	GT	TBC	
Key Workforce Risks				
19/61 **19/80**	• Update the narrative on key workforce risks • Produce an updated leavers flowchart • Action from Integrated Governance Committee to be brought to next meeting	SO SO/MKS SO	September 2019 September 2019 October 2019	Complete Complete Complete
	BAF			
19/95	• Review workforce sustainability risk, prior to new Trust board	MKS	December 2019	

BOARD OF DIRECTORS

Tuesday 7th January 2020

Paper Title:	**Workforce & OD Committee Assurance Report**
Date of meeting:	10th December 2019 – Summary 13th November 2019 – Approved Minutes
Report of:	Claire Dove, Committee Chair
Paper Prepared by:	Jackie Friday, WOD Committee Administrator

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Summary and/or supporting information:	This paper provides a summary from the recent Workforce & OD Committee Assurance Committee meeting 10th December 2019 along with the approved minutes from the 13th 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** ☐
Resource Impact:	None
Associated risk (s)	BAF 1.1 – Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations – current risk IxL: 3x3 BAF 2.1 – Workforce Sustainability – current risk IxL: 3x3

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

1. **Introduction**

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

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

2. **Agenda items received, discussed / approved at the meeting)**
   - Marketing & Communications Staff Engagement
   - Mandatory Training
   - Staff Survey Update
   - SALS Proposal
   - RMP update

3. **Key risks / matters of concern to escalate to the Board (include mitigations)**
   - Managing Staff Sickness/winter problems

4. **Positive highlights of note**
   - SALS proposal – principles approved – action plan to be presented to next meeting
   - Good response on Staff Survey

5. **Issues for other committees**
   - RABD – sickness levels
   - Review of risk register – discussion re the review of the BAF following Board

6. **Recommendations**

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

BOARD OF DIRECTORS

Tuesday 7th January 2020

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

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

1. Introduction

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

2. Background

Throughout 2019, excellent progress was made with regards to digital and Information Technology developments at Alder Hey. Notable achievements include:

- Development, sign off and mobilisation of Digital Futures strategy with a clear vision for the delivery of outstanding digital excellence
- Excellent progress with the Global Digital Exemplar programme
- International digital maturity accreditation achieved
- Good progress with Technology roadmap implementation including strengthening resilience, cyber security and operational IT service
- Excellent progress with Community IT upgrades

Heading into 2020, this work will continue with a focus on staff, children young people and families experience of digital and supporting improved outcomes with the use of digital technology. 2020 will see significant developments with the implementation of the next generation Electronic Patient Record – Meditech Expanse with strengthened clinical leadership and divisional integration.

3. Digital Futures Delivery

Digital Futures sets out a clear vision for the delivery of digital ambitions over the next five years. The strategy is focussed around three key transformation themes, namely:

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

The transformation themes are underpinned by a technology roadmap, with the first year of delivery largely around improving on delivering Information Technology basics well whilst striving for international accreditation in relation to digital maturity, developing an Electronic Patient Record that works well for staff and having in place great tools to interact with Children, Young People and Families through technology.

3.1 Governance

New governance arrangements have been mobilised to oversee the delivery of Digital Futures.

The Digital Oversight Collaborative (DOC) has been in place since October 2019. Replacing the GDE Programme Board, the DOC has met twice, and has oversight of the digital strategy delivery, operational IT delivery and major digital programme developments.

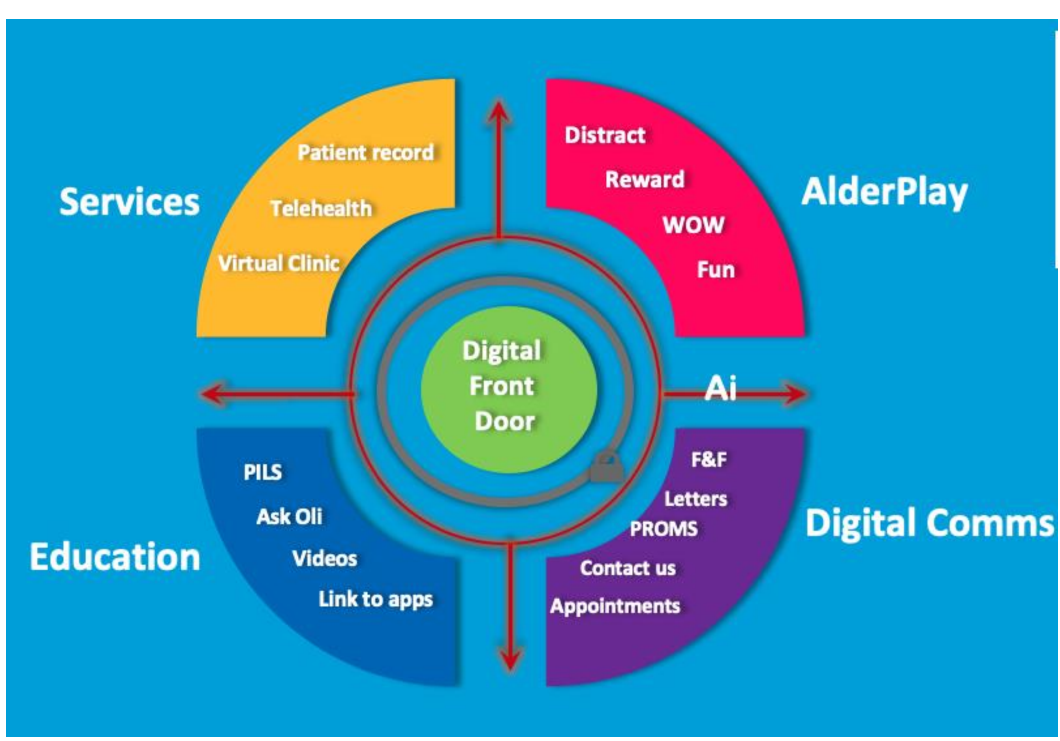
Reporting into the DOC are a number of groups established and in development including:

- Digital Clinical Design Authority
- Operational IT Group
- Programme Delivery Group
- Digital, Innovation and Research forum

3.2 Digital Children, Young People and Families

Our Digital Children, Young People and Families theme is driven by our organisational approach of putting children and young people first.

Good progress has been made in this area, with the development of a vision and concept for our digital front door. The vision (diagram below) has four component parts and would be the front door digitally for a range of Alder Hey digital services.



This concept is the emerging strategy for interacting digitally with Alder Hey and will move to business case development and ultimately implementation throughout 2020.

Strategically this will link into regional plans linked to person held records and national plans with the NHS App.

3.3 Digital Quality Improvement

There have been a number of significant developments and progress with regards to the digital transformation programmes that sit as part of the Digital Futures digital quality improvement theme.

3.3.1 Global Digital Exemplar Programme

The Trust is now in the final three months of the GDE programme. Progress in 2019 has been excellent with the delivery of 50 specialty packages, leadership in the development of

the regional health information exchange programme and developments of Alder Play. The final financial assurance visit was held in October 2019, with positive feedback releasing the remaining national financial commitments for the programme. The Trust will undergo a formal accreditation visit in early 2020 including confirmation of achievement of remaining milestones, benefits realisation and blueprint development.

Work is underway with divisions and specialties to clearly map outcome improvements that have been supported through the implementation of the GDE programme.

3.3.2 Healthcare Management and Information Systems Society (HIMSS) Accreditation

HIMSS is a national digital maturity model based on 8 levels from 0-7. It is a worldwide standard and highlights the level of use of technology in the delivery of safe, high quality care in healthcare. It is widely adopted worldwide, however adoption in the UK is limited largely due to the levels of digitisation in provider trusts. A national priority as part of the GDE programme was to support Trusts to be digital exemplars with internationally benchmarked standards against HIMSS.

The most digitally mature Trusts in the world are at HIMSS Level 6 or 7. It is a prerequisite for Trusts to achieve HIMSS Level 6 prior to being considered for Level 7 accreditation.

Alder Hey underwent a HIMSS Level 6 accreditation in December 2019 and were successfully accredited with this international accolade. We are the first paediatric Trust in the UK, the first in the North of England and the fourth nationally to achieve this accreditation. There are no UK Trusts with a HIMSS Level 7 accreditation.

For Alder Hey, this demonstrates excellent use of technologies in supporting the delivery of high quality, safe care. Significant developments include the roll out of closed loop technologies to support medicines administration.

3.3.3 Meditech Expanse

A formal programme of work has been initiated with regards 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 the Chief Operating Officer have been established and implementation planning is underway.

Programme leadership and clinical roles have been appointed to, and the design and development of the new system will commence imminently. Clinical roles include Divisional Chief Clinical Information Officers to ensure divisional leadership and integration and will sit as part of a wider clinical digital leadership model.

3.3.4 Paperfree Health Records

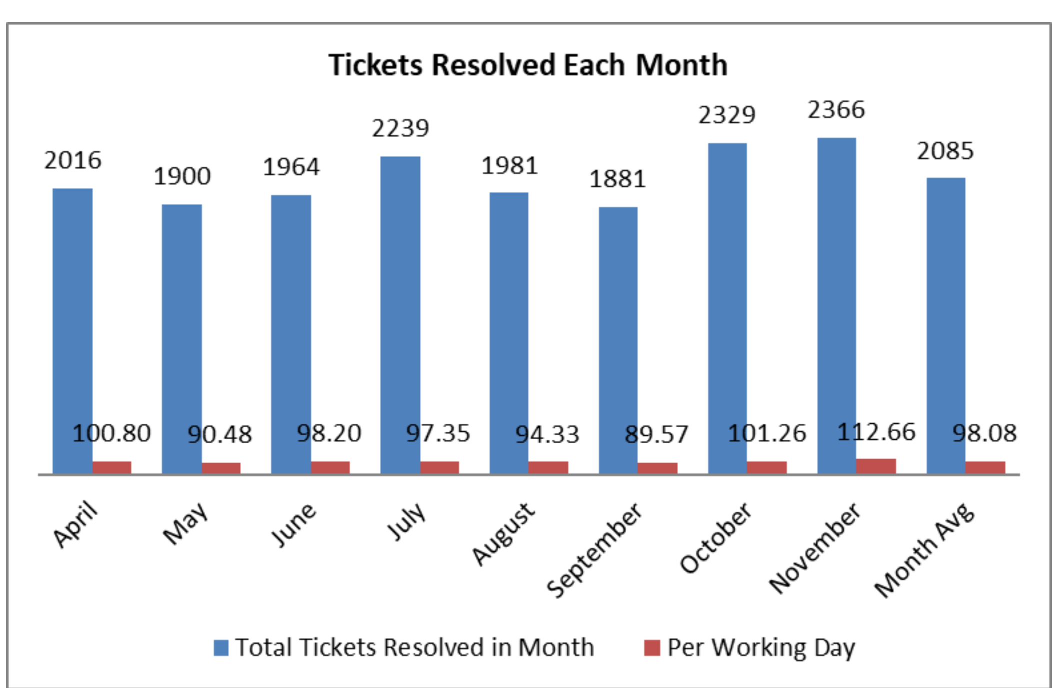
A programme of work with regards to paperfree health records is underway. Major progress has been made with this through the GDE programme, however further work and focus is required and has commenced in the final period of 2019. This will see the phasing out of any remaining physical records.

3.4 Technology Roadmap / Operational IT Performance

Work has been ongoing from an operational IT perspective to develop a proactive, staff focussed delivery model. Included in this is work with regards to operational IT performance. This work will be iterated over time with divisions.

3.4.1 Activity

With regards to activity, the overall average number of IT incidents resolved on a monthly basis is on average 2,085 incidents and service requests. The chart below demonstrates activity for year to date and the number resolved per working day by operational IT teams.



Through a range of service improvements, plans are in place to reduce the number of incidents by 10-20% by April 2020. This reduction then supports a move to a more proactive model of service to front line teams. These service improvements include the implementation of self-service password reset, new starters account automation process and other initiatives to reduce activity. Work is ongoing with divisions to design and test these processes with services.

3.4.2 Service Desk

Currently Alder Hey's Service Desk is provided externally by an external third party. The model of service provided is traditional and not satisfactory for front line teams. Best practice would see service desks with the processes to resolve approximately 50% of IT incidents as they are logged by users, with a range of logging approaches to ensure quality and efficiency.

Alder Hey Service Desk will be moving to a new provider via an NHS Shared Service Provider, Informatics Merseyside on the 1st February 2020. As part of this arrangement, the first line incident logging performance target will be 50% fixed first time. Current performance of the externally provided service desk is less than 10%.

Additionally, the current service desk model does not proactively provide updates for staff or provide the facility for customer satisfaction surveys. These measures will also be included in the new service desk.

3.4.3 Technology Roadmap Service Improvement Plan

Progress is positive with regards to the technology roadmap service improvement plan with key updates summarised below:

- Replacement Computers: Over 1,100 devices have been issued with another 700 to deploy by the end of January 2020
- Windows 10: Windows 7 is formally out of support January 2020 although NHS Digital have extended support with Microsoft for a further 12 months. Plans are ongoing to upgrade all devices by the end of January with 68% of devices now Windows 10
- Office 365: the trust migrated 4,100 mailboxes to this new cloud email platform in December 2019. The suite of tools through Office 365 will be developed in 2020 providing online collaboration, secure messaging, video conferencing and other digital tools for staff
- Community Service Improvement: Community staff migration completed in October. Over 400 new devices have been issued to community staff. New service delivery arrangements planned from 1st February in partnership with Informatics Merseyside
- Critical Area Floorwalking: proactive daily visits in place in key clinical areas
- Data Centre Strategy and Resilience: core infrastructure resilience configured. Thorough simulation testing and commissioning scheduled for January 2020. Infrastructure in place to fail over to should there be a major issue.
- Cyber Security: proactive tools for cyber security in place, cyber security lead in post

4. Conclusion

There have been significant developments delivered throughout 2019. Delivery was remarkable both in terms of scale and pace of achievements. National assurance and international accreditation have confirmed Alder Hey as a national leader in the field of digital maturity.

2020 plans and priorities are cited as part of the Digital Futures strategy but include significant work on continuous service improvement linked to delivering brilliant basics for staff, development of a Digital Front Door, a focus on HIMSS Level 7 and a move to a next generation Electronic Patient Record. Delivery of these plans will further develop Alder Hey's digital capability and support improved outcomes for children and young people.

