Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Tuesday 1st May 2018 commencing at 10:15
Venue: Meeting Room 1, Innovation Hub

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY						
Board Business						
1.	**18/19/40**	**10:30**	**Apologies.**	Chair	To note apologies.	--
2.	**18/19/41**	**10:31**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	--
3.	**18/19/42**	**10:32**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **10th April 2018.**	Read Minutes
4.	**18/19/43**	**10:35**	**Matters Arising:** - **Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Read Attachment
5.	**18/19/44**	**10:40**	**Key Issues/Reflections.**	All	The Board to reflect on key issues.	Verbal
Growing Through External Partnerships						
6.	**18/19/45**	**10:50**	**University of Liverpool Strategy on Women and Child Health.**	Professor Louise Kenny	For information and discussion.	Verbal
7.	**18/19/46**	**11:00**	**Liverpool Women's Reconfiguration options/ Neonatal.**	L Shepherd	To update the Board on progress.	Verbal
8.	**18/19/47**	**11:10**	**Arts Programme and next steps.**	V Charnock	To provide information on the work that has taken place during the last 2 years and to highlight the ambitions for the next 3 years.	Presentation
Delivery of outstanding care						

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9.	**18/19/48**	**11:20**	**NHS Improvement Operational Plan for 2018/19.**	J Grinnell/ A Bateman	For discussion and approval.	To follow
10.	**18/19/49**	**11:30**	**Delivery of the Corporate Plan 2018/19 - Divisional Presentations.**	A Bateman C Duncan A Hughes C McLaughlin C Orton	To receive an update on progress.	Presentations
11.	**18/19/50**	**12:20**	**Booking and Scheduling Review update.**	Natalie Deakin/ Lachlan Stark	To provide an update.	Presentation
1230 – 1300 LUNCH						
12.	**18/19/51**	**13:00**	**Serious Incidents Report.**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read Report
13.	**18/19/52**	**13:10**	**Clinical Quality Assurance Committee: Chair's update:** - **Annual Report.** - **Chair's verbal update from the meeting that took place on the 18.4.18.** - **Approved minutes from the meeting took place on the 21.3.18.**	A Marsland	To receive the annual report and review the minutes from the meeting held: 21.3.18.	Read report
14.	**18/19/53**	**13:20**	**Alder Hey in the Park update.**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
The best people doing their best work						
15.	**18/19/54**	**13:30**	**People Strategy Update.**	M Swindell	To provide an update.	Read reports
Strong Foundations						

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16.	**18/19/55**	**13:50**	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	J Gibson	To receive an update on programme assurance including the 2018/19 change programme.	Read Report
17.	**18/19/56**	**14:00**	**Corporate Report.**	C Liddy/ H Gwilliams/ M Swindell	To note delivery against financial, operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of March 2018.	Read report
18.	**18/19/57**	**14:10**	**Board Assurance Framework.**	E Saunders	To receive the BAF report.	Read report
19.	**18/19/58**	**14:20**	**CQC Action Plan**	E Saunders	To provide the Board with progress to date (position to end of March)	Read report
20.	**18/19/59**	**14:25**	**Directors' Register of Interest 2017/18.**	E Saunders	To receive and note the Register of Directors Interests 2017/18.	Read report
21.	**18/19/60**	**14:30**	**Audit Committee:** - **Annual Report.**	S Igoe	To receive the annual report and review the minutes from the meeting held on: 25.1.18.	Read Minutes
Game Changing Research and Innovation						
22.	**18/19/61**	**14:35**	**Global Digital Exemplar (GDE).**	P Young	To update the Board on the programme.	Read report
Any Other Business						
23.	**18/19/62**	**14:40**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting: Tuesday 22nd May 2018 at 10:00am, Institute In The Park, Large Meeting Room						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation

REGISTER OF TRUST SEAL
The Trust Seal was not used during the month of **April 2018**

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Draft Minutes of the meeting held on **Tuesday 10th April 2018 at 10:00am,**
Small Lecture Theatre, Institute in the Park

Present:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr S Ryan	Medical Director	(SR)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mrs M Barnaby	Interim Director of Strategy	(MB)
	Mr C Duncan	Director of Surgery	(ChrD)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs K McKeown	Committee Administrator (minutes)	(KMc)
	Mrs. C. McLaughlin	Director of Community Services	(CMc)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr A Williams	Director of CAMHS	(AW)
Agenda item: 08	Mr J Gibson	External Programme Assurance	(JG)
09	Mr J Gibson	External Programme Assurance	(JG)
09	Dr. M. Gladstone	Consultant Paediatrician	(MG)
	Mr J Gibson	External Programme Assurance	(JG)
28	Kerry Turner	LiA Lead/FTSU Champion	(KT)
30	Stuart Clark	Community Physiotherapist	(SC)
30	Lee Evans	Community Physiotherapist	(LE)
31	Mr P Young	Chief Information Officer	(PY)
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs C Dove	Non-Executive Director	(CD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)

Staff/Patient Story

The parent of a patient who had a recent stay at Alder Hey was invited to the Trust Board to share his son's experience. Mr. Short explained that his son was brought in via the Accident and Emergency department due to having a rash and feeling unwell. His son was seen promptly and a decision was made to admit him onto Ward 3C. Mr. Short informed the Board of the great service that his son had received, highlighting one outstanding nurse who was in his words "a shining example". Mr. Short informed the Board that he had sent an e-mail to Hilda Gwilliams commending this relatively young nurse, who in his opinion could offer lessons in caring.

Mr. Short explained to the Board that he is also a member of staff and the outstanding treatment and service that his son was given made him feel proud to work for the Trust.

Hilda Gwilliams informed the Board that the compliment had been shared with the nurse that Mr. Short had referred to.

The Chairman thanked Mr. Short for sharing his son's story with the Board.

18/19/01 Apologies

The Vice Chair noted the apologies received from Michael Beresford, Claire Dove, Sian Falder, Jeannie France-Hayhurst, Ian Quinlan and Louise Shepherd. It was reported that Sir David Henshaw would join the meeting later on in the day and that Steve Igoe would Chair the meeting in Sir David's absence.

18/19/02 Declarations of Interest

There were none to declare.

18/19/03 Minutes of the previous meetings held on 6th March 2018
Resolved:

The Board received and approved the minutes from the meeting held on the 6th March 2018.

18/19/04 Matters Arising and Action Log

Action 17/18/242.2: *Meditech update* – A detailed report is to be submitted to CQAC in April 2018. Feedback has been positive following a number of meetings between Alder Hey and Meditech to agree a solution. Improvements have been made around the collection of data in conjunction with the team. It was felt that having Meditech on site has proved beneficial and it was confirmed that Meditech are reviewing their operating model.

Action 17/18/264.1: *Alder Hey Promotional Pack* - It was confirmed that the relevant changes have been made to the promotional pack following feedback. **ACTION CLOSED**

Action 17/18/268.2: *Funding for the Haven Room* - It was confirmed that this request will be processed via the Charity. **ACTION CLOSED**

Action 17/18/275.1: *Delivering Outstanding Care* - The target set for ensuring children and families are 'very happy' with their experience of Outpatients services has been reviewed and amended. **ACTION CLOSED**

Action 17/18/275.2: *Delivering Outstanding Care* – Work is taking place to review the support being received by Clinicians in the Outpatients Department. One area that the Trust has challenged itself with is going live on the 11.4.18 and an update will be provided on the 1.5.18 around the outcome.
Action: HG/AB

Action 17/18/ 282.1: *Any Other Business* – It was confirmed that the large meeting room in the Institute in the Park has been named in memory of Tony Bell, former CEO, who sadly passed away in February. **ACTION CLOSED**

18/19/05 Key Issues/Reflections

Hilda Gwilliams provided the Board with an update on the CQC inspection reporting timescale.

18/19/06 Draft Clinical and Sustainability Strategy

It was agreed to discuss the agenda item during part 2 of the Trust Board meeting.

18/19/07 Liverpool Women's Reconfiguration Options/Neonatal

It was reported that a reiteration of the original joint presentation was submitted to NHS England in March 2018 to offer assurance that progress is being made and to obtain approval in order to commence implementation of the plan. The Board was advised that NHS England felt that it was a high quality proposal. The presentation was also submitted to the Neonatal Network to endorse the joint approach, of which they were supportive.

It has been agreed with NHS England Specialist Commissioners to submit the business case following amendments. It was reported that the business case has been amended and approved by the Liverpool Women's Hospital Trust Board and is ready for submission to NHS England.

Adam Bateman informed the Board that the plan will be progressed over a three year period. It was reported that Commissioners have agreed to fund the first element of the plan but have not committed long-term as of yet.

John Grinnell highlighted the joined up work that has taken place to date and the Board discussed the staffing element of the plan along with governance/compliance.

Resolved
The Trust Board noted the update and affirmed its continued support for this area of work.

18/19/08 International and Private Patients

The Board was provided with a summary update on 'Non-NHS and International Patient' activity and the proposal for exploring a partnership with a Non-NHS and International healthcare organisation to facilitate an expansion of services at scale.

Joe Gibson informed the Board that it was agreed at the Council of Governors meeting on the 13.3.18 that in principle the project should go ahead as long as there isn't an impact on NHS patients. The report has also been submitted to the Resources and Business Development Committee to ensure the process is being managed appropriately. It was reported that Dr. Steve Ryan has agreed to chair the Medical Advisory Committee that will be a key part of the governance of the initiative. It was confirmed that the Trust Board/Council of Governors will be apprised of progress at each stage and will also be involved in the approval process. John Grinnell has agreed to be the Executive sponsor for the Strategic Procurement project and Christian Duncan has agreed to be the Executive Clinical sponsor.

A discussion took place around the infrastructure of the project team, pricing/costing, volume of business and the options for procuring a partnership. Joe Gibson highlighted the importance of being able to refer to the narrative in terms of 'private patients' when engaging the market place and inviting interest. Steve Igoe highlighted the sensitivity of this work and the importance of ensuring that the organisation is clear about alignment and who it partners with, in order to protect the Trust's reputation. Joe Gibson advised the Board that the project hasn't commenced yet and updates will be provided at each stage. The Board agreed to support the proposal

and acknowledged that there will be an element of learning for the Trust as a result of moving forward with this project.

Resolved:
The Board noted the contents of the Non-NHS and International Patient Partnership report and approved the proposal.

18/19/09 International Child Health Strategy

The Board received the 2018-20 strategy and plans for the proposed Department of International Child Health (ICH) and was provided with an overview of the current position in Alder Hey with respect to involvement in health activities abroad. Melissa Gladstone provided information around the rationale for having a Department for ICH along with the themes, benefits and governance of the strategy,

Jo Williams queried the process for ensuring the Trust gets the balance right so that it is accessible to all and does not become exclusive to particular groups of patients. Melissa Gladstone informed the Board of the strategy that is being developed for the engagement of the hospital as a whole, which will incorporate patients and their families. Surveys are also taking place to gather appropriate information and the Trust is going to host an International Child Health Conference to promote this area of work.

Michael Beresford asked about the accountability of the ICH team/department. Joe Gibson reported that the ICH Board will feed into the Trust Board for the first year of the project. Work has commenced to address gaps/risks and the department's work will be managed via Milestone Plans which are in the process of being compiled.

Following further discussion the Trust Board agreed to ratify the 2018-20 strategy and plans for the Department of ICH.

Resolved:
The Trust Board ratified the 2018-20 strategy and plans for the Department of International Child Health.

18/19/10 Pipe Corrosion Issue

John Grinnell informed the Board of the issue relating to the corrosion of water pipes across the hospital and advised on the number of leaks that have escalated rapidly. It was reported that an urgent risk assessment has been conducted which concluded that there is a significant and likely risk to the safety of children, families and staff as a result of pipework corrosion resulting in a failure in the hospital's heating system, with a potentially catastrophic outcome.

The Trust has written to Project Co asking them to ensure that a thorough inspection of the heating system and pipework is undertaken within a timescale that reflects the urgency and scale of the situation, and that a programme and plan for the replacement of the corrosive pipework is put in place with a view to commencement as soon as is practically possible. It was confirmed that Project Co has responded on both counts and the Trust is awaiting the first draft of the action plan this week.

The Board discussed the mitigations required to address the heating system failure and leaks along with patient safety and the impact on the hospital from an operational perspective. Following discussion, it was agreed that this risk should be incorporated on the Board Assurance Framework due to its potential catastrophic impact and must only be closed once the Trust is assured that the risk has been mitigated completely.

Resolved:
It was agreed to incorporate the risk relating to pipe corrosion across the hospital on to the Board Assurance Framework.

18/19/11 Mortality Report, Q3 2017/18

The Board received and noted the content of the Mortality Report for Q3, 2017/18. The following points were highlighted and discussed:

- It was reported that the Trust's metrics are all within the benchmark with some exceeding the benchmark.
- The Alder Hey mortality review process was rewritten following the release of the CQC report "Learning, Candour and Accountability: review of the way NHS Trusts review and investigate deaths" (Dec 2016). It was agreed across the Trust and the new process began in February 2018. The Board was advised that this area of work is progressing well and the organisation is continuing to develop the process led by Dr Julie Grice, chair of the Hospital Mortality Review Group.
- Steve Ryan reported on the 3 in-hospital deaths in the quarter where there were factors which may have played a role in the child's death. It was confirmed that two of the cases were beyond the Trust's control but it was felt that lessons could be learnt from both cases. The third case was subject to a mortality review and a full RCA was instigated by the team who had looked after the patient. Steve Ryan reported on the outcome of the RCA which brought about much learning and confirmed that the Trust had expressed its apologies to the family.
- David Powell queried as to why the same peer group is used continuously to benchmark performance indicators and asked if the group chosen could be altered in order to make information/statistics more meaningful. Steve Igoe pointed out that assurance is provided as a result of looking at data and seeing similarities in the peer group as well as investigating each death, which is the process that the Trust follows. Anita Marsland informed the Board of the in-depth discussions that take place at CQAC re mortality in order to offer assurances to the Trust Board. Following discussion it was agreed to raise David Powell's query at CQAC.
- Erica Saunders reported that AQuA have offered to conduct a half- day session on mortality. Steve Ryan confirmed that the Trust has been in conversation with AQuA who were very complimentary about the organisation's mortality report. A query was raised as to whether any concerns had been reported by staff members in respect to this area of work. Steve Ryan confirmed that there hadn't. Jo Williams highlighted the huge progress that has been made following the mortality review.
  Action: SR

Resolved:
The Board noted the contents of the Mortality Report for Quarter 3.

18/19/12 Quality Strategy Update

Clinical Quality Assurance Committee.

The Board noted the Chair's verbal update from the Clinical Quality Assurance Committee meeting that took place on the 21st of March. It was confirmed that the Trust's Quality Summit will take place on the 14th of May 2018.

Resolved:
The Board noted the approved minutes from the Clinical Quality Assurance Committee meeting that took place on the 21st February 2018.

18/19/13 Integrated Governance Committee

The Chair advised of the debates that have taken place during committee meetings in respect to risk and confirmed that the new process for risk registers and revalidation is working, with colleagues having more clarity around ownership of risks. The Board was informed that the issue relating to pipe corrosion across the hospital will be discussed during May's meeting.

Resolved:
The Board noted the approved minutes from the Integrated Governance Committee Meeting that took place on the 16th of February 2018.

18/19/14 Getting it Right First Time
Resolved:
This item has been deferred to the 22.5.18.

18/19/15 Listening into Action
Resolved:
This item has been deferred until the 1.5.18.

18/19/16 Serious Incident Reports

The Board received and noted the contents of the Serious Incidents report for February 2018. The following points were highlighted and discussed:

- StEIS 2018/2696 - Hilda Gwilliams informed the Board that a meeting had taken place with the patient's family and Consultant in order to discuss any concerns or questions they wished to be addressed. It was reported that the main area of focus for the family was the way they had been treated by Cheshire Police following the arrival of the emergency services to their home. The Board was advised that this is the third case where families have raised concerns in respect to how they have been treated by police officers in similar circumstances. Hilda Gwilliams reported that Julie Knowles is in the process of making arrangements to liaise with Cheshire Constabulary to discuss public relations.
- StEIS 2018/1590 – An investigation is on-going to establish as to whether an apparent injury was overlooked during admission and in theatre prior to operating on the patient. Further statements are being gathered and a further panel meeting is to be held.
- StEIS 2017/30500 – An RCA is being conducted following the unexpected death of a neurosurgical patient. It was reported that the Trust has asked the Royal College of Surgeons to carry out an external review of the case following concerns raised. A meeting has also taken place with the family to make them aware of the investigation but the parents of the child advised that they didn't have any concerns regarding the care their child received at Alder Hey. A question was raised as to whether the Divisions will receive the right support during the investigation. Christian Duncan confirmed that they will.

Resolved:
The Board received February's Serious Incident Report and noted the new/closed incidents and the progress in the management of open incidents.

18/19/17 Cardiac Review

The Board was provided with an overview of the new model of care for post-operative cardiac patients. The Board discussed the purpose and process for designing a new model, along with the meeting structure and reporting arrangements.

Adam Bateman informed the Board that the standard for the new model is to guarantee that the Trust won't cancel operations on the day. Hilda Gwilliams reported that reflection will take place around the complaints received for this area of work along with the concerns raised by parents in respect to facilities and waiting areas.

John Grinnell highlighted the importance of engaging with commissioners to make them aware that the model of care for post-operative cardiac patients could be a new clinical model. Adrian Hughes requested that the model be aligned with some of the High Dependency Unit (HDU) models and delivery of high dependency care on the wards.

Resolved:
The Board received and noted the presentation on the New Model of Care for Post-Operative Cardiac Patients.

18/19/18 Alder Hey in the Park Site Development Update

David Powell provided an update to the Trust Board on the Alder Hey in the Park Site development. The following points were highlighted and discussed:

- *Sale of Land* - It has been agreed to continue discussions around the sale of land with Liverpool City Council following May's elections. A discussion took place around local opposition to the sale of land and it was confirmed that the Trust is in the process of compiling a communications plan to address the wider context of the Springfield development of the park.
- *Institute in the Park (Phase 2)* – Completion of Phase 2 is set for July 2018 with occupants of the building having been confirmed. A discussion took place around the allocation of space in the new building. Christian Duncan pointed out that it would be beneficial to move clinical teams with research interests into the new building and transfer other staff into the main building. Mark Flannagan informed the Board of the report that has been compiled to address agile working/movement of staff.
- *Topping Out Ceremony* – It was reported that the Topping Out ceremony has been scheduled for the 4th June.
- *Alder Centre* - The Trust has gone out to tender for the construction of the new Alder Centre. It was reported that the tenders submitted are of a higher cost than expected and will have to be reviewed.
- *Communications Strategy* – The Trust has appointed a new member of staff to develop activities and increase the park footprint.
- *Community Cluster* – The Contract for the Community Cluster building has been awarded to Culinan studios.
- *Park and Environment* - Jo Williams felt that the Trust is missing an opportunity to promote the park from a public health perspective, e.g. cycle tracks, general health and wellbeing. David Powell informed the Board that the Trust tried to articulate the health and wellbeing opportunities that the park offered, three years ago. Ambitions were shared with commissioners but the Trust didn't receive the required support. It was reported that

discussions are taking place with the Council regarding this matter from a 'Child Health in Liverpool' perspective. Steve Igoe highlighted the importance of compiling a plan in order to progress this area of work. Christian Duncan queried as to whether the Trust has a Health and Wellbeing Lead. David Powell confirmed that organisational psychologist Dr Jo Potier works with Melissa Swindell two days per week and agreed to liaise with Jo regarding this matter.
Action: DP

Resolved:

The Board noted the update on the Alder Hey in the Park Site development

18/19/19 People Strategy Update

The Board received and noted the contents of the People Strategy report for February/March 2018. The following points were highlighted and discussed:

- The porter service Organisational Change consultation has been extended to explore further options with full trade union engagement to bring about a satisfactory conclusion and it is anticipated that consultation closure will now take place during April 2018. A discussion took place around the risk to the organisation in the event of industrial action and it was confirmed that the risk would be minimal.
- It was reported that sickness absence rates have decreased to 5.5%. Steve Igoe queried as to whether the Trust is seeing any themes in relation to staff sickness. Melissa Swindell reported that mental health issues and work related stress are the organisation's top reasons for sickness.
- It was confirmed that core mandatory training as of end of March 2018 is above target at 91.24% and overall the mandatory training figure is 90.25%. .

Resolved:

The Trust Board noted the People Strategy update for February/March 2018.

18/19/20 Equality Act

This item was not discussed.

18/19/21 Gender Pay Gap

The Board was asked to note the Trust's first Gender Pay Gap report 2018 produced to meet the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017 which came into force on the 31st March 2017.

Melissa Swindell informed the Board that the report includes the statutory requirements of the Gender Pay Gap legislation and provides further context to help understand and contextualise the data. It was pointed out that it is important to recognise that the gender pay gap differs to equal pay. Equal pay is in relation to pay differences between men and women who carry out the same job for different pay, which is unlawful. The gender pay gap shows the difference in average pay of all men and the average pay of all women employed by the Trust. It is therefore possible to have genuine pay equality but still have a gender pay gap.

The Board discussed the mandatory calculations along with the mean and median gender pay gaps. It was pointed out that the data informs the organisation that on

average female employees earn 33% less than male employees and the median data tells us that female employees earn 12% less than male staff.

Melissa Swindell explained that there are more women employed in band 1, 2 and 3 jobs which influences the average figure. She reported that the figures for the consultant medical staff group skew the overall picture. This is because there are more male consultants employed with a greater length of service who therefore get paid at the high level band and there are also more men achieving Clinical Excellence Awards. The Board was informed that work will need to take place to ensure there aren't any gaps and to also encourage women to apply for Clinical Excellence Awards. Steve Igoe pointed out that the metrics in the report are very blunt and there is also a large amount of staff not included in the data. It is also about having a process in place to make sure the Trust promotes women.

Resolved:
The Board received and noted the Gender Pay Gap report.

18/19/22 New Pay Deal

Melissa Swindell briefed the Board on the proposals for the new NHS pay deal. It was confirmed that the pay deal will be fully funded by the Treasury over a three year period, as follows:

- Year 1 – Staff will receive a 3% pay rise on top of their pay band.
- Year 2 – Staff will receive a 2.7% pay rise on top of their pay band.
- Year 3 – Staff will receive a 1.67% pay rise on top of their pay band

The Board was advised of the forthcoming increment process for each pay band and the key headlines;

- Pay band 1 is to be eradicated.
- Incremental progression won't be automatic.
- Change to sickness absence pay.
- Changes to ESR.
- Pay deal agreement to be signed off by June 2018.

It was confirmed that the New Pay Deal presentation will be submitted to the Workforce and Organisation Development Committee for comment and an update on the outcome of the discussion will be provided to the Trust Board in May.
Action: MS

Resolved:
The Board noted the contents of the New Pay Deal presentation

18/19/23 Programme Assurance Update

Resolved:

The Board received and noted the update provided on the Assurance status of the change programme.

18/19/24 Corporate Report

The Corporate report for month 11, 2017/18 was submitted to the Board for information and assurance purposes. The following points were highlighted and discussed:

- *Patient Safety* – February showed excellent results in the patient safety domain, with zero grade 3 and above pressure ulcers, zero never events, zero incidents of moderate harm and above, and zero SIRIs declared in month. There were four medication errors resulting in harm, which maintains a significant cumulative reduction compared to last year.
- *Patient Experience* - It was reported that the Trust is hitting its target for children and young people in play and learning and the Board was informed of the new initiative for processing PALS.
- *Clinical Effectiveness* – The Board was advised of the PHE analysis that has taken place across the region. It was reported that the Trust is working with external partners to focus on this area and improve the organisation's position. Steve Ryan advised the Board that the Trust is at the top end of the PHE results table and confirmed that this relates to one particular patient and there is very little that can be done to decolonise this patient. The Trust is looking to acquire expert advice on this matter.
- *Patient Centred Services* - Continuing high levels of ED attendance have challenged A&E and as a result of this the Trust has seen performance reduce slightly to 92.6%. This figure has since increased to 97% thanks to the implementation of enhanced plans and the commitment of staff in the Divisions. Clinic utilisation has also dropped in February. It was confirmed that a Chaired group is being established to address utilisation.
- *Finance* – John Grinnell advised the Board that the Trust will be reporting a trading surplus for the year of £1.2m which is £1.1m ahead of the original plan. This overachievement relates mainly to underspends on capital charges due to delays in the capital programme. Additionally there are three one off exceptional items totalling £8.2m which contributed towards the control total and enabled the Trust to achieve an additional £9.3m of matched STF 1:1 funding. The Trust also received bonus STF funding of £3.3m. Therefore the total control total surplus is £22m. A discussion took place around STF funding and the effect that it has had on the organisation's deficit figure. The Board was informed of the potential audit risk as a result of the £3.5m PFI match swap deal not being fully signed off to date.

Resolved:
The Board received the Corporate Report for Month 11.

18/19/25 Board Assurance Framework

Erica Saunders presented the Board Assurance Framework (BAF) for March 2018.

It was reported that the red risk relating to the organisation's financial environment is to be down-scored on the BAF and the risk relating to pipe corrosion across the hospital is to be included. The Board was advised of the significant assurance from MIAA via the Assurance Framework Opinion.

Resolved:
The Board received and noted the content of March's BAF update.

18/19/26 Council of Governors by-election Results

Resolved:
The Board noted the outcome of the by-election results for April 2018.

18/19/27 Freedom to Speak-up

The Board was provided with an update regarding the implementation of the framework to support the prescribed *Freedom to Speak Up* Guardian role at the Trust and the key findings and recommendations from the 2017 *Freedom to Speak Up* Survey.

The following points were highlighted and discussed:

- Of the ten cases that have been referred to the Guardian/Advocates, five have been closed and five are open with four coming under the same umbrella. Feedback has been requested from three individuals as to whether they would use this route again.
- The Trust has identified eight FTSU Advocates, with a further two having expressed an interest. It was confirmed that each Division is represented
- It was reported that four of the eight Advocates had participated in a national training programme and the remaining four will attend when more dates are release by the NGO.

Resolved:
The Board noted the updated position and endorsed the planned direction of travel to integrate this initiative with the Trust's existing arrangements for raising concerns, including *Raise It, Change It*.

18/19/28 CQC Action Plan

Resolved:
The Board noted the feedback on the next steps with CQC.

18/19/29 Research Update

Stuart Clark and Lee Evans delivered a presentation to the Trust Board on the development of a gym based exercise programme for children with neuro-disabilities. The Board was advised of the rationale for the programme and the work that took place with the cohort in order to produce fitness results. A discussion took place around the learning of the programme and the next steps.

Steve Ryan asked as to whether the results have you been shared with the young people who took part in the programme. It was confirmed that the cohort received their results prior to the commencement of the programme and upon completion of the programme. Steve Ryan queried the channels used for promoting findings. It was reported that this has been done via the use of a newsletter.

Resolved:
The Board received and noted the presentation.

18/19/30 Global Digital Exemplar

The Board was provided with an update on the progress of the GDE Programme to date. Peter Young reported on the achievement of Milestone Three and confirmed that funding was released in March 2018.

The Board discussed the progress of the work that has continued to ensure phase four milestones are achieved; Interoperability Proof of Concept, Speciality Package project, Point of Care Testing and financials. The Chair queried as to whether there are any issues that could hinder the programme. Peter Young confirmed that all work is on track.

Resolved:
The Board noted the GDE Programme update.

18/19/31 Liaison Committee

Resolved:

The Board noted the minutes from the Liaison Committee meeting that took place on the 14.2.18.

18/19/33 Any Other Business

There was none to discuss.

Date and Time of next meeting: Tuesday 1st May 2018, at 10:00am, Small Lecture Theatre, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 10.4.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for May 2018							
6.3.18.	17/18/275.2	Change Programme.	***Delivering Outstanding Care*** - Review the support being received by clinicians in the Outpatients department.	Hilda Gwilliams.	1.5.18.		**10.4.18 -** Work is taking place to review the support being received by Clinicians in the Outpatients Department. One area that the Trust has challenged itself with is going live on the 11.4.18 and an update will be provided on the 1.5.18 around the outcome.An update will be provided on the 1.5.18
6.3.18.	17/18/242.1	Matters Arising and Action Log	***Booking and Scheduling Review Update*** - Provide a further update to the Trust Board on the 1.5.18.	Adam Bateman	1.5.18.		**10.4.18** - This action has been included on May's Trust Board agenda. **ACTION CLOSED**
6.3.18.	17/18/263.1	Draft Financial Plan 2018/19	Present the final version of the 2018/19 Financial Plan to the Trust Board on the 22.5.18.	John Grinnell	22.5.18.		**10.4.18** - This action will be addressed via the NHSI Operational Plan for 2018-19. **ACTION CLOSED**
Actions for 22nd May 2018							
10.4.18.	18/19/11.1	Mortality Report	Discuss possible ways to see if the benchmarking of performance indicators can produce more meaningful data/statistics, for example, using alternative peer groups when benchmarking.	CQAC/ Steve Ryan	22.5.18.		
10.4.18.	18/19/22.1	New Pay Deal	Feedback to be provided on the new pay deal report following discussion at the Workforce Organisational Development Committee.	Melissa Swindell	22.5.18.		

Status	
Overdue	

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 10.4.18

Alder Hey Children's NHS Foundation Trust

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

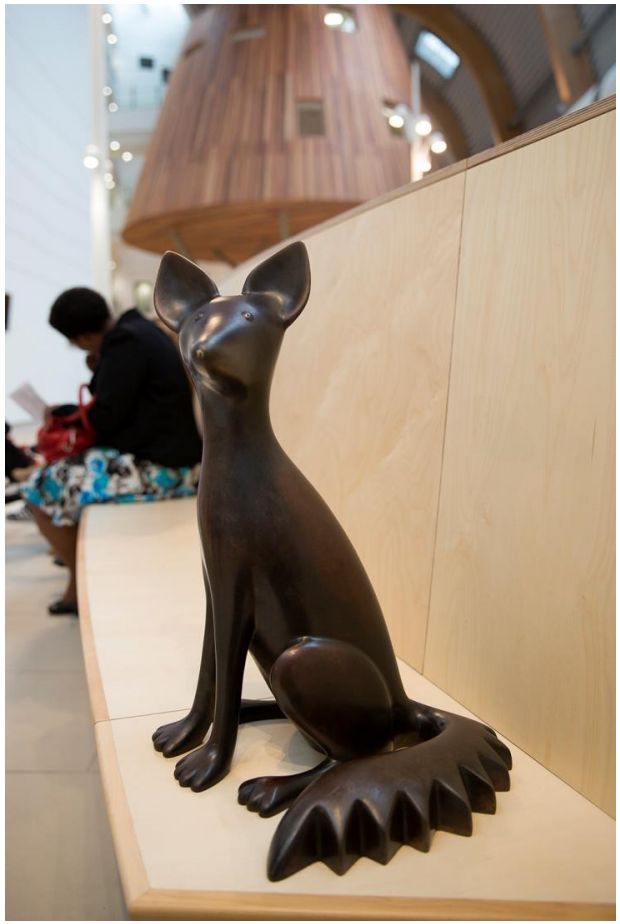
Alder Hey Children's NHS
NHS Foundation Trust

Alder Hey Children's Hospital: Arts for Health

Vicky Charnock, Arts Coordinator

Inspired by Children

- Alder Hey has had an active arts for health programme since 2006.
- My role is two fold: managing the participatory programme, and to support the work of the Blank Canvas Group with the commissioning programme. I was part of Strategic Team developing art for our new building.



- Our Aims

- Improve patient stay through positive experiences.
- Improve the wellbeing of patients through participatory arts.
- Support patients to establish a better quality by life whilst in hospital by addressing the underlying issues associated with prolonged treatment journeys.
- Provide opportunities for patients to develop new transferable skills and life experiences, such as decision-making and creative expression.

- Our interactive arts programme:
- It is participatory, patient centred and patient led.
- We consult with patients and families to develop the programme and evaluate our programmes to monitor effectiveness.
- We monitor numbers, write case studies, consult with staff and use patient evaluation forms; some projects have an external evaluator.
- Work across the hospital and community sites.

- We have a number of strategic arts partnerships through our Cultural Champions programme: Tate Liverpool, FACT, Merseyside Dance Initiative, Live Music Now, Royal Liverpool Philharmonic, DadaFest, Bluecoat Display Centre, Manchester Metropolitan University, Small Things Dance Collective and Twin Vision.
- Many of our projects focus on supporting long term patients and their families.

- Until 2017 – 18, we would normally work with over 3,000 patients directly each year and deliver over 250 workshops in all art forms: dance, music, digital arts, storytelling, animation, creative writing, performance and visual arts.
- In the last twelve months, we have delivered 586 workshops and worked with 5,000 children.

- Music Matters
- Winners of Lottery funded Peoples Project through public vote
- 8 musicians on 8 inpatient wards once a week
- 320 workshops, worked with 1600 patients

- Music Matters
- 98% enjoyed the sessions
- 92% said it improved their stay in hospital
- 84% said it helped them to forget about their illness or condition

Inspired by Children

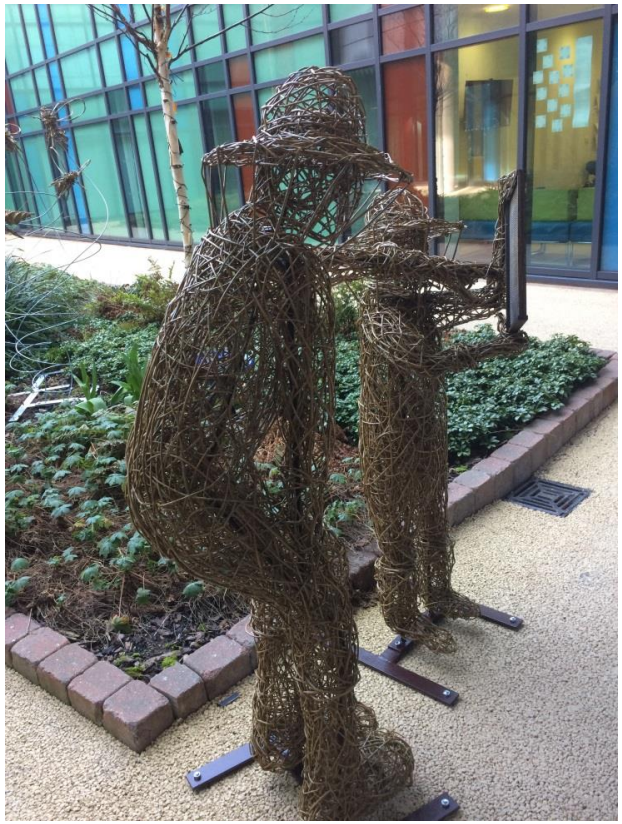
- Music Matters
- *"The music session today was fantastic, the lady who performed was amazing, we all joined in as a family and it left us all with a really positive and enjoyable memory to look back on at such a difficult and hard time. I would highly recommend these sessions and believe they are a great idea for helping the child feel like there is something to look forward to and make them smile. I think these sessions are one of the best ideas the hospital has to offer for children."*
  Mum of Miley aged 7 years

Alder Hey Children's NHS
NHS Foundation Trust

- Music as Medicine
- Partnership with Live Music Now, funded by Youth Music foundation
- Supporting long term patients
- Embedding bespoke training for early career musicians through 'buddy scheme'
- Producing training resource to be launched nationally through Youth Music

Inspired by Children

- Making a Difference
- Partnership with Bluecoat Display Centre, funded by Arts Council England
- Two month residency on Ward 3A with willow artist Caroline Gregson
- Legacy piece created for Radiology Courtyard



Alder Hey Children's NHS
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Inspired by Children

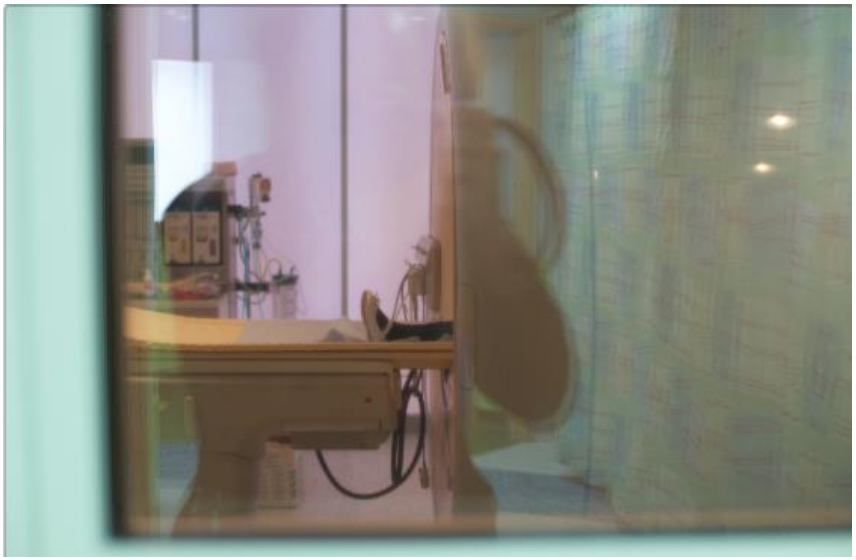
Alder Hey Children's NHS
NHS Foundation Trust

- Animating Lives
- Partnership with Tate Liverpool and Twin Vision, funded by Awards for All
- Four month animation residency on Ward 4A
- Made short animated film inspired by Tracey Emin's 'My Bed' shown at Tate Liverpool

Inspired by Children

- Animating Lives
- Animation made by patients was shown on first floor galleries at Tate Liverpool for one week, along with documentary film and models.
- A workshop was held attended by families who took part in the project
- Seen by 1,000s visitors

- The Harmonic Oscillator
- International collaboration between Australian artist Vic McEwan, Manchester Metropolitan University, Tate Liverpool and Alder Hey that took place between 2014 - 18.
- Exploration into how sound in hospitals can impact on well being.
- Series of investigations, sound recordings, workshops with patients.



- The Harmonic Oscillator
- Exhibition at Tate Liverpool featuring artwork made in response to residency
- Presentation at International Conference of Culture, Health and Wellbeing in Bristol June 2017
- Publication 'Critical Care'
- Series of events and exhibitions in Australia
- Radio documentary
- An app for patients and families to use (still in development)

- Elation: Dance Programme
- Continued dance and movement workshops led by Small Things Dance Company, funded by Arts Council England
- Work published in Journal of Nursing Children and Young People
- Launch of UKs first paediatric dance app, 'smalldances' aimed at supporting parents/carers/staff of long term hospitalised children

- National Recognition

- Our arts programme was cited as model of good practice in the July 2017 All Party Parliamentary Inquiry into Arts, Health and Wellbeing

- Next 12 months
- Medical Mavericks
- Two year project funded by Heritage Lottery Fund, exploring Liverpool's medical history through the lives of 3 innovators
- 3 animation making residencies
- Touring exhibition
- An educational app
- Patient Forum Group will participate and guide the project

- Next 12 months
- Young DadaFest: Alder Hey
- 3 year programme funded by Children in Need, in partnership with DadaFest
- Coordinated programme of individual artistic development sessions for 20 young disabled children led by professional disabled artists. Patients will choose according to interests.
- Work will be performed, exhibited, screened at Young DadaFest showcase event.

- Next 12 months
- Building Stories: New partnership with Comics Youth, organisation led by young people for young people
- Series of workshops using drawing, comic production and cartoons to enable young people to tell their stories, building confidence and self esteem
- Taking part in Childrens Art Week and The Big Draw

- What We'd Like To Do
- EXPAND PARTICIPATORY MUSIC on wards
- EXPAND LIVE MUSIC programme for Performance Space and develop new partnerships
- Develop STAFF CULTURAL PROGRAMME
- Develop FORMALISED TRAINING for early career musicians/artists
- RESEARCH: e.g. A&E assessing compliance with music
- EMBED AWARENESS of benefits of arts and health e.g. nurses induction
- CHILD CENTRED e.g. patient curated Tate exhibition
- INNOVATION: New apps/technology
- Link to NATIONAL EVENTS

Funding

- Arts Programme funded by outside charitable organisations for last four years
- Last year, raised over £100,000 directly and over £300,000 from partners
- From September, no funding for music provision
- External funding makes long term planning impossible
- Need core funding as baseline to plan programme and as match funding for projects

Alder Hey Children's NHS
NHS Foundation Trust

Inspired by Children

OUR PLAN
INSPIRED BY CHILDREN

NHS
Alder Hey Children's
NHS Foundation Trust

FINAL

Operational Plan 2018-19

CONFIDENTIAL

Contents

1. Links to the local Health and Care Partnership for Cheshire and Merseyside

Alder Hey Children's NHS Foundation Trust has consolidated planned service and quality improvements to maximise the benefits of the move into a state of the art hospital in October 2015. Delivery against the Trust's vision: 'Alder Hey, A Healthier Future for Children and Young People' has been at the heart of an overall programme of work which focuses on:

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

Alder Hey's planning process supports the vision and priorities set by the Health and Care Partnership for Cheshire and Merseyside to 2021. During 2017/18 Alder Hey has contributed to the work of the Women's and Children's cross-cutting theme and to the interim leadership and continued success of Liverpool Community Health NHS Trust, for which it held a management contract from May to November 2017. Opportunities for place-based care and working as part of neighbourhood teams in Liverpool are already part of the way Alder Hey services are organised. There is shared interest with primary care providers to enhance skills and knowledge of community based multi-disciplinary neighbourhood teams to support care for children closer to home.

Excellent joint working with Liverpool Women's NHS Foundation Trust to develop neonatal services has resulted in a joint business case for the provision of a single neonatal service across the two sites. This supports the Health and Care Partnership's aims to improve the health and care of the population through delivery of safe maternity, neonatal, gynaecology and paediatric services.

Alder Hey will contribute to a shared understanding of how acute paediatric and neonatal care is performing under its current configuration. This will enable effective and well-informed decisions to be made and will help to identify areas of focus and opportunity. Alder Hey supports the importance of and need for a service-line by service-line review of the current acute paediatric care model in order to generate the evidence and data required to inform an explicit decision on the locations of acute paediatric provision, based on analysis of future patient flows and as part of key priority 1: delivering care more efficiently.

Alder Hey will proactively participate in the Health and Care Partnership's proposed engagement approach and constructively contribute as members of existing networks of clinicians across primary and secondary care, work with other staff across the health and care system and engage with patients and carers to create a dialogue in the design of the priority work programmes. The intelligence identified above will be utilised as an input to identify at a range of levels, change agents who have experience and who are motivated to influence at all levels. Alder Hey is part of the Health and Care Partnership's Clinical Congress, which is a key mechanism for clinical engagement along with existing networks of clinicians, particularly at and within Local Delivery System level and increasingly at neighbourhood level.

Alder Hey has a streamlined clinically-led management structure, implemented in October 2016, that enables clinical leaders to drive the innovation and service transformation required to ensure that the Trust remains able to deliver the requirements set out in the Five Year Forward View. Each Division's plan will be developed and refined with clear objectives and delivery plans to meet the challenges required over the next two years.

The Alder Hey transformation approach uses three clinical Divisions as the delivery vehicle with a matrix management approach which aligns their local plans with the strategic themes within the Health and Care Partnership. Each clinical Division's plan has clear objectives and ambitious delivery plans aligned to the Health and Care Partnership themes in order to meet the challenges required over the next two years.

In 2018/19 Alder Hey will continue to develop and improve care pathways for children accessing health services. The Division of Medicine has organised itself around pathways of care to support greater clinical service integration and reduce variation across patient pathways. Work is underway to develop a 'New Paediatric Model of Care' to improve access, facilitate discharge and reduce variation in the care of children and to enhance the quality of patient experience and clinical outcomes.

The Integrated Community Services Division is working with commissioners to provide a single point of access to care in the community for children, where navigation through the myriad of health interventions for children with complex needs is simplified, improving access to care and outcomes as a result. Visibility of local paediatric hubs will improve access to health care for all children in their localities. Improving access for Children and Adolescents with Mental Health needs remains a high priority.

The Division of Surgery has delivered infrastructure improvements to support and enable clinical teams to deliver the best quality for children and focus on the delivery of world class care, with outcomes ranked at the highest possible level. Work continues in partnership with Liverpool Women's Hospital on the future model for one service across two sites for neonatal services, as described above and with Liverpool Heart and Chest Hospital NHS Foundation Trust in the care and transition of children and young people with Congenital Heart Disease.

