Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Tuesday 22nd May 2018 commencing at 10:00
Venue: Meeting Room 1, Innovation Hub

AGENDA

BOARD PHOTOGRAPH (10:00am-10:15am)

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
STAFF STORY						
Board Business						
1.	**18/19/71**	**10:30**	**Apologies.**	Chair	To note apologies.	--
2.	**18/19/72**	**10:31**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	--
3.	**18/19/73**	**10:32**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **1st May 2018.**	Read Minutes
4.	**18/19/74**	**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.	**18/19/75**	**10:40**	**Key Issues/Reflections.**	All	The Board to reflect on key issues.	Verbal
Strong Foundations – Part 1						
6.	**18/19/76**	**10:50**	**2017/18 Draft Annual Report and Accounts.** - **Ernst and Young External Audit Year-end Draft Report, 2017/18.** - **Draft Letter of Representation.** - **Draft Letter of**	E Saunders/ J Grinnell/ S Igoe	To approve the Annual report and Accounts.	Read reports

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Representation for the Quality Accounts. - **PFI Deal – Year-end Accounting of Compensation Payment, April 2018.**			
Growing Through External Partnerships						
7.	**18/19/77**	**11:05**	**Joint Neonatal Partnership – AH & LWH**	L Shepherd	To update the Board on progress.	Verbal
Delivery of outstanding care						
8.	**18/19/78**	**11:10**	**Cardiac Post-Operative Model of Care Update and CHD Network Update.**	A Bateman/ S Ryan	To provide an update.	Presentation
9.	**18/19/79**	**11:20**	**Serious Incidents Report.**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report
10.	**18/19/80**	**11:25**	**Position Statement for Complaints & PALS, May 2018.**	A Hyson	To receive the position statement for May 2018.	Read report
11.	**18/19/81**	**11:30**	**Clinical Quality Assurance Committee: Chair's update:** - **Chair's verbal update from the meeting that took place on the 16.5.18.** - **Approved minutes from the meeting took place on the 18.4.18.**	A Marsland	To receive the minutes from the meeting held on the 18.4.18.	Read report
12.	**18/19/82**	**11:35**	**Global Digital Exemplar (GDE).**	P Young	To update the Board on the programme.	Read report
The best people doing their best work						
13.	**18/19/83**	**11:45**	**People Strategy Update.** • **Workforce Organisational**	M Swindell	To provide an update.	Read reports

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Development Committee Annual Report for 2017/18. • **Chair's verbal update from the meeting that took place on the 21.5.18.** • **Annual Workforce Profile Report.**			
14.	**18/19/84**	**12:00**	**Ground Round – HEE Annual Assessment Visit Feedback.**	G Lamont	To provide an update	Presentation
15.	**18/19/85**	**12:10**	**Freedom to Speak Up Guidance.**	E Saunders	For information	Read report
Strong Foundations						
16.	**18/19/86**	**12:15**	**Board Self – Certification of Compliance with the Provider License**	E Saunders	To approve the declaration in relation to general condition 6 and the corporate governance statement, AHSC's and Governor Training.	Read report
Lunch 12:30pm-1:00pm						
17.	**18/19/87**	**13:00**	**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
18.	**18/19/88**	**13:10**	**Corporate Report.**	J Grinnell/ 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 April 2018.	Read report
19.	**18/19/89**	**13:20**	**Board Assurance Framework.**	E Saunders	To receive the BAF report.	Read report
20.	**18/19/90**	**13:40**	**CQC Action Plan**	E Saunders	To provide the Board with progress to date (position to end of April).	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Game Changing Research and Innovation						
21.	**18/19/91**	**13:55**	**Research, Education and Innovation Committee:** • **2017/18 Annual Report** • **Approved minutes from the meeting held on the 11.1.18.**	I Quinlan	To receive the annual report and review the minutes from the meeting held on the 11.1.18.	Read reports
Any Other Business						
22.	**18/19/92**	**14:00**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting: Tuesday 3rd July 2018 at 10:00am, Large Meeting Room, Institute in the Park.						

REGISTER OF TRUST SEAL
Lease of Burlington House - 2.5.18.

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 1st May 2018 at 10:15am,**
Meeting Room 1, Innovation Hub

Present:	Mr I Quinlan	Vice Chair (Chair)	(IQ)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	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 L Shepherd	Chief Executive	(LS)
	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)
	Prof M Beresford	Assoc. Director of the Board	(PMB)
	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)
Agenda item: 56	Mr J Gibson	External Programme Assurance	(JG)
45	Professor L Kenny	Executive Pro-Vice-Chancellor, University of Liverpool	(LK) (PLK)
47	Ms V Charnock	Arts Coordinator	(VC)
50	Mr L Stark	Head of Performance	(LS)
50	Ms N Deakin	Project Manager	(VC)
62	Mr P Young	Chief Information Officer	(PY)
Apologies:	Mr. A. Bateman	Chief Operating Officer	(AB)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Sir D Henshaw	Chairman	(SDH)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)

Patient Story

An Oncology patient who has been receiving treatment since November 2017 was invited along to May's Trust Board meeting with her parents to share the positive experience that the family have had whilst in the care of Alder Hey.

Katie's parents praised the staff at Alder Hey for the way in which they have cared for Katie and commented that the medical care has been outstanding. Katie's mum, Sharna, informed the Board that the staff have become like a second family and reiterated Katie's words "when you enter Alder Hey it is like having a blanket wrapped around you".

The Board asked Katie about the highs and lows of her time spent at Alder Hey. Katie informed the Board that the Chef on the ward, Marie, is amazing and goes out of her way to encourage children to eat by making a dish that you feel like at the time.

Katie felt that the medical staff were very open about forthcoming treatment so that she could prepare herself and they spoke to her on an individual basis, which made her feel included in the detail of her care.

Hilda Gwilliams informed the Board that Katie had come up with an idea during her stay on the ward in relation to having an area for patients who were in the age range of 7 to 12 and suggested turning one of the bathrooms into a 'Tween Room'. It was agreed to look into this matter via the Charity.
Action: JW/JFH

Louise Shepherd asked the family as to whether there was anything that could have been done to improve their stay. Katie's dad, Chris, highlighted the issue around the system for paying for car parking long stay passes and the difficulties with the current system out of hours. Katie's dad explained there were days when his daughter was able to go home during the week which meant that there was still credit on the parking card which would have been lost if the card was returned. John Grinnell undertook to review this with the cash office.
Action: JG

The vice Chair thanked the family for sharing their story with the Board and wished them well for the future.

18/19/40 Apologies

The Vice Chair noted the apologies received from Adam Bateman, Sian Falder, Sir David Henshaw and Jo Minford.

18/19/41 Declarations of Interest

There were none to declare.

18/19/42 Minutes of the previous meetings held on 10th April 2018

Resolved:
The Board received and approved the minutes from the meeting held on the 10th of April 2018.

18/19/43 Matters Arising and Action Log

Action 17/18/242.2: *Review the support being received by clinicians in the Outpatients department* - An update will be provided on the 22.5.18.

18/19/44 Key Issues/Reflections

A discussion took place regarding the recent high profile legal matter concerning a patient at Alder Hey. The Board expressed its sincere sympathy for the family at this difficult time.

18/19/45 University of Liverpool Strategy on Women's and Children's Health

On behalf of the Senior Management Team at Liverpool University, Professor Louise Kenny commended Alder Hey for the way in which they addressed the recent challenges at the Trust. Professor Kenny advised of the statement that was released by the University of Liverpool following an LHP Board meeting, in support of Alder Hey.

Professor Kenny provided the Board with some background information in respect to her career and gave an overview of the University's strategy for women's and children's health. Professor Kenny pointed out that the faculty has lost its direction in respect to the national context, to the detriment of the University and the city as a whole. The university has a big task ahead to build a clinical academic capability and it was confirmed that the faculty's Task and Finish group has agreed that women's and children's health is the main NHS-facing area that will support the overall strategy. A restructure of the faculty is taking place and will be complete in readiness for the next academic term. It was reported that the University will be looking at how it can shape and invest in the faculty with recruitment as a number one priority. Professor Kenny felt that a partnership with Alder Hey will put the University on the map for clinical excellence.

Louise Shepherd commented that it was really positive to be able to have this conversation and pointed out that the opportunities of partnership working are vast. A discussion took place around relationship building and the focus of the academic work which will concentrate on pregnancy, childbirth and childhood. Claire Dove pointed out that Liverpool is still associated with poverty, poor housing, poor diet and other determinants of deprivation; she felt that research should be conducted to address these inequalities. Professor Kenny informed the Board that the University hasn't got all of the answers to this question but was confident that the child will emerge as a theme for the University with science and engineering supporting this work, which could bring a package of solutions to address this area. Professor Kenny pointed out that University of Liverpool does not want to compete against other establishments to hold on to branding but it does want to build an institute for child health where everyone is welcome.

The Board was informed of the re-instatement of honorary appointments for clinical directorates. Professor Kenny advised that anyone who would like an honorary contract in recognition of their commitment to research would be welcome to apply, following the guidelines.

Michael Beresford advised of the pump priming for new leaders to work on projects and the next round of NIHR funding. Professor Kenny informed the Board of the annual competition which will see NHS clinicians working in partnership with a colleague at the University of Liverpool. The entry criteria for the competition is that it has to be in het NHS, the applicant hasn't worked with a university colleague before, an indication of the targeted programme is required along with participation in a peer review.

Claire Dove highlighted the importance of publicising the partnership work that is being conducted around women and child health. A discussion took place about the barriers that are being experienced locally and regionally which is hindering progress. Louise Shepherd highlighted the importance of setting the bar together in order to move forward with this area of work and pointed out the lack of support/funding from commissioners for the children's agenda. It was confirmed that there will be no investment for children's services in 2018/19.

Professor Louise Kenny thanked the Board for inviting her to present to the Board and stated that she looked forward to forging a strong partnership with Alder Hey going forward.

18/19/46 Joint Neonatal Partnership

Louise Shepherd informed the Board that the plan for joint working between Alder Hey Hospital and the Liverpool Women's Hospital has been submitted to the

commissioners who, it was confirmed, are really supportive. A meeting between the two trusts is taking place on the 2.5.18 and it was agreed to provide an update to the Trust Board on the 22.5.18.

18/19/46.1 Action: LS

Resolved
The Board noted the update.

18/19/47 Arts Programme and Next Steps

Louise Shepherd introduced the Trust's Arts Co-ordinator, Vicky Charnock, to Board members explaining that Vicky had been invited to share a presentation about the work that has been conducted over the last twelve months with very little funding.

Vicky Charnock presented a number of slides to the Trust Board which provided information on the aims of the Active Arts for Health programme, the work that has taken place over the last twelve months which has received national recognition, and the plans for the forthcoming twelve months. The Board was informed that as of September there will be no funding for the provision of music. It was reported that external funding makes long-term planning impossible and there is a need for core funding as a baseline in order to plan the programme and be successful in match funding for projects.

Jo Williams commended Vicky Charnock on the work that has taken place and felt that it would be beneficial to share this presentation with the Charity.

Michael Beresford and Louise Kenny highlighted the opportunity of linking in with the University of Liverpool to discuss the possibility of a work experience programme from a science and engineering perspective. Vicky Charnock reported that the Trust has a full time music therapist and agreed to speak to her regarding this matter. Louise Shepherd highlighted her concerns in respect to the real need for a base line of funding in order to progress this area of work.

18/19/47.1 Action: VC

Resolved:

The Board received and noted the Arts for Health presentation.

18/19/48 NHS Improvement Operational Plan for 2018/19

The Trust Board received the NHS Improvement Operational Plan for 2018/19 and was provided with a summary of the key themes relating to the activity plan, the new approach for workforce planning and risks, the delivery of the Financial Plan and the Winter Plan. It was confirmed that the Operational Plan was submitted to NHS Improvement on the 30.4.18 following approval by the Operational Delivery Board and the Resources and Business Development Committee. A draft version of the Winter Plan was also submitted to NHS Improvement on the same date.

Resolved:

The Board approved the NHS Improvement Operational Plan for 2018/19.

18/19/49 Divisional Presentations

Surgical Care Division

Christian Duncan presented the 2018/19 priorities for the Surgical Care Division, highlighting the Divisions top three delivery risks:

1. Booking and Scheduling,
2. Staffing levels and recruitment,
3. Patient flow and bed capacity.

A discussion took place around the financial risks and it was confirmed that the Division is carrying circa £3.2m of financial risk going into 2018/19.

Jo Williams highlighted the impact that the UC24/GP staffing issue are having on the organisation and queried as to whether this matter can be addressed. The Board was informed that UC24 have not been able to support all shifts, especially over the winter period. It was confirmed that discussions are in the process of taking place directly with GPs to look at a way forward. An event has also been scheduled for the 22nd of June to look at ways to treat patients in the community which may have a positive effect on the front door.

Medicine Division

Adrian Hughes presented the Division's main focal points of the Business Plan for 2018/19. The Board was informed of the Divisions top six delivery risks, the year-end challenges from a financial perspective and the activity plan that has been agreed for the forthcoming financial year. Adrian Hughes advised that the Division is sighted on workforce and leadership.

A discussion took place around learning within the Division. Adrian Hughes reported that the Division has learnt from others and is setting resources aside so as to have a closer oversight, for example, huddles three times per week. It was also felt that the approach that Surgery has taken this year has made a dramatic difference to Medicine.

Community Division

Catherine McLaughlin presented a summary of the 2018/19 Operational Plan for the Community Division. The Board was informed of the risks relating to workforce, estates and community. A discussion took place around the top three delivery risks and the Divisional control total for 2018/19. Catherine McLaughlin raised the issue of the block contract for CAMHS and the barriers that this type of contract creates for the service, highlighting the £1.6m potential risk that is being managed with governance and via the team.

Hilda Gwilliams queried as to whether discussions could take place with commissioners to review the block contract for CAMHS. John Grinnell felt that further work would need to take place before commencing discussions with commissioners. Cath McLaughlin pointed out that the key issues for the organisation is that the Trust doesn't have a children's commissioner which leads to fragmentation as providers. Louise Shepherd informed the Board that Director of Children's Services at Liverpool City Council is taking this matter seriously and is intent on progressing this area of work.

Mags Barnaby queried the types of activity that come into the Trust, the route they come via and questioned as to whether patients would need to come to Alder Hey if they received care closer to home. Following discussion, Mags Barnaby felt that it would be beneficial to conduct a piece of work to look at this criterion.

Clinical Research Division

Matthew Peak presented the 2018/19 priorities for the Clinical Research Division. The Board was advised of the forthcoming themes for integration, key metrics and the top four delivery risks.

Mathew Peak informed the Board of the importance of developing via integration and understanding each other's language from a partnership perspective. In respect to key metrics, Matthew felt that an organisational approach is required to address this area of work and pointed out that the Division is very fragile due to the lack of investment, contributions, staffing and recruitment.

A discussion took place around the positive integrated cross division discussions that are taking place at the present time. Adrian Hughes pointed out that getting a shared understanding in a timely manner is important for progress and felt that the strategy developed by Alder Hey needs to be shared with others across the city.

18/19/50 Booking and Scheduling Review Update

Lachlan Stark provided the Trust Board with some background information on the original assessment, explained the booking system process and gave an overview of the different workstreams.

The Board discussed the Brilliant Patient Booking Systems high level plan along with the hybrid booking roll out plan. Lachlan Stark reported on the outcomes/benefits to date following a review of booking systems and confirmed that there had been a reduction of £29k in postage, a reduction in incoming calls, patients are being booked in priority/chronological date order, there are less frustrated families and teams are much happier as a result of the reduction in calls from unhappy families. It was also reported that the organisation has seen an improvement in booking systems for Cardiology and Dermatology.

Ian Quinlan queried the KPIs for this area of work. Lachlan Stark advised that metrics are being produced in line with the proposed improvements and assumptions.

Resolved:

The Board noted the update provided on the Brilliant Patient Booking Systems.

18/19/51 Serious Incident Reports

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

- Hilda Gwilliams informed the Board that a number of recommendations have been included in section one of the report following the latest CQC inspection.
- It was reported that there were no new serious incidents in March 2018 and there are still three ongoing cases from Feb; StEIS 2018/1590, StEIS 2018/2696 and StEIS 2017/30500. Two of these cases are being reviewed externally which Steve Ryan has commissioned.
- *Duty of Candour Incidents* – Reference No: 27828 – It was confirmed that this case was not a serious incident but had been ranked as moderate harm. This incident has been reported to MHRA in line with best practice and a Duty of Candour letter was sent to the family. The Board was advised of the circumstances relating to this patient. Louise Shepherd felt that it was important to look at how this incident can be registered formally. Hilda

Gwilliams informed the Board that Duty of Candour incidents are reported via the Integrated Governance Committee.

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

18/19/52 Clinical Quality Assurance Committee

The Board received the 2018/19 Annual Report for the Clinical Quality Assurance Committee and noted the Committee's priorities.

The Board noted the Chair's verbal update from the Clinical Quality Assurance Committee meeting that took place on the 18.4.18. It was reported that the Committee received a presentation during April's meeting on stranded children and a decision was made to address this area of work on a quarterly basis.

Resolved:

The Board received and noted:

- 2018/19 Annual Report for the Clinical Quality Assurance Committee.
- The approved minutes from the Clinical Quality Assurance Committee meeting that took place on the 21.3.18.

18/19/53 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:

- *Demolition* – The programme was 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.
- *Alder Centre* – It was reported that the tenders submitted for the construction of the Alder Centre are of a higher cost than expected. Work is taking place to review the scope of the project.
- *Park and Environment* - A new park co-ordinator has been appointed and is expected to commence in post mid-May. The Lancashire Wildlife Trust has now completed this year's 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. The Board was advised of the work that has taken place with schools and John Moores University to promote the park. David Powell confirmed that the park is going to be addressed via the quality agenda.
- *International Design and Build Consultancy* - Jersey design work will continue for the next six months bringing income into the Trust, enhancing its reputation. A meeting has also taken place 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* - A two day design start-up workshop is due to take place on the 10th and 11th of May with all user teams participating. Discussions are underway to look at an option to phase in the development of a larger and fit for purpose Dewi Jones Unit at an earlier stage, and an external bid for funding has been made by the Community Services Division.

Louise Shepherd informed the Board that a meeting had taken place with the Headmaster of Sandfield Park School and the Director of Children's Services,

Steve Reddy, to discuss funding for the construction of a new school in the park. The Board discussed the issues hindering progress along with the cost and it was felt that it would be beneficial to build the Dewi Jones Unit and the school at the same time. John Grinnell confirmed that a meeting is due to take place with Specialist Commissioners to try to progress discussion around funding to assist with the building of the Dewi Jones Unit.

Resolved:

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

18/19/54 People Strategy Update

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

- Core mandatory training as of the end of March 2018 is above target at 93.2% with overall mandatory training at 90.23%. It was reported that the new Learning and Development manager is working with ESR to progress e-learning.
- Melissa Swindell reported that the Trust remains above the sickness absence target of 5% and confirmed that a large piece of work is taking place to manage this.
- *Porter Service Organisational Change Consultation* – Following a Trade Union ballot it was reported that the porters had failed to agree with the Trust's proposal. A query was raised by the Porters around an opportunity to trial the proposal. It was confirmed that the Trust is looking to explore a number of opportunities to accommodate a three month pilot, and dialogue remains open with Trade Unions.
- The Board was advised of the two on-going tribunal cases. It was confirmed that updates will be provided on both cases in due course.

Resolved:

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

18/19/55 Programme Assurance Update

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

Joe Gibson provided an overview of the proposed change programme for 2018/19 and the scope of the programme assurance framework.

It was reported that four of the big themes from the five models of care have received provisional ratings. Joe Gibson pointed out that the depth of analysis of where targets are will help with aspiration to transformation. The Board was informed of the additional staff who will be joining the Project Management Office (PMO) to help increase the pipeline work.

The Board discussed the financial benefits profile for month 12 and it was reported that 85% of sustainability had come from the strong foundations workstream, for example; collaborative procurement, coding and capture.

Anita Marsland felt that the change programme is becoming more embedded across the Trust as evidenced through conversation during April's Clinical Quality Assurance Committee.

Resolved:

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

18/19/56 Corporate Report

The Corporate report for month 12, 2017/18 was submitted to the Board for information and assurance purposes. The following points were highlighted and discussed:

- *Patient Safety* – The year end position for never events is 0 against a target of 0 for the year. It was reported that during 2016/17 there was a major focus on theatres and it was pointed out that this year's position has been sustained as a result of the tremendous effort of staff in those areas.
- *Pressure Ulcers* - March maintained zero for grade 3 and 4 pressure ulcers and zero never events. There were 94 incidents of harm reported in month, two of which were of moderate harm. The Board was advised that all of the pressure ulcers are equipment related and it was confirmed that this area of work is going to be a main focus for 2018/19. The Trust is also working with engineers to try and develop innovative solutions.
- The Trust has sustained its position for strong incident reporting and the number of complaints received are low in comparison to the organisation's peers. The Board was advised of the two pilot projects that have commenced at local level to try and address the increasing concerns around PALs.
- *Clinical effectiveness* – There were no MRSA infections in March, however there was one C. difficile infection which the Trust is appealing. Steve Ryan pointed out that the YTD figures for MRSA do not reflect the exact position owing to one particular patient who can't be decolonised. The Trust is looking to acquire expert advice on this matter.
- *Finance* - John Grinnell advised the Board that 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.

  The Board discussed the risk relating to the PFI 'two for one' deal and was advised that discussions are taking place with the Auditors around the certainty of this income as the deal hasn't been closed within the 2017/18 audit period.

  Louise Shepherd felt that the Trust's secure financial position will enable the organisation to move forward in the right direction, and commended the teams who have worked tirelessly to achieve this outcome.

Resolved:
The Board received the Corporate Report for Month 12.

18/19/57 Board Assurance Framework

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

The Board was provided with an overview of the contents of the BAF. It was reported that further to the decision at the last Board, a stand-alone risk has been incorporated

in the BAF relating to a small number of buildings issues including the corrosion of pipework across the hospital.

A discussion took place around the pipework risk and it was confirmed that a plan of action will be established by July 2018 following feedback on the outcome of the pipe samples. Erica Saunders informed the Board that this item is discussed on a weekly basis via the Executive Comm Cell huddle.

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

18/19/58 CQC Action Plan

It was reported that the Trust has received a draft report from CQC following the inspection in February; factual accuracy comments were in the process of being compiled for submission by 9th May.

Louise Shepherd provided the Board with an overview of the contents of the report and confirmed that the outcome was very positive with the organisation being rated overall as 'good'. In terms of individual service reviews the following comments were made:

- A review of Community Services took place and came out as requiring improvement in three areas. It was pointed out that this was the first time that this area of work had been inspected and this outcome was expected. These ratings are considered a baseline and will not be incorporated into the overall ratings for the Trust this time.
- Critical Care and Diagnostics were rated as good in every category, with Critical Care receiving outstanding in the caring domain; Outpatients has also improved in two domains.
- Louise Shepherd informed the Board that there were two areas within the report where the Trust was not in accord with the draft rating awarded; this matter will be broached with the Deputy Chief Inspector of Hospitals when she visits the Trust on the 3.5.18.

Resolved:
The Board noted the draft CQC report.

18/19/59 Directors' Register of Interest 2017/18
Resolved:
The Board received and noted the Directors' Register of Interest for 2017/18.

18/19/60 Audit Committee
Resolved:
The Board received and noted:

- The 2018/19 Annual Report for the Audit Committee.

18/19/61 Global Digital Exemplar

The Board was provided with an update on the progress of the GDE Programme to date.

- *Share2Care – Regional Portal:* It was confirmed that the PID for the healthcare sharing platform has been formalised.

- *Mobile Phlebotomy Solution*: A number of mobile phlebotomy printers have been configured and deployed to wards across the Trust to enable the quick and easy printing of blood labels.
- *Voice Recognition:* The voice recognition solution is still in deployment across the Trust. The organisation has 700 users trained including Junior Doctors. As a result of the Standard Document release statistics show usage is now higher than ever.

Resolved:
The Board noted the progress of the GDE Programme; the finalisation of Milestone Three and on-going progress towards Milestone Four in July 2018.

18/19/62 Any Other Business

There was none to discuss.