5. Recommendations

Trust Board is asked to:

- Note 2019 achievements including
  - HIMSS Level 6 accreditation
  - Community IT improvements
  - Technology Roadmap progress including data centre resilience
- Support 2020 plans and priorities

Kate Warriner
Chief Digital and Information Officer
December 2019

Alder Hey Children's NHS
NHS Foundation Trust

Innovation Committee

Minutes of the meeting held on **Monday 18th November 2019,**
Tony Bell, Board room, Institute in the park

Present:	Mrs S Arora	Non-Executive Director (Chair)	(SA)
	Mr I Hennessey	Clinical Director of Innovation	(IH)
	Mrs C Liddy	Director of Operational Finance and Innovation	(CL)
	Mr J Grinnell	Director of Finance	(JG)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs L Shepherd	Chief Executive	(LS)
	Mr M Peak	Director of Research	(MP)
In Attendance:	Mr M Flannagan	Director of Communications	(MF)
	Mr R Guerrero	Consultant	(RG)
	Mrs E Hughes	Assoc, Chief Innovation Officer	(EH)
	Mrs R Lea	Assoc. Finance Director	(RL)
	Mrs J Tsao	Committee Administrator	(JT)
Apologies:	Dr F Marston	Non-Executive Director	(FM)

19/20/11 Declarations of Interest
There were none to declare.

19/20/12 Minutes of the previous meeting held on 9th October 2019
Resolved:
Innovation Committee approved the minutes from the last meeting held on 9th October 2019.

19/20/13 Innovation Performance Report
An update was received on the three activities and the projects within them:
Engagement
A request for further resources was to be presented at both Execs and Operational Delivery Board.

Projects and Pipeline
Transdermal Sensor Project will be activated and will be resourced by Liverpool John Moores University once contracts are agreed with legal. It is estimated the project will take at least 12 months for proof of concept research.

For the next Innovation Committee on 10th December it was agreed a portfolio review with expected key milestones and funding needs for top projects will be presented.
13.1 Action: CL/EH

The Innovation Agency are bringing 9 NHS Trust's together to create a shared sources. The Innovation Agency have requested business support and there were discussions around Alder Hey submitting a proposal for this.

Speakman – Gabrielle Foundation have agreed to invest £50k into the Shine and Cortisol project for legal fees to establish a contract. Louise Shepherd referred to Jim Davies, lawyer who had supported the Trust previously and agreed to re-connect with Jim to establish if he had any capacity to support the Trust further with innovation legal support.
13.2 Action: LS

Resolved:
Innovation Committee noted progress against the performance report.

19/20/14 **Portfolio Review**
It was agreed this item would be re-presented after a review of Key Performance Indicators and inclusion of milestones. The Chair requested that until KPIs have been agreed they are referred to as shadow KPIs.
Action: EH

Local Trust Warrington and Halton NHS Foundation Trust will be fast followers of Alder Hey's Ask Oli process.

Resolved:
Innovation Committee noted progress against the portfolio review.

19/20/15 **Alder Hey Innovation Ltd**
Previously named Alder Hey Ventures the committee received the structure, proposed aims and benefits for Alder Hey Innovation Ltd.

One of the aims was to provide agile procurement and partnering to reduce the current timescale process of 6 months.

Under the Operating Model Recommendation: Surplus profits and ROIs will either be re-invested in to new projects or back in to Alder Hey.

Claire Liddy went through a model used at Oxford Innovation that had been in place for over 30 years, it was expected the Alder Hey Innovation Ltd would take 5-10 years to be established.

Prof. Matthew Peak asked for capacity of research trials to be considered when establishing new trials as currently there is only capacity for three drug trials to be in place at one time.

It was agreed that there will be continued investigation into Innovation Ltd structure and presented back in January Committee
Action EH/CL

Claire Liddy referred to the Liverpool Health Ventures report and agreed to circulate this to the committee after the meeting.
Action: CL

Resolved:
Innovation Committee noted the recent name change and progress to date.

19/20/16 **ACORN Action Plan**
The ACORN action plan was presented to the Innovation Committee in October with 13 outstanding actions. Over the last 4 weeks, a further 3 recommendations have been completed, leaving 10 actions left to be completed.

3 actions are linked to a new commercial deal with partners. An initial meeting has taken place with a follow up meeting planned for mid-November. Once the terms have been agreed the actions can be completed. 6 actions are linked to the governance of Innovation Ltd.

Resolved:
Innovation Committee noted the position of the ACORN action plan.

19/20/17 **Global Meditech Building**
The Innovation Committee discussed options for the Global Meditech building to be either on site or based in Liverpool City Centre.

A discussion was held on expectations and goals to be set. It was agreed a session would be held outside of the meeting with: Louise Shepherd, Matthew Peak, Rafael Guerro and Claire Liddy.
Action: JT

Resolved:
Innovation Committee received an update on Global Meditech Building.

19/20/18 **Innovation Advisory Board**
Resolved:
This item would be deferred until the December meeting.

19/20/19 **Financial Plan**
The Innovation department has established 3 trading accounts for 19/20, although only 2 of these are currently live:
- Innovation Hub – core innovation team and services provided to AH
- Alder Hey Living Hospital – services provided to the JV established with AH Charity
- Alder Hey Ventures – subsidiary not yet live and therefore no income or expenditure

A financial plan has been developed for each of the accounts which show a break even position by the end of March 20. This is dependent on a two key factors:
- Income – income required of £221k by the end of March
- Trust – the Trust are contributing £311k in 19/20 to fund the core innovation team.

Claire Liddy noted further resources are required and the financial team are working through.

Resolved:
Innovation Committee received an update against the financial plan, going forward quarterly updates would be received.

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

Date and Time of next meeting: Tuesday 10th December 2019, at 14:30, Innovation Hub, Ground Floor.

BOARD OF DIRECTORS

Tuesday 7th January 2020

Paper Title:	**Innovation Committee Assurance Report from the November meeting**
Date of meeting:	10th December 2019
Report of:	Shalni Arora, 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 Innovation Committee meeting held on 9th October 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:	

1. Introduction

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

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

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

Innovation Ltd update
Innovation Performance report
Portfolio Review
Innovation Advisory Board & Externals for Committee
Innovation Risks

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

Inclusion of long term funding needs to sustain the program as a BAF risk.
Risk register presented which included an intellectual property challenge from a 3rd party.

Detailed discussion around the ideal size of the innovation portfolio and matching capacity with resource.

4. Positive highlights of note

Detailed review of the top 8 pipeline projects / products completed by the Committee, including a review of the 5 year startup funding requirements.
Global Med-Tech building case is progressing with various funding sources and partners being explored.
2 external advisors will be contacted regarding inviting to Innovation Committee

Issues for other committees
Risk items for the IGC

5. Recommendations

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

Board of Directors

Tuesday 7th January 2020

Paper Title:	**Constitutional Change**
Report of:	**Director of Corporate Affairs**
Paper Prepared by:	Governance Manager

Purpose of Paper:	Decision ■ Assurance ☐ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Trust Constitution
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

BOARD OF DIRECTORS

Proposed Constitutional Change

1. Purpose

The purpose of this paper is to set out a proposal to amend the Trust's Constitution in relation to the composition of appointed governors as set out in Annex 4.

2. Background

The Council of Governors is made up of 25 elected governors and 10 appointed governors.

Appointed governors represent stakeholder organisations such as the local authorities, partnership organisations and local voluntary sector bodies. Elected governors represent members of the public or patients, parents and carers and staff governors.

3. Foundation Trust Constitution

The Trust's Constitution currently contains the provision that the Council of Governors consists of:

1) Governors appointed by:
    a) Primary Care Trusts for which the Trust provides goods or services;
    b) Local Authorities for an area which includes the whole or part of an area of a public constituency;
    c) Partnership organisations, including local Universities and voluntary organisations.

2) Governors elected by:
    a) Members of the public or patients, parents and carers in each of the Constituencies defined in Annexes 1 and 3 of this Constitution;
    b) Individuals within each class of the Staff Constituency defined in Annex 2 of this Constitution.

More than half of the members of the Council of Governors shall be elected by those in 2) a) above.

4. Rationale for proposed change

The Board has recently undertaken a refresh of the Trust's five year strategic plan, resulting in the final version of 'Our Plan 2019 – 2024' which was issued in November 2019. One of the key strategic pillars of the strategy 'Sustainability through External Partnerships' is clearly key to the success of the Trust's plans to work collegiately on the children's health agenda as part of the wider health and social care system. Given the vital role played by the Council of Governors, it is timely for consideration to be given to the composition of the appointed side of the Council and how it supports the achievement of this key pillar.

Therefore, in order to ensure that the Council properly reflects the partnership arrangements that it has, a review has been undertaken by a small working group which met on 13th November, focusing upon the current appointed governor composition and to make recommendations for reconfiguration. The working group consisted of Lead Governor - Kate Jackson, Appointed Governor (LCC) – Barbara Murray, Erica Saunders – Director of Corporate Affairs, Dani Jones – Director of Strategy and Partnerships and Jill Preece - Governance Manager.

Following the review, the group concluded that the current composition of appointed governors is no longer fit for purpose in terms of representing key stakeholder groups and agreed that the following changes be submitted to both governing bodies for consideration.

5. Recommendation

The Board is asked to approve an amendment to ANNEX 4 of the Trust's Constitution so that it reads: *(changes highlighted in yellow)*

ANNEX 4 – COMPOSITION OF COUNCIL OF GOVERNORS

The Council of Governors consists of:

(1) Governors appointed by:

(a) Stakeholders to represent the Trust's main stakeholders;
(b) Other Local Authorities (Liverpool City Region) for an area which includes the whole or part of an area of a public constituency;
(c) Partnership organisations, including local Universities and voluntary, local interest and community groups.

(2) Governors elected by;

(a) Members of the public or patients, parents and carers in each of the Constituencies defined in Annexes 1 and 3 of this Constitution;
(b) Individuals within each class of the Staff Constituency defined in Annex 2 of this Constitution.

More than half of the members of the Council of Governors shall be elected by those in (2)(a) above.

Composition

Appointed Governors

Organisation appointing	Number to be appointed	Role
~~North Wales Authorities~~ Other Local Authorities (Liverpool City Region)	1	
Local Authorities:		
Liverpool City Council	2	To represent key local non-NHS health economy partners, one of whom should be the senior officer with responsibility for children's services
Any local authority within the Alder Hey catchment (Public Health)	1	To provide public health expertise to the Council of Governors, preferably at director level

Partnership Organisations:		
Local Universities:		
Liverpool University	1	To ensure a strong teaching and research partnership to ensure that the Trust continues to provide training for children's specialist clinicians and continues to undertake research into childhood illnesses.
John Moores University and Edge Hill University	1 (can be appointed on a rotational basis)	As above.
Voluntary ~~Organisations~~ / Local Interest / Community Groups:		
Voluntary organisations Representatives chosen from the list attached at Annex 4A	2	To ensure the representation of a wide range of organisations with an interest in children's services.
~~Commissioners~~ Stakeholders	2	To represent the Trust's main ~~commissioners~~ stakeholders
Total Appointed Governors	**10**	

6. Process and Next Steps

Under the terms of the Constitution any amendments must be approved by both the Council of Governors and the Board of Directors. This proposal was approved by the Council at its meeting on 11th December 2019, subject to approval by the Board. The amended document must 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.

Jill Preece – Governance Manager
Erica Saunders - Director of Corporate Affairs
January 2020

BOARD OF DIRECTORS

Tuesday, 7 January 2020

Paper Title:	**Board Assurance Framework Refresh against Strategic Plan 2019-2024 (and December update)**
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:	Strategic Plan 2019-2024 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 refresh against Strategic Plan 2019-2024 (and December update)

1. Purpose

The Board Assurance Framework (BAF) is a tool for the Board to corporately assure itself about successful achievement of the organisation's strategic objectives and how the key strategic threats and risks to delivery are managed and mitigated.

Following approval of the Trust's Strategic Plan – 'Our Plan' 2019-2024, a workshop session was held to discuss and shape a new Board Assurance Framework to reflect how the Board intends to mitigate strategic risks that are likely to threaten the achievement of the trust's strategic plans and provide assurance that long term objectives are being proactively managed, in accordance with the agreed risk appetite in each area.

This report is a summary of the proposed changes to the Board Assurance Framework (BAF) for review and agreement.

2. Review of the BAF

At the workshop held in December Board members' undertook an exercise 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 are likely to present a risk to delivery of the Trust's refreshed strategic objectives to 2024.

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 – the full Corporate Risk Register can be found at Appendix B. The full BAF document is included as Appendix A.

3. Recommendation

The Board is asked to:

- Discuss and approve the proposed changes to the 2019/20 BAF, and
- Note the corporate risk register.

4. Summary of BAF - at 2 January 2020

The diagram below shows some movement with the BAF both in terms of risks improving and worsening; this is mainly due to the changes to the workforce risks following the December Board session.

Ref, Owner	Risk Title		Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 HG	**Not achieving outstanding quality for children and young people as defined by the Health and Social Care Act (2012)** **New suggested risk title: Inability to deliver safe and high quality services**		3-3	2-2	STATIC	STATIC
1.2 AB	**Achievement of national and local mandatory & compliance standards** **New suggested risk title: Inability to deliver accessible and timely services to patients in line with national standards**		3-3	3-2	**WORSE**	STATIC
1.3 JG	**The Hospital Environment** **CLOSE RISK – captured on corporate risk register**		4-3	4-2	BETTER	**CLOSED**
1.4 JG	**Sustainable operational delivery in the event of a 'No Deal' exit from EU**		3-3	3-1	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability and Development**		4-3	4-2	STATIC	**WORSE**
2.2 MS	**Staff Engagement** **New suggested risk title: Employee Wellbeing**		3-4	3-3	STATIC	**WORSE**
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	**Service Sustainability, Growth and the Trust's role in a sustainable local health economy** **New suggested risk title: 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, Education & Innovation**		3-3	3-2	STATIC	STATIC
4.2 KW	**Digital Strategic Development and Operational Delivery**		4-2	3-2	STATIC	BETTER

5. Changes since 3 December 2019 Board meeting

External risks

- ***Service sustainability, growth and the Trust's role in a sustainable local health economy (DJ)***

  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.