Alder Hey is proactively participating in Health and Care Partnership derived opportunities for cost reduction through working collaboratively in respect of back and middle office functions and towards opportunities for improved effectiveness and efficiency. Alder Hey appointed a new Director of Strategy in early 2018 with responsibility to collaborate with partners to support the aims of delivering services for children more efficiently, improving the quality of care and improving the health of the population.

2. Activity Planning

The Trust continues to refine and develop its approach to capacity and demand models to support delivery of waiting times in line with the NHS Constitution standards and focus on the latest targets identified within the refreshed national planning guidance appropriate to children's services. We have continued to develop our established approach using our Intensive Support Team (IST) database that supports delivery of RTT waiting times, service developments and NHS Constitution requirements to achive the current incomplete pathway, cancer and diagnostic standards. Also in line with the Trust's previous approach, the baseline demand for next year has been modelled by Specialty and by Point of Delivery. This is based on an average demand level and takes into account the profiled activity plan. We are also planning around revised activity levels to reflect winter demand and occupancy levels to maintain non-elective flow. Each activity plan has been developed by the respective management team by reviewing forecast outturn and amending accordingly, reviewing to confirm that this will ensure delivery of the current range of access targets, is deliverable within the current financial envelope and is supported clinically.

Elective pathway planning

The approach to 2018/19 capacity and demand planning identified paediatric sub-specialities that have capacity constraints which may impact on their ability to deliver 18 week RTT pathways and/or deliver against anticipated contract volumes and growth. These specialties are monitored each week through the Trust's established weekly performance forum, within which remedial plans are developed as required.

Community CAMHS consists of five sub-specialty areas, single point of access, primary mental health service, Specialist CAMHS (Liverpool/Sefton) and the newly established eating disorder service. Community CAMHS provided in Liverpool and Sefton, is funded on a block contract agreement. During 2017/18 additional funding to support improvements in accessing mental health services in a crisis has resulted in the development of a crisis care model with access to support seven days per week. Neurodevelopmental Paediatrics provides expert diagnostic and management provision for children with neurodevelopmental, neuro-disability and complex needs. 2017/18 saw the consolidation of the Neurodevelopmental pathway in Liverpool and resulted in shorter waits for patients undergoing the diagnostic pathways for ASD and achievement of 18 week RTT for children in community paediatrics. Further development work is planned with clinical teams in Sefton to support a commissioned diagnostic pathway for Sefton children.

The Trust also continues to closely track diagnostic and cancer standards in parallel to ensure these are achieved.

Emergency pathway planning

The brand and reputation of the hospital has continued to be a strong pull for parents across the city and beyond; the Trust had planned accordingly for a further increase in A&E attendances following the opening of the new hospital facility in 2015. This trend has continued in the last year; the A&E Department saw a 10% increase in attendances in November 2017 with equivalent proportions of presenting clinical acuity. Alder Hey's A&E team continues to manage demand through a Multi-Disciplinary approach. In liaison with the co-ordinating commissioner (Liverpool CCG) and local A&E Delivery Board, the Trust continues to develop plans that will mitigate the demand placed upon the A&E team. This is incorporated into ongoing A&E improvement plans and a strive to achieve the four hour waiting standard. Primary Care Streaming has contributed to the Department's success.

To support the Trust's planning assumptions, its approach to managing 2017/18 and 2018/19 capacity and demand shortfalls is based upon leveraging the synergies created through the clinically led Divisional structures and support via a formal transformational approach and methodology. This is supported by established Programme Management Office (PMO) assurance processes. The key projects that will support capacity planning through improved productivity and efficiency include:

- Brilliant Booking and Scheduling
- Patient Flow
- Best in Outpatient Care
- Comprehensive Mental Health Care
- Models of Care

These programmes of work will be clinically led with management support and clear Executive sponsorship.This is underpinned by the Trust's Quality Strategy and our focus on patient safety, staff satisfaction, effective care, the right environment and service reliability. This ensures that each programme has a specific Project Initiation Document and milestone plan attached which is formally

monitored through the programme governance structure. A revised Corporate Report and integrated performance framework are currently being developed to reflect current practice with thresholds benchmarked against best practice and Model Hospital standards.

3. Quality Planning

2017/18 has been a strong year for Alder Hey in terms of quality performance with the strengthening of governance arrangements, including a further embedding of the Trust's devolved management model resulting in greater ownership of local quality related matters and resulting in improved ward to board reporting of risk, incidents and shared learning. A clear focus on the provision of the highest quality care continues to deliver outstanding examples of clinical and non clinical excellence.

Our priorities going forward continue to be driven by compliance with national and local standards and we remain committed to the Trust's vision to deliver '*a healthier future for children and young people'* whilst striving to be world leading in our approach to innovation, research and achievement of the best clinical outcomes.

This vision is clearly and extensively displayed across the organisation in an eye-catching format, through screensavers, presentations and in large poster format and is widely recognised by staff, bringing the whole strategy to life for all and reflecting the theme of an award winning 'Hospital in the Park' (see Diagram 1). The strategic plan on a page represents a real drive to deliver the basics of healthcare brilliantly, with a focus on '*delivery of outstanding care*' and providing the right support to our workforce in terms of recruitment, retention and valuing and recognizing our staff for the great things they do, thereby ensuring we have '*the best people doing their best work'*. The Trust will also focus energy on '*growing the future*' with a strong emphasis on '*sustainability through external partnerships'* and on continuing to invest in '*game changing research and innovation'.*

These plans are underpinned by the strong foundations laid by the Trust over a number of years and which we will continue to further strengthen to ensure the sustainability of Alder Hey as an outstanding child-centred organisation.

The Trust has hosted three visits from CQC in the current year. The first was a responsive unannounced inspection in April 2017, which covered three core services: Medicine, Surgery and Community CAMHS. The Trust is currently making good progress with its action plan in response to the associated reports. The second and third more recent visits were a short notice visit to inspect our community services, an unannounced inspection of four more core services: outpatients, critical care, diagnostics and end of life care and finally a planned 'Well Led' review, which took place at the end of February. We expect to receive the draft reports from these inspections in April, although initial feedback was positive and particulary commented upon our maturity as an organization, our child-focused services, the respectful relationships observed among staff and patients and families and some outstanding practice observed in some areas. However, there will be areas where we need to improve and we will respond positively to these. We remain registered with CQC without conditions and are fully compliant with the registration requirements.

Quality Improvement

The Trust's quality strategy, 'Inspiring Quality', continues to place focus on the importance of strong clinical leadership to drive quality improvement across the organisation. The appointment of two senior consultants as co-directors of Clinical Effectiveness and Transformation, supported by strong managerial leadership has been instrumental in developing a revised Quality Improvement Plan for 2018-20 (see Diagram 2). The plan identifies three key quality improvement aims:

- Children and Families first, every time
- No preventable harms or deaths
- Outstanding clinical outcomes for children

The plan was created through wide consultation including with children and young people and their carers, and a number of priorities in these areas have been identified, including focus on delivering the best

outpatient care, improving access through our booking and scheduling processes, reduction of central line infections and a local focus on clinical outcomes at specialty level. In addition, we have made significant improvement throughout the current year on identification and early treatment of sepsis, and the Quality Improvement Plan will ensure we retain this focus with emphasis being placed on improving care for any deteriorating patients.

Our approach to Quality Improvement focuses on four key areas:

- *Establish a culture of children and family first*
  Whilst continuing to gather feedback using a range of different methodologies, we will also actively engage children and families in finding and implementing solutions to highlighted issues and service redesign using recognised co-creation/co-design methodology.

- *Further embed a safety culture across the organisation*
  We have maintained our position as one of the highest reporters to NRLS in our peer group, which is recognised as an indicator of a strong safety culture. We will continue to provide appropriate training for all staff, including human factors training to support the development of a 'just and learning culture'.

- *Continue to empower our workforce through Listening into Action (LiA)*
  We have seen great engagement from staff and numerous examples of improvement owned and delivered by the frontline workforce. We will continue this approach and will spread ownership and empowerment across the workforce such that local teams will continue to set and deliver their own improvement goals.

- *Build QI capability in the organisation*
  2018/19 will be a key year for building the QI capability in the organisation. We are seeking to use a partnership approach, utilizing the local QI expertise of 'Advancing Quality Alliance' (AQuA) to help to set and embed our QI approach and to develop a clear training plan and identify the necessary resources that will help to move the culture of the organisation to one of continuous quality improvement. We are also exploring a potential partnership with 'Sick Kids' hospital in Toronto, which is a world renowned organisation with international expertise and a clear culture of continuous quality improvement, and will provide us with excellent learning and sharing opportunities.

The Quality Improvement Plan describes the key priorities of the organisation for 2018-20. However there will be many other areas of ongoing quality improvement across the Trust. These are defined broadly into three levels of QI:

1. **Change Programme** – large scale, high priority, complex and transformational projects with Executive leadership and reporting through the Trust's Programme Assurance Framework

2. **Quality Improvement Projects** – local projects requiring a degree of oversight and leadership and supported by the Quality Improvement Team and Listening into Action.

3. **Business as Usual** – day to day local improvements based on supporting delivery of the Trust's two year operational plan, divisional business plans and departmental work plans. This improvement work will be delivered locally and may seek the advice / support of Listening into Action team as required.

In planning to deliver continuous quality improvement as an embedded way of working, the Trust recognises that improvements in the quality of care comes from:

- leadership and a culture that both understands and values quality improvement
- Trust Boards and senior leaders who accept personal responsibility for quality and develop expertise in quality improvement

- listening to and learning from the experiences of patient and carers and assuring their full participation in quality improvement
- the intentional actions of staff equipped with the skills needed to bring about the changes
- substantial and sustained commitment of time and resources

.
Additionally, the Trust will continue to provide assurance that all changes and developments do not have an adverse effect on the quality of patient care, not do they disadvantage any of the children, young people and carers that we serve, particularly those with disability or protected characteristics. This assurance will be provided by undertaking a Quality Impact Assessment and an Equality Analysis for any proposed service developments or change projects. These will be reviewed and signed off by the Medical Director or Chief Nurse.

The operating principles for the QIA framework at Alder Hey remain the same as last year:

- The patient comes first – not the needs of any organisation or professional group
- Quality is everybody's business – from the ward to the board; from the supervisory bodies to the regulators, from the commissioners to primary care clinicians and managers
- If we have concerns, we speak out and raise questions without hesitation
- We listen in a systematic way to what our patients and our staff tell us about the quality of care
- If concerns are raised we listen and 'go and look'
- We share our hard and soft intelligence on quality with others and actively look at the hard and soft intelligence on quality of others
- If we are not sure what to decide or do, then we seek advice from others
- Our behaviours and values will be consistent with the NHS Constitution

Workforce engagement
Staff are well settled into the new hospital building and, as evidenced in the 2017 staff survey results, are becoming increasingly satisfied with their working life. The survey was completed by 54% of staff and the percentage that said they '*would recommend Alder Hey as a place to* work' increased by 11%.
More staff said they:

- feel more enthusiastic about their roles
- have more opportunity to use initiative, use skills and make improvements
- have better opportunities for flexible working opportunities
- had a performance appraisal, and are reporting better quality appraisals
- feel their work is valued
- feel that communication between senior managers and staff is effective

The departmental detail of the staff survey will be provided locally and each area will review their results and develop an action plan to continue to make improvements.

In addition to expanding our LiA approach, we will continue to provide other avenues for staff to raise any issues or areas of concern they may have through our '*Raise it, Change it'* mechanism or through direct contact with our '*Freedom To Speak Up'* Guardian or one of the team of local Champions and Advocates that supports him.

Global Digital Exemplar (GDE)
Alder Hey was selected amongst the most technologically advanced hospitals in the UK as a 'digital exemplar' to drive new ways of using digital technology to drive radical improvements in the care of patients. Great strides have been made over the first of a three year investment and we plan to continue this work with a particular focus on:

- Continued development of digitized clinical pathways to reduce variation and ensure evidence based best practice is the norm at Alder Hey. Strong emphasis is place on NICE guidelines and National Standards when reviewing the clinical pathways.
- Standardised electronic documentation to improve the quality and accuracy of record keeping.

- Roll out of voice recognition technology to enhance and hasten the return of clinic letters to GPs and speedier communication of other electronic documentation.
- Further development and roll out of the 'Alder Play' App to improve the experience of our children and young people. This App will provide information in advance of a child's visit to support familiarization with the environment, and will provide distraction in the form of games, avatars, and a reward system using digital stickers for achieving certain tasks and milestones.
- Establishing a clinical excellence portal which will provide easy to access, interactive, clinical performance information to our clinical teams, enabling them to track performance and keep a regular focus on the specific measures relevant to the team.

The Trust hs a clear focus and drive on improving its systems and processes utilising the most advanced technology and ultimately improving clinical outcomes for our children and young people.

Quality Governance

The Trust has been keen to ensure that it optimises the Quality Governance Framework first published by Monitor in 2010, subsequently adopted by NHS Improvement and which also informs the Well Led Governance Framework published by NHS Improvement and revised in June 2017. The Trust has continued to undertake regular self-assessments of its position against each element of the framework, under the auspices of the Clinical Quality Assurance Committee; this exercise was completed on three occasions during 2017/18 – May, September and December.

This ongoing consideration of the Quality Governance Framework meant that the Board was sighted on the developmental benefits for the organisation from commissioning an independent review under the Well Led Governance Framework. The review was undertaken by Mersey Internal Audit Agency in partnership with AQuA (Advancing Quality Alliance) from November 2017, involving a wide range of senior staff from the Trust as well as taking in the views of Governors and external stakeholders.

The draft report was received in February 2018; its overall conclusion was that Alder Hey was well-led, stating: '*It is an organisation that has lived values, a talented Board, a determined strategic intent and a momentum to developing a clinical leadership model.'* The report sets out a range of developmental recommendations across the CQC's eight well led Key Lines of Enquiry; it is the intention of the Board to hold a workshop session early in 2018/19 facilitated by the review leads from which the Trust's response and priorities for action will be agreed, with timescales for completion.

In embedding the model of devolved governance, we have established additional roles of Head of Quality for each Division, and appointed matrons to strengthen and support quality governance across the organisation. Also the appointment of an Associate Director of Nursing and Governance has strengthened the corporate oversight of risk and governance whilst supporting local wards and departments to standardise and further improve recording of risks and incidents. This will be an area of continued focus over the next 12 months with a drive to ensure follow up of action plans, feedback and shared learning become embedded throughout the Trust.

Diagram 1 – Alder Hey Strategic Plan

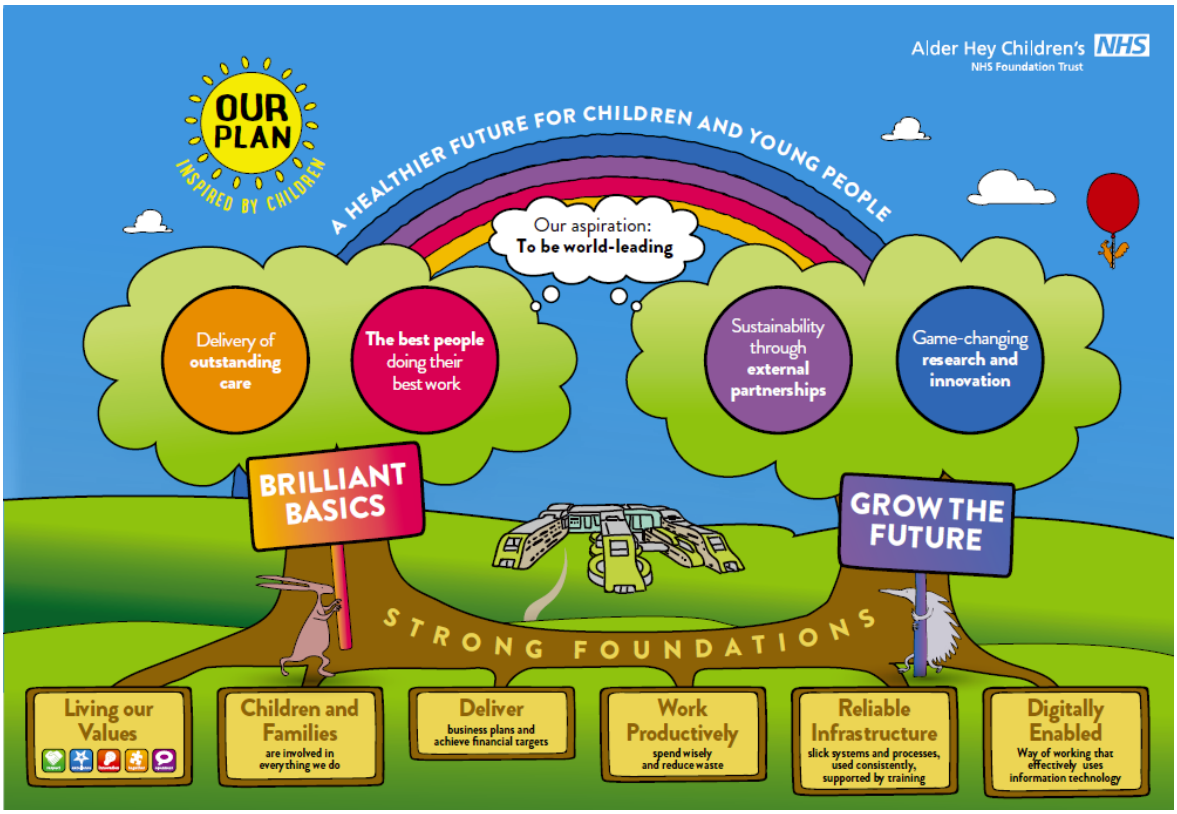
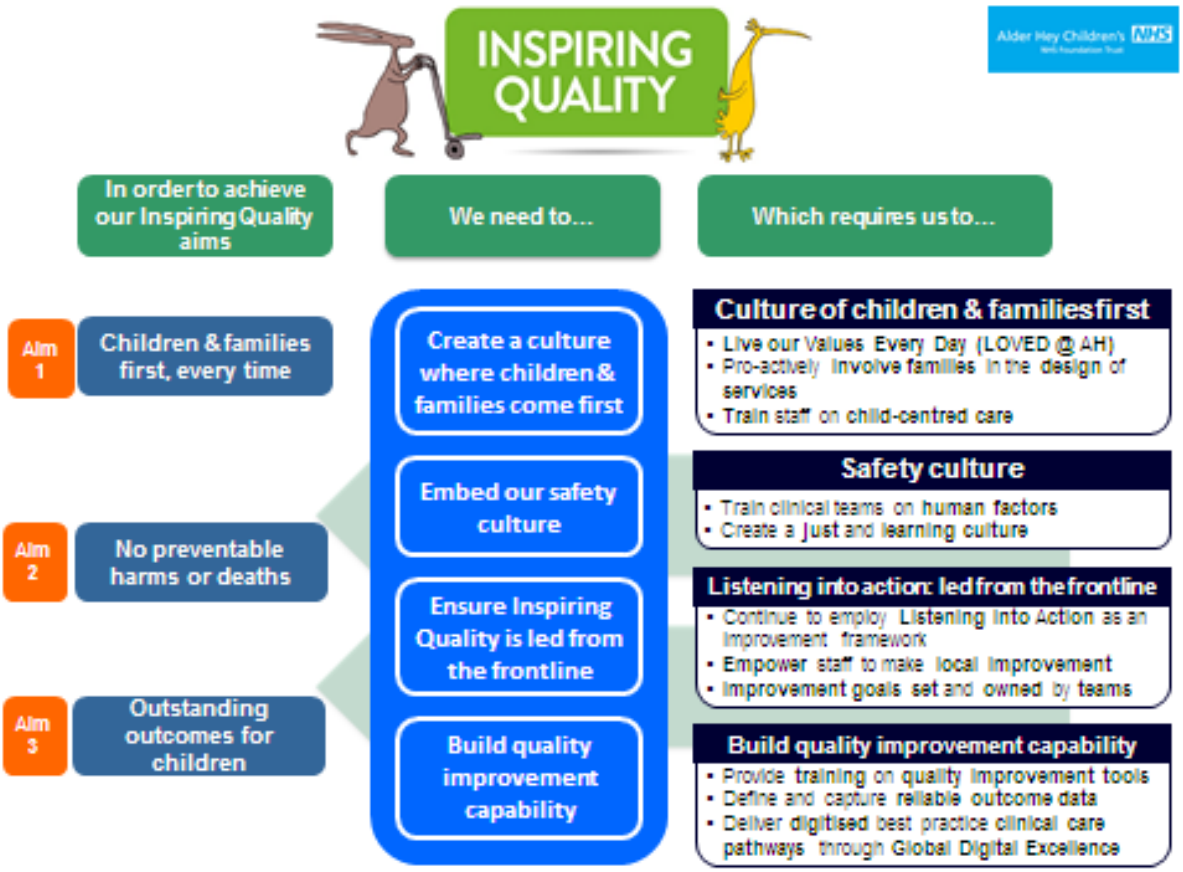


Diagram 2 – Alder Hey Quality Improvement Plan 2018-20



4. Workforce Planning

The workforce planning process, developed within the context of the Trust's clinical, activity and financial strategies, remains an integral element of the local operational business planning process. Key to developing these plans has been clinical engagement, with the clinical leaders of the three Divisions taking an inclusive approach and fully engaging with a wide range of staff in the development of their business and workforce plans.

In addition to the plans being developed in response to the clinical and activity strategies, they have taken into account local health and care system commissioning strategies such as the approach to urgent care and children's community and mental health services. The workforce planning process also supports the vision and priorities set by the Health and Care Partnership for Cheshire and Merseyside to 2021.

The Trust's WTE increased in-year in 2017, a significant proportion of which related to the TUPE transfer of a number of children's community services from Liverpool Community Health in April 2017. For 2018/2019, given the opportunities that the Trust has available to it, its specialist status and the potential to earn additional income and improve quality, the assumption is that there will be zero growth except where activity and income is aligned.

Robust systems are in place to allow for the regular review and challenge of workforce risks and plans at Board and sub-Board level on a monthly basis:

- Workforce risks are identified in the Board Assurance Framework and Corporate Risk Register,
- Workforce metrics are included within the monthly Corporate Report
- Workforce risks are discussed and actions agreed at the Workforce and Organisational Development Committee.

Workforce risks are presented and reviewed alongside quality and safety metrics, as well as activity and financial plans, ensuring that there is a joined up approach to addressing the risks presented. Ward Dashboards have enabled data to be collated and presented locally, allowing Ward Managers to triangulate metrics and identify areas of risk for their particular areas.

Using PMO methodology, all Trust change projects are required to have a Quality Impact Assessment (QIA) as described above, which includes a comprehensive Equality Impact Assessment. Any proposals to reduce workforce are carefully managed and risk assessed.

Focus for 2018/19

The workforce planning process has focused on financial as well as service objectives. The Trust is cognisant of the requirement to achieve local workforce efficiency savings and are also considering a number of collaboration opportunities across the Cheshire and Merseyside footprint. The Carter Review, and data from the Model Hospital approach will necessitate a review in 2018/19 of middle and back office functions, ensuring we are working as efficiently and effectively as possible. Implementation of an e-rostering system in 2018 will enable the Trust to more effectively plan and schedule its clinical workforce.

Whilst the Trust has demonstrated significant success in the reduction of nursing agency spend in the last 12 to18 months, a focus for 2018/19 will be to critically review all temporary staffing spend; this will be coupled with a robust review of sickness absence processes and support mechanisms to ensure we are managing this effectively. This will all be supported through an enhanced focus on staff wellbeing during the year.

Alder Hey continues to develop the skills and scope of practice of its workforce against the backdrop of an evolving care climate for children and their families. This is to ensure that the organisation has the resilient workforce required to work collaboratively and flexibly to meet their needs. While focusing primarily on the healthcare workforce, it is well recognised that the social care and community interface with children and young people is of paramount importance, as there is an increasing proportion of integrated services which transcend health and social care with whom the Trust collaborates in a learning context.

In light of this, the Trust is developing new and existing roles to support continued clinical and technological innovation as well as managing any workforce implications of new and emerging service delivery models within a refreshed divisional structure. This is exemplified through the development of, for example:

- Supporting student Physicians Associates placements to allow for the scoping of the role, and to assess suitability for the organisation
- Increased placement provision for non-commissioned nursing ans AHP programmes
- Development of a paediatric nurse associate role within the clinical teams
- Working collaboratively on a locally developed apprenticeship trailblazer standard for Operating Department Practitioner roles.
- Increased number of training places for Advanced Nurse Practitioners
- Partnership working with local HEI to run a new training programme for individuals educated to Masters level to undertake a shortened course to become a registered Children's nurse.

The Trust will increase opportunities to enter the workforce through supported pre-employment programmes, apprenticeships, work-experience and voluntary roles. Having successfully secured employer provider status for the delivery of apprenticeships in 2017, it is intended to utilise the apprenticeship levy as a vehicle to support growth of skills and competences of existing and newly appointed clinical and non-clinical staff, both in standard and higher level pathways of learning, with the aim of delivering 50 apprenticeship starts in 2018/19. Apprenticeships are a key component of our plans to improve diversity across the workforce, and we will work with the local community to offer opportunities to a wide range of prospective employees.

Rates of attrition for new nursing recruits remain high (30%) and the Trust has invested time in improving the experience for new starters and developed a successful recruitment and retention package. Through effective implementation of this recruitment plan, safe staffing levels have been sustained. Alder Hey has demonstrated significant success in this highly competitive regional and national market, and during 2017, 114.68 WTE registered nurses were recruited as a result of local and national campaigns. We will continue with this approach into 2018/19.

Up to 7% of the nursing workforce has been identified as likely to retire over the next 2 to 3 years, largely among specialist nurses. In order to effectively plan for their succession Alder Hey is working with education institutions to provide structured investment in education and training and develop new team structures within the current workforce so as not to leave gaps in service delivery.

Developments during 2018/19 will be a new model of Clinical Educators to support the new NMC standards for nurse training which are due to be released by May 2018. These will be delivered by one of our local HEI's, as an early adopter for the September 2018 cohort.

The development of an Acute Care Team; an early response team which would assist the medical workforce and the current senior nursing team to ensure that the highest quality of care is given 24 hours a day, 7 days a week will also be an area of focus. It is envisaged that the effects Trust wide will be increased safety and hospital productivity, including a reduction in the in length of hospital stay and reduction in HDU and PICU bed days from unplanned admission following in-patient deterioration.

We will continue to maximize our partnerships with education providers, which include developing a collaborative, inter-professional education offer across a number of clinical teams to promote cross-professional planning for education.

Other strategic priorities for the workforce during 2018/19 will be centered on wellbeing, clinical and system leadership, diversity and inclusion, communications and engagement and the implementation of the proposed Agenda for Change reforms. Demonstrating its commitment to workforce issues, the Trust has invested additional resources into the HR & OD teams in support of the delivery of these key strategic priorities, which includes the recruitment of ESR, OD and L&D and apprenticeship expertise.

5. Financial Planning

5.1 Overview

- The Trust's financial plans for 2018/19 set out accept the control total surplus of £4.4m. The plan achieves a UOR of 1 (in quarter 4) and a CIP of £6.9m (2.8%). The plans assume receipt of £6.2m STF funding in the year. The financial plan for 2018/19 improves the underlying deficit position 2018/19 from £(4.3)m last year to £(1.8)m
- The Trust Board accepts its allocated controls total, recognising both that the plan laid out is challenging and carries a level of risk to be resolved, but also recognising the need to deliver financial sustainability and progress towards financial balance. The challenges to achieving control total relate to the timing of delivery of transformation programme given the last notification of the control total stretch of £1.6m and resolution of Wales HRGv4+ price issues.
- The Trust's has agreed 2018/19 contract variations with both Consortia CCGs, Wales and NHS England contracts
- The strategy for the next year continues to deliver against the Five Year Strategic Plan and focuses on operationalising key schemes including the site development master plan, progressing strategic plans in terms of specialised services, expanding community and mental health offer, growing international and partnership models and expanding commercial offerings.

5.2 Key Risks

- The CiP Programme requires £6.9m of savings which includes the unachieved CIP from 2017/18 and the total equates to 2.9%; this is a challenging target and will require a significant amount of quality improvement to release capacity to support an ambitious business development agenda. The programme is in the early stages of development and there is a high risk of slippage.
- Sustainability and Transformation Funding. There continues to be unprecedented pressure of the emergency system, particularly impacting on The Trusts ability to deliver the A&E standard and therefore claim the 30% STF; failure to claim this cash funding would compromise the affordability of Capital essential medical equipment programme.
- There remains several an ongoing contractual risks relating largely to NHS England and Sefton CCG that if left unresolved could result in a material risk to control total.
- National Pay award direct funding not aligned to Alder hey cost base.
- Wales Funding HRGv4+ (£0.7m) has been assumed and included in control total assumptions.
- The capital plan has been agreed in light of national guidance, includes spend approved by the trust Board and is in line with the Trust's strategic plan, however there remains significant pressure on Capital Funding to allow the successful delivery of the Trust strategic including growth agenda.

The financial plan for 2018/19 is challenging and contains risk, and takes into account opportunities for CIP and productivity and growth opportunity presented by the New Hospital facilities, technology enabled by GDE and Footprint work streams such as the review of women's and children's services across Cheshire and Merseyside.

To support delivery of the financial plan, there is weekly focus on financial performance and an internal Financial Sustainability Board has been established to tackle and monitor sustainability savings and any adverse deviation from plan. This meeting reports in weekly to the Executive team, the aim being to ensure the Trust takes prompt action to mitigate financial risks to support delivery of the plans agreed.

Actions that the Trust is taking to improve underlying deficit and to allow return to recurrent break-even; This programme of financial improvement is overseen by Resources and Business development committee on behalf of the Trust Board:

- Internal sustainability progress integrated with the revised Delivery Management Office (DMO) which tracks both CIP delivery and change project milestone delivery and benefits realisation
- Capital programme restricted and prioritised to align to strategic developments and ensure availability of essential medical equipment.
- Robust pay cost control measures led by the CEO, HRD, Chief Nurse and DoF; including a workforce sustainability plan which provides a fortnightly focus on significant pay cost variances and plans to reduce which includes temporary / agency spend; restrictions around temporary staffing and introduction of agency 'break glass' procedure and rigorous absence management policies
- Quality Improvement Team established led by clinicians, to drive through sustainability and transformation internally and externally.
- Weekly Executive led Communication cell established to monitor key performance indicators across quality, operational and financial domains.
- Cash improvement strategy to increase minimum daily cash balance above £10m including daily reporting of cash balance and weekly cash flow monitoring and robust management of cash through various methods including implementation of a debt escalation policy, review and extension of payment terms wherever possible, review of supplier contracts to maximise discounts.

5.3 Financial Forecasts and Modelling

Table 1 2017/18 Budget and outturn and 2018/19 Final Plans

	17/18 Budget £'000	17/18 Outturn £'000	18/19 Draft £'000	18/19 Final £'000
Clinical Income	204,629	213,373	217,217	220,227
Non clinical Income	20,798	28,949	21,707	21,912
Total Income	**225,427**	**242,322**	**238,924**	**242,139**
Pay Costs	(145,296)	(150,090)	(151,267)	(152,259)
Non Pay Costs	(67,223)	(74,809)	(72,810)	(75,239)
Total Expenditure	**(212,519)**	**(224,899)**	**(224,077)**	**(227,498)**
Capital Charges/Interest	(16,954)	(15,909)	(16,636)	(16,431)
MASS/Restructuring	(247)	(261)	0	0
Underlying Deficit	**(4,293)**	**1,253**	**(1,789)**	**(1,790)**
One Off schemes		8,150		
STF Income	4,431	12,563	6231	6231
Control Total	**138**	**21,966**	**4,442**	**4,441**
Summary KPI's:				
CIP %	**3.5%**	**3.2%**	**2.7%**	**2.9%**
CIP £	**£8m**	**£7.6m**	**£6m**	**£6.9m**
Cash	**£3.5m**	**£12.2m**	**£10m**	**£17.3m**
UOR	**2**	**1**	**2**	**1**
WTE	**3,226**	**3,244**	**3,214**	**3,214**
Capital Spend	**£29m**	**£16.8m**	**£19.3m**	**£24m**

Key assumptions 2018/19 Plans

The financial plans for 2018/19 have been set taking account of the national tariff assumptions and commissioning environment in the NHS, the Trust's Strategic Plan, cost pressures, risk of performance delivery and clinical investment to support national and local quality standards. The pay costs have been uplifted to reflect incremental drift and an assumed 1% inflationary pay award.

- Pay award 1%, any national increase to be factored in once confirmed
- Non-pay inflation included
- Assumes Wales fund HRGv4+ (£0.7m)
- CiP £6.9 including carry forward from 2017/18
- Prudent ROI commercial stretch contribution built into budget

Key changes since draft submission

The financial plans for 2018/19 have been updated to reflect:

- 2017/18 Draft Final Accounts
- Capital 17/18 slippage and updates
- Cash flow monthly forecasting
- CiP schemes, risk and profile
- Agreed contracts

5.4 Activity Plans

Table 3 Activity Volumes by POD

POD	2017/18 Plan	2017/18 Outturn	2018/19 Plan	Movement from Outturn	Movement from Outturn %
Elective	6,327	4,712	5,813	1,101	23%
Day Case	22,980	22,141	23,805	1,664	8%
Non Elective	13,769	15,185	14,971	-214	-1%
Outpatients	207,005	210,365	223,049	12,684	6%
A&E	56,463	59,862	59,713	-149	0%

Key Activity and Income changes

- Elective plan is 514 spells lower than the 2017/18 plan. This reflects the fact that the plan is under performing in 2017/18, though note that some of the underperformance relates to the winter elective Cap, and business development.
- Day case plan is 825 spells higher than the 2017/18 plan, which relates to approved business cases.
- Outpatient increase of 16,044 attendances relates to approved business cases.
- £2.5m included as the full year effect of approved service developments, which relates largely to outpatients and day case.
- £3.3m full year effect income 2017/18 CIP included

Commissioner Contracts

The Trust has agreed 2018/19 contract variations with Consortium CCGs as part of the Acting as One Agreements, NHS England and Wales (without HRGv4+). However the remains several item across all contracts that needs to be resolved in year, they can be summarised as;

- Targeted investment proposals due for decision in quarter 1
- Disputes relating to Liverpool Community Health transfer April 2017.
- Service and Local price reviews relating to NHS England
- Pipeline business cases e.g. Neonates, Specialist Rehabilitation etc.

The income plans for 2018/19 are largely based on the above contract agreements.

5.5 Single Oversight Framework Finance metrics

Table 4 Use of Resources (UoL) Rating

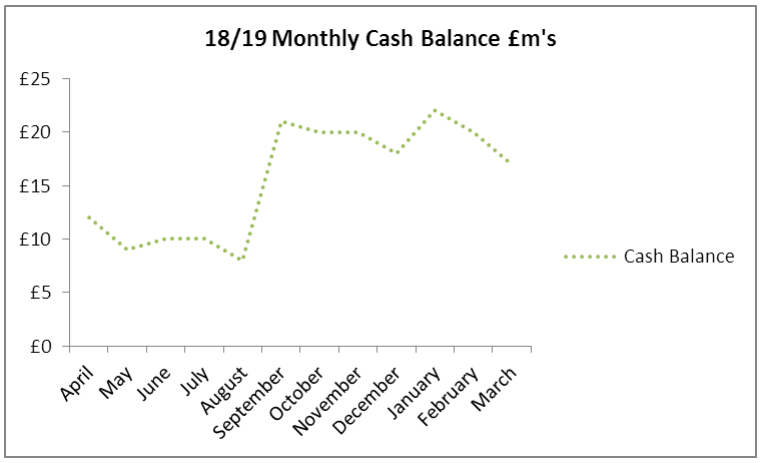
- Overall forecast risk rating of 1.

Capital Service Cover rating	3
Liquidity rating	1
I&E Margin rating	1
Variance From Control total rating	1
Agency rating	1
Overall Rating	**1**

Cash and Borrowings

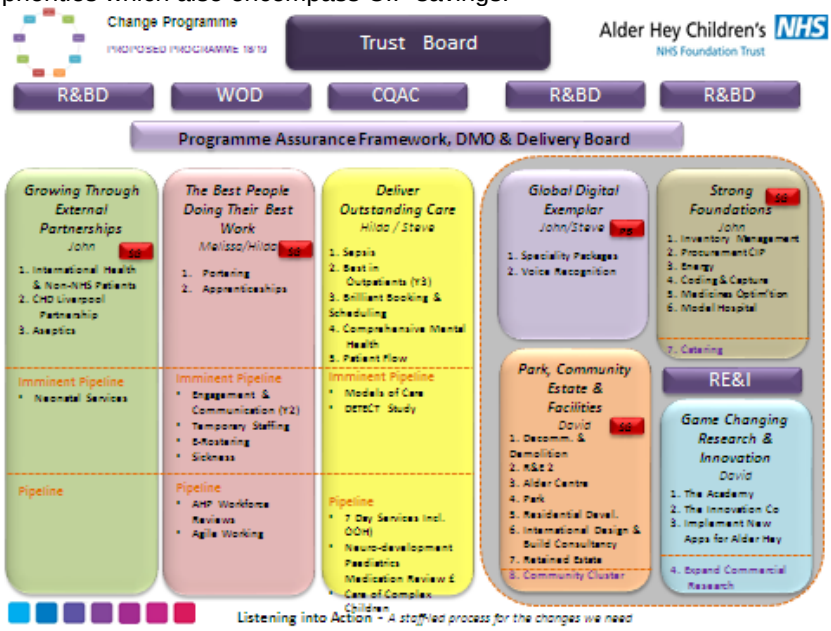
- Forecast cash position for March 2019 is £17.3, this assumes £4.4 surplus in 2017/18 with £6.2m STF match and a bonus amount.

	£m
Opening Balance	**12.2**
I&E 1819	4.4
add back Depreciation	6.1
Capex	-24.0
Donated income cash R&E2	3.9
Alder Centre	1.2
Loan Community Cluster	4.2
PDC	1.3
Loan repay	-2.3
PFI repay	-2.2
Finance Lease	-0.1
Receivables	14.4
Working capital Movements	- 1.8
Forecast Cash March 2019	**17.3**



5.6 Sustainability Savings 2018/19 - Cost Improvement Programme

- A CIP strategy and approach has been developed and integrated with the Trust's quality improvement and transformation programme. The Trusts plans also reflect and take account of the Cheshire and Merseyside Sustainability and Transformation plans. The Trusts plan on a page outlines our priorities which also encompass CIP savings.



- The Trusts transformation plans are built around the improving the clinical effectiveness agenda, which will maximise clinical engagement. The Trust will leverage initiatives such as 'Getting it Right First Time for Patients' to ensure quality improvements drive financial sustainability. The Trusts CiP and Saving plans will focus on the following key priorities
  - Doing the Basics Brilliantly
  - Leveraging the infrastructure (new hospital environment and Global Digital Excellence Exemplar)
  - Growing the Business (e.g. community services and Cardiac Surgery)
  - Maximising Commercial income (international, research and education)
- An in year target of £6.9m
- The focus is around cost reduction and income growth, with a continuation and maximisation of transactional schemes such as medicines optimisation and procurement. The main work streams in line with the Trust strategy as indicated on the diagram below are:
  - Delivery of Outstanding Care
  - The Best People Doing their Best Work
  - Sustainability Through External Partnerships
  - Game Changing Research and Development
  - Strong Foundations

The CIP and S&T Programme for 2018/19 will be governed through a Programme Assurance Framework and embedded within the Assurance Committees of the Board governance structure. Following the introduction of the Quality Improvement Approach the Trust has enhanced the governance to include a delivery function, the Sustainability Board, as described above.

Workstream	Target £000's
Deliver Outstanding Care	2,300
Sustainability Through External Partnerships	800
The Best People Doing Their Best Work	1,000
Game Changing Research and Innovation	500
Strong Foundations	2,200
Park, Community Estate & Facilities	0
Global Digital Exemplar (GDE)	1,000
Subtotal: Strategic Workstreams	**7800**
Divisional Business	-843
Grand Total	**6957**

Procurement

The Trust has updated its '10 Point Plan for Better Procurement' which outlines the strategic objectives of the procurement function. Key activities connected to this are:

- Adoption of a Zero Inflation policy: active resistance of all supplier inflationary uplift requests.
- Tightened controls on purchase order activity. All suppliers have been written to, outlining that invoices will not be paid without a valid purchase order. Trust staff are also provided with training on compliance with the Trust's Standing Financial Instructions and other financial governance obligations.
- Workshops have been held with all Clinical Business Units to identify further potential savings opportunities to add to the Procurement work plan.
- Materials Management in Theatres: The Procurement Department has now taken over the responsibility for all Theatres purchases. This has resulted in savings being achieved in relation to better stock management, reduction of waste (expired stock) and improved processes.

- Production of a comprehensive Procurement work plan which comprises a detailed list of savings schemes aimed at achieving the Procurement cost improvement target. Areas where CIP savings opportunities will be explored (this list is not exhaustive) are outlined below:

Key initiatives:

- Catalogue Management. Where practicable, all items procured are covered by robust and compliant purchasing arrangements and catalogued to facilitate the achievement of best value, price consistency and efficient invoice payment routines.
- A business case is being produced to procure a Trust wide Inventory Management solution. This will assist in reducing the stockholdings held and eliminate waste in relation to stock obsolescence and expiry of out of date products.
- Innovation. Working with the Trust's Clinical Innovation leads to identify new product developments and potential savings opportunities.
- Product standardisation. Rationalisation exercise being undertaken to reduce the variety of products purchased.
- Collaboration and partnership arrangements. Continuing to build on the relationships with procurement partners such as Health Trust Europe, NHS Supply Chain and North West Procurement Development.

- Agency staff. Proactively engaging with agencies via the appropriate frameworks to ensure that the price caps are implemented.
- Stronger clinical focus - To continue to deliver savings, clinical leadership in procurement activities is essential. To enable this, the following actions will be undertaken:
    - Medical Director to propose a "clinical champion" for procurement
    - Consider ring-fencing clinical P.A. time to enable more proactive clinical engagement
    - Clinical Procurement Group to be chaired by a lead clinician
- Engagement with FOM Category Towers - migrate to national deals (if beneficial) as they become available
- Commitment based procurement - maximise purchasing leverage by offering long term commitment to suppliers
- Better Business Intelligence - a suite of spend analysis reports and procurement dashboards will be produced
- More formal collaboration across Cheshire & Merseyside - progression of STP wide collaborative working / contracting, including Alder Hey leading on an STP wide Theatres Products Procurement Group.
- Strategic Approach will now be undertaken, including:
    - Formal Contract Management of Key Suppliers
    - Weekly review of Divisional spend - thus assisting in monitoring run rate performance
    - Closer working with Business Accountants and B.I. Team
    - Stronger integration with clinical teams (Category Managers embedded more in Divisions)

As a specialist Trust, Alder Hey has only recently been given access to the PPIB benchmarking tool. This tool is now being used to benchmark prices for commonly purchased products and, where it is identified that the Trust is not obtaining best prices for certain products, the benchmarking information is being used as leverage to negotiate price improvements, where applicable.

NHS Productivity and Model Hospital

The Trust is now included in the Model Hospital Portal. The Trust has commenced an internal process to identify key opportunities and a dash board for Committee scrutiny.

Agency Caps

The Trust has developed a plan around agency staffing caps. HR, Finance and Procurement have been working together to establish a robust 'break glass' process. So far the process has been effective in eliminating nurse agency and additional actions are established to ensure best practice approach put a number of controls. The Trust is confident that the Agency control of £3m will be achieved in 2018/19

The key actions the Trust is taking include but not limited to:

- Standardisation of agency partners for non-medical (NHS Professionals) and medical (Staff Flow). Any exceptions require 'break glass' process
- Eliminate use of non-framework compliant providers
- Conversion of all agency to NHS professionals and expedite recruitment
- Enhanced spend reporting and transparency data
- New Trust policy and process for advisors and consultancy.
- Standardisation and reduction of Medical locum rates

5.7 **Capital Planning**

The Trust's capital programme presented is required to be completed in full to meet prior commitments and progress the completion of the redevelopment of the hospital site and provide accommodation for the staff currently housed in the retained estate which is due to be demolished..