Date and Time of next meeting: Tuesday 22nd 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 1.5.18

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.	22.5.18.		**1.5.18 -** An update will be provided on the 22.5.18 around the outcome.
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	3.7.18.		**1.5.18 -** An update will be provided on the 22.5.18 around the outcome.
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.		**1.5.18 -** An update will be provided on the 22.5.18 around the outcome.
1.5.18.		Patient Story.	*Oncology Ward* **-** Look into the funding via the Charity to convert a bathroom into a breakout space for children aged between 7-12.	Jo Williams/ Jeannie France-Hayhurst	22.5.18.		**1.5.18 -** An update will be provided on the 22.5.18 around the outcome.
1.5.18.	18/19/46.1	Joint Neonatal Patnership - AH & LWH.	The Board will be provided with a further update on the Joint Neonatal Partnership on the 22.5.18.	Louise Shepherd	22.5.18.		**1.5.18 -** An update will be provided on the 22.5.18 around the outcome.
1.5.18.	18/19/47.1	Arts Programme and Next Steps.	Discussion to take place between Vicky Charnock and Michael Beresford around the posibility of a work experience programme being devised between the University of Liverpool and Alder Hey to support the Active Arts for Health Programme.	Vicky Charnock/ Michael Beresford	22.5.18.		**1.5.18 -** An update will be provided on the 22.5.18 around the outcome.
Closed Actions							
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**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 1.5.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
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**

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 22nd 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

May 2018
Complaints & PALS position statement

In 2017/18 the Trust received 89 formal complaints – this is the first time we have seen an increase in complaints in the last three years. 6 complaints where withdrawn – five by the complainant and one as this related to a patient safety incident and was subsequently investigated using the RCA process.

The Trust has seen an increase in overall activity in 2017/18 , 320,826, compared to 284,381 in 2016/17. The complaints this year are 0.025% of the total activity.

Main themes of formal complaints have been

Treatment/Procedure **46**
Consent, Communication, Confidentiality **26**
Access, Admission, Transfer, Discharge **15**
Clinical Assessments (Diag, Scans, Tests) **1**
Environmental/Structural Issue **1**

PALS concerns in 2017/18 have seen an increase in contacts compared to the previous year – 1349 to 1296. Q4 saw a very sharp increase – the highest on record for the last 5 years.

Processes and improvements May 2018 -

A review of the themes of PALS contact for the year has been completed and we know that 65% of the contacts made to the PALS office come in by phone call or face: face. 35% come in by email/letter.

Out of the total number of PALS concerns raised 33% relate to appointments – delay, cancellations, or waiting times

Waiting Time For Appointment 186
Appointment - Cancellation(OP) 124
Appointment - Delay (OP) 137

From these categories the main specialities that are involved are
Community Paediatrics
ENT
Ophthalmology
Gastroenterology

Community Division have been particularly keen to look at ways of being able to manage parental concerns relating to waiting times for appointments. The Community triumvate are facilitating a meeting to discuss these issues and develop a strategy to manage and respond to the concerns raised. 20% of the total number of PALS contacts relates to the Community Division

In patient areas

A request made to look at in patient areas and adopting a new model for resolving concerns.
In 2017/18 ward 3A had 21 PALS logged and 4C 6. A meeting was held with the Ward Managers to pursue a more formalised way of resolving concerns on the ward before the parents present at the PALS office.
Both Ward Managers felt that their Band 6 staff already have a great deal of involvement with families and resolve a lot of concerns at ward level. This information however is not captured

Action *– local concern form on Ulysses needs revising to make it a more simple form to complete and also be recorded as a local concern. This will enable data to be extracted that will demonstrate the amount of concerns the ward staff resolve in the clinical area.*

Posters for both of the wards will be trialled to signpost parents/carers to the staff who can assist with resolving their concerns -
Appendix A

Additionally both Ward Managers were asked to consider undertaking a formal weekly Walk about – this will be advertised in each ward area and any issues will be logged for a record of interaction and actioned as required at the time any concern is noted.
Appendix B

Complaints training sessions

To ensure staff understand the principles of good customer care and effective complaints handling a training programme has been designed to be delivered monthly in the Trust – this was advertised on the intranet for all staff to attend. Uptake for booking on the sessions has been phenomenal with I excess of 50 staff booking on within the first 5 days of the sessions being advertised (including a community session for a staff group being delivered in Sefton).
Appendix C

Action:- *need to look at getting training sessions on to ESR to enable accurate staff training records.*

Current position re formal complaints

At the time of compiling this report (15.5.18) the Trust has 16 live complaints. 6 of these exceed the Trusts internal 25 working days timeframe with parents/complainants being aware of the delay – 2 out of the 6 outstanding relate to the same complainants and on compassionate grounds the response has not yet been sent to the family.

There are also 2 second stage complaints where the complainant is dissatisfied with the response and has come back to the Trust for further local resolution.

Appendix A


Alder Hey Children's NHS
NHS Foundation Trust
tell us
I don't want to complain, but....
Our aim is to make your stay as comfortable as possible.
If something is concerning you, please ask to speak to the person in charge, Ward Sister or Ward Manager. They should be able to sort out the problem straight away.
Ward Sister
Ward Manager
If after speaking with a member of staff you feel we have not been able to resolve your concerns you can also:-
• Contact our PALS and Complaints team on 0151 252 5161/5374
• Email the PALS team on PALS@alderhey.nhs.uk
• Visit The PALS teams in the atrium next to WH Smith
Delivery of outstanding care
The best people doing their best work
Sustainability through external partnerships
Game changing research and innovation

Appendix B

Alder Hey Children's NHS
NHS Foundation Trust

Ward Manager walk-about..

Ward Manager 4C- Ruth Hubberstey will be walking around the ward every Thursday morning between 10am – 11am to say "hello" and make sure your stay on the ward is as well managed as it can be.

If you would like to speak to Ruth, please make the nurse looking after your child aware and he/she can let Ruth know to come and meet with you.

Appendix C

Date	Start Time	Finish Time	Room
22/06/2018	15:00	16:00	Room 7 Mezzanine (18)
13/07/2018	12:30	13:30	Room 7 Mezzanine (18)
24/08/2018	10:00	11:00	Room 7 Mezzanine (18)
14/09/2018	12:30	13:30	Room 7 Mezzanine (18)
19/10/2018	15:00	16:00	Room 7 Mezzanine (18)
16/11/2018	12:30	13:30	Room 7 Mezzanine (18)
19/11/2018	09:30	10:30	Room 7 Mezzanine (18)
07/12/2018	12:00	13:00	Room 7 Mezzanine (18)
18/01/2019	15:00	16:00	Room 7 Mezzanine (18)

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 18th April 2018
10.00 am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Hilda Gwilliams	Chief Nurse
	John Grinnell	Director of Finance
	Pauline Brown	Director of Nursing
	Dame Jo Williams	Non-Executive Director
	Jeannie France-Hayhurst	Non-Executive Director
	Steve Ryan	Interim Medical Director
	Cathy Umbers	Associate Director of Nursing & Governance
	Steve Igoe	Non-Executive Director
	Adrian Hughes	Director, Medicine Division
	Christian Duncan	Director, Surgical Division
	Rachel Greer	
	Jacqui Ruddick	Head of Quality, Medicine Division
	Stefan Verstraelen	Head of Quality, Surgery Division
	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
	Nik Barnes	Chief Clinical Information Officer
	Jill Preece	Governance Manager
	Julie Creevy	Executive Assistant (Minutes)

18/19/01 Apologies:

	Louise Shepherd	Chief Executive
	Mark Peers	Public Governor
	Mags Barnaby	Interim Director of Strategy
	Erica Saunders	Director of Corporate Affairs
	Melissa Swindell	Director of HR
	Matthew Peak	Director of Research
	Tony Rigby	Deputy Director of Risk & Governance
	Adam Bateman	Acting Chief Operating Officer
	Mark Flannagan	Director of Communications
	Julie Williams	Governor
	Lachlan Stark	Head of Planning and Performance
	Cathy Wardell	Associate Chief Nurse, Medicine
	Jo McPartland	Consultant Paediatric Pathologist

18/19/02 Declaration of Interest
None declared

18/19/03 Minutes of the previous meeting held on 21st March 2018
Resolved:
CQAC approved the minutes of the previous meeting held on 21st March 2018.

18/19/04 Matters Arising and Action Log
17/18/89 - action to be left on the action log, to enable N Barnes to update CQAC once appropriate.

17/18/78 'Complaints' – A Hyson confirmed that with effect from week commencing 23rd April 2018 that there will be rewewed focus on Complaint role, and that there will be a corporate Head of Quality role. AH is currently utilising 2 wards to explore 2 models and the team are working alongside Ward Managers to ensure progress is made in this area.

AH confirmed that she is also working with community colleagues, to work together with teams to identify what works bests for the divisions, in terms of complaints, as all wards would not benefit from the same approach – one model would not fit all wards. Atrium area, car parking and catering team would also be reviewed.

Action: AH to present position statement at May CQAC meeting

17/18/92/ Sepsis –Briefing paper to CQAC – this item could be closed and removed from the action log, given it is an agenda item.

17/18/118 Meditech update - this item to be removed from action log.

17/18/132 Programme Assurance meeting - HG stated that due to unforeseen circumstances that she had not yet been able to meet with J Gibson & S Ryan, and that a meeting would be diarised to progress this item further.

Action: HG to meet with JG & SR

17/18/133 Transition – HG confirmed that the funding issue for £500 had now been resolved and this item could be removed from the action log.

17/18/136 Facilities – lifts & crates – HG confirmed that she had spoken with M Deveraux who had liaised with Facilities teams to ensure that this issue is addressed, this item to be removed from the action log.

18/19/05 Standed Children/Young People
CM presented an update regarding Stranded Children/Young People.

Key issues as follows:-
- Reasons for delayed discharges related to the following:-

- Complex Care Package Delay – work continuing to address continuing healthcare assessment, - the Trust is late in identifying when patients require continuing healthcare.
- Repatriation – considerable ongoing work had taken place to work with teams to provide support.
- Consultant Review – the Trust does not have a designated consultant with this issue built into job plan.
- Equipment
- Parental Engagement

- CMcL confirmed that from July-December 2017 – this related to 7374 Total LoS >30 days.
- As at 11th April 2018 34 'stranded' children remained at Alder Hey equating to average LoS 153, with a total LoS equating to 5525 – this excludes DJU and Critcal Care bed days.

Barriers to discharge as follows:-

- Late identification of complexity and the social impact was noted as the most signficiant barrier.
- Medical management of complexity and support required – the Team are currently working to address this issue.
- Timely conversations needed regarding prognosis – these conversations are taking place, however the team plan to review the robustness of them.
- Impact of social media, crowd funding etc – piece of work required in order to review this further
- Lack of case management and a single advocate – progress to be made to educate divisions, as a number of familieis currently receive 365 /24/7 care – and further work is required in order to educate divisions/families to reach an understanding that these families will no longer receive 365 24/7 care going forward.
- Care packarge set up and fragility of maintenance – with the default position for patients to return to Alder Hey once the care package had failed – further work required regarding this issue.
- Repatriation and shared care – ongoing work is progressing to return patients to there normal place of residence.
- Housing: - Suitable adapted housing provision/delays in adaptions.
- Lack of 'Step down' provision – Community team are working with the Finance Team regarding how to support these children, currently trailing a 'step down' bed.
- Children 'Living' in Alder Hey – 5 patients

CQAC noted progress made in order to support Discharge.

Community Division required support as follows:-

- Challenge of custom and practice
- Identification of medical leaders to be part of the complex service – progress is being made.
- Repatriation and transition required forensic attention and grip.

- Funds to be identified to allocate additional PA's to a few key consultants to enable the MDT's to be established.
- Band 5 support officer required.
- Integration of transition team, into the team to support the operational grip required.
- Address 'Branding' issues e.g. palliative care, bereavement services – teams needed to be seen as 'Family support' in this context.
- CM requested for CQAC to ensure that Complexity and 'Stranded' patients is kept on the CQAC agenda in order to ensure progress continues at pace.

JFH stated that it would be helpful to have sight of the associated costs relating to the 5 children who are living at Alder Hey, together with the results of the benefits/improvement relating to these children whilst living on site. CM confirmed that the finance team are currently working through the associated costs.

AM thanked CM for her update, and confirmed that CQAC would continue to receive regular updates with regards to 'Stranded' patients and associated complexities.

Dame JG emphasised the importance of transforming mindset and highlighted the importance regarding engagement internationally and externally/engaging with voluntary sectors and engaging with special need organisations to enable support i.e. technological support – potential offering of any 'kit'. Dame JG stated that it would also be helpful for CQAC to have sight of a case example going forward. CM confirmed that this could be arranged for a future meeting.

Action: CM to ensure a case sample is shared with CQAC for future meeting, once appropriate.

18/19/06 Sepsis Update

DP presented Sepsis update, key issues as follows:-

Progress to date as follows:-

IT

- Following on from Meditech meeting, ongoing work regarding 'sepsis status', data linkage, inaccurate saving.
- Standard documents – short and longer term updates
- Algorithm error – correction envisaged within weeks

Informatics

- Meeting to review 'sepsis status' plans

E Learning

- Draft package complete
- Rollout April – May 2018
- ESR: Solution for Junior doctor access ? Trial

Guidelines – updates regarding inpatient sepsis, IM dosing – meeting scheduled for 19th April 2018

Discussion took place regarding PEWS >3 rule. DP stated that Sepsis Steering Group recommended that the >PEWS rule be withdrawn, as the rule is not being followed as a group, and given that the Sepsis pathway is now in place, risk in having rule not followed and escalation problems still required thought. AM queried the process for making that decision. HG stated that the Medical Director evoked the PEWS score/rule. PB stated that the safety thermometer takes place regularly each month and data from last year showed 5-17 patients had been triggered, PB stated that it would be helpful to know where this rule did not apply to.

Action: HG to feedback to Steve Ryan to address/advise. CQAC to receive a position statement/outcome at next CQAC meeting.

18/19/07 Meditech Update

NB presented Meditech update, key issues as follows:-
Update on Sepsis pathway/progress as follows:-

- Alder Hey Team are working with Meditech Team to enable improved functionality to enable progress relating to ongoing software, whilst also requesting developments.
- Update PEWs and Standard document questions – immediate update.
- Detailed review of questions, resulting in improved functionality.
- Guide for what sepsis is and how to use the documents.
- Decide on role access to parts of the pathway – and work to address who should have access.

CQAC noted that good progress had been made since Meditech had visited the Trust.

CQAC reviewed the Standard pathway flowchart detailing flow once doctor logs first sepsis concern.

Next Steps:-

- Meditech had confirmed functionality.
- Sepsis Steering Group planned for 18th April 2018 to agree set of questions/wording redesign to include within pathway, together with roles and escalation.
- Report writing to gather data in Clinical Intelligence Portal – web based portal to allow processes and specifying data in order to track referrals, team currently working with information team to ensure much richer data.
- Team envisage by June 2018 standard document rollout.
- NB confirmed that he and H Swanston were visiting teams to provide feedback and shared learning, with videos being established to ensure shared learning, to enable greater understanding throughout the organisation.

- Further discussion planned at Sepsis Steering Group on 18th April 2018 with regards to clarification regarding Sepsis stepdown.

J Grinnell stated that he fully appreciated that the teams are working together, which had resulted in a new way of working with Meditech which has resulted in improved benefits, J Grinnell recognised progress and stated that he is keen to feedback to meditech regarding proactive response made from meditech team.

AM thanked NB for his update regarding progress to date and look forward to receiving update at a future meeting.

18/1908 CQC Action Plan

HG presented CQC action plan and confirmed that all necessary evidence/information had been embedded within the action plan. Majority of actions had been completed. Dame Jo W stated that it would be helpful to remove those items that had been completed, HG confirmed that this would be actioned for the next meeting.

Action: JP to remove completed actions from CQC action plan.

18/19/09Programme Assurance/progress update

JG presented progress update as follows:-

- Savings achieved for 2017/18 were £157k which is behind target of £587k by £430k.
- It remains critical that the new projects are fully scoped (PIDs) with benefits defined and project documention to be completed by the April 2018 Programme Board.
- The refreshed 18/19 Programme had been aligned with the strategy refresh and CQAC would be 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 1st April 2018. 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).
- J Gibson stated that discussion is required with regards to Exec Leadership regarding potential for J Gibson and MB to provide backfill for SR & HG due to current constraints on both SR & HG.

- **Action: Discussion to take place regarding Exec leadership/ backfill support**.

- J Gibson confirmed that 2 additional managers were due to commence w/c 23rd April 2018 within the Programme office, to further enhance team structure.

  J Grinnell stated that it was evident that there was a much clearer set of objectives to enable CQAC to track going forward, with improved mechanisms now in place.

  AM thanked J Gibson for his update.

18/19/10 CQAC Annual Report/workplan

AM presented the Annual Report & CQAC Annual workplan – which were both noted and accepted by the Committee.

18/19/11 Update on Operational Priorities

HG stated that the priorities update had previously been shared at Operational Delivery Board on 29th March 2018, document referred to key themes – Delivering outstanding care, Supporting the best people to do their best work, Building strong external partnerships, Game-changing research & innovation .

18/19/12 Corporate Report – Quality Metrics

HG presented the Corporate Report – Quality Metrics key issues as follows:-

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 SIRI's declared in month. There were 4 medication errors resulting in harm, which maintain a significant cumulative reduction compared to last year.

Patient Experience

- Complaints had remained high over the winter, with 14 reported in February, the highest in any month this year. PALS attendances had also remained high with 144 in February. The percentage of families 'recommending' Alder Hey through the Friends and Family test had dropped below the thresholds in outpatients and in A&E, whilst the number of responses in community and mental health remained low. Inpatient questionnaire feedback had improved in 3 out of the 5 questions, and work continues to improve all measures to reach their threshold. HG stated that the Alder Hey 'App' would be incorporating key questions from the friends and family test.

Clinical Effectiveness

- There were 4 infections recorded in February, which is 72 year to date compared to 93 this time last year. There were zero MRSA bacteraemia and zero C.difficile infections in month. For sepsis

metrics, the percentage of ED patients receiving antibiotics within 1 hour was 42.3% (deterioration), whilst for in-patients this was 86.4% which is an improvement and the hightest performance this year. There was 1 in-hospital death this month, compared to 5 in February last year.

HG stated that Public Health England information showed Alder Hey in an outlier position. The Trust had requested Public Health England to undertake a cluster review,which the team are working through at present, with a comprehensive plan in place.

AM thanked HG for her update.

18/19/13 Board Assurance Framework

HG presented the Board Assurance Framework.

CQAC noted that there were no significant changes within the BAF this month.

SI stated that he welcomed regular monthly sight of the BAF and wouldn't envisage seeing significant movement.

AM thanked HG for update.

18/19/14 Investment plan regarding Quality Improvement Programme

J Grinnell stated that there is a programme of work to support the Quality Improvement agenda and that clinical oversight had been agreed. J Grinnell confirmed that that funds had been assigned for Quality Impovement process going forward.

AM thanked J Grinnell his update.

18/19/15 Clinical Quality Steering Group key issues report

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

- CQAC were requested to support CQSG in requesting a detailed progress report relating to action/support plans that are being developed in order to provide assurance regarding COSHH management, as there is currently no database that is able to store risk assessments and information to support wards and departments in managing substances potentially hazarouds to health. CU confirmed that discussions had taken place with A Kinsella and that further discussions were required with M Swindell, despite this CQSG had made several attempts to request plan, to no avail.
  CQAC agreed that this would be escalated to Health & Safety Committee and ?Integrated Governance Committee?

  Action: Position statement /progress to be tracked through Health and Safety Committee and IGC.

- Ongoing work had taken place to address concern regarding medical devices – with equipment being cleaned at ward level prior to being sent to BMA – POC undertaking discussions with relevant Ward Managers and relevant team to address this issue.
- Key trainer availability to support device training.
- Patient profiling – challenges regarding implementation of patient profiling data recommendations – CQSG had a clear view on establishing a task and finish working group, to review issues to help implement the recommendations from the report. The report was approved and is now accessible via the intranet. CQSG are regularly reviewing this issue, and should CQSG require any assistance from CQAC this will be requested.

CQAC received and noted CQSG key issues report, and thanked CQSG committee members for continued support.

18/19/16 Any other business

- JFH stated that the entrance to the hospital required urgent improvement, with cigarette butts, chewing gum/litter/car park etc. JFH also stated that there is floor paint which is coming off the floors.

  HG stated that given the additional presence from the public during the previous week that this had impacted upon site entrances/exits. This had also been raised with police during 'Gold' command meetings. There had been extra provision made to address issue, and the Trust is continuing to work with the council to address this issue with regards to additional visitors and impact on the Trust site.

Action: HG & J Grinnell to address themes and follow issues up further with council and with facilities/interserve team.

- Dame JW alluded to the Quality Summit and stated that if there is opportunity regarding scoping the agenda, that it would be beneficial to give some thought regarding the horizontal connections between divisions – integration/developing crossovers/interaction and whether there is any possibility of accelerating this within Quality Summit agenda.

  J Grinnell & H Gwilliams confirmed that there would be opportunity to flex the programme to include the above.

Action: J Grinnell & H Gwilliams to follow up/feedback to A Bateman to action as appropriate.

- CQAC noted that there was a briefing scheduled by L Shepherd at 12.30 regarding ongoing legal case, and welcomed NEDS/staff to attend.

18/19/17 Date and Time of Next meeting -

10.00 am – Wednesday 16th May 2018, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
22nd 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 Board is asked to note the updated progress of the Trusts GDE Programme the achievement of Milestone Three and progress towards Milestone Four.
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 1st May 2018 work has continued to ensure phase four milestones are achieved; primary areas of work include:

Share2Care – Regional Portal

The Share2Care Programme recently completed a bid 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)

The bid has been submitted and successful candidates will receive feedback in Late May / Early June.

Meanwhile there are a number of additional workshops which have been scheduled to ensure all user acceptance testing is completed. The aim is to ensure all technical user acceptance testing is completed by the 22nd May and all clinical user acceptance testing is completed by the 19th June. Alder Hey are leading the way with our technical user acceptance testing completed and clinical user acceptance testing due to start imminently.

Benefits baseline: Pre-implementation survey undertaken. Findings identified that 0% of clinicians are able to access clinical information they need easily; 0% are satisfied with the current process for accessing clinical information from other Trusts. Time taken to collate information from other Trusts ranges from hours to days.

Patient Portal

Work has commenced on scoping the Patient Portal which will form part of the interoperability solution and Share2Care Programme across the STP. Current scoping has involved a number of patients and attendance at Patient Forums. Work is now underway via a number of Clinical Advisory Groups to engage with clinicians about the current scope and gain an understanding of their views.

Benefits baseline: Information is not readily available to patients; average turnaround time from submitting a Patient Access Request to receiving their record is 21 calendar days. Average PALS and Complaints relating to communication failures, conflicting information and query regarding appointments is 72 per quarter.

Speciality Packages

We are now live within ten specialities including Chronic Pain, Gynae, Emergency Department, Community Matrons, Rheumatology, Transition, Dietetics, Pre-Op, Tissue Viability and Standard Documents

Following the go live of ten speciality packages we can evidence that we have followed a standard process to achieve over twenty Person-centred, Evidence-based, Data driven, Metric-defined, Accessible Pathways (PEDMAPs).

There are nineteen speciality packages on-going with requirements gathering and development at various stages, this includes, Physio, Occupational Therapy, Orthotics, Community Paeds, General Surgery, Phlebotomy, Haematology, Community Physio,

Safeguarding / Rainbow, Orthopaedics, Vascular Access, Immunology & Infectious Diseases, Burns, Neurosurgery, Learning Disabilities, Patient Flow, Respiratory, Transfusion and Gastro.

As a result of the above work we are on track to achieve our NHS Digital Milestone of twenty one speciality packages by July.

Benefits baseline: No digitised clinical pathways. Average length of stay 2.78 days. Individual specialty packages have bespoke benefits identified and are available to view in the SOPB on SharePoint.

3.0 Upcoming Deliverables

- Continue to engage specialities to ensure the delivery of twenty one Speciality Packages by Milestone 4,
- Develop a Business Case to engage other Trusts in joining the interoperability Share2Care Programme,
- Continue the deployment of Welch Alyn integration into Meditech on Ward 3A.