- ***Workforce Equality, Diversity & Inclusion (MS)***

  Risk reviewed and updated to reflect changes. All gaps in controls have associated actions.

- ***Sustaining operational delivery in the event of a 'No Deal' exit from the European Union (JG)***

  Under review pending central advice.

Internal risks:

- ***Achievement of National and Local Mandatory & Compliance Standards (AB)***

  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.

  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).

- ***Inability to deliver safe and high quality services (HG)***

  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.

- ***Financial Environment (JG)***

  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.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Programme Review paper prepared for January Board including risk assessment.

- ***Digital Strategic Development and Operational Delivery (KW)***
  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.

- ***Workforce Sustainability and Development (MS)***
  Risk reviewed and updated to reflect changes. All gaps in controls have associated actions.

- ***Employee Wellbeing (MS)***
  Risk reviewed and updated to reflect changes. All gaps in controls have associated actions

- ***The Hospital Environment (JG)***
  Risk now closed.

- ***Research, Education & Innovation (CL)***
  No change to risk score.

Erica Saunders
Director of Corporate Affairs
7 January 2020

Appendix A. Links between BAF and high scored risks – as at 2 January 2020

BAF Risk	Strategic Aim	Related Corporate Risk
1.1 Inability to deliver safe and high quality services	Delivery of **outstanding care**	(1866) Risk of patient harm due to unnecessary variability in care, due to out of date guidelines being consulted or failure to access guidance. (1921) Lack of robust mechanisms for ensuring emergency bleep system is working (1984) Delays in children being able to access Cardiac treatment, and delayed stepdowns from critical care meaning that this capacity is not available for other patients (201) Risk of being unable to meet staffing duty rota requirements in line with best practice standards (1169) Fragile Medical Workforce within the Haematology Service (1270) Waiting time for ASD and ADHD assessment
1.2 Achievement of national and local mandatory & compliance standards	Delivery of **outstanding care**	(1524) Risk of harm due to inappropriate care of advice to patients over the age of 16 by paediatricians and specialist nurses with lack of clinical knowledge about this age group and their presentations
1.4 Sustainable operational delivery in the event of a 'No Deal' exit from EU	Delivery of **outstanding care**	None
2.1 Workforce Sustainability & Capability	**The best people** doing their best work	(1169) Fragile Medical Workforce within the Haematology Service (1984) Delays in children being able access Cardiac treatment, and delayed stepdowns from critical care meaning that this capacity is not available for other patients. (1270) Waiting time for ASD and ADHD assessment (201) Risk of being unable to meet staffing duty rota requirements in line with best practice standards
2.2 Staff Engagement	**The best people** doing their best work	None
2.3 Workforce Equality, Diversity & Inclusion	**The best people** doing their best work	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	Sustainability through **external partnerships**	None
3.4 Financial Environment	Sustainability through **external partnerships**	None
4.1 Research, Education & Innovation	Game-changing **research and innovation**	None
4.2 Digital Strategic Development and Operational Delivery	Game-changing **research and innovation**	None

Board Assurance Framework 2019-20

BAF 1.1	Strategic Objective : Delivery of Outstanding Care	Risk Title: Inability to deliver safe and high quality services		
Related CQC Themes : Safe, Caring , Responsive, Well Led		**Link to corporate risk/s:** 1886, 1921, 1984, 201, 1169, 1270		
Exec Lead : Hilda Gwilliams	**Type** : Internal, known	Current IxL 3-3	Target IxL 2-2	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 care landscape.	

Existing Control Measures	Assurance Evidence
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 via Integrated Governance Committee 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 Governance 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, Clinical Quality Assurance Committee, Executive Committee, 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. (Inspiring Quality)	Board and sub-board committees 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.	Nursing Workforce report and associated Board minutes.
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	Audit committee reports and minutes.
CQC regulation compliance	CQC action plan monitoring via Board and sub board 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**
1. Alignment of workforce plans across the system	31/03/2020	Discussions taking place to address demand surges and associated pressures.
2. International recruitment in line with UK Guidance	30/01/2020	Recruitment trip completed. Full target of 75 nurses achieved, with first cohort anticipated to arrive in the UK as of 30 Jan 2020 with high levels of competencies associated to PICU/ HDU and surgical acute areas. Surgical ACN to agree placement plans with wider nursing leadership team.

Executive Leads Assessment
December 2019 – 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.
September 2019 - Hilda Gwilliams No change to score in-month. Action updated to reflect actions implemented following receipt of RPIR on 13/9.

BAF 1.2	Strategic Objective : Delivery of Outstanding Care		Risk Title : Inability to deliver accessible and timely services to patients in line with national standards		
Related CQC Themes : Safe, Caring , Responsive, Well Led, Effective			**Link to corporate risk/s:** 1524		
Exec Lead : Adam Bateman		**Type** : Internal, known	Current 3x3	Target 3x2	Trend: STATIC

Risk Description
Failure to provide outstanding care due to delays in planned care, delays in emergency care and services that do not meet the needs of users

Existing Control Measures	Assurance Evidence
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 ▪ 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 CAMHS ▪ Investment in additional workforce in CAMHS ▪ 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 CAMHS and community paediatrics. Request submitted to Sefton CCG for urgent investment in

community paediatric services.		
4. Comprehensive, real-time and digital access times dashboard for Community Paediatrics and CAMHS		
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	30/06/2020	Alternative service provision models e.g. pathways within ASD/ADHD assessment processes Use of external provision (third party provider) when required to manage demand in line with agreed waiting times. Recruitment commenced for Speech & Language, Neuro developmental Practitioner and Clinical Psychology
3. Additional workforce capacity in CAMHS and new pathways	30/06/2020	Recruitment commenced for additional practitioners in CAMHS New CBT group treatment session designed
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
Executive Leads Assessment		
December 2019- 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. 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.		
September 2019 - Erica Saunders Risk reviewed - no change to score in month. All actions remain on track. Challenges remain within ED due to record attendances over the summer months		

BAF 1.3	Strategic Objective : Delivery of Outstanding Care	Risk Title : The Hospital Environment – CLOSE		
Related CQC Themes : Safe		**Link to corporate risk/s:** 1588, 1388, 825		
Exec Lead : John Grinnell	**Type** : Internal, known	Current IxL	Target IxL	Trend:

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

Existing Control Measures	Assurance Evidence
Monthly issue meetings	Maintenance of Issues List and Issues Review Meeting
Monthly liaison meetings	Liaison minutes reported to Trust Board monthly
Regular reports to IGC	IGC Agendas, Reports and Minutes
Building Management Services Risk Register	Risk Register held on Ulysses – reported to IGC
NED / ED / Project Co senior group overseeing management of pipework risk	Letter of agreed actions. Minutes of meeting
Water Safety Group meets monthly	Minutes

Gaps in controls / assurance
1. Pipes. Non-destructive testing initially looks accurate with a first phase test underway which we hope will evidence as a risk management methodology
2. Water ingress. Temporary repairs in place which are proving resilient. Long term solution now planned for Spring 2020
3.

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

Executive Leads Assessment
November 2019 - John Grinnell Risk score reduced as progress made on water ingress with no re-occurrence, improved water temperature ranges and positive feedback on non-destructive testing of pipework.
October 2019 - John Grinnell Risk reviewed - no change to score whilst awaiting rectification plans from Project Co. No water ingress in-month.
September 2019 - John Grinnell Agreement reached with Project Co. to jointly commission an independent survey of the fabric of the roof. Awaiting outcome of non-destructive pipe testing validation meeting with Project Co. directors and members of the Board being convened to oversee.

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			**Link to corporate risk/s :** NONE		
Exec Lead : John Grinnell		**Type** : External	Current IxL 3-3	Target IxL 3-1	Trend: STATIC

Risk Description
Failure of measures put in place nationally and locally in the event of a 'no deal' exit from the EU to safeguard the organisations ability to deliver services and maintain business continuity

Existing Control Measures	Assurance Evidence
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 frameworks completed and submitted to NHSE.
Internal command team structure focusing on eight key areas each week to assess level of risk and update plans based on national information. Group responds to national guidance as it is published.	- Weekly report to Executive Team to address deficits and escalate as required.

Gaps in controls / assurance
1. Supply issues in the event of a 'no deal' exit from the EU
2.
3.
4.
5.

Actions required to reduce risk to target rating	Timescale	Latest progress on actions
1. Guidance from NHSE is to suspend active processes pending outcome from Election. Work continuing on our assurance framework on any actions not yet green.	22/12/19	Update report going to Board on 1 October to provide assurance in relation to business continuity plans
2. Continue to engage NHSE colleagues to ensure centrally managed mitigations are understood and adequate	22/12/19	Actions as above
3.		

Executive Leads Assessment
December 2019
November 2019 - Lachlan Stark Risk review undertaken today. NHSE Webinars paused pending outcome of election. Maintained risk levels due to lack of clarity despite extensive work locally and nationally regarding supply chain. Current exit scheduled to 31 Jan 2020.
October 2019 - Lachlan Stark Risk review undertaken today. NHSE Webinars set to rollout which may alter the risk rating but EU exit extension currently pushed back to 31 Jan 2020.
September 2019 - John Grinnell Risk reviewed, no change to score. Actions updated to reflect latest position. Weekly group in place with full oversight

BAF 2.1	Strategic Objective : The Best People Doing Their Best Work in the Best Place	Risk Title : Workforce Sustainability and Development		
Related CQC Themes : Safe, Effective, Responsive, Well-Led		**Link to corporate risk/s:** 1169, 1984, 201, 1270		
Exec Lead : Melissa Swindell	**Type** : Internal, known	Current IxL 4x3	Target IxL 4x2	Trend: **WORSE**

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
Workforce KPIs tracked through the corporate report and divisional dashboards	Corporate Report
Bi-monthly Divisional Performance Meetings	Regular reporting of delivery against compliance targets via divisional reports
High quality mandatory training delivery 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 intranet
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 developments	Reporting to HEE
People Plan implementation	People Strategy report monthly to Board
International Nurse recruitment	75 skilled nurses to join the organisation across 20/21
PDR and appraisal process in place	Monthly reporting to Board
Apprenticeship Strategy implementation	Bi-monthly reports to WOD OFSTED 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 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 remains at 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.	24/12/2019	Progress delayed. Under review for a roll out for business planning for 2020/21
4. Succession planning completed for the Executive Team. To be rolled out to the Divisional senior management teams in January 2020	29/02/2019	In progress

Executive Leads Assessment
December 2019 - 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

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:** NONE	
Exec Lead : Melissa Swindell	**Type** : Internal, known	Current IxL 3x4	Target IxL 3x3 / Trend: **WORSE**

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
The People Plan implementation	Monthly Board reports
Wellbeing Strategy implementation	Wellbeing Steering Group ToRs, reports to WOD
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 minutes
Values based PDR process	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)	201 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 updates provided to WOD
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

Staff Advice and Liaison Service (SALS) service not yet implemented

Wellbeing team to support sickness absence not yet implemented

Junior Doctor experience not as positive as it should be

Actions required to reduce risk to target rating	Timescale	Latest progress on actions
SALS proposal approved at WOD in December 2019	Dec 2019	Proposal in development
Appoint to the wellbeing team	Jan 2020	Team Leader appointed; team to be appointed Jan 20
1. 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

December 2019 - 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 remain on track, risk rating remains the same

September 2019 - Melissa Swindell

Risk Reviewed, actions remain on track, risk rating remains the same

BAF 2.3	Strategic Objective : The Best People Doing Their Best Work	Risk Title : Workforce Equality, Diversity & Inclusion		
Related CQC Themes : Effective, Well-Led		**Link to corporate risk/s** : NONE		
Exec Lead : Melissa Swindell	**Type** : Internal, known	Current IxL 3x4	Target IxL 3x2	Trend: STATIC

Risk Description
Failure to proactively support the development of a diverse and inclusive workforce which truly represents the local population, and ensure that Alder Hey is a place where all staff feel their contribution as an individual is recognised and valued, and the care we provide reflects this.

Existing Control Measures	Assurance Evidence
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
BAME Network established, sponsored by Director of HR & OD	BME Network minutes
Disability Network established, sponsored by Director of HR & OD	Disability Network minutes
LGBTQIA+ Network established, sponsored by Director of HR & OD	LGBTQIA+ Network minutes
Actions taken in response to 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
Actions taken in response to WDES	- Monthly recruitment reports provided by HR to divisions - Workforce Disability Equality Standards Bi-monthly report to WOD
Time to Change Plan	- Time to Change Plan
Leadership Strategy; Strong Foundations Programme includes inclusive leadership development	11 cohorts of the programme fully booked till Nov 2020
Gaps in controls / assurance	
Workforce is not representative of the local community we serve	
BME staff reporting lower levels of satisfaction in the staff survey	

1. **Actions required to reduce risk to target rating**		
Work with the BME and Disability Networks to develop specific action plans to improve experience.	31/12/19	Time to change plan implemented Oct 19
Work with Community Engagement expert to develop actions to work with local community	31/12/19	scoping expertise to identify potential C&M NHS resources

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

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 :** NONE		
Exec Lead : David Powell		**Type** : Internal, known	Current IxL 3-3	Target IxL 3-2	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
Business Cases developed for various elements of the Park & Campus	Approved business cases for various elements of the Park & Campus
Monitoring reports on progress	Monthly report to Board Stakeholder events / reported to Trust Board
Heads of Terms agreed with LCC for joint venture approved	
Redevelopment Steering Group	Reports into Programme Board
Monthly reports to Board & RABD	Highlight reports to relevant assurance committees and through to Board
Capacity Lab have been engaged for a period of 3 months to complete a piece of work/proposal for setting up a Community Interest Company as well as supporting the Trust to bring partners on board with the development and providing some financial contributions	

Gaps in controls / assurance
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
1. Complete cost assessment and scheme rationalisation	22/10/2019	Cluster schemes prepared for market test
2. Secure approval for plans to increase Park footprint	12/11/2019	Park plans signed off by stakeholder groups March 19
3. Agree Park management approach with LCC	31/12/2019	Outline process agreed with LCC
4. Complete cost plan for final park works	31/12/2019	Phase 1 park tendered
5. Assessment of status including risk of all development 31/10/2019 projects	31/12/2019	Report to November Board
6. Secure planning	29/11/2019	Planning secured
7. Agree plan for bringing forward Park clearance	31/12/2019	Plan agreed at November Board
8. Agree detailed plan for Phase 1 Park works	31/12/2019	Consultation process in train