CAPITAL PROGRAMME	£m
ESTATES & SITE DEVELOPMENT	12.0
IM&T	3.7
MEDICAL EQUIPMENT	3.2
OTHER	5.1
TOTAL DRAFT CAPITAL PROGRAMME	**24.0**

FUNDED BY -	£m
DH LOAN	4.2
GDE PDC 2018/19	1.3
ALDER CENTRE LIBOR	1.2
DEPRECIATION / AMORTISATION	3.6
CH FUNDING / UNI CONTRIBUTIONS R&E2 BALANCE	3.9
CASH	9.8
Total	**24.0**

Capital expenditure for 2018/19 is £24m which includes schemes delayed from 2017/18

- Capital programme includes must do and essential schemes i.e.
  - High priority medical equipment
  - Essential site re-configuration to allow future disposal of land
  - Essential works to accommodate 600 staff from residual estate
  - New construction as part of the Site Development Master Plan
  - Centrally funded digital excellence project
  - Completion of Charitably funded Research and Education Phase 2
  - Build the Libor funded Parent Bereavement Centre the Alder Centre
- Funded by Trust cash, ITFF loan, charity and central funding for digital excellence.
- The Trust is continuing the detailed review and risk assessment of medical equipment replacement requirements over the next five years. The current plans assume all medical equipment will be funded by Trust cash (£2.4m), however early findings indicate more funding may be required. As mitigation the Trust is therefore reviewing the 'must do' requirements and will look to achieve a sustainable solution utilising lease options, charitable options, managed services etc.

6. Risk Assessment

The Trust's key risks in 2018/19 are consistent with those identified within the previous year and are described below together with the Trust's mitigations.

- Financial sustainability in a challenging environment
  - Mitigation:
    - develop a broader service base
    - promote a national alliance on paediatric tariff

- Ability to continue to grow
  - Mitigation:
    - develop meaningful partnerships
    - develop new business models with NHS partners
    - develop new NHS business, international operation and innovation

- Workforce
  - Mitigation:
    - Maximise Employer-Provider status for apprenticeships
    - Maintain supply of nurses via nurse pool – 40 WTE above establishment
    - Develop the Alder Hey Academy including collaborative working with HEI's and local schools
    - Develop new and expanded roles e.g. nurse social worker, Advanced Nurse Practitioners to support medical workforce
    - Deliver our health and wellbeing strategy for staff.

7. Membership and Elections

The Board at Alder Hey has continued to develop a close and productive relationship with its Council of Governors in the last 12 months, ably facilitated by our Lead Governor who is in turn supported by the Chair and Senior Independent Director. This year's election round has again resulted in a number of new governors who will participate in the Trust's local induction and will also attend in the *GovernWell* core skills module in the coming months. More established governors are encouraged to take up some of the other modules, particularly around constructive challenge and accountability. Alder Hey governors also participate in the North West Governors' Forum meetings. Following a recent by-election, one of the public governor roles and one patient seat remained vacant, however these vacancies will be rolled into the annual election round in the summer.

Membership Strategy – the Council of Governors has an active Membership Committee which meets on a monthly basis and is mandated to lead the Trust's engagement programme with members and the wider community. It is supported by the Trust's Communications Team and works to an agreed set of objectives created to reflect the overall aims of the Membership Strategy. The objectives for the coming year are a consolidation of previous work, given the ongoing nature of the governors' role around communication.

- **Newsletter** - to continue on a quarterly basis.
- **Member Communications** – this will again be a major focus in the coming year. The Trust has recruited to a second 12 month internship role in partnership with the Management School at the University of Liverpool, given the success of the first year of piloting this role. The postholder leads on the development of the membership database and will continue the effort to populate a greater number of members' email addresses and ultimately move to an electronic communication platform rather than printed media. The benefits of this will be twofold: to move Alder Hey towards a greater social media presence as befits our core demographic, as well as to generate a cost saving by radically reducing the amount of printing and postage associated with member communications.
- **New Governor Induction** – in addition to undergoing a formal structured induction session accompanied by an information pack, a "buddy" system will be re-established for new governors to support their introduction into the role.
- **Training** – as many Governors as possible will attend GovernWell events to support our efforts in respect of member engagement, as well as core skills. A plan to commission bespoke training on site for those governors unable to travel to GovernWell courses due to work and other commitments is to be considered and taken forward. Towards the end of last year some of the governors received social media training; further sessions are being considered for the year ahead.
- **Links to the Children and Young Peoples' Forum** – this will be the other major focus in the coming year and beyond, aiming to continue to strengthen the link between the Council of Governors and the Children and Young People's Forum; this will facilitate joint working and provide a regular link from the Forum to the Council, for example through young people attending Governors' meetings to share issues and potentially encourage forum members of the right age group to stand for election as governors.
- **Annual Members' meetings** - the Committee also acts as a steering group for the planning and organisation of the Annual Members' meeting, the theme of which for the current year was the Trust's innovation effort, as well as the delivery of the statutory elements. In the coming years, consideration will be given to reinstating Trust Open Days within the new facilities.
- **Public Health** – one of the local authority governors will facilitate involvement with Liverpool City Council's 'One Liverpool' initiative and more general Trust/City Council collaboration. In addition, the Governors continue to be central to the Trust's work to address key public health issues such as smoking and how this problem can be alleviated on the hospital site.

Alder Hey Children's NHS
NHS Foundation Trust

Patient centred

Division of Surgical Care Priorities for 2018/19

Quality Improvement	Staff Engagement & Workforce Planning	Access to Care & Growth
Trust Quality Strategy **Robust Governance Processes** **Booking & Scheduling / Transcription / Data Quality**	**Investment** • Resilient Staffing Levels • Training & Education **Recruitment** **Engagement** • LiA • Reward & Recognition • Wellbeing	**Partnerships** **Patient Flow** • SAFER Bundle **Growth**

Top 3 Delivery Risks

Alder Hey Children's NHS
NHS Foundation Trust

- Booking & Scheduling
- Staffing levels & Recruitment
- Patient Flow and Bed Capacity

Elective capacity during Winter

Proposed Metrics

Quality Improvement & Governance	• Number of Harms • Reduction in Medication errors • Safety Culture Assessment • Patient and Family Feedback
Staff Engagement & Workforce Planning	• Staff Survey: Recommended Place to Work • Local "temperature checks" • Nurses per shift • Number of staff recognised/nominated for awards
Access to Care & Growth	• Average activity per working day • Number of theatre lists per week • Patient waiting times • Specialty specific volume metrics

Alder Hey Children's NHS
NHS Foundation Trust

Best in Operative Care

Delivering Safety, Excellence and Wellbeing in Theatres

Pre-Operative Assessment Service

- Improve safety, quality and patient experience
- Reduce cancellations

Incident Reporting and Management

- Use of Ulysses within Theatres
- Safety Culture

Workforce Development

- NatSips
- Recruitment and Retention
- CPD, Training, Career progression
- Human Factors

Emergency Surgery

- Consolidate and further improve Emergency pathways

Materials Management

- Reduced incidents / cancellations due to stock
- Reduce expired stock / wastage
- Reduce cost

Theatre Scheduling and Planning

- Re-allocated sessions
- Review under-utilised lists
- Realignment of sessions

Patient Access and Flow
(Additional Project Group)

Alder Hey Children's NHS
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Financial Planning

Category	2016/17 Actual £m	2017/18 Actual £m	2018/19 Budget £m
Income	96.0	104.3	108.5
Pay Expenditure	(55.8)	(58.5)	(59.7)
Non Pay Expenditure	(15.3)	(15.7)	(15.1)
Total (Net Income)	**24.9**	**30.1**	**33.7**

Target to increase our Net Income by £3.6m includes **£2.1m Financial Sustainability target**:

- Growth
- Coding
- Procurement
- Other Savings

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Financial Risks

	Description	£m
1	**Delivery of activity** - Cardiac programme (25 spells) £375k - Clinical workforce recruitment £482k - Winter Capacity / Medical outliers £612k	**£1.5**
2	**Delivery of Sustainability target** - 2017/18 Recurrent gap carried forward £238k - 2018/19 In year risk adjusted forecast £564k	**£0.8**
3	**Unresolved Income Pressures** - Spinal Case Mix £431k - Excess Bed Days £500k	**£0.9**

The Division is carrying c.3.2m of financial risk going into 2018/19.

This is in addition to the risks which are being managed within Departmental budgets as described in formal Financial Planning and Cost Pressure meetings.

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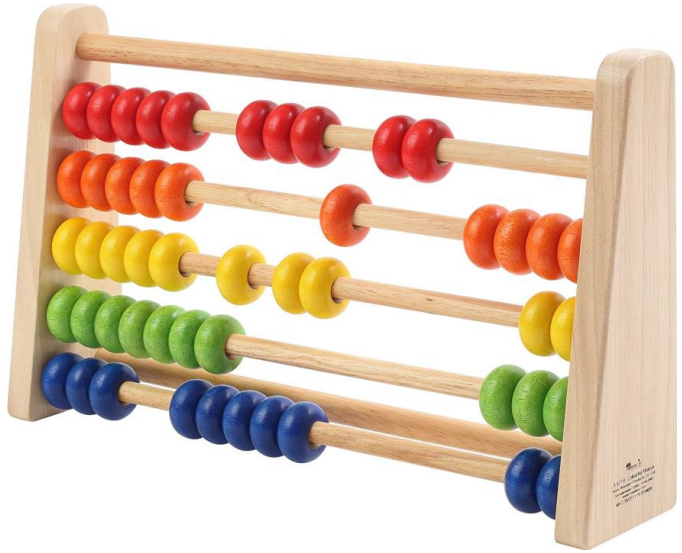
Division of Medicine Business Plan 2018/19

Keep it Simple and Count to 7

- **One** Plan on a Page
- **Two** Parts to Our Vision
- **Three** Focal Pillars
- **Four** Strategic Objectives
- **Five** Operational Priorities
- **Six** Delivery Risks
- **Seven** Workforce Gaps



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Alder Hey Children's NHS
NHS Foundation Trust
1
OUR PLAN
INSPIRED BY CHILDREN
A HEALTHIER FUTURE FOR CHILDREN AND YOUNG PEOPLE
Our aspiration:
To be world-leading
Delivery of outstanding care
The best people doing their best work
Sustainability through external partnerships
Game-changing research and innovation
BRILLIANT BASICS
GROW THE FUTURE
STRONG FOUNDATIONS
Living our Values
Children and Families
are involved in everything we do
Deliver
business plans and achieve financial targets
Work Productively
spend wisely and reduce waste
Reliable Infrastructure
slick systems and processes, used consistently, supported by training
Digitally Enabled
Way of working that effectively uses information technology

build strong foundations, grow healthier futures

2 VISION

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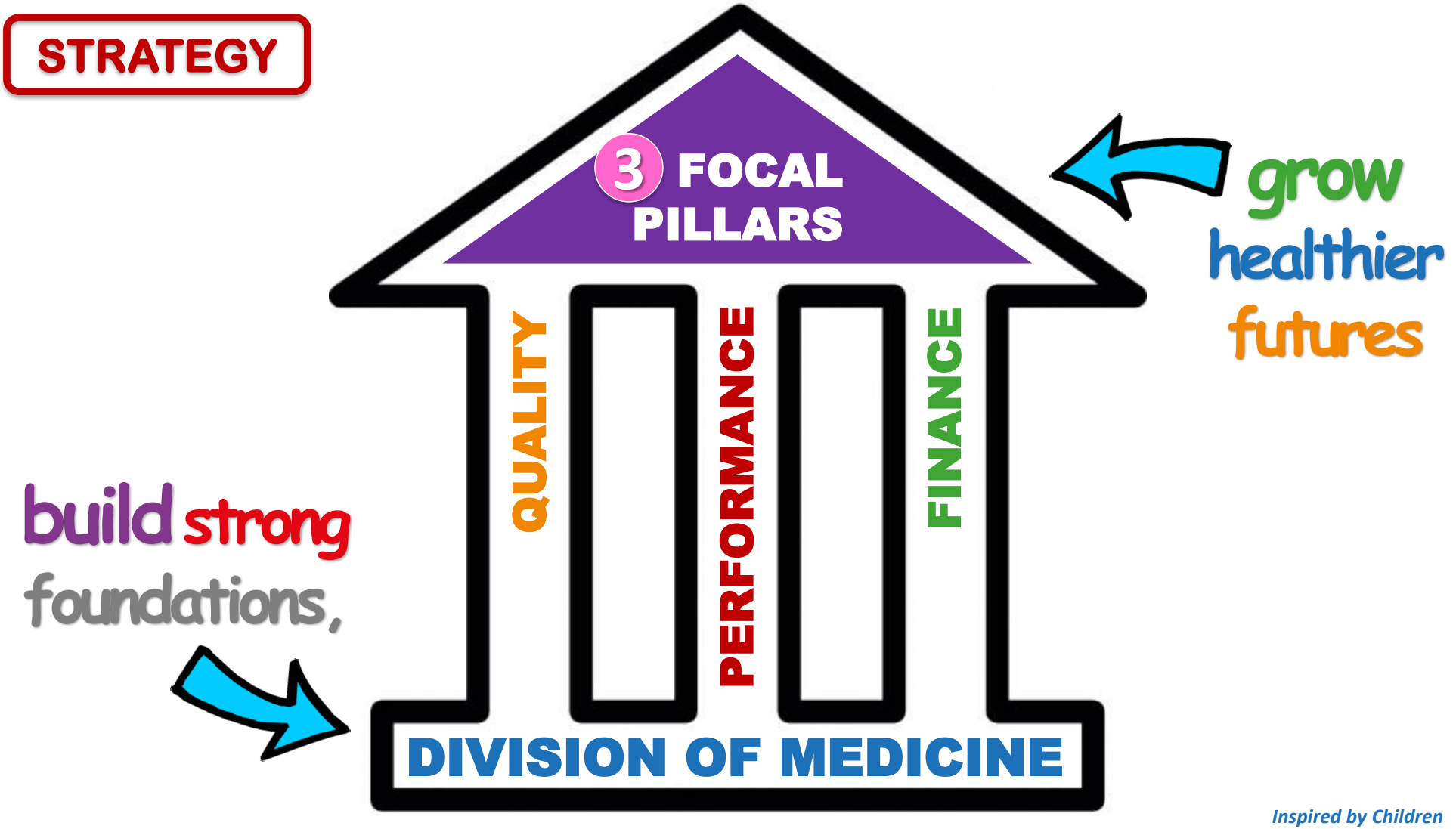
STRATEGY



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Plan on a page for the DIVISION OF MEDICINE

Our Vision: A healthier future for children and young people

Our Aspiration: To be world-leading

Our Inspiration: We are inspired by children

Vision & Goals

By 2020, Alder Hey will improve the health & wellbeing of Children & Young People throughout the world, by ..

Doing the Basics Brilliantly - **for our patient experiences, our staff lives, and to be able to grow**

Growing the Future - **rapid and sustained growth: 10% NHS growth and £5m commercial ambition**

4

Strategic Objectives

1) Delivery of outstanding care

…being recognised for delivering **outstanding safe, caring, child and family-centred** services, with **world-class outcomes**

…in the best possible environment for children and young people; i.e. as **close to home** as possible or at our bespoke **Children's Health park**

2) The best people doing their best work

…inspiring our **talented workforce** to actively drive **quality improvement**

…supporting the ongoing development of a **positive and healthy culture**, in which our people can give of their best

…**investing** in our people

3) Sustainability through external partnerships

…with health, social care , the third sector and academia, to join up care for the children we support

…**growing our business** by 50% - locally nationally and internationally

4) Game-changing research & innovation

…being a **centre of excellence for children's health** through our world-class **innovation, research & education offers**

…being **brilliantly digitally enabled**, to match the expectations of the children & families we serve

18/19 Operational Priorities

We will deliver this through the following 20 DIVISIONAL Operational Priorities for 18/19:

- Engage quality improvement approach
- Outstanding performance against all CQC domains.
- Digital pathways
- Improve patient services focused on 5 Key Priorities, concentrating in particular on: Patient Flow and the SAFER Bundle.
- Validation of our waiting lists.
- Higher throughput of patients through Medical Day case and Outpatients.

- Build leadership capability (Clinical and Non Clinical)
- Workforce Planning including Medical job planning.
- Deliver new apprenticeships and nursing developments
- Continue Governance success & Risk Register overhaul
- Regular coding audits
- Promote staff wellbeing
- Improve divisional communication

- Develop our international child health business
- Aseptics Unit Development
- Productivity Benchmarking in Laboratories
- Align with 'One Liverpool' programme

- Growing our Research portfolio
- Models of Care
- Continue reference site alliances.
- Explore innovative patient flow methodology

Quality Performance Finance

Strong Foundations

Built upon Strong Foundations:

Systematic approach to inspiring Quality & Improvement - "The Alder Hey Way"

Living our values: Respect, Excellence, Innovation, Openness, Together	Children and families are involved in everything we do	Deliver business plans and achieve financial targets	Work productively, spend wisely and reduce waste	Reliable infrastructure, systems and processes, that enhance quality & safety, used consistently and supported by training	A digitally enabled way of working that effectively uses information technology to improve patient and staff experience

Divisional Objectives for 2018/19

		5 Key Operational Priorities	Measure	Target Date
Build Strong Foundations	1	**Maintain Financial Performance** Using our Divisional Focal Pillars …	Continue & Improve [c.f. Activity Plan]: Recording; Coding; Throughput [esp MDU]	Q1
Build Strong Foundations	2	**SAFER Bundle** … focus more on what matters to patients.	Reduce ALL Length of Stay cohorts by 10%. Greater Throughput.	Q2
Grow Healthier Futures	3	**Clinical Service Leads** Appoint and Establish …	Assign 13 performance assoc posts with financial benefits agreed: £1PA = 2PAs Productivity	Q2
Grow Healthier Futures	4	**Service Reviews** … will inform ambition / potential for …	Strategic and Performance orientated Service Reviews with each Care Group	Q3
Grow Healthier Futures	5	**Define Future Growth** … Research, International, Innovation, Non NHS	Construct Expansion Models for a Sustainable Future. 	Q4

Top 6 Delivery Risks for 18/19

		Category	Risk Score
1	Fragile Services	Strategy	5
2	Delivery Management Support	DMO	3
3	Double Counting	Financial	3
4	Additional Priorities / Buffer Room	Leadership	4
5	Burnout / Staff Sickness	HR	2
6	Conflicting / Unclear Messaging	Communications	2

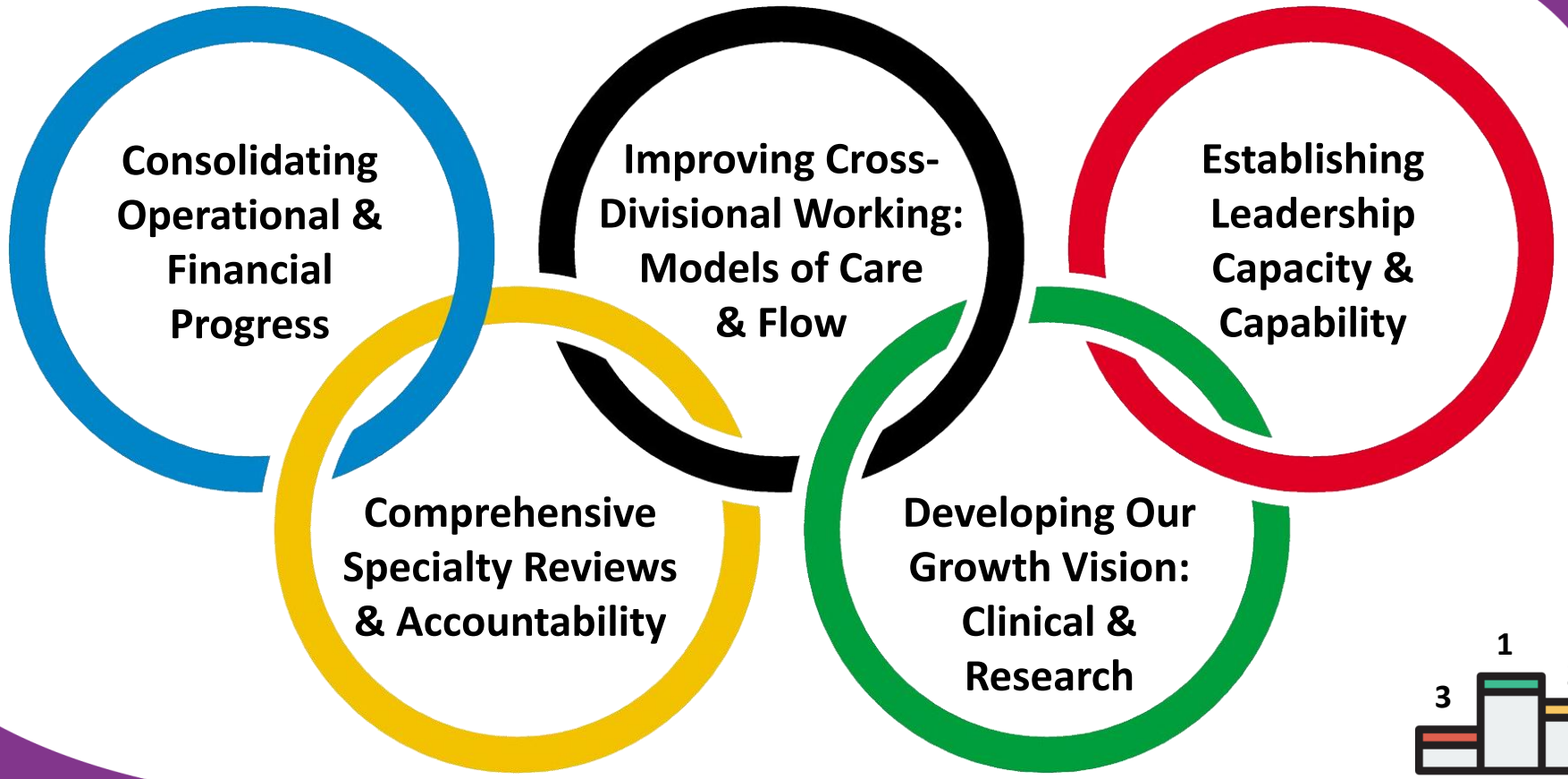
The Best People Doing The Best Work:

7 Workforce Gaps and Proposals

Workforce Gap	How Resolving?	Lead	Target Date
1. Nursing	Rapid Response Business Case	C Wardell	Q1
2. Junior Doctors	Out of Hours Working Group	A Hughes	Ongoing
3. Therapists	AHP Service Review	W Weston	Q4
4. Models of Care	Models of Care Group	A Hughes	Q3
5. Consultants	Haem Business Case; Service Reviews	G Smith	Q1
6. Radiology	Radiology Business Manager Business Case	C Landes	Q1
7. Aseptics	Aseptics Business Case	C Barker	Q1

Conclusions:

5 Key Operational Priorities



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Financial Headlines

Comparison of 2017/18 and 2018/19 Budgets:

- Income: £78m to £85m
- Expenditure: £74m to £80m
- Control Total: £3.9m to £5.0m
- Key reasons are pay uplift, tariff inflation, CIP).

CIP [Sustainability Plans]:

- £2.2m with NO CARRY FORWARD from 2017/18

Risks identified of £2.7m to this plan 

- Cost Pressures / Service Developments £1.8m
- Sustainability Target £700k
- Activity Risk £200k

Cross Divisional Priorities

Cross Divisional Operational Priorities	Divisional Response and Ideas
1) Brilliant Patient Booking Systems	Continue capacity based booking system (hybrid). Prioritise EPPF
2) Comprehensive CAMHS	Work together re "Reduction in LoS for emergency admissions for MH"
3) New Models of Care	Communicate Theory to Practicalities and Benefit. Calculate Benefits.
4) Best in Outpatient care	Continue to reduce Transcription backlog. Clinical and Clinical support engagement.
5) Patient Flow	Collaborate to improve DC/EL pathways. SAFER Bundle; Bed Management Module

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Community Division 18/19 Operational Plan

SUMMARY VERSION

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Division of Community
18/19 OPERATIONAL PLAN SUMMARY

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Delivering outstanding care	The best people doing their best work	Sustainability through external partnerships	Game-changing research & innovation
Develop role of community services within child & family centred pathways *children should be cared for at home or as close to home as possible* **Improve service responsiveness** *Monitor, measure and improve waiting times for all services* **Deliver services from facilities which are fit for purpose & designed around the needs of patients and families** *Critical review of community estates and IM&T*	**Invest to ensure resilient staffing levels** **Use of apprenticeship posts & ensure that staff can access training opportunities** **Staff engagement through…** • **LiA** • **Innovative communication** • **Involving people!** **Recruitment & retention improvements through flexibility and innovation**	**Key partner in the transformation of community services for children in Liverpool** **Development of network approach to delivery of Tier 4 CAMHS services with other providers** **Deliver new pathways in Sefton for Neurodevelopmental paediatrics**	**Grow the research profile within the division** **Increase the number of staff and patients participating in research** **Innovate to solve problems in community** **Use technology within home environment to support children to be cared for at home**

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TOP 3 priorities

	Community Division	KPI
1	**Comprehensive CAMHS** Deliver a range of improvements in mental health services which will ensure that children and young people receive the right level of care, at the right time to meet their needs. This includes ensuring we have the right number of tier 4 beds and our access to all CAMHS (including urgent care) is appropriate and timely.	Max 12 week wait for CAMHS intervention Increase in T4 bed provision from 7-9 Improvement in staff morale & CQC rated 'GOOD'
2	**Patient experience** Integration of pathways between hospital and home to reduce the number of children who stay in hospital longer than they need to. Active engagement with Liverpool Children and Families Transformation plan to ensure greater integration of services across health and social care.	Reduction on LOS for children who stay in hospital more than 30 days
3	**Responsiveness** Ensure that capacity matches demand for all community services. Improve measurement and visibility of waiting times and ensure that all services have the right capacity to meet the needs of patients.	18week RTT for all applicable services in community Fit for purpose IT system and processes

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Top 3 Delivery Risks with mitigation

Workforce

- Improved workforce planning to address gaps and predict
- Innovative role development
- Training in Quality Improvement to support delivery of transformation required

Estates and IM&T

- Critical review of all estates to ensure meeting needs of patients
- Investment in community focussed IM&T strategy

Financial risks within 18/19 plan and ability to deliver sustainability target

- Good financial governance at team and department level
- Working together with other Divisions to achieve overall plan

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Financial Plan 18/19

Division Control Total - £4.3m Surplus

	17/18 Budget £	17/18 Forecast £	18/19 Budget £
Income			
Clinical Income	25,936,508	25,936,866	26,426,037
Non Clinical Income	234,546	396,327	110,175
Total Income	**26,171,054**	**26,333,193**	**26,536,212**
Expenditure			
Pay Costs	19,111,554	19,734,207	19,450,373
Other Non Pay	3,208,828	3,349,235	2,811,831
Total Expenditure	**22,320,382**	**23,083,442**	**22,262,203**
Control Total surplus/ (deficit)	**3,850,672**	**3,249,751**	**4,274,009**

Key risk to plan £1.6m

Budget Assumptions

- Assumes no medical gaps
- Assumes LCH budget pressures are resolved

Business cases 18/19 forward look…..

- Sefton Neurodevelopmental pathway
- Community dietetics
- Sefton CAMHS
- Liverpool ASD pathway
- Mental Health liaison service

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BOARD OF DIRECTORS

Tuesday 1st May 2018

Report of:	Clinical Research Division
Paper Prepared by:	Professor Matthew Peak/Dr Charlie Orton
Subject/Title:	Clinical Research Division Operational Plan 2018/19
Background Papers:	Slide pack prepared
Purpose of Paper:	To inform Trust Board of Clinical Research Division key operational highlights for 2018/19
Action/Decision Required:	For information
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Link to Liverpool integrated research strategy for child health and Trust strategic pillar for 'Game Changing Research'
Resource Impact:	To be discussed

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Clinical Research Division 2018/19 Operational Plan

Alder Hey Trust Board
1st May 2018
Professor Matthew Peak: Director of Research

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Division of Clinical Research Priorities for 2018/19

THEME = INTEGRATION

- Quality Improvement
- Workforce Planning
- Internal/External Partnerships
- Survive and Sustain

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Internal/External Partnerships

- *Internal*
  - Productive and resilient cross-Divisional working (Director and ACOO level)
  - Taxonomy of activity – shared operational planning
  - Develop a credible/influential cadre of clinical research leadership
- *Liverpool*
  - Role of Alder Hey/UoL Strategic Liaison Committee
  - Influence post clinical research review
  - Influence Joint Research Service
  - Ensure significant/strategic infrastructure awards are supported both to deliver to plan and to grow
- *National/International*
  - Recognise and proactively support Alder Hey contribution to influential networks/consortia (e.g. EuPFI, c4c, PedCRIN)

Key Metrics

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Quality Improvement	• Sponsor Oversight Committee fully functioning • Number of study audits completed • % of SOPs reviewed on time • CQC & Ward round scores/recommendations • Patient and Family Feedback
Workforce Planning	• Number of new clinical academics/trainees • Induction and training programme delivered (% of staff) • Number of research nurses with enhanced clinical skills • Number of staff recognised/nominated for awards • Number of CRD core staff
Internal/External Partnerships	• Cross Divisional Working with a shared vision/mission • New research infrastructure applications/awards • Strategic and/or new commercial partnerships
Survive & Sustain	• No further loss of highly experienced staff • RTT for 80% commercial trials and 14 new contracts • Number of teams with protected research time • Reinvestment volume through revised financial model

Top 4 Delivery Risks

1. Lack of investment in research infrastructure
2. Contribution of >£500K per annum and £115k CRF cost pressure; CRD unsustainable
3. Inadequate Research Nurse leadership; staffing recruitment and burn out (within all four Clinical Divisions, e.g. Principal Investigators)
4. Need improvement in organisational agility to support delivery of time-limited infrastructure/study awards (e.g. recruitment processes)

Financial Principles

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Research Fundamentals: Regulated (CQC/MHRA) Mandated (NHS Constitution) Improves Outcomes	***Core Team Functions*** Leadership Regulatory Affairs Safety Quality	'Cost' to the organisation	SAFETY
Research Infrastructure	***Delivering Research*** CRN – recruit at volume CRF – novel therapies Improves quality	Cost Neutral	QUALITY/ CAPABILITY
Research Esteem	***Research Awards*** External Grants NIHR Infrastructure Clinical Academic Posts	Cost Neutral	
Research Growth	***Outward Facing*** Commercial Research CRF Support Posts supporting growth	Generates surplus	CAPACITY

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Opportunities for Financial Sustainability

Grow The Future

- With other Clinical Divisions, co-design a research finance model which supports growth
- Corporate approach to supporting clinical academic training and careers across all professions

CRD workforce focused on growth

- Institute Research Nurse leadership at a level commensurate to meet the needs of external sponsors and quality standards
- Organisation attuned to research business logic/standards through re-engineering from CRF Manager/Industry Manager

Be selective

- Build on existing areas of critical mass
- Invest in academic partnerships which offer the best opportunity for success

Invest to grow

- Judicious use of all Research Capability Funding allocation for growth in line with research strategy
- Invest in key appointments supporting academic (e.g. Paediatric Medicines Research Unit) and specialist (e.g. CRF growth) posts

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Brilliant Patient Booking Systems

Trust Board 1 May 2018

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Vision

The vision of the project is to provide a booking system that allows patients and families to book, cancel and re-book clinic appointments in the easiest way possible to them and because of our brilliant booking systems and tight processes, our clinic utilisation reaches 90%. Patients and families will be able to book their clinic appointments via their mobile phone or email and 95% of our patients and families will be very happy with our booking and scheduling system. In addition, carers and families of our most complex children will be able to co-ordinate multiple appointment into fewer days resulting in less visits to the hospital.

Our operational plan 2018-20

5 improvement priorities

Project overview document

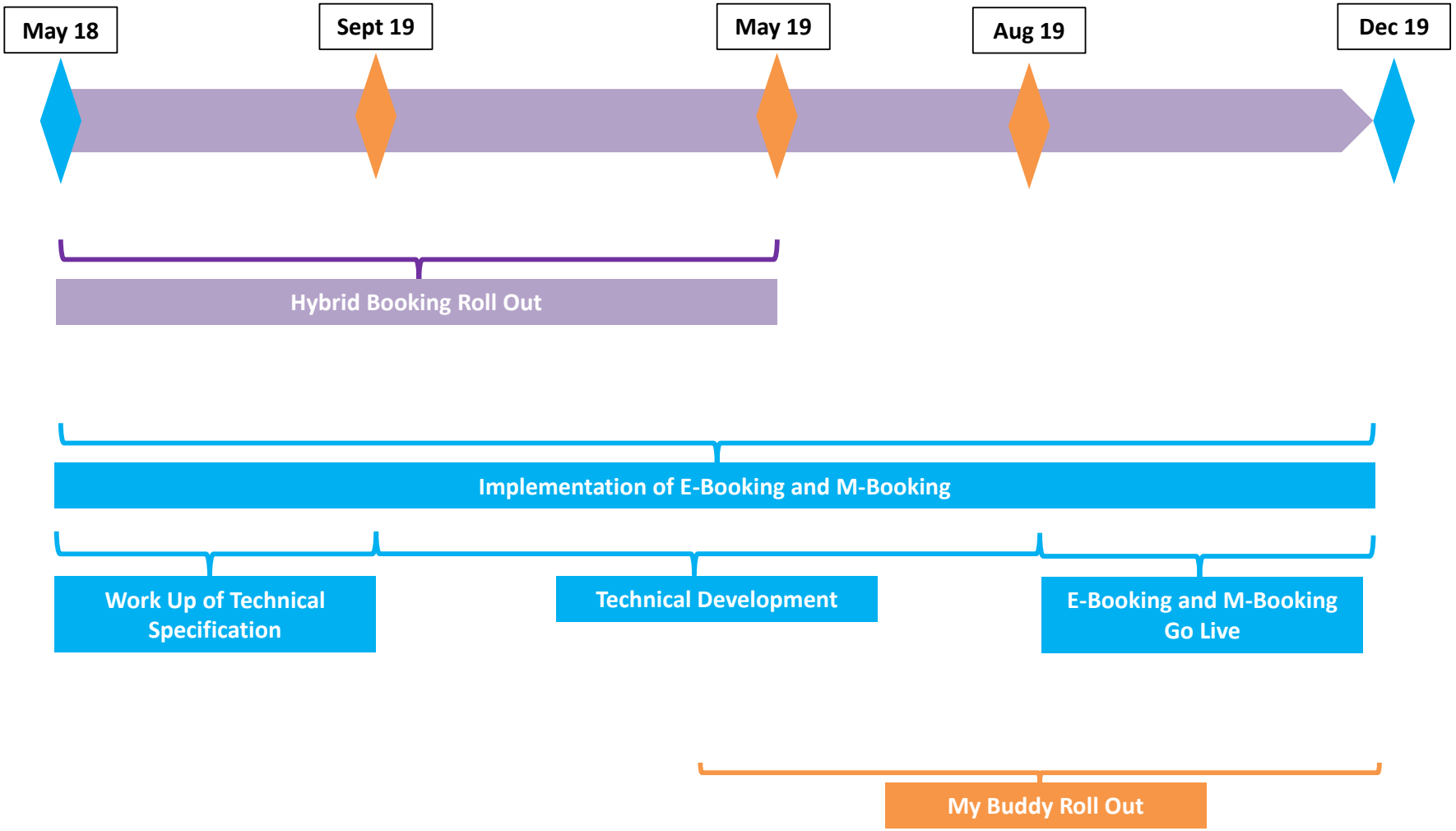
Delivery of **Outstanding care**

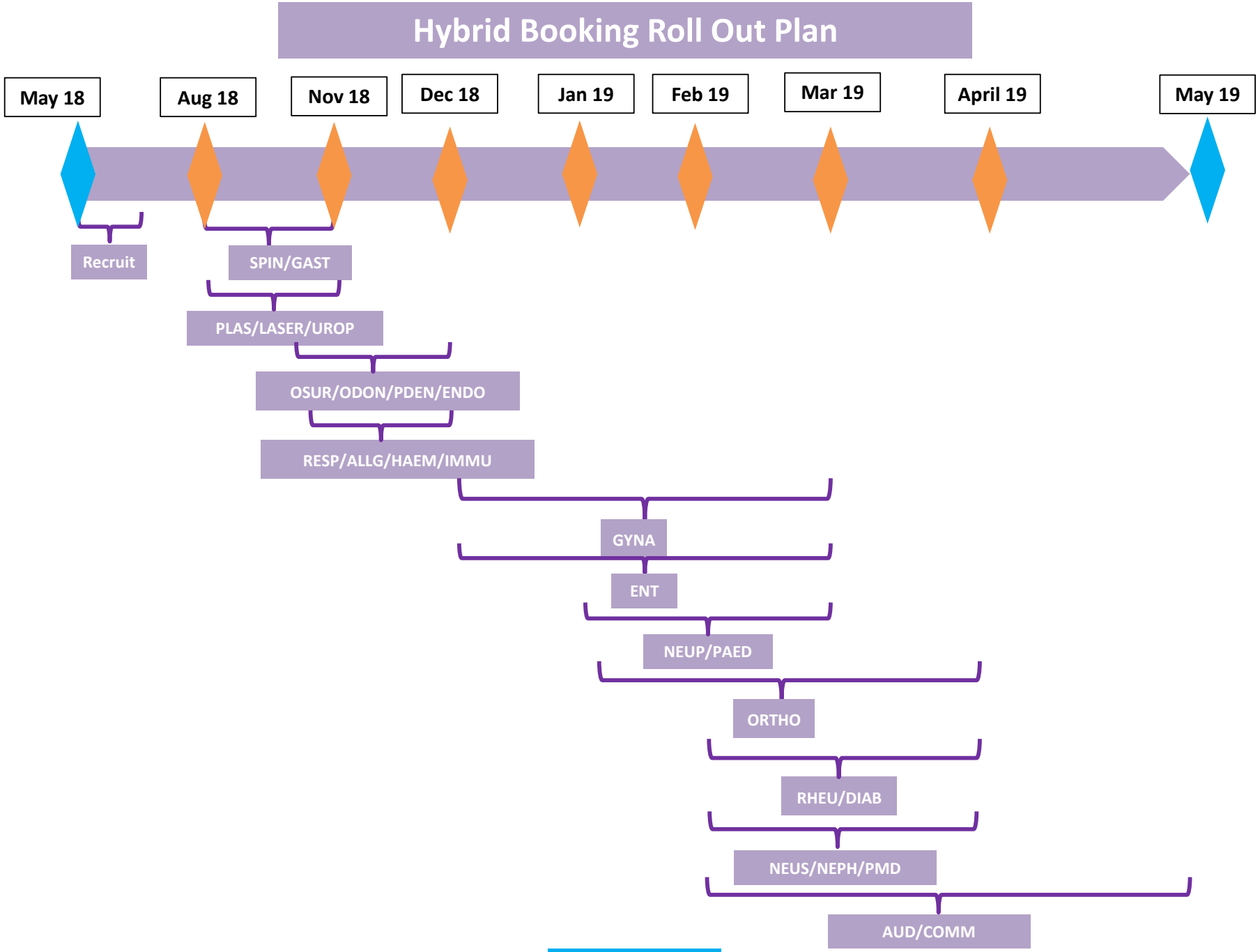
Project title (improvement priority): Brilliant Patient Booking Systems

Brilliant Patient Booking Systems

What	To provide a booking system that puts children and families first and meets the needs of clinicians that use it.		
Why	▪ Improve patient experience ▪ Reduce appointment cancellations ▪ Reduce the time from referral to first outpatient appointment ▪ Improve clinicians' experience of our systems		
How	Capacity-based booking system (Hybrid Booking)	E- booking and M-booking systems	'My buddy' for patients with multiple appointments
When	May 2019	December 2019	December 2019

Brilliant Patient Booking Systems High Level Plan




Hybrid Booking Roll Out Plan
May 18
Aug 18
Nov 18
Dec 18
Jan 19
Feb 19
Mar 19
April 19
May 19
Recruit
SPIN/GAST
PLAS/LASER/UROP
OSUR/ODON/PDEN/ENDO
RESP/ALLG/HAEM/IMMU
GYNA
ENT
NEUP/PAED
ORTHO
RHEU/DIAB
NEUS/NEPH/PMD
AUD/COMM

Outcomes / Benefits

Dermatology ✓
Cardiology ✓
Ophthalmology ✓
Gen. Paeds ✓

Outcomes / Benefits realised so far…

- A reduction of £29k in postage
- Reduction in incoming calls
- Patients being booked in priority / chronological date order
- Patient experience – less frustrated families
- Staff experience – team much happier with reduction in calls from unhappy families

FINANCE ASSESSMENT

Project Overview Document - THEME

Trust Strategic Aim

Project Title (improvement priority): Brilliant patient booking systems

Project Purpose: To provide a booking system that puts patients and families first and meets the needs of clinicians that use it

Benefits/ Impact

SMART objectives

Benefit	Q1	Q2	Q3	Q4	Total
Bed days saved	0	0	0	0	0
Spells	0	0	0	0	0
Outpatient	-£32	£202	£202	£202	£574
WTE	0	0	0	0	0
£000's	0	0	0	0	0

Assumptions:

1) Using Average Outpatient income of £119 per appointment, an increase of 35 appointments per day from July (and using % of 1819 working days)
2) Reduction in Postage Spend relating to Partial Booking only - starting May
3) IT Tech support will not be an additional cost
4) Additional Consultant PA starting in July
5) Using Estimates of £100k plus VAT for external partner support starting May – need further information
6) B&S needs additional support – case being prepared to go to IRG – estimates used for this and will be updated when have further info

Benefits

Benefit	How Measured	Baseline	Proposed Improvement	Benefit Start Date
Patients and Families' experience of he booking process	Information Gathering Event / Questionnaires / Text message surveys	TBC	95% of patients / families are very happy with the booking process	August 2018
Increase in clinic utilisation	Number of Patients seen / Number of Patients who could have been potentially seen	703 patients seen in Outpatients per working day (85% clinic utilisation)	738 patients seen in Outpatients per working day (90% clinic utilisation) – Additional 35 patients seen per day over year equates to £574k	August 2018
Improve clinician's experience of our booking systems and processes	Questionnaire / survey	TBC	95% of clinicians are very happy with our booking systems and processes	August 2018
Decrease in postage expenditure	Annual expenditure with PSL 17/18	£421,837 spent on postage in 17/18 (PSL)	Reduction of 10% (partial booking letters circa. £40k)	August 2018

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BOARD OF DIRECTORS

Tuesday 1st May 2018

Report of:	Chief Nurse
Paper Prepared by:	Chief Nurse and Clinical Risk Manager
Subject/Title:	Duty of Candour and Incident management, including all incident investigations of moderate harm or above.
Background Papers:	Seven Steps to Patient Safety. National Patient Safety Agency 2004. Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. Incident Investigation reports.
Purpose of Paper:	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour. .
Action/Decision Required:	Note and approve current assurance position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• **Patient Safety Aim** – Patients will suffer no harm in our care. • **Patient Experience Aim** – Patients will have the best possible experience • **Clinical Effectiveness** – Patients will receive the most effective evidence based care.
Resource Impact	n/a

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1. Background:

NHS England published a revised 'Serious Incident Framework' in 2015, and an updated 'Never Events Policy and Framework' 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, sets 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 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.

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

The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory Duty of Candour be introduced for health and care providers. This is further to the contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. In April 2015 this became law for all providers and the CQC guidance requires Trusts to achieve a verbal Duty of Candour for moderate harm and above incidents within 10 working days. This should be followed up with a written Duty of Candour in a suitable timeframe.

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

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

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

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

Current position

Table 1 shows the Trust's 2017/18 performance for serious incidents requiring investigation (SIRI). All moderate harm and above incident investigations are monitored via the monthly performance assurance meetings with individual Divisions, focusing on the management of investigations, including lessons learned and assurance of progress with actions for improvement. In addition, a monthly report of progress with actions, from SIRI investigations is presented to the Clinical Quality Steering Group, with exceptions reported to Clinical Quality Assurance Committee.

During this reporting period there were no serious incidents or safeguarding incidents reported.

Table 2 shows there are three ongoing serious incident investigations, which comply with external requirements, including application of duty of candour.

Table 3 shows the Trust had one moderate harm incident during this reporting period, and the management of this investigation is compliant with external requirements, including application of duty of candour.