4.0 Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
ED Specialty Package	Increased income – ECDS Early Adopter site	Income received for being an Early Adopter site	N/A	£20,000 Mar-2018	£20,000 Mar-2018
Booking & Scheduling – Bi-directional texting	Improve efficiency in clinic utilisation	DNA rates for specialties live	Jan-Mar 17 8.3%	Reduction	Jan-Mar 18 7.8%
Specialty Packages	Improve patient flow digitisation of the acute bronchiolitis clinical pathway	Additional income costed as a result of released beds	Apr-Jan 17 2247 bed days	Increased income	Apr-Jan 18 1827 bed days £312,000 Additional income

5.0 Milestone Assurance

Work is underway to achieve Milestone 4 by the 31st July 2018. NHS Digital will be attending Alder Hey at the end of June or beginning of July to commence their assurance testing for this milestone.

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

15th May 2018

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

22nd 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 April 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 April 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. The winner for March is Sara Melville and the recognition award is currently being arranged. Sara has been recognised as re-defining and digitising the vascular access pathway to ensure vascular access is only used when absolutely necessary and to validate the type of vascular access obtained is the most appropriate option for the treatment and patient.

Staff Survey

The 2017 Staff Survey results show significant improvements from the previous year's results. Alder Hey has been recognised by the Association of UK University Hospitals (AUKUH), in their detailed analysis of the Staff Survey, as the most improved Trust in terms of our ranking on the total number of key findings on which we achieved statistically significant improvements, and our ranking on the net number of significant improvements across the survey. Work continues on local staff survey conversations and actions.

2. Workforce Sustainability and Capability

Education, Learning and Development

Apprenticeships

Following Apprenticeship week in March 2018 we received almost 70 expressions of interest (EOIs) from existing staff who wanted more information about how to take an Apprenticeship. Currently we are unable to deliver in-house Apprenticeships in some of the subject areas that were highlighted as being valuable to improve performance. We have identified external providers to deliver these Apprenticeships in the following subjects: Leadership & Management L5, Business Administration L2 & L3, Information Technology L2 and L3, Medical Administration L3 and Hospitality L2 and L3.

Wirral Metropolitan College and Southport College have been to the Trust to deliver Information Advice and Guidance (IAG) sessions about the above Apprenticeships and to provide a full overview about expectations whilst being an Apprentice. They can provide provision from September 2018 for 24 existing members staff.

There is ongoing work to support remaining staff with internal provision. We expect a further 10 learners to start an Apprenticeship under Alder Hey's banner as an Employer-Provider in July, once new staff are in place to deliver it. If all learners currently waiting sign up to their Apprenticeship we will have reached over 68% of our target for the year.

Mandatory Training

Core mandatory training as of end of April is above target at 93.1% and overall mandatory is 89.79%. The team are continuing to monitor training compliance and issue weekly reports 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

Following the business case in support of strengthening resources in the HR function, the following posts are now in place.

- Sarah Smith, ESR Lead
- Darren Shaw, L&D Manager

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, agreed with staff side and circulated to staff as the final. 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. The counter proposal has been approved and is part of the final change paper which has circulated by management. The new service will be in operation from early July.

Employee Relations Activity

The Trust's current ER activity stands at 23 cases. There are 10 disciplinary cases (1 through fast track); 4 Bullying and Harassment cases; 2 grievances; 2 final absence dismissal cases (1 pending appeal); 1 formal capability cases; 3 MHPS Capability cases and 2 Employment Tribunal (ET) cases.

Employment Tribunal Cases

- A tribunal has now been scheduled for 11th-14th December for an ET Claim relating to unfair dismissal and wrongful dismissal.

- An ET Claim relating to disability discrimination and protected disclosure is scheduled to go ahead will be heard at the Liverpool Employment Tribunal in November 2018.

Corporate Report

The HR KPIs in the April Corporate Report are:

- Sickness rates have decreased again to 4.52% in month and the cumulative position is 5.12% - There has been a steady decrease for 3 consecutive months now.
- Mandatory training compliance dipped slightly to 93.1%, but remains above compliance threshold.

Alder Hey has been invited to be part of a national staff health and wellbeing improvement programme being led by NHS Improvement in order to improve the health and wellbeing of our workforce and to reduce sickness absence rates. The first workshop is due to take place on 31st May 2018 in Birmingham, which the Trust hopes to benefit from a comprehensive support package around health and wellbeing provision and sickness absence management.

Alder Hey Children's NHS
NHS Foundation Trust

Workforce and Organisational Development Committee Annual Report 2017-2018

The Workforce and Organisational Development Committee

The Workforce and Organisational Development Committee (WOD) was established by the Board of Directors to be responsible for providing strategic direction and board assurance in relation to all workforce matters, and making recommendations, as appropriate, on workforce matters to the Board of Directors, in support of the delivery of high quality patient and family centred care. In addition, to support the organisation in delivering a positive patient centred culture, embedding the values and behaviours that the trust aspires to demonstrate.

The principal devolution of the Board's responsibilities to the Committee is as follows:

- Oversee the development and implementation of the Trust's People & OD Strategy to assure the Trust Board that the strategy is implemented effectively and supports the Trust's vision and values, by receiving progress reports against the annual plan and Key Performance Indicators.

- Monitor workforce risks contained in the Trust's Corporate Risk Register and Board Assurance Framework, and risks arising from transformation and Quality Improvement programmes, and report these to the Trust Board as required.

- Ensure mechanisms are in place to support the development of leadership capacity and capability within the Trust, including talent management.

- Ensure the optimum design and development of the workforce to ensure that the Trust has productive, engaged staff with the right skills, competencies and information to meet the required contractual obligations. Receive reports relating to workforce planning.

- Monitor the overall resilience of the organisation and staff, and support the development of a positive and healthy culture through appropriate measurement of engagement and wellbeing.

- Ensure that the Trust is meeting its legal obligations in relation to equality and diversity. This will include overseeing the development of the workforce elements of the Equality Delivery Scheme (EDS), Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) action plans and ensure the effective implementation of the EDS by receiving regular reports against the action plans.

- Ensure robust and proactive plans are in place for supporting innovative approaches to diversity and inclusion, ensuring we support all staff from all backgrounds to have a positive experience working at Alder Hey.

- Obtain assurance that arrangements are effective to support effective partnership working with Trade Unions. More specifically the Committee will oversee the development of the Partnership Agreement.

- Obtain assurance that the Trust has an appropriate pay and reward system that is linked to the delivery of the Trust's strategic objectives and desired behaviours.

- Provide assurance to the Board that there are mechanisms in place to allow staff to raise concerns and that are dealt with in line with policy and national guidance.

- Monitor education, training and learning activities to ensure it complies with required regulations i.e. Learning and Development Agreement, Education Outcomes Framework Deanery, GMC Standards, CQC, Health Education England. Receive regular reports from Education Governance Group.

- Ensure that processes are in place to support the mental and physical health and wellbeing of Trust staff. Monitor and review the Trust's Occupational Health Service, receiving reports where required.

  Ensure delivery of an improved strategy for internal communications, and monitor progress against this strategy. To advise of any significant issues identified through internal communications.

The conduct of this remit was achieved firstly, through the Committee being appropriately constituted, and secondly by the Committee being effective in ensuring internal accountability and the delivery of assurance on specific issues.

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, the membership comprises:

MEMBERSHIP: 1 Non-Executive Director [Chair]
2 Non-Executive Directors
Director of Human Resources & Organisational Development – [Deputy Chair]
Chief Operating Officer
Director of Nursing (or Deputy)
Medical Director (or Deputy)
Director of Marketing & Communications
1 x Representative from each Division

Minutes of the Committee are presented to the Board and are supported by a summary report from the Committee Chair. Terms of Reference are revised annually and were last approved in December 2017

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Achievements

In discharging its duties the Committee met its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from relevant individuals.

The following areas were the main focus of the Committee's attention:

- Governance and Programme Assurance for all workforce projects relating to the 'Change Programme'
- Monitoring of the Listening into Action journey
- Monitoring of Mandatory Training progress against targets
- Approval of the Staff Survey action planning process
- Scrutiny of progress against the targets and measures contained within the People Strategy
- Ratification of all relevant workforce policies
- Monitoring of key workforce risks and assurance that strategic plans and operational policies exist to mitigate all significant risks
- Approval of the Trust approach to Engagement and Communications
- Approval of the Trust Apprenticeship Strategy and review of progress
- Approval of the Library and Knowledge Management Strategy
- Approval of the Workforce Equality and Diversity Objectives and review of progress against those objectives
- Monitoring of the Management and Leadership Development Strategy

Self Assessment

During the year the Committee has complied with 'good practice' recommended through:-

- Agreement and monitoring of an annual work programme.
- Prepared an Annual Report of its activities

Assurance Statement

Through the various mechanisms set out above, the Committee has gained assurance that the delivery of the Trust People Strategy was on track and all key workforce risks

were being managed. 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

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2018/19:

- Focus on monitoring the implementation of the refreshed People Strategy.
- Focus on monitoring measures agreed to improve diversity across the organisation.
- Focus on the key areas which would receive increased focus from the Committee in 2017/18 which would enable the Trust to deliver its people related targets, namely
    - Wellbeing
    - Leadership
    - Future workforce needs
- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.

Claire Dove
Committee Chair April 18

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE
2018-19 AGENDA TIMETABLE

Agenda Item	April	June	August/ September	October	December	February
Review and agree WOD TOR					✓	
Discuss and identify key workforce themes/risks			✓			✓
Review/amend and approve People Strategy	✓					
Monitor progress against People Strategy	✓	✓	✓	✓	✓	✓
Ratify employment policies	✓	✓	✓	✓	✓	✓
Review workforce risks for inclusion in Board Assurance Framework	✓	✓	✓	✓	✓	✓
Sign-off Annual Report to the Trust Board						✓
Change Programme Assurance	✓	✓	✓	✓	✓	✓
Equality & Diversity Monitoring Process	✓	✓	✓	✓	✓	✓
Staff Survey Results (dependent upon date of publication)	✓					✓
Nurse Workforce Report	✓		✓			✓

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE MEMBERSHIP ATTENDANCE 2017/18

	19th April	21st June	29th September	8th November	12th December	15th February	Attendance
Mrs C Dove - Chair (Non-Executive Director)	✓	X	✓	✓	✓	✓	5/6
Mr I Quinlan (Non-Executive Director)	X	X	✓	X	X	✓	2/6
Mrs J France-Hayhurst (Non-Executive Director)	✓	✓	X	✓	X	X	3/6
Mrs M Swindell (Director of HR&OD	✓	✓	✓	✓	✓	✓	6
Mrs Mags Barnaby (Interim COO) Mr A Bateman (COO joined Feb 18)	X	X	✓	X	✓	✓	3/6
Mrs H Gwilliams or Deputy (Chief Nurse)	X	X	X	✓	X	✓	2/6
Mr S Ryan or Deputy (Medical Director)	X	X	X	✓	X	✓	2/6
Mr M Flannagan Director of Marketing & Communications (joined WOD 8/11/2017)				✓	✓	✓	3/3

Alder Hey Children's NHS
NHS Foundation Trust

THE NHS CONSTITUTION
the NHS belongs to us all

Workforce Profile Data

April 2018

Contents

Introduction

Alder Hey Children's NHS Foundation Trust is committed to creating an environment which is inclusive, supportive and friendly to everyone within our communities, whether patients, parents, carers and staff. A key priority to Alder Hey is providing the best possible experience to our children, young people and families.

The purpose of this report is for the Trust to evidence its commitment to the principles of the NHS Constitution and compliance with the general equality duty across our service functions.

The NHS is founded on a common set of principles and values that bind together the communities and people it serves – patients and public – and the staff who work for it. Seven key principles guide the NHS in all it does. They are underpinned by core NHS values which have been derived from extensive discussions with staff, patients and public. The NHS Constitution establishes the principles and values of the NHS in England (NHS Constitution 2012).

The first of these principles states "The NHS provides a comprehensive service available to all irrespective of gender, race, disability, age, sexual orientation, religion and belief. It has a duty to each and every individual that it serves and must respect their human rights. At the same time, it has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population".

In addition, the Equality Act 2010 public sector equality duty (s149) states that in the exercise of their functions, public authorities must have due regard to the need to:

- eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act;
- advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

This report has produced data based on the content of the Electronic Staff Record to include **age, gender, ethnicity, disability, sexual orientation and religion and belief.**

Employee relations data relating to the last 2 years **January 2016 to January 2018** is included in this report in addition to data for flexible working, training and recruitment data. The Trust system that holds staff information was updated to 'Electronic Staff Record (ESR) Enhanced' with effect from 1st April 2017. This enables staff to personally update their equality demographic data; this should result in improved quality of data for future reporting. We are working on how best to report data relating to our BME network to the workforce committee to enable the Trust to monitor profile, recruitment, career progression and promotion and staff experience in relation to this group of staff to progress the workforce race equality standard (WRES) action plan.

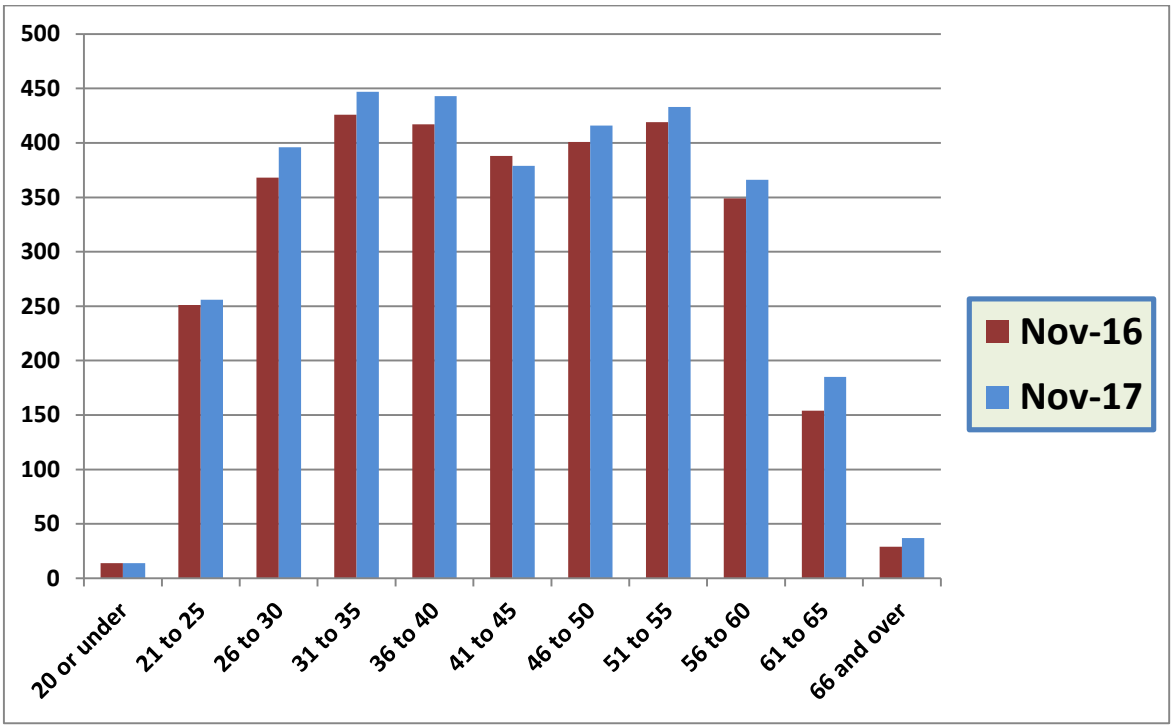
The data is from 1st December 2016 to 30 November 2017.

Priorities for 2018/19

- Improve the quality of staff equality demographic data by reducing the number of non-disclosures across the protected characteristics
- To consider how we monitor non-mandatory training opportunities by protected characteristic
- To review and broaden the content of this report to reflect workforce initiatives taken in response to data/information, stakeholder engagement and mandatory reporting requirements.

1. Trust Age Profile

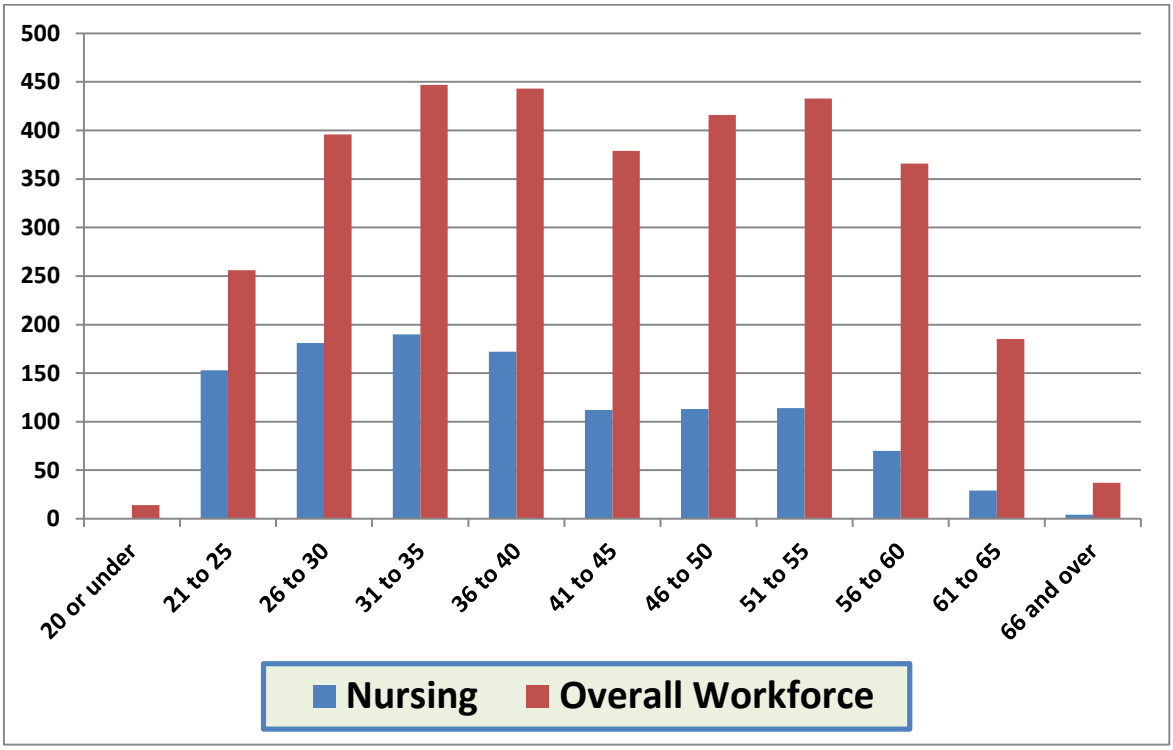
The total number of staff employed by the Trust in November 2017 is 3372 which is an increase from 2016 at 3216. The highest percentage of working age group is **31-35** years at 13.26% followed by 36-40 years at 13.14%. The most significant changes from the previous report are an **increase in staff in age band 61 to 65** years which has increased from 0.86% to 1.10%. There is a slight decrease in staff from last year in 41-45 age category (please see the graph and table below).



Overall	Nov-17		Nov-16	
Age Band	Total	% of Staff	Total	% of Staff
20 or under	14	0.42%	14	0.42%
21 to 25	256	7.59%	251	7.44%
26 to 30	396	11.74%	368	10.91%
31 to 35	447	13.26%	426	12.63%
36 to 40	443	13.14%	417	12.37%
41 to 45	379	11.24%	388	11.51%
46 to 50	416	12.34%	401	11.89%
51 to 55	433	12.84%	419	12.43%
56 to 60	366	10.85%	349	10.35%
61 to 65	185	5.49%	154	4.57%
66 and over	37	1.10%	29	0.86%
Grand Total	3372	100.00%	3216	100.00%

2. Trust Age Profile – Nursing compared to Overall Workforce

The largest age group in the nursing workforce continues to be age band **31-35 years** at 16.70%. The next highest group is age group **26-30 years** (15.91%). The number significantly drops at 56-60 years (6.15%) compared to those working in this age band across the Trust overall (10.85%). There are 1,138 (compared to 1,122 last year) nurses in total working across the Trust.



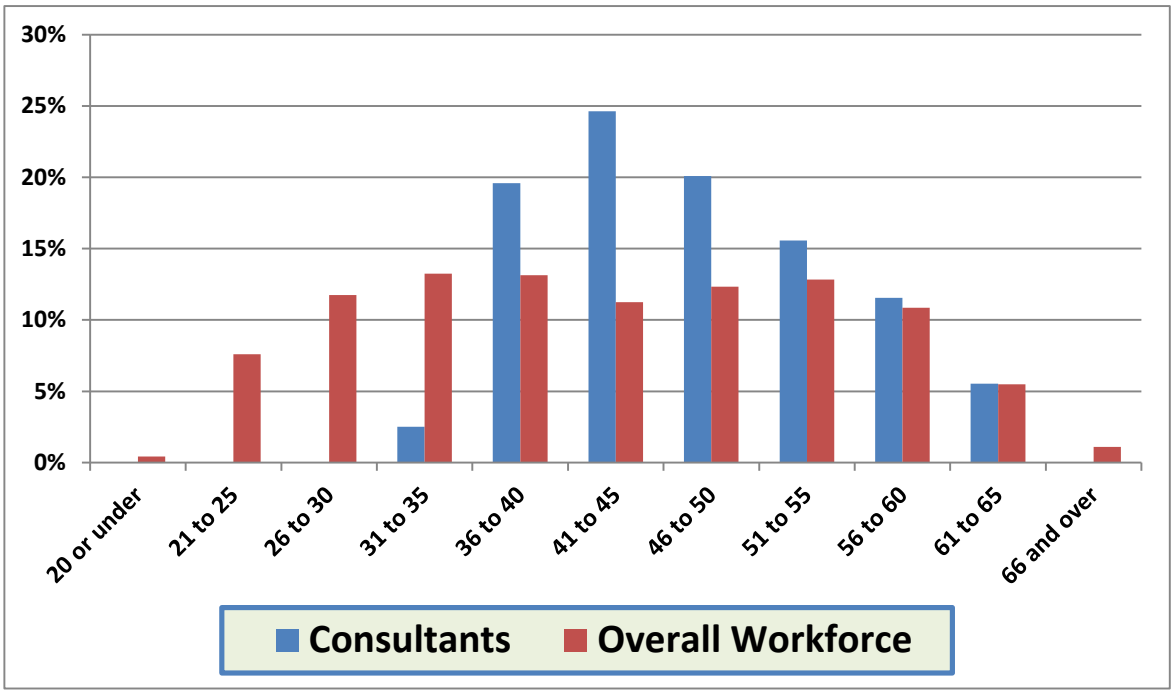
Age Band	No of Staff	% Nursing
20 or under	*	*
21 to 25	153	13.44%
26 to 30	181	15.91%
31 to 35	190	16.70%
36 to 40	172	15.11%
41 to 45	112	9.84%
46 to 50	113	9.93%
51 to 55	114	10.02%
56 to 60	70	6.15%
61 to 65	29	2.55%
66 and over	*	*
Total	**1138**	

* indicates n= less than 10.

% values for those less than 10 have also been removed.

3. Trust Age Profile – Consultant compared to Overall Workforce

Nearly half of the consultant workforce (45%) is aged **41-50 years**. By comparison, this age band makes up only a quarter of the overall workforce (23.58%). There continues to be only marginally higher levels from age 51+ compared to the overall workforce. The youngest age consultants are represented is 31 to 35 years with less than 10 in number with a similar low representation from 61+ years.



Age Band	No of Staff	% Consultants
20 or under	0	0.00%
21 to 25	0	0.00%
26 to 30	0	0.00%
31 to 35	*	*
36 to 40	39	19.60%
41 to 45	49	24.62%
46 to 50	40	20.10%
51 to 55	31	15.58%
56 to 60	23	11.56%
61 to 65	11	5.53%
66 and over	*	*
Total	**199**	

* indicates n= less than 10.

% values for those less than 10 have also been removed.

4. Trust Profile by Disability

The total number of staff who has disclosed that they have a disability is **88 staff** making up **2.61%** of the workforce. The **number disclosing has improved** from 69 staff (2.15%) last year.