Executive Leads Assessment
December 2019 – David Powell Programme Review paper prepared for January Board including risk assessment.
November 2019 - David Powell Review in advance of December Board
October 2019 - David Powell Review in advance of November Board
September 2019 - David Powell Risk reviewed post completion of Phase 1 park tender

BAF 3.2	Strategic Objective : Sustainability through External Partnerships	Risk Title : 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
Related CQC Themes : Caring, Effective, Responsive, Well-Led		Link to corporate risk/s : NONE
Exec Lead : Dani Jones	Type : External, known	Current IxL 4x3 = 12 / Target IxL 4x2 = 8 / 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
Divisional Performance Management Framework – includes clear trajectories for challenged specialties to deliver	Monthly to Board via RABD and Board. (Example of monthly divisional-level detail attached)
Accreditations confirmed through national review processes - REMOVE	
Five year plan agreed by Board and Governors in 2014- REMOVE	
Compliance with All Age ACHD Standard	- Strategic Partnerships & International Clinical Business and non NHS Patient Services - 7 Day Working Project - CIPs in new Change Programme subject to assurance and sub-committee performance management.
Involvement of trust executives, NEDs and Governors in development of international patient proposals	Service development strategy for Private / International patient proposal approved by Council of Governors as part of strategic plan sign off (March 18, September 18)
Compliance with All Age ACHD Standard	ACHD Level 1 service now up and running; developing wider all-age network to support – agreement reached to host at Alder Hey.
Service development strategy including Private / International patient proposal approved by Governors as part of strategic plan sign-off (March 2018, September 2018) - REMOVE	
Capacity Plan identifies beds and theatres required to deliver business development 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 through Partnerships included in Strategic Business planning – both annual operational plan and the developing long term / strategic plan Monitored at Programme Board and via Strategy & Ops Delivery Board
Internal review of service specifications as part of Specialist Commissioning review	Compliance with final national specifications.
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.
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 about partnership plans, our role in the system and growth that supports children and young people's needs as well as system needs	'Our Plan' approved at Trust Board October 2019
'One Liverpool' plan to 2024: system plan detailing clear strategic intent re: Starting Well and children and young people's services	Evidences alignment of Alder Hey's plan with those of our integrated care system and evidences the drivers for key partnerships within.
Involvement of Trust Executives in partnership governance arrangements	TOR & Minutes – NW Paediatric Partnership Board

Gaps in controls / assurance

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

Actions required to reduce risk to target rating	Timescale	Latest progress on actions
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	31/01/2019	
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	28/02/2019	
4. Continue to develop joint partnership hosting arrangements for existing and pending ODNs with RMCH	31/06/2020	
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
December 2019 – 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.
September 2019 - Dani Jones Risk reviewed: updated to include our future and role in the wider system, 'Our Plan', staff sessions and One Liverpool plan. No change to risk level in month.

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 :** NONE		
Exec Lead : John Grinnell		**Type** : Internal, known	Current 4x4	Target 4x3	Trend: STATIC

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

Existing Control Measures	Assurance Evidence
Organisation-wide financial plan	Monitored through Corporate Report and in detail through RBoard/RABD
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 - Internal and External Audit reporting through Audit Committee. - Financial management training for budget holders and senior managers
Capital Panning Review Group	5 Year capital plan ratified by Trust Board
Bi-Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	Bi-Monthly Performance Management Reporting
Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation.	Monitored through Exec Comm Cell and Exec Team
Weekly sustainability delivery group overseeing efficiency programme	Weekly Financial Sustainability delivery meeting papers
CIP subject to programme assessment and sub-committee performance management	Tracked through Execs / RABD
RABD deep dive into key financial risk areas at every meeting	RABD Agendas, Reports & Minutes

Gaps in controls / assurance
1. Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan.
2. 'Grip' on CIP
3. Affordability of Capital Plans
4. Cost of Winter escalating
5. Long Term Plan shows £3m shortfall

Actions required to reduce risk to target rating	Timescale	Latest progress on actions
1. Tracking actions from Sustainability Delivery Group	31/03/2020	On target
2. Develop fully worked up CIP programme - £1.5m gap	31/03/2020	CIP continues to be managed weekly at SDG. Links with financial recovery and 6 workstreams which will also improve CIP position. On target to deliver CIP.
3. Five Year capital plan	31/01/2020	Revised Capital Plan agreed by Board however latest LTP shown potential further cash shortfalls. Mitigation strategy to be further worked up based on likely delays to schemes in the latter part of the five year plan.
4. Cost of Winter	31/01/2020	Clear tracking of all pressures in place with full impact assessment. Discussions with NHSE/I and commissioners regarding system support to additional investments we are making.
5. Long Term Financial Plan	31/01/20	Current shortfall against 20/21 plan which has been largely impacted by removal of central PSF support and ongoing dilution of paediatric tariff. Ongoing work with Paediatric

		Alliance to evidence the shortcomings of the tariff for complex paediatric cases and a supporting lobbying programme.
Executive Leads Assessment		
December 2019 – 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		

BAF 4.1	Strategic Objective : Game Changing Research and Innovation	Risk Title : Research, Education & Innovation **RE-DESCRIBE** **Where are we growing the future? Need to really leverage the commercial opportunity.**		
Related CQC Themes : Responsive, Well-Led		**Link to corporate risk/s :** NONE		
Exec Lead : Claire Liddy	**Type** : Internal, known	Current IxL 3-3	Target IxL 3-2	Trend: STATIC

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

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

Gaps in controls / assurance
1. Sporadic meetings of RIE committee
2. Governance structure for Innovation Board to be agreed
3. Re-energise Research governance processes
4. Reporting frameworks and standards for all services to be agreed/harmonised

Actions required to reduce risk to target rating	Timescale	Latest progress on actions
1. Develop a robust Academy Business Model		
2. Agree incentivisation framework for staff and teams: for research time & innovation time.	31/03/2020	Framework refresh
3. Complete collaboration contract with University of Liverpool. This is a strategic agreement - deadline reset to March 2020 as part of 3 year join planning with UoL VP.	31/03/2020	
4. Complete review and implement new structures and framework for research, innovation & education	01/10/2019	

Executive Leads Assessment
November 2019 - Claire Liddy Updated and reviewed. Risk static
October 2019 - Claire Liddy Updated and reviewed
September 2019 - Claire Liddy Updated actions and owners. risk score static

BAF 4.2	Strategic Objective : Game Changing Research and Innovation	Risk Title : Digital Strategic Development and Operational Delivery		
Related CQC Themes : Safe, Caring, Effective, Responsive, Well-Led		**Link to corporate risk/s :** NONE		
Exec Lead : Kate Warriner	**Type** : Internal, known	Current IxL 4-2	Target IxL 3-2	Trend: BETTER

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

Gaps in controls / assurance

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

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

Executive Leads Assessment

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.

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

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

BOARD OF DIRECTORS

Tuesday 07/01/2020

Paper Title:	Corporate Risk Register Report
Report of:	John Grinnell, Deputy Chief Executive/Director of Finance
Paper Prepared by:	Cathy Umbers, Associated Director of Nursing and Governance

Purpose of Paper:	Decision ☐ Assurance ■ Information ☐ Regulation ☐
Background Papers and/or supporting information:	Integrated Governance Committee minutes and associated papers
Action/Decision Required:	To note ☐ To approve ■
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Delivery of **outstanding care** ■ **The best people** doing their best work ■ Sustainability through **external partnerships** ■ Game-changing **research and innovation** ■ **Strong Foundations** ■
Resource Impact:	Resources identified to support management of risks as required.

1. Introduction

This paper provides the Board with the opportunity to scrutinise the current Corporate Risk Register (CRR) and review the changes to the register between 1st November 2019 and 6th January 2020.

2. Corporate Risk Register

The CRR has been updated to highlight the current position, following review, by the Executive Management Team on 19th December 2019. The summary of the CRR is included at Appendix 1 of this report.

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 2065 (risk score 15).

The summary report highlights the trend for each individual active current high risk, in addition to the current controls and actions to mitigate the risks to support achievement of the identified target score. Furthermore, the risks are aligned to the strategic objectives and the Care Quality Commission Key Lines of Enquiry, domains.

The high risks as shown on the Trust risk profile, at **Table 1**, accounts for 2.6% % of all risks, currently on the Trust Risk Register.

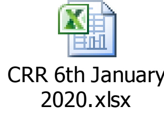
Table 1. Trust Risk Profile (383 risks)

Very Low Risk			Low Risk			Moderate Risk				High/ Extreme Risk				No risk rating
1	2	3	4	5	6	8	9	10	12	15	16	20	25	
4	**4**	**5**	**17**	**8**	**69**	**44**	**86**	**26**	**102**	**4**	**5**	**1**	**0**	**8**
13 (3.4%)			**94 (24%)**			**258 (67%)**				**10 (2.6%)**				**2%**

3. Corporate risk reduced and closed

There were 19 high risks reduced during this reporting period and 2 high risk closed, although both have been re-evaluated and opened as new risks at a reduced level. A summary of the reduced and closed risks is included at Appendix 2 of this report.

Appendix 1 Corporate Risk Register (CRR)



CRR 6th January 2020.xlsx

Appendix 2.

High risks reduced					
Ref	**Risk description**	**Previous score**	**Current Risk Score**	**Target Risk Score**	**Agreed Mitigation/Action**
1187	Resilience in core IT systems with no secondary data centre in place	16	12	4	Procure and Implement new resilience equipment
1241	Insufficient Capital Funding to complete the park as per the Land Swap Agreement with Liverpool City Council	16	12	6	Additional resource is being explored to enable some dedicated time to bringing in goods or income to support development of the park in a phased approach
1306	Ability to recruit junior doctors to fill gaps in rotas in the Division of Surgery	16	6	6	Development of long term strategy
1388	Risk of pipe burst due to corrosion	16	12	6	Monthly meeting to be setup with execs/non execs and SPV to monitor progress.
1588	Inadequate Ventilation system on Critical care Manusa	16	5	5	Exploring options to upgrade/change the ventilation system
1668	Potential failing to respond to the results of diagnostic tests.	15	12	5	Establish results functionality in Expanse and work with clinical group as part of Expanse deployment to establish how best to use the new functionality - Due end March 2020. Rheumatology Team to lead a notices pilot
1715	Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease.	25	5	5	None identified. It was agreed by executives that while it would be catastrophic should this risk be realised it would be rare in terms of likelihood.
1787	Error in the prescribing, preparation, administration and monitoring of Parenteral Nutrition	15	12	5	Prescribing of TPN through the meditech system will be pursued Protocols and new prescriptions for standard bags for neonates and older children will be produced Non-medical prescribers (dieticians and pharmacists) to be appointed to support prescribing and the development of a Trust Nutrition Team. This was one of the recommendations by the RCPCH review within the Trust and is being led by ACN Medicine Criteria for initiation of TPN will be agreed with all relevant teams Video demonstrating appropriate set-up for TPN required on the intranet Set up TPN Steering Group
1904	Ability to fill nursing duty rotas effectively on ward 4A	16	12	6	Secure funding for band 4 AP's to undertake band 5 nurse training to increase Authorisation given from division to place independent national advert to recruit experienced orthopaedic and neurosurgical nursing staff.

					International recruitment
1919	Failure to reach 80% compliance with front line Staff influenza vaccination in 2019-20	15	10	6	Flu Campaign IPCN generate uptake report every week and send to Exec and divisions each week until end of Flu season Training of Peer based vaccinators Walk rounds by IPC team Walk rounds by Team prevent
1961	Loss of access to clinical and corporate IT systems	15	10	5	Produce monthly dashboards demonstrating progression against all critical and high actions. Compliance for this was dependant on new Cyber monitoring tool and dashboard to report against Cyber and CareCert alerts. This has now been purchased and is being configured during Nov/Dec; this will then allow for management dashboard and reports to be produced. Board Approval in September to proceed with funding to enhance the trusts cyber defence tools. Product evaluation ongoing and further Cyber/Security Audits in train for November via MIAA, report due end of November. New Cyber Security specialist hired till end March to review all policies, processes and evaluate new cyber defence tools, these would then be implemented Jan/Feb 2020 subject to evaluation and procurement process. IT Health Dashboard has been purchased to support DTSP toolkit and carecert compliance. This has been installed but needs configuring during Nov/Dec to allow for tailored dashboards and management reporting
1965	Risk of patients lost to follow up following discharge	15	10	4	Gap analysis for all clinical areas to determine when additional ward clerks required, how many currently in place, what is the deficit, Development of Business Case,
2003	Financial Risk against the demolition budget	15	12	6	Discuss cost pressure with Finance Dept. in context of overall Development capital plan.
2016	unsustainable vascular access service across Trust	20	8	4	Recruitment process progressing.
654	Staff acquiring airborne hospital acquired Infections whilst delivering patient care	16	9	4	Staff influenza vaccination campaign with support of communication team Divisions to create plan for improving fit testing compliance including the Medical staff
799	Failure to control contractors on site (CHP) & Retained	16	12	4	Building services have been liaising with key departments to ensure that all contractors brought on to site have provided the necessary documentation and approved to attend to carry out the works. BST to provide report identifying locations sky visitor installed and list of staff trained in use of the system.

825	Risk of potential deliberate jumping from height from internal balconies	15	10	6	A third report was commissioned by the building service team which Project Co undertook. The report has indicated that the handrails cannot be removed (see attachment). Associate director of estates has indicated that a further discussion will take place between specialist architect and P Co's architect to determine the reasons.
884	Failure of RO Plant supporting Haemodyalsis	16	12	4	Regular meetings between Interserve and Renal unit.
947	Lack of resilience in Meditech EPR with no secondary data centre in place	16	12	4	1. Meditech 6 resilience implemented by the end of 2019 2. Meditech Expanse resilience in partnership with CCC implemented in line with go live of system in 2020
High risks closed					
902	Ability of clinical staff to view patient information electronically between systems i.e. EMIS and Meditech	16	12	4	Agree with IMersey a training package for AH staff who need viewing access to EMIS. Meditech training for view access to EMIS users. Agree local level of support for community from IM&T to include service desk and technician support to community teams. Identify all staff who require mobile devices and agree roll out plan Comprehensive plan to: improve network connectivity provide appropriate devices Migrate iMersey connected staff to AH network Risk closed and new risk opened , reference 2077 - current risk rating 12
964	Risk of elective list errors due to planning and scheduling processes	15	15	4	Following divisional review this risk has been closed and re-opened under 2047 (risk rating 12) and 2048, separating the risk elements.