Table 1 SIRI performance data:

SIRI (General)												
2017/18												
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
New	3	1	2	4	0	2	0	1	2	4	0	0
Open	2	4	4	6	8	5	3	1	1	3	3	3
Closed	2	1	0	1	2	3	4	2	1	0	4	0
Safeguarding												
Month	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
New	0	0	0	1	0	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	1	0	0	0	0	0	0	0

Table 2

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 2018/2696	30/01/2018	Medicine	Patient's Consultant informed via Ormskirk Hospital of child's death on 22/01/2018. Patient diagnosed with congenital hyperinsulinism, Beckwith Weidemann Syndrome and Gastroesophageal Reflux Disease. Patient seen in outpatients by	Jo Blair, Endocrinology Consultant and Joanne Kendrick, Ward Manager, 3C	Awaiting results of post-mortem, post-mortem report not yet finalised. RCA on hold until outcome of post-mortem becomes available.	Extension agreed 17th May 2018	Duty of Candour completed including letter sent to family.

			Consultant 13/12/2018, mother had issues with feeding and referral to Speech and Language Therapy Team (SALT) was made. No reports of choking episodes or difficulty swallowing. Although the referral stated urgent, the appointment did not occur. Following review of baby's care the Consultant reported the incident and decision taken that this was a serious incident that required further investigation.				
StEIS 2018/1590	18/01/2018	Surgery	Child transferred from Whiston Hospital on 23/10/2017 due to secondary scalding episode and trauma to buttock from a smashed ceramic mug. The patient was operated on 24/10/17 to repair laceration to buttock and was discharged on 27/10/17. Patient attended Emergency Department 27/12/2017, reviewed by surgical doctor who noted left sided foot drop. On review of	Sarah Wood, Consultant Surgeon and Dianne Topping, Senior Nurse	2nd RCA panel held, RCA report being written.	Extension agreed 8th May 2018	Duty of Candour completed including letter sent to family.

			case, it is felt that there was a missed laceration to the nerve in the buttock during initial investigation and surgery. If this was recognised during initial surgery, patient would not have had a secondary nerve graft procedure.				
StEIS 2017/30500	13/12/2017	Surgery	Unexpected death of neurosurgical patient.	Rachael Hanger, Theatre Matron and Simon Kenny, Consultant Surgeon	Independent review of case being undertaken. Patient's family have forwarded questions to be addressed as part of investigation, which have been shared with independent expert, review expected to be completed within 4 weeks.	Extension agreed 31st May 2018	Duty of Candour completed including letter sent to family.

Table 3

Duty of Candour Incidents (excluding SIRI's)							
Reference Number	**Date investigation started**	**Type of investigation**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance**	**Duty of Candour applied**
27828	15/03/2018	RCA Level 1	Patient on ECMO required bronchoscopy, showed foreign body in airway was the tip of an inline suction catheter. Patient required further bronchoscopy and retrieval of foreign body. Incident reported to MHRA in line with best practice.	Bron Robinson, Clinical Nurse Manager, ICU	Information gathering underway.	Progressing.	Duty of Candour completed including letter sent to family.

**Level 1 investigation,*

END

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee Annual Report 2017/18

Clinical Quality Assurance Committee

The purpose of the Clinical Quality Assurance Committee is to provide assurance to the Board of Directors that the Trust's systems, processes and culture ensure the highest standards of clinical quality in terms of patient safety, clinical effectiveness and patient/carer experience to our children and young people and their families.

The Committee has delegated authority from the Trust Board to oversee the effectiveness of clinical quality, clinical practice and clinical governance within the Trust, ensuring that all supporting systems and processes enable staff to adhere to their duty of candour. It does this principally via the Divisions and Clinical Directors who have the authority to implement the Trust's Quality Strategy and supporting Quality Aims within and across divisions, supported by the central functions.

The principal devolution of the Board's responsibilities are as follows:

Quality Strategy

- To oversee the development, implementation and evaluation of the Trust's Quality Strategy and its underpinning strategies, in accordance with the Monitor/NHSI *Quality Governance Framework*.
- To monitor the performance of the Trust against its agreed Quality Aims and all national mandatory/regulatory targets and quality standards.
- To provide assurance to the Board of Directors that the key clinical risks to the organisation are being identified and managed appropriately.

Quality Improvement Culture

- To seek assurance that all staff are fulfilling their **responsibilities** for delivering high quality, child-centred services under the auspices of the Trust's *Quality Improvement Culture* approach.
- To seek assurance that the right mechanisms, **leadership and culture** are in place to address, monitor and manage the quality of clinical/patient services.
- To monitor the effectiveness of the Trust's framework for raising concerns.

Constitution

The terms of reference are reviewed and revised annually and were last approved by the Committee in July 2017. The Membership comprises:

- Non-Executive Directors x3, including the Chair of the Committee, Chair of the Audit Committee and Integrated Governance Committee
- Medical Director
- Chief Nurse
- Director of Finance
- Chief Operating Officer
- Director of Corporate Affairs
- Director of HR

Expected to attend each meeting: Divisional Directors (x3), Deputy Director of Nursing, Associate Director of Quality, Director of Research and Director of Infection Prevention & Control. To ensure that CQAC remains strategic and assurance led, it is also

supported by the Clinical Quality Steering Group (CQSG) which monitors quality assurance at an operational level and reports in to CQAC.

Achievements in 2017/18

- Following the April 2017 unannounced inspection by the Care Quality Commission which resulted in an overall rating of 'Good' with 'Outstanding' in the Caring domain, the Committee took responsibility for overseeing the implementation of the associated action plan, which was fully completed during the year with the exception of one remaining system issue relating to transition services; this action was carried over to the 2017/18 Action Plan.
- As part of the devolved governance structure, the Committee kept a strong focus on maintaining a programme assurance function on the 'Delivering Outstanding Care' element of the Framework.
- The Committee retained a particular focus upon the implementation of the Trust's sepsis strategy, requesting regular updates from the clinical leads to provide assurances relating to the care of the deteriorating child and the delivery of the 2017-19 CQUINs specifically relating to sepsis.
- The Committee approved and monitored its annual work programme, regularly reviewed the Quality Report and those risks for which the Committee is responsible for oversight. The Trust's Quality Account and limited assurance work undertaken by External Audit and the reports arising from their review were presented to the Committee.
- A new programme of Quality Assurance Ward/Department Rounds was implemented for 2017/18 which commenced fully in September 2017. The purpose of this programme is to:-
    - Facilitate a deep dive at ward/department/specialty level into quality and performance noting areas of good practice and any actions being taken at a local level to address areas of concern.
    - Provide both quantitative and qualitative information to demonstrate that the services are safe, effective, responsive, caring and well-led in line with the CQC's Key Lines of Enquiry (KLOE).
    - For the wards/departments to review standards of care being delivered via the results of the latest Quality Care Assessment Tool (QCAT) where completed, the ward dashboard and other quality metrics used within the speciality.
    - For specialities to provide an overview of the results of any external peer reviews of their service, and/or benchmark against relevant national speciality guidance or standards.
    - Provide an opportunity for ward/departments and speciality staff to talk directly to Executive and Non-Executive Directors.
    - Enable members of the Board to familiarise themselves with clinical environments and the day-to-day activities occurring at Ward/Department/speciality level, hearing first hand from front-line staff.
    - Enable members of the Board to consider any issues facing the ward/ department that are escalated and need their input or support to resolve.
    - To support the golden thread of ward to board reporting through transparency, by testing out and gaining assurance that what is reported to the Board is consistent with what is happening at a local level.

The programme commenced in September 2017 and by the end of March 17 assurance rounds undertaken. Both quantitative and qualitative assurance has been presented by all services, via the presentations and walk arounds, which have shown to the board members a clear link between board and local assurance.

Assurance Statement

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

Committee Priorities for 2018/19

- A key focus for the Committee in the coming year will be maintaining momentum with the new Quality Ward Round process continuing to provide an in depth understanding for Committee members of the issues facing different parts of the organisation;
- The Committee will continue to oversee the implementation of the Quality Strategy and associated aims in the context of the Trust's overall strategic direction and re-stated ambition to achieve an overall Outstanding rating from CQC.
- The governance arrangements that underpin the Change Programme and its specific projects will again be a key focus for the Committee in the coming year.
- The Committee will continue to hold the Divisions to account for quality performance and will seek to drive measurable improvements in key quality indicators linked to the Quality Aims.

Anita Marsland
Committee Chair
18 April 2018

APPENDIX A

CLINCIAL QUALITY ASSURANCE COMMITTEE - RECORD OF ATTENDANCE 2017/18

Quorum: A quorum shall consist of the Chair or nominated deputy, one other NED, two Executive Directors (one of whom must be the Medical Director or Nursing Director or Chief Nurse, or their designated deputy.
In exceptional circumstances, teleconference participation by a member will be permitted and this will count towards a quorum.

Member/Date of Meeting	2017									2018			TOTAL
	19th April	17th May	21st June	19th July	16th Aug	20th Sept	18th Oct	15th Nov	15th Dec	17th Jan	21st Feb	21st Mar	
Mrs Anita Marsland (Non-Executive Director)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)		✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	✓ (Chair)	11/11
Mr Steve Igoe (Non-Executive Director)	X	✓	X	X		X	✓	X	X	✓	X	✓	4/11
Mrs Jeannie France-Hayhurst (Non-Executive Director)	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	11/11
Dame Jo Williams (Non-Executive Director)	✓	X	✓	X		✓	✓	✓	✓	✓	X	✓	8/11
Mr Steve Ryan (Medical Director)	X	✓	X	✓		X	✓	✓	✓	✓	✓	✓	8/11
Mr John Grinnell (Director of Finance)	✓	✓	✓	✓		X	✓	✓	X	✓	X	✓	8/11
Mrs Mags Barnaby (Interim Chief Operating Officer)	X	✓	✓	✓		✓	✓	X	✓				6/7
Mr Adam Bateman (Chief Operating Officer)						✓	✓	✓	X	✓	✓	✓	6/7
Mrs Hilda Gwilliams (Director of Nursing)	X	✓	✓	X		X	✓	✓	✓	X	✓	✓	7/11
Ms Erica Saunders (Director of Corporate Affairs)	X	✓	✓	✓		✓	✓	✓	✓	✓	X	✓	9/11
Mrs M Swindell (Interim Director of HR & OD)	✓	✓	✓	X		X	✓	✓	✓	✓	X	✓	8/11

CANCELLED

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 21st March 2018
10.00 am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Louise Shepherd	Chief Executive
	Hilda Gwilliams	Chief Nurse
	Lachlan Stark	Head of Planning and Performance
	John Grinnell	Director of Finance
	Pauline Brown	Director of Nursing
	Erica Saunders	Director of Corporate Affairs
	Melissa Swindell	Director of HR
	Dame Jo Williams	Non-Executive Director
	Matthew Peak	Director of Research
	Tony Rigby	Deputy Director of Risk & Governance
	Jeannie France-Hayhurst	Non-Executive Director
	Adam Bateman	Acting Chief Operating Officer
	Mark Flannagan	Director of Communications
	Joe Gibson	Programme Director
	Steve Ryan	Interim Medical Director
	Cathy Umbers	Associate Director of Nursing & Governance
	Steve Igoe	Non-Executive Director
	Denise Boyle	Associate Chief Nurse, Surgery
	Anne Hyson	Head of Quality - Medicine
	Cath McLaughlin	Director, Community Services Division
	Will Weston	Associate Chief of Operations
	Sarah Stephenson	Head of Quality

In Attendance

David Porter	Consultant
Glenna Smith	General Manager – Medicine
David Porter	Lead for Sepsis
James Ashworth	Sepsis Team
Val Shannon	Volunteer Manager
Jacqui Rogers	Transition Service Nurse Lead
Dr Lynda Brook	Clinical Lead for Transition
Jill Preece	Governance Manager
Julie Creevy	Executive Assistant (Minutes)

17/18/126 Apologies:

Mark Peers	Public Governor
Julie Williams	Governor
Cathy Wardell	Associate Chief Nurse, Medicine
Adrian Hughes	Director, Medicine Division
Christian Duncan	Director, Surgical Division

17/18/127 Declaration of Interest

None declared

17/18/128 Minutes of the previous meeting held on 21st February 2018

Resolved:

CQAC approved the minutes of the previous meeting held on 21st February 2018.

17/18/129 Maters Arising and Action Log

17/18/31 - Quality metrics – CQAC dashboard – CQAC noted that this is a continuing evolving programme, with phase 1 on track to report on Month 1. CQAC to receive a update at May 2018 meeting. CQAC agreed this item would be closed and removed from the action log.

17/18/89 – Review of Clinical Investigations – HG confirmed that N Barnes had no further update to provide at present, CQAC would receive a updated at May 2018 meeting.

17/18/44 – Clinical support for audits – HG confirmed that there were 2 issues with regards to devolved governance issue, which had now been resolved, and that further meetings were scheduled for 21st March and 23rd March to address a remaining issue. CQAC agreed that this item could now be closed and removed from the action log.

17/18/78 – Complaints - 'Learning from complaints' – HG reported that a meeting was scheduled for 23rd March with A Hyson to review proposed corporate new process, with the aim of reducing the number of PALS. HG confirmed that a ½ day learning session would be held in due course and that a scoping session had been arranged for 28th March to agree format for the learning session. CM emphasised the importance of including community division specifically to provide support regarding ADHD/ASD patients. HG confirmed that a proposal would be shared at the April CQAC meeting.

17/18/80 - Quality metrics - ES confirmed that following discussion with Iain Hennessey, Simon Minford/Tricia Roberts would attend May 2018 CQAC meeting to provide CQAC with an update.

17/18/92 – Sepsis/Meditech – J Grinnell confirmed that the Meditech team had visited the Trust and had spent 3 days on site, the Team had worked very closely with the Sepsis team, potential solutions had been discussed. J Grinnell stated that there continued to be challenging issues, which would need to be reviewed further, however CQAC noted that the visit was a positive step and noted the further challenges.

Action: - next CQAC meeting JG to provide a briefing paper to be presented to CQAC.

17/18/109 – CQC Action plan – Transition Update – this was scheduled as an agenda item and could be removed from the action log.

17/18/109 – CQC action plan update for committee chairs – this item had been shared with committee chairs and could be removed from the action log.

17/18/109 – CQC action plan to be refined with action column – this item is complete and can be removed from the action log.

17/18/116 – Place Report & Advocacy – this item to be removed from the action log.

17/18/130 Sepsis Update

David Porter, James Ashworth & Glenna Smith provided a Sepsis update as follows:-

- Meeting had taken place with Meditech team delegation, to discuss:-
  - Single form – with meditech team unable to identify a solution to enable 1 place to record sepsis data
  - Data linkage
  - 'Sepsis status'
  - Inaccurate saving.
  - Standard documents
  - Algorithm error – programme error, Sepsis team had requested a rapid fix to be addressed as a priority within the next 14 days.
- Informatics – no change
  DP stated that following the meditech meeting that some issues had not been fully solved, however potential progress had been made.
- E-learning – draft package complete, with expected roll out in April 2018, some progress made regarding ESR – further progress required relating to Junior doctor access and target setting. MS confirmed that the ESR Lead commences in post on 2nd April and that progress will be made regarding this issue during April 2018.
- Sepsis team are working with the Informatics team regarding antibiotics pre and post-rollout.
- NICE applied to ED patients - Data from pre – sepsis pathway and all febrile children attending ED, DP reminded CQAC that the clinician involved is required to use own clinical judgement as some specific age range patients are identified as high risk – when the patient is in fact low risk.
- Time to Antibiotics from diagnosing to dosing – ED - mean time 70 mins (median 71.0 mins)
  Inpatients – mean time 41.1 mins (median 26.5 mins).

Action: HG/P Brown to meet with D Porter regarding detail regarding 24/7 business case.

17/18/131 CQC Action plan & update regarding progress to date

ES presented the CQC Action Plan, March update report representing progress made to the end of Feb 2018. The action plan had been apportioned out to relevant monitoring committees to ensure oversight in terms of implementation of actions and supporting evidence. SI commented that this had worked extremely well for Information Governance Committee and confirmed that he was content with this way of reporting going forward.

ES reported that the Trust's quarterly engagement meeting with the CQC was scheduled for 29th March 2018, when progress against the action plan would be discussed. Colleagues were commended for the steady progress made against actions to date in spite of recent pressures i.e. winter, regulatory inspections etc.

CQAC noted that the committee are expected to see further improvements regarding during April 2018.

SI queried the process for confirming complete closure of actions in terms of whether or not CQC would be likely to re-inspect against actions that had been completed, evidenced and closed.

ES confirmed that this process takes place during the CQC engagement meetings. CQAC noted that it would be important to ensure that the process is followed up in writing, ES stated that this would be discussed with CQC on 29th March.

Dame JW talked about being proactive in terms of challenging ourselves and identifying areas of risk to service delivery. ES stated that a planning group had been established early in 2018 to ensure organisational readiness for future inspections. This group was then superseded by the February inspections; ES reported that it would now be timely to revisit this group and embed into the Trusts governance structures.

17/18/132 Programme Assurance/progress update

J Gibson stated that ongoing work continued to further define projects and confirmed that the draft PIDs would be reviewed on 29th March 2018. Discussions regarding capacity for the programme is planned for Executive Team meeting on 22nd March. J Gibson stated that this year the team had further systematically reviewed projects. The Red rated project 'Best in Operative Care' is not projected to achieve the planned benefits in the timescales and the plans are significantly out of date on sharepoint.

The latest forecast is savings of £157K which is behind the target of £587K BY £430k. It is critical that the new projects are scoped (PIDs) and benefits defined by the March 2018 Programme Board.

- The amber rated projects are: 'Best in Community Care'; 'Best in Acute Care' and 'Deteriorating patient' - further work required to tidy up the project documentation.
- The 'Outpatients' project retains a green assurance rating.

The refreshed 18/19 Programme had been aligned with the strategy refresh and the next CQAC meeting will receive reports on the following projects:-

- Sepsis
- Best in Outpatients
- Brilliant Booking & Scheduling
- Comprehensive Mental Health
- Patient Flow
- Models of Care

J Gibson stated that further thought would be required regarding executive sponsors, given that all projects are currently aligned to S Ryan & H Gwilliams.

Action: J Gibson/HG & SR to discuss further.

CQAC welcomed this approach.

J Grinnell stated the importance of planning & execution of the projects to ensure further transparency.

AM thanked J Gibson for his update.

17/18/133 Transition Update

J Rogers, Transition Services Nurse Lead & Dr. Lynda Brook, Clinical Lead for Transition presented the Transition update, key issues as follows:-

- Professionals recognised the importance of good transition
- Removal of barriers as follows
  - Lack of reciprocal services
  - Family & professional fears
  - Lack of resources
  - Poor communication, timing & planning
  - Whole Trust approach
  - Overarching '10 Steps Transition Pathway'
  - Actively address identified service gaps
  - Education & training
  - Develop and share resources
  - Prompt earlier transition planning
  - Facilitate communication between teams and services
  - Holistic, person-centred approach

New items as follows:-

- Implementing the Trust Transition policy which had been ratified in 2017.
- Transition is live on Meditech 6
- Transition training – 1 hour training to enable as much engagement as

possible.

- Transition Exception Register is now live
- Work continues to (Re) engage adult services – SR had written to adult providers to request a named Executive Lead in all Trusts
- Website - with growing resources/videos/standards which is available to all www.10stepstransition.org.uk
- Challenge remains regarding lack of clinician time and adult services engagement.
- The Trust transition policy is in place, but there are years of work ahead
- 3rd Transition Conference is scheduled on 29th June 2017, Institute in the Park, JR stated that all were welcome to attend.

JR requested supporting for funding of £500.00 for the Transition Conference.

C McLaughlin requested that discussion was required at the next CQAC meeting regarding 'Lost patients'.

Action: Discussion for April CQAC meeting regarding 'Lost patients'

Action: HG to review issue regarding clinical time and also to review obtaining funding of £500.00 for Transition conference.

Implications for CQAC

- Requirements for reporting to CQAC
- Transition Exception Register
- Patients accessing the Trust above transition age
- Transition incident reporting via Ulysses

Support from CQAC as follows:-

- Double clinic appointments for transition preparation
- Sustainability of Transition Team specifically Transition Lead Nurse

AM thanked JR & LB for update.

17/18/134 PLACE report & advocacy

VS provided an update on the Patient-Led Assessments of the Care Environment (PLACE) assessment**.** The aim of PLACE assessments is to provide a snapshot of how the Trust is performing against a range of non-clinical activities which impacts on the patient experience of care – Cleanliness; the Condition, Appearance and Maintenance of healthcare premises, the extent to which the environment supports the delivery of care with Privacy and Dignity; and the quality and availability of food and drink.

The PLACE assessment was undertaken over a period of 3 days during May 2017 and involved 12 members of staff, together with independent assessors who comprised of previous patients and forum members, parents of current inpatients, newly appointed volunteers, members of local Healthwatch group and a Trust governor.

The following areas were assessed:-

- 1C Therapies
- Critical care .Retained estates-clinical areas
- 3A Day surgery
- 3B Radiology
- 3C Outpatient department
- 4A Corridors and public areas
- 4B External areas
- 4C Dewi Jones
- AED – EDU

A team of at least 4 assessors attended each area, once the assessment had been completed the recorded findings were entered on and electronic database and submitted to Health and Social Care Information Centre.

Results as follows:-

- Cleanliness - 95.78% - National average (98.38%)
- Food & Hydration – 88.59% - National average (89.68%) – some of the Trust food not labelled
- Privacy, dignity & wellbeing – 87.50% - National average (83.68%)
- Condition, appearance & maintenance – 90.95% - National average (94.02%) – this related to the retained estate.
- Disability 68.58% - National average 82.56% - this related to the retained estate

VS confirmed that following the findings of the PLACE assessment the Trust had produced an action plan containing 149 items and that 121 items had since been completed, with the remaining items on target for completion at the end of March 2018.

VS had been in discussion with Birmingham Children's to request whether representatives from Alder Hey could attend Birmingham's PLACE assessment in order for shared learning.

PLACE assessment is discussed at the Children's Forum and will be discussed further at its next meeting in May 2018.

J Grinnell stated it would be beneficial to highlight the difference in the scoring regarding the retained estate, and that this would be a helpful theme for communications to be involved in for the next assessment.
MF confirmed that he would like the comms team (J Fitzpatrick) to be fully involved for the assessment.

CQAC agreed that it would be beneficial for CQAC to review the report earlier for the next assessment.

AM thanked VS for her update.

17/18/135 Corporate Report – Quality Metrics

HG provided an update on Quality metrics, key issues as follows:-

Patient Safety

Trust had maintained a significant improvement compared to last year which now stands at 21 year to date, compared to 52 for the same period last year. There were 2x Grade 3 pressure ulcers which are associated with medical devices and are the subject of investigation. Options are being explored to cushion the devices in an attempt to reduce the associated pressure ulcers. Clinical incidents resulting in harm was 84 in month, including 1 catastrophic, 1 major harm incident and 2 moderate harm incidents. This also impacted on the spike in SIRI's with 4 being declared in month.

Patient Experience

An increase in complaints over the winter months had been evident, with 12 being recorded in January 2018. An increase in PALS attendances was also seen in month. Attention is focussed on strengthening the management of complaints and early intervention to avoid issues being escalated. Further work is progressing to ensure we are capturing the Family & Friends feedback from patients in Community and in CAMHS. Most in-patient survey feedback is good, although 'patients knowing their planned date of discharge' has deteriorated in month.

HG stated that the %of patients who know their planned discharge date – element of this is now within the GDE pathway.

Inpatient & outpatient feedback remained challenging for Community Division, S Stephenson had meet with V Shannon and had agreed to use text messaging for Family & Friends, with assistance from volunteering team.

Clinical Effectiveness

There were 3 infections recorded in January 2018. This maintains a downward trajectory compared to last year. There were 2 MRSA bacteraemia in month relating to the the same patient on separate occasions. There had been zero C.difficile infections for 14 consecutive months. Sepsis metrics are now being capture within the corporate report, with 'patients receiving antibiotics within 60 minutes' for ED being 60% and the same measures for inpatients being 74% in January 2018. There were 7-in hospital deaths this month compared to 4 in January 2017.

AM thanked HG for her update.

17/18/136Board Assurance Framework

ES presented the Board Assurance Framework, key issues as follows:-

BAF 1.1. Delivery of Outstanding Care – key actions required as follows:-

- Continue work with the divisions HR Business Partners to reduce the sickness rate to the expected Trust standard.

- Ensuring the nursing educational budget is sufficient to meet post graduate nurse education and development requirements.
- Ensuring the opportunity for development of non-registered staff to commence registered nursing training programme is implemented and funded.

BAF 1.2 Delivery of Outstanding Care –progress of actions as follows:-

- Operational teams sighted on ensuring and maintaining flow across the hospital via weekly performance, bed meetings etc.
- Winter Plan revised and widely shared, highlighting 'red weeks' and including seasonal capacity projections.
- All matron roles now filled, new Head of Quality for Surgery appointed.
- ED plan for March had been agreed at Operational Delivery Board.
- Further work required regarding horizon scanning.

BAF 2.4 Strong Foundations – key risk to year end remains regarding concluding commissioner contract over performance agreements and any further impact of the winter on our elective activity programme.

Trust is in discussions with NHSI regarding formal approval of required £8M interim cash support.

Mandatory training had increased to 93%.

ES stated that strategic risks were being calibrated and welcomed any comments.

CQAC noted that the Nursing Workforce section would benefit from further strengthening given that the template is not always populated.

JFH alluded to the negative impact upon patients when patients and parents witness a facilities crate being used in a patient lift, instead of a service lift, which could be an infection prevention control issue. HG confirmed that this should not happen and that this would be followed up.

Action: HG to liaise with Facilities team to address issue.

AM stated that it would be beneficial for the NEDS to attend NED colleagues committees to obtain further insight into different Board sub committees. This was welcomed.

Action: NEDs to attend a Board sub committee meeting.

ES thanked HG for her update.

17/18/137Coeliac Update

A Hyson updated CQAC regarding an incident reported regarding a child who was referred to Dr. Verhoeff, General Paediatric Consultant with suspected epilepsy in her clinic within the community. GP referring included blood results in the referral letter. Bloods had been taken on 6th September

2016 for a TTG investigation. On investigation of this case and in liaison with the CCG it was requested an investigation be commenced to look at the potential of whether there have been any other children who did not have their TTG results acted upon and referred in to the Coeliac service as required. It had since been established that there are a number of patients (13) who have been identified positive for Coeliac disease who have not since been referred in to the speciality service. 6 of these patients have since been seen in the Coeliac service and treated appropriately.

Outcome will be shared in due course.

AM thanked AH for her update.

17/18/138 Clinical Quality Steering Group key issues report:-

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

- Progress had been made in relation to the development of the divisional quality dashboard with the 3 Heads of Quality looking to implement a draft by April 2018.
- A SOP had been devised for reviewing clinical incidents resulting in harm to ensure that all incidents resulting in any level of harm are reviewed to ensure accuracy. The SOP contains a step by step guide on how to review clinical incidents and would be rolled out shortly.
- Transition and Interpreting Services Annual Report: 18 incidents reported relating to Interpret services relating to the lack of details in the request by Appointments Team. However in spite of the chalenges, the families on each occasion attended for their appointments. Improved reporting is required on Ulysses for Interpreter incidents. There was 2100 sessions of face to face interpreting in 2017 costing £86,149. The cost of telephone interpreting equates to £8,336 incorporating 930 sessions.

  Update regarding external visitors policy – PoC confirmed that the SOP had been reviewed and updated as appropriate. AM queried how the SOP and visitors were monitored, PoC confirmed that the comms team oversee VIP/visitors. PoC stated that the monitoring of the policy is reported through RABD with exceptions.

  Discussion took place regarding arts/performance area. MF requested whether a meeting could be arranged to discuss a shared planned approach to ensure that the operational team, charity team and comms team are all aligned. AM stated that CQAC required assurance regarding whether a robust process is in place, and that there is appropriate provision in place. MF confirmed that G Kennedy liaises directly with L Stark, Task and the Operational Team in order to consider the impact on the rest of the Trust.
  CQAC received and noted CQSG key issues report, and thanked CQSG committee members for continued support.

17/18/1396 Date and Time of Next meeting -

10.00 am – Wednesday 18th April 2018, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 1/05/2018

Report of	Development Director
Paper prepared by	Associate Development Director
Subject/Title	Development Directorate Report - Alder Hey in the Park, and Estate Developments
Background papers	Nil
Purpose of Paper	The purpose of this report is to update the Trust Board and Development Project progress.
Action/Decision required	The Board is asked to acknowledge the content of the report; the progress achieved and acknowledge areas where support may be required.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ Sustainability through external partnerships
Resource Impact	Capital projects

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development																															SRO: David Powell Author: Sue Brown
Programme 2017/18	Apr-17				Aug-17				Sep-17				Oct-17					Mar-18				Apr-18				May-18					Jun-18				
Week Commencing	3	10	17	24	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	3	10	17	24	1	8	15	22	29	5	12	19	26	
The Park																																			Park project coordinator post has been vacant for the two months, however new person is expected to start in early May. This has resulted in some slippage on project development, which is hopefully to be resolved by new appointee. The Lancashire Wildlife Trust has now completed this years volunteer work in the park. Following completion of the new foot path with disabled access into the forest area, the first task for the new coordinator will be writing a brief for interactive interpretation boards to be funded by the Veolia trust.
Decommissioning & Demolition (Phase 1 & 2)																								Completed											Programme progressed as plan and has completed on schedule. Additional work has been agreed within the budget to prepare land levels in preparation for the Alder centre, Community Cluster and temporary car park schemes. Next demolition phase not due to commence until 2019/20.
Future Development																																			The development at the North East of the site is still under consideration following the putting on hold of the proposed residential scheme.
The Institute Phase II																																			The Institute phase 2 build was reported to be delayed until August 4th at the site meeting of April 25th. Trust is encouraging a reduction in this delay and arranging access agreements for Trust commissioning from early July so occupancy can still be achieved in September. User group meetings have commenced with Universities although some University partners have yet to sign financial agreements. Negotiation continues to reduce additional costs to meet available budget via value engineering and contract negotiation.
Alder Centre																																			Following the high cost within building tender returns discussions and regular meetings have continued with architects AHMM and QS to reduce building costs to match available funding. Input from Trust Advisors is generating some productive value engineering ideas which are expected to achieve financial results but the exercise has caused several weeks slippage in the start of the scheme.
International Design & Build Consultancy																																			Jersey design work continues for the next 6 months bringing income into the Trust and enhancing our reputation. Meeting has also occurred with BDP with the intention to develop an MOU and partnership agreement with them particularly in relationship to their existing offices and business in Shanghai and the Far East.
Community Cluster Building (Neuro-developmental Hub)																																			Design competition has completed approved via Trust Board. Pid has been written and placed on SharePoint, this was presented at the programme Board in April. A start up meeting has taken place between Cullinan Director and David Powell and a two day design start-up workshop schedule for May 10th & 11 the with all user teams participating. The option to phase in the development of a larger and fit for purpose DEWI Jones Unit at an earlier phase is under discussion currently and a external bid for funding has been made by the Community Services Division.
Site Clearance																																			The plan submitted to the board and approved in December 2017 has been under some review with regards to keeping as many services on site as possible (3 services were planned to move off site). A pressure has developed in view of maintaining an additional service on site to support other Clinical service developments and support divisional operational planning, this presents some challenges against the planned accommodation for 2020. The plan therefore is subject to some review by the senior and executive team, with the approach to Agile working requiring specific focus and resource. Also a review of Medical Record Services has been commissioned to analyse the long term projection /requirement for space and storage.
Sefton Services (Relocations)																																			Plans to relocate some Sefton Services due to notice served on current buildings is progressing on track to deliver in June 2018. Lease agreement for Burlington House is complete and Sefton Carers Building agreement due to complete this month and refurbishment work has commenced. Users fully engaged in the process and CAMHS young people involved in design and choice of furniture /fittings .

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

1st May 2018

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for March 2018
Background Papers:	None
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	none
Link to: **Trust's Strategic Direction Strategic Objectives**	The Best People Doing their Best Work
Resource Impact:	None

1. Staff Engagement

Reward & Recognition

The monthly Star Awards for March are currently being collated by the Reward and Recognition panel. All past and present winners continue to be displayed on the board in the Atrium.

Staff Survey

The National 2017 Staff Survey has now been shared with Divisions and depts. who have all been asked to review their feedback and commence facilitated discussions with staff on the outputs of the survey.

2. Workforce Sustainability and Capability

Education, Learning and Development

Apprenticeships

Our Apprenticeship Delivery Manager is continuing to meet with Divisional and department leads to help promote apprenticeships and communicate the benefits of the programme to their staff. A number of meetings have also taken place with external providers to explore the apprenticeship offer for our existing staff for the following apprenticeships;

- Business Administration
- Information Technology
- Leadership and Management (All levels)
- Medical Administration
- Hospitality

Mandatory Training

Core mandatory training as of end of March is above target at 93.2% and overall mandatory is 90.23%. These figures remain above the Trust target. The team are continuing to monitor the issue with weekly reports being generated for dept. leads to keep on top of compliance.

Workforce Diversity

The BME and Disability Networks continue to actively develop, and we remain sighted on our goals to increase the diversity of our workforce, agreeing a set of tactical actions with the Chair of the Workforce and OD Committee in December to practically move the agenda forward. A key strand of this will be a focus on apprenticeships.

HR Services

A business case in support of strengthening resources within the HR function has been approved, with additional resources to manage ESR, OLM, apprenticeships and training delivery. These posts will be recruited to over the coming weeks and months.

Employee Consultations

Hotel Services

The porter service Organisational Change consultation has been extended to explore any further options with full trade union engagement to bring about a satisfactory conclusion and it is anticipated that consultation closure will now take place during May 2018.

Crisis Care – Community Division

Consultation has concluded on the out of hour's crisis care provision for Single Point of Access (SPA). A counter proposal from staff side has been submitted. This counter proposal has requested an additional WTE to support the rota and is being considered by management, outcome to be confirmed within the next two weeks.

Employee Relations Activity

The Trust's current ER activity stands at 23 cases. There are 9 disciplinary cases; 4 Bullying and Harassment cases; 1 grievance; 3 final absence dismissal cases (1 pending appeal); 1 formal capability cases; 3 MHPS Capability cases and 2 Employment Tribunal (ET) cases.

Employment Tribunal Cases

- An ET Claim relating to unfair dismissal and wrongful dismissal; we are awaiting the outcome of a recent directions hearing.

- An ET Claim relating to disability discrimination and protected disclosure is scheduled to go ahead. Notification has now been confirmed of a hearing at Liverpool Employment Tribunal in November 2018, over a three week period.

Corporate Report

The HR KPIs in the March Corporate Report are:

- Sickness rates have decreased to 5%
- Mandatory training compliance dipped slightly to 93.2%

Actions to address shortfalls are being addressed by members of the HR & L&D team with the management teams, with a specific focus on sickness absence. Ongoing ESR training and support has been provided to managers by the HR Team to ensure accuracy in recording, and the action plans for mandatory training have been implemented.

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board

Tuesday 1st May 2018

Report of:	External Programme Assurance
Paper Prepared by:	Joe Gibson, External Assurance and John Grinnell, Executive Sponsor
Subject/Title:	Programme Assurance Summary Change Programme
Background Papers:	Reports to the Trust Board as attached
Purpose of Paper:	To apprise the Trust Board of the Assurance status of the change programme and the actions that have been requested of Executive Sponsors
Action/Decision Required:	For information
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	The change programme is fundamental to the Trust's strategic direction' and links to all strategic objectives.
Resource Impact:	Nil

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Change Programme

Programme Summary (to be completed by **Executive Sponsor** of the assurance framework)

1. The Programme Board of 26 Apr 18 will mark the end of the transition from the 17/18 to the 18/19 programme and the drive is now directed to expediting the planning phase across all work streams.
2. The Delivery Management Office (DMO) now has 2 additional project managers appointed (re-deployed from other duties) to give a team of 4 which will make a real difference to the tempo and standard of project working.
3. The Programme Board continues to mature in its working and is now a forum with the right strategic focus where executive sponsors have focussed debate on the priorities, the need for pace, and unblock issues through timely decision making.
4. The scope of the change programme for FY 18/19 will be finalised at the 26 Apr 18 Programme Board; initiatives for which programme management will not be value adding will be removed from the scope.

J Grinnell 24 Apr 18

Programme Summary (to be completed by **External Programme Assessment**)

1. This Board report contains assurance reports submitted to the following sub-Cttes: **CQAC on 18 Apr 18, WOD on 24 Apr 18 (papers circulated but meeting cancelled) and R&BD on 25 Apr 18.**
2. The weekly 'Financial Sustainability Board', with delegated authority from the Programme Board, continues to robustly pursue the required contribution to CIP benefits from the change programmes; this remains a key risk but (for the time being) is being effectively managed albeit there is still a shortfall to bridge.
3. The assurance effort will now be directed to a full check and assessment of all project domains against the new scope of the work streams across the programme. The results of this first full assessment will be available for the next Trust Board.

J Gibson 24 Apr 18

CIP Summary (to be completed by **Programme Assurance Framework**)

See CIP status at slide 3 of this pack. In sum, the 17/18 change programme contribution to CIP has seen a significant shortfall of £763k – the transactional measures in 'Strong Foundations' have been the backbone of the effort – meaning efficiencies had to be found from other areas.

Change Programme

PROPOSED PROGRAMME 18/19

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

R&BD | WOD | CQAC | R&BD | R&BD

Programme Assurance Framework, DMO & Delivery Board

Growing Through External Partnerships
John — SG

1. International Health & Non-NHS Patients
2. CHD Liverpool Partnership
3. Aseptics

Imminent Pipeline
- Neonatal Services ↓

Pipeline

The Best People Doing Their Best Work
Melissa/Hilda — SG

1. Portering
2. Apprenticeships

Imminent Pipeline
- Engagement & Communication (Y2) ↓
- Temporary Staffing ↓
- E-Rostering ⟺
- Sickness ↓

Pipeline
- AHP Workforce Reviews ↓
- Agile Working ↓

Deliver Outstanding Care
Hilda / Steve

1. Sepsis
2. Best in Outpatients (Y3)
3. Brilliant Booking & Scheduling
4. Comprehensive Mental Health
5. Patient Flow

Imminent Pipeline
- Models of Care ⟺

Pipeline
- 7 Day Services Incl. OOH) ↓
- Neuro-development Paediatrics Medication Review £ ↓
- Care of Complex Children ⟺

Global Digital Exemplar
John/Steve — PB

1. Speciality Packages
2. Voice Recognition

Park, Community Estate & Facilities
David — SG

1. Decomm. & Demolition
2. R&E 2
3. Alder Centre
4. Park
5. Residential Devel.
6. International Design & Build Consultancy
7. Retained Estate
8. Community Cluster

Strong Foundations
John — SG

1. Inventory Management
2. Collaborative Procurement
3. Energy
4. Coding & Capture
5. Medicines Optim'tion
6. Model Hospital

7. Catering ⟺

RE&I

Game Changing Research & Innovation
David

1. The Academy
2. The Innovation Co
3. Implement New Apps for Alder Hey

4. Expand Commercial Research ⟺

Listening into Action - *A staff-led process for the changes we need*

CIP Status – Month 12 FY17/18

Division	Director	Year to Date			In Year Forecast			Recurrent Savings		
		Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Community	Catherine McLaughlin	699	700	1	699	700	1	699	249	-450
Medicine	Adrian Hughes	3,013	3,053	40	3,013	3,053	40	3,013	3,018	5
Surgery	Christian Duncan	2,890	2,929	38	2,890	2,929	38	2,890	2,652	-238
Subtotal		**6,602**	**6,682**	**80**	**6,602**	**6,682**	**80**	**6,602**	**5,919**	**-682**
Alder Hey in the Park	David Powell	406	324	-82	406	324	-82	406	158	-248
Facilities	Hilda Gwilliams	298	86	-212	298	86	-212	298	528	230
Nursing & Quality	Hilda Gwilliams	97	0	-97	97	0	-97	97	0	-97
Finance & IMT	John Grinnell	244	202	-42	244	202	-42	244	298	54
Human Resources	Melissa Swindell	112	76	-36	112	76	-36	112	92	-20
Other Corporate Services	Erica Saunders	112	116	4	112	116	4	112	112	0
R&D	Michael Beresford	130	130	0	130	130	0	130	130	0
Grand Total		**8,000**	**7,616**	**-384**	**8,000**	**7,616**	**-384**	**8,000**	**7,238**	**-762**

Workstream	Year to Date			In Year Forecast			Recurrent Savings		
	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	587	157	-430	587	157	-430	587	160	-427
Growing Through External Partnerships	159	69	-90	159	69	-90	159	69	-90
The Best People Doing Their Best Work	402	22	-381	402	22	-381	492	276	-216
Game Changing Research and Innovation	230	130	-100	230	130	-100	230	130	-100
Strong Foundations	3,592	3,704	112	3,592	3,704	112	3,592	3,663	71
Subtotal: Strategic Workstreams	**4,970**	**4,082**	**-888**	**4,970**	**4,082**	**-888**	**5,060**	**4,297**	**-763**
Business as Usual	3,030	3,534	504	3,030	3,534	504	2,940	2,941	1
Unidentified	0	0	0	0	0	0	0	0	0
Grand Total	**8,000**	**7,616**	**-384**	**8,000**	**7,616**	**-384**	**8,000**	**7,238**	**-762**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Delivering Outstanding Care

Work Stream Summary (to be completed by Executive Sponsor of the assurance framework)

The latest forecast is savings of £638k which is ahead of the target of £587k by £51k. Despite the improvements the executive sponsors are requested to review the saving potentials arising from these quality improvements as a matter of urgency, converting the opportunities into savings.

It remains critical that the new projects are fully scoped (PIDs) with benefits defined and project documentation complete by the April 2018 Programme Board.

Claire Liddy, Director of Operational Finance – 10 Apr 18

Work Stream Summary (to be completed by External Programme Assessment)

The refreshed 18/19 Programme has been aligned with the strategy refresh and CQAC is able to see that future meetings will receive reports on the following projects:

- **Sepsis**
- **Best in Outpatient Care** (new Phase)
- **Brilliant Booking & Scheduling** (new Project)
- **Comprehensive Mental Health**(new Project)
- **Patient Flow** (new Project)

The new projects are completing their 'Initiation' phase during April and ratings of all domains will commence from 1 Apr 18. Given the partial evidence currently available, and the ongoing reconfiguration of SharePoint to reflect the new scope, the projects have been given a provisional 'amber' rating (although this could turn to red if insufficient evidence is available in 3 weeks time).

Joe Gibson, External Programme Assessment – 10 Apr 18

Programme Assurance Framework
Delivering Outstanding Care (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	CQAC	Report Date	10 Apr 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating:

1.0 Deliver Outstanding Care 18/19						
CQAC	Best in Outpatient Care	The Best in Outpatients Project aims to deliver an outstanding experience of outpatient services for children, families and professionals as well as safely increase the number of patients we see in clinic	Hilda Gwilliams / Adam Bateman		provisional amber rating during project initiation phase - full ratings will commence from 1 May 2018	full project documentation in development
CQAC	Brilliant Booking and Scheduling	To provide a booking system that puts patients and families first and meet the needs of clinicians that use it.	Adam Bateman		provisional amber rating during project initiation phase - full ratings will commence from 1 May 2018	full project documentation in development
CQAC	Comprehensive Mental Health	Deliver improvements in mental health services to better meet the needs of children and young people. Be recognised as leading the way for CAMHS services nationally	Cath McLaughlin		provisional amber rating during project initiation phase - full ratings will commence from 1 May 2018	full project documentation in development
CQAC	Patient Flow	Improve our processes to enable timely implementation of clinical decisions, and support patients through their pathway efficiently: minimising delays and reducing time spent in hospital. This project consists of 3 workstreams; Expanding Day Surgery, Expanding Pre-Op Assessment and SAFER Bundle.	Adam Bateman		provisional amber rating during project initiation phase - full ratings will commence from 1 May 2018	full project documentation in development
CQAC	Sepsis	This project will ensure prompt recognition and management of the deteriorating patient and implementation of the Sepsis Pathway	Hilda Gwilliams			Project implementation meeting notes available to December 2018. PID complete. Benefits defined, tracking/reporting of benefits has commenced. The key target, Time to Antibiotic Presecription from Diagnosis is against a threshold of 90%. Milestone Plan expires at the end of April 2018 and needs extending to show activities and milestones for 2018/19. Comms/ Engagement Plan available, evidence has been provided for certain activities. Risks to be updated on Ulysses. EA/QIA complete. **Last updated 6 March 2018.**

Programme Assurance Framework
Delivering Outstanding Care (Completed by Assurance Team)

Sub-Committee	CQAC	Report Date	10 Apr 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Financial
Reporting: at Month 11

	Year to Date			In Year Forecast		
Workstream	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	479	525	**46**	587	638	**51**
Growing Through External Partnerships	133	58	-75	159	69	-90
The Best People Doing Their Best Work	315	2	-312	402	50	-352
Game Changing Research and Innovation	187	104	-83	230	130	-100
Solid Foundations	95	0	-95	142	0	-142
Subtotal: Strategic Workstreams	**1,208**	**688**	-520	**1,520**	**887**	-633
Business as Usual	4,823	4,504	-319	6,480	5,543	-936
Unidentified	0	0	**0**	0	0	**0**
Grand Total	**6,032**	**5,193**	-839	**8,000**	**6,430**	-1,570

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary

The best people doing their best work

Work Stream Summary (to be completed by Executive Sponsor of the assurance framework)

As requested by the Programme Board, 'e-Rostering' and 'Temporary Staffing' have now moved into the imminent pipeline and should be fully mobilised as a matter of urgency. The proposals for 'Engagement and Communication' and 'Sickness' should be reviewed by the Programme Board for the fit with the 'programme' (the question being whether project management would add value to these initiatives).