	Headcount		%	
Disabled	**Nov-17**	**Nov-16**	**Nov-17**	**Nov-16**
No	3284	3147	97.39%	97.85%
Yes	88	69	2.61%	2.15%
Grand Total	3372	3216		

5. Trust Profile by Gender

The Trust profile by gender indicates that the workforce total is comprised predominantly, as expected, of female employees at **84.05 %.**

	Headcount		%	
Gender	**Nov-17**	**Nov-16**	**Nov-17**	**Nov-16**
Female	2834	2659	84.05%	84.05%
Male	538	557	15.95%	15.95%
Grand Total	**3372**			

5a. Staff Group Analysis by Gender

The majority of the **male workforce has changed from** medical and dental professions to **administrative and clerical**. The majority of **female staff is in nursing and midwifery** followed by administrative and clerical staff groups.

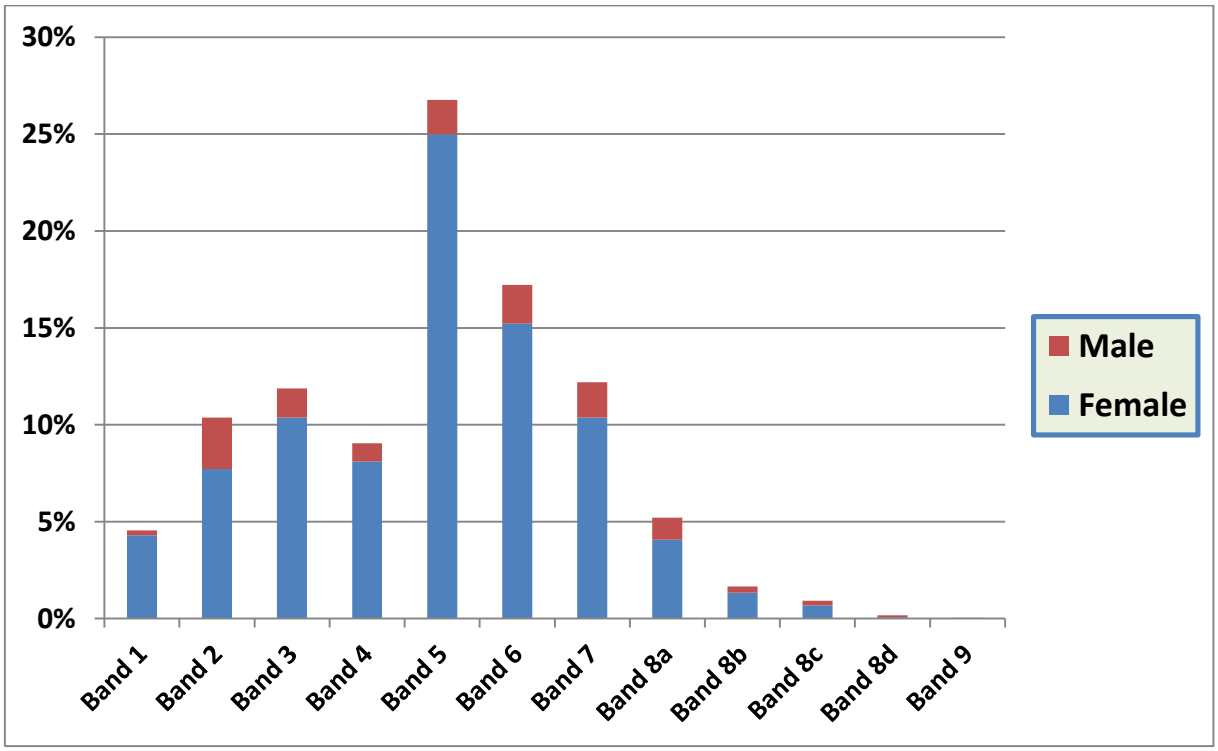
Staff Group	Female	Male	Grand Total
Add Prof Scientific and Technic	177	36	213
Additional Clinical Services	394	67	461
Administrative and Clerical	564	133	697
Allied Health Professionals	247	23	270
Estates and Ancillary	170	54	224
Healthcare Scientists	79	36	115
Medical and Dental	126	128	254
Nursing and Midwifery Registered	1077	61	1138
Grand Total	**2834**	**538**	**3372**

5b. Trust Profile - Gender by AFC Band

Approximately 24.98% of the **female** workforce on agenda for change pay banding is paid at **band 5** and 15.22% at a band 6.

The **male** workforce on agenda for change pay banding is mainly paid on **band 2** (2.67%) followed by band 6 (1.98%).

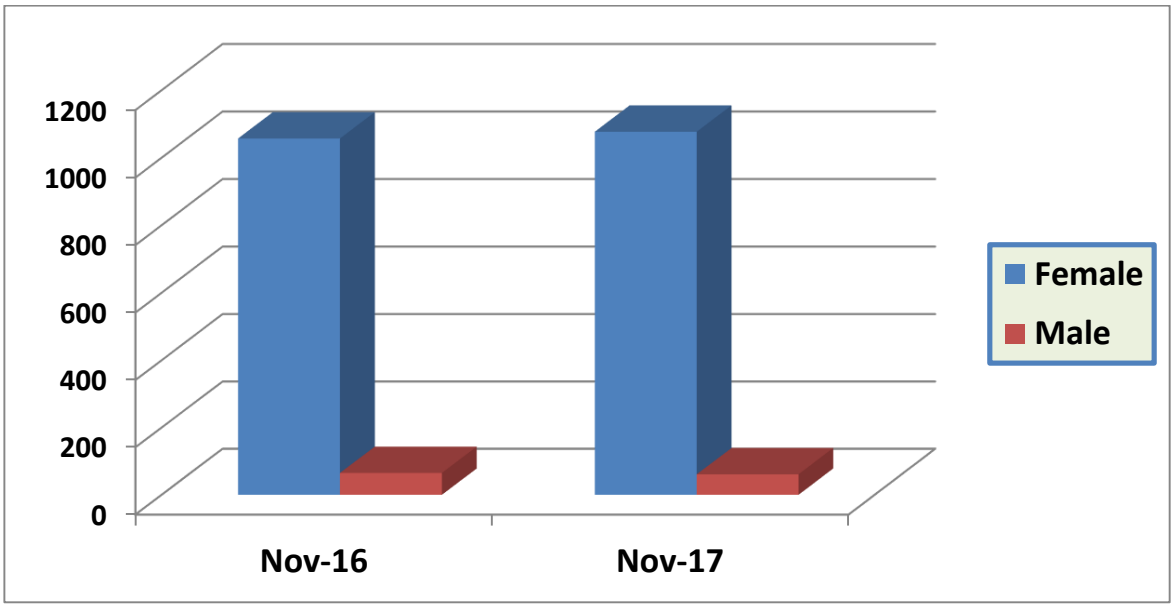
For more detailed information please refer to the Trust Gender Pay Gap Report published on the Trust website.



* indicates n= less than 10.
% values for those less than 10 have also been removed.

6. Trust Gender Profile – Nursing

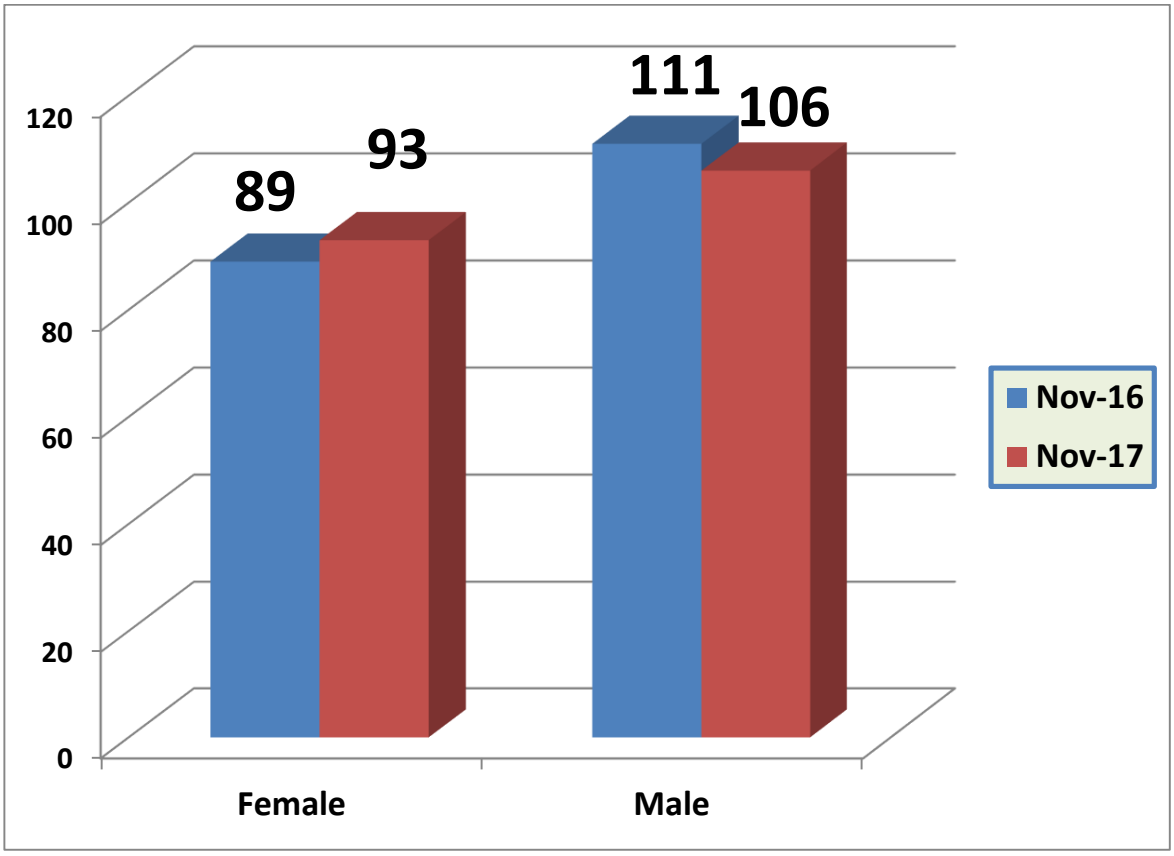
The profile by gender in the nursing workforce shows predominantly a female workforce at 94.64% as expected with **5.36% being males**. This shows that nationally and locally there is a lot of work to do in promoting the profession to the male gender as it appears that nursing is still regarded stereotypically as a female profession.



	Headcount		%	
Gender	Nov-16	Nov-17	Nov-16	Nov-17
Female	1057	1077	94.21%	94.64%
Male	65	61	5.79%	5.36%
Total	**1122**	**1138**		

7. Trust Gender Profile – Consultant

The profile by gender in the workforce at consultant level continues to reflect a **higher male representation** at 53.27% males compared to 46.73% females. This is similar to last year's report with a slight increase in female staff and decrease in male staff.



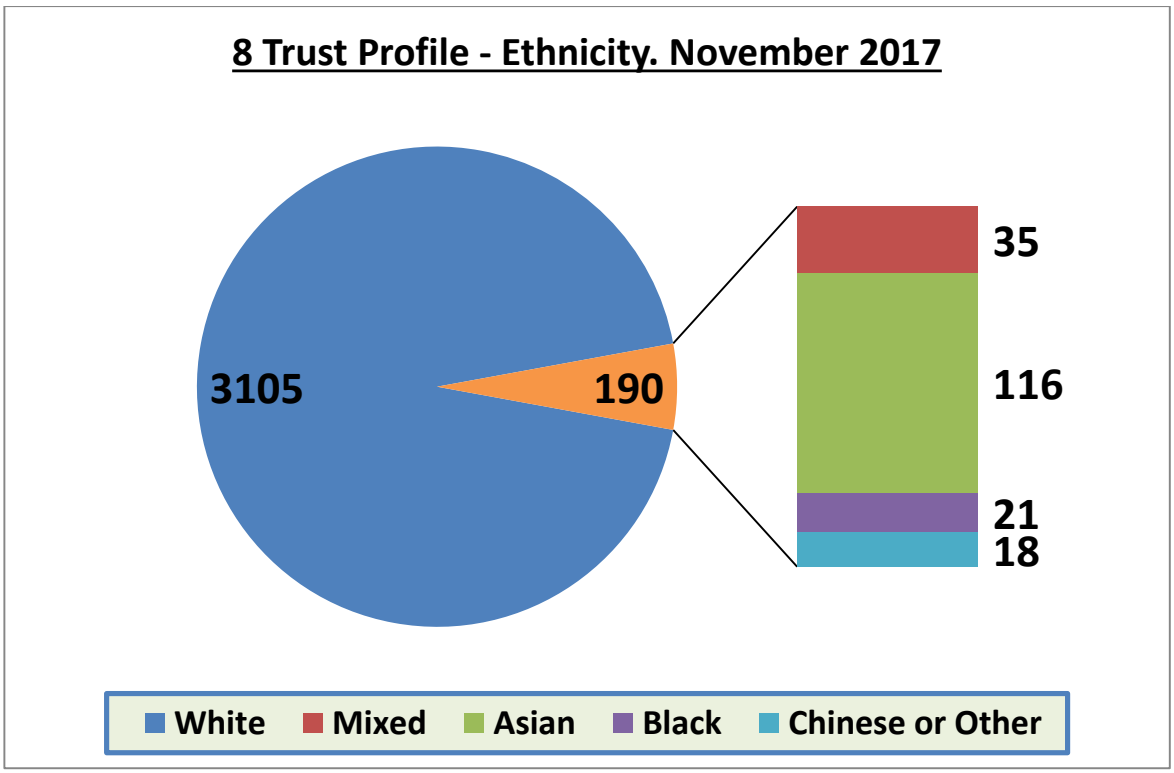
	Headcount		%	
Gender	**Nov-16**	**Nov-17**	**Nov-16**	**Nov-17**
Female	89	93	44.50%	46.73%
Male	111	106	55.50%	53.27%
Total	**200**	**199**		

8. Trust Profile – Ethnicity Overall

The Trust profile by ethnicity indicates the largest representation is White at 94% and 6% being from a black and minority ethnic group.

The Trust is looking to increase the ethnic diversity of its workforce by 1% (equivalent to 60 staff) over the next 5 years 2016-2021.

For more detailed information please refer to the Workforce Race Equality Standard (WRES) published on the website.



8b Trust Profile - Ethnicity

The second largest representation in the Trust workforce by ethnicity is Asian or Asian British – Indian employees with numbers low in other ethnic groups. The **number not stated has decreased slightly** from 90 to 78 compared to the previous year.

Ethnic Origin	Total
A White - British	2948
B White - Irish	47
C White - Any other White background	102
C2 White Northern Irish	*
CA White English	*
CC White Welsh	*
CK White Italian	*
CY White Other European	*
D Mixed - White & Black Caribbean	13
E Mixed - White & Black African	*
F Mixed - White & Asian	9
G Mixed - Any other mixed background	10
GD Mixed - Chinese & White	*
H Asian or Asian British - Indian	91
J Asian or Asian British - Pakistani	8
K Asian or Asian British - Bangladeshi	*
L Asian or Asian British - Any other Asian background	11
LB Asian Punjabi	*
LE Asian Sri Lankan	*
LH Asian British	*
LK Asian Unspecified	*
M Black or Black British - Caribbean	8
N Black or Black British - African	11
P Black or Black British - Any other Black background	*
PE Black Unspecified	*
R Chinese	3
S Any Other Ethnic Group	11
SD Malaysian	3
SE Other Specified	*
Unspecified	*
Z Not Stated	76
Grand Total	3372

* indicates n= less than 5.

8c. Trust Ethnicity Profile – Comparing by Trust, Local, Regional and National.

This chart shows that Liverpool has a higher than national and regional average of mixed ethnic groups yet we employer a low percentage of staff from this group. Even though our highest ethnic group is Asian we continue to employ fewer than the number expected when comparing local, regional and national figures by comparison. Liverpool also has a higher than regional average of black population and the number we employ continues to be low. The Trust has put a number of initiatives in place to address this as detailed in the Workforce Race Equality Standard (WRES) Action Plan published on the Trust website.

Source: Census 2011

Ethnicity	Trust 2017	Trust 2016	Liverpool	North West	England
White	92.08%	92.04%	88.91%	90.21%	85.42%
Mixed	1.04%	0.75%	2.52%	1.57%	2.25%
Asian	3.44%	3.33%	4.16%	6.20%	7.82%
Black	0.62%	0.56%	2.64%	1.39%	3.48%
Chinese or Other	0.53%	0.53%	1.77%	0.63%	1.03%
Not Stated / Undefined	2.28%	2.80%			

9. Trust Ethnicity Profile by Staff Group

The majority of white staff is in the nursing staff group (1053) with a high number of staff from black and minority ethnic origin (Asian/Indian) belonging to the medical and dental staff group (68) and a smaller number (Asian/Indian) in the nursing staff group (25). We have few staff in other ethnicity categories across staff groups.

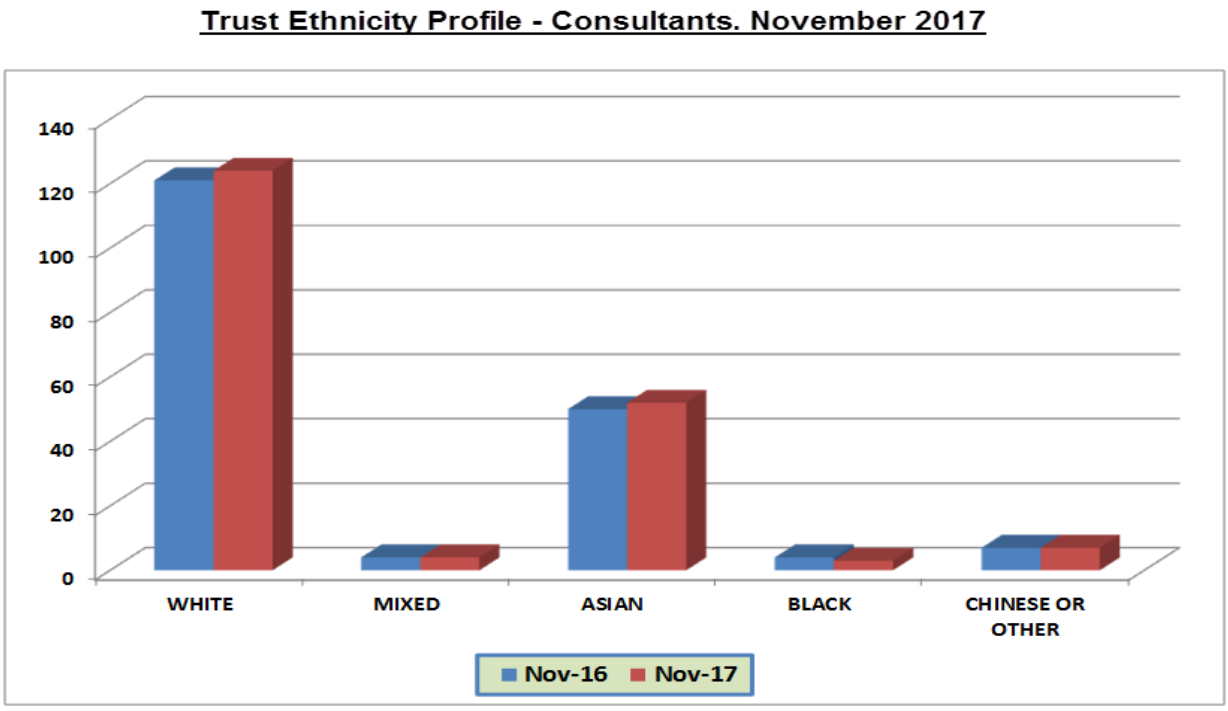
Ethnic Origin	Add Prof Scientific and Technic	Additional Clinical Services	Administrative and Clerical	Allied Health Professionals	Estates and Ancillary	Healthcare Scientists	Medical and Dental	Nursing and Midwifery Registered	Grand Total
WHITE	205	449	661	261	216	103	157	1053	3105
MIXED	3	5	5	*	0	*	5	11	35
ASIAN	*	*	9	*	*	6	68	25	116
BLACK	*	*	6	0	*	*	*	7	21
CHINESE OR OTHER	*	0	3	*	0	*	11	*	18
TOTAL	**211**	**456**	**684**	**268**	**221**	**114**	**244**	**1097**	**3295**

* indicates n= less than 5

% values for those less than 5 have also been removed to prevent identification.

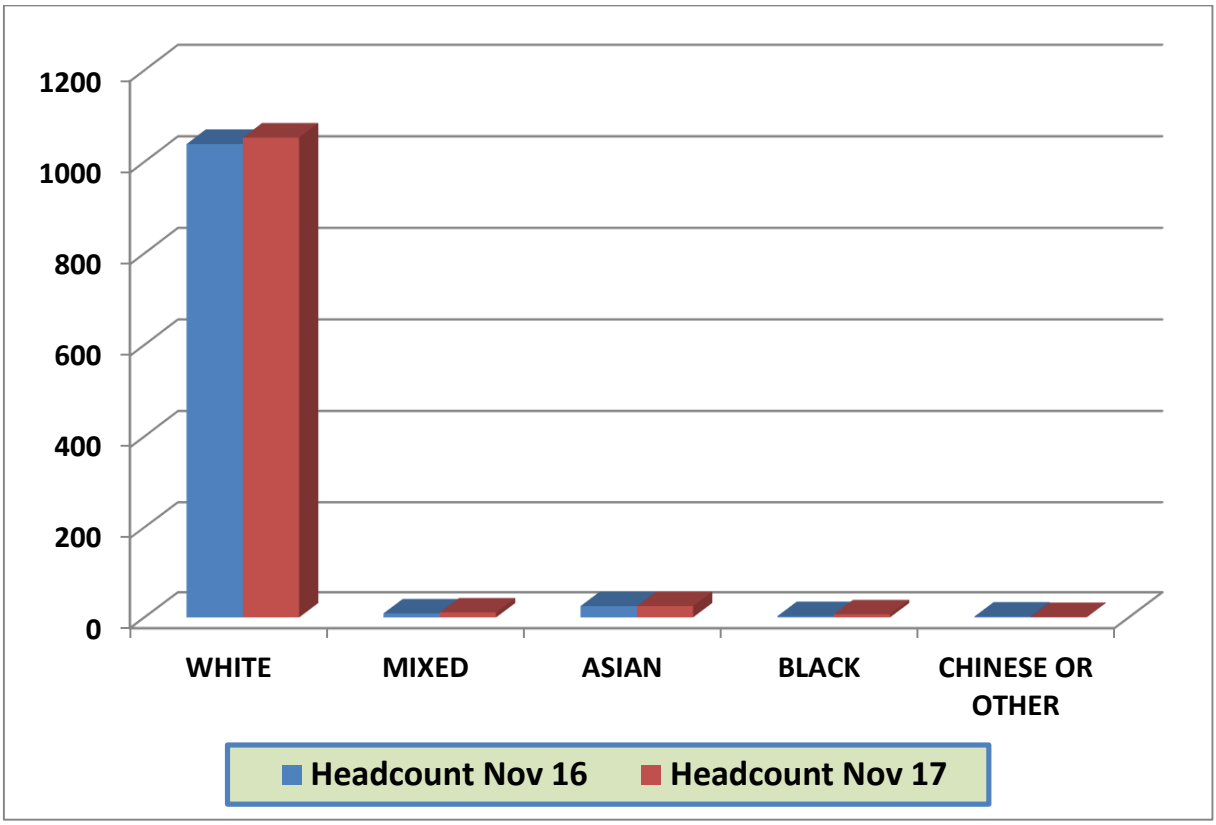
10. Trust Ethnicity Profile – Consultants

This chart indicates that the consultant workforce is predominantly of white ethnicity with consultants of Asian ethnicity making up the majority of black and minority ethnic staff.