Ref	Risk Owner	Date Identified	Risk Cause	Risk Description	Controls/Mitigations	Action(s)	Risk Score	Target	Trend	Link to Strategic Objective	Link to CQC domain
Corporate Risk Register Report (CRR)) 06/01/2020											
2067	Associate CN Medical Division	20/12/2019	Our workforce numbers of nurses and dietitians are below England's national average according to National Paediatric Diabetes Audit and Royal College of Paediatrics and Child Health.	May not be able to meet the National Best Practice Tariff (BPT) resulting in our BPT payment being removed	2 new Band 6 PDSN have been employed commenced in post	Intense training programme for new staff in post	15	9	new	The Best People Doing their Best Work.	Safe Well led
2035	COO	25/11/2019	A new programme of work to review and redesign pathways is in development.	Lack of capacity and / or capability of workforce to undertake pathway review and implementation of changes	None identified	Inspiring Quality are procuring a partner to develop capability within the workforce and this will start in January 2020.	16	?	new	The Best People Doing their Best Work.	Safe Well led
201	Director of HR& OD	12/04/2011	Staff ill-health, wellbeing issues above the Trust target of 4%	Risk of being unable to meet staffing duty rota requirements in line with best practice standards	Occupational Health Provider, Team Prevent established with focused work on H&WB and sickness absence. Team Prevent support for wellbeing - appointment of a Health Trainer supporting stress and wellbeing. HR Business Partners and HR Advisors providing regular coaching, workshops, training sessions. Increased focus on the effective management of sickness absence at divisional level. Monthly meetings with HR team and depts. to review action plans for managing sickness in each of the respective areas. Health and wellbeing forum to address the wellbeing agenda for the Trust. Working with NHSI on a national programme for improving employee health and wellbeing.	The managerial teams within the trust will need to support clinical teams with capacity release to ensure the progress of review and redesign is not limited due to lack of capacity.	16	6	⇔	The Best People Doing their Best Work.	Safe Well led
1131	Director of Community and Mental Health	17/08/2016	No plan in place to ensure clinical notes are scanned and/or archived in a timely manner. Large quantity of paper records in departments across the Division which are not yet scanned - CAMHS, Community Paediatrics, therapy and community nursing teams, which means the information is not visible to other clinical teams. No process for archiving or scanning notes created by teams transferred in from LCH (April 2017).	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. Developing trust wide implementation plan	Agreement regarding process for archiving notes, space and SOP for retrieval Review records management processes as part of overall Trust review of clinical records in line with progress towards a digital records management solution. Participate in trust review of current state and contribute to development of strategic vision for records management in the future. Records which have been scanned into EMIS require archiving/storage offsite and/or closed cases which are not scanned require storage. Agree process and source provider of storage facilities. Division to identify project management resource to work with Medical Records and IT to develop project plan to address risk.	16	4	↑	The Best People Doing their Best Work.	Safe Well led
1169	Medical Director	21/12/2016	Insufficient paediatric consultant Haematologist at Alder Hey and nationally.	Ability to staff non-malignant Haematology medical staff rota.	Locum consultant oncologist, Junior doctors acting up via Royal College, Consultant Haematologists undertaking high intensity on call, 1/2.	3174: Job planning for Haematology medical workforce. 2379: ANP training programme (2 staff on course).	20	5	⇔	The Best People Doing their Best Work	Well-Led, Safe

1866	Medical Director	22/03/2019	guidelines and pathway's past expected review date	incorrect treatment and care prescribed and implemented.	A central database of guidelines on intranet available	Recovery plan in place and progressing at pace	15	6	⇔	Delivery of Outstanding Care	Well-Led, Safe
1270	Director of Community & Mental Health	02/05/2017	Increased waiting times for ASD and ADHD diagnostic assessments in Sefton due to a lack of commissioned NICE compliant pathways.	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 CCG for on-going monitoring. Data is now 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	ensuring all relevant job plans are fit for purpose Commence a prescription audit measuring against ADHD recommended medication regimes	16	8	⇔	Delivery of Outstanding Care	Safe, Well-Led
1524	Director of Community & Mental Health	12/12/2017	Lack of capacity in adult ADHD service to transition patients.	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 CCGs. Quarterly project progress reports to divisional board meeting (Liverpool). Trust Transition Policy in place (C62 - Transition To Adult Services - attached) ADHD medication care pathway Formal contract withdrawal notice on the care provision to adults receiving ADHD specific medications and care ceasing from 1 April 2019. CCG made arrangements of adult service provision by Merseycare Formally agreed process for transitioning adults with ADHD to CWP (adult facility) Liverpool cohort project team in place Joint CWP/ Alder Hey Transition SOP	Identify cohort of patients to be transitioned and write to the families to make them aware of the process	16	8	⇔	Delivery of Outstanding Care	Safe, Well. Led
1921	COO	09/07/2019	SOP not being followed	Potential risk of failing to respond to the Trust bleep system process.	Stand Operating procedure, daily tests at 100.00 hours, Quarterly reports re compliance to Resus Committee from Facilities	**Non Identified**	15	4	⇔	Delivery of Outstanding Care	Safe, Well-Led
1984	Director of Surgery	20/09/2019	Lack of bed capacity on the cardiac unit (Ward 1C) is leading to cancellations of patients, delayed stepdowns from PICU and general HDU and an inability to take emergency patients	Delays in children being able access Cardiac treatment (delayed stepdown from critical care meaning that this capacity is not available for other patients).	1C (cardiology) patient flow group review capacity issues and identify any children who can be safety nursed in other areas of the trust . Daily review on the ward round all the children who need a bed on the cardiac unit and make informed decisions of priority . Daily huddle to review bed availability and prioritise any emergency cases. Weekly list planning meeting - to look ahead to the next week and anticipate any issues and manage case mix of cases as appropriate	Weekly planning meeting to review pathways to provide more effective patient flow in line with SAFER	15	4	⇔	Delivering outstanding care	Effective, Well-Led

BOARD OF DIRECTORS

Tuesday 07/01/2020

Paper Title:	Integrated Governance Committee (IGC)
Report of:	Kerry Byrne, Non- Executive Director, Chairperson Integrated Governance Committee
Paper Prepared by:	Cathy Umbers, Associated Director of Nursing and Governance

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

1. Introduction

The purpose of this paper is to provide the Board with assurance that the Integrated Governance Committee (IGC) is compliant with its terms of reference.

2. Background

The Divisions and Corporate Services presented their Risk Management Reports to the committee, focusing on high risks, and others that required committee input. The Corporate Risk report was also presented and discussed, including evidence of improvements, areas where further work was required to ensure the risks are mitigated to tolerable level. The committee was advised that there are currently 28 high risks identified in the Trust and 4 new high risks were identified since the last reporting period.

3. Conclusion

While it was acknowledged that good progress has been achieved in managing risk, it was agreed that further focused work is required to enable the committee be assured that risks are being managed effectively in all Divisions and Corporate Services. The Division leads were advised to focus on risk management in their services and review effectiveness of assurance processes. This will support the work of the Integrated Governance Committee going forward.

4. Recommendations

The Board is asked to note the content of the Integrated Governance Committee minutes and assurance progress.

INTEGRATED GOVERNANCE COMMITTEE
11th September 2019
Time: 10:00-12:00
Venue: Institute in the Park, Lecture Theatre 4

Present:

Mrs K Byrne	Non-Executive Director **(Chair)**	(KB)
Mr M Flannagan	Director of Communications	(MF)
Mr A Bateman	Chief of Operations	(AB)
Mrs M Swindell	Director of HR & OD	(MS)
Mrs P Brown	Director of Nursing	(PB)
Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mrs R Greer	Assoc. Chief of Op (Community)	(RG)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Christian Duncan	Director of Surgery	(CD)
Mr Dean Eyre	Associate Director of Operational IT	DE)
Mrs K Warriner	Chief Digital Information Officer	(KW)

In Attendance:

Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mrs C Fox	Programme Director for Digital	(CF)
Mrs A Appleton	Healthcare Planning Manager (CHP)	(AA)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mr J Taylor	General Manager – Research	(JT)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Mrs J Fitzpatrick	Information Governance Manager	(JF)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mrs C Barker	Chief Pharmacist	(CB)
Mrs A Chew	Associate Director of Finance	(AC)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mrs S Stephenson	Head of Quality for Community	(SS)
Mrs E Hughes	Associate Chief Innovation Officer	(EH)

In Attendance Other:

Mrs J Keward	Infection Control Nurse	(JK)
Mr P Sanderson	Head of Pharmacy	(PS)
Mrs J Preece	Governance Manager	(JP)
Miss L Calder	Minute Taker	(LC)

Apologies:

Mr J Grinnell	Director of Finance	(JG)
Mrs N Murdock	Medical Director	(NM)
Mr D Houghton	Senior Project Manager	(DH)
Mrs C Liddy	Deputy Director of Finance & Development	(CL)
Mrs L Cooper	Divisional Director of Community	(LC)
Mr D Powell	Director of Development Directorate	(DP)
Mr A Williams	Director of Community	(AW)
Mr A Hughes	Director of Medicine	(AH)
Mrs S Brown	Senior Project Manager	(SB)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mrs E Saunders	Director of Corporate Affairs	(ES)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mr S Atkinson	Interim Associate Director of Estates	(SA)
Ms L Fearnehough	Head of Technical Services	(LF)
Mrs V Weston	Assoc. Dir. of Infection Prevention	(VW)

APROVED

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
Housekeeping					
	1.	**Apologies for absence**	Noted			
	2.	**Chair's introduction**	KB asked could the updates from any actions be included as part of the Risk Management Reports going forward, KB will refer to the Actions List to make sure we don't miss any actions. Following this introduction KB will deal with any actions which don't fall easily into any of the reports. This will support the smooth running of the meeting. Graphs in reports - KB advised that the graphs within a number of reports contain decimal points on their axis rather than whole numbers and asked that this be corrected for future reports. Risk owners – KB advised that there are occasions where, for example, a clinical risk has been assigned to either IM&T or Finance. As a general rule such risks should sit in the divisions, and where IT or finance support is required (or other function), actions should be discussed and assigned to other areas. If they are high clinical risks then they may be assigned in terms of ownership to the relevant clinical executive e.g. Medical Director or Chief Nurse, following discussion. However, the risk manager in the Division remains responsible for the day to day management of the risk including overseeing actions to mitigate and escalating accordingly. Lastly an update on direction of travel for IGC …. KB advised that she has previously mentioned that she has had discussions with the Board and Executives to how we further evolve	Graphs to incorporate whole numbers and not decimal points in line with template Risk owners to check for any such risks and update. IM&T and Finance particularly to identify any such risks allocated to them and liaise with the relevant risk	All All	29th Nov 19 29th Nov 19

APPROVED

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			IGC to better meet the requirements of the CQC in particular Well-Led, and given the devolved governance model. There will be a working group set up shortly to determine the future direction of travel to achieve Trust requirements and this will require the input from each of the divisions. KB advised she will keep the committee members updated of progress at future IGC meetings.	owner		
19/20/58	2.1	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 10th July 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.			
19/20/59	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 on 2nd September 2019, and is inclusive of all high risks on the register from 1st July 2019 – 31st August 2019. There were 27 **high risks** on the register at the time of reporting. **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 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			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			providing incorrect information" **Actions overdue completion** **Risk no 1187 risk rating 16** – One overdue action reference 4665 **Risk no 1270 risk rating 16** – Overdue action reference 7116. **Risk no 1312 risk rating 15** – Overdue action reference 857. **Risk no 1524 risk rating 16** – Overdue action reference 7248 **Risk no 1668 risk rating 15** – Overdue actions reference 6989, 6991, 6992, 5136. **Risk no 1730 risk rating 15** – Overdue action reference 6690. **Risk no 1751 risk rating 15** – Overdue action reference 5828. **Risk no 1808 risk rating 15** – Overdue action reference 6674. * **Risk no 1715 risk rating 25** – Overdue action reference 7956. **Risk no 1241 risk rating 16** – initial risk rating same as current with controls identified **Risk no 1388 risk rating 16** – Initial risk rating same as current with 2 controls identified. **Risk no 1701 risk rating 16** – Initial risk rating same as current with one control identified. **Risk no 964 risk rating 16** – Initial risk rating same as current with 7 controls identified. **Risk no 825 risk rating 15** – No gaps identified. **Risk no 884 risk rating 16** – No gaps identified. **High risks** **Risk no 1715 risk rating 25 - Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease.** AM advised this			

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			risk related to not being able to review echo reporting clearly; however there are a number of controls in place. The critical care team are working closely with IM&T to purchase software to have a clear place for the echos up and running as soon as possible. CU advised planning needs to be in place and expedite as soon as. The scoring of 5x5 suggests this risk is imminent (e.g. could happen this week) and that the outcome will be catastrophic. AM advised not being able to see echo MDT as it doesn't function properly. At the moment the cardiologists are not reporting in the same way and it's not always clear if the patient is safe for surgery and this is a complicated problem to deal with however we are mitigating the risk in the interim. Christian Duncan, Director of Surgery advised there are 2 incidents relating to echo so far which were picked up in other ways before it got to this risk rating. AM advised that the Clinical consultants wanted this risk rated as a 5x5 but feels it should be rated at 4x4. CD advised he will speak with his colleagues in relation to this risk and AM will report back to IGC. **New high risks identified = 5** **Risk no 1919 risk rating 15** – "Failure to reach 80% compliance with front line Staff influenza vaccination in 2019-20" – Initial risk rating same as current risk rating with controls identified. Action overdue. **Risk no 1921 risk rating 15** – "Lack of robust mechanisms for ensuring emergency bleep system is working" – Initial risk rating same as current risk rating with controls identified. No actions to address gaps identified, target risk rating 10. **Risk no 1958 risk rating 16** – "Reduction in critical care capacity and significant disruption to the care of children who require intensive or high dependency care associated with the unplanned closure of critical care beds" – Decreased from a 20.			