'AHP Review' and 'Agile Working' remain in the programme 'pipeline' until sufficient capacity and capability is in place to decide upon as credible launch date for each of the projects.

Further work is required to identify the schemes to deliver the £1m target in 2018/19 before the next committee

Claire Liddy, Director of Operational Finance 17 Apr 18

Work Stream Summary (to be completed by External Programme Assessment)

The overall ratings have improved, albeit only 2 projects are currently being rated as others remain in the pipeline.

These shortfalls in assurance needs to be rectified so that there is a complete grip on the progress of the work stream.

Joe Gibson, External Programme Assurance 17 Apr 18

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	WOD	Report Date	17 April 2018
Workstream Name	The Best People Doing Their Best Work	Executive Sponsor	Hilda Gwilliams/ Melissa Swindell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
3.0 The Best People Doing Their Best Work 18/19													
WOD	Apprenticeships	To operationalise the Apprenticeship Strategy and realise the benefits of apprentiseship qualitifcations following introduction of the Apprenticeship Levy.	Melissa Swindell		🟡	🟢	🟡	🟢	🟡	🟡	🟢	🟢	Reports to Workstream Steering Group, notes or minutes required on project sharePoint site. PID available, financial benefits to be completed. Milestone Plan available and on track. Comms/Engagement activities detailed in PID and Delivery Plan - evidence required where possible. Evidence that risks are up-to-date on Ulysses is required. EA/QIA complete. **Last updated 13 April 2018**
WOD 3.2c	Improving Portering Services Project	The aim of this project is to deliver an effective portering service which meets all KPIs agreed by the Trust relating to all portering tasks and to ensure that the department has the right resource at the right times throughout the working day and week .	Hilda Gwilliams		🟢	🟢	🟢	🔴	🟢	🟡	🟢	🟢	Team meetings and briefing notes available. PID available which contains benefits and metrics. Milestone Plan available, shows significant slippage of the overall end date, updated 21 November 2017. Evidence available of Comms/ Engagement activities. Risks captured on Risk Log and these require review. EA/QIA complete. **Last updated 8 February 2018.**

Programme Assurance Framework
The Best People Doing Their Best Work (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	WOD	**Report Date**	17 April 2018
Workstream Name	The Best People Doing Their Best Work	**Executive Sponsor**	Hilda Gwilliams/Melissa Swindell

Financial
Reporting: at Month 12

Workstream	In Year Forecast			Recurrent Savings		
	Target £000's	Forecast £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	587	157	-430	587	160	-427
Growing Through External Partnerships	159	69	-90	159	69	-90
The Best People Doing Their Best Work	402	22	-381	492	276	-216
Game Changing Research and Innovation	230	130	-100	230	130	-100
Strong Foundations	3,592	3,704	112	3,592	3,663	71
Subtotal: Strategic Workstreams	**4,970**	**4,082**	**-888**	**5,060**	**4,297**	**-763**
Business as Usual	3,030	3,534	504	2,940	2,941	1
Unidentified	0	0	0	0	0	0
Grand Total	**8,000**	**7,616**	**-384**	**8,000**	**7,238**	**-762**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Global Digital Exemplar

Work Stream Summary (to be completed by Executive Sponsor of the assurance framework)

Renewed efforts are being made to maximise the clinical engagement with GDE; a good example was described at CQAC on 18 April 18 concerning the interaction of the GDE-Meditech expertise with the Sepsis project – it was observed that this could be an exemplar of pathway analyses and re-design.

As previously stated, the operational divisions need to take ownership of, and mange through, the opportunities offered by GDE; these efforts need to be governed and facilitated by the GDE Programme Board. SMART metrics of benefits is the aim.

Claire Liddy, Director of Operational Finance – 18 April 2018

Work Stream Summary (to be completed by External Programme Assessment)

As previously stated, the lack of 'evidenced' financial contribution of 'realised' GDE opportunities remains a concern.

At risk of repetition, the GDE Programme Board continues to govern the programme to a high level of professionalism with sound governance. On SharePoint, the evidence to support the assurance process is of good quality.

The 'Voice Recognition' project (see previous report) continues to be 'amber' rated – for reasons external to the high standard of project management – as a result of difficulty realising the planned benefits. This is an operational issue for the Trust to resolve under the auspices of the GDE programme governance.

Joe Gibson, External Programme Assessment – 18 April 2018

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	18 April 2018
Workstream Name	Global Digital Exemplar	Executive Sponsors	John Grinnell / Steve Ryan

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
4.0 Global Digital Exemplar 18/19													
R&BD 4.1	GDE	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	Steve Ryan/ John Grinnell										Overall benefits profile and schedule has now been finalised, 'Strategic Owner' column on SoPB to be updated to reflect current trust executive appointments. Milestone Plan on Dashbaord shows several delivery dates missed, some by significant amounts of time. Further stakeholder evidence has been uploaded and a register is being maintained. Risk protocols vis-à-vis national and Trust sytsems have been harmonised. **Last updated 13 April 2018.**
R&BD 4.1a	Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Steve Ryan/ John Grinnell										Overall benefits profile and schedule is shown on the SoPB tracker. Project Plan tab of 'Project Controls' has been updated for the first part of 2018. Risk protocols vis-à-vis national and Trust systems are now harmonised and finalised. Risks and issues aggregated at GDE programme level. **Last updated 29 March 2018.** QIA/EA will be assured and assessed at project level.
R&BD 4.10	Voice Recognition	Deploy voice recognition solution in Medisec and Meditech	Steve Ryan/ John Grinnell										PID and detailed project workbook on SharePoint. Details of financial benefits on separate document, these have not been realised as planned. Project Plan is being kept up to date and the overall standard of the workbook is excellent. Comms/engagement activities detailed in PID, evidence required where possible. Risks detailed in workbook. EA/QIA has been signed and uploaded. **Last updated 12 April 2018.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Growing Through External Partnerships

Work Stream Summary (to be completed by Executive Sponsor of the assurance framework)

Executive Sponsors should take a close interest in their respective projects and support the project teams to achieve green rated assurance and delivery.

As per the observations in previous reports, the CHD Partnerships and Aseptics continue to work to identify and measure clear benefits of the work in hand using SMART metrics. The International and Non-NHS project is preparing a closure report.

Claire Liddy, Director of Operational Finance – 18 April 2018

Work Stream Summary (to be completed by External Programme Assessment)

As stated in previous updates, the work stream continues to show a shortfall in the financial contribution to the wider CIP programme. The issue is a shortfall of £90k against a target of £159k. Although partnership propositions have particular risks associated, by definition being dependent on external factors, the clear aspiration should be for improved benefits forecasting on 2018/19.

The formation of the Department of International Child Health having been completed, the International & Non-NHS Patients project is now preparing a project closure report.

Joe Gibson, External Programme Assessment – 18 April 2018

Sub-Committee	R&BD	Report Date	18 April 2018
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Growing Through External Partnerships (Completed by Assurance Team)

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
2.0 Growing Through External Partnerships 18/19													
R&BD 2.3	**International Health & Non-NHS Patients**	Establish International service offer including: International Health Partnerships and non-NHS patients	John Grinnell		🟢	🟡	🟡	🔴	🟢	🟡	🟢	🟢	Steering Group meeting notes available to July 2017. PID complete. Milestone Plan last updated 27 March and shows some slippages hence the amber rating; a forward looking plan for 18/19 is being developed (and a closure report prepared on SharePoint). Details/evidence of comms to be provided where possible, significant evidence of engagement now on SharePoint. Risks on Ulysses, SharePoint needs update. EA/QIA complete. **Last updated 27 March 2018.**
R&BD 2.5	**CHD Liverpool Partnership**	The aim of this project is to deliver the potential Level One centre status for adult congenital heart disease across the NW/North Wales and Isle of Man; bringing together a partnership of 4 Liverpool providers.	Steve Ryan		🟢	🟢	🟡	🟡	🟡	🟢			PID on SharePoint, following NHSE decision on 30 Nov 17, project documentation will now be developed to provide a mobilisation plan. Milestone Plan needs to show idicator of positive delivery (milestone achieved) as well as timelines. Benefits need to be further refined with evidence on SharePoint. Risk Regsiter, Action Notes and '5 March 2018 - Action Notes' uploaded. Actions Plans need to be tracked / kept up to date. **Last updated 6 April 2018.**
RABD 2.6	**Aseptics**	Validate and commission aseptic unit. To provide internal service which reduces outsourcing to minimal levels. Take unit to licence to offer income generating opportunities.	John Grinnell		🟢	🟡	🟡	🟡	🟡	🟢	🟢	🟢	List of project team names available (Sep 17) and notes of meetings to 9 Oct 17. Scope is decribed by the DRAFT Business Case Form on SharePoint: 'Proposal for Commissioning, Validation and Licensing of the Pharmacy Aseptic Services Unit'. Targets and benefits are now included on a separate tracker and realisation will commence in Apr 19. Gantt chart in place, with some missed milestones, but is being closely tracked. Some evidence of stakeholder engagement now uploaded. Audit of Aseptic Services has been uploaded to SharePoint. EA/QIA signed off. Evidence of meetings to September 2017. **Last updated 23 March 2018.**

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	18 April 2018
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Programme Assurance Framework

Growing Through External Partnerships (Completed by Assurance Team)

Financial Benefits Profile - at Month 12:

	In Year Forecast			Recurrent Savings		
Workstream	Target £000's	Forecast £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	587	157	-430	587	160	-427
Growing Through External Partnerships	159	69	-90	159	69	-90
The Best People Doing Their Best Work	402	22	-381	492	276	-216
Game Changing Research and Innovation	230	130	-100	230	130	-100
Strong Foundations	3,592	3,704	112	3,592	3,663	71
Subtotal: Strategic Workstreams	**4,970**	**4,082**	**-888**	**5,060**	**4,297**	**-763**
Business as Usual	3,030	3,534	504	2,940	2,941	1
Unidentified	0	0	0	0	0	0
Grand Total	**8,000**	**7,616**	**-384**	**8,000**	**7,238**	**-762**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Park, Community Estate and Facilities

Work Stream Summary (to be completed by Executive Sponsor of the assurance framework)

As stated in several previous assurance reports:

- The 'Neuro-Developmental Hub' project needs to be scoped in terms of rationale and objectives
- The work stream needs to bring the documentation to a standard that will attain green ratings for all projects

Claire Liddy, Director of Operational Finance – 18 April 2018

Work Stream Summary (to be completed by External Programme Assessment)

The work stream ratings have not improved since the February report: the position remains that there are shows 7 projects with evidence on SharePoint and, of those: 1 green rated, 3 amber and 3 red. The Executive Sponsor now needs to engage with all project teams as the wider evidence base on SharePoint – for all these projects – is becoming weaker.

Of the three red rated projects:
- 'Residential Development' shows no substantive progress om the plan.
- 'Park', is red rated due to delays on the plan and lack of revised milestones for missed objectives, last updated Feb 18.
- 'International Design & Build Consultancy' remains red rated due to lack of project documentation and evidence of planning.

Joe Gibson, External Programme Assessment – 18 April 2018

Sub-Committee	**R&BD**	**Report Date**	**18 April 2018**
Workstream Name	Park, Community Estate and Facilities.	**Executive Sponsor**	**David Powell**

Programme Assurance Framework

Park, Community Estate and Facilities (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 18/19													
R&BD 5.1	**Decommission & Demolition**	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell		🟢	🟢	🟡	🟢	🟡	🟢	🟢	🟢	PID available, however details of benefits requires review in line with revised/ updated dates. Milestone plan shows slippage (car park area; however, demolition now achieved). Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses, some require review. **Last updated 11 April 2018.**
R&BD 5.2	**R&E 2**	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell		🟡	🟡	🟡	🔴	🟡	🟡	🟢	🟢	Team action notes available to 13 September. PID available, benefits to be confirmed. Milestone Plan shows some delays (tenancy agreements) now over 4 months from original milestone date and some other 'outstanding' milestones are yet to be updated. Details of comms/engagement activities to be confirmed and evidence provided where possible. Issues Log uploaded, risks to be entered on Ulysses. EA/QIA completed and signed off. **Last updated 12 March 2018.**
R&BD 5.3	**Alder Centre**	To plan, develop and construct the new Alder Centre within the park setting	David Powell		🟢	🟢	🟢	🔴	🟢	🟢	🟢	🟢	Steering Group meeting notes available. Scope/approach defined in PID (revised recently). Benefits defined in PID. Milestone Plan has been revised recently - shows procurement of contrator has now been completed (although some 5 months off track). Evidence of Comms/ Engagement activities. Risks to be confirmed on Ulysses. EA/QIA complete. **Last updated 26 March 2018.**
R&BD 5.4	**Park**	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell		🟢	🟡	🟡	🔴	🟢	🟡	🟢	🟢	Updated PID on SharePoint - confirmation of updates required/approval at Steering Group. Benefits defined in PID, tracking/reporting of delivery required. Milestone plan shows multiple actions that have missed deadlines with extended delays and many with no revised milestones. Risks on Ulysses - need confirmation these are up to date. EA/QIA complete. **Last updated 14 February 2018.**
R&BD 5.5	**Residential Development**	To create a high quality residential scheme that co-ordinates with the themes and activities within the wider park site	David Powell		🟡	🟢	🟢	🔴	🟡	🟢	🟢	🟢	Scope/approach and benefits defined in PID. Plan shows extended delays - now beyond 6 months - with planning permission and public consultation milestones missed; revised milestones are now showing on the plan. Evidence required of comms/engagement activities. Risks on Ulysses and require review (last review May 2017). EA/QIA complete. **Last updated 26 March 2018.**
R&BD 5.6	**International Design & Build Consultancy**	To develop business in advising other health organisations - both nationally and internationally - with organisational new builds	David Powell		🟡	🟡	🟡	🔴	🟡	🔴			Work stream reports need to be augmented with evidence of notes/minutes of project meetings. Draft/outline PID on SharePoint. All project documentation to be fully developed including risk register. **Last updated 5 February 2018.**
R&BD 5.7	**Reprovision of Retained Estates**	To re-provide a high standard of working accommodation for those teams and services currently lodged in interim facilities on the retained estate	David Powell		🟢	🟡	🟡	🟡	🟡	🔴	🟢	🟢	Some statistics available on numbers for whom estate/space is needed. A high level critical path has been uploaded as well as an option for external provision of space. Milestone plan shows numerous delays with an average of some 2 months. All project documentation to be fully developed. Important to have the 'people' aspects detailed on the plans for all departments (personal move plans, consultation, 'day in the life' etc as per hospital move). **Last updated 9 April 2018.**
R&BD 5.8	**Neuro-Developmental Hub (TBC)**	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell										SOA' available. All project documentation awaiting strategic decision on strategy. **Last updated 20 September 2017.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Strong Foundations

Work Stream Summary (to be completed by Executive Sponsor of the assurance framework)

Inventory Management and Procurement Projects have now been configured for the FY18/19 delivery schedule. The project documentation needs to be regularly updated on SharePoint, it has not been so in the past few weeks.

The Energy project aims should now also be considered in terms of its project structure, specifically in terms of planning and reporting against plan together with explicit tracking of target measures.

The documentation for Medicines Optimisation needs to be brought up to date on the SharePoint site.

Claire Liddy, Director of Operational Finance – 18 April 2018

Work Stream Summary (to be completed by External Programme Assessment)

Ratings for the four projects have reverted to amber as a coherent evidence base of the project working is not currently being maintained.

As Executive Sponsors have now initiated planning for FY18/19, the project teams should be in a position to improve the ratings by Mat 2018.

Notwithstanding some governance issues in mobilising 2018/19, the financial delivery for 17/18 was extremely impressive at £3.66m and exceeded the stretch targets.

Joe Gibson, External Programme Assessment – 18 April 2018

Programme Assurance Framework

Strong Foundations (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	18 April 2018
Work stream Name	Strong Foundations	Executive Sponsor	John Grinnell/ David Powell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
7.0 Strong Foundations 18/19													
RABD 7.1	Inventory Management	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell		●	●	●	●	●	●	●	●	Documentation relevant to this specific type of project now on SharePoint. Detailed POD available with precise metrics. Plan updated to November 17, benefits profile also needs to be updated. Evidence of stakeholder engagement uploaded although this appears relatively narrow. EA/QIA now signed off. **Last updated 27 March 2018.**
RABD 7.2	Procurement CIP	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell		●	●	●	●	●	●	●	●	Documentation relevant to this specific type of project now on SharePoint. Plan last updated 15 Feb 18. Evidence of stakeholder engagement now uploaded but not extensive. EA/QIA signed off. **Last updated 28 March 2018.**
RABD 7.3	Medicine Optimisation	To deliver the trust MO strategy and deliver quality improvements and financial benefits	Steve Ryan		●	●	●	●	●	●	●	●	Submitted Project Initiation Slide packs to Financial Sustainability Board. POD now uploaded and plan; dealines for actions and benefits to be completed. EA/QIA needs final signatures. **Last updated 14 March 2018.**
RABD 7.6	Energy	To bring down energy cost and ensure budget forecast matches contractual target. Forecast budget for next 12 months for all fuels in line with contractual usage.Once the contractual target of 46.7 G has been achieved look at ways of reducing further by means of energy awareness for staff.	David Powell		●	●	●	●	●	●	●	●	Project documentation now available available on SharePoint. Precision required on benefits sought and delivered. More detail required in the project plan. Evidence provided concerning risks. EA/QIA to be signed off and scanned copy uploaded. **Last updated 7 March 2018.**

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	18 April 2018
Work stream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Programme Assurance Framework

Growing Through External Partnerships (Completed by Assurance Team)

Financial Benefits Profile - at Month 12:

	In Year Forecast			Recurrent Savings		
Workstream	Target £000's	Forecast £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	587	157	-430	587	160	-427
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Strong Foundations	3,592	3,704	112	3,592	3,663	71
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Business as Usual	3,030	3,534	504	2,940	2,941	1
Unidentified	0	0	0	0	0	0
Grand Total	8,000	7,616	-384	8,000	7,238	-762

Corporate Report

Mar 2018

Table of Contents

Executive Summary

Mar 2018

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18
N	N	N	N	N	N	N	N	N	N	N	N

Highlights

Despite the continued high levels of ED attendance with more complex and sicker children attending we have achieved robust ED performance at 97%. We have also achieved diagnostic, incomplete pathway and cancer standards despite NHSE directives to cancel all elective activity. Cancelled ops on the day and have 28 day breaches have increased slightly however we have continued to see robust operational performance despite the winter challenges. Winter plan remains in place to support Flow and maintain hospital activity.

Challenges

Significant challenges remain around the maintenance of flow and ED attendance. Despite the increased demand we have achieved our 4hr standard however this has impacted upon our ability to maintain our elective programme. Significant challenges remain with maintaining primary care streaming with 50% of shifts unfilled by UC24 for March. Team continue to backfill with non-GP medical staff and APNP but gaps remain. A consequence of reducing EL IP activity is our 18 week backlog has increased which will require focus to reduce down post winter plan. EL & cardiac activity below plan due to capacity challenges.

Patient Centred Services

Anticipated deterioration noted in performance metrics for March reflective of continued challenging operational conditions. Continuing high levels of ED attendance have challenged A&E however this metric has been achieved with achievement of STF target linked to M12. All other NHSI core standards have been achieved for March. Winter plan still operational which does have an adverse affect on metrics as IP activity is kep low to maintain hospital occupancy <93%. We have attempted to maximise El activity however have had to manage increasing ED attendance resulting in increased cancelled ops and 28 day breaches. OP utilisation is low and requires further divisional review however we have had half term impact. Theatre utilisation has increased slightly

Excellence in Quality

The number of infections and number of medication errors showed a significant improvement on last year. There were no MRSA infections in March, however there was one C. difficile infection, the first for 15 months. The sepsis position improved in A&E, however this dropped slightly to 79% for in-patients. There were 6 hospital death in March, giving 65 for the year compared to 76 in 2016-17.
Formal complaints reduced to 5 in month resulting in 90 for the year compared to 70 last year, and PALS attendances reduced to 129. A&E and OPD remain behind the FFT target, whilst inpatients, community and mental health perform well, although the number of responses in MH remains low. Inpatient satisfaction shows improvement in 3 out of 5 questions, with 'knowing the planned date of discharge' being the poorest performing measure.
March maintained zero grade 3/4 pressure ulcers and zero never events. There were 94 incidents of harm reported in month, 2 of which were of moderate harm.

Financial, Growth & Mandatory Framework

The Trust is reporting a trading surplus for the year of £1.2m which is £1.1m ahead of the original plan. There were three one off exceptional items totalling £8.2m which contributed towards the control total and enabled the Trust to achieve an additional £9.3m of matched STF 1:1 funding. The Trust also received an additional £3.3m of bonus STF. Therefore the total control total surplus is £22m.

Income is ahead of plan by £2.1m. Shortfalls in elective income (£0.7m) and outpatients (£0.5m) are offset by over performance in non elective activity (£0.8m). Elective activity is behind plan by 17%, non elective is ahead by 24% and outpatient activity is behind by 14%.

Pay budgets are 0.9m overspent for the month relating to use of temporary staffing and the impact of unachieved savings targets. The Trust underachieved the CIP target for the year by £0.4m. Cash in the Bank is £12.2m. Monitor Use of Resources rating of 1 which is better than plan.

Great Talented Teams

The PDR window for 18/19 is now open (April to July) - from end of July it is expected that compliance is at least 90% . Sickness has seen further improvement and is now 5%, which is still higher than the Trust threshold of 4.5% but a drop of 0.6% from February. A task and finish group is currently being set up to address issues affecting sickness and health and wellbeing. An area of focus will be on areas of high absence and putting strategies in place to address this. Mandatory training for March is 93.2% which has dipped slightly since February but is higher than the Trust Target of 90%

Leading Metrics

Mar 2018

Alder Hey Children's NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Feb 2018	Mar 2018	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	92.6 %	97.2 %	▲	
RTT: 90% Admitted within 18 weeks		88.3 %	88.5 %	▲	
RTT: 95% Non-Admitted within 18 weeks		91.3 %	91.0 %	▼	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.1 %	92.1 %	▲	
Diagnostics: Numbers waiting over 6 weeks		3	1	▼	
Average LoS - Elective (Days)		3.0	3.2	▲	
Average LoS - Non-Elective (Days)		2.0	2.1	▲	
Daycase Rate		74.2 %	71.3 %	▼	
Theatre Utilisation - % of Session Utilised	90.0 %	85.6 %	86.2 %	▲	
28 Day Breaches	0.0	2	6	▲	
Clinic Session Utilisation	90.0 %	84.2 %	83.9 %	▼	
DNA Rate	12.0 %	10.4 %	11.4 %	▲	
Cancelled Operations - Non Clinical - On Same Day		20	24	▲	

Excellence in Quality

Metric Name	Goal	Feb 2018	Mar 2018	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	90.0 %	94.7 %	93.1 %	▼	
IP Survey: % Treated with respect	100.0 %	99.4 %	99.8 %	▲	
IP Survey: % Know their planned date of discharge	80.0 %	59.0 %	60.1 %	▲	
IP Survey: % Know who is in charge of their care	95.0 %	90.9 %	91.6 %	▲	
IP Survey: % Patients involved in play and learning	80.0 %	79.6 %	75.0 %	▼	
Pressure Ulcers (Grade 3 and above)		0	0	–	
Total Infections (YTD)	79.0	80	84	▼	
Medication errors resulting in harm	6.0	5	6	▲	
Clinical Incidents resulting in minor harm & above		80	93	▲	

Great and Talented Teams

Metric Name	Goal	Feb 2018	Mar 2018	Trend	Last 12 Months
Corporate Induction	90.0 %	94.0 %	96.7 %	▲	
PDR	90.0 %	82.6 %	82.6 %	–	
Medical Appraisal		52.1 %	67.6 %	▲	
Sickness	4.5 %	5.6 %	4.9 %	▼	
Mandatory Training	90.0 %	94.6 %	93.2 %	▼	
Staff Survey (Recommend Place to Work)		64.0 %	64.0 %	–	
Actual vs Planned Establishment (%)		94.9 %	93.9 %	▼	
Temporary Spend ('000s)		926	1067	▲	

Financial, Growth and Mandatory Framework

Metric Name	Feb 2018	Mar 2018	Last 12 Months
CIP In Month Variance ('000s)	-410	864	
Monitor Risk Ratings (YTD)	3	1	
Trading Surplus/(Deficit)	519	23077	
Capital Expenditure YTD % Variance	-91.7 %	24.1 %	
Cash in Bank (£M)	10.2	12.2	

Exceptions

Mar 2018

Alder Hey Children's NHS
NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Last 12 Months
Medical Appraisal	87.0%	77.7%	77.7%	33.3%	79.2%	81.0%	8.0%	8.0%	11.6%	13.6%	24.0%	52.1%	67.6%	
Sickness	4.7%	4.5%	4.6%	4.6%	5.1%	5.0%	4.9%	5.5%	5.3%	5.8%	6.4%	5.6%	4.9%	
CIP In Month Variance ('000s)	-183	-52	69	161	-72	37	5	-459	-433	-149	54	-410	864	
Monitor Risk Ratings (YTD)	2	3	3	3	3	3	3	3	3	3	3	3	1	
Trading Surplus/(Deficit)	5,972	-1,905	-448	-127	-270	-1,691	-456	317	1,296	88	1,726	519	23,077	

Early Warning (negative trend but not failing - Top 5 based on % change)

Metric Name	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Last 12 Months
RTT: 92% Waiting within 18 weeks (open Pathways)	92.1%	92.1%	92.1%	92.1%	92.0%	92.0%	92.1%	92.2%	92.0%	92.0%	92.2%	92.1%	92.1%	
Average LoS - Non-Elective (Days)	1.9	2.0	2.2	2.0	2.1	2.2	2.1	2.0	2.0	2.0	2.1	2.0	2.1	
Theatre Utilisation - % of Session Utilised	86.8%	87.2%	87.3%	88.3%	86.1%	87.5%	86.5%	86.4%	84.4%	85.8%	87.2%	85.6%	86.2%	
IP Survey: % Treated with respect	100.0%	98.5%	100.0%	98.8%	99.4%	99.3%	99.5%	99.3%	99.8%	99.4%	100.0%	99.4%	99.8%	
Cash in Bank (£M)	6.5	6.2	5.2	3.7	11.3	10.4	9.1	10.9	6.8	8.2	6.7	10.2	12.2	

Challenge (Top 5 based on % change)

Metric Name	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Last 12 Months
28 Day Breaches	2	4	2	5	1	9	0	8	5	5	0	2	6	
Clinic Session Utilisation	87.9%	86.7%	85.9%	85.0%	85.7%	84.8%	83.9%	85.5%	86.8%	83.0%	85.9%	84.2%	83.9%	
PDR	59.2%	2.1%	12.4%	48.3%	78.7%	84.7%	86.2%	87.3%	86.9%	87.3%	87.3%	82.6%	82.6%	
IP Survey: % Know their planned date of discharge	75.7%	79.4%	69.1%	65.5%	64.0%	53.9%	65.0%	57.4%	61.9%	62.5%	52.1%	59.0%	60.1%	
Total Infections (YTD)	104	6	9	13	15	20	26	36	49	58	68	80	84	

Patient Safety

Mar 2018

Alder Hey Children's NHS
NHS Foundation Trust

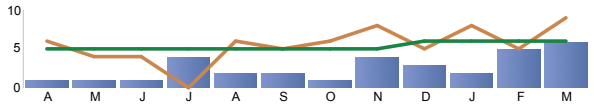
Summary

March maintained zero grade 3 and above pressure ulcers along with zero never events. There were 3 readmissions to PICU in month. There were 94 incidents with associated harm reported in month, 2 of which were of moderate harm. There were 6 medication errors resulting in harm, giving 32 for the year, compared to 60 last year. This has maintained and overachieved the sign up to safety three year target to reduce harm from medication errors by 50%.

17/18 16/17 Threshold

Medication Errors

Medication errors resulting in harm — 6 (goal: 6.0)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	1	1	4	2	2	1	4	3	2	5	6
16/17	6	4	4	0	6	5	6	8	5	8	5	9

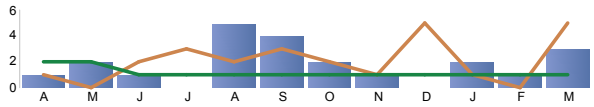
Pressure Ulcers

Pressure Ulcers (Grade 3 and above) — 0 (Est. Baseline)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0	1	0	2	0	0	0	0	1	2	0	0
16/17	1	0	1	0	0	1	0	0	1	0	0	1

Readmissions to PICU within 48 hrs

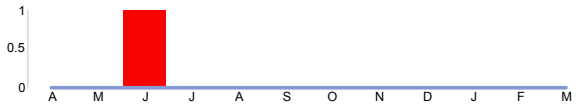
Readmissions to PICU within 48 hrs — 22 (goal: 14.0)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	2	1	0	5	4	2	1	0	2	1	3
16/17	1	0	2	3	2	3	2	1	5	1	0	5

Never Events

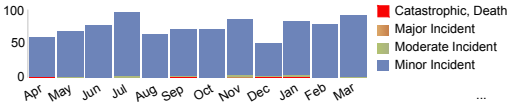
Never Events — 0 (goal: 0.0)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0	0	1	0	0	0	0	0	0	0	0	0
16/17	1	0	0	0	0	0	0	1	0	0	0	0

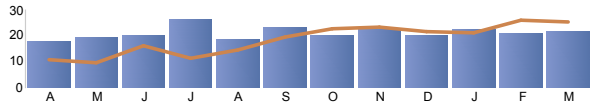
Incidents

Clinical Incidents resulting in minor harm & above — 93



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	60	70	78	97	65	73	72	88	52	85	80	93
16/17	47	41	62	37	46	60	68	79	61	61	69	103

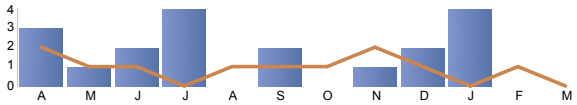
% of Total Clinical Incidents that resulted in Minor Harm & above — 22.0 %



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	18	19	20	21	21	21	21	21	21	22	21	22
16/17	11	10	12	12	12	13	14	16	16	17	17	18

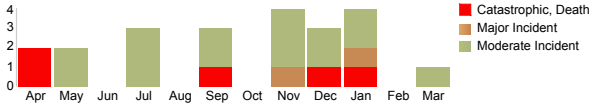
Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) — 0



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3	1	2	4	0	2	0	1	2	4	0	0
16/17	2	1	1	0	1	1	1	2	1	0	1	0

Clinical Incidents resulting in moderate harm, major/severe harm or death — 22



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	2	0	3	0	3	0	4	3	4	0	1
16/17	2	0	1	0	0	2	0	1	1	2	2	1

Patient Experience

Mar 2018

Alder Hey Children's NHS Foundation Trust

Summary

There were 5 complaints in March, a marked reduction on the previous month. This gives 90 complaints for the year compared to 70 last year. There was a slight reduction in PALS attendances to 129 in March. A&E and Outpatients remain slightly behind the Family & Friends Test target, whilst inpatients, community and mental health are ahead of target, although the number of responses in mental health remains low. Inpatient satisfaction shows improvement in 3 out of 5 questions, although 'knowing the planned date of discharge' remains the poorest performing measure.

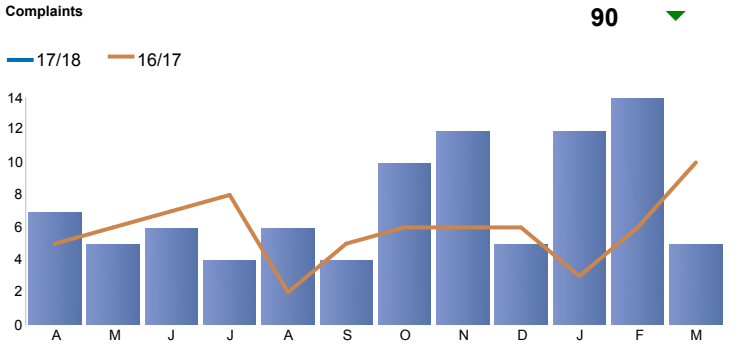
Inpatient Survey

Metric Name	Goal	Feb 2018	Mar 2018	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	90.9 %	91.6 %	▲	
% Patients involved in play and learning	80.0 %	79.6 %	75.0 %	▼	
% Know their planned date of discharge	80.0 %	59.0 %	60.1 %	▲	
% Received information enabling choices about their care	90.0 %	94.7 %	93.1 %	▼	
% Treated with respect	100.0 %	99.4 %	99.8 %	▲	

Friends and Family

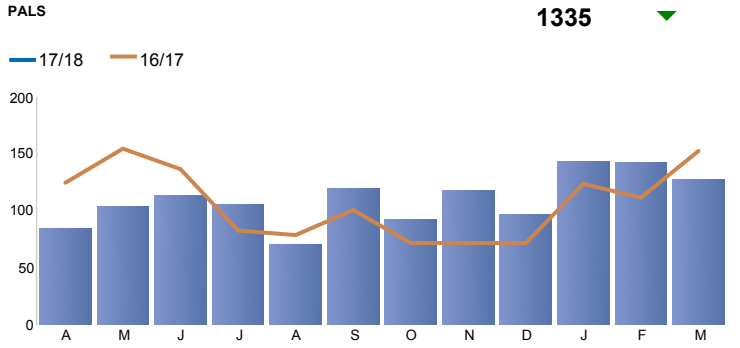
Metric Name	Goal	Number of Responses	Feb 2018	Mar 2018	Trend	Last 12 Months
A&E - % Recommend the Trust	87%	273	85.6 %	86.4 %	▲	
Community - % Recommend the Trust	96%	88	100.0 %	97.7 %	▼	
Inpatients - % Recommend the Trust	96%	633	96.6 %	96.8 %	▲	
Mental Health - % Recommend the Trust	88%	7	82.8 %	100.0 %	▲	
Outpatients - % Recommend the Trust	94%	861	91.8 %	89.3 %	▼	

Complaints



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	5	6	4	6	4	10	12	5	12	14	5
16/17	5	6	7	8	2	5	6	6	6	3	6	10

PALS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86	105	115	107	72	121	94	119	98	145	144	129
16/17	125	155	137	83	79	101	72	72	72	124	112	153

Clinical Effectiveness

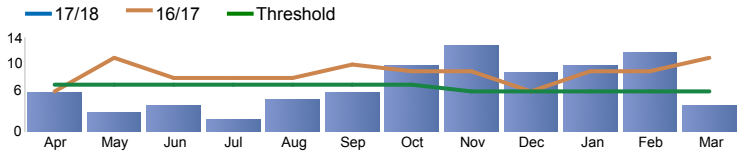
Mar 2018

Alder Hey Children's NHS Foundation Trust

Summary

There were 4 infections recorded in March, which is 84 for the year, a significant reduction compared to 104 infections last year. There were zero MRSA bacteraemia, which remains at 4 year to date, and after 15 months without a C. difficile infection, there was one infection in March, which is the subject of an investigation. The percentage of ED patients receiving antibiotics within 1 hour increased to 61%, whilst for in-patients this dropped to 79%. There were 6 hospital death in March, giving 65 for the year compared to 76 in 2016-17.

Infections



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6	9	13	15	20	26	36	49	58	68	80	84
16/17	6	17	25	33	41	51	60	69	75	84	93	104

Total Infections (YTD)

84 ▼ *(goal: 79.0)*

Hospital Acquired Organisms - MRSA (BSI) (YTD)

4 – *(goal: 0.0)*

Hospital Acquired Organisms - C.difficile (YTD)

1 ▲ *(goal: 0.0)*

Outbreak Infections (YTD)

34 –

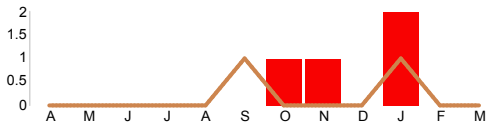
Cluster Infections (YTD)

0 –

Legend

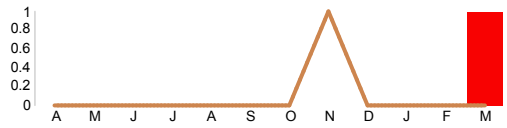
17/18
16/17
Threshold

Hospital Acquired Organisms - MRSA (BSI) 0 *(goal: 0.0)* –



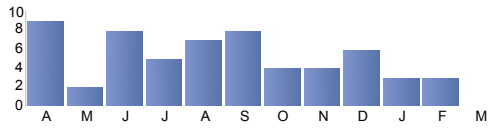
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0	0	0	0	0	0	1	1	0	2	0	0
16/17	0	0	0	0	0	1	0	0	0	1	0	0

Hospital Acquired Organisms - C.difficile 1 *(goal: 0.0)* ▲



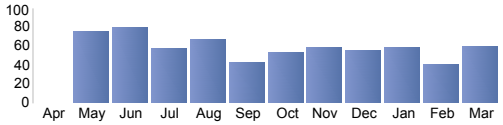
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0	0	0	0	0	0	0	0	0	0	0	1
16/17	0	0	0	0	0	0	0	1	0	0	0	0

Acute readmissions of patients with long term conditions within 28 days 59 *(Est. Baseline)*



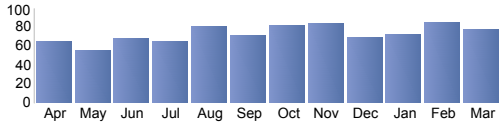
YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	9	11	19	24	31	39	43	47	53	56	59	59

Sepsis: % Patients receiving antibiotic within 60 mins for ED



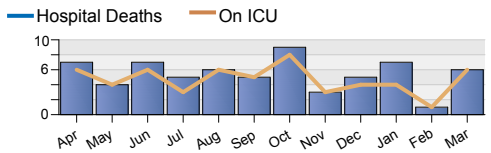
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18		76.5%	80.8%	59.1%	68.8%	44.4%	54.5%	60.0%	57.1%	60.0%	42.3%	60.9%

Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	66.7%	57.1%	69.6%	66.7%	82.6%	72.4%	83.7%	85.4%	70.3%	74.1%	86.4%	79.2%

Mortality in Hospital



Deaths in Hospital

Actual	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	4	7	5	6	5	9	3	5	7	1	6
16/17	7	8	6	6	8	2	7	6	8	4	5	9

Access

Mar 2018

Alder Hey Children's NHS Foundation Trust

Summary

Incomplete, diagnostic, cancer and 4 hr access standard achieved for March. Winter plan remains active within which DC & IP TCI's are being managed to maintain occupancy levels sufficient to support ED outflow. ED attendance continues to remain high with increased acuity resulting in a higher than planned level of NEL admissions. This knocks into the EL programme despite planning assumptions and cancellations. Hospital has remained operationally busy which reflects high levels of occupancy. Choose & Book capacity available to meet referral demand.

18 Weeks

RTT: 90% Admitted within 18 weeks 88.5 %

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
88.0%	89.5%	88.3%	89.9%	88.8%

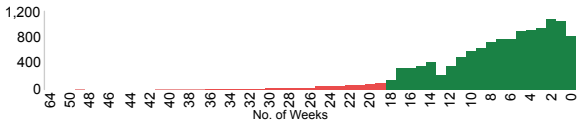
RTT: 95% Non-Admitted within 18 weeks 91.0 %

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
88.9%	89.1%	89.2%	90.1%	90.6%

RTT: 92% Waiting within 18 weeks (open Pathways) 92.1 % *(goal: 92.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
92.2%	92.1%	92.1%	92.1%	92.1%

Open Pathways Weekly Profile Mar 2018



0-18 Wks	19-36 Wks	36-51 Wks	52+ Wks
12,033	759	112	1

Cancer

Cancer: 2 week wait from referral to date 1st seen - all urgent referrals 100.0 % *(goal: 100.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	100.0%	100.0%	97.4%	100.0%

All Cancers: 31 day wait referral to treament 100.0 % *(goal: 100.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	96.4%	100.0%	96.3%	100.0%

All Cancers: 31 day wait until subsequent treatments 100.0 % *(goal: 100.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	100.0%	100.0%	100.0%	100.0%

Diagnostics

Diagnostics: % Completed Within 6 Weeks 99.8 % *(goal: 99.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
99.8%	100.0%	100.0%	99.9%	99.7%

Waiting Times Failed 1

Waiting Times Passed 6

Number of Diagnostics

412

Admissions and Discharges

Bed Occupancy

Bed Occupancy (Funded Beds) 85.8 %

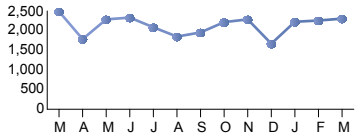
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
83.9%	79.8%	78.9%	81.4%	85.2%

Provider

Convenience and Choice: Slot Availability 97.2 % *(goal: 96.0 %)*

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
97.0%	98.0%	98.4%	98.8%	97.9%

Referrals Received (GP)



Emergency Department

Mar 2018

Alder Hey Children's NHS Foundation Trust

Summary

We achieved 97.2% which was significantly above the 95% target. Thee numbers of attendees in March continued to reflect the high numbers we have seen in 2017/18. NEL admissions also remained high.

Additional resources were put in to support flow and staffing numbers to help manage demand and delivery of the target in March.

ED

ED: 95% Treated within 4 Hours

97.2 % (goal: 95.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
96.7%	96.0%	95.3%	93.8%	94.6%

ED: Total Time in ED (95th Percentile)

237.0 mins (goal: 240.0 mins)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
714.0	717.0	753.0	824.4	810.2

ED: Longest Wait Time (Hrs)

10.7 (goal: 0.0)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
30.6	61.3	28.5	33.6	35.1

ED: Number Treated Over 4 Hours

153

ED to Inpatient Conversion Rate

16.9 %

Mar 2018

ED

ED: 60 minute 'Time to Treat Decision' (Median)

92.0 mins (goal: 60.0 mins)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
227.0	247.5	206.0	266.5	291.0

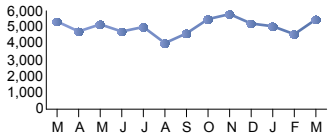
ED: Percentage Left without being seen

3.3 % (goal: 5.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
2.3%	3.0%	2.8%	4.1%	3.6%

ED: Number of Attendances

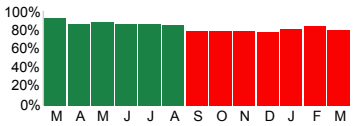
5477 Mar 2018



Ambulance Services

Ambulance: Acute Compliance

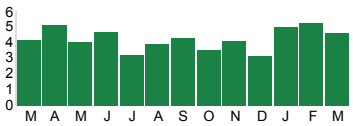
81.0 % (goal: 85.0 %)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
90.1%	88.4%	84.2%	79.3%	81.4%

Ambulance: Average Notification to Handover Time (mins)

4.6 mins (goal: 15.0 mins)



Ambulance: Patients Waiting between 30 and 45 minutes

3

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
11.0	9.0	4.0	10.2	6.0

Ambulance: Patients Waiting between 45 and 60 minutes

0

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
2.0	2.0	1.0	1.0	0.0

Productivity & Efficiency

Mar 2018

Alder Hey Children's NHS Foundation Trust

Summary

March continues with the winter plan in place and ongoing ED attendance & NEL challenges to manage. Increased NEL attendance has driven up EL cancellations. Winter plan has maintained flow to limit on the day cancellations and 28 day breaches. ED attendance remains high with increased acuity. Theatre utilisation increased through careful management of teams. OP utilisation has decreased slightly with increases noted with DNA's reflective of Easter and school holidays.