11. Trust Ethnicity Profile – Nursing

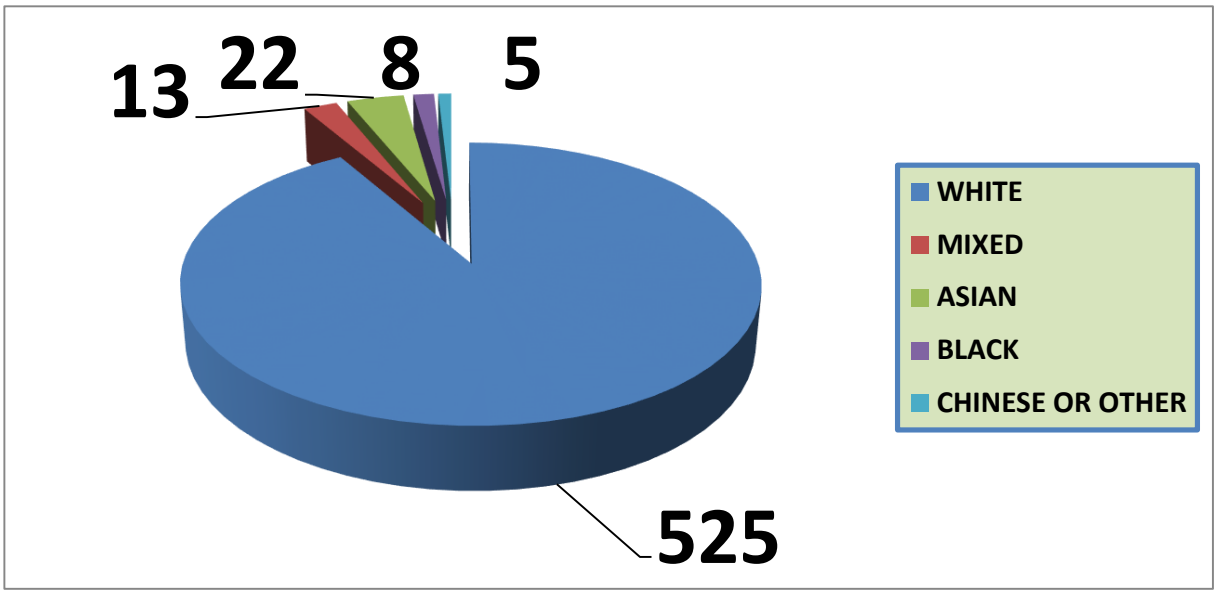
The Trust profile for ethnicity in the nursing workforce is 96.34% white ethnicity with 4.02% from black and minority ethnic (BME) ethnicity. This is an increase in the number of BME nurses compared to last year.



Ethnic Origin	Nov-17	Nov-16	% Nov 17	% Nov 16
WHITE	1053	1039	96.34%	96.38%
BME	44	39	4.02%	3.61%
Grand Total	**1093**	**1078**		

12. Trust Profile - New Starter Ethnicity

The Trust profile for ethnicity by new starters shows that the largest group represented by ethnicity is white at 92% (compared to 78% last year). Figures for new starters of BME ethnicity make up 8% compared to 21% last year when there was a 14% starter's from 'Chinese or other' ethnicity. Further analysis shows that from this 21%, there were two Chinese, two other ethnic and the remainder not declared included in this figure. The data for this year is more accurately recorded with undisclosed ethnicity being separated from the 'Chinese and Other' figure.



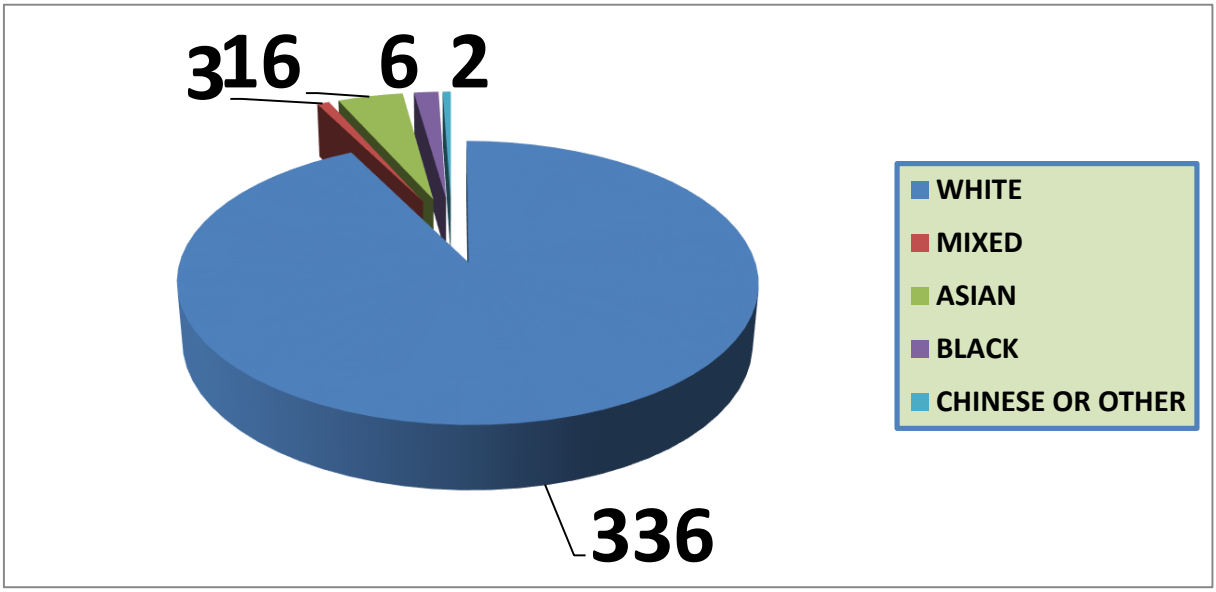
	Nov-16		Nov-17	
Ethnic Origin	**% of Starters**	**Headcount**	**% of Starters**	**Headcount**
WHITE	78.11%	371	91.62%	525
MIXED	0.63%	*	*	13
ASIAN	4.63%	22	3.84%	22
BLACK	1.89%	9	1.40%	8
CHINESE OR OTHER	14.74%	70	0.87%	5
TOTAL		475		573

* indicates n= less than 5

% values for those less than 5 have also been removed to prevent identification.

13. Trust Profile - Leavers Ethnicity

The data suggests that there a high number of leavers in 2016 from the Chinese or other ethnic category. When we further analysed this data we found that there is only one that identified as Chinese, four from 'other' and thirteen from not specified. Numbers for ethnic groups are similar comparing 2016 to 2017.



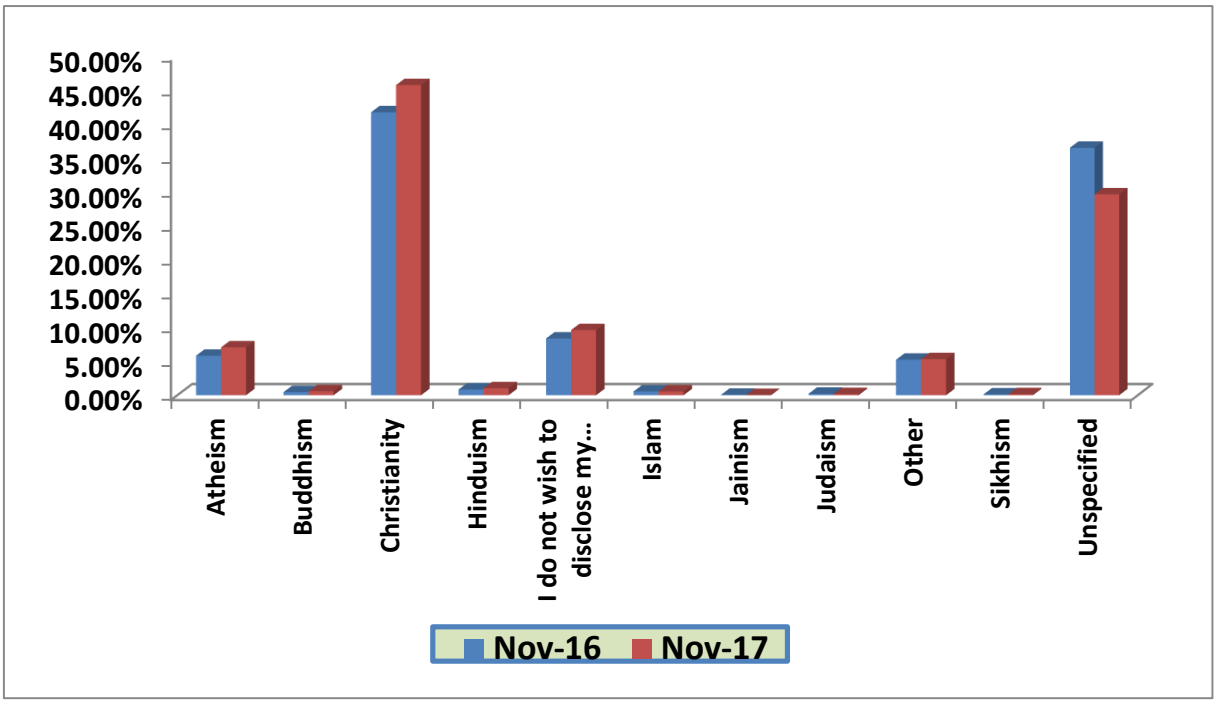
	Nov-16		Nov-17	
Ethnic Origin	**% of Leavers**	**Headcount**	**% of Leavers**	**Headcount**
WHITE	87.32%	303	86.15%	336
MIXED	*	*	*	*
ASIAN	5.19%	18	4.10%	16
BLACK	*	*	1.54%	6
CHINESE OR OTHER	5.19%	18	*	*
TOTAL		347		363

* indicates n= less than 5

% values for those less than 5 have also been removed to prevent identification.

14. Trust Profile - Religious Belief

The largest religious group is categorised as Christianity at 46% of the workforce. There has been an **improvement in disclosure** with 30% (last year 37%) showing as "Unspecified". There is less than 1% of staff declaring Buddhism, Islam, Judaism, Sikhism, Jainism and Hinduism. There has been a slight increase in staff stating that they do not wish to disclose their religion.



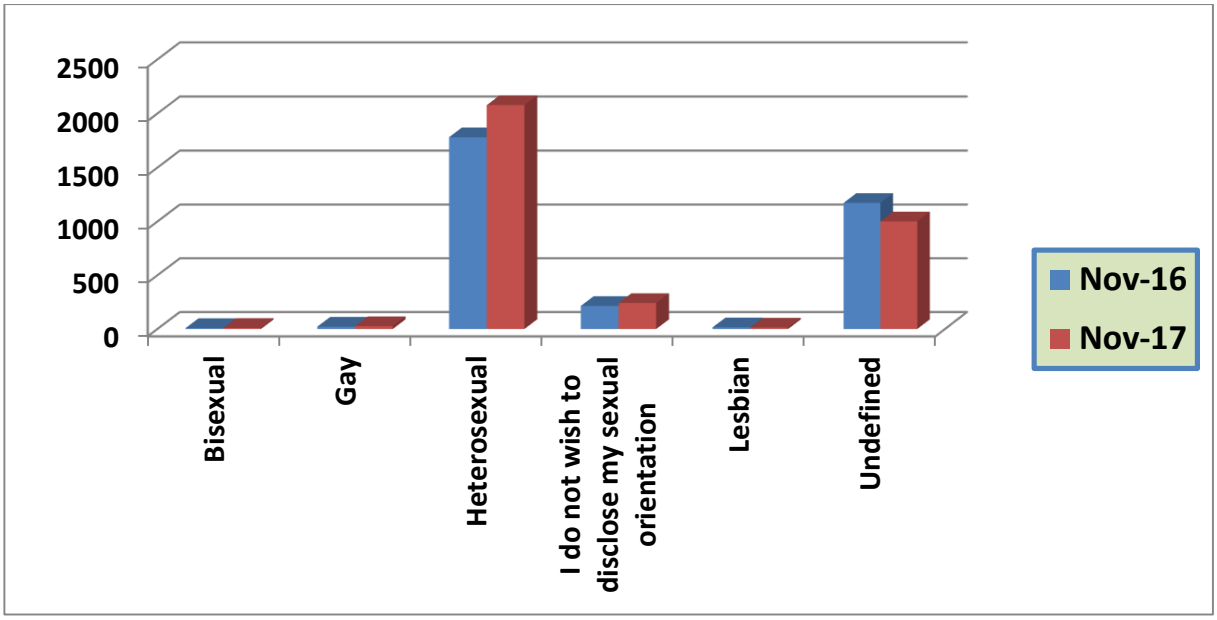
	Nov-17		% of Workforce	
Religious Belief	**Headcount**	**% of Workforce**	**Nov-16**	**Nov-17**
Atheism	239	7.09%	5.85%	7.09%
Buddhism	20	0.59%	0.47%	0.59%
Christianity	1542	45.73%	41.73%	45.73%
Hinduism	35	1.04%	0.84%	1.04%
I do not wish to disclose my religion/belief	325	9.64%	8.40%	9.64%
Islam	19	0.56%	0.56%	0.56%
Jainism	*	*	0.06%	0.03%
Judaism	6	0.18%	0.22%	0.18%
Other	180	5.34%	5.25%	5.34%
Sikhism	5	0.15%	0.12%	0.15%
Unspecified	1000	29.66%	36.50%	29.66%
Grand Total	**3372**			

* indicates n= less than 5

% values for those less than 5 have also been removed to prevent identification.

15. Trust Profile - Sexual Orientation

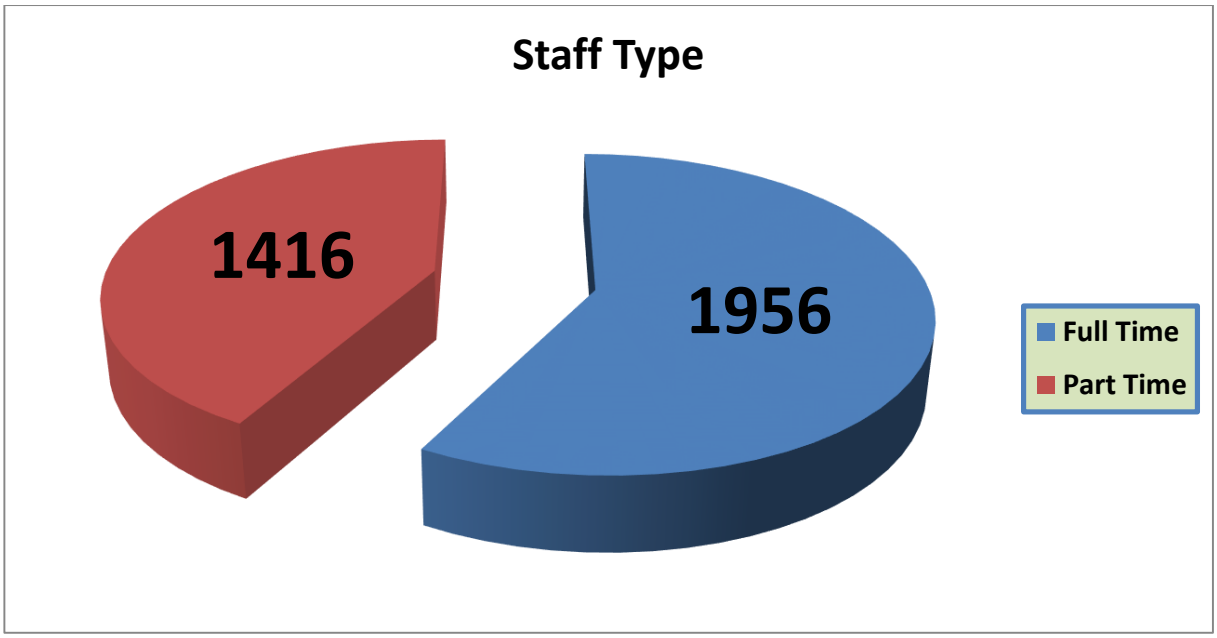
The majority of staff who have disclosed has stated that they are 'heterosexual' with a large number stating 'undefined' the same as religion and belief. **There has been an improvement in numbers of staff disclosing their sexual orientation compared to last year.** We need to try and encourage staff to complete this data with the provision of 'enhanced ESR' this year and reduce the number 'undefined'.



Sexual Orientation	Nov-16	Nov-17
Bisexual	9	10
Gay	22	27
Heterosexual	1781	2078
I do not wish to disclose my sexual orientation	215	242
Lesbian	16	14
Undefined	1173	1001
Grand Total	**3216**	**3372**

16. Trust Profile - Flexible Working

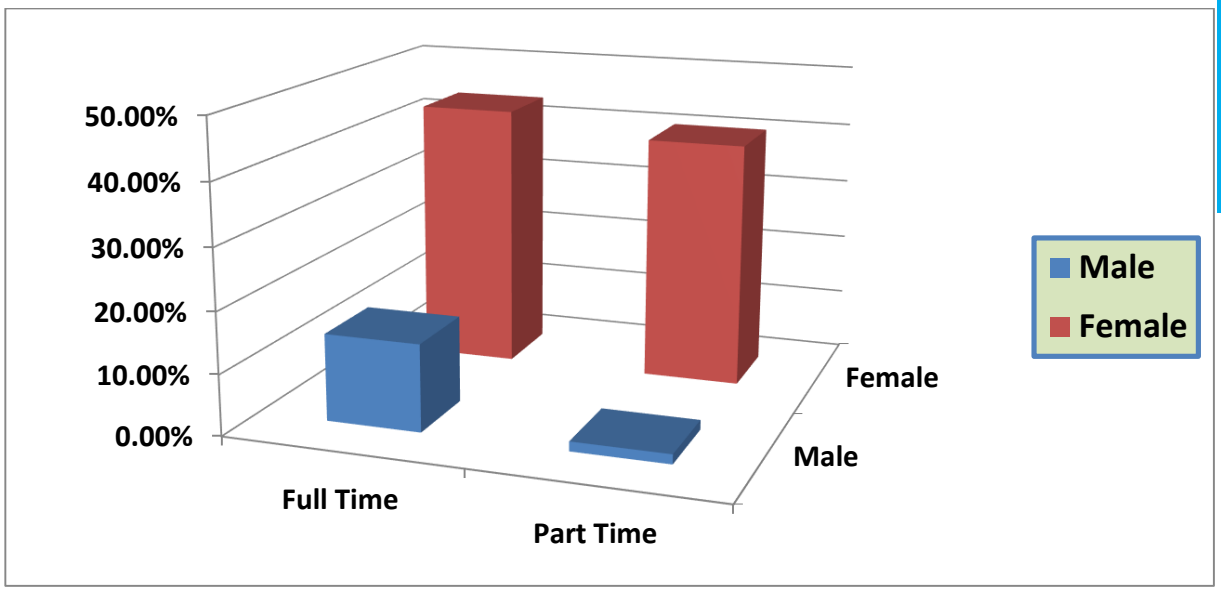
The profile for flexible working shows that 58% of staff works full time with 42% of staff working part time with similar figures to the previous report. This split is likely to be proportionate with the percentage of the workforce (85%) being female with a higher proportion of females having primary care responsibilities for childcare.



	Headcount		% of Workforce	
Staff Type	**Nov-16**	**Nov-17**	**Nov-16**	**Nov-17**
Full Time	1857	1956	57.74%	58.01%
Part Time	1359	1416	42.26%	41.99%
Grand Total	**2995**	**3372**		

17. Trust Profile - Flexible Working by Gender

These figures show that there is almost a relatively similar split of female staff working part time 40% compared to full time 42%. In comparison there is only a **minority of male staff working part time 4%** compared to full time 15%. These figures are similar to last year's reported data.



	Headcount				% Within Gender			
	Nov-16		Nov-17		Nov-16		Nov-17	
Employee Category	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
Full Time	1376	481	1472	484	42.79%	14.96%	43.65%	14.35%
Part Time	1283	76	1362	54	39.89%	4.13%	40.39%	1.60%
Grand Total	**2659**	**557**	**2834**	**538**				

18. Profile of Applicants

The table below indicates very similar trends in the percentages of female to male ratios for applications; shortlisted candidates and appointed figures when compared to last year's report. Therefore, there is little or no significant differences observed.

Gender	Applications	%	Shortlisted	% Short / Short	Appointed	% Apptd / Apptd
Male	2,289	24.40%	555	22.80%	61	23.90%
Female	7,055	75.10%	1850	76.10%	192	75.30%
Undisclosed	52	0.60%	27	1.10%	2	0.80%

Analysis of Applicants by Disability

The figures indicate that compared to the previous year's report, the Trust has had a decrease of 0.6% number of applicants with a disability (404 compared to 431 in the previous year's report) and seen an increase in the number of staff appointed at 5.5% compared to 4.2%. There has been an increase in the number of 'not disclosed' at 1.70% (158) compared to 1.3% (111) in the previous year.

Description	Applications	%	Shortlisted	% Short / Short	Appointed	% Apptd / Apptd
Yes	404	4.30%	114	4.70%	14	5.50%
No	8,834	94.00%	2280	93.80%	237	92.90%
Undisclosed	158	1.70%	38	1.60%	4	1.60%

Analysis of Applicants by Impairment

The figures regarding types of disability are fairly comparable and reflective of the Trusts data in last year's report. The figures show similar trends with learning disability and long-standing illnesses having the highest figures and likelihood of being appointed.

Description	Applications	%	Shortlisted	% Short / Short	Appointed	% Apptd / Apptd
Physical Impairment	85	18.00%	16	11.90%	2	13.30%
Sensory Impairment	59	12.50%	15	11.20%	1	6.70%
Mental Health Condition	50	10.60%	15	11.20%	3	20.00%
Learning Disability/ Difficulty	94	20.00%	36	26.90%	5	33.30%
Long-Standing Illness	124	26.30%	36	26.90%	3	20.00%
Other	59	12.50%	16	11.90%	1	6.70%

Analysis of Applicants by Ethnicity

There were 9,252 applicants who disclosed their ethnicity. Of that number, the recruitment data suggests there are 8,050 (87%) white ethnicity applicants of whom 2,103 (26%) were shortlisted and 218 (10%) appointed. Also, there were 1,202 (13%) BME applicants of whom 280 (23%) were shortlisted and 37 (13%) appointed. **The figures shows an increase in applications from BME applicants** (13% compared to 10%), however a reduction in shortlisted (23% compared to 26%) and appointed (13% compared to 17%); the majority of BME applications continue to be from Asian or Asian British ethnicity. The number of Black or Black British African applicants has remained the same as the previous year making up 2.6% of the applications.

Description	Applications	%	Shortlisted	% Short / Short	Appointed	% Apptd / Apptd
WHITE - British	7,602	80.90%	1976	81.30%	198	77.60%
WHITE - Irish	91	1.00%	33	1.40%	4	1.60%
WHITE - Any other white background	357	3.80%	94	3.90%	16	6.30%
ASIAN or ASIAN BRITISH - Indian	335	3.60%	81	3.30%	13	5.10%
ASIAN or ASIAN BRITISH - Pakistani	111	1.20%	22	0.90%	2	0.80%
ASIAN or ASIAN BRITISH - Bangladeshi	29	0.30%	5	0.20%	1	0.40%
ASIAN or ASIAN BRITISH - Any other Asian background	86	0.90%	23	0.90%	2	0.80%
MIXED - White & Black Caribbean	63	0.70%	16	0.70%	3	1.20%
MIXED - White & Black African	32	0.30%	6	0.20%	1	0.40%
MIXED - White & Asian	22	0.20%	5	0.20%	1	0.40%
MIXED - any other mixed background	62	0.70%	14	0.60%	1	0.40%
BLACK or	35	0.40%	10	0.40%	1	0.40%

BLACK BRITISH - Caribbean						
BLACK or BLACK BRITISH - African	242	2.60%	50	2.10%	2	0.80%
BLACK or BLACK BRITISH - Any other black background	32	0.30%	9	0.40%	0	0.00%
OTHER ETHNIC GROUP - Chinese	41	0.40%	11	0.50%	0	0.00%
OTHER ETHNIC GROUP - Any other ethnic group	112	1.20%	28	1.20%	4	1.60%
Undisclosed	144	1.50%	49	2.00%	6	2.40%

Analysis of Applicants by Age Band

The majority of applications continue to be from the 25-29 age groups with the highest appointments in this age group compared to the 20-24 age groups last year.

Description	Applications	%	Shortlisted	% Short / Short	Appointed	% Apptd / Apptd
Under 18	4	0.00%	1	0.00%	0	0.00%
18 to 19	107	1.10%	18	0.70%	2	0.80%
20 to 24	1,530	16.30%	277	11.40%	30	11.80%
25 to 29	2,165	23.00%	489	20.10%	49	19.20%
30 to 34	1,610	17.10%	443	18.20%	48	18.80%
35 to 39	1,084	11.50%	313	12.90%	33	12.90%
40 to 44	795	8.50%	263	10.80%	32	12.50%
45 to 49	777	8.30%	240	9.90%	22	8.60%
50 to 54	716	7.60%	207	8.50%	24	9.40%
55 to 59	423	4.50%	127	5.20%	10	3.90%
60 to 64	155	1.60%	47	1.90%	5	2.00%
65 to 69	19	0.20%	4	0.20%	0	0.00%
70 and over	4	0.00%	2	0.10%	0	0.00%
Undisclosed	7	0.10%	1	0.00%	0	0.00%

Analysis of Applicants by Religious Belief

Figures are similar to the previous year with a higher number of non-disclosure (862) compared to last year (774). There does not appear to be anything significant when comparing figures.