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			Risk no 1961 risk rating 15 – "Risk to Patient Care and operational delivery caused by cyber security issues" – Initial risk rating same as current with controls identified. **Risks reduced/closed** **Risk no 1312 (Closed)** – Tendering for subcontracted provision – risk was reviewed and concluded the risk is obsolete. **Risk no 1808 (Closed)** – Fire risk in the Institute in the Park – An interim solution has been found. However, the initial, current and target risk ratings are the same; 15. There are no evidence of controls in place and an action overdue with no progress update. **Risk no 1887 (Closed)** – Unsafe patient area – This risk is being managed via risk 1958. **Risk no 1588 risk rating 15 (reduced from 20)** – Ventilation system on Critical Care. Initial risk rating was the same as current risk rating with control identified (15), action overdue (reference 7108). Action due for completion 31.08.19, last progress update entered 30.07.19. **Note;** 20 of 27 (70%) high risks remain static. Of 27 risks 15 have actions overdue completion date, which raises concerns around their management. CU advised that while there is evidence of progress, there needs to be a concentrated focus on actions to mitigate the risks, ensuring the right actions are in place. If there is no evidence of improvements then a review of the actions needs to take place and an assessment of whether alternative or additional actions are required. Also consistent monitoring of the actions and evidence of this on the register in the progress section is needed to provide assurance to the committee. KB advised there are a number of risks not aligned to the appropriate division, as discussed			

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			earlier and this needs to be addressed. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/60	**2.5**	**Board Assurance Framework (BAF)**	Erica Saunders (ES) was not in attendance to present the Board Assurance Framework. In the absence of the Director of Corporate Affairs the committee noted the content of the BAF. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/61		**BAF Deep Dive Report** **Digital and IM&T**	Kate Warriner (KW) presented the BAF 4.2 risk (which also incorporated IM&T high risks from the CRR). KW advised that the description of BAF risk 4.2 is "failure to deliver a Digital Strategy". If delivered it will place Alder Hey at the forefront of technological advancement in paediatric healthcare and deliver a high quality resilient digital and information technology service to staff. The Digital Futures Strategy and Investment Plan have been signed off and we have good controls in place. Integration with digital and divisional teams has been mitigated however there remains a gap within the Medicine Division. Internally and externally there is misunderstanding of the Digital Transformation Plan with an oversight from NHSE. In terms of scale and volume of change there are a lot of adjustments required and from a controls perspective there are clear KPIs in place. Within Digital Strategic Development and Operational Delivery there are three key areas. 1. IT Operating Model Review - This is fairly unique and there are multiple partners involved and the Trust are looking at what the operational model is now and in the future. There are appraisals in development for IT resilience and there are core applications in use and around patient records. The capital has been approved at Trust Board Sept 19. There are a number of			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			controls in place to back up should there be any issues and the Trust should have resilience in place by the end of 2019. 2. Cyber security vulnerabilities - any NHS organisation's cyber security is one of the highest risks. There are a number of controls which need to be in place to get to a good position and have resilience in place. In addition, the Trust has a live dashboard to see any vulnerability. The more digital the organisation the more risks to cyber security. 3. In terms of Digital focus there need to be reflections outside of the meeting as there are considerable risks and some of the BAF risks identified are very wide. This would sit as part of the Working Group. It would be best to agree to split this out and take through RABD using a related business approach. KB commented that some of the risk detail in the BAF relating to resilience and cyber security was operational risks rather than strategic but that she understood it had been added to the BAF given its' significance to raise it to Board level for action to be taken. KB further commented that, as the CRR will be reported to Board regularly now, in future operational risks should stay on the CRR and will be escalated to Board through this mechanism rather than the BAF. KB advised that the Project risks are to go through the Project Board. JG has asked Natalie Deakin, Project Manager to produce a report on the Project risks.			
	3.	**Risk Register Management Reviews**				
19/20/62	**3.0**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. • Total number of risks = 59			

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		• Number of new risks identified since the last reporting period = 5 (1920, 1923, 1928, 1947, 1958) • Number of risks closed and removed from the risk register = 4 (970, 1556, 1743, 1887) • Number of risks with an overdue review date = 2 • Number of risks with no agreed action plan = 11 • Number of risks with changed risk scores = 7 (2 increased, 5 decreased) • Number of high/extreme risks escalated to the Executive Team = 6 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 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 higher risk score and escalated into this category. **High risks with a score of 15+** **Risk no 1715 risk rating (25)**: Misdiagnosis or failure to identify critical (duct dependant) congenital heart disease. (Increased risk score from 10 to 25) *See CRR report for risk discussion **Risk no 1306 risk rating (16)**: Concerns around junior doctor shortages in surgery. AM advised that there are plans in to mitigate, including focus on rotas. **Risk no 1904 risk rating (16)**: Availability of trained nurses on Ward 4A. (Increased risk score from 12 to 16). The division need to strengthen numbers of qualified nurses on ward 4A. 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 the Division are taking staff from other areas, however due to the issues identified this is monitored on a daily basis. PB advised there is a new intake of			

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			nurses starting soon so risk should be mitigated soon. **Risk no 1958 risk rating (16)**: Reduction in critical care capacity and significant disruption to the care of children requiring intensive or high dependency care associated with the unplanned closure of critical care beds. AM advised this is due to water coming into HDU from the roof space above the unit and also problems with wood lice which impacted on ward activity, however there are plans in place to mitigate. **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 with the support of the Digital Team progress has been made. A pilot started on 21st Aug 19 and with IM&T 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 it forward and roll it out to the Trust. **Risk no 1588 risk rating (15)**: Inadequate Ventilation system on Critical care Manusa cubicle. Critical care does not have a fully isolated cubicle. The solution is for Estates and Building services to resolve however the division are assisting Graeme Dixon to progress this as fast as possible. AM to update the next IGC Meeting with an end point to completion of this work. **<u>Risks scores increased</u>** **Risk no 1715, 1904 (see above)** **<u>New risks</u>** **Risk no 1920 risk rating 9**: Risk of not having the equipment required to undertake surgical procedures.			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Risk rating 1923 risk rating 1: The potential infection of patients undergoing cardiac surgery on cardiopulmonary bypass with aerosolised environmental Mycobacterium from water vapour released by the theatre heater-coolers. Actions to mitigate following investigation have been completed. **Risk no 1928 risk rating 6**: Backlog of patients who need dental treatment through theatres. **Risk no 1947 risk rating 6**: Potential to expose children to complications of blood transfusion. [Gap in assurances post-Brexit]. **<u>Ongoing risk</u>** **Risk no 1881 risk rating 12: Access to Critical Care – The** committee requested an update on progress with managing this risk. AM advised there have been amendments to physical activity regarding staffing element to cover the reception desk from 8am to 8pm. The division are working with HR and the process to recruit into this post has commenced. The risk has not changed however the actions to mitigate have. CU asked is there an end date to when the desk will be manned as there is an issue around people tailgating to gain access to the unit and families who need to get in cannot? AM advised he is working with action owners to get to an end point to manage this risk. CU advised this risk is a high moderate and as with any risk at this level if not acted on in a timely manner could either end up with the risk being realised or increasing. AMC advised the Surgery Division are short on the review element of managing risks, due to resources within the team. However the division have focused on the risk agenda and have reviewed risks in the reporting period. AM added that the division do have assurance that risks are being managed effectively.			

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			Resolved that: the Committee NOTED the contents of the paper			
19/20/63	**3.1**	**Medicine Division**	Cath Wardell (CW) presented the risk management report for Medicine. • Total number of risks = 89 • Number of new risks identified since the last reporting period = 12 (1926, 1932, 1935, 1936, 1937, 1938, 1939, 1940, 1941, 1942, 1943, 1960) • Number of risks closed and removed from the risk register = 12 (1539, 513, 1759, 1471, 1591, 1345, 1589, 134, 1267, 1889, 1344, 1191) • Number of risks with an overdue review date = 25 • Number of risks with no agreed action plan = 2 (1835, 1941) • Number of risks without actions = 5 these need to be reviewed by manager/owner: - if risk target has been reached then risk can be closed, if not then further actions need to be considered. Risk No's – 898, 1891, 581, 260, 1540. • Number of risks with changed risk scores = 10 (Decreased) • Number of high/extreme risks escalated to the Executive Team = 6 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **High risks** **Risk no 884 risk rating 16 "Failure of RO Plant supporting Haemodialysis"** Current controls: Internal workarounds and testing of water quality by clinical team, weekly checks from IFM and meetings with Interserve and Renal Team to provide assurance regarding delivery of operational plan. CW advised there are good controls in place and the division are working with the executives and the unit to mitigate. Patients who are not able to have dialysis the division have			

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		been able to defer to Manchester and controls are in place. The business case for a new water plant has been approved and will be in place by end Nov 2019 and this risk will be mitigated. Building Services have been overseeing this working to ensure it happens. AB advised this was submitted to Capital Review two weeks ago and agreed. **Risk no 1938 risk rating 15 "Inadequate number of trained nursing staff to deliver safe and effective care for children and young people diagnosed with Diabetes".** CW advised that an agreement has been made that the team can employ two nurses rather than one. Meeting with the Finance team to determine diabetes budget and plan for Nurse recruitment. **Risk no 1169 risk rating 20 "Fragile Medical Workforce within the Haematology Service".** Current controls: 2 x Advanced Nurse Practitioner (ANPs) in place to support ANP gaps. Recruitment of 2 Locum Consultants. Actions being taken: ANP training programme in place - 2 staff on the course and job planning for Haematology. Haematology Briefing paper written and discussed with Medical Director and the Chief Operating Officer on 31/05/2019. Paper contained an update on the current status of the service, plus a range of options we are working through to cover the on call service. Further meeting with Medical Director and Head of Haematology on the 7th June 2019 to discuss progress. Meeting arranged for 12th June with Head of Haematology and Consultant Haematologist from the Royal Liverpool to progress. These actions are being monitored on a daily basis. Confirmation that Locum Consultant will be re-joining the service on the 1st August 2019. CW advised this risk is showing as static however there are a lot of controls put in place. A Haematology Business plan has been completed and there is an agreement for the senior registrar in Haematology to act up with support from the			

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			Haematology consultants. The management of this risk feels more robust now and the division will look at reducing over the next few months. **Risk no 1251 risk rating 16 "Lack of Consultant cover for Palliative Care".** Controls include Consultant Paediatric Nephrologist to provide cross cover and meetings arranged between Medicine and Community Division management teams on a 2-3 week basis. Actions being taken include: working with Commissioners to develop a transformative model of care for Alder Hey and the region. Solution of recruiting an additional Consultant from Chester has not evolved, meeting held with Divisional Director, Divisional Associate Chief Nurse and Service Manager to discuss the plans regarding possible solutions. The Trust's Chief Operating Officer is meeting with the senior leadership team within the Division to discuss and monitor progression of the work plan. CW advised this is an on-going risk and is very challenging. There are lots of controls in place and the division are now working more closely with Claire House and looking at ways to reduce this risk. The division have recently recruited a Clinical Lead who is due to start in the next few months. Nationally there is a shortage of Palliative Care Consultants. The job description for Palliative Care Consultant post is in draft and will need approving before the division can progress. **Risk no 1730 Risk rating 15 IT design of the Neurophysiology Department"** "Current design of the neurophysiology department with standalone network for EEG explorations and standalone machines for EMG, intra-operative monitoring and invasive EEG related imaging is vulnerable to failure. Recent incidents have been recorded in relation to this risk." Controls include functioning PC in place with access to all systems where required and additional PCs are now available within the nursing			

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			area of the department and Trust laptop available for use. Action plan in place; awaiting further contact from the department to follow up issues being tracked as part of the issue log. LF advised IT are working with the department to integrate the Neurophysiology network transfer to Alder Hey. CW advised there has been excellent progress made to date. KB advised this is a risk where the risk owner needs looking at. KW advised she is taking over this risk. This risk is expected to close in the next few months. **Risk no 1787 Risk rating 15 "Error in the prescribing, preparation, administration and monitoring of Parenteral Nutrition (PN)"** Controls include the PN Policy, Alaris GP pumps have had profiles added to help prevent mix up of rates, template prescriptions contain information to guide prescribers in the prescribing of PN. Actions being taken include: Non-medical prescribers (dieticians and pharmacists) to be appointed to support prescribing and the development of a Trust Nutrition Team, different coloured light protective bags to be introduced for PN within the Trust, prescribing of PN through the Meditech system will be pursued. Risk reviewed and actions updated following meeting 14/06/19. No change in risk score yet. **New risks** **Risk no 1926 risk rating 12** - Risk to patients due to delayed resulting and diagnosis of Sickle Cell (Pathology). **Risk no 1932 risk rating 6** - Current Department staffing not suitably trained to meet the requirements to respond for EPPR Fit testing and Decontamination (Emergency Department). **Risk no 1935 risk rating 15** – Workload for existing nursing staff exceeds national average recommendation. Unable to ensure required patient contact is maintained (Diabetes). **Risk no 1936 risk rating 9** – Workload for existing nursing staff			

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			exceeds capacity to deliver, causing additional pressure to complete Best Practice Tariff requirements (Diabetes). **Risk no 1937 risk rating 12** - Risk to organisational reputation as Alder Hey is one of the largest Children and Young Person's Diabetes services in England (Diabetes). **Risk no 1938 risk rating 15** – Inability to deliver Best Practice Tariff service criteria to our patient population (Diabetes). **Risk no 1939 risk rating 10** – Diabetes nurse specialists provide out of hours on call cover for 420 children and young people with diabetes. These contacts are often about insulin dose adjustments / alteration of ratios for calculations. Currently 1 team member has the V300 Non-Medical Prescribing qualification (Diabetes). **Risk no 1940 risk rating 9** – Diabetes nurses run a current caseload of approximately 83 patients (per WTE). They have been giving out of hours' insulin dose advice for many years but are now aiming to access the non-medical prescribing qualification in order to have a recognised qualification to support their prescription advice (Diabetes). **Risk no 1941 risk rating 16** - Diabetes nurses may not be able to access the V300 qualification which would put them out of line with their regional diabetes nurse counterparts (Diabetes). **Risk no 1942 risk rating 12** - Risk of ventilator failure due to a lack of consistent maintenance arrangements for patients with ventilators (Long Term Ventilation). **Risk no 1943 risk rating 12** - Demand outweighs capacity (Ultrasound). Previous years' service creep and new work adding to pressure for service delivery with Key Performance Indicator timeframes. **Risk no 1960 risk rating 9** - Long waiting times for elective outpatient			