Length of Stay

Average LoS - Elective (Days) 3.2 ▲

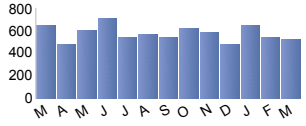
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
2.9	3.1	3.0	3.0	3.1

Average LoS - Non-Elective (Days) 2.1 ▲

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
2.0	2.1	2.1	2.0	2.1

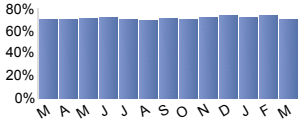
Day Case Rate

Daycases (K1/SDCPREOP) 535 ▼



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
1,820	1,819	1,674	1,724	1,737

Daycase Rate 71.3 % ▼



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
71.2%	71.9%	70.9%	72.5%	72.7%

Bed Refusals

Bed Refusals 0 (goal: 0.0) –

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
1	0	0	0	1

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 86.2 % (goal: 90.0 %) ▲

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
86.8%	87.6%	86.7%	85.5%	86.4%

Cancelled Operations - Non Clinical - On Same Day (%) (YTD) 1.2 % (goal: 0.8 %) ▲

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
1.1%	1.2%	1.4%	1.1%	0.9%

Cancelled Operations - Non Clinical - On Same Day 24 ▲

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
77	83	94	81	63

28 Day Breaches 6 (goal: 0.0) ▲

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
9	11	10	18	8

Outpatients

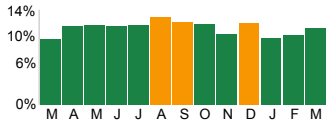
Clinic Session Utilisation * 83.9 % (goal: 90.0 %) ▼

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
85.8%	85.8%	84.8%	85.3%	84.7%

OP Appointments Cancelled by Hospital % 15.1 % (goal: 5.0 %) ▼

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
14.7%	13.4%	13.1%	13.6%	14.7%

DNA Rate 11.4 % (goal: 12.0 %) ▲



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
11.0%	11.8%	12.4%	11.5%	10.6%

OP: New/Follow Up 2.7 ▼

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
2.7	2.6	2.6	2.8	2.7

Facilities

Mar 2018

Alder Hey Children's NHS Foundation Trust

Summary

During March we have increased the number of cleaning audits completed. This has highlighted areas that attention needs to be focused on to ensure that cleaning standards, across the Trust, increase.

Facilities

Cleanliness Performance VH — 97.3 % (goal: 98.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
97.7%	99.7%	96.9%	98.2%	98.3%

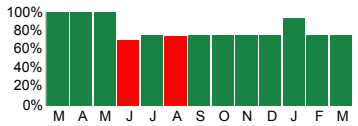
Cleanliness Performance H — 96.8 % (goal: 95.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
94.0%	94.6%	96.0%	96.3%	97.1%

Cleanliness Performance S — 99.2 % (goal: 85.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
96.5%	90.3%	84.6%	91.8%	95.3%

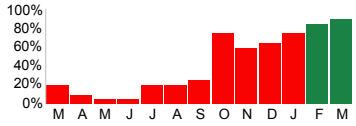
Cleanliness Performance L — 75.0 % (goal: 75.0 %)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	90.0%	75.1%	75.0%	81.3%

Facilities

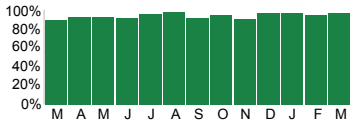
Audit Compliance — 90.0 % (goal: 85.0 %)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
40.0%	6.7%	21.7%	66.7%	83.3%

Facilities - Other

Routine Maintenance Resolution — 97.1 % (goal: 85.0 %)



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
96.6%	92.6%	95.7%	94.2%	96.5%

PPM% — 90.5 % (goal: 85.0 %)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
96.1%	94.8%	97.9%	97.5%	93.4%

CAMHS

Mar 2018

Alder Hey Children's NHS Foundation Trust

Summary

(RTT) has risen from 13 to 14 weeks and our RTT % has decreased by 2% to 72%. Sefton is at 62% improvement of 2%.This is due to; increase in the amount of urgent partnership requests we have received throughout March which has impacted our capacity to see routine patients. Preparation for the SPA organisational change which will mean Liverpool CAMHS will be completing the choice (assessment) appointments. 5 WTE vacancies to be advertised. Once in post these positions will have a positive impact on our waiting list. We will receive further posts to support the increase workload (choice).

Waiting Times

CAMHS: Avg Wait to Partnership Appt (Weeks)- Liverpool Specialist 13.0

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0.0	43.0	51.0	47.0	44.0

CAMHS: Avg Wait to Partnership Appt (Weeks)- Sefton Specialist 25.0

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0.0	43.0	51.0	47.0	44.0

Eating Disorder Pathway

Routine EDYS Pathway Average Wait in Weeks 4

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0.0	6.0	5.0	6.1	10.2

Urgent EDYS Pathway Average Wait in Weeks 0

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0.0	1.0	0.1	2.2	1.9

DNA Rates

CAMHS: DNA Rate - New 14.8 % ▲ *(goal: 10.0 %)*

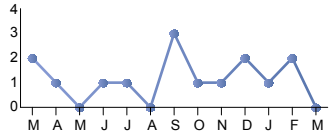
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
13.4%	13.8%	18.8%	12.7%	12.5%

CAMHS: DNA Rate - Follow Up 18.2 % ▲ *(goal: 14.0 %)*

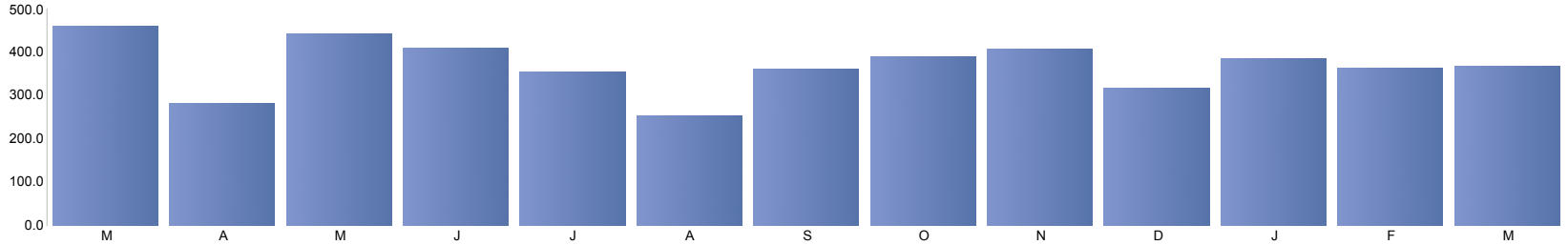
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
17.7%	17.7%	21.0%	17.0%	15.4%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 0 ▼



CAMHS: Referrals Received



External Regulation

Mar 2018

Alder Hey Children's NHS Foundation Trust

Summary

The Trust is currently rated as Good by CQC and remains registered without conditions. We are compliant with our Provider Licence and at the end of March continue to be placed in segment 2 under the NHS Improvement Single Oversight Framework

NHSI - Governance Concern

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
N	N	N	N	N	N	N	N	N	N	N	N

NHSI - Risk Rating

Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18
3	3	3	3	3	3	3	3	3	3	3	1

NHSI Mar 2018

Metric Name	Goal	Feb 18	Mar 18	Trend
ED: 95% Treated within 4 Hours	95.0 %	92.6 %	97.2 %	▲
RTT: 90% Admitted within 18 weeks		88.3 %	88.5 %	▲
RTT: 95% Non-Admitted within 18 weeks		91.3 %	91.0 %	▼
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.1 %	92.1 %	▲
Monitor Risk Ratings (YTD)	3.0	3	1	▼
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait until subsequent treatments	100.0 %	100.0 %	100.0 %	–
Hospital Acquired Organisms - C.difficile	0.0	0	1	▲

NHSI - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
88.0%	89.5%	88.3%	89.9%	88.8%

RTT: 95% Non-Admitted within 18 weeks

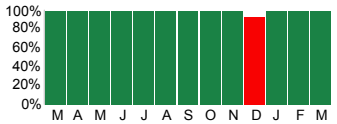
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
88.9%	89.1%	89.2%	90.1%	90.6%

RTT: 92% Waiting within 18 weeks (open Pathways)

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
92.2%	92.1%	92.1%	92.1%	92.1%

NHSI - All Cancers

Cancer: 2 week wait from referral to date 1st seen - all urgent referrals



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	100.0%	100.0%	97.4%	100.0%

All Cancers: 31 day wait referral to treament

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	96.4%	100.0%	96.3%	100.0%

All Cancers: 31 day wait until subsequent treatments

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
100.0%	100.0%	100.0%	100.0%	100.0%

NHSI - A&E 4 Hour Target

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
96.7%	96.0%	95.3%	93.8%	94.6%

NHSI - C difficile

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
0	0	0	0	1

NHSI - Data Completeness

No Data Available

Workforce

Mar 2018

Alder Hey Children's NHS
NHS Foundation Trust

Summary

The PDR window for 18/19 is now open (April to July) - from end of July it is expected that compliance is at least 90% . Sickness has seen further improvement and is now 5%, which is still higher than the Trust threshold of 4.5% but a drop of 0.6% from February. A task and finish group is currently being set up to address issues affecting sickness and health and wellbeing. An area of focus will be on areas of high absence and putting strategies in place to address this. Mandatory training for March is 93.2% which has dipped slightly since February but is higher than the Trust Target of 90%

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Last 12 Months
Add Prof Scientific and Technic	3.6%	3.6%	3.9%	4.6%	4.2%	4.9%	2.8%	3.6%	4.4%	4.0%	3.7%	4.1%	
Additional Clinical Services	7.1%	7.4%	7.3%	7.7%	6.1%	6.0%	7.6%	8.0%	8.7%	8.3%	7.1%	6.5%	
Administrative and Clerical	2.8%	2.3%	2.4%	3.7%	4.5%	4.3%	4.4%	4.3%	4.8%	5.2%	4.7%	4.0%	
Allied Health Professionals	2.9%	3.2%	3.8%	3.2%	2.8%	2.7%	3.0%	2.4%	2.4%	4.1%	4.0%	3.3%	
Estates and Ancillary	10.7%	9.2%	9.2%	10.8%	14.7%	12.3%	13.2%	11.4%	10.2%	12.8%	12.7%	10.6%	
Healthcare Scientists	1.0%	3.3%	4.0%	4.6%	1.5%	2.9%	2.0%	3.2%	2.2%	0.9%	1.8%	1.4%	
Medical and Dental	1.2%	1.7%	1.7%	2.0%	1.9%	1.7%	2.4%	2.1%	3.0%	2.9%	2.1%	1.4%	
Nursing and Midwifery Registered	5.1%	5.4%	5.3%	5.1%	4.8%	5.0%	6.1%	5.8%	6.7%	7.5%	6.2%	5.7%	
Trust	4.5%	4.6%	4.6%	5.1%	5.0%	4.9%	5.5%	5.3%	5.8%	6.4%	5.6%	4.9%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Last 12 Months
Add Prof Scientific and Technic	197	199	201	200	197	199	199	196	197	198	201	202	
Additional Clinical Services	391	393	392	400	397	408	409	405	403	404	412	410	
Administrative and Clerical	612	622	619	625	627	625	623	625	627	634	634	630	
Allied Health Professionals	209	210	213	215	216	219	223	224	223	221	226	223	
Estates and Ancillary	187	185	184	184	183	182	182	180	180	180	180	180	
Healthcare Scientists	107	107	109	110	110	108	107	107	107	108	111	112	
Medical and Dental	244	243	247	241	248	249	251	247	247	251	253	255	
Nursing and Midwifery Registered	968	970	972	965	960	1,019	1,025	1,019	1,008	1,000	999	1,000	

Staff in Post Headcount (rolling 12 Months)

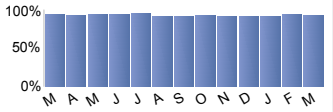
Staff Group	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Last 12 Months
Add Prof Scientific and Technic	218	220	223	223	219	220	219	216	218	220	223	225	
Additional Clinical Services	469	470	468	477	473	485	487	483	480	482	490	488	
Administrative and Clerical	701	710	709	714	715	712	710	712	713	718	718	714	
Allied Health Professionals	258	259	262	264	265	267	271	272	271	269	274	271	
Estates and Ancillary	234	231	231	230	229	228	228	226	226	227	227	227	
Healthcare Scientists	117	117	119	119	119	119	116	116	116	118	121	121	
Medical and Dental	286	286	289	284	290	293	294	292	291	295	297	299	
Nursing and Midwifery Registered	1,093	1,095	1,097	1,091	1,086	1,146	1,152	1,146	1,134	1,123	1,122	1,122	

Finance

Temporary Spend ('000s) 1067 ▲

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
3	3	3	3	3

Actual vs Planned Establishment (%) 93.9 % ▼



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
92.2%	94.8%	94.3%	93.5%	94.0%

Appraisals

Medical Appraisal 67.6 % ▲

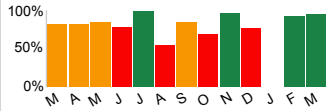
Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
68.5%	76.9%	57.8%	11.1%	51.4%

PDR 82.6 % (goal: 90.0 %) –

Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
67.2%	21.0%	83.1%	87.2%	84.2%

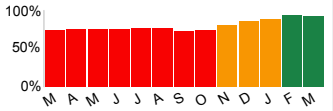
Training

Corporate Induction 96.7 % (goal: 90.0 %) ▲



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
79.5%	82.6%	81.0%	80.6%	95.0%

Mandatory Training 93.2 % (goal: 90.0 %) ▼



Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18
77.1%	76.1%	76.6%	80.9%	92.4%

Performance by CBU

Mar 2018

Alder Hey Children's NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	69.7%	86.4%	85.1%
Convenience and Choice: Slot Availability	100.0%	92.3%	100.0%
DNA Rate (Followup Appts)	14.9%	11.5%	8.9%
DNA Rate (New Appts)	18.7%	11.2%	12.4%
Referrals Received (GP)	356	815	1,134
Temporary Spend ('000s)	202	316	514
Theatre Utilisation - % of Session Utilised		83.5%	86.8%
Trading Surplus/(Deficit)	454	-47	2,928

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		3.2	3.2
Average LoS - Non-Elective (Days)		1.5	3.3
Cancelled Operations - Non Clinical - On Same Day	0	0	24
Daycases (K1/SDCPREOP)	0	73	454
Diagnostics: % Completed Within 6 Weeks		100.0%	94.7%
Hospital Initiated Clinic Cancellations < 6 weeks notice	30	67	41
OP Appointments Cancelled by Hospital %	17.8%	18.3%	12.7%
RTT: 90% Admitted within 18 weeks		90.4%	88.0%
RTT: 92% Waiting within 18 weeks (open Pathways)	96.7%	89.8%	92.6%
RTT: 95% Non-Admitted within 18 weeks	93.8%	89.6%	91.4%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores		97.0%	98.4%
Hospital Acquired Organisms - C.difficile	0	0	1
Hospital Acquired Organisms - MRSA (BSI)	0	0	0
Medication Errors (Incidents)	7	33	44

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	100.0%	100.0%	91.7%
Mandatory Training	95.7%	93.8%	91.5%
PDR	83.9%	81.5%	83.3%
Sickness	6.0%	4.2%	4.5%

CBU Performance - Community

Mar 2018

Alder Hey Children's NHS Foundation Trust

Key Issues
DNAs and short notice cancels remain a concern. A targeted piece of work to review this being undertaken.

Support Required
project manager support

Operational

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	83.0%	79.1%	81.9%	79.9%	79.2%	76.9%	80.1%	83.3%	80.6%	73.4%	77.4%	75.6%	69.7%	
DNA Rate (New Appts)	12.0%	15.9%	16.1%	19.0%	17.7%	18.4%	13.2%	15.7%	13.4%	15.7%	13.9%	16.5%	18.7%	
DNA Rate (Followup Appts)	13.3%	15.1%	14.2%	15.8%	15.2%	20.0%	17.5%	13.8%	13.7%	15.8%	11.4%	13.1%	14.9%	
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%	100.0%	
Referrals Received (GP)	385	230	387	324	321	232	331	405	394	270	338	344	356	
Temporary Spend ('000s)	150	67	103	116	146	169	195	141	167	131	146	136	202	
Trading Surplus/(Deficit)	442	343	414	299	224	145	263	284	271	247	211	377	454	

Patient

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	88.4%	87.9%	85.4%	91.8%	91.4%	93.1%	87.3%	87.9%	83.2%	90.0%	89.1%	90.6%	93.8%	
RTT: 92% Waiting within 18 weeks (open Pathways)	94.4%	94.0%	97.4%	94.3%	94.6%	96.5%	96.1%	96.3%	96.8%	97.3%	97.3%	96.5%	96.7%	
Average LoS - Elective (Days)							14.00				20.00			
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	8	15	3	12	5	13	8	19	17	19	10	10	30	
Daycases (K1/SDCPREOP)	0	0	2	0	1	0	0	1	3	0	0	0	0	
Cancelled Operations - Non Clinical - On Same Day	0	0	0	0	0	0	0	0	0	0	0	0	0	
OP Appointments Cancelled by Hospital %	20.5%	22.8%	14.5%	18.8%	13.3%	17.3%	16.1%	15.2%	16.9%	16.9%	12.4%	13.9%	17.8%	
Diagnostics: % Completed Within 6 Weeks														

Quality

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
Medication Errors (Incidents)	1	3	2	3	2	7	9	11	7	2	2	8	7	
Cleanliness Scores														
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
Corporate Induction	100.0%	82.9%		88.9%	100.0%	57.1%	100.0%	33.3%	100.0%	100.0%		100.0%	100.0%	
PDR	67.0%	0.0%	5.7%	26.5%	71.0%	82.8%	87.4%	90.4%	88.8%	90.4%	90.4%	83.9%	83.9%	
Sickness	5.9%	5.1%	5.6%	5.7%	6.4%	6.3%	7.0%	5.8%	5.6%	6.7%	6.0%	5.6%	6.0%	
Mandatory Training	57.1%	57.1%	56.1%	55.2%	74.5%	75.3%	74.6%	75.1%	80.3%	86.7%	89.8%	96.8%	95.7%	

CBU Performance - Medicine (Part 1)

Mar 2018

Alder Hey Children's NHS Foundation Trust

Key Issues

Theatre Utilisation improved in March, but we saw a dip in out Outpatient Utilisation, which coincided with a significant increase in our F/Up DNA rate. We will be reviewing the areas of increase DNA rate to understand the reasons. we have seen an improvement in our Non-Admitted RTT again in March which reflects the work the team are undertaking on our challenged specialties.

Sickness has reduced again in March to 4.2% and our Mandatory Training remains above 90%

Support Required

None required

Operational

Metric Name	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Last 12 Months
Theatre Utilisation - % of Session Utilised	85.4%	81.1%	83.6%	84.6%	76.9%	81.8%	82.0%	81.5%	79.6%	82.5%	79.9%	80.6%	83.5%	
Clinic Session Utilisation	89.1%	86.5%	87.1%	84.8%	87.1%	87.1%	86.6%	86.9%	88.5%	86.5%	88.0%	89.1%	86.4%	
DNA Rate (New Appts)	10.0%	15.0%	12.6%	12.6%	12.9%	12.3%	10.5%	13.4%	10.6%	14.0%	11.1%	11.1%	11.2%	
DNA Rate (Followup Appts)	8.8%	12.1%	11.9%	10.5%	10.6%	11.2%	11.2%	11.2%	8.9%	10.2%	8.3%	8.7%	11.5%	
Convenience and Choice: Slot Availability	99.4%	98.0%	96.3%	100.0%	100.0%	98.0%	91.4%	99.4%	97.8%	100.0%	99.7%	96.3%	92.3%	
Referrals Received (GP)	822	577	747	792	729	636	635	724	758	564	744	772	815	
Temporary Spend ('000s)	302	290	322	222	323	326	250	186	242	207	211	276	316	
Trading Surplus/(Deficit)	1,012	-298	108	-152	-390	-302	94	131	1,222	346	1,176	809	-47	

Patient

Metric Name	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Last 12 Months
RTT: 90% Admitted within 18 weeks	91.5%	96.4%		95.7%	90.5%	95.5%	100.0%	94.2%	92.7%	85.3%	83.2%	93.4%	90.4%	
RTT: 95% Non-Admitted within 18 weeks	90.9%	90.9%	86.2%	88.8%	89.1%	87.3%	86.8%	89.0%	90.1%	85.2%	80.6%	88.7%	89.6%	
RTT: 92% Waiting within 18 weeks (open Pathways)	94.8%	94.9%	94.5%	94.0%	93.6%	93.3%	94.2%	92.7%	91.2%	92.6%	92.9%	93.0%	89.8%	
Average LoS - Elective (Days)	3.20	3.50	3.40	2.94	3.05	2.90	3.06	2.89	3.33	4.06	3.54	3.22	3.17	
Average LoS - Non-Elective (Days)	1.57	1.62	1.60	1.51	1.65	1.49	1.63	1.39	1.41	1.50	1.75	1.57	1.52	
Hospital Initiated Clinic Cancellations < 6 weeks notice	27	20	18	23	17	16	21	32	30	41	26	55	67	
Daycases (K1/SDCPREOP)	70	58	70	103	70	71	63	76	74	49	58	66	73	
Cancelled Operations - Non Clinical - On Same Day	3	1	3	1	2	1	2	2	5	2	0	1	0	
OP Appointments Cancelled by Hospital %	14.4%	17.8%	11.5%	13.7%	14.8%	13.7%	13.6%	14.3%	13.5%	15.4%	15.5%	18.1%	18.3%	
Diagnostics: % Completed Within 6 Weeks	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	

Quality

Metric Name	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Last 12 Months
Medication Errors (Incidents)	35	25	34	27	25	31	19	29	22	27	28	30	33	
Cleanliness Scores	99.0%		97.0%			96.0%	96.0%	97.6%	95.4%	97.8%		98.0%	97.0%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	1	0	2	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Last 12 Months
Corporate Induction	68.8%		81.8%	61.5%	100.0%	50.0%	80.0%	70.0%	100.0%	70.0%		96.2%	100.0%	
PDR	69.7%	2.9%	15.4%	41.3%	73.8%	79.7%	82.2%	84.0%	85.0%	84.0%	84.0%	81.5%	81.5%	
Sickness	4.5%	4.0%	4.8%	4.3%	4.7%	3.8%	4.1%	5.0%	5.3%	5.1%	5.7%	4.8%	4.2%	
Mandatory Training	79.7%	80.1%	80.0%	80.5%	79.0%	78.3%	75.7%	77.3%	82.2%	86.6%	88.9%	94.7%	93.8%	

CBU Performance - Medicine (Part 2)

Mar 2018

Alder Hey Children's NHS Foundation Trust

Key Issues

PATIENT: all metrics improved except for NM <2 weeks. Investigations into causes have commenced so that performance can be remedied next month. Concern still over MRI (GA) however a new theatre list to rectify this will be starting in May.
QUALITY: pathology TATs still a concern especially as it was anticipated there would be an improvement following a change to the ICU order sets and discussions with oncology. Focus for next month will be on TATs now that UKAS submission is complete.

Support Required

Patient

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	87.0%	96.0%	91.0%	92.0%	90.0%	90.0%	86.0%	97.9%	88.4%	97.0%	99.0%	99.0%	99.0%	
Imaging - % Reporting Turnaround Times - ED	90.0%	80.0%	64.0%	76.0%	83.0%	82.0%	85.0%	96.7%	96.7%	78.0%	99.0%	86.0%	88.9%	
Imaging - % Reporting Turnaround Times - Inpatients	90.0%	78.0%	74.0%	79.0%	85.0%	85.0%	79.0%	97.8%	94.4%	78.0%	94.0%	79.0%	85.0%	
Imaging - % Reporting Turnaround Times - Outpatients	94.0%	92.0%	90.0%	92.0%	98.0%	98.0%	92.0%	89.5%	90.0%	95.0%	96.0%	93.0%	97.0%	
Imaging - Waiting Times - MRI % under 6 weeks	85.0%	71.0%	81.0%	67.0%	68.0%	77.0%	79.0%	93.7%	96.8%	96.0%	73.0%	88.0%	89.0%	
Imaging - Waiting Times - CT % under 1 week	87.0%	95.0%	89.0%	87.0%	87.0%	89.0%	87.0%	93.3%	94.4%	84.0%	85.0%	81.0%	88.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	93.0%	93.0%	94.0%	93.0%	94.0%	92.0%	91.0%	98.9%	100.0%	91.0%	92.0%	89.0%	91.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	87.0%	84.0%	88.0%	90.0%	91.0%	90.0%	87.0%	95.6%	93.3%	85.0%	84.0%	87.0%	87.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	93.0%	88.0%	95.0%	89.0%	100.0%	93.0%	72.0%	100.0%	96.8%	83.0%	92.0%	90.0%	82.0%	
BME - High Risk Equipment PPM Compliance	88.0%	80.2%	91.7%	91.6%	91.2%	90.1%	84.6%	90.2%	90.1%	89.2%	87.6%	84.7%	88.0%	
BME - Low Risk Equipment PPM Compliance	79.0%	100.0%	82.0%	81.9%	80.4%	75.5%	74.6%	70.9%	76.0%	77.7%	80.4%	81.5%	84.0%	
BME - Equipment Pool - Equipment Availability	100.0%	91.4%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	45.0%	57.0%	37.0%	60.0%	65.0%	63.0%	57.0%	61.0%	60.0%	61.0%	58.0%	51.0%	50.0%	
Pharmacy - Dispensing for Out Patients - Complex	98.0%	98.0%	100.0%	100.0%	96.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	63.0%	63.0%	63.0%	54.3%	54.5%	80.0%	90.0%	100.0%	100.0%	100.0%	100.0%	94.1%	92.9%	

Quality

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	87.9%	89.7%	89.9%	91.0%	88.1%	88.1%	91.0%	89.1%	87.4%	87.6%	87.7%	88.0%	87.8%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	99.8%	
Reporting times for perinatal autopsies in 56 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%	
Blood Traceability Compliance	99.6%	99.4%	100.0%	100.0%	99.5%	99.8%	99.8%	99.2%	99.5%	100.0%	99.8%	99.6%	99.6%	

CBU Performance - Surgery

Mar 2018

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Clinic Utilisation-planned for March is 103%. Action taken with specialties with planned <100% and methods for appointment reminders (e.g. text reminders) is being piloted in several specialties.
Theatre Utilisation– Deep dive into list planning for lowest specialties in March taking place to ensure optimal scheduling.
28 day breaches – Multiple cancelled operations led to scheduling difficulties to relist within 28 days; issue not expected to reoccur in future months.

Support Required

- Continued support from GDE team for TCI to Theatre pathway programme to improve theatre booking and scheduling processes and visibility of patient level information
- Progress improved outpatient booking system to enhance patient experience and data quality.
- Support from and involvement in strategic priority groups (e.g. patient flow and brilliant booking systems) to assist in delivery of performance metrics

Operational

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
Theatre Utilisation - % of Session Utilised	87.1%	88.3%	87.9%	88.9%	87.7%	88.6%	87.3%	87.3%	85.2%	86.4%	88.3%	86.4%	86.8%	
Clinic Session Utilisation	88.2%	87.9%	86.0%	85.9%	86.2%	84.9%	83.2%	85.2%	87.0%	82.9%	86.2%	83.6%	85.1%	
DNA Rate (New Appts)	9.8%	10.2%	11.7%	12.4%	11.6%	12.6%	11.8%	12.3%	12.6%	12.7%	11.6%	11.8%	12.4%	
DNA Rate (Followup Appts)	8.3%	9.9%	10.1%	9.7%	10.6%	11.4%	11.3%	10.9%	9.1%	11.0%	9.0%	9.0%	8.9%	
Convenience and Choice: Slot Availability	95.3%	98.2%	99.5%	96.0%	99.0%	100.0%	100.0%	99.8%	97.4%	98.7%	97.1%	99.2%	100.0%	
Referrals Received (GP)	1,280	977	1,152	1,215	1,035	980	988	1,087	1,134	833	1,143	1,141	1,134	
Temporary Spend ('000s)	443	516	402	456	511	554	429	479	383	331	408	434	514	
Trading Surplus/(Deficit)	2,821	1,826	2,930	3,321	2,980	2,574	2,506	2,634	2,379	1,819	2,524	1,891	2,928	

Patient

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
RTT: 90% Admitted within 18 weeks	87.2%	86.9%	90.3%	87.8%	88.8%	87.8%	85.0%	88.5%	90.0%	90.5%	90.7%	87.1%	88.0%	
RTT: 95% Non-Admitted within 18 weeks	89.1%	90.1%	89.8%	88.2%	88.1%	90.2%	90.7%	91.2%	91.2%	91.6%	92.9%	92.6%	91.4%	
RTT: 92% Waiting within 18 weeks (open Pathways)	90.9%	90.9%	90.8%	91.3%	91.2%	91.2%	90.9%	91.6%	92.0%	91.3%	91.4%	91.3%	92.6%	
Average LoS - Elective (Days)	2.62	2.58	3.57	2.57	3.10	2.91	3.03	2.36	2.76	3.30	2.62	2.88	3.15	
Average LoS - Non-Elective (Days)	2.64	2.84	3.06	2.57	2.86	2.96	2.74	2.90	3.17	3.18	2.67	2.90	3.28	
Hospital Initiated Clinic Cancellations < 6 weeks notice	22	19	23	28	35	32	26	27	26	37	24	58	41	
Daycases (K1/SDCPREOP)	582	426	540	609	472	499	485	552	521	435	590	472	454	
Cancelled Operations - Non Clinical - On Same Day	28	6	54	18	29	14	46	24	35	13	19	19	24	
OP Appointments Cancelled by Hospital %	13.7%	13.2%	11.2%	12.7%	12.0%	12.8%	11.8%	12.3%	13.2%	13.2%	12.9%	14.0%	12.7%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	92.6%	94.7%	

Quality

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
Medication Errors (Incidents)	47	40	56	48	42	55	32	30	46	25	39	44	44	
Cleanliness Scores	97.7%				97.6%	93.9%		95.5%	97.4%	98.3%	97.7%	98.4%	98.4%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	1	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	1	

Workforce

Metric Name	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Last 12 Months
Corporate Induction	94.1%		90.0%	100.0%	100.0%	60.0%	71.4%	85.0%	88.9%	77.8%		88.2%	91.7%	
PDR	45.1%	1.9%	11.2%	63.0%	87.6%	91.1%	90.1%	89.5%	88.1%	89.5%	89.5%	83.3%	83.3%	
Sickness	4.4%	4.5%	4.4%	4.7%	4.8%	4.7%	4.6%	5.1%	4.8%	6.0%	6.4%	5.2%	4.5%	
Mandatory Training	79.3%	80.6%	80.7%	81.5%	79.1%	77.0%	73.0%	73.8%	80.9%	85.8%	89.3%	93.5%	91.5%	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 1 May 2018

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, Governance Manager
Subject/Title	2018/19 Board Assurance Framework Update (April 2018)
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF update report
Action/Decision required	The Board is asked to discuss and note the changes to the Board Assurance Framework – April position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Alder Hey Children's NHS
NHS Foundation Trust

Board Assurance Framework 2018/19

1. Purpose

This report is a summary of the current Board Assurance Framework (BAF) for review and discussion.

2. Review of the BAF

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

Alder Hey Children's NHS
NHS Foundation Trust

Ref, Owner	Risk Title		Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 HG	**Maintain care quality in a cost constrained environment**		4-2	4-2	STATIC	STATIC
1.2 ES	**Mandatory & Compliance Standards**		5-1	3-1	STATIC	STATIC
1.3 DP	**New Hospital Environment**		4-3	4-2	-	**NEW**
STRATEGIC PILLAR: Game-Changing Research And Innovation						
2.1 DP	**Research, Education & Innovation**		3-3	3-2	STATIC	WORSE
2.2 DP	**Failure to fully realise the Trust's Vision for the Park**		3-3	3-2	STATIC	BETTER
2.3 JG	**IT Strategic Development**		3-4	3-3	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.2 MB	**Business Development & Growth**		4-3	4-2	STATIC	STATIC
3.3 MB	**Developing the Paediatric Service Offer**		4-3	4-2	STATIC	STATIC
3.4 JG	**Financial Environment**		5-4	4-4	STATIC	STATIC
STRATEGIC PILLAR: The Best People Doing Their Best Work						
4.1 MS	**Workforce Sustainability & Capability**		4-3	4-2	STATIC	STATIC
4.2 MS	**Staff Engagement**		3-3	3-1	STATIC	STATIC
4.3 MS	**Workforce Diversity & Inclusion**		3-3	3-1	STATIC	STATIC

Changes since April 2018 Board meeting

The diagram above shows that the majority of the risks on the BAF remained static. The risk relating to 'Research, Education & Innovation' is showing a worsened position as we enter into 2018/19, with 'Failure to fully realise the Trust's Vision for the Park' showing an improved position.

External risks

- ***Business development and growth (MB)***
  Final Strategy to May Board. Scope of service growth required for sustainability requires further clarification.

- ***Mandatory and compliance standards (ES)***
  All compliance targets achieved at end of April. Trust is projecting a financial risk rating of 2. No governance concerns.

- ***Developing the Paediatric Service Offer (MB)***
  Trust Board Workshop to be scheduled for June 2018 to consider growth and sustainability scenarios to inform clinical and sustainability strategy.

Internal risks:

- ***New Hospital Environment (DP) NEW***
  Clutch of commissioning issues still to be resolved including pipework corrosion, water temperatures and delay in achieving operating theatre temperature control. Are currently under review with some attendant action plans still requiring completion.

  Next steps-complete reviews and agree all action plans for outstanding issues.

- ***Maintain care quality in a cost constrained environment (HG)***
  Successful recruitment, nurse leadership OPD.

- ***Financial Environment (JG)***
  New financial plan agreed subject to Board approval. Key commissioner contracts now agreed with the exception of Sefton CCG. Focus now on ensuring we have a fully worked-up CIP plan.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  New Park Manager appointed

- ***IT Strategic Development (JG)***
  ImageNow and bed management module key next phases of the programme. Clinical Advisory Group in place supporting these developments. Real progress being made on STP wide intra-operability platform

- ***Workforce Sustainability & Capability (MS)***
  Progress continues with apprenticeship programme. Training compliance still above 90%. Sickness Absence Task and Finish project defined.

- ***Staff Engagement (MS)***
  Local Staff Survey data shared with all teams to discuss locally. Alder Hey Life staff magazine published.

- ***Workforce Diversity & Inclusion (MS)***
  Workforce Profile Report developed ready for publication in May. Data analysed to identify areas of focus.

- ***Research, Education & Innovation (DP)***
  Research, Education & Innovation Committee refreshed and relaunched for 18/19

Erica Saunders
Director of Corporate Affairs
1 May 2018

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.1	**Strategic Objective:** Delivery Of Outstanding Care	Risk Title: Failure to maintain appropriate levels of care quality in a cost constrained environment.		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led				
Exec Lead: Hilda Gwilliams	**Type:** Internal, Known	Current IxL: 4-2	Target IxL: 4-2	Trend: STATIC

Risk Description

Failure to maintain appropriate levels of care quality in a cost constrained environment.

Existing Control Measures

• Quality impact assessment completed for all planned changes	• Risk assessment and utilisation of risk registers in responding to risks.
• Quality section of Corporate Report performance managed at Clinical Quality Assurance Committee and Trust Board.	• Division and Corporate Dashboards in place and monitored consistently via performance framework
• Weekly Meeting of Harm monitors incidents, including lessons learned, immediate actions . Escalation process in place	• Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).
• Annual nursing workforce assurance report presented to Board, aligned to Nursing and Midwifery Council Standards.	• Continuous monitoring of professional re validation compliance for the workforce via Electronic Staff Record (ESR)
• Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	• Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework
• Quality Strategy 2016-2020 implemented to deliver safe and effective services, with measurable Quality Aims.	• Acute Provider Infection Prevention and Control framework implemented and monitored internally and externally via the Clinical Commissioning Group External review on Infection Prevention and Controlresulted in action plan to address issues identified and track improvements.
• Internal Nursing pool established and funded	• Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.
• Annual inpatient Patient Survey reports	

Assurance Evidence	Gaps in Controls/Assurance
Impact assessments monitored via the Performance Board Risk assessments etc. monitored via the Integrated Governance Committee Clinical Quality Assurance Committee and Trust Board Quality monitor the quality section of Corporate Report. Performance framework monitored via Performance Board Weekly meeting of Harm outcomes including lessons learned reviewed by Executive team and by exception the Trust Board. Quality Assurance Rounds available on Trust Governance and Assurance web page for viewing accessible for all staff and shared across divisions. Annual Nursing workforce report to Board, including fill rate compliance. Nursing re validation report via Clinical Quality Assurance Committee. Governance and Risk monitored via the Integrated Governance Committee Infection Prevention and Control 'Acute Providers Framework' reports are monitored via the Trust Board. Quality performance monitored via the Clinical Quality Performance Group (external monitoring via Clinical Commissioning Group) NRLS national reports (incidents) Annual CQC patient survey results - performance monitored via Trust Board.	National reduction in post graduate education training Budget. Reduced investment opportunity to respond to clinical development as a result of this reduction. Nursing maternity leave continues to rise - currently 10 WTE above the expected rise. Reduced student nurse higher education applications due to funding changes nationally.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
please work with the divisions HR Business Partners to reduce the sickness rate to the expected trust standard.	Sickness policy recently reviewed and updated Sickness data produced monthly by HR and reviewed at Divisional Board meetings and corporately via WOD. Progress monitored at Matrons and ACN meetings with the Ward Managers. Action plans are in place at ward and departmental level HR support is in place for Managers across the Divisions
Please ensure nursing educational budget is sufficient to meet post graduate nurse education and development requirements. Please advise of plan	
Please ensure the opportunity for development of non-registered staff to commence registered nurse training programme is implemented and funded.	Opportunities for non registered nurses to undertake apprenticeships with funding drawn down from the levy. This will form part of our overarching apprenticeship offer and will also form a core part of our workforce strategy for nursing

Executive Lead's Assessment
APRIL 2018: Successful recruitment, nurse leadership OPD

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.2	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: Mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective					
Exec Lead: Erica Saunders	**Type:** Internal, Known		Current IxL: 5-1	Target IxL: 3-1	Trend: STATIC

Risk Description

Failure to meet targets due to lack of capacity to fulfil activity projections

Existing Control Measures

• Operational Delivery Board taking action to resolve performance issues as they emerge	• Emergency Planning & Resilience meetings in pace
• Divisional Executive Review Meetings taking place monthly with 'three at the top'	• Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and Divisional Dashboards.	• Risks to delivery addressed through Operational Board, RBD, CQAC, WOD, IGC & CQSG and then through to Board
• Early Warning indicators now in place	• Weekly performance meetings in place to track progress
• 6 weekly meetings with commissioners (CQPG)	• Divisional leadership structure to implement and embed clinically led services
• Weekly Exec Comm Cell overseeing key operational issues and blockages.	• Refresh of Corporate Report undertaken for 2018/19

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through assurance committees & Board. Monthly reporting to the Board via the Corporate Report. Monitor / NHSI governance risk rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against NHSI Provider Licence to Board Divisional/Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly review meeting and report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. ED 4 hour target. Assurance required to underpin Divisional reporting on CQC standards Work with CCG to manage demand & develop / fully utilise existing capacity across PC

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitor the use of surgical beds to ensure full activity plan delivered	
ED plan for March approved at Operational Board in February based on additional medical shifts in ED, additional specialty doctor cover and to staff the four additional beds in ED.	Review of cardiac surgery pathway underway led by COO. Aiming to deliver full CCAD requirements going forward
Plans to ensure performance sustained across the year need to be embedded and maintained	Operational teams continue to be sighted on ensuring and maintaining flow across the hospital via weekly performance (comm cell), bed meetings etc.

Executive Lead's Assessment

APRIL 2018: All compliance targets achieved at end of April. Trust is projecting a financial risk rating of 2. No governance concerns

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.3	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: New Hospital Environment		
Related CQC Themes: Safe					
Exec Lead: David Powell	**Type:** Internal, New		Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Sale of PFI Project co. whilst a number of commissioning risks are still present could lead to lack of focus and problems in maintaining safe environment

Existing Control Measures

• Monthly issue meetings	• Monthly liaison meetings
• Regular reports to IGC	• Liaison minutes reported to Trust Board monthly
• Building Management Services Risk Register	

Assurance Evidence	Gaps in Controls/Assurance
Maintenance of Issues List Issues Review Meeting Escalation to Liaison meeting Red Button escalation mechanism Help Desk monitoring reports	Some repeat/overlap reporting Some lack of clarity over risk ownership/H&S role

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Replacement programme for pipe work to be agreed with builder	Cost obtained for replacement programme
COO updating Action Plan to address key water safety issues	
Interserve developing water safety action plan	

Executive Lead's Assessment

APRIL 2018: Clutch of commissioning issues still to be resolved including pipework corrosion, water temperatures, delay in achieving operating theatre temperature control. Are currently under review with some attendant action plans still requiring completion.