Description	Applications	%	Shortlisted	% Short / Short	Appointed	% Apptd / Apptd
Atheism	1,135	12.10%	312	12.80%	35	13.70%
Buddhism	56	0.60%	15	0.60%	2	0.80%
Christianity	5,754	61.20%	1499	61.60%	152	59.60%
Hinduism	176	1.90%	50	2.10%	10	3.90%
Islam	313	3.30%	80	3.30%	7	2.70%
Jainism	4	0.00%	0	0.00%	0	0.00%
Judaism	15	0.20%	6	0.20%	3	1.20%
Sikhism	10	0.10%	2	0.10%	0	0.00%
Other	1,071	11.40%	239	9.80%	17	6.70%
Undisclosed	862	9.20%	229	9.40%	29	11.40%

Analysis of Applicants by Sexual Orientation

There is nothing significant to report when comparing these figures.

Description	Applications	%	Shortlisted	% Short / Short	Appointed	% Apptd / Apptd
Lesbian	69	0.70%	21	0.90%	2	0.80%
Gay	136	1.40%	29	1.20%	0	0.00%
Bisexual	93	1.00%	35	1.40%	2	0.80%
Heterosexual	8,650	92.10%	2232	91.80%	238	93.30%
Undisclosed	448	4.80%	115	4.70%	13	5.10%

Analysis of Applicants by Marital Status

The majority of applications are age 20-29 and are therefore more likely to be single.

Description	Applications	%	Shortlisted	% Short / Short	Appointed	% Apptd / Apptd
Married	2,821	30.00%	827	34.00%	102	40.00%
Single	5,726	60.90%	1325	54.50%	121	47.50%
Civil partnership	171	1.80%	41	1.70%	5	2.00%
Legally separated	55	0.60%	15	0.60%	3	1.20%
Divorced	307	3.30%	102	4.20%	14	5.50%
Widowed	39	0.40%	9	0.40%	1	0.40%
Undisclosed	277	2.90%	113	4.60%	9	3.50%

19. Trust Profile - Training Data

Training data in relation to non-mandatory courses / CPD

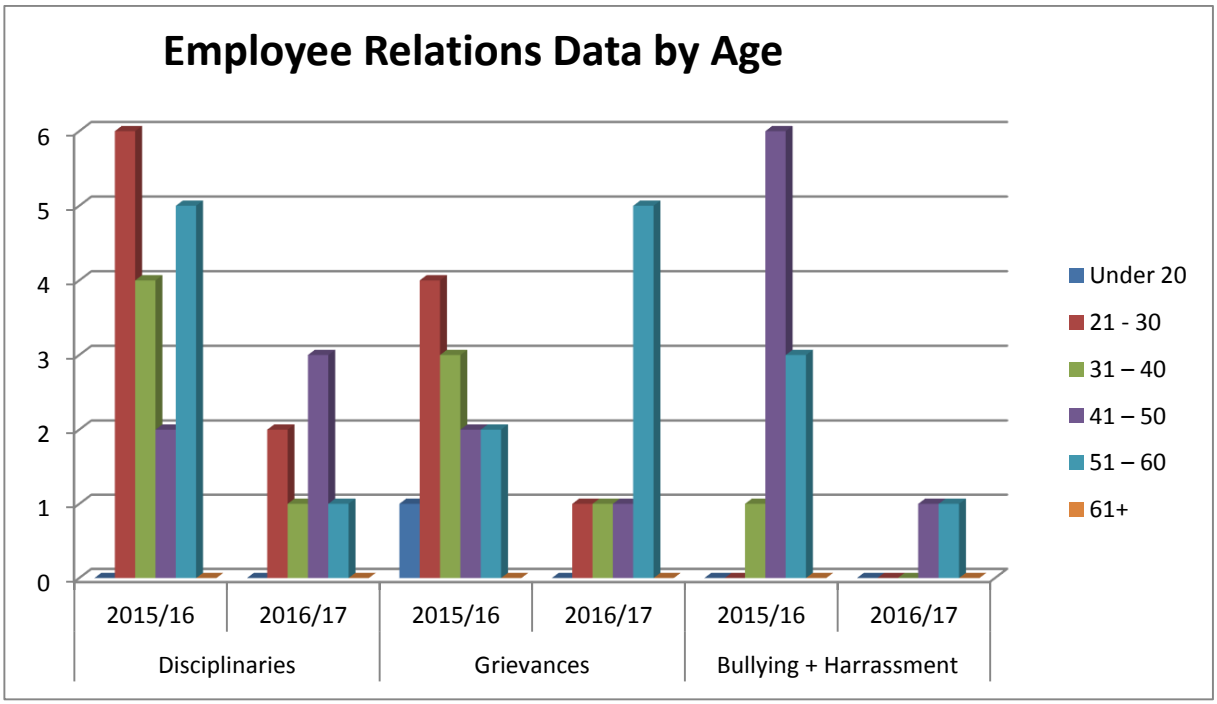
Applications for training and decisions in this regard are made locally. We will endeavour to find a solution to try and monitor this data to support the Workforce Race Equality Standard.

20. Employee Relations Data Age / Gender/ Ethnicity

Age Range:

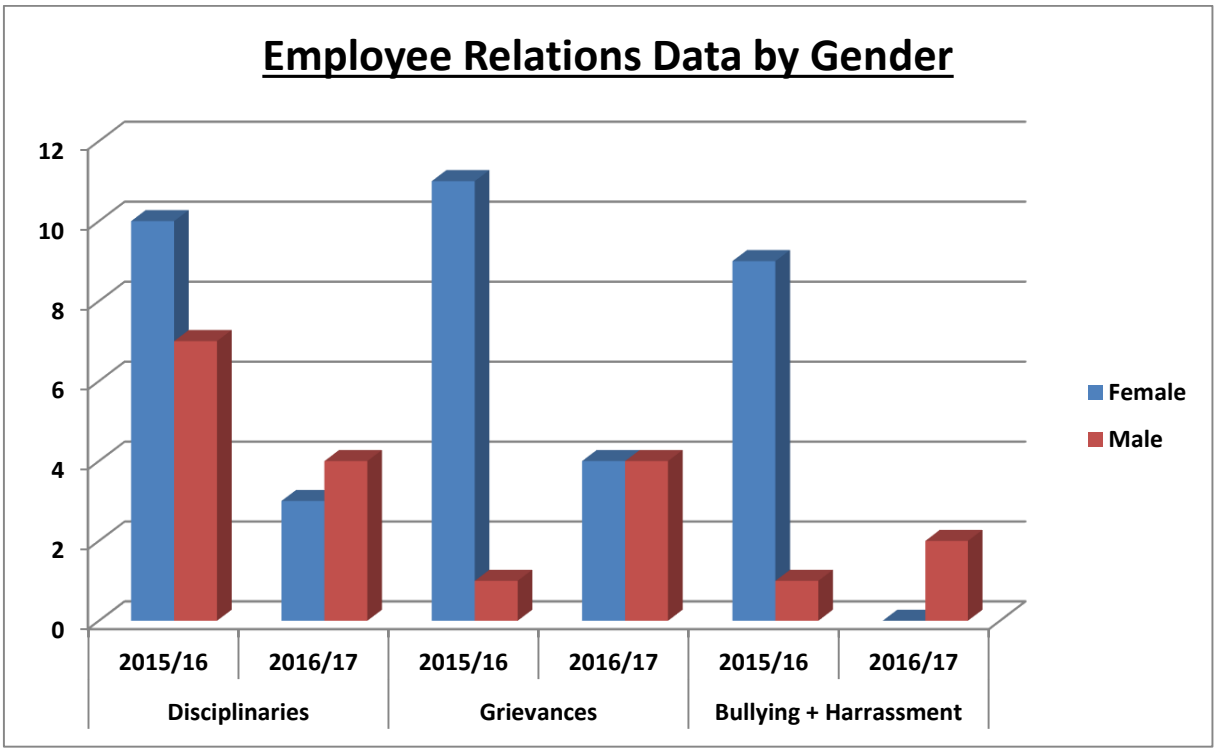
	Disciplinaries		Grievances		Bullying + Harassment	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Under 20	0	0	1	0	0	0
21 - 30	6	2	4	1	0	0
31 – 40	4	1	3	1	1	0
41 – 50	2	3	2	1	6	1
51 – 60	5	1	2	5	3	1
61+	0	0	0	0	0	0
Total	17	7	12	8	10	2

There are a higher number of 21-30 year olds subject to disciplinaries. There are a higher number of 51-60 year olds involved in grievances.



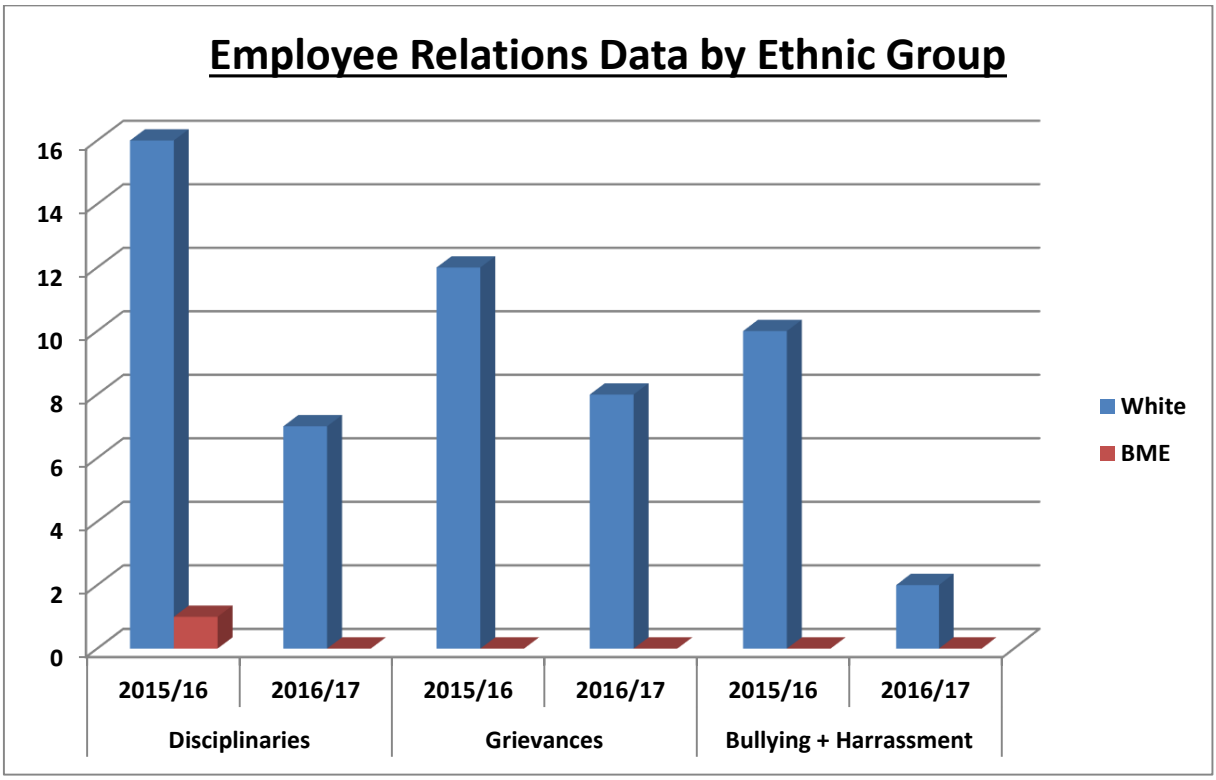
Gender:

	Disciplinaries		Grievances		Bullying + Harassment	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
Female	10	3	11	4	**9**	**0**
Male	7	4	1	4	**1**	**2**



Ethnicity:

	Disciplinaries		Grievances		Bullying + Harassment	
	2015/16	2016/17	2015/16	2016/17	2015/16	2016/17
White	16	7	12	8	10	2
BME	1	0	0	0	0	0



There are too few black and minority ethnic staff to report anything meaningful regarding employee relations data. The Trust has a BME network that will enable the Trust to better monitor the workplace experiences of staff.

National Guardian
Freedom to Speak Up

NHS
Improvement

Guidance for boards on Freedom to Speak Up in NHS trusts and NHS foundation trusts

May 2018

Contents

Introduction

Effective speaking up arrangements help to protect patients and improve the experience of NHS workers. Having a healthy speaking up culture is an indicator of a well-led trust.

This guide sets out our expectations of boards in relation to Freedom to Speak Up (FTSU). Meeting the expectations set out in this guide will help a board to create a culture responsive to feedback and focused on learning and continual improvement.

This guide is accompanied by a self-review tool. Regular and in-depth reviews of leadership and governance arrangements in relation to FTSU will help boards to identify areas of development and improve.

The Care Quality Commission (CQC) assesses a trust's speaking up culture during inspections under key line of enquiry (KLOE) 3 as part of the well-led question. This guide is aligned with the good practice set out in the well-led framework, which contains references to speaking up in KLOE 3 and will be shared with inspectors as part of the CQC's assessment framework for well-led.

Completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and oversight bodies to evaluate how healthy the trust's speaking up culture is.

About this guide

This guide has been produced jointly by NHS Improvement and the National Guardian's Office and represents current good practice.

We want boards to treat this guide as a benchmark; review where they are against it and reflect on what they need to do to improve. We expect that the board, and in particular the executive and non-executive leads for FTSU, will complete the review with proportionate support from the trust's FTSU Guardian.

The good practice highlighted here is not a checklist: a mechanical 'tick box' approach to each item is not likely to lead to better performance.

The attitude of senior leaders to the review process, the connections they make between speaking up and improved patient safety and staff experience, and their judgements about what needs to be done to continually improve, are much more important.

Key terms used in this guide

- **The board**: we use this term when we mean the board as a formal body.
- **Senior leaders**: we use this term when we mean executive and non-executive directors.
- **Workers**: we use this term to mean everyone in the organisation including agency workers, temporary workers, students, volunteers and governors.

We will review this guide in a year. In the meantime, please provide any feedback to enquiries@improvement.nhs.uk

Our expectations

Leaders are knowledgeable about FTSU

Senior leaders are knowledgeable and up to date about FTSU and the executive and non-executive leads are aware of guidance from the National Guardian's Office. Senior leaders can readily articulate the trust's FTSU vision and key learning from issues that workers have spoken up about and regularly communicate the value of speaking up. They can provide evidence that they have a leadership strategy and development programme that emphasises the importance of learning from issues raised by people who speak up. Senior leaders can describe the part they played in creating and launching the trust's FTSU vision and strategy.

Leaders have a structured approach to FTSU

There is a clear FTSU vision, translated into a robust and realistic strategy that links speaking up with patient safety, staff experience and continuous improvement. There is an up-to-date speaking up policy that reflects the minimum standards set out by NHS Improvement. The FTSU strategy has been developed using a structured approach in collaboration with a range of stakeholders (including the FTSU Guardian). It aligns with existing guidance from the National Guardian. Progress against the strategy and compliance with the policy are regularly reviewed using a range of qualitative and quantitative measures.

Leaders actively shape the speaking up culture

All senior leaders take an interest in the trust's speaking up culture and are proactive in developing ideas and initiatives to support speaking up. They can evidence that they robustly challenge themselves to improve patient safety, and develop a culture of continuous improvement, openness and honesty. Senior leaders are visible, approachable and use a variety of methods to seek and act on feedback from workers. Senior leaders prioritise speaking up and work in partnership with their FTSU Guardian. Senior leaders model speaking up by acknowledging mistakes and making improvements. The board can state with confidence that workers know how to speak up; do so with confidence and are treated fairly.

Leaders are clear about their role and responsibilities

The trust has a named executive and a named non-executive director responsible for speaking up and both are clear about their role and responsibility. They, along with the chief executive and chair, meet regularly with the FTSU Guardian and provide appropriate advice and support. Other senior leaders support the FTSU Guardian as required. For more information see page 8 below.

Leaders are confident that wider concerns are identified and managed

Senior leaders have ensured that the FTSU Guardian has ready access to applicable sources of data to enable them to triangulate speaking up issues to proactively identify potential concerns. The FTSU Guardian has ready access to senior leaders and others to enable them to escalate patient safety issues rapidly, preserving confidence as appropriate.

Leaders receive assurance in a variety of forms

The executive lead for FTSU provides the board with a variety of reliable, independent and integrated information that gives the board assurance that:

- workers in all areas know, understand and support the FTSU vision, are aware of the policy and have confidence in the speaking up process
- steps are taken to identify and remove barriers to speaking up for those in more vulnerable groups, such as Black, Asian or minority ethnic (BAME), workers and agency workers
- speak up issues that raise immediate patient safety concerns are quickly escalated
- action is taken to address evidence that workers have been victimised as a result of speaking up, regardless of seniority
- lessons learnt are shared widely both within relevant service areas and across the trust
- the handling of speaking up issues is routinely audited to ensure that the FTSU policy is being implemented
- FTSU policies and procedures are reviewed and improved using feedback from workers.

In addition the board receives a report, at least every six months, from the FTSU Guardian. For more information see page 11 below. Boards should consider inviting workers who speak up to present their experience in person.

Leaders engage with all relevant stakeholders

A diverse range of workers' views are sought, heard and acted on to shape the culture of the organisation in relation to speaking up; these are reflected in the FTSU vision and plan.

The organisation is open and transparent about speaking up internally and externally. Issues raised via speaking up are part of the performance data discussed openly with commissioners, CQC and NHS Improvement. Discussion of FTSU matters regularly takes place in the public section of the board meetings (while respecting the confidentiality of individuals). The trust's annual report contains high level, anonymised data relating to speaking up as well as information on actions the trust is taking to support a positive speaking up culture. Reviews and audits are shared externally to support improvement elsewhere.

Senior leaders work openly and positively with regional FTSU Guardians and the National Guardian to continually improve the trust's speaking up culture. Likewise, senior leaders encourage their FTSU Guardians to develop bilateral relationships with regulators, inspectors and other local FTSU Guardians. Senior leaders request external improvement support when required.

Leaders are focused on learning and continual improvement

Senior leaders use speaking up as an opportunity for learning that can be embedded in future practice to deliver better quality care and improve workers' experience. Senior leaders and the FTSU Guardian engage with other trusts to identify best practice. Executive and non-executive leads, and the FTSU Guardian, review all guidance and case review reports from the National Guardian to identify improvement possibilities. Senior leaders regularly reflect on how they respond to feedback, learn and continually improve and encourage the same throughout the organisation.

The executive lead responsible for FTSU reviews the FTSU strategy annually, using a range of qualitative and quantitative measures, to assess what has been achieved and what hasn't; what the barriers have been and how they can be overcome; and whether the right indicators are being used to measure success.

The FTSU policy and process are reviewed annually to check they are fit for purpose and realistic; up to date; and takes account of feedback from workers who have used them. A sample of cases is audited to ensure that:

- the investigation process is of high quality; outcomes and recommendations are reasonable and the impact of change is being measured
- workers are thanked for speaking up, are kept up to date throughout the investigation and are told of the outcome
- investigations are independent, fair and objective; recommendations are designed to promote patient safety and learning; and change will be monitored.

Positive outcomes from speaking up cases are promoted and as a result workers are more confident to speak up. This is demonstrated in organisational data and audit.

Individual responsibilities

Chief executive and chair

The chief executive is responsible for appointing the FTSU Guardian and is ultimately accountable for ensuring that FTSU arrangements meet the needs of the workers in their trust. The chief executive and chair are responsible for ensuring the annual report contains information about FTSU and that the trust is engaged with both the regional Guardian network and the National Guardian's Office.

Both the chief executive and chair are key sources of advice and support for their FTSU Guardian and meet with them regularly.

Executive lead for FTSU

The executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- overseeing the creation of the FTSU vision and strategy
- ensuring the FTSU Guardian role has been implemented, using a fair recruitment process in accordance with the example job description and other guidance published by the National Guardian
- ensuring that the FTSU Guardian has a suitable amount of ringfenced time and other resources and there is cover for planned and unplanned absence.
- ensuring that a sample of speaking up cases have been quality assured
- conducting an annual review of the strategy, policy and process
- operationalising the learning derived from speaking up issues
- ensuring allegations of detriment are promptly and fairly investigated and acted on
- providing the board with a variety of assurance about the effectiveness of the trusts strategy, policy and process.

Non-executive lead for FTSU

The non-executive lead is responsible for:

- ensuring they are aware of latest guidance from National Guardian's Office
- holding the chief executive, executive FTSU lead and the board to account for implementing the speaking up strategy. Where necessary, they should robustly challenge the board to reflect on whether it could do more to create a culture responsive to feedback and focused on learning and continual improvement
- role-modelling high standards of conduct around FTSU
- acting as an alternative source of advice and support for the FTSU Guardian
- overseeing speaking up concerns regarding board members – see below.

We appreciate the challenges associated with investigating issues raised about board members, particularly around confidentiality and objectivity. This is why the role of the designated non-executive director is so important. In these circumstances, we would expect the non-executive director to take the lead in determining whether:

- sufficient attempts have been made to resolve a speaking up concern involving a board member(s) and
- if so, whether an investigation is proportionate and what the terms of reference should be.

Depending on the circumstances, it may be appropriate for the non-executive director to oversee the investigation and take on the responsibility of updating the worker. Wherever the non-executive director does take the lead, they should inform the FTSU Guardian, confidentially, of the case; keep them informed of progress; and seek their advice around process and record-keeping.

The non-executive director should inform NHS Improvement and CQC that they are overseeing an investigation into a board member. NHS Improvement and CQC can then provide them with support and advice. The trust would need to think about how to enable a non-executive director to commission an external investigation (which might need an executive director to sign-off the costs) without compromising the

confidentiality of the individual worker or revealing allegations before it is appropriate to do so.

Human resource and organisational development directors

The human resource (HR) and/or organisational development (OD) directors are responsible for:

- ensuring that the FTSU Guardian has the support of HR staff and appropriate access to information to enable them to triangulate intelligence from speaking up issues with other information that may be used as measures of FTSU culture or indicators of barriers to speaking up
- ensuring that HR culture and practice encourage and support speaking up and that learning in relation to workers' experience is disseminated across the trust
- ensuring that workers have the right knowledge, skills and capability to speak up and that managers listen well and respond to issues raised effectively.

Medical director and director of nursing

The medical director and director of nursing are responsible for:

- ensuring that the FTSU Guardian has appropriate support and advice on patient safety and safeguarding issues
- ensuring that effective and, as appropriate, immediate action is taken when potential patient safety issues are highlighted by speaking up
- ensuring learning is operationalised within the teams and departments they oversee.

FTSU Guardian reports

Reports are submitted frequently enough to enable the board to maintain a good oversight of FTSU matters and issues, and no less than every six months. Reports are presented by the FTSU Guardian or a member of the trust's local Guardian network in person.

Reports include both quantitative and qualitative information and case studies or other information that will enable the board to fully engage with FTSU in their organisation and to understand the issues being identified, areas for improvement, and take informed decisions about action.

Data and other intelligence are presented in a way that maintains the confidentiality of individuals who speak up.

Board reports on FTSU could include:

Assessment of issues

- information on what the trust has learnt and what improvements have been made as a result of trust workers speaking up
- information on the number and types of cases being dealt with by the FTSU Guardian and their local network
- an analysis of trends, including whether the number of cases is increasing or decreasing; any themes in the issues being raised (such as types of concern, particular groups of workers who speak up, areas in the organisation where issues are being raised more or less frequently than might be expected); and information on the characteristics of people speaking up (professional background, protected characteristics)

Potential patient safety or workers experience issues

- information on how FTSU matters relate to patient safety and the experience of workers, triangulating data as appropriate, so that a broader picture of FTSU culture, barriers to speaking up, potential patient safety risks, and opportunities to learn and improve can be built

Action taken to improve FTSU culture

- details of actions taken to increase the visibility of the FTSU Guardian and promote the speaking up processes
- details of action taken to identify and support any workers who are unaware of the speaking up process or who find it difficult to speak up
- details of any assessment of the effectiveness of the speaking up process and the handling of individual cases
- information on any instances where people who have spoken up may have suffered detriment and recommendations for improvement
- information on actions taken to improve the skills, knowledge and capability of workers to speak up and to support others to speak up and respond to the issues they raise effectively

Learning and improvement

- feedback received by FTSU Guardians from people speaking up and action that will be taken in response
- updates on any broader developments in FTSU, learning from case reviews, guidance and best practice

Recommendations

- suggestions of any priority action needed.