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			service. **Closed risks** (1539, 513, 1759, 1471, 1591, 1345, 1589, 134, 1267, 1889, 1344, 1191) CW advised that there are 25 risks overdue review. There has been a lot of work completed previously but due to sickness within the division this has declined. There are 10 risks with a reduced risk score. The high risks the division has not been able to reduce these however we are working on it. CW advised that 6 of the new risks have come about from Diabetes due to issues in the team with staffing levels and sickness. 3 of these risks are sitting at 15+, however it is expected these will be reduced imminently with mitigations in place. CW advised that the Medicine Division are working on reducing their risks even though there is not a significant reduction at this time. There is still a lot of work to complete, however CW is confident the Division is showing assurance of effective management of risk. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/64	**3.2**	**Community Division**	Rachel Greer (RG) presented the risk management report for Community. • Total number of risks = 56 (includes 7 change programme risks) • Number of new risks identified since the last reporting period = 4 (1922, 1927, 1929, 1931) • Number of risks closed and removed from the risk register = 7 (1633, 1809, 1885, 1629, 1642, 1811, 1819)			

Item No	Item		Key Point Discussions	Action	Owner	Time Scale
			• Number of risks with an overdue review date = 2 • Number of risks with no agreed action plan = 7 • Number of risks with changed risk scores = 4 (decreased) • 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 1922 risk rating 6 - High temperature and lack of air flow in therapy rooms (Sefton CAMHS) -** High temperature and lack of air flow in therapy rooms having a negative impact on staff and young people. Whilst windows can be opened to aid airflow, there are restrictors on windows means that they cannot be opened wide. A quote for air conditioning received and being reviewed by senior team. RG advised that the action is to improve ventilation and this work will be completed before we get into Summer 2020. **Risk no 1927 risk rating 9 - Schools trailblazer risk rating -** Loss of staff from Sefton CAMHS following successful bid to be a 'trailblazer' pilot site for Mental Health Support team. Additional staff are being recruited to Liverpool CAMHS; if current staff from Sefton CAMHS are recruited to the new service, it will negatively impact on Sefton CAMHS capacity and waiting times. Actions to address include focus on staff health and wellbeing in Sefton CAMHS and training/development opportunities. RG advised the division have additional actions to ensure they maintain workforce. **Risk no 1929 risk rating 9 - Lack of ownership of IT system utilised for patient flow and room management in Outpatients (In Touch) -** Operational impact on services utilising Outpatient estate because there would be disruption to room booking process; Impact on patient			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			flow within the department impacting on patient experience. Control is that Meditech clinic lists and paper solution in place if In Touch system not available. RG advised the division are working with IT to ensure controls are in place. **Risk no 1931 risk rating 8 - Risk of disruption and delays to the provision of Outpatient services as a result of set working patterns -**. Impact on patient experience if clinics are delayed starting due to staffing levels. Nursing and reception rotas are completed in advance of clinics and staffing gaps are highlighted and responded to with contingency measures, but this is not a permanent planned solution to scheduling the Outpatient service. NHS Professionals staff are booked when required to address staffing gaps; gap is that NHS Professionals staff are not permanent staff and not always familiar with Outpatient environment. **High Risks** **Risk no 1524 risk rating 16 - Risk of harm due to inappropriate care or advice provided to patients over the age of 16, by paediatricians and specialist nurses with lack of clinical knowledge about this age group and their presentations.** Ensure all relevant job plans are fit for purpose. Alder Hey working with CWP to identify cohort, and replicate transition process that has been agreed and completed for those who were 18+. To meet with transition leads to discuss this risk and consider how the Transition Policy should be inclusive of a process when adult services are not in a position to either accept referrals as no service exists, or where an adult service exists and significant waits are evident. RG advised the division is working closely with Mersey Care and Liverpool CCG to transition patients. It would be beneficial if we can transfer patients as we are funded for block periods. **Risk no 1270 risk rating 16 - Waiting time for ASD and ADHD**			

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			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. RG advised that a Project Manager has started in post to support this improvement. This risk still remains high but expected to reduce soon with mitigations. **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. IT a standing item on Weekly Management meetings. Bi-weekly community task and finish group established to review connectivity issues access all sites and agree actions to improve incident reporting. RG advised the migration into Alder Hey and devices will reduce this risk as soon as this is in place. There is an end point of Dec 2019. RG advised there has been an increase in the number of risks caused by the transfer of risks from the Outpatients Department to Community and that some of the new risks are related to Outpatients. RG advised the committee that the Division are confident they are effectively managing the risks for Community, while recognising there is ongoing work required. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/65	**3.3**	**Research Division**	Jason Taylor (JT) presented the risk management report for the			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Research Division. • Total number of risks = 5 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 1 • Number of high/extreme risks escalated to the Executive Team = 1 (1751) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 1 (1917) **High risks with a score of 15+** **Risk no 1751 risk rating 15 – "Unsustainable business model for clinical research and the research strategy."** This risk was first identified on 24th October 2018. The research finance model does not enable both research growth and a contribution to the overall Trust's financial solvency. Research income contributes to some of the funding however there is insufficient funding to allow growth of the team and only supports the research delivery staff and no additional support. JT advised that the business model was funded and had been approved. The division are in the process of recruitment and the post will be advertised over the next few weeks. JT advised that he started working full-time in Research last week and is in the process of reviewing the Research risks. **Changes in risk profile or category**			

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			Risk no 1917 risk rating 9 - Clinical Research Division Staffing Capacity. This risk was first identified on 20th June 2019. JT advised clinical research has no outstanding actions and are satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/66	**3.4**	**Infection Control Service**	Jo Keward (JK) presented the risk management report for Infection Prevention and Control. • Total number of risks = 7 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 3 • Number of risks with an overdue review date = 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 **High Risks** Risk no 654 **risk rating 16 (increased from 12) "Staff acquiring airborne hospital acquired infections whilst delivering patient care".** JK advised there is a comprehensive plan in place to ensure actions are being performed in areas and is being monitored centrally by IPC and Divisions have been asked to provide a training plan to ensure all necessary staff have been trained. IPC have asked for assurances of training completed over a 1 month period. CU advised			

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		that the IPC team should arrange a meeting with Triumvirate in the three divisions to ensure the expectations are clear and the plans are consistent across the Trust. JK advised this was discussed at the IPC Committee meeting. There is an issue of the medical staff not being trained. We have the data capture to know who the staff are but this is more work to ensure all medical staff know how to use the aerosol equipment. There is a meeting with the rep to trial the machine and await its arrival. Risk no 1919 **risk rating 15 Failure to reach to risk 80% compliance with front line Staff influenza vaccination in 2019-20.** JK advised the risk has not decreased and they are poised to start the Flu Campaign on 23rd Sept 19. Divisions to create an action plan on how they are going to ensure that 80% of their front line staff are vaccinated against flu. The IPC team will be targeting a lot of providers in the Community. 5 of likelihood will be realised in spite of all actions in place as no vaccine is 100% effective. This should be based on controls. PB advised she will look at this risk with IPC team. **Closed risks** **Risk no 1372 (Closed)** - (Inadequate cleaning of the environment could provide a reservoir for pathogens) Risk is being adequately mitigated with the systems and processes implemented. **Risk no 1374 (Closed)** - (Increasing prevalence of HCAI MSSA Bacteraemia within the Trust) we are mitigating this risk effectively with the controls in place. **Risk 1439 (Closed)** - (Risk of long stay patients acquiring vaccine preventable diseases) has been moved to the Medical Division Risk Register as the Division are now leading on the Immunisation strategy.			

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			Risk no 1777 risk rating 12 – No designated Infection, Prevention and Control (IPC) support for the Community Division – JK advised there were gaps in staff knowledge to support the Community Division however IPC are working closely with them and developing a staff member in-house. JK advised IPC are satisfied with management of risks on the register. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/67	**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 (1456) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk score = 0 • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>High risks</u>** **Risk no 1921 risk rating 15 – Lack of robust mechanisms for ensuring emergency bleep system is working.** There is a risk that the emergency teams may not attend calls for deteriorating patients. MD advised that issues have been raised around patient safety and we	Risk no 1921 MD to report back to next	MD	29th Nov 19

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			are looking at all risks around bleeps. A working group has been set up to look at the bleeps. KB asked for a report back to the next IGC meeting. MD advised all risks are within review date and Facilities are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	IGC Meeting		
19/20/68	**3.6**	**IM&T & Global Digital Excellence**	Cathy Fox (CF) presented the risk management report for IM&T including GDE. • Total number of risks = 23 (IM&T and 6 GDE) • Number of new risks identified since the last reporting period = 3 (Cyber security – ref 1961, GDE/HIMSS ref 1962 and closed loop medication target ref 1966) • 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 = 5 (947, 1187, 1701, 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 risks with a score of 15+</u>** **Risk no 947 risk rating 16 – "Meditech Infrastructure does not have hot fail over site (Disaster Recovery Platform)."** Risk reported on the BAF. PO's have been placed this week for the hardware and professional services from our Meditech Integrator.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Hardware will be installed during November and backups taken locally at Alder Hey. It is hoped to have tested DR in place by mid-December. IT cannot give a definitive date at present as dependent on delivery of hardware and other project dependencies. **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 9th July 19. This provided the Trust with 3 solutions, associated costs and benefits/ risks. The bulk of the kit has been delivered to Alder Hey. Bolton side will be delivered and installed Monday the 4th Nov 19. Dell resource is then lined up over the next couple of weeks for build and configuration. The migration of servers is then passed to the AH Technical Team. Again timeline for completion is mid-December but will only be able to confirm end date once the migrations begin and we can understand the time taken to copy the data over the network. **Risk no 1701 risk rating 16 – "Loss of access to patient data/ records held in MD Analyze"** Support in finding adequate support for existing solution and resources to instate a support contract. LF advised there was a Data Centre Workshop held yesterday and it is going to the Executive meeting for discussions. CF advised as it stands the Trust can access information in MD Analyze. However the team are looking at a new provider to mitigate. Orthopaedics and Neurology use this system. KW advised the information could be printed and scanned and put on ImageNow with the support from the division. IM&T are unable to estimate an end date for this project as would depend on the volume of information as to how long it would take to scan. KW and IT to pick up with some due diligence.			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		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/influence the process. **Risk no 1961 risk rating 15 – Cyber Security** – Board approval required to proceed with the IT Resilience and Cyber Security proposal. **New risks** **Risk no 1961 risk rating 15** (see above) **Risk no 1962 risk rating 12** – Risk of not delivering the objectives of the closed loop medication (BMV) target which would mean not delivering key improvements to patient safety as not achieving GDE milestones/HIMSS accreditation. **Risk no 1966 risk rating 12** – The Trust does not deliver its targets around the closed loop administration of medicines/bloods/human milk. CF advised that IM&T risk management has improved greatly and they have had a thorough review of the risk register and are comfortable with their current position. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/69	**3.7**	**Human Resources** Melissa Swindell (MS) presented the risk management report for Human Resources. • Total number of risks = 8 • Number of new risks identified since the last reporting period = 1 (1925) • Number of risks closed and removed from the risk register = 0			