Next steps-complete reviews and agree all action plans for outstanding issues.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** Game-Changing Research And Innovation	Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led				
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: WORSE

Risk Description	
Failure to exploit new opportunities in research, innovation & education due to incomplete management systems.	
Existing Control Measures	
• Establishment of RIE Board Sub-committee	• Steering Board reporting through to Trust Board
• RABD review of contractual arrangements	• Programme assurance via regular Programme Board scrutiny
• Digital Exemplar budget completed and reconciled	• Innovation Co budget in place
Assurance Evidence	**Gaps in Controls/Assurance**
Research Strategy Committee set up as a new Board Assurance Committee Research, Education and Innovation Committee established Secured ERDF funding for Innovation Team Innovation Board established	Sporadic meetings of RIE committee Governance structure for Innovation Board to be agreed Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Educational Partnerships to be cemented	Refresh of framework
Execute plan to increase research portfolio	Refresh of framework
Develop a robust Academy Business Model	Framework refresh
Establish pipeline structure for work-streams (Acorn and Crucible)	Heads of Terms agreed with Crucible. Acorn paperwork received for authorisation
Execute contract for RIE with back to back arrangements with the Charity and HEIs	LJMU Contract now agreed internally
Agree incentivisation framework for staff and teams	
Executive Lead's Assessment	
APRIL 2018: REI committee refreshed and relaunched	

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.2	**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					
Exec Lead: David Powell		**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: BETTER

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	
• Business Cases developed for various elements of the Park & Campus	• Alignment with the 'Alder Hey in the Park' vision and the 'Alder Hey Campus' visions
• Heads of Terms agreed with LCC for joint venture approved	• Redeveloped Steering Group
• Monthly reports to Board & RABD	
Assurance Evidence	**Gaps in Controls/Assurance**
Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Stakeholder events held/reported back to Trust Board Representation at Friends of Springfield Park Group Monthly Board report	Fully reconciled budget with Plan. Risk quantification around the development projects.
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Appoint new park project lead	Job advertised
Secure approval for plans to increase Park footprint	Consultation held with local residents regarding plans to expand Park
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)
Income generation opportunities to be thoroughly explored (grant applications) and reconcile requirement for funding versus available	Draft Business Case prepared. First grant application successful.
Executive Lead's Assessment	
APRIL 2018: New Park manager appointed	

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.3	**Strategic Objective:** Game-Changing Research And Innovation		Risk Title: IT Strategic Development		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: John Grinnell	**Type:** Internal, Known		Current IxL: 3-4	Target IxL: 3-3	Trend: STATIC

Risk Description

Failure to deliver an IM&T Strategy which will place Alder Hey at the forefront of technological advancement in paediatric healthcare

Existing Control Measures

• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Monthly update to Trust Board on GDE Programme
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical Engagement in IT Roadmap
• NHSE external oversight of GDE programme	

Assurance Evidence	**Gaps in Controls/Assurance**
Regular progress reports presented to RABD and Operational Board & Trust Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews NHSE tracking of GDE Programme	IM&T Strategy out of date - update work in progress to produce Roadmap Internal Programme Assurance Reports
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
IT Roadmap to be concluded	Meeting held with Meditech to agree how we work more effectively going forward and have more onsite presence

Executive Lead's Assessment

APRIL 2018: ImageNow and bed management module key next phases of the programme. Clinical Advisory Group in place supporting these developments. Real progress being made on STP wide intra-operability platform

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.2	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Business Development and Growth.		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led				
Exec Lead: Margaret Barnaby	**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Risk to business development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities

Existing Control Measures

• Divisional Performance Management Framework.	• Clear trajectories for challenged specialities to deliver.
• Business Development Plan	• 2016 Change Programme Projects (Strategic Partnerships & International Clinical Business and non NHS Patient Services)
• Five year plan agreed by Board and Governors in 2014	• Capacity Plan identifies beds and theatres required to deliver BD Plan.
• Service development strategy including Private / International patient proposal approved by Council of Governors as part of strategic plan sign off.	• Capacity Plan identifies beds and theatres required to deliver BD plan
• Jan 2016 :- Weekly meeting with divisions established to review forward look re elective and day case patient bookings to ensure activity scheduled meets contract requirements	

Assurance Evidence	Gaps in Controls/Assurance
Business growth and market analysis reports considered fully by Marketing & Business Development Committee and reported regularly to RBDC. Business Development Committee and reported regularly to Board via RBDC. Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Early warning indicators for leading indicators. Potential delay to cardiac growth - current gap c. £0.8m forecast against 16/17 CIP target

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Development of the international agenda	
Operational Business Planning underway - to contain forecasts regarding growth opportunities	

Executive Lead's Assessment

APRIL 2018. Final Strategy to May Board. Scope of service growth required for sustainability requires further clarification.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.3	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Developing the Paediatric Service Offer		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led				
Exec Lead: Margaret Barnaby	**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Failure to maximise opportunities with regard to service reconfiguration and potential loss of accreditation of key specialist services

Existing Control Measures

• Internal review of service specifications as part of Specialist Commissioning review.	• Analysis of compliance and actions agreed where not fully met.
• Gap/risk analysis against all draft national service specification undertaken and action plans developed.	• Accreditations confirmed through national review processes.
• Compliance with Neonatal Standards	• Compliance with All Age ACHD Standard
• Post implementation review of Trauma Business Case.	• Current derogations secured in relation to specialist service specs.
• Growing Through External Partnerships - Change Programme Workstream (All Projects)	• Change Programme - 7 Day Working Project
• The 'Out Of Hours' Group will steer a 6-month review of the shape of general paediatrics	

Assurance Evidence	Gaps in Controls/Assurance
Key developments monitored through Divisions Monitored at Performance Management Group. Monthly to Board via RABD & Board Compliance with final national specifications	Inability to recruit to highly specialist roles due to skill shortages nationally. 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. Potential elective underperformance due to cancelled sessions. Awaiting final results re. CHD service at national level. Working with partners including CMFT to progress transfer of adult CHD services and to support partners during transition

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
CHD Liverpool partnership - development of Level 1 status for adult congenital heart disease across North West / NW / Wales and Isle of Man, bringing together a partnership across 4 Liverpool providers. Partnership achieved November 2017.	
Strengthening the paediatric workforce	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.
Agreement of key partnerships for sustainability 2018/19 achieved on 30th November 2017. Actions now in planning and delivery phase, with Executive Oversight provided by the CEO Oversight Group, and planning delivery through the joint CHIG Group. Delivery will take up to two years.	
Delivery of a refreshed clinical and sustainability strategy	Refreshed Draft Clinical and Sustainability Strategy went to April Trust Board. It was decided that a Board Workshop was needed to look at Growth and Sustainability questions in more details. This is planned for June 2018.
Development of a single neonatal service business case across Alder Hey & LWH	This is now finalised and submitted to NHS England Spec Commssioiners. Strong support received, further work requested for completion in May 2018. Both Trust Boards have approved the Neonatal Business Case

Executive Lead's Assessment

APRIL 2018: Trust Board Workshop to be scheduled for June 2018 to consider growth and sustainability scenarios to inform clinical and sustainability strategy.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.4	**Strategic Objective:** Sustainability Through External Partnerships		Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: John Grinnell	**Type:** Internal, Known		Current IxL: 4-4	Target IxL: 4-3	Trend: STATIC

Risk Description	
Failure to deliver Trust control total and financial risk rating	
Existing Control Measures	
• Organisation-wide financial plan.	• Monitor financial regime and financial risk ratings.
• Financial systems, budgetary control and financial reporting processes.	• Capital Planning Review Group
• Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• 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	• Financial Recovery Board in place
• CIP subject to programme assessment and sub-committee performance management	
Assurance Evidence	**Gaps in Controls/Assurance**
Monthly Corporate Performance Report presented to both Board and the RABD. Specific Reports (i.e. NHSI Plan Review by RABD) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support divisional performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP Recovery Plan still demonstrating £2M gap although mitigating close gap consolidated Conclude commissioner year-end discussions
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Tracking actions from Financial Recovery Board	Activity tracking in place
Conclude commissioner year end positions	all contracts / agreements concluded for 2017/18
Conclude Sefton CCG contract negotiaitions	
Develop fully worked up CIP programme	
Executive Lead's Assessment	
APRIL 2018: New financial plan agreed subject to Board approval. Key commissioner contracts now agreed with the exception of Sefton CCG. Focus now on ensuring we have a fully worked-up CIP plan.	

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.1	**Strategic Objective:** The Best People Doing Their Best Work		Risk Title: Workforce Sustainability & Capability		
Related CQC Themes: Safe, Effective, Responsive, Well Led, Well Led					
Exec Lead: Melissa Swindell	**Type:** Internal, Known		Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Failure to always have the right people, with the right skills and knowledge, in the right place, at the right time

Existing Control Measures

• Compliance tracked through the corporate report and divisional dashboards	• Divisional Performance Meetings.
• Mandatory Training fully reviewed in 2017, and aligned competencies on ESR.	• Mandatory training records available online and mapped to Core Skills Framework
• Permanent nurse staffing pool	• 'Best People Doing our Best Work' Steering Group implemented
• Attendance management process to reduce short & long term absence	• Positive Attendance Policy
• Large-scale nurse recruitment event 4 times per year	• Training Needs Analysis linked to CPD requirements

Assurance Evidence	**Gaps in Controls/Assurance**
Regular reporting of delivery against compliance targets via corporate & divisional reports Monthly reporting to the Board via the Corporate Report Reporting at ward and SG level which supports Ward to Board	Inability to train staff due to clinical workforce and acuity preventing them leaving the clinical areas. Not meeting compliance target in relation to mandatory training in specific areas Sickness Absence levels higher than target. No formalised Education Strategy

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
This risk has no actions in place.	

Executive Lead's Assessment

APRIL 2018: Progress continues with apprenticeship programme. Training compliance still above 90%. Sickness Absence Task and Finish project defined.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** The Best People Doing Their Best Work		Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: Melissa Swindell	**Type:** Internal, Known		Current IxL: 3-3	Target IxL: 3-1	Trend: STATIC

Risk Description

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

Existing Control Measures

• Internal Communications Strategy in development by new incumbent into Director of Communications role	• Roll out of Leadership Development and Leadership Framework
• Action Plans for Engagement, Values and Communications.	• Medical Leadership development programme
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action methodology
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.

Assurance Evidence	Gaps in Controls/Assurance
Outcomes from Annual Staff Survey reported to the Board. PDR completion rates Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data now sent to Divisions on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board	None recorded.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
This risk has no actions in place.	

Executive Lead's Assessment

APRIL 2018: Local Staff Survey data shared with all teams to discuss locally. Alder Hey Life staff magazine published.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.3	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Workforce Diversity & Inclusion		
Related CQC Themes: Well Led, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-1	Trend: STATIC

Risk Description

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

Existing Control Measures

• Equality, Diversity & Human Rights Group	• WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.
• Workforce Plan established	• Staff Survey results analysed by protected characteristics, where possible and actions taken by E&D Lead.
• Workforce Planning Policy signed off at WOD June 2015	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	• BME Network established, sponsored by Director of HR & OD
• Disability Network established, sponsored by Director of HR & OD	• Actions taken in response to the WRES
• Action plan specifically in response to increasing the diversity of the workforce.	

Assurance Evidence	**Gaps in Controls/Assurance**
Monthly recruitment reports provided by HR to divisions Quarterly reports to the Board via WOD on diversity and inclusion issues Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication	LGBTQ Network not yet in place Comprehensive TNA needs further development

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Establish LGBTQ network	
Newly appointed L&D Manager to work with E&D Manager to develop TNA	

Executive Lead's Assessment

FEBRUARY 2018: BME staff survey data being analysed for trends and hotspots.
MARCH 2018: Gender Pay Gap Report published and approved by Ops Board, to be received by Trust Board in April 18.
APRIL 2018: Workforce Profile Report developed ready for publication in May. Data analysed to identify areas of focus.

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Key	
B	Completed
G	In progress and on track to be completed by target date
A	Risk of non-completion by target date
R	Overdue

No.	Must / should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	Individual action BRAG	Overall action BRAG	Target completion date	Monitoring Committee	Required outcome / output	Evidence
1	Must	Trust	**Serious Incidents** Must ensure that all serious incidents are reported in line with the trust policy and initial investigations are carried out in a timely way so that any immediate actions to mitigate risk are identified	1.1 Review and revision of Trust incident management framework including serious incidents	Hilda Gwilliams Chief Nurse	Cathy Umbers Associate Director of Nursing and Governance	**Update beginning of Jan 2018:** Draft revision completed	Complete	In progress	**Complete:** 20 December 2017 – and ongoing	Clinical Quality Assurance Committee		
				1.2 Align the Trust mortality and morbidity review process with incident management process			**Update beginning of Jan 2018:** completed	Complete		**Complete:** 20 December 2017			
				1.3 Relaunch of the Trust Incident management including serious incident framework via intranet, team brief, governance processes 'Board to Ward'			**Update beginning of Mar 2018:** Trust incident management including serious incident policy completed and on Trust intranet.	Complete		**Complete:** 10 February 2018			Management of Incidents Incorporati
				1.4 Review and update of the Ulysses incident management module in the Trust Electronic Risk Managed system			Initial review completed. Plan in place to increase super users (Ulysses technical experts) across Divisions, awaiting identified staff confirmation from Divisions to enable training progress.	Complete		**Complete:** 20 December 2017 – and ongoing			
				1.5 Develop and implement step by step guides to support staff understanding of mandatory requirements in terms of process including timeliness of actions			**Update beginning of Jan 2018:** Draft completed	Complete		**Complete:** 20 December 2017			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				1.6 Relaunch the incident reporting section of the Ulysses incident management module following completion of the review and update, and development of step by step guides			**Update beginning of Mar 2018:** Partially completed – Step by step guides developed and on Trust intranet.		~~28 February 2018~~ Revised timescale: May 2018			Step by Step guide to reporting incidents Step by Step Guide to Managing Incident communication guide on ULYSSES.docx action module on ULYSSES V2 February
				1.7 Incident management including serious incidents will be standing item at all Governance meetings from Board to ward. Assurance reports will be provided including timeliness of reporting and process management of serious incident investigations, lessons learned and progress with actions			**Update beginning of Mar 2018:** Partially completed – incident management a standing item at governance meetings.		~~28 February 2018~~ Revised timescale: May 2018			
				1.8 Development of regular lessons learned and actions taken newsletter to be published widely across Trust including Trust intranet			**Update beginning of Mar 2018:** Developed and available on Trust intranet.	Complete	**Complete:** 28 February 2018			
2	Must	Trust	**Sepsis** Must take action to ensure all children and young people receive treatment in relation to sepsis within appropriate timeframes. Have a process to monitor adherence to policy for patient's treated for sepsis	2.1 Provide training to new clinical staff on induction in the NICE sepsis pathway and staff responsibilities for assessing, investigating and responding promptly to patients suspected of having sepsis	Steve Ryan Medical Director	David Porter Clinical Lead	**Update 24th October 2017:** Introduction of a Sepsis Team from July 2017. 99% training for front line nursing staff achieved. All doctor and nurse induction programmes include sepsis training. E-Learning package in development. Trust committed to maintaining dedicated staff within the sepsis team to deliver education and training on sepsis management, monitor performance and drive improvement.	Complete	Complete	**Complete:** 31 October 2017 and ongoing	Sepsis Steering Group Clinical Quality Assurance Committee	Children and young people will receive treatment in relation to sepsis within appropriate timeframes (60 mins for high risk / red flag sepsis; 180 mins for moderate risk) 90% compliance with staff training in line with Trust	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				2.2 Continuous monitoring and audit of sepsis management in Emergency Department and inpatient wards with associated monthly reports			**Update beginning of Jan 2018:** Reports have been provided monthly for both ED and Inpatients since May 2017, and despite the CQC no longer requesting the data, this continues to be produced. The Sepsis Nurses have been presenting case reviews since August 2017, with more structured case reviews introduced from December 2017, which included themes for delays in treatment.	Complete	**Complete:** 31st November 2017 – and ongoing	Sepsis policy	
				2.3 Review all cases of sepsis where antibiotics were given outside NICE recommended timeframes (60 mins for high risk / red flag sepsis, 180 mins for moderate risk) to identify factors leading to the delay			**Update beginning of Jan 2018:** The Sepsis Nurses have been presenting case reviews since August 2017, with more structured case reviews introduced from December 2017, which included themes for delays in treatment. Additionally the COO has introduced weekly updates on the number of cases that were treated within 60mins for Exec Comm Cell.	Complete	**Complete:** 31st November 2017		
				2.4 Report and disseminate all trends / themes / barriers surrounding delays in antibiotic administration to Sepsis Steering Group, CQAC and Best in Acute Care to maintain hospital oversight and inform changes in practice and policy.			**Update 24th October 2017:** Sepsis Steering Group commenced in February 2017 Regular reporting to CQAC began in April 2017 Best in Acute Care programme began in July 2017	Complete	**Complete:** 31st July 2017 and ongoing		
				2.5 Disseminate audit results to staff through Divisional leadership, risk and governance communication structure and by regular hospital Grand Round sessions			**Update beginning of Jan 2018:** Updates were provided to the Divisions in September 2017, and the team presented to Grand Round on 20th October 2017. An update was also presented to the Infection Prevention & Control Committee on 12th December 2017.	Complete	**Complete:** December 2017		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				2.6 Submit progress and CQUIN update to CCG			**Update 24th October 2017:** Submission to CQC commenced in May 2017 First submission of CQUIN in August 2017 for Quarter 1.	Complete		**Complete:** 31st August 2017 and ongoing			
				2.7 Submit monthly report to CQC			**Update 24th October 2017:** Submissions to CQC started in May, and first submission of CQUIN in August 17 for Q1.	Complete		**Complete:** 31st August 2017 and ongoing			
3	Must	Trust	**Fit and Proper Persons** Must ensure that robust arrangements are in place to govern the fit and proper person's process	3.1 Incorporate the fit and proper persons process into the Trust Recruitment and Selection Policy	Melissa Swindell Director of Human Resources and OD	Sharon Owen Head of Human Resources	**Update 24th October 2017:** The Trust has fully incorporated the fit and proper persons process into the Trust Recruitment and Selection Policy, which was ratified on 21st June 2017	Complete	Complete	**Complete:** 21st June 2017	Workforce and Organisational Development Committee (WOD)	All relevant posts to be fully checked in accordance with the fit and proper persons requirements.	Recruitment and Selection Policy - E2.p
				3.2 Devise and implement a standard operating process (SOP) to provide full clarity of the process and responsibilities			**Update 24th October 2017:** SOP has been implemented	Complete		**Complete:** 21st June 2017			
4	Must	Trust	**Safeguarding Level 3** Must take action to ensure all staff who are involved with assessing, planning, and evaluating care for children and young people are trained to safeguarding level three in line with the safeguarding children and young people: roles and competencies for health care staff Intercollegiate Document (2014)	4.1 Cleanse ESR system to ensure all roles are aligned to correct safeguarding mandatory training competencies	Hilda Gwilliams Chief Nurse	Julie Knowles Assistant Director of Safeguarding	**Update 24th October 2017:** Cleanse of competencies against positions in ESR has already been completed and has seen a significant increase in the figures reported. The Trust has sourced systems expertise to ensure ESR is set up to accurately report against the Trust requirements	Complete	In progress	**Complete:** 31st August 2017	Workforce and Organisational Development Committee	90% compliance in Level 3 safeguarding training	
				4.2 Monitor compliance with Level 3 safeguarding training across the Trust, within Divisions, and within specific departments			**Update beginning of April 2018:** Monthly monitoring continues. Figure for Level 3 Safeguarding as at 21 March 2018 92.85%	Subject to Monthly monitoring		No completion date as training compliance tasks will renew on an annual basis (or three yearly depending on training cycle)			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				4.3 Produce and share regular detailed mandatory training reports at divisional and departmental level, reported by staff group, which show compliance with Level 3 safeguarding training down to individual staff member level			**Update beginning of April 2018:** Ward managers are receiving regular monthly ward/ service department specific reports which is assisting with monitoring and oversight of compliance	Complete		**Complete**			
				4.4 Dedicate additional resource from within the Safeguarding Team to lead on training			**Update 24th October 2017:** Senior lead for safeguarding training appointed	Complete		**Complete:** 31st August 2017			
				4.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update beginning of Mar 2018:** The dedicated specialist nurse has been and continues to provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance. See 4.2	Complete		**Complete:** 31st March 2018			
				4.6 Report performance monthly at community and statutory services business meetings				Complete		**Complete:** 27th October 2017 and ongoing			
				4.7 Improve access to the ESR training database to improve accuracy and responsiveness to training			**Update 24th October 2017:** ESR App launched for phones for wider user engagement	Complete		**Complete:** 31st March 2017			
5	Must	Trust	**APLS** Must ensure that there is a member of staff trained in advanced paediatric life support available in every department at all times as outlined in the Royal College of Nursing guidelines	5.1 Perform Trust wide resuscitation Training Needs Analysis against national guidance	Hilda Gwilliams Chief Nurse	Rob Griffiths Theatre Manager / Phil O'Connor Deputy Director of Nursing	**Update 23rd October 2017:** Complete	Complete	In progress	**Complete:** 30th September 2017	Resuscitation Committee Clinical Quality Steering Group Clinical Quality Assurance	80% compliance against Trusts Resuscitation Policy	
				5.2 Recruit additional resuscitation training officers as required			**Update beginning of Feb 2018:** New leadership structure in place – complete.	Complete		31st December 2017			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				5.3 Update Resuscitation policy			**Update beginning of Mar 2018:** Resuscitation Policy ratified by CQSG on 13.2.18	Complete	~~31st December 2017~~ ~~31 January 2018~~ **Complete:** Feb 2018	Committee	Resuscitation Policy - C23.pdf	
				5.4 Develop phased roll out plan to maintain compliance against RCN standard based on service need			**Update 14 December 2017:** Resuscitation training SOP approved and implemented. 18 APLS courses planned for 2018 alongside 65 PLS courses	Complete	**Complete:** 30th November 2017		SOP - R01 - Resuscitation Training	
				5.5 Review compliance monthly at Resuscitation committee and Clinical Quality Steering Group			**Update 23rd October 2017:** Complete – Standing agenda item NB: still validating data on ESR	Complete	**Complete:** 30th November 2017		rc meet 28 Feb 2018 agenda..docx	
				5.6 Deliver 80% compliance to ensure APLS trained member of staff on each identified area per shift in line with service need			**Update beginning of Apr 2018:** 100% compliance achieved for having an APLS trained member of staff on every shift where required. Overall APLS compliance is on target to deliver 90% by March 2019.		31st January 2018 – 31st March 2019			
				5.7 Audit quarterly compliance against Resuscitation policy and phased roll out			**Update beginning of Feb 2018:** Resuscitation policy complete, awaiting ratification by CQSG. Audit commenced for the following: 1) Checking resuscitation trolleys 2) Emergency bleep test	Complete	31st January 2018			Safety Alert Checking Resuscitatic

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

6	Must	Trust	**Mandatory training** Must ensure that compliance with mandatory training is improved, particularly for medical staff.	6.1 Cleanse ESR system to ensure all roles are aligned to correct mandatory training competencies	Melissa Swindell Director of Human Resources and OD	Sharon Owen Head of Human Resources	**Update 24th October 2017:** Cleanse of competencies against positions in ESR has already been completed and has seen a significant increase in the figures reported. The Trust has sourced systems expertise to ensure ESR is set up to accurately report against the Trust requirements	Complete	Complete	**Complete:** 31st August 2017	Workforce and Organisational Development Committee	90% compliance in mandatory training	
				6.2 Produce and share regular detailed mandatory training reports at divisional and departmental level, reported by staff group which shows compliance down to individual staff member level			**Update 24th October 2017:** A full suite of detailed mandatory training reports have been compiled with targeted areas of low compliance being addressed	Complete		**Complete:** 31st January 2018			
				6.3 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update 24th October 2017:** L&D Officer has been meeting managers in areas where there is low compliance to establish a clear action plan that significantly increases compliance by end of January 2017	Complete		**Complete:** 31st January 2018			
				6.4 Scope development of further e-learning packages and the roll out of the ESR portal to provide staff with further means of accessing training			**Update beginning of Feb 2018:** Exercise required to finalise the position on the e-learning packages for all core subjects	Complete		~~31st January 2018~~ **Complete:** 31st March 2018 for the e-learning completion			
				6.5 Provide monthly Trust wide communication on mandatory training compliance			**Update 24th October 2017:** Communications has commenced and been issued trust wide on the importance of ensuring compliance with mandatory training and this will	Complete		**Complete:** 31st March 2018			
				6.6 Review and update training needs analysis in mandatory training policy			**Update beginning of Jan 2018:** Policy ratified	Complete		**Complete:** December 2017			P80. Mandatory Training Policy - M31

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7	Must	Trust	**Risk assessments** Must ensure that formal risk assessments are undertaken in all departments and all identified risks are captured on the risk register where needed	7.1 Undertake formal risk assessment on all wards assessing the level of risk posed by resuscitation equipment being in different areas within the ward	Melissa Swindell Director of Human Resources and OD	Rob Griffiths Theatre Manager / Phil O'Connor Deputy Director of Nursing	**Update 30th October 2017:** Risk assessment complete as new standardised trolleys implemented Trust wide as per action 11.1	Complete	In progress	**Closed:** 29th October 2017	Integrated Governance Committee Health and Safety Committee	Formal risk assessments will be undertaken in all departments with all identified risks captured on the risk register Risk Assessments and Risk Registers will be up to date with appropriate review dates and evidence that actions identified to mitigate risk are in place in the Medical and Surgical Divisions
				7.2 Undertake formal risk assessment on all wards assessing the risk of children absconding or being abducted		Greg Murphy LSMS	**Update 23rd October 2017:** As per action 12.4			Revised timescale: 30 April 2018		
				7.3 Develop a Trust wide plan to support staff to undertake formal risk assessments in all departments in line with the Trust Risk Management Strategy and Risk Assessment policy for: • Environment • COSHH • Display Screen Equipment (DSE)		Amanda Kinsella Health and Safety Manager	**Update beginning of Mar 2018:** Plan discussed at Workforce and OD Committee February 15th 2018. This will address actions in 7.3, 7.5, 7.7, 7.8, 7.9	Complete		~~31st January 2018~~ **Complete** 15 Feb 2018		
				7.4 Health and Safety team to upload generic Risk Assessments onto the Risk Register to prevent duplication of risk assessments and associated risks		Amanda Kinsella Health and Safety Manager	**Update beginning of Mar 2018:** Revising and reviewing risk assessments			~~30th November 2017~~ Revised timescale Sept 2018		
				7.5 Provide Divisions with generic templates for environmental and DSE risk assessments with best practice examples of how to complete		Amanda Kinsella Health and Safety Manager	**Update beginning of Mar 2018:** See 7.3	Complete		**Complete** 31st March 2018 and ongoing		
				7.6 Identify staff who have had the required training and experience to undertake lead roles in Divisions for corporate Health and Safety functions and subject specific risk assessments		Amanda Kinsella Health and Safety Manager	**Update 14 December 2017:** Action complete	Complete		30th November 2017		

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				7.7 In collaboration with Health and Safety team, ensure appropriate staff are trained and supported to undertake / be involved in undertaking risk assessments for environmental and DSE in line with the Trust Risk Management strategy		Amanda Kinsella Health and Safety Manager	**Update beginning of Mar 2018:** See 7.3	Complete		**Complete** 31st March 2018			
				7.8 In collaboration with Health and Safety team, ensure appropriate staff are trained and supported to undertake / be involved in undertaking stress risk assessments for staff as required		Amanda Kinsella Health and Safety Manager	**Update beginning of Mar 2018:** See 7.3	Complete		**Complete:** 31st March 2018			
				7.9 Widely disseminate Health and Safety training schedule		Amanda Kinsella Health and Safety Manager	**Update 14 December 2017:** Training schedule for Manual handling, risk assessment and stress risk assessment training has been disseminated. Further aspect of H&S Training to be rolled out in the New Year.	Complete		**Complete:** 30th November 2017			
8	Must	Community CAMHS	**Lone working** Must ensure that lone working practices are implemented, to ensure the safety of staff and others.	8.1 Each member of CAMHS staff to receive a copy of the Trust policy and CAMHS guideline and sign to they have read and understood the documents	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 14 December 2017** Task and Finish Group set up in Sefton. Next meeting 12th December. Signed forms received for 50% of staff. Aim to get all staff by the end of December 2017.	Complete	In progress	~~30th September 2017~~ ~~31st November 2017~~ **Complete:** Revised timescale 31st December 2017	CAMHS Clinical Governance Integrated Governance Committee	Safe and robust lone working practices are implemented and sustained	Lone Working mobile phones PADs .msg

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				8.2 Disseminate process for use of Trust mobile phones to all CAMHS staff			**Update 14 December 2017** SOP being developed for Liverpool CAMHS. Sefton CAMHS agreeing this process in Task and Finish group.	Complete	30th September 2017 ~~31st November 2017~~ **Complete:** Revised timescale 31st January 2018		Lone Working mobile phones PADs .msg
				8.3 Provide a briefing to all staff on the use of Personal Alarm Devices (PAD)			**Update 14 December 2017** Agreement on the type of devices to be used in Sefton not yet agreed – to be discussed and agreed at the next task and finish group 12th Dec 2017	Complete	30th September 2017 ~~31st November 2017~~ **Complete:** Revised timescale 31st December 2017		Lone Working mobile phones PADs .msg
				8.4 Test the PADs			**Update 14 December 2017** Order did not go forward due to disagreement of type of device. – to be discussed and agreed at the next task and finish group 12th Dec 2017	Complete	~~30th September 2017~~ **Complete:** 31st December 2017		
				8.5 Set up lone worker face to face training sessions with the Trust's LSMS to train on the policy and guidance			**Update February 2018** Sessions have been booked with the LSMS	Complete	~~15th November 2017~~ **Complete:** 31st January 2018		Lone Worker Sessions.msg RE Lone Worker Sessions.msg

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				8.6 Agree process for how lone working process is to be implemented for new starters on induction			**Update 14 December 2017** CAMHS induction checklist updated to cover Lone Worker policy and process.	Complete	**Complete:** 30th November 2017			CAMHS Induction Checklist.docx
				8.7 Audit of lone worker process			**Update beginning of Feb 2018** Audit tool being produced to audit implementation of guidance. First Audit to be completed April 2018.		~~31 January 2018~~ ~~28 February 2018~~ Revised timescale 31 April 2018			
9	Must	Community CAMHS	**Confidential information** Must ensure that the confidentiality of patient information is maintained, and that patient records are only accessible to authorised staff.	9.1 Provide keys to ensure and enable all offices can be locked if no one is in the office	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 26th October 2017:** Keys issued	Complete	**Complete:** 30th September 2017	CAMHS Clinical Governance Information Governance Committee Integrated Governance Committee	Patient confidentiality will be maintained with records only accessible to authorised staff	Sefton CAMHS IG poster.pptx IG SpotCheckProforma
				9.2 Implement the 'Clear Desk' policy			**Update 26th October 2017:** Communication sent to all CAMHS Sefton staff about the Clear Desk policy	Complete	**Complete:** 31st August 2017			
				9.3 Provide confidential waste bins on floor 4 and 5 to make it easier for staff to dispose of patient information safely, securely and promptly			**Update 26th October 2017:** Confidential waste bins in place	Complete	**Complete:** 31st August 2017			
				9.4 Undertake Information Governance spot check audits			**Update February 2018** Independent spot checks completed for Liverpool and Sefton by the IG Manager	Complete	~~31st December 2017~~ **Complete** 31 January 2018			
				9.5 Disseminate guidance on clear desk principles / safe haven procedures and secure emails to all staff			**Update 26th October 2017:** Shared at away day (May 17) and via email / business meeting	Complete	**Complete:** 31st May 2017			
				9.6 Staff to use booking schedule system to ensure that clinic rooms are used for			**Update beginning of Feb 2018:** Letter sent to all CAMHS staff	Comp	~~15th December~~			

				appointments only and not personal offices in order to support lone worker practices and information governance			by AW, Director of Mental Health			~~2017~~ **Complete:** 31st January 2018			

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Medicine and Surgery

No	Must / should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	Individual action BRAG	Overall action BRAG	Target completion date	Monitoring Committee	Required outcome / output	Evidence
10	Should	Medicine / Surgery	**Resuscitation roles** Review the systems in place to enable staff to be clear about their roles and responsibilities during an emergency resuscitation scenario	10.1 Deliver 90% compliance with Resuscitation Training policy	Hilda Gwilliams Chief Nurse	Rob Griffiths Theatre Manager Phil O'Connor Deputy Director of Nursing	**Update 23rd October 2017:** Commenced		In progress	31st March 2019	Resuscitation Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	90% compliance with Trusts resuscitation policy. 90% staff aware of their roles and responsibilities	
				10.2 Introduce in-situ emergency simulation training and ensure each ward / department receives this training twice a year			**Update beginning of Jan 2018:** Commenced in December 2017, plug programme developed for delivery across all clinical departments	Complete		**Complete:** 30th November 2018			
				10.3 Update Trusts Resuscitation policy and re-issue to all staff			**Update beginning of Mar 2018:** Resuscitation Policy approved 13.2.18	Complete		~~31st December 2017~~ ~~31 January 2018~~ **Complete:** February 2018			Resuscitation Policy - C23.pdf
				10.4 Audit staffs understanding of their roles and responsibilities during a resuscitation attempt			**Update beginning of Apr 2018:** Audit commenced with aim of 100 respondents.	Complete		~~28th February 2018~~ **Complete:** 31 March 2018			Cardiac Arrest questionnaire March 1
11	Should	Medicine / Surgery	**Resuscitation Equipment** Ensure that all resuscitation equipment on inpatient wards is checked fully in line with the hospital resuscitation policy	11.1 Roll out of new resuscitation trolleys, defibrillators with associated checklists and trolley checking standard operating procedure	Hilda Gwilliams Chief Nurse	Rob Griffiths Theatre Manager	**Update 23rd October 2017:** Complete 29th October 2017	Complete	Complete	**Complete:** 31st October 2017	Resuscitation Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	Resuscitation equipment checked in line with Trusts resuscitation policy	
				11.2 Audit compliance against new trolley checking standard operating procedure		Cathy Wardell Associate Chief Nurse Medicine Denise Boyle Associate Chief Nurse Surgery	**Update beginning of Jan 2018:** Trolleys are checked twice daily (start of day and night shift) by the nursing staff on the ward (they are sealed so only the top contents and the seal intact) after each use and a full contents check once a month. Draft SOP to be ratified at January's resus committee meeting.	Complete		~~31st December 2017~~ Revised timescale 31 January 2018			Resus Trolley deployment list.xlsx Trolley Defibs cheking audit (2).xlsx

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							Compliance is audited weekly by the resus team and issues highlighted to W.M / Sister and now incident reported. Audit is reviewed monthly at resus committee. As compliance increases this will be reviewed but whilst relatively new we will continue auditing weekly.						Resuscitation Policy - C23 Formatted For R
12	Should	Medicine / Surgery	**Absconsion / abduction** Review the systems in place to mitigate the risk of children and young people absconding or being abducted from the ward areas	12.1 Review child absconsion policy	Hilda Gwilliams Chief Nurse	Pauline Brown Director of Nursing	**Update beginning of Apr 2018:** Finalising policy and will go to next Policy Review Group meeting (March meeting cancelled)		In progress	~~31st January 2018~~ ~~31 March 2018~~ Revised timescale: 30 April 2018	Integrated Governance Committee	Risk of absconsion or abduction mitigated	
				12.2 Fit guards to all exit buttons on in-patient wards to make identification of the exit button less obvious		Greg Murphy LSMS	**Update 23rd October 2017:** Complete. Guards fitted to all exit buttons on in-patient wards August 2017. Spot check security audit conducted in September 2017 confirmed all in place	Complete		**Complete:** 30th September 2017			
				12.3 Issue a Trust Risk Alert reminding staff that risk assessments to be undertaken for children and young people considered to be at risk of absconding		Pauline Brown Director of Nursing	**Update beginning of Dec 2017:** Action complete	Complete		**Complete:** 30th November 2017			Safety Alert - Patients at risk of abs
				12.4 Annual risk assessment of abduction risk to be undertaken on all in-patient wards with Matrons / Ward Managers		Greg Murphy LSMS	**Update beginning Apr 2018:** Child abduction policy reviewed and updated on occupying the new hospital building Finalising policy and will go to next Policy Review Group meeting (March meeting cancelled)			~~31st March 2018~~ Revised timescale: 30 April 2018			
13	Should	Medicine / Surgery	**Mandatory training** Expedite plans and actions to enable all staff to improve compliance with mandatory training to the trust's target of at least	13.1 Disseminate Divisional mandatory training reports and specific communication produced by Learning and Development	Melissa Swindell Director of Human Resources and OD	Will Weston Associate Chief Operating Officer Medical Division			In progress	31st December 2018	Workforce and Organisational Development Committee	90% compliance in mandatory training	
				13.2 In collaboration with L&D						31st			

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			90%	team, devise specific and targeted actions in any areas with compliance less than 90%		Andy McColl Associate Chief Operating Officer Surgical Division				December 2018			
14	Should	Medicine	**Medical records** Have safe storage facilities in place for medical records on all wards to protect children and young people's confidentiality	14.1 Review system in place on Surgical Wards where CQC found that all paper based records were stored securely and were clearly identifiable at every nursing station	Hilda Gwilliams Chief Nurse	Catherine Wardell Associate Chief Nurse	This has been actioned and responsibility given to ward managers who are presently looking at different note trolleys as well as the ones on surgical wards.	Complete	Complete	**Complete:** 31st December 2017	Information Governance Committee Integrated Governance Committee	Medical records will be safely stored to protect confidentiality	
				14.2 Implement same system on Medical Wards to ensure a safe and consistent approach throughout the hospital			**Update beginning of Jan 2018:** Revised timescale 31 January 2018 **Update beginning of Feb 2018:** Trollies or storage system in place. Ward Managers & Staff vigilant in not leaving notes around.	Complete		~~31st December 2017~~ **Complete:** 31 January 2018			
15	Should	Medicine	**Disease Specific Pathways** Have disease specific pathways in place that are based on up to date evidenced based practice and a system for assurance during the period of transition from paper to electronic pathways	15.1 Review and disseminate diabetic pathways	Steve Ryan Medical Director	Adrian Hughes Associate Medical Director Medicine	**Update 27th October 2017:** • Revised DKA guideline has been in operation since May 2017. • The newly diagnosed guideline has been rewritten and has been emailed out to the diabetes team who have made no further changes, this should be ready to use as soon as it can be released. • The Hyperglycaemia guideline has been rewritten and is awaiting team approval (this also forms part of the surgical guideline) • The Type 2 guideline is a new document and is currently in draft form, I'm aiming to have this available for use later in the summer.		In progress	• **Complete** • Timescale April 2018 • Timescale April 2018 • Timescale July 2018	Divisional Risk and Governance Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	Guidelines.pptx Specific disease pathways will be in place Trust will be assured of patient safety during transition from paper to electronic pathways	

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				15.2 Design and develop a website for and with our diabetic patients and their families in order to provide comprehensive and up to date accessible information and education			**Update 27th October 2017:** Website development underway with involvement from a patient and parent		31st December 2018			
				15.3 Implement the Alder Hey Acute Asthma pathway based on the British Thoracic Society guidance issued in September 2016			**Update 27th October 2017:** Alder Hey Asthma pathway in use from November 2016. Input into BTS guidance by Alder Hey consultant. The Alder Hey pathway is being adopted by other centres nationally as best practice	Complete	**Complete:** November 2016			
				15.4 Implement the Alder Hey Bronchiolitis pathway developed in conjunction with patients and families			**Update 27th October 2017:** Alder hey Bronchiolitis pathway in use from April 2017. The pathway has a focus on empowering parents to hold and feed babies. When compared with other pathways known to the team the parental empowerment is what makes this pathway unique	Complete	**Complete:** 30th April 2017			
16	Should	Medicine / Surgery	**Appraisals** Improve staff appraisal rates to reach the at least the trust's target of 90%	16.1 Ensure the process for appraisals (PDR's) is communicated widely across the Trust so that all staff are aware of their role and responsibilities. This includes the process that there is a four month window annually (commencing April) in which to complete the PDR's across the Trust in order to manage the process effectively and ensure all staff have opportunity to reflect how Trust objectives align to their role	Melissa Swindell Director of Human Resources	Will Weston Associate Chief Operating Officer Medical Division ~~Adam Bateman~~ Andy McColl Associate Chief Operating Officer Surgical Division	**Update 14 December 2017:** PDR 84% on 29/11/17. Slow, but sure improvement over the last two months. Next step is to cleanse ESR to make sure all staff listed against division of medicine are correct. ESR export sent to service and operational managers to complete and sent back to HR for validation and amendments are made week commencing 4/12/17.	Complete	In progress	**Complete:** 30th November 2017	Workforce and Organisational Development Committee Divisional Board	90% compliance with staff appraisal rates	
				16.2 Provide training to support managers with the process and to facilitate effective PDR's by reviewing performance for the year, reviewing achievements against agreed developments and planning of personal developments for the forthcoming year			**Update 30th October 2017:** Training in place	Complete	**Complete:** 31st October 2017 and ongoing			

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				16.3 Produce and share regular detailed PDR reports at divisional and departmental level			**Update 14 December 2017:** PDR reminders sent out regularly e.g. 06/11/2017.	Complete		**Complete:** 30th November 2017 and ongoing			
				16.4 Review local progress on ESR			**Update beginning of Mar 2018:** Clinton completes, which will allow for easier and more accurate analysis of target areas.	Subject to Monthly		No completion date – subject to monthly monitoring			
				16.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update beginning of Apr 2018:** 2018/19 PDR window now open managers will be provided with local data and support to ensure compliance in all areas by end of July 2018.	Subject to Monthly monitoring		30th November 2017 and ongoing No completion date – subject to monthly monitoring			
				16.6 Annual review of PDR documentation and update as required			**Update beginning of Apr 2018:** 2018/19 Documentation has been confirmed as the same as last year and is available on the intranet	Complete		**Complete:** 31st March 2018			
17	Should	Medicine	**MHA Training** Consider training on the Mental Capacity Act for clinical staff being part of the mandatory training	17.1 Review the requirement / content for mandatory training on the Mental Capacity Act with Trust Learning and Development department	Melissa Swindell Director of Human Resources	Catherine Wardell Associate Chief Nurse Medical Division	**Update beginning of Mar 2018:** C Wardell liaising with J Knowles to action this.		In progress	~~31st January 2018~~ Revised timescale April 2018	Clinical Quality Steering Group Clinical Quality Assurance Committee	All staff receive appropriate mandatory training	
18	Should	Medicine	**Display Screens** Ensure visual display screens on the wall behind the desk to the entrance of wards do not compromise patient confidentiality	18.1 Review practice at Information Governance Committee meeting	Hilda Gwilliams Chief Nurse	Catherine Wardell Associate Chief Nurse Medical Division	**Update beginning of Mar 2018:** Privacy Impact Assessment undertaken. Consideration to be given to relevance of display screens.	Complete	In progress	~~31st January 2018~~ **Complete:** March 2018	Information Governance Committee Integrated Governance Committee	Relevant information to maintain patient safety and patient flow is available and patient confidentiality is not compromised	PIA Screening V1 - electronic whiteboard
				18.2 Benchmark practice with other paediatric hospitals / wards			**Update beginning of Apr 2018:** Benchmarking exercise to be undertaken via the Association of Chief			End of April 2018			

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							Children's Nurses					
				18.3 Scope the impact that turning off the visual display screens in some medical wards has had			**Update beginning of Apr 2018:** Impact scoped. The risk balance is that of being able to identify at a glance the upcoming care and treatment required by an individual patient (for example medication due) versus a member of the public being able to view the patients name – particularly in a safeguarding case. Therefore users must identify when a safeguarding risk is high and consider not using the display screens in these circumstances. This will be presented to April IGC with a view to their sign off of this practice	Complete	**Complete:** March 2018			
19	Should	Medicine / Surgery	**Risk Registers** Identify review dates on all risk registers and review monitor that actions identified to mitigate risk are in place in medical services and surgical services	19.1 Review Risk Register at Divisional Board / Risk and Governance meetings or bespoke Divisional Risk Register meeting	Hilda Gwilliams Chief Nurse	Adrian Hughes Associate Medical Director for Medicine Christian Duncan Associate Medical Director for Surgery	**Update beginning of Apr 2017:** 'Risk Register review' added as a SAI of the Surgical Division's Integrated Governance & Quality Assurance Board meeting.		In progress	31st December 2018	Integrated Governance Committee	Risk Registers will be up to date with appropriate review dates and evidence that actions identified to mitigate risk are in place in the Medical and Surgical Divisions Focused assurance, that each and every risk is being managed effectively, i.e. risks clearly identified from assessment, risk rating reflects assessment of controls, gaps in controls, actions for improvement and progress	
				19.2 Risk Managers to be identified on each risk assessment, in addition to Risk Owners			**Update 30th October 2017:** All risks currently under review as per action 19.4 and all Risk Managers will be assigned. **Update beginning of Apr 2017:** Now complete	Complete		**Complete:** 31st December 2018		
				19.3 Ensure all staff responsible for inputting and managing risks on the Risk Register are trained and aware of their role and responsibilities			**Update beginning of Apr 2017:** Training available within the Trust All staff identified within Division of Medicine have had training in risk management Train the trainer approach to be considered to develop risk			31st March 2018 and ongoing		

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							management expertise across the Trust, and a systematic cascade of training in each Division					with actions, review completed in line with timeframes identified on risk assessment, and escalation completed in a timely manner.
				19.4 Set up immediate Task and Finish group for each Division to validate risk registers attended by the senior team for each of the three Divisions			**Update 30th October 2017:** Monthly corporate meetings to support Divisions to review and progress Risk Registers have been commenced Chaired by the Associate Director of Risk and Governance. Meetings will take place for a minimum of six months to ensure significant assurance evident that risk is managed effectively and understood An additional meeting to be set up to support corporate services (for example medicines management, health and safety, infection control, information governance and records management, Governance and quality assurance, IM&T, Business Continuity) in the same way	Complete	**Complete:** 20th October 2017 and ongoing	Corporate risk registers to include all high risks only and linked to corporate objectives
				19.5 Each Division to present their Risk Registers, focusing on high risks or others that may impact on the achievement of corporate objectives, at all Integrated Governance Committee meetings			**Update beginning of Jan 2018** Presentation of Divisional Risk Registers at Integrated Governance Committee has commenced Committee reports presented to focus on level of risk associated with the issues being presented, and actions to mitigate to achieve target risk rating. **Work ongoing** Risks elevated to 15 or above to transfer to executive responsible for associated corporate objectives, until mitigated to at least a high	Complete	**Complete:** 31st December 2017 **Remains in progress**	

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							moderate (meaning risk score = 12) and then transfer back to original risk owner. Management of the risk locally to remain with the identified risk manager / function where risk originated as identified on the Risk Register	Complete	In progress				
20	Should	Medicine / Surgery	**Ward Curtains** Consider implementing a schedule for replacing curtains in the ward areas	20.1 Update the programme for planned curtain replacement, according to risk category	Hilda Gwilliams Chief Nurse	Lesley Cooper Domestic Operations Manager	**Update 14 December 2017** Programme has been updated according to risk category Very High Risk – 3 months High Risk – 6 months Significant Risk – 12 months	Complete	In progress	**Complete:** 30th November 2017	Infection Prevention and Control Committee	100% compliance with planned replacement programme	
				20.2 Audit compliance with updated replacement programme on a quarterly basis			**Update 14 December 2017** This is planned to commence as per date agreed, records will be stored on k drive			Quarterly commencing 31st March 2018			
				20.3 In addition to planned replacement, replace curtains as part of an environmental deep clean and on request if visibly not clean			**Update 14 December 2017:** Curtains are replaced on an ongoing basis if not visibly clean and always when a deep clean is undertaken	Complete		**Complete:** 30th November 2017 and ongoing			
21	Should	Surgery	**SSI** The management team should consider ways in which to improve monitoring of surgical site infections for patients who have undergone non-specialist surgery	21.1 Develop a Business Case to support the delivery of surgical site infection (SSI) data for all specialities within the Surgical Division	Steve Ryan Medical Director	Christian Duncan Associate Medical Director Surgical Division	**Update 26th October 2017:** Complete. Business case approved by Divisional Board and Investment Review Group 27th July 2017	Complete	In progress	**Complete:** 27th July 2017	Surgical Division Infection Control Board Infection Prevention and Control Committee	Improved monitoring of SSI in non-specialist surgery with associated opportunity to learn lessons, improve practice and reduce rates of infection	
				21.2 Recruit to data analyst role			**Update January 2018:** We have now recruited 1.4WTE site surveillance officers into post with start dates of mid Feb.	Complete		**Complete:** Revised timescale end Feb- mid March 2018			
				21.3 Develop the required SSI			**Update February 2018:** Staff have been recruited and are in post, one started 12/02/18, the 1.0 FTE starts	Complete		31st January 2018			

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							first week of March.					
				21.4 Commence SSI data collection			**Update beginning of Apr 2018:** Full time SSI Officer commenced in post and has started data collection. We are also in the process of re-appointing a 0.3 SSI officer.	Complete	**Complete:** Revised timescale March 2018			
				21.5 Review and disseminate reports of SSI data findings within the Surgical Division and to the Trust through Infection Prevention and Control Committee			**Update beginning of Apr 2018:** Electronic database now developed – data not yet ready for dissemination.		~~31st March 2018~~ Revised timescale 30 June 2018			
22	Should	Surgery	**CD Discard** The management team should make sure that discarded controlled drugs across all departments are recorded appropriately	22.1 Pharmacy to undertake audit of all wards every 6 months as per Medicines Management Code Section 12	Steve Ryan Medical Director	Catrin Barker Chief Pharmacist	**Update 26th October 2017:** April audit demonstrates the following improvements since the last audit: 1. Recording of wastage at ward / departmental level 57% to 82% since previous audit 2. Documenting of administration/destruction from 72% to 94% since last audit		In progress	31st April 2018	Medicines Management Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	All controlled drugs discarded will be recorded appropriately
				22.2 Share audit results with Ward Manager and Matron to establish local action plan for improvement Ward Manager or Matron to re-audit a month later to ensure actions implemented and compliance improved to acceptable standard						31st April 2018		
				22.3 Liaise with other hospitals to check and benchmark practice for discarding controlled drugs (CD)			**Update beginning of April 2018:** Reminders about disposal at ward level have been sent out. A CD audit of compliance is being completed to check response. Details on alternative CD books have been obtained. PICU and HDU are to try			31st December 2017 – and ongoing		CD in theatre template.docx Controlled Drugs in Theatres_April2016 (.