Resources

Care Quality Commission (2017): Driving Improvement Accessed at: www.cqc.org.uk/sites/default/files/20170614_drivingimprovement.pdf

National Guardian Office (2017): Example job description Accessed at: http://www.cqc.org.uk/sites/default/files/20180213_ngo_freedom_to_speak_up_guardian_jd_march2018_v5.pdf

National Guardian Office (2017): Annual report Accessed at www.cqc.org.uk/sites/default/files/20171115_ngo_annualreport201617.pdf

NHS Improvement (2014) Strategy development toolkit Accessed at https://improvement.nhs.uk/resources/strategy-development-toolkit/

NHS Improvement (2016) Freedom to speak up: whistleblowing policy for the NHS Accessed at https://improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/

NHS Improvement (2017): Creating a vision https://improvement.nhs.uk/resources/creating-vision/

NHS Improvement (2016/17): Creating a culture of compassionate and inclusive leadership Accessed at https://improvement.nhs.uk/resources/culture-leadership/

NHS Improvement (2017): Well Led Framework Accessed at: https://improvement.nhs.uk/resources/well-led-framework/

National Framework (2017): Developing People - Improving Care Accessed at: https://improvement.nhs.uk/resources/developing-people-improving-care/

National Guardian Office (2018): Guardian education and training guide

Accessed at: http://www.cqc.org.uk/sites/default/files/20180419_ngo_education_training_guide.pdf

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Alder Hey Children's NHS
NHS Foundation Trust

NHS Improvement Provider Licence Self-Assessment - Update as at April 2018

Licence Condition	Current position	Assurance	Gap	Action
Section 1 – General Conditions				
G1 - Provision of information	All monitoring submissions provided by deadline via the portal. Additional documents provided on request, e.g. following quarterly review meeting.	• Quarterly reports scrutinised and approved by RBD and submitted to Audit Committee to oversee assurance process • Operational DoF checks financial returns before submission and reports to RBD • Annual Report and Accounts audited and scrutinised by Audit Committee then BoD	None identified at present	Keep NHSI reporting requirements under review via monthly bulletins
G2 – Publication of information	Trust reports placed in the public domain in accordance with NHSI requirements, e.g. Annual Report and Accounts	• Hard copies of reports available at AMM and within Trust premises; summary sent to members • Trust website • Trust Publication Scheme	None identified at present	NHSI bulletins and guidance for any new requirements
G3 – Payment of fees to Monitor	This condition reflects the power given to NHSI/Monitor under the Act to require licensees to pay fees in relation to its regulatory functions. Fees are not currently in place, not has any decision	N/A	N/A	None required at present. Provision has never been implemented

Licence Condition	Current position	Assurance	Gap	Action
	yet been taken as to whether NHSI will begin to charge fees.			
G4 - Fit and proper persons	Trust arrangements have been updated to reflect CQC regulation 19 (applies to directors only). This includes a separate declaration, amendments to Directors' contracts/letters of appointment, additional checks around insolvency and disqualification and revised Recruitment Policy	• Annual declaration process • Directors undergo enhanced DBS checks and other robust pre-employment checks • Existing directors undergoing DBS refresh • Annual checks for insolvency and disqualification	None at present	None outstanding – CQC satisfied with current arrangements following last inspection
G5 – Monitor guidance	Guidance consistently and stringently followed	• Reports to Board Committees e.g. Annual Plan, Annual Report and Accounts, Corporate Report (Single Oversight Framework) • Well Led review completed. • FTSU guidance for boards and self-review tool to come to next two meetings. • Quality Governance Framework – quarterly reviews to CQAC.	None identified at present	Continue to track new guidance through appropriate committee on publication
G6 – Systems for compliance with licence conditions	Systems and processes are currently set up to ensure compliance with provisions of	• Corporate Report links to Single Oversight Framework	None identified at present	Compliance with Licence conditions formally reviewed by the Board as

Licence Condition	Current position	Assurance	Gap	Action
and related obligations (i.e. NHS Acts and Constitution)	the Licence and other mandatory requirements; risk set out in BAF. Constitution amended to reflect 2012 Act.	• Quarterly Reports to NHSI reviewed by RBD • Certification produced in accordance with paras 10 and 11 of this Condition in May 2016 covering financial year.		part of its annual work plan.
G7 – Registration with the Care Quality Commission	Currently registered without conditions for all relevant services	All inspection and registration issues reported through CQAC and BoD	None identified at present	Continue with regular engagement meetings with CQC; ensure NHSI informed of all key issues.
G8 – Patient eligibility and selection criteria	This condition requires licensees to set and publish transparent patient eligibility criteria and to apply these in a transparent manner. Explicit eligibility criteria are not currently published for individual AH services, however they are covered in a range of activities: • Declarations of compliance with specialist service specifications; • Information on individual services provided on trust website; • Clinical discussions at MDT level including where any ambiguity exists for example with regard to age limits (16 – 18) and where adult transition services are not	• At MDT level • Compliance with service specifications issued by Spec Comm. • Quality contract monitoring by CCG	Individual eligibility and selection criteria not currently published together in one place due to nature of services – all children under 16 eligible depending on clinical need.	Statement to form part of Annual Report

Licence Condition	Current position	Assurance	Gap	Action
	established			
G9 – Application of S.5 (Continuity of Services)	All previous Mandatory Services migrated to Commissioner Requested Services as of 1st April 2013. Five services were derogated as part of original Spec Comm assessment of trusts against service specifications in 2013/14, three now remain outstanding. New spec issued for CHD in 2015/16.	NHSE (Spec Comm) contract monitoring meetings	Derogation remains in place for Neonatal, Haemoglobinopathies and Palliative Care.	Strategic discussions to be concluded with key partners within 2017/18
Section 2 – Pricing				
P1 – Recording of Information	Under this condition NHSI may require licensees to record information on their costs in line with guidance. They may also require licensees to record other information, e.g. quality and outcome data to support NHSIr in carrying out its pricing functions. PLICS has been developed and rolled out to Divisions; and finance team have developed a suite of reports in support of service line reporting.	• Reports to RBD and Audit Committee • Trust submits reference costs data to DH in line with timetable and guidance • Trust takes part in voluntary exercise to share Patient Level Costing data with NHSI. • Suite of quarterly reports to Divisions/CBUs regarding service line, consultant, procedure and patient level cost and income performance. • The Trust was awarded the highest MAQS score in	None identified at present	Continue to develop and refine reporting / costing at service line level / patient level costing.

Licence Condition	Current position	Assurance	Gap	Action
		the country		
P2 – Provision of information	As G1 above. NHSI places particular emphasis on the availability of consistently recorded and accurate information on costs to enable them to set prices for NHS services at an appropriate level.	Reports to RBD and Audit Committee. Trust has self-assessed its data quality and costing processes against NHSI's assessment framework and has scored gold which is the highest in the country.	None identified at present	As above P1
P3 – Assurance report on submissions to Monitor	Links to P2 above – NHSI will require assurance on the accuracy of the costing information provided.	Reports to RBD and Audit Committee as required	N/A	N/A
P4 – Compliance with the National Tariff	This condition imposes an obligation on providers as well as commissioners to charge for NHS services in line with National Tariff.	Reports to RBD and Audit Committee as required. Contracts signed with commissioners based on national standard contracts. Impact of national tariffs reflected in 2018/19 financial plans agreed by the Board.	None currently identified	None in terms of compliance with the Licence condition, however the impact of the 2018/19 tariff on the Trust will need to be closely monitored and discussed with NHSI as part of the quarterly reporting cycle.
P5 – Constructive engagement concerning local tariff modifications	The Act gives NHSI responsibility for setting the process and rules around local pricing modifications. This condition requires licensees to engage constructively with	Reports to RBD	None currently identified	Trust will follow guidance as and when applicable and where local pricing modifications are agreed with Commissioners which meet NHSI's criteria for

Licence Condition	Current position	Assurance	Gap	Action
	commissioners to try to reach local agreement before applying to NHSI for a local modification. Head of Contracting works closely with local commissioners to address specific service issues.			notification.
Section 3 – Choice and Competition				
C1 – The right of patients to make choices	This condition requires licensees to notify their patients when they have a choice of provider either under the NHS Constitution or conferred locally by commissioners. It requires providers to tell patients where they can find information about the choices they have in a way that is not misleading. Any information provided to AH patients would be on the basis of clinical need. No inducements are offered to referring clinicians by the Trust under any circumstances. Patients are informed of their NHS Constitution right to choosing alternative providers for those waiting longer than 18 weeks from RTT.	Reports to RBD re contract performance.	None currently identified	Patient information leaflets to be updated as required to include aspects on choice where appropriate
C2 – Competition oversight	This condition prohibits the licensee from entering into or maintaining agreements that	This will be considered on a case by case basis when the Trust bids for or establishes	None currently identified	None currently identified

Licence Condition	Current position	Assurance	Gap	Action
	have the object or effect of preventing, restricting or distorting competition to the extent that it is against the interests of health care users.	contractual arrangements for the provision of services. Trust follows EU guidance where applicable. Major contract changes reviewed and approved by the Board and or R&BD.		
Section 4 – Integrated care				
IC1 – Provision of integrated care	Trust actively pursuing plans to deliver better integration of children's services in the city with Liverpool CCG and other partners.	Reports to BoD	None currently identified	None from a compliance perspective
Section 5 – Continuity of Services				
CoS1 – Continuing provision of Commissioner Requested Services	All services currently delivered as per contract/agreed specification issued by commissioners	Quality meetings with commissioners. Reports by exception to Board Contract performance review meetings with Commissioners	See G9 above	See G9 above
CoS2 – Restriction on the disposal of assets	Trust has an up to date asset register which is kept and maintained by the Finance team	Reports to Audit Committee.	None currently identified	None currently identified
CoS3 – Standards of corporate governance and financial management	Trust has robust corporate and financial governance arrangements that are compliant with all relevant guidance including that issued by NHSI	Internal and external audit reports provided to Audit Committee, Board and Governors	None currently identified	Track any updates and changes to guidance
CoS4 – Undertaking	NHSI/Monitor defines the	N/A	N/A	N/A

Licence Condition	Current position	Assurance	Gap	Action
from the ultimate controller	'ultimate controller' as being anybody that could instruct the licensee to carry out particular actions, i.e. the parent company of a subsidiary that has been licensed by Monitor. If there is no single body that could instruct the licensee in this way, the licensee does not have an ultimate controller and there is no need for an undertaking under this condition. Monitor has clarified that governors and directors of FTs are not regarded as ultimate controllers and will not need to provide undertakings.			
CoS5 – Risk pool levy	In the event of a provider entering special administration, the costs of administration will be met by a central fund known as the risk pool. This condition requires the licensee to contribute to the funding of the pool if NHSI/Monitor requests it.	N/A	N/A	N/A
CoS6 – Co-operation in the event of financial distress	This condition applies when a licensee fails to meet the test of sound financial management (as per CoS3) under the RAF, in which case the licensee is required to provide information to 3rd parties as directed by	Corporate Report scrutinised by RBD and BoD Ops Board and Exec Performance Reviews oversee operational delivery	None identified	Trust financial position continues to be subject to regular review and update

Licence Condition	Current position	Assurance	Gap	Action
	NHSI and allow access to premises. We are currently rated as 2 under the SOF.			
CoS7 – Availability of resources	This condition sets out the Board certification requirement which aims to provide NHSI with reassurance that the Board has given consideration to the resources to be dedicated to the provision of CRS over the coming 12 month period.	All previous updates to certification requirements have been fulfilled either by the entire Board or by RBD as part of its delegated authority	None identified	Certificate to be drafted for consideration by the Board to the required timescale and to be available for NHSI audit purposes
Section 6 – NHS Foundation Trust Conditions				
FT1 – Information to update the register of NHS foundation trusts	Trust constitution, annual report, annual accounts and auditor's report have been consistently provided to NHSI/Monitor within the specified timescales.	Reports to the Board. Publication of Trust information on NHSI's website	None identified	Ensure any changes to guidance are tracked e.g. New requirements in the ARM
FT2 – Payment to Monitor in respect of registration and related costs	This condition creates the provision for Monitor to charge fees specifically to FTs for the cost of regulation e.g. maintaining registers etc. No decision has yet been taken by NHSI/Monitor as to whether this will be put into practice however a separate consultation is planned. NB Monitor has had the power to levy fees from FTs since 2004 but has chosen not to do so.	N/A	N/A	Keep watching brief

Licence Condition	Current position	Assurance	Gap	Action
FT3 – Provision of information to advisory panel	Monitor has set up its 'Panel for Advising Governors' as described by the 2012 Act. The panel has been created as a source of independent advice to governors in order to help them fulfil their role; the focus is on governors using the panel when their trust has failed in its obligations either under the constitution or the Act. Licensees are required to provide information to the panel when requested. NB. The Act requires a majority of governors to support the submission of a query following consideration at a full meeting of the Council of Governors.	Governors are provided with all Board papers and full information about the Trust via Basecamp and at regular meetings. Key issues presented to Governors at every meeting Governors are regularly reminded that Board meetings are open to the public	None currently identified	Ensure any new Governors are aware of the process for submitting a query to the Panel as part of induction
FT4 – NHS foundation trust governance arrangements	This condition builds upon the existing requirements set out in the Code of Governance and other guidance documents including the ARM. The Trust has consistently complied with the requirements to demonstrate the effectiveness of its governance arrangements.	External and internal audit reports to Audit Committee	None identified at present	Continue to ensure requirements are adhered to.

Erica Saunders
May 2018

Self-Certification Template - Condition FT4
Alder Hey Children's NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Corporate Governance Statement - in accordance with Foundation Trust condition 4 (Foundations Trusts and NHS trusts)
Certification on training of Governors - in accordance with s151(5) of the Health and Social Care Act (Foundation Trusts only)

These Declarations are set out in this template.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

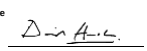
Worksheet "FT4 declaration"

Corporate Governance Statement (FTs and NHS trusts)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements, setting out any risks and mitigating actions planned for each one

1	Corporate Governance Statement	Response	Risks and Mitigating actions
1	The Board is satisfied that the Licensee applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
2	The Board has regard to such guidance on good corporate governance as may be issued by NHS Improvement from time to time	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
3	The Board is satisfied that the Licensee has established and implements: (a) Effective board and committee structures; (b) Clear responsibilities for its Board, for committees reporting to the Board and for staff reporting to the Board and those committees; and (c) Clear reporting lines and accountabilities throughout its organisation.	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
4	The Board is satisfied that the Licensee has established and effectively implements systems and/or processes: (a) To ensure compliance with the Licensee's duty to operate efficiently, economically and effectively; (b) For timely and effective scrutiny and oversight by the Board of the Licensee's operations; (c) To ensure compliance with health care standards binding on the Licensee including but not restricted to standards specified by the Secretary of State, the Care Quality Commission, the NHS Commissioning Board and statutory regulators of health care professions; (d) For effective financial decision-making, management and control (including but not restricted to appropriate systems and/or processes to ensure the Licensee's ability to continue as a going concern); (e) To obtain and disseminate accurate, comprehensive, timely and up to date information for Board and Committee decision-making; (f) To identify and manage (including but not restricted to manage through forward plans) material risks to compliance with the Conditions of its Licence; (g) To generate and monitor delivery of business plans (including any changes to such plans) and to receive internal and where appropriate external assurance on such plans and their delivery; and (h) To ensure compliance with all applicable legal requirements.	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
5	The Board is satisfied that the systems and/or processes referred to in paragraph 4 (above) should include but not be restricted to systems and/or processes to ensure: (a) That there is sufficient capability at Board level to provide effective organisational leadership on the quality of care provided; (b) That the Board's planning and decision-making processes take timely and appropriate account of quality of care considerations; (c) The collection of accurate, comprehensive, timely and up to date information on quality of care; (d) That the Board receives and takes into account accurate, comprehensive, timely and up to date information on quality of care; (e) That the Licensee, including its Board, actively engages on quality of care with patients, staff and other relevant stakeholders and takes into account as appropriate views and information from these sources; and (f) That there is clear accountability for quality of care throughout the Licensee including but not restricted to systems and/or processes for escalating and resolving quality issues including escalating them to the Board where appropriate.	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions
6	The Board is satisfied that there are systems to ensure that the Licensee has in place personnel on the Board, reporting to the Board and within the rest of the organisation who are sufficient in number and appropriately qualified to ensure compliance with the conditions of its NHS provider licence.	Confirmed	[including where the Board is able to respond 'Confirmed'] Please complete Risks and Mitigating actions

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature 

Name Sir David Henshaw

Signature 

Name Louise Shepherd

Further explanatory information should be provided below where the Board has been unable to confirm declarations under FT4.

A [ ] Please Respond

Worksheet "Training of governors"

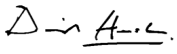
Certification on training of governors (FTs only)

The Board are required to respond "Confirmed" or "Not confirmed" to the following statements. Explanatory information should be provided where required.

2 Training of Governors

1	The Board is satisfied that during the financial year most recently ended the Licensee has provided the necessary training to its Governors, as required in s151(5) of the Health and Social Care Act, to ensure they are equipped with the skills and knowledge they need to undertake their role.	Confirmed	OK

Signed on behalf of the Board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sir David Henshaw	**Name**	Louise Shepherd
Capacity	Chairman	**Capacity**	Chief Executive
Date	22 May 2018	**Date**	22 May 2018

Further explanatory information should be provided below where the Board has been unable to confirm declarations under s151(5) of the Health and Social Care Act

A

Self-Certification Template - Conditions G6 and CoS7

Alder Hey Children's NHS Foundation Trust

Foundation Trusts and NHS trusts are required to make the following declarations to NHS Improvement:

Systems or compliance with licence conditions - in accordance with General condition 6 of the NHS provider licence
Availability of resources and accompanying statement - in accordance with Continuity of Services condition 7 of the NHS provider licence (Foundation Trusts designated CRS providers only)

These Declarations are set out in this template.

Templates should be returned via the Trust portal.

How to use this template
1) Save this file to your Local Network or Computer.
2) Enter responses and information into the yellow data-entry cells as appropriate.
3) Once the data has been entered, add signatures to the document.

Worksheet "G6 & CoS7"

Declarations required by General condition 6 and Continuity of Service condition 7 of the NHS provider licence

The board are required to respond "Confirmed" or "Not confirmed" to the following statements (please select 'not confirmed' if confirming another option). Explanatory information should be provided where required.

1 & 2 General condition 6 - Systems for compliance with license conditions (FTs and NHS trusts)

1	Following a review for the purpose of paragraph 2(b) of licence condition G6, the Directors of the Licensee are satisfied that, in the Financial Year most recently ended, the Licensee took all such precautions as were necessary in order to comply with the conditions of the licence, any requirements imposed on it under the NHS Acts and have had regard to the NHS Constitution.	Confirmed	OK

3 Continuity of services condition 7 - Availability of Resources (FTs designated CRS only)

EITHER:

3a	After making enquiries the Directors of the Licensee have a reasonable expectation that the Licensee will have the Required Resources available to it after taking account distributions which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate.	Confirmed	Please fill details in cell E22

OR

3b	After making enquiries the Directors of the Licensee have a reasonable expectation, subject to what is explained below, that the Licensee will have the Required Resources available to it after taking into account in particular (but without limitation) any distribution which might reasonably be expected to be declared or paid for the period of 12 months referred to in this certificate. However, they would like to draw attention to the following factors (as described in the text box below) which may cast doubt on the ability of the Licensee to provide Commissioner Requested Services.		Please Respond

OR

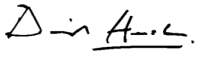
3c	In the opinion of the Directors of the Licensee, the Licensee will not have the Required Resources available to it for the period of 12 months referred to in this certificate.		Please Respond

Statement of main factors taken into account in making the above declaration

In making the above declaration, the main factors which have been taken into account by the Board of Directors are as follows:

The Trust Board has signed off an annual plan for the year that sees it delivering a £4m surplus and sees itself clearly as a going concern. The plan highlights a series of risks of delivery particularly with regard to commissioners affordability risks and delivery of our efficiency plan. Despite these risks the Board have mitigations in place.

Signed on behalf of the board of directors, and, in the case of Foundation Trusts, having regard to the views of the governors

Signature		**Signature**	
Name	Sir David Henshaw	**Name**	Louise Shepherd
Capacity	Chairman	**Capacity**	Chief Executive
Date	22 May 2018	**Date**	22 May 2018

Further explanatory information should be provided below where the Board has been unable to confirm declarations under G6.

A

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board

Tuesday 22nd 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. Given that the Programme Board of 26 Apr 18 marked the end of the transition from the 17/18 to the 18/19 programme, the programme assurance for May 18 has been a careful review of all available evidence lodged onto the SharePoint site.
2. The deterioration in ratings across the work streams points to a need for leadership interventions by Executive Sponsors to understand what support and decisions may be needed to improve the assurance ratings by means of a strong evidence base.
3. The Programme Board will need to receive confirmation, at its meeting on 31 May 2018, that Executive Sponsors have identified the means by which the delivery the change programme can be accelerated.
4. Some planned projects have been removed from the pipeline as the DMO is waiting for them to be initiated, again these issues will need to be addressed at the next Programme Board.

J Grinnell 16 May 18

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

1. This Board report contains assurance reports submitted to the following sub-Cttes: **RE&I on 10 May 18, CQAC on 16 May 18, WOD on 24 Apr 18** (papers as prepared for original meeting which was postponed until 21 May 18) **and R&BD on 23 May 18.**
2. The weekly 'Financial Sustainability Board' has initiated a review of the contributions form the change programme work streams following a review of the small level of benefits reported in the month 1 CIP position.
3. The assurance ratings have deteriorated and a concerted effort is now required to bring the programme onto an even keel and increase the evidence of project planning, governance, engagement and delivery.

J Gibson 16 May 18

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

See CIP status at slide 3 of this pack. In sum, the 18/19 change programme contribution is off to a slow start. Executive Sponsors are requested to address the issue of realising CIP benefits.