Alder Hey Children's NHS
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Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		(1736) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 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 IGC = 0 **New risks** **Risk no 1925 risk rating 6 - Current e-forms for contractual amendments, not adequate and could impact on staff pay** Employees can be over or underpaid depending on how the information from the current e-forms is interpreted. Data quality relating to manager self-service ESR access, finance coding and payroll can also be impacted as the forms are missing some key fields to support maintaining this information. There is also no backup process in place should the e-forms go down which could cause significant delays to processing change forms, maternity leave and leavers, resulting in a large volume of pay errors. These forms have not been developed in house and there is no internal knowledge or skill to amend or fix the e-forms should they require updating. MS advised this risk needs more controls and actions in place to mitigate. MS advised that Human Resources are satisfied with the position of the risks on their register and are comfortable that all risks have been reviewed with action plans in place. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/70	**3.8**	**Finance**	Alison Chew (AC) presented the risk management report for Finance.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Total number of risks = 4 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 1 • 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 AC advised that Procurement continue to work with NEP to improve the system and iron out any issues. AC advised the committee that the Finance department have no overdue and no risks without agreed action plans and is satisfied at this point with the management of risks on the register. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/71	**3.9**	**Building Services & Estates**	Graeme Dixon (GD) presented the risk management report for Building Services. • Total number of risks = 9 • Number of new risks identified since the last reporting period = 1 • Number of risks closed and removed from the risk register = 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 = 3 • 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
			High risks with a score of 15+ **Risk no 1388 risk rating 20 – "Pipe corrosion"** Meeting held with Execs/Non Execs on current status. Monthly meeting to be planned with the SPV (landlords) in order to track actions and progress. GD advised that Building Services is waiting an update from SPV regarding the pipework as there are 35 areas to date that need replacing. GD advised that the pipework is being monitored rather than replaced by SPV at this time. The thermal imaging that is being used determines category 3- 4 corrosion. GD advised that a piece of pipework that was replaced 2 years ago needs replacing again due to corrosion. This will be picked up at the Corrosive Pipework Meeting with SPV that is scheduled on 16th Sept 19. **Risk no 825 risk rating 15 – "Internal balconies".** Feasibility study undertaken by contractors on the 26th April 19. GD advised that Stuart Atkinson (SA), Interim Associate Director of Estates has concerns of what is in place in the CHP building at present in terms of risk. Full length glass is a solution, however very expensive. Any changes will not happen quickly as the landlords need to agree any decisions the Trust makes. GD advised the current design of the balconies is standard which is included in other Paediatric Trusts however the balconies are not in the same position within the building in other Trusts. JG advised the Trust needs to find a route to a conclusion as we need to mitigate this risk. GD advised that Building Services commissioned their own Architect to come and look at the internal balconies. The Architect reported that the handrail in place at present is part of the integrity of the glass and feels that to mitigate the risk the glass should be full height. There is Trust variations with Project Co and they need to take the time to come back and reassess the situation as this risk has been under discussion for 18 months. KB has asked GD complete a report update for the next IGC meeting.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			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			
19/20/71a	**3.10**	**Development Directorate**	Angela Appleton (AA) presented the risk management report Development Directorate. • Total number of risks = 17 • Number of new risks identified since the last reporting period = 11 (1933, 1934, 1945, 1946, 1950, 1952, 1953, 1954, 1955, 1956, 1957) • Number of risks closed and removed from the risk register = 6 (1858, 1934, 1946, 1245, 1883, 1746) • Number of risks with an overdue review date = 0 • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 2 (1 increased 1 decreased) • Number of high/extreme risks escalated to the Executive Team = 1 (1241) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 <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. The Trust are now planning to hand back the park to LCC in 2022 with inflation currently running between 30% & 40%. SB advised Development Directorate are currently looking at alternative designs to meet budget. AA advised this risk has increased			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		to 16 due to the contract with Liverpool City Council. AA advised that 7 of the risks for the Development Directorate are linked to the Fire Strategy. **Risk no 1412 risk rating 6 - Universities not all signed contracts for phase 11.** AA advised that John Moores and the University of Liverpool have not signed formal funding agreement contracts yet due to discussions and negotiations of space and building facilities taking longer than anticipated to reach an agreement. KB advised that for future reports all new risks need to have detail of what the risk is not the title alone. AA advised that the Development Directorate risks continue to reduce as progress is made and the Directorate are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	All new risks need to have detail of what the risk is not the title alone.	All	29th Nov 19
19/20/72	**3.11**	**Health & Safety**	Melissa Swindell (MS) presented the risk management report for Health & Safety. • Total number of risks = 9 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 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			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		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. MS advised that the TVE work order needs to go to IRG for funding approval before implementation. **Update on realised risks** **Risk no 1836 risk rating 9 – "Lift Entrapment – arrangements for out of hours (Institute in the Park)".** H&S transferred this risk to the Estates Department as the risk refers to lift entrapment in the Institute in the Park specifically. MS advised that there is now a security person in post out of hours and they have received training. Ongoing work progressing to support mitigation. **Risk no 1386 risk rating 12 – "Lift Entrapment – CHP"** Near miss incident (patient entrapment) – Design of lift car hatch to roof makes it extremely difficult to pass vital medical equipment into the lift in the event of entrapment. Following extensive reviews of the design with the lift company, they have presented a design and costings to modify each bed lift, making the hatch accessible, but also ensuring the lift is aesthetically pleasing. Decision required to proceed modify bed lifts and a decision will be required if modification should be roll out to public lifts. AK advised the report has been submitted to CPG and the Executives for financial approval and Building Services are waiting to start completion of the work. MS advised the committee that Health & Safety are satisfied with the progress at this point.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
19/20/73	**3.12**	**Business Preparedness & Emergency Planning**	Elaine Menarry (EM) presented the risk management report for Business Preparedness & Emergency Planning. • Total number of risks = 13 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 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 (1470) • Number of high/extreme risks escalated to the Executive Team = 0 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 **<u>Changed risk score</u>** **Risk no 1470 risk rating 12 (increased from 6)** – **Delayed response to major incident by staff who don't carry a bleep**. Given the time taken (half an hour) to send out the major incident cascade message, the Emergency Preparedness Group recommended this score is increased. A meeting is scheduled for 19th September 2019 with IM&T, Facilities Manager and switchboard business continuity lead to look at automating the process further using an app. Emergency Preparedness Group has requested this is expedited as an urgent action. EM advised that cascades of messages are to go out as discussed at the EPG. There will be 77 automated messages to go out. EM advised all risks are within review date and Business Preparedness & Emergency Planning is satisfied with management of risks on the			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/74	**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 = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 0 JF advised that she stills need to agree with IM&T how the additional items for the DSPT and information asset management evidence will be met for 2019/20 submission of the Toolkit – (1753 & 1893) and whether these items should move to the IM&T risk register? Also, Data Flow Mapping is still a weak area. This risk may increase by the time of this meeting (1828). JF advised she needs to speak to ES and KW about risks 1753 & 1893 around moving DSPT related risks to IT. Risk 1893 Information Asset Management Tool JF needs to discuss this area with IM&T as there is no funding available for tools which will not prevent Information Asset Management from moving forward, but does make it more challenging. An ongoing issue is the Data Flow Maps and ensuring these are submitted and available for scrutiny. They are necessary due to the ongoing BREXIT situation and the uncertainty of a no deal. In the	JF to speak to ES/KW about risks 1753/1893 JF to speak to IT about funding available for tools.	JF JF	9th Oct 19 9th Oct 19

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		event of a no deal the UK will be deemed a 3rd country and there is risk that transferring data from EU to UK will stop. There are steps that can be taken with Standard Contract Clauses available from the ICO, but in the first instance the Trust needs to ascertain whether there are any data transfers to and from the EU. From the information received to-date, this seems unlikely, but there are unknowns. Overall the Trust is at 83% compliance with IG training. Surgery had reached 85% compliance for their IG training; however Estates and Facilities are still around 50%. Additional ancillary training has been arranged for those groups – but JF emphasised that staff must attend. Failure to reach 95% compliance target set by NHS Digital will result in the Trust failing the Toolkit from the previous year as we were given a reprieve, this will impact on CQC inspection as part of their 'Well led' Key Line of Inquiry as Data Security & Protection Toolkit evidence is an area they review. Part of that evidence includes IG Training compliance figures. The consequences of failing the Toolkit not only impacts on CQC inspection, there is also the reputational damage to the Trust as well the loss of income from research studies. Most institutions that commission research studies request a review from NHS Digital to undertake an assessment of DSPT evidence to determine whether a Trust is suitable to fund use in a study. No approval means no study at the Trust which is a loss of income/revenue and reputational damage which is embarrassing given that Liverpool University is based on site. PB also pointed out that without staff being trained in IG there is a greater risk of data breaches that could lead to a fine from the Information Commissioner's Office. JF advised the Committee good progress has been made with managing the IG risks and IG are satisfied with progress made to date. **Resolved** that: the Committee NOTED the contents of the paper			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
19/20/75	**3.14**	**Medicines Management & Pharmacy**	Catrin Barker (CB) presented the risk management report for Medicines Management & Pharmacy. CB introduced the new Head of Pharmacy Paul Sanderson (PS) to the committee. • Total number of risks = 12 • Number of new risks identified since the last reporting period = 1 (1924) • Number of risks closed and removed from the risk register = 4 (1471, 1589, 1344, 1191) • Number of risks with an overdue review date = 1 (1209) • Number of risks with no agreed action plan = 0 • Number of risks with changed risk scores = 0 • Number of high/extreme risks escalated to the Executive Team = 1 (1787) • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 1 (1924 national incident related to supply of parenteral nutrition for home patients current score 10) **Risks closed** **Risk no 1471 (Closed) –** Sodium valproate Pregnancy Prevention Plan implementation **Risk no 1589 (Closed)** – Update to Antimicrobial App for I-Phones; **Risk no 1344 (Closed)** Pharmacy and ASU cold store failure. CB advised that it took 18 months to progress with the new cold store facility and work commenced on 26th July and is now complete. **Risk no 1191 (Closed)** - Warfarin prescribing on Meditech			

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		Overdue risks **Risk no 1209 risk rating 12 – "Move to preparation of chemotherapy worksheets/labels and stock control".** **High risks** **Risks no 1787 risk rating 15 – "Error in the prescribing, preparing and administration of parenteral nutrition."** CB advised there has been considerable work ongoing around this high risk. MDT meeting monthly. Meeting notes embedded into risk on Ulysses after each meeting. CB advised there are on-going challenges with dealing with this risk however there are controls and actions in place to mitigate. **New risks** **Risk no 1924 risk rating 10 – Parenteral Nutrition treatment (intravenous feeding) not available resulting in admission to hospital.** CB advised this is a nationally recognised risk. NHRA has reduced capacity across England and this is now being managed through a national site. There have been 18 patients affected and Pharmacy have been able to transfer them to another supplier. There is now a logistic solution in place with same day courier service Calia delivery service to patients. Pharmacy/Comms/Medical Director had immediate face to face meeting with parents to explain the situation and alleviate any concerns. They also had publicity with the Echo and the Southport Post for local families to pick up. No patients have been admitted and the service are managing this risk effectively in the interim. CB advised the Committee, Medicines Management & Pharmacy recognise that while ongoing work is required, good progress made to			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			date. **Resolved** that: the Committee NOTED the contents of the paper			
19/20/76	**3.15**	**Marketing & Communications**	There was no representative to present the risk management report for Marketing & Communications. The committee noted the content of the report submitted. • 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 **Resolved** that: the Committee NOTED the contents of the paper			
19/20/77	**3.16**	**Innovation**	Emma Hughes (EH) presented the risk management report for Innovation Department. • Total number of risks = 3 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 (1700) • 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			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Changes in the risk profile or categories of risk being reported that need to be brought to the attention of IGC = 0 EH advised there are 3 risks for Innovation and for risk 1400 there is an action plan in place and this has been reviewed. This risk is listed as a Project risk and EH is looking at why it's been listed this way. EH advised Innovation is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
		Meeting Effectiveness Review				

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INTEGRATED GOVERNANCE COMMITTEE

ACTION LIST COMPLETED

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
19/20/10a	Risk 1756 – Multi-storey car park fire alert.	Awaiting decision on business case to look at costs for sprinkler system. Provide update at the next IGC Meeting.	G Dixon	10th July 19	11th Sept 19	Sprinkler system was not fitted due to the cost. The car park is fully compliant and meets the national requirement.
18/19/123	Risk no 1831 **–** unauthorised access to patient data held within Natus System Unsuccessful capture of data.	LF to bring this to the attention of information Governance and speak to JF outside of the IGC meeting.	L Fearnehough /J Fitzpatrick	Update 11.09.19. **Action.**	11th Sept 19	C Fox advised this action has been completed and the risk has been closed.
18/19/127	Risk no 1832 - Signing of electronic documents. Impacting on the visibility of document to other users.	L Fearnehough to pick risk up with M Levine	10th July 2019	Update 11.09.19 **Action completed.**	11th Sept 19	This is being picked up in risk 1668 as risks are connected.
Item 2	Divisional Governance Meetings schedule of calendars for the year.	Leads to provide dates of their DIGC meetings for the rest of the calendar year for the Chair to attend.	Divisional Leads	**11th Sept 19**	3rd Sept 19	Divisions provided information to LC.
19/20/03	Risk 1882 - risk of additional admissions to hospital including PICU and delays to discharge - H Cibinda advised the title of risk has been updated.	Title of the risk is to be updated	C Wardell	11th Sept 19	11th Sept 19	CW advised that the title of the risk has been updated. The CCG are paying for new equipment and this is now in place and the risk has now been eliminated.
19/20/40	Risk no 1919 risk rating 15 Failure to reach 80% compliance with front line staff influenza vaccination in 2019-20 Risk Owners of IPC risks. If MS not the right owner of risks who will they assign	VW/JK to speak to divisions to ensure plan is in place.	V Weston / J Keward	11th Sept 19	11th Sept 19	Transferred to risk 19/20/66 Some of risks have been transferred to other risk owners. MS has stayed as Exec Lead for the Flu

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Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
	these risks to?	MS to discuss with VW	M Swindell			Vaccination
19/20/42	IM&T Risk Management Report Financial Implications of the risks of the IMT report to be included. Update the assurance statement within the IMT report as 6.25% is incorrect.	To complete details on the financial risks on IM&T report L Fearnehough Update the assurance statement within the IM&T report	L Fearnehough	11th Sept 19	11th Sept 19	Detail of financial risks update on report and sent through to LC. Detail of assurance statement on report updated and sent through to LC.
19/20/45a	Directorate Risk Management Report to update an error in the changed risk scores.	To update error in the changed risk scores.	S Brown	11th Sept 19	24th July 19	Updated report sent through to LC.
19/20/46	Risk no 1836 risk rating 9 – Lift Entrapment – arrangements for out of hours (Institute in the Park).	To provide an update on the out of hours arrangements for (Institute in the Park)	A Kinsella	11th Sept 19	11th Sept 19	There is now a security person in post out of hours and they have received training.
19/20/53	**Risk no 1909 "Current risk rating 15** (Business Support Unit) Information leaflets for parents, children and young people may not be clinically updated and reviewed and therefore providing incorrect information. There needs to be more detail on this risk. It is currently not clear the % of leaflets that are out of date.	Important where risks from various registers will be combined into summary reports so individual risks need to be understandable outside of the context of their original risk register.	P Brown/A Hyson	11th Sept 19	11th Sept 19	Risk scores have reduced to score of 12 this is a significant improvement 15%. There is a full action plan which will be going to CQAC 12th Sept 19 for approval. This specific action has therefore been removed from the Log and updates will be provided as appropriate.
Meeting Effective ness Review	High risk Workforce risks extracted from Ulysses.	CU to extract workforce information from Ulysses and send to MS to present to WOD	C Umbers	11th Sept 19	30th Aug 19	Report was submitted to MS to present to WOD.

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INTEGRATED GOVERNANCE COMMITTEE

ACTION LIST OUTSTANDING

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Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
18/19/86	Risk no 799 – Failure to control contractors (CHP) & Retained Estate.	MS to speak to GD outside of meeting and update next IGC Meeting.	M Swindell	29th Nov 19		GD advised Building Services has been managing the contractors and there have been no further issues.
18/19/124	Risk no 1131 - Process for scanning and archiving clinical notes within Community Division.	To provide an update at the next IGC Meeting.	A Bateman	29th Nov19		Looking at outsourcing and should be in place end of Sept 19.
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		
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		
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		AK to update IGC once this has been completed.

Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
19/20/36	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.	Working with action owners to get to an end point to manage this risk. To provide an update at next IGC meeting.	A McColl	29th Nov19		See Section 3.0 for current position.
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,	J Taylor	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.
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. MS to provide an update to IGC Jan 20.
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		
Chairs Intro	IGC Risk Management Reports – graphs.	Graphs to incorporate whole numbers and not decimal points.	All	All future Meetings		
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	All	All future Meetings		

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Item no	Risk	Action	Action Owner	Expected completion date	Date completed	Comments
		allocated to them and liaise with the relevant risk owner.				
Chairs Intro	Risk Management Principle – Risk description.	All risk 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		
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		
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		

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