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							using the Theatre style CD books. Suitable ward CD registers are being looked into.						 Ward Controlled Drugs Oct 2016.pptx
				22.4 Investigate whether CD books are available that allow for discards to be recorded more clearly			**Update January 2018** Only suitable when wards mostly giving injections.	Complete	**Complete:** 31st December 2017				
				22.5 Provide training to ward staff to ensure they are aware of their role and responsibilities regarding recording discards as per Medicines Management Code Section 12			**Update January 2018:** Training package sent to ward managers for use	Complete	30th November 2017 and ongoing				
				22.6 Review Medicines Management Code and update as required			**Update January 2018:** The MMC has been reviewed and reflects the current legally required processes for management of CDs.	Complete	**Complete:** 31st December 2017				
23	Should	Medicine / Surgery	**MAR** The management team should consider ways in which to improve the meditech system so that it accurately reflects the time that medicines had been administered, reducing the potential risk of a medication overdose	23.1 Issue a Safety Alert advising users of the correct way to close a MEDITECH session to avoid the system closing before all data has saved	Steve Ryan Medical Director	Cathy Fox Head of Clinical Systems	**Update 25th October 2017:** Action complete. Two Safety Alerts have been sent to all users	Complete	**Complete:** October 2017	Global Digital Exemplar Programme Board Operational Delivery Board	Accurate recording of medication administration to reduce the risk of associated medication errors		
				23.2 Complete testing and sign off of Multi User Desktop. Multi User Desktop is enhanced functionality as part of Fast User Switching which allows up to four user accounts to run simultaneously on a computer. This will significantly reduce the risk of a MEDITECH session closing prematurely before data, such as medicines administration, has saved				Complete	**Complete:** 4th November 2017				
				23.3 Commence pilot of Multi User Desktop in Emergency Department and Ward 3A to support use of the ELIS system with appropriate end user support			**January 2018:** Pilot commenced. Now in the process of reviewing the outcome of the pilot and next steps for the roll-out.	Complete	**Complete:** 1st December 2017				

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				23.4 Present pilot results and rollout plan to Global Digital Exemplar Programme Board on 12th December 2017. If agreed, commence rollout to all clinical areas with appropriate end user support from January 2018						31st May 2018			
24	Should	Medicine / Surgery	**Ward Co-ordinator** The hospital should find ways in which to make sure that there is always a supernumerary co-ordinator available in all areas, at all times to support staff	24.1 Undertake annual establishment of ward areas based on national standards (Royal College of Nursing / Paediatric Intensive Care Society / British Association of Perinatal Medicine), patient acuity and professional judgement	Hilda Gwilliams Chief Nurse	Pauline Brown Director of Nursing / Divisional Associate Chief Nurses	**Update March 2018:** In November 2017, the National Quality Board published improvement tools specifically for the care of children and neonates: Safe, Sustainable and Productive Staffing: An improvement resource for children and young people's in-patient wards in acute hospitals / neonatal care. A review of all ward establishments will take place from February to June 2018 in line with the new NQB improvement tools and the findings will be reported back to Trust Board in September 2018		In progress	~~28th February 2018~~ Review findings to Board Sept 2018	Clinical Quality Assurance Committee		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				24.2 Undertake annual audit of nurse staffing against RCN core standards to identify gaps			**Update March 2018:** An audit against the RCN standards has been repeated in February 2018 involving the Ward Managers, Matrons and Associate Chief Nurses for all in patient and day case wards. A previous audit of compliance against the core standards conducted in February 2017 demonstrated Trust compliance with 11 standards, partial compliance with 3 standards and no compliance with one standard. The recent audit has demonstrated an improvement against the standards compared to February 2017 with one standard moving from a RAG rating of Red no compliance to Amber partial compliance following the appointment of Matrons, and a comprehensive review of resuscitation training incorporating identified service need for APLS trained nurses on each shift. Audit result forms part of Trust Board Nursing Workforce paper to be presented at March 2018 Board	Complete		**Complete:** 28th February 2018			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				24.3 Review nursing model in wards where a supranumery co-ordinator is not currently being allocated			**Update March 2018:** Nursing model reviewed as part of the RCN audit. Improved position. PICU, HDU, Ward 4A and Ward 1C Neonatal (day only) already had funded establishment above the baseline bedside funded establishment for a supernumery shift co-ordinator. In 2017 funded establishment increased on Ward 1C Cardiac (day only) to enable supernumery shift co-ordinator. Additional funding now agreed for Ward 3A which will enable a supernumery co-ordinator 24 hours per day. All Ward Managers supernumery. All wards now benefit from presence of a supernumery Matron. All wards allocate a nurse to take charge and co-ordinate the shift. This model requires nurses on the shift to increase the number of patients they care for to facilitate a supernumery co-ordinator, or the co-ordinator cares for patients as well as taking charge of the ward	Complete		**Complete:** 28th February 2018			
				24.4 If a gap in funded establishment is identified which is contributing to no supranumery co-ordinator, escalate to the attention of the Trust Board through bi annual nurse staffing paper			**Update beginning of April 2018:** Staffing paper presented to Trust Board of Directors on 6 March 2018. Improved position and gaps noted by Board	Complete		**Complete:** 30th March 2018			13. Nurse Workforce Report.pdf

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

25	Should	Medicine / Surgery	**Appraisals** The management team should ensure that all staff receive a full annual appraisal in line with the trust supervision policy	25.1 Ensure the process for appraisals (PDR's) is communicated widely across the Trust so that all staff are aware of their role and responsibilities. This includes the process that there is a four month window annually (commencing April) in which to complete the PDR's across the Trust in order to manage the process effectively and ensure all staff have opportunity to reflect how Trust objectives align to their role	Melissa Swindell Director of Human Resources	Will Weston Associate Chief Operating Officer Medical Division ~~Adam Bateman~~ Andy McColl Associate Chief Operating Officer Surgical Division	**Update December 2017:** PDR 84% on 29/11/17. Slow, but sure improvement over the last two months. Next step is to cleanse ESR to make sure all staff listed against division of medicine are correct. ESR export sent to service and operational managers to complete and sent back to HR for validation and amendments are made week commencing 4/12/17.	Complete	In progress	**Complete:** 30th November 2017	Workforce and Organisational Development Committee Divisional Board	90% compliance with staff appraisal rates
				25.2 Provide training to support managers with the process and to facilitate effective PDR's by reviewing performance for the year, reviewing achievements against agreed developments and planning of personal developments for the forthcoming year			**Update 30th October 2017:** Training in place	Complete		**Complete:** 31st October 2017 and ongoing		
				25.3 Produce and share regular detailed PDR reports at divisional and departmental level			**Update beginning of Dec 2017:** PDR reminders now sent out regularly e.g. 06/11/2017.	Complete		**Complete:** 30th November 2017 and ongoing		
				25.4 Review local progress on ESR			**Update beginning of Mar 2018:** Waiting for appraisal window to open on first April. Booking appraisals into the calendar currently	Subject to Monthly monitoring		No completion date as training compliance tasks will renew on an annual basis (or three yearly depending on training cycle)		
				25.5 Provide designated and targeted support to those areas of low compliance and work with managers to establish action plans to achieve a minimum of 90% compliance			**Update beginning of Mar 2018:** Targeted work continues by Associate Chief Nurse and Divisional HR Business Partner to address low PDR completion and relatively high sickness rates.	Subject to Monthly monitoring		No completion date as training compliance tasks will renew on an annual basis (or three yearly		

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

									depending on training cycle)				
				25.6 Annual review of PDR documentation and update as required			**Update beginning of April 2018:** Appraisal window opens 2/4/18. Staff currently encouraged to book in appraisals in advance of this window which will run until July. Documentation has been confirmed as the same as last year and is available on the intranet.	Complete	**Complete:** 31st March 2018			
26	Should	Surgery	**Cancelled operations** The hospital should consider ways in which to reduce the number of cancelled surgical procedures, and when this does happen to facilitate a further appointment within 28 days of the cancellation	26.1 Undertake capacity and demand modelling for the surgical wards	Mags Barnaby Chief Operating Officer	~~Adam Bateman~~ Andy McColl Associate Chief Operating Officer Surgical Division	**Update 30th October 2017:** Modelling completed for the winter period. However the 'Best in Operative Care' steering group are progressing an annual plan based on annual bed occupancy This has meant that this winter operationally the Trust has implemented maximum in patient numbers per day, per ward This should see a real reduction in on the day cancellations and will be monitored daily	Complete	In progress	**Complete:** 27th October 2017	Operational Delivery Board Forward View meeting	The hospital should consider ways in which to reduce the number of cancelled surgical procedures, and when this does happen to facilitate a further appointment within 28 days of the cancellation	
				26.2 Realign the Operating Theatre schedule to balance out the elective patients across the week						30th April 2018			
				26.3 Implement a daily huddle to review the day ahead based on winter pressures and to review any on the day cancellations that day and identify clear actions to ensure that the patient is re-dated within 28 days			**Update 30th October 2017:** Complete, daily huddle implemented from 30th October 2017	Complete		**Complete:** 27th October 2017			
				26.4 Introduce an escalation process whereby any patients not given an appropriate date are escalated to a senior manager to resolve with clinical teams			**Update 30th October 2017:** Complete, commenced 30th October in line with the daily huddle	Complete		**Complete:** 27th October 2017			

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				26.5 Implement a more robust reminder service for patients			**Update 30th October 2017:** Currently this is a manual call however via the 'GDE Programme' we are progressing a two way text reminder service		31st May 2018			
				26.6 Review why discharges are delayed, resulting in lack of bed availability, within the Surgical Division utilising Clinical Utilisation Review (CUR)			**Update 30th October 2017:** Complete. Review undertaken and supporting actions identified following the review are: • Implement Nurse led discharge process • Increased nurse led prescribing- allowing those patients awaiting TTO's to be discharged by the nursing team • Estimated discharge dates given to all patients on admission with a clear plan to achieve this. This date will be visible for families and clinical staff	Complete	**Complete:** 27th October 2017			

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Community CAMHS

No	Must/ should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	Individual action BRAG	Overall action BRAG	Target completion date	Monitoring Committee	Required outcome / output	Evidence
27	Should	Community CAMHS	**Risk Assessments** Should ensure that all risk assessments are routinely reviewed, and the outcome of these reviews is clearly documented	27.1 GDE CAMHS work to include making the process of managing and viewing the risk assessments clearer	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update February 2018** Work in on going – process is in test mode currently – aiming for full implementation in May.		In progress	~~31st January 2018~~ Revised timescale May 2018	CAMHS Clinical Governance	Risk assessments are routinely reviewed, and the outcome of these reviews is clearly documented	Super SOP meeting.ics CAMHS Record Keeping Audit Tool.dc
				27.2 Development of a Super SOP to incorporate the processes for risk assessment			**Update March 2018** Progress being made – to confirm target date for first draft at the next CAMHS governance meeting.			~~29th February 2018~~ Revised timescale April 2018			
				27.3 Monthly audit of record keeping			**Update 14 December 2017** First audit of 20 records completed – audit results being written up. Some minor changes needed to audit form. Discussion of results from this first audit to be discussed at the CAMHS Governance meeting 21/12/17.	Complete		**Complete:** 30th November 2017			
28	Should	Community CAMHS	**Furniture** Should ensure that the environment, including furniture, is clean, well maintained, and in a good state of repair	28.1 Undertake environmental risk assessments	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update 14 December 2017** CAMHS Sefton risk assessment – 3 rooms outstanding	Complete	Complete	~~30th September 2017~~ ~~10th November 2017~~ **Complete:** 31st December 2017	CAMHS Clinical Governance	All furniture will be clean, well maintained, and in a good state of repair	Environmental Risk Assessment - Liverpo
				28.2 Risk assess whether appropriate to move furniture from current locations to new sites			**Update February 2018** Meetings progressing regarding move – proposed move of June 18.	Complete		**Complete:** 31st January 2018			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

29	Should	Community CAMHS	**Design / decoration** Should ensure that the design and decoration of the environment is suitable for children and young people	29.1 Consider as part of the move from existing locations to new sites for Sefton and Liverpool. Involvement of the patient users groups to be set up	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update January 2018** Work is ongoing with the patient groups. Sefton move to take place first.	Complete	Complete	31st December 2018 - ongoing	CAMHS Clinical Governance	The design and decoration of the environment will be suitable for children and young people evidenced by the involvement of patient user groups	
30	Should	Community CAMHS	**Soundproofing** Should ensure that all rooms are adequately soundproofed	30.1 Obtain advice from the Estates department on monitoring sound proofing	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update January 2018** Estates have designed the partitioning to clinic rooms in Burlington to have a 'severe' duty acoustic value of 51 db	Complete	In progress	**Complete:** 10th November 2017	CAMHS Clinical Governance	All rooms will be assessed for soundproofing	
				30.2 Clarify which clinic rooms currently have adequate sound proofing and those that lack sound proofing			**Update February 2018** Due to false ceilings and walls no consultation rooms are soundproof. Move to new location in June 18	Complete		~~31st December 2017~~ **Complete:** 31st January 2018			-
				30.3 Ensure rooms in new locations are assessed for sound proofing prior to moves			**Update February 2018** Will be tested prior to move in June 18.			~~31st December 2018~~ Revised timescale June 2018			-
31	Should	Community CAMHS	**Languages** Should ensure that people are provided with information in a language or format they understand	31.1 Undertake a review of Trust current position on the translation of clinic letters / reports / patient information	Andrew Williams Director of CAMHS	Sarah Stephenson Head of Quality	**Update March 2018** Trust policy being reviewed and updated.		In progress	~~30th November 2017~~ ~~31 January 2018~~ Revised timescale end of April 2018	CAMHS Clinical Governance	Ensure that people are provided with information in a language or format they understand	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				31.2 Undertake a review of how other organisations provide information in a language or format that families can understand			**Update February 2018** Completed	Complete		~~31st December 2017~~ **Complete:** 31st January 2018			
				31.3 Implement actions based on feedback			**Update March 2018** Need to confirm all correspondence has been updated.			~~31st December 2017~~ ~~31st January 2018~~ Revised timescale End of April 2018			
32	Should	Community CAMHS	**Staff morale** Should ensure that effective strategies are in place to improve morale	32.1 Present update reports from the two working groups (Sefton / Liverpool) to the CAMHS Board	Andrew Williams Director of CAMHS	Kate Brizell General Manager CAMHS	**Update February 2018** To go to March 18 Board	Complete	Complete	~~31st January 2018~~ **Complete:** 28 February 2018	CAMHS Board	Should ensure that effective strategies are in place to improve morale	CAMHS BOARD STAFF MORALE PRES STAFF MORALE REPORT 2017 FINAL Quality Update - Oct 2017.pptx Quality Update - Nov 2017.pptx
				32.2 Widely share the compliments and achievements in the monthly Quality Updates			**Update 26th October 2017:** Standing section for the Quality Updates from September 2017	Complete		**Complete:** 30th September 2017			
				32.3 Explore a Divisional 'Star of the Month'			**Update 14 December 2017** Decision made to use Trust process and use this to nominate staff from the division. Nominations being made	Complete		**Complete:** 30th November 2018			
33	Should	Community CAMHS	**Raising concerns** Should ensure that staff feel confident in raising concerns about the service.	33.1 Monitor logging of Ulysses incidents to ensure incidents for all areas are increasing	Andrew Williams Director of CAMHS	Sarah Stephenson Head of Quality	**Update 14 December 2017** Incidents across CAMHS are increasing. Sessions held with staff at Liverpool and Sefton. Incidents are monitored and reported in the monthly Quality Update which shows the	Complete	Complete	**Complete:** 30th September 2017 and ongoing	CAMHS Clinical Governance	Enable staff to feel confident in raising concerns about the service and ensure staff know how they	Quality Update - Dec 2017.pptx

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

							increasing levels of incident reporting.				can raise concerns	Incident reporting process - 2017 - AH s
				33.2 Promote the use of existing Trust mechanisms for raising concerns including 'Raise It Change It' and 'Freedom to Speak Up' through wide communications to teams			**Update February 2018** Quality Update and Integrated Governance meeting in February 2018	Complete	~~30th November 2017~~ Revised timescale **Complete:** 31st January 2018			
				33.3 Investigate option for Community Head of Quality to become a Freedom to Speak Up Champion for the Division			**Update February 2018** Two FTSU identified for Community Division. Details on Trust intranet page.	Complete	~~31st October 2018~~ **Complete:** 31st January 2018			Freedom to Speak Up.msg

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Amber action from 2015 inspection Action Plan

21. Continue to develop relationships with adult health and social care providers to ensure the safe and effective transition of care for young people					
Outcome	**Actions**	**Responsibility**	**Time-frame**	**Assurance**	**Progress**
Overarching Transition Framework agreement across Healthy Liverpool	Develop shared framework with relevant partners	MD/ Clinical Lead	12 months	Healthy Liverpool Programme governance	**Update beginning of April 2018:** The Transition team met with specialist commissioner NHSE in January to discuss moving forward with the plans for the complex patient CQUIN. The Transition team met with Transition leads at St Helens and Knowsley (Whiston) DON, and Chief Nurse from Aintree. Plans have been discussed regarding Transition of patients with complex neuro-disabilities. Both Trusts are planning meetings with Consultant Specialists Neuro/Gastro/ respiratory and the equivalent Consultants from AHFT to be in attendance to discuss a number of patient cases, and what the adult services may require from AHFT in terms of support, in order to take over the care of this complex group of YP. A provisional date for the Aintree meeting has been set for the 22nd June 2018. All patients over the age of 18 years on the Transition Exception Register (TER) have identified consultant leads. We have met with the service managers, and engaged with most of the Consultant leads and confirmed plans to deliver Clinical Transition preparation for most patients. Non clinical transition preparation has commenced for all the over 18 year old patients with complex neuro-disabilities, and all these patients have dates up to June 2018. AHFT Executive Transition Lead has formally written to all Trusts in the Region on three occasions, asking for a named Transition lead in their organisations for AHFT Transition team to contact and work with. To date all milestones of the Complex patient CQUIN have been achieved, in parallel to implementing Transition into four additional specialities this year. Transition into Meditech 6 is designed and went live two weeks ago, as did the TER. The GDE team have advised the designated team (Transition team) once trained, it is the designated teams are responsible to deliver this training, and the GDE team move onto other projects. The Transition team have discussed adding this to the Transition training. The end of year report is to be finalised by next week. Awaiting further Transition CQUIN milestones for year two, NHSE have been contacted and enquiries made regarding this. • AHFT Transition team continue to chair the North West Transition Network and TFSL Regional Action Group (Combined meeting/TER) • A member of the Transition team represented AHFT at the Manchester CHWWB on a Transition workshop, and delivered AHFT Transition work to date. Since we have been invited back to support their developments in June this year • A member of the transition team presented on request to an AQuA Transition workshop. Following this AHFT Transition team have been invited to support AQuA to develop the Transition Curriculum for the coming year. • Transition team continue to support the PhD Student who is researching the 10 steps Transition pathway • Transition team continue to deliver transition training, and last month delivered

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

					Transition training to two CQC inspectors in Formby whilst presenting to community physiotherapists, OT's and SALT. • Transition teams second article almost ready for publication • Transition team with Edge Hill will soon be finalising the MCA, DOL's and Best interest patient and parent information leaflet, to use when transition planning commences The 3rd annual North West Collaborative Transition Conference is planned for the 29th June 2018, and sponsorship has been secured to fully support this event, to enable all delegates to attend free of charge. This will be advertised this week on Eventbrite.	

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 1 May 2018

Report of	Director of Corporate Affairs
Paper prepared by	Governance Manager
Subject/Title	Directors' Register of Interest 2017/18
Background papers	N/A
Purpose of Paper	The purpose of this paper is to provide the Board with the Register of Directors Interests 2017/18
Action/Decision required	The Board is requested to receive and note the Register of Directors Interests 2017/18
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Robust corporate governance arrangements support the achievement of all Trust Strategic Objectives: ➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	N/A

1. Executive Summary

This paper provides the current Register of Directors Interests. Updates to the register are provided to the Board at annual intervals, and in line with the Trusts Declaring Conflicts of Interest and Gifts and Hospitality Policy. Directors have a responsibility to inform the Director of Corporate Affairs when a new interest arises.

2. Current position

The Codes of Conduct and Accountability for NHS Boards, require the declaration of Board Members' and Directors' interests and the maintenance of a register of interests. This is reinforced through the Trusts Standing Orders.

The Board has a clear view that it aspires to the highest standards of probity and governance. Setting out publicly its Declarations of Interests makes it clear to key stakeholders, commissioners and the public that the Board aims to meet these standards and ensure good conduct in public business.

3. Recommendation

The Board is requested to note the Directors Register of Interests attached at appendix A.

Alder Hey Children's NHS
NHS Foundation Trust

REGISTER OF DIRECTORS' INTERESTS 2017/18

	Political Party / Charitable or Voluntary Organisation Interests relevant to the Work of the Trust	Nothing to declare
Sir David Henshaw (Trust Chair)	**Name of organisation:** Sir David Henshaw Partnership Ltd. **Relationship:** Consultancy **When did business interest begin:** **How is this relevant to the Trust:** no conflict at present **Name of organisation:** National Museum Liverpool **Relationship:** Chair **When did business interest begin:** March 2017 **How is this relevant to the Trust:** no conflict at present	
Steve Igoe (Non-Executive Director)	**Name of organisation:** Edge Hill University (EHU) **Relationship:** Deputy Vice Chancellor **When did business interest begin:** Jan 1996 **How is this relevant to the Trust:** EHU holds a partnership with Alder Hey **Name of organisation:** Institute of Chartered Accounts in England **Relationship:** Member **When did business interest begin:** September 1986 **How is this relevant to the Trust:** Professional Body	

Anita Marsland (Non-Executive Director)	**Name of organisation:** UHS **Relationship:** Director & Owner **When did business interest begin:** May 2012 **How is this relevant to the Trust:** Healthcare Consultancy **Name of organisation:** EY **Relationship:** Subject Matter Resource **When did business interest begin:** May 2012 **How is this relevant to the Trust:** Healthcare Consultancy	
Louise Shepherd (Chief Executive)	**Name of organisation**: Liverpool Health Partners **Relationship:** Director **When did business interest begin:** 2009 **How is this relevant to the Trust**: Research Collaboration	
Dame Jo Williams (Non-Executive Director)	**Name of organisation:** Vivo Care Choices **Relationship:** Chair of the Board **When did business interest begin:** October 2016 **How is this relevant to the Trust:** Provider of Health Care Services	
Mark Flannagan (Director of Marketing & Communications)	**Name of organisation**: Portland Communications **Relationship:** Advisor **When did business interest begin:** June 2017 **How is this relevant to the Trust:** Provide advice – verbal and email – on the company's pitches to become the agency for a number of bodies, including pharmaceutical companies, and membership bodies in health	
Louise Dunn (Director of Marketing)	**Name of organisation:** GlaxoSmithKline **Relationship:** Shareholder & former employee **When did business interest begin:** June 1999 **How is this relevant to the Trust:** Pharmaceuticals & vaccines	

Steve Ryan (Medical Director)	**Name of organisation:** Steve Ryan Healthcare **Relationship:** Provides healthcare strategy and leadership support **When did business interest begin:** April 2017 **How is this relevant to the Trust:** Assists healthcare organisations in planning & strategy and quality improvement. Currently not undertaking contracts of commissions.	
Jeannie France-Hayhurst (Non-Executive Director)	**Name of organisation**: Alder Hey Children's Charity **Relationship:** Trustee **When did business interest begin:** 2015 **How is this relevant to the Trust:** Raises funds for Alder Hey **Name of organisation**: Cheshire University **Relationship:** Council Member **When did business interest begin:** 2016 **How is this relevant to the Trust:** University **Name of organisation**: Moreton Hall Educational Trust **Relationship:** Chairman **When did business interest begin:** 2000 **How is this relevant to the Trust:** Private School **Name of organisation**: Spurstow Property Group **Relationship:** Director of property companies **When did business interest begin:** 2016 **How is this relevant to the Trust:**	
John Grinnell (Director of Finance)	**Name of organisation:** Playworld Ltd. **Relationship:** Company Secretary (no dealings with hospital) **When did business interest begin:** 2007 **How is this relevant to the Trust:** Indoor Children's Play Centre	

Hilda Gwilliams (Chief Nurse)		✓
Claire Liddy (Acting Director of Finance) to April 2017		✓
Debbie Herring (Director of Strategy)		✓
Erica Saunders (Director of Corporate Affairs)		✓
Therese Patten (Director of Strategy)		✓
Melissa Swindell (Director of HR & OD)		✓
Michael Beresford (Assoc. Director of the Board)		✓
Claire Dove (Non-Executive Director)		✓
Margaret Barnaby (Interim Director of Strategy)		✓
David Powell (Development Director)		✓
Ian Quinan (Non-Executive Director)		✓
Adam Bateman (Acting Chief Operating Officer)		✓

Alder Hey Children's NHS
NHS Foundation Trust

Draft Audit Committee Annual Report 2017/18

The Audit Committee

The aim of the Audit Committee is to provide one of the key means by which the Board of Directors ensures effective internal control arrangements are in place. In addition, the Committee provides a form of independent check upon the executive arm of the Board.

As defined within the NHS *Audit Committee Handbook* (2014), the Committee has responsibilities for the review of governance, risk management and internal control covering both clinical and non-clinical areas. In discharging these duties the Committee is required to review:

- Internal financial control matters, such as safeguarding of assets, the maintenance of proper accounting records and the reliability of financial information.
- Risks regarding disclosure statements (for example the Annual Governance Statement) which are supported by the Head of Audit Opinion and other opinions provided.
- The underlying assurances as detailed in the Board Assurance Framework.
- The adequacy of relevant policies, legality issues and Codes of Conduct.
- The policies and procedures related to fraud and corruption.

The conduct of this remit is achieved firstly, through the Committee being appropriately constituted, and secondly by the Committee being effective in ensuring internal accountability and the delivery of audit and assurance services.

This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

In accordance with the terms of reference which are reviewed on an annual basis to take into account governance developments and the remit of other assurance committees, the membership of the Committee comprises three Non-Executive Directors. Its chair has 'recent relevant financial experience' which is best practice. The Director of Finance and Director of Corporate Affairs together with the Deputy Director of Finance are invited to attend, and the Committee may request the attendance of the Chief Executive and any other officer of the Trust to answer any points which may arise. In addition, the Internal and External auditors are invited to each meeting, together with regular attendance from the Local Counter Fraud Specialist. A schedule of attendance at the meetings is provided in Appendix A which demonstrates full compliance with the quorum requirements and regular attendance by those invited by the Committee. The Audit Committee members have also had the opportunity through the year to meet in private with internal audit and external audit.

Six meetings were held during the financial year 2017/18 of which one, in May was devoted to consideration of the auditors report on the Annual Accounts and ISA 260. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

Minutes of the Audit Committee are presented to the Board and are supported by a verbal report from the Committee Chair.

Achievements in 2017/18

In discharging its duties, the Committee meets its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from the auditors and fraud specialists.

<u>Self-Assessment</u>

During the year the Committee has complied with 'good practice' recommended through:-

- Agreement and monitoring of an annual work programme aimed at testing the adequacy of the control environment
- Prepared an Annual Report of its activities
- Reviewed and updated its terms of reference

Work undertaken

At each meeting the Audit Committee has considered:

- The Board Assurance Framework report
- Internal Audit Reports in accordance with the approved 2017/18 work plan
- External Audit Reports in accordance with the approved 2017/18 work plan

In addition throughout the year the Audit Committee has reviewed and dealt with the following matters:

- Annual Governance Statement
- Consideration of the 2017/18 Annual Accounts
- NHS Improvement (Monitor) quarterly returns
- External Assurance Report on the quality account
- External Audit report on the financial statements to 31st March 2017 and ISA 260
- Losses and special payments
- Gifts & Hospitality Register
- Waiver Activity Report
- Counter Fraud reports by the MIAA specialist in accordance with the approved 2017/18 work plan
- The findings and recommendations of the Risk Management Review
- Regular reports of the Trust's Policy Review schedule
- Oversight of changes to the Trust's Programme Assurance arrangements
- Approval of the Treasury Management Policy
- Internal Audit work plan for 2017/18
- External Audit strategy relating to the Audit of the Trust's 2016/17 Accounts
- Financial Statement audit risks for 2017/18
- Accounting policies for the 2017/18 Financial Statements
- Audit Committee work plan 2017/18
- Review and approval of the terms of reference for the Audit Committee
- Annual Reports of the Trust's assurance committees, including Clinical Quality Assurance Committee

Key Conclusions

The key role of the Committee is to establish the following:

- Assurance Framework is fit for purpose
- Systems for risk management identify and allow for the management of risk
- Organisation has robust governance arrangements
- Organisation has self-assessed against the CQC Standards
- Organisation has robust systems of financial control
- Organisation operates a robust control environment

Based on the information provided, the Committee members can confirm that they agree to the declaration reported to the Board of Directors in respect of the Annual Governance Statement.

This opinion is based upon the Committee's processes for gaining assurance as summarised below.

Internal Processes

In accordance with the Committee's authority, in addition to the Director of Finance, other officers of the Trust were called to attend the Committee to provide updates.

Following receipt of audit reports the Committee has directed audit resources to complete follow-up reviews into specific issues and high risk areas. The Committee will review outstanding actions until completion. A database is maintained of all audit recommendations which is reviewed by exception. Additionally, to support the Committee's control of implementation of key actions, internal audit include within their plan provision for follow-up of the implementation of audit recommendations. During the year the Committee chair was focussed on gaining assurance around follow up actions in order to ensure the closure of any potential gaps in the control environment.

The Annual Report and Accounts and the Quality Account were reviewed by External Audit and the reports arising from their review presented to the Committee.

The Committee reviewed the findings of other significant assurance functions of the Trust including the Clinical Quality Assurance Committee and Resources and Business Development Committee by receiving and scrutinising the Annual Reports in support of approving the Annual Governance Statement.

Independent Assurances / Audit

External Audit

The provision of External Audit services was delivered by KPMG to April 2017 following new regulations issued by the National Audit Office in April 2017 meaning that NHS organisations can no longer retain the services of the same audit firm for both core financial audit services and tax advice. Given the specialist nature of the tax advice historically received from the tax team at KPMG this meant the core financial audit function was re-tendered.

A competitive tender process was undertaken during the summer of 2017, following which a recommendation was made to the Council of Governors to award the contract to Ernst & Young. This recommendation was approved by the Council of Governors at its meeting in September 2017 for an initial three year period, with the option to extend for a further 2 one year extension periods.

The work of External Audit can be divided into two broad headings:-

- To audit the financial statements and provide an opinion thereon,
- To form an assessment of our use of resources.

The Committee has approved an External Audit Plan and receives regular updates on the progress of work including audit work undertaken on the quality account. An unqualified opinion on the accounts for 2017/18 was provided to the Board on the 22 May 2018.

Internal Audit

The Internal Audit service is provided by Mersey Internal Audit Agency (MIAA), an independent NHS organisation. The Director of Audit Opinion and Annual Report for 2017/18 reports that MIAA have demonstrated their compliance with Public Sector Internal Audit Standards. Internal Audit provides an independent and objective appraisal service embracing two key areas:-

1. The provision of an independent and objective opinion to the Accountable Officer, the Board and the Audit Committee on the degree to which risk management, control and governance support the achievement of the agreed objectives of the organisation.

2. The provision of an independent and objective consultancy service specifically to help line management improve the organisation's risk management, control and governance arrangements.

The Audit Committee contributed to the risk assessment and subsequently approved the content of the Internal Audit Plan. This plan was structured to provide the Director of Audit Opinion which gives an assessment of the:

- design and operation of the underpinning Assurance Framework and supporting processes;

- range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year, this assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses; and
- process by which the organisation has taken steps to implement and embed the systems and processes to ensure regulatory compliance with the CQC fundamental standards.

The key conclusion from their work for 2017/18 as provided in the Director of Audit Opinion and Annual Report was that 'Substantial Assurance', can be given that that there is a good system of internal control designed to meet the organisation's objectives, and that controls are generally being applied consistently.

During the course of the year the Committee ensured that regular progress reports were received from MIAA on the delivery of the Internal Audit Plan. As part of this process the Committee have influenced changes to the plan to direct work to risk areas identified during the course of the year.

Fraud

As with the Internal Audit Service, Counter Fraud is provided by Mersey Internal Audit Agency.

As requested by the Committee to meet mandated requirements, an annual report was provided outlining the delivery of the fraud plan for 2017/18. A self-assessment against compliance with the Standards for Providers issued by NHS Counter Fraud Authority for 2017/18 was undertaken. The Trust has rated itself overall as GREEN. The Counter Fraud service provided regular updates to the Committee on work undertaken to prevent and detect fraud including any investigations.

Assurance Statement

Through the various mechanisms set out above, the Audit Committee has gained assurance that the Trust's control environment is operating at a satisfactory level. It has clearly expressed its expectations in relation to areas where controls need to be strengthened and these will be addressed in the coming year.

Committee Developments/Priorities for 2018/19

Whilst the Committee has performed its duties as delegated by the Board and mandated through governance requirements, in the forthcoming year focus will be given to developing and responding to the system reforms and risks as detailed below:-

- To maintain a review of our Terms of Reference and activities to fully support the governance arrangements within the Trust and to ensure the Board continues to be appropriately briefed on our activities.
- To develop our work plan based on the Assurance Framework and focus audit resources into risk areas and the provision of assurances from the organisation.
- To continue oversight of the revised governance and assurance arrangements relating to the delivery of the Trust's change programme as discharged through the Board's key assurance committees.
- To enhance assurance through the attendance of key officers to account for actions taken in respect of internal and external reviews.
- To embed the monitoring and reporting of follow-up actions taken in respect of internal audit reports and especially those reported as "Limited Assurance".
- To receive formal reports from the Trust's key assurance committees to provide effective oversight of the systems and processes of assurance
- To ensure the Annual Governance Statement is presented and reviewed by the Audit Committee prior to Board approval.

Steve Igoe, Audit Committee Chair
19 April 2018

APPENDIX A

AUDIT COMMITTEE - RECORD OF ATTENDANCE 2017/18

Quorum: Two Non-Executive Directors

Member/Date of Meeting	2017				2018	TOTAL
	28 April	24 May	5 Oct	23 Nov	25 Jan	
Members						
Mr Steve Igoe (Non-Executive Director)	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	✓ **(Chair)**	**5/5**
Mrs Anita Marsland (Non-Executive Director)	✓	✓	X	✓	✓	**4/5**
Mrs Jeannie France-Hayhurst (Non-Executive Director)	X	X	✓	X	X	**1/5**
In attendance						
Mr John Grinnell (Director of Finance/Deputy CEO)	✓	✓	✓	✓	✓	**5/5**
Mrs C Liddy (Deputy Director of Finance)	✓	✓	✓	✓	✓	**5/5**
Ms Erica Saunders (Director of Corporate Affairs)	✓	✓	✓	✓	✓	**5/5**
KPMG (External Audit)	**JL**	**EK / AL**				**2/2**
Ernst & Young (External Audit)			**CD / HR**	**CD / HR**	**CD / HR**	**3/3**
MIAA (Audit Agency)	**MMc / LC**	**MMc / LC**	**MMc / LC**	**MMc / LC**	**MMc / LC**	**5/5**
Local Counter Fraud Service	**DD**		VM	DD	VM	**4/4**

KPMG Representatives:
Mrs A Latham (AL); Ms J Burrows (JB); Ms E Kirkby (EK); Mrs J Lewis (JL)

Ernst & Young Representatives:
Mrs C Davies (CD); Mr H Rohimun (HR)

Mersey Internal Audit Agency Representatives:
Mrs M McMahon (MMc); Ms L Cobain (LC)

Local Counter Fraud Service – Representatives attend for presentation of fraud related reports
Ms V Martin (VM); Darrell Davies (DD)

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
1st May 2018

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Associate Director IM&T Jennifer Wood, GDE Programme Manager
Action/Decision required	The Trust Board is asked to note the updated progress towards participation in NHS England's GDE Programme and subsequent initiation of the Programme.
Background papers	N/A
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	IM&CT Strategy Significant contribution to the strategic objectives for:- - Clinical Excellence - Positive patient experience - Improving financial strength - World class facility

1.0 Executive Summary

The purpose of this paper is to provide the Board with an update on the progress of the Trusts Global Digital Exemplar (GDE) Programme; especially the achievement of Milestone Three and measures in place to achieve Milestone Four.

2.0 Update of Progress

Since the previous update to Board on 10th April 2018 work has continued to ensure phase four milestones are achieved; primary areas of work include:

Share2Care – Regional Portal

The Share2Care Programme have been invited to compete to become one of five new Local Health and Care Record Exemplars (LHCRE), each potentially receiving up to £7.5m in national investment. The bid comprises of The North West Coast (Cheshire, Mersey, Cumbria and Lancashire)

Each regional LHCRE will build on existing local work to share records and further develop joined up regional health and care information reference sites, focused on improving direct patient care.

Core requirements for successful bidders will be expected to show that they have a robust IG framework; consent/a citizen opt-out standard; technology and data and interoperability standards; a robust approach to cyber security and utilise national services, particularly record locators.

The bid has now been submitted and successful candidates are expected to be announced in Late May / Early June.

Mobile Phlebotomy Solution

A number of mobile phlebotomy printers have been configured and deployed to wards across the Trust. These will sit on the Computer on Wheels and enable the quick and easy printing of blood labels.

Benefits baseline: Number of incidents reported around blood sample labelling 149 over a 12 month period.

Voice Recognition

The voice recognition solution is still in deployment across the Trust. We now have 700 users trained including Junior Doctors. As a result of the Standard Document release statistics show usage is now higher than ever.

Voice Recognition is currently being deployed within Community who are finding the solution extremely useful.

A review of the voice recognition roll-out plan is underway with Service Managers and Clinical Leads to engage those specialities that are keen to use the system and ensure training is provided.

Benefits baseline: 54% positive response rate to 'Digital dictation is useful and helps with my clinical practice'.

Outpatient Review

Work is still underway to ensure 'quick wins' are resolved within Outpatients. Some of the issues resolved to-date include technical fixes such as the weight range on Meditech being corrected, comms being re-circulated to clinicians explaining how to sign off individual letters in Medisec, and correct user permissions being applied in Meditech.

A regular Outpatients technical issues review meeting is held internally within IM&T.
IM&T have met with the clinic co-ordinators for the following specialities / clinics to-date:

- Level 1.2 ENT / Neuro
- Level 1.2 Dental
- Level 2.2 Cardiac
- Level 2.2 Ophthalmology

This has allowed for the flow for each of these clinics to be identified including the issues with them and where they can be improved on. These issues identified have been added to the Outpatients issues log. This has allowed for common themes in the issues to be identified.

Further meetings with the co-ordinators of the other clinics are scheduled to take place over the next few weeks.

Benefits baseline: A survey has been sent to clinicians to understand their experience in outpatients as a whole by asking "How do you rate your current experience as a clinician in outpatients?" (0-10% being very poor and 91-100% as excellent)

The survey has been completed by 42 people and has shown the majority voting for 51-60%. This is closely followed by 71-80%.

3.0 Upcoming Deliverables

- Deployment of Welch Allyn integration technology across Wards,
- Review of PACs deployment within Speech and Language Therapy to ensure full usage,
- Review of Patient Portal scope with a view to engaging suppliers,
- Requirements gathering and digitisation of twenty one Speciality Packages by Milestone 4,
- Review of Proof of Concept STP Platform Post Proof of Concept,

4.0 Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
PACS and other 'ologies GAIT Lab	Improve clinical compliance with Information Governance	Compliance with legislation around data storage	Uncompliant	Compliant Mar-2018	Compliant Mar-2018

	Legislation				
Specialty Packages	Increased income from outpatient procedure coding	Actual income received above plan for outpatient procedures	N/A	N/A	£394,387 above plan at Mar-2018
Fast User Switching	Improve staff experience logging into systems in clinical areas	Positive response rate to survey	N/A	50% Mar-2018	59% Mar-2018

5.0 Milestone Assurance

A review of current GDE Milestones has been carried out against Trust Operational Priorities and other associated Projects. As a result of this review a decision has been made to realign the milestones; and milestone assurance will be carried out in July, as opposed to May, 2018.

It should be noted that key deliverables will be revised in line with the new milestones and assurance timescales; for example eighteen Specialty Packages were due in May, the revised milestone will ensure twenty one Speciality Packages are delivered by July 2018.

The Programme is now working towards the implementation of projects within Milestone Four; these include:

- Deployment of Twenty One Speciality Packages,
- Review of E-Consent Systems and associated Workflows,
- Implementation of the STP Platform Proof of Concept,
- Development of PACS for use in EEG,
- Deployment of Continuous Infusions project following pilot,
- Development of the Patient Portal.

6.0 Recommendations

The Trust Board are asked note the progress of the Trusts GDE Programme; the finalisation of Milestone Three and on-going progress towards Milestone Four (31st July 2018).

Peter Young
Chief Information Officer

23th April 2018