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. CHD Liverpool Partnership
2. Aseptics

Pipeline
- Neonatal Services

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

1. Portering
2. Apprenticeships

Pipeline
- E-Rostering

Deliver Outstanding Care
Hilda / Steve

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

Pipeline
- Models of Care
- Care of Complex Children

Global Digital Exemplar
John/Steve — PB

1. Speciality Packages
2. Voice Recognition

Strong Foundations — SG
John

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

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

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 1 FY18/19

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Division	Director	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Recurrent Target £000's
Community	Catherine McLaughlin	92	11	-81	92	11	-81	1,104	363	-741	1,104	357	-747	134	0	229	314	428	1,104
Medicine	Adrian Hughes	94	35	-58	94	35	-58	2,193	1,065	-1,129	2,193	1,123	-1,070	423	133	509	1,182	-53	2,193
Surgery	Christian Duncan	111	74	-37	111	74	-37	2,363	1,514	-849	2,363	1,547	-816	685	323	506	641	208	2,363
Subtotal: Clinical Divisions		**297**	**120**	**-176**	**297**	**120**	**-176**	**5,660**	**2,941**	**-2,719**	**5,660**	**3,027**	**-2,633**	**1,241**	**456**	**1,244**	**2,137**	**582**	**5,660**
Alder Hey in the Park	David Powell	30	1	-29	30	1	-29	364	12	-352	364	12	-352	12	0	0	0	352	364
Facilities	Hilda Gwilliams	10	2	-8	10	2	-8	206	150	-56	206	171	-35	112	0	38	0	56	206
Nursing & Quality	Hilda Gwilliams	8	0	-8	8	0	-8	158	0	-158	158	0	-158	0	0	0	0	158	158
Finance	John Grinnell	8	6	-2	8	6	-2	134	70	-64	134	70	-64	70	0	0	0	64	134
IM&T	Peter Young	11	0	-11	11	0	-11	150	73	-77	150	80	-70	0	0	73	0	77	150
Human Resources	Melissa Swindell	4	0	-4	4	0	-4	95	43	-53	95	50	-45	0	0	43	0	53	95
Corporate Other Dept	Erica Saunders	0	0	-0	0	0	-0	90	0	-90	90	0	-90	0	0	0	0	90	90
Subtotal: Non-Clinical Divisions		**71**	**9**	**-63**	**71**	**9**	**-63**	**1,197**	**348**	**-849**	**1,197**	**383**	**-814**	**194**	**0**	**153**	**0**	**849**	**1,197**
Innovation		8	0	-8	8	0	-8	100	0	-100	100	0	-100	0	0	0	0	100	100
Academy		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Research & Development		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**376**	**129**	**-248**	**376**	**129**	**-248**	**6,957**	**3,289**	**-3,668**	**6,957**	**3,410**	**-3,547**	**1,435**	**456**	**1,397**	**2,137**	**1,532**	**6,957**
															27%	*20%*	*31%*	*22%*	

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	208	7	-201	208	7	-201	2,500	87	-2,413	2,500	87	-2,413	87	0	0	229	2,184	2,500
Sustainability Through External Partnerships	Margaret Barnaby	67	0	-67	67	0	-67	800	0	-800	800	0	-800	0	0	0	0	800	800
The Best People Doing Their Best Work	Melissa Swindell	83	16	-67	83	16	-67	1,000	132	-868	1,000	132	-868	87	0	45	110	758	1,000
Game Changing Research and Innovation	David Powell	42	0	-42	42	0	-42	500	0	-500	500	0	-500	0	0	0	0	500	500
Strong Foundations	John G/Claire L	183	3	-180	183	3	-180	2,200	1,166	-1,034	2,200	1,353	-847	31	117	1,018	937	98	2,200
Park, Community Estate & Facilities		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	-23	0
Global Digital Exemplar (GDE)	Peter Young	83	0	-83	83	0	-83	1,000	0	-1,000	1,000	0	-1,000	0	0	0	0	1,000	1,000
Subtotal: Strategic Workstreams		**667**	**26**	**-640**	**667**	**26**	**-640**	**8,000**	**1,385**	**-6,615**	**8,000**	**1,572**	**-6,428**	**205**	**117**	**1,063**	**1,299**	**5,316**	**8,000**
Divisional Business		-290	102	393	-290	102	393	-1,043	1,904	2,947	-1,043	1,838	2,881	1,230	339	335	838	-3,785	-1,043
Unidentified		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**376**	**129**	**-248**	**376**	**129**	**-248**	**6,957**	**3,289**	**-3,668**	**6,957**	**3,410**	**-3,547**	**1,435**	**456**	**1,397**	**2,137**	**1,532**	**6,957**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Game Changing Research & Innovation

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

Some outline plans have been developed and are now being tracked with elements of implementation having commenced; however the overall assurance standard of the work stream is weak and this should be addressed by the sub-committee on behalf of the Trust Board.

The forecast of income for 18/19 is not explicitly linked to transparent plans and this aspect need to be addressed as a matter of urgency.

The executive sponsor is requested to review the standards of project working and evidence and fix the issues.

Claire Liddy, Director of Operational Finance – 9 May 18

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

The previous advice concerning 'amber' rated projects shows no evidence – on SharePoint – of having been acted upon. Therefore, due to lack of evidence of project team meetings and plans that have either ceased or have little forward looking content, the ratings for 2 projects are now 'red'.

The comments for the attention of the Project Team, Steering Group and sub-Committee are on the Dashboard and should be expedited under the leadership of Executive Sponsors.

The project regarding the 'Expansion of Commercial Research' still awaits initiation and has been removed from change programme scope until that happens.

Joe Gibson, External Programme Assurance - 9 May 18

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Framework

Game Changing Research & Innovation (to be completed by Assurance Team)

Sub-Committee	RE & I	Report Date	9 May 18
Workstream Name	Game Changing Research & Innovation	Executive Sponsor	David Powell, Michael Beresford

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
6.0 Game Changing Research & Innovation 18/19													
RE&I 6.1	The Academy	To set up the Alder Hey Academy to establish/consolidate Alder Hey as a leading international provider of Education	David Powell										PID now out of date, needs to be refreshed. Action Notes from team meeting of 18 Oct 17 uploaded (further evidence expected). Benefits are all off-track according to the tracker. Milestone Plan shows few forward milestones. Comms/ Engagement activities to be tracked with evidence provided where possible. Risks transferred to Ulysses and have been reviewed, evidence of review by project team required on SharePoint. EA/QIA signed by Execs. **Last updated 21 April 2018.**
RE&I 6.2	The Innovation Co	To set up Innovate Co. a subsidiary of the Trust charged with running the Trust's Innovation Machine	David Powell										Project team meeting minutes/notes to be uploaded. Milestone plan and risk log available. Milestone Plan on SharePoint significantly out of date and no forward looking milestones. All project documentation to be uploaded in line with Alder Hey Programme Management standards. Risks now on Ulysses, to be reviewed regularly. EA/QIA completed and signed. **Last updated 9 May 2018.**
RE&I 6.3	Implement New Apps for Alder Hey	To set up the Acorn Partnership charged with creating a pipeline for developing the Innovation Machine's Apps	David Powell										PID on SharePoint but all key milestones now passed, needs updating. Benefits defined in PID, tracking has commenced. Milestones in Apps for Alder Hey Plan cease in Mar 18 and not updated since Feb 18. Comms/Engagement activities have a plan but this needs internal stakeholders added. Risks on Ulysses, to be reviewed regularly. EA/QIA has been completed and signed. **Last updated 21 February 2018.**

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)

Both the quality and sustainability benefits of the revised work stream are at significant risk given the assurance ratings overleaf.

As stated in my previous comments: 'it was critical that the new projects were re fully scoped (PIDs) with benefits defined and project documentation complete by the April 2018 Programme Board'.

The executive sponsor is requested to review the standards of project working and evidence and fix the issues.

Claire Liddy, Director of Operational Finance – 9 May 18

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

CQAC is able to see the refreshed 18/19 Programme - aligned with the strategy refresh – ratings fro the following projects:

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

The new projects were completing their 'Initiation' phase and generating all initial project documents during April 2018. Full assurance ratings commenced on 1 May 18 and, from the partial evidence currently available, the overall ratings are mainly red. It is recommended that urgent focus be brought to bear to bring the governance and delivery to an improved standard.

Joe Gibson, External Programme Assessment – 9 May 18

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

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	CQAC	Report Date	9 May 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/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
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		🟡	🔴	🟡	🟡	🟡	🟡	🟢	🟢	The project team is yet to be fully defined and there is no evidence of meetings from 1 Apr 18, althought here are ToRs and a meeting schedule. The PID is incomplete. The benefits are yet to be fully defined and there is no indication of overall financial benefits. Of the 6 tabs on the milestone plan, 2 have yet to be populated with milestones and 2 missed milestones on the Workforce element need revised dates. There is no date shown by which risks have been reviewed. **Last updated 5 May 18.**
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		🟢	🟡	🟡	🔴	🟢	🔴	🔴	🔴	Project team meetings are scheduled, documented and well attended. The PID is incomplete. The wider benefits are yet to be fully defined, although the Hybrid Booking Business case is of a high qulaity. The Gantt Project Plan is largely incomplete and there is a missed milestone needing a revised date. Risks are yet to be rated. EA/QIA yet to be drafted. **Last updated 8 May 18.**
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		🔴	🟡	🔴	🔴	🔴	🔴	🔴	🔴	Then only evidence on SharePoint is an incomplete PID. All project documentation to be initiated and uploaded and a project team to form and show evidence of meetings and actions. **Last updated 17 Apr 18.**
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		🟢	🟡	🟡	🔴	🟡	🔴	🔴	🔴	Evidence of team meetings and the start of a draft plan for pre-operative assessment. Incomplete PID for SAFER project with benefits to be defined. Risks to be rated. EA/QIA to be completed. **Last updated 9 May 18.**
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 2017. PID complete. Benefits defined, tracking/reporting of benefits has commenced but last up-dated fiugures are December 2018. The key target, Time to Antibiotic Presecription from Diagnosis is against a threshold of 90% was at 63% (ED ONLY) and 73% (Inpatients ONLY) and target was for both to be 90% by March 2018. Milestone Plan was last updated February 2018 and 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.**
CQAC	**DETECT Study**	Using smart technology to reduce critical deterioration	Hilda Gwilliams		Provisional 'amber' rating as project only recently initiatied at April Programme Board. Full ratings will commence June 2018.								

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**

Programme Assurance Summary
Global Digital Exemplar

Alder Hey Children's NHS
NHS Foundation Trust

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

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.

The May GDE Programme Board agreed to form a benefits 'sub-Group' to address the issue of deliverable and measurable benefits.

Claire Liddy, Director of Operational Finance – 16 May 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.

The GDE Programme Board continues to govern in an exemplar fashion. The evidence presented ion SharePoint continues to be of high quality.

The 'Speciality Packages' project has moved from 'green' to 'amber' rated due to a lack of recent update to the project plan. The 'Voice Recognition' project (see previous reports) remains 'amber' rated – for reasons external to the high standard of project management – as a result of difficulty realising the planned benefits.

Joe Gibson, External Programme Assessment – 16 May 2018

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	R&BD	Report Date	16 May 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		🟢	🟢	🟡	🟡	🟢	🟢	🟢	🟢	Minutes and Agenda up to April 2018 in evidence. Overall benefits profile and schedule has now been finalised, 'Strategic Owner' column on SoPB still requires updating to reflect current trust executive appointments; internal CIP Tracker shows no financial benefit yet delivered in 2018. Milestone Plan on Dashboard shows several key delivery dates missed, some by significant amounts of time, as discussed at May GDE Programme Board. Further stakeholder evidence has been uploaded and a register updated to March 2018. Risk protocols vis-à-vis national and Trust sytsems have been harmonised. **Last updated 8 May 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; internally, there are no financial benefits yet reported for 2018. Project Plan last updated 7 weeks ago, 27 March 2018, and many milestones outstanding are unreported. 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 15 May 2018.**

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	16 May 2018
Workstream Name	Global Digital Exemplar	Executive Sponsor	John Grinnell/Steve Ryan

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Financial Benefits Profile - at Month 1:

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Division	Director	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Recurrent Target £000's
Community	Catherine McLaughlin	92	11	-81	92	11	-81	1,104	363	-741	1,104	357	-747	134	0	229	314	428	1,104
Medicine	Adrian Hughes	94	35	-58	94	35	-58	2,193	1,065	-1,129	2,193	1,123	-1,070	423	133	509	1,182	-53	2,193
Surgery	Christian Duncan	111	74	-37	111	74	-37	2,363	1,514	-849	2,363	1,547	-816	685	323	506	641	208	2,363
Subtotal: Clinical Divisions		**297**	**120**	**-176**	**297**	**120**	**-176**	**5,660**	**2,941**	**-2,719**	**5,660**	**3,027**	**-2,633**	**1,241**	**456**	**1,244**	**2,137**	**582**	**5,660**
Alder Hey in the Park	David Powell	30	1	-29	30	1	-29	364	12	-352	364	12	-352	12	0	0	0	352	364
Facilities	Hilda Gwilliams	10	2	-8	10	2	-8	206	150	-56	206	171	-35	112	0	38	0	56	206
Nursing & Quality	Hilda Gwilliams	8	0	-8	8	0	-8	158	0	-158	158	0	-158	0	0	0	0	158	158
Finance	John Grinnell	8	6	-2	8	6	-2	134	70	-64	134	70	-64	70	0	0	0	64	134
IM&T	Peter Young	11	0	-11	11	0	-11	150	73	-77	150	80	-70	0	0	73	0	77	150
Human Resources	Melissa Swindell	4	0	-4	4	0	-4	95	43	-53	95	50	-45	0	0	43	0	53	95
Corporate Other Dept	Erica Saunders	0	0	-0	0	0	-0	90	0	-90	90	0	-90	0	0	0	0	90	90
Subtotal: Non-Clinical Divisions		**71**	**9**	**-63**	**71**	**9**	**-63**	**1,197**	**348**	**-849**	**1,197**	**383**	**-814**	**194**	**0**	**153**	**0**	**849**	**1,197**
Innovation		8	0	-8	8	0	-8	100	0	-100	100	0	-100	0	0	0	0	100	100
Academy		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Research & Development		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**376**	**129**	**-248**	**376**	**129**	**-248**	**6,957**	**3,289**	**-3,668**	**6,957**	**3,410**	**-3,547**	**1,435**	**456**	**1,397**	**2,137**	**1,532**	**6,957**
															27%	*20%*	*31%*	*22%*	

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	208	7	-201	208	7	-201	2,500	87	-2,413	2,500	87	-2,413	87	0	0	229	2,184	2,500
Sustainability Through External Partnerships	Margaret Barnaby	67	0	-67	67	0	-67	800	0	-800	800	0	-800	0	0	0	0	800	800
The Best People Doing Their Best Work	Melissa Swindell	83	16	-67	83	16	-67	1,000	132	-868	1,000	132	-868	87	0	45	110	758	1,000
Game Changing Research and Innovation	David Powell	42	0	-42	42	0	-42	500	0	-500	500	0	-500	0	0	0	0	500	500
Strong Foundations	John G/Claire L	183	3	-180	183	3	-180	2,200	1,166	-1,034	2,200	1,353	-847	31	117	1,018	937	98	2,200
Park, Community Estate & Facilities		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	-23	0
Global Digital Exemplar (GDE)	Peter Young	83	0	-83	83	0	-83	1,000	0	-1,000	1,000	0	-1,000	0	0	0	0	1,000	1,000
Subtotal: Strategic Workstreams		**667**	**26**	**-640**	**667**	**26**	**-640**	**8,000**	**1,385**	**-6,615**	**8,000**	**1,572**	**-6,428**	**205**	**117**	**1,063**	**1,299**	**5,316**	**8,000**
Divisional Business		-290	102	393	-290	102	393	-1,043	1,904	2,947	-1,043	1,838	2,881	1,230	339	335	838	-3,785	-1,043
Unidentified		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**376**	**129**	**-248**	**376**	**129**	**-248**	**6,957**	**3,289**	**-3,668**	**6,957**	**3,410**	**-3,547**	**1,435**	**456**	**1,397**	**2,137**	**1,532**	**6,957**

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 are requested to take the necessary actions for their respective projects in supporting the project teams to achieve green ratings in terms of the assurance standards.

The International and Non-NHS project closure report is due to be submitted to the Programme Board on 31 May 2018.

Claire Liddy, Director of Operational Finance – 16 May 2018

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

The CHD Liverpool Partnership Plan needs more work to provide a detailed set of actions and milestones for the entirety of the project cycle.

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 – 16 May 2018

Sub-Committee	R&BD	Report Date	16 May 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 2.5	**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 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' now dated 23 April 2018'. Targets and benefits are being closely tracked but not yet reaching aspired thresholds, full realisation will commence in Apr 19. Gantt chart in place and being tracked; however, there are significant delays to milestones, but is being closely tracked. Inceasing levels of evidence of stakeholder engagement now being uploaded. Audit of Aseptic Services has been uploaded to SharePoint. EA/QIA signed off. Evidence of meetings to September 2017. **Last updated 14 May 18.**

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	16 May 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 1:

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Division	Director	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Recurrent Target £000's
Community	Catherine McLaughlin	92	11	-81	92	11	-81	1,104	363	-741	1,104	357	-747	134	0	229	314	428	1,104
Medicine	Adrian Hughes	94	35	-58	94	35	-58	2,193	1,065	-1,129	2,193	1,123	-1,070	423	133	509	1,182	-53	2,193
Surgery	Christian Duncan	111	74	-37	111	74	-37	2,363	1,514	-849	2,363	1,547	-816	685	323	506	641	208	2,363
Subtotal: Clinical Divisions		**297**	**120**	**-176**	**297**	**120**	**-176**	**5,660**	**2,941**	**-2,719**	**5,660**	**3,027**	**-2,633**	**1,241**	**456**	**1,244**	**2,137**	**582**	**5,660**
Alder Hey in the Park	David Powell	30	1	-29	30	1	-29	364	12	-352	364	12	-352	12	0	0	0	352	364
Facilities	Hilda Gwilliams	10	2	-8	10	2	-8	206	150	-56	206	171	-35	112	0	38	0	56	206
Nursing & Quality	Hilda Gwilliams	8	0	-8	8	0	-8	158	0	-158	158	0	-158	0	0	0	0	158	158
Finance	John Grinnell	8	6	-2	8	6	-2	134	70	-64	134	70	-64	70	0	0	0	64	134
IM&T	Peter Young	11	0	-11	11	0	-11	150	73	-77	150	80	-70	0	0	73	0	77	150
Human Resources	Melissa Swindell	4	0	-4	4	0	-4	95	43	-53	95	50	-45	0	0	43	0	53	95
Corporate Other Dept	Erica Saunders	0	0	-0	0	0	-0	90	0	-90	90	0	-90	0	0	0	0	90	90
Subtotal: Non-Clinical Divisions		**71**	**9**	**-63**	**71**	**9**	**-63**	**1,197**	**348**	**-849**	**1,197**	**383**	**-814**	**194**	**0**	**153**	**0**	**849**	**1,197**
Innovation		8	0	-8	8	0	-8	100	0	-100	100	0	-100	0	0	0	0	100	100
Academy		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Research & Development		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**376**	**129**	**-248**	**376**	**129**	**-248**	**6,957**	**3,289**	**-3,668**	**6,957**	**3,410**	**-3,547**	**1,435**	**456**	**1,397**	**2,137**	**1,532**	**6,957**
															27%	*20%*	*31%*	*22%*	

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	208	7	-201	208	7	-201	2,500	87	-2,413	2,500	87	-2,413	87	0	0	229	2,184	2,500
Sustainability Through External Partnerships	Margaret Barnaby	67	0	-67	67	0	-67	800	0	-800	800	0	-800	0	0	0	0	800	800
The Best People Doing Their Best Work	Melissa Swindell	83	16	-67	83	16	-67	1,000	132	-868	1,000	132	-868	87	0	45	110	758	1,000
Game Changing Research and Innovation	David Powell	42	0	-42	42	0	-42	500	0	-500	500	0	-500	0	0	0	0	500	500
Strong Foundations	John G/Claire L	183	3	-180	183	3	-180	2,200	1,166	-1,034	2,200	1,353	-847	31	117	1,018	937	98	2,200
Park, Community Estate & Facilities		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	-23	0
Global Digital Exemplar (GDE)	Peter Young	83	0	-83	83	0	-83	1,000	0	-1,000	1,000	0	-1,000	0	0	0	0	1,000	1,000
Subtotal: Strategic Workstreams		**667**	**26**	**-640**	**667**	**26**	**-640**	**8,000**	**1,385**	**-6,615**	**8,000**	**1,572**	**-6,428**	**205**	**117**	**1,063**	**1,299**	**5,316**	**8,000**
Divisional Business		-290	102	393	-290	102	393	-1,043	1,904	2,947	-1,043	1,838	2,881	1,230	339	335	838	-3,785	-1,043
Unidentified		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**376**	**129**	**-248**	**376**	**129**	**-248**	**6,957**	**3,289**	**-3,668**	**6,957**	**3,410**	**-3,547**	**1,435**	**456**	**1,397**	**2,137**	**1,532**	**6,957**

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 'Community Cluster' project needs to be fully mobilised so that ratings of all domains can be conducted.
- There is now a real urgency for this work stream needs to bring the documentation to a standard that will attain green ratings for all projects.

Claire Liddy, Director of Operational Finance – 16 May 2018

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

The work stream ratings have deteriorated since the report at the beginning of May: the position remains that there are shows 7 projects with evidence on SharePoint and, of those: 1 green rated, 1 amber and 5 red. As previously stated, the Executive Sponsor now needs to engage with all project teams as the wider evidence base on SharePoint – for all these projects – is weak.

Joe Gibson, External Programme Assessment – 16 May 2018

Sub-Committee	**R&BD**	**Report Date**	**16 May 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 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 that all planned activities have now completed; confrimation required that there is no further planned acitivity. Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses, some require review. **Last updated 7 May 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										Progress Meeting Notes available to February 2018; however, these are on the build only and do not cover commissioning. PID available, benefits to be confirmed. Milestone Plan shows some delays (tenancy agreements) now over 10 months from original milestone date and some other key milestones are running late; there is a key dependency on the 'Agile' working project which remains in 'pipeline' status. No details of comms/engagement or 'HWWWITF' type activities. Issues Log uploaded, risks to be entered on Ulysses. EA/QIA completed and signed off. **Last updated 10 May 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 7 May 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 7 May 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 7 May 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 7 May 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										No evidence of meetings available on SharePoint. A high level critical path has been uploaded as well as an option for external provision of space. Milestone plan shows numerous delays - ranging between 2-6 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 7 May 2018.**
R&BD 5.8	**Community Cluster**	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell										Draft PID uploaded 1 Feb 2018, 'Initiation' Slides uploaded 27 Mar 2018. All other project documentation yet to be developed. **Last updated 27 Mar 18.**

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	16 May 2018
Work stream Name	Park, Community Estates and Facilities	Executive Sponsor	John Grinnell

Programme Assurance Framework

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

Financial Benefits Profile - at Month 1:

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Division	Director	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Recurrent Target £000's
Community	Catherine McLaughlin	92	11	-81	92	11	-81	1,104	363	-741	1,104	357	-747	134	0	229	314	428	1,104
Medicine	Adrian Hughes	94	35	-58	94	35	-58	2,193	1,065	-1,129	2,193	1,123	-1,070	423	133	509	1,182	-53	2,193
Surgery	Christian Duncan	111	74	-37	111	74	-37	2,363	1,514	-849	2,363	1,547	-816	685	323	506	641	208	2,363
Subtotal: Clinical Divisions		**297**	**120**	**-176**	**297**	**120**	**-176**	**5,660**	**2,941**	**-2,719**	**5,660**	**3,027**	**-2,633**	**1,241**	**456**	**1,244**	**2,137**	**582**	**5,660**
Alder Hey in the Park	David Powell	30	1	-29	30	1	-29	364	12	-352	364	12	-352	12	0	0	0	352	364
Facilities	Hilda Gwilliams	10	2	-8	10	2	-8	206	150	-56	206	171	-35	112	0	38	0	56	206
Nursing & Quality	Hilda Gwilliams	8	0	-8	8	0	-8	158	0	-158	158	0	-158	0	0	0	0	158	158
Finance	John Grinnell	8	6	-2	8	6	-2	134	70	-64	134	70	-64	70	0	0	0	64	134
IM&T	Peter Young	11	0	-11	11	0	-11	150	73	-77	150	80	-70	0	0	73	0	77	150
Human Resources	Melissa Swindell	4	0	-4	4	0	-4	95	43	-53	95	50	-45	0	0	43	0	53	95
Corporate Other Dept	Erica Saunders	0	0	-0	0	0	-0	90	0	-90	90	0	-90	0	0	0	0	90	90
Subtotal: Non-Clinical Divisions		**71**	**9**	**-63**	**71**	**9**	**-63**	**1,197**	**348**	**-849**	**1,197**	**383**	**-814**	**194**	**0**	**153**	**0**	**849**	**1,197**
Innovation		8	0	-8	8	0	-8	100	0	-100	100	0	-100	0	0	0	0	100	100
Academy		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Research & Development		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**376**	**129**	**-248**	**376**	**129**	**-248**	**6,957**	**3,289**	**-3,668**	**6,957**	**3,410**	**-3,547**	**1,435**	**456**	**1,397**	**2,137**	**1,532**	**6,957**
															27%	*20%*	*31%*	*22%*	

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	208	7	-201	208	7	-201	2,500	87	-2,413	2,500	87	-2,413	87	0	0	229	2,184	2,500
Sustainability Through External Partnerships	Margaret Barnaby	67	0	-67	67	0	-67	800	0	-800	800	0	-800	0	0	0	0	800	800
The Best People Doing Their Best Work	Melissa Swindell	83	16	-67	83	16	-67	1,000	132	-868	1,000	132	-868	87	0	45	110	758	1,000
Game Changing Research and Innovation	David Powell	42	0	-42	42	0	-42	500	0	-500	500	0	-500	0	0	0	0	500	500
Strong Foundations	John G/Claire L	183	3	-180	183	3	-180	2,200	1,166	-1,034	2,200	1,353	-847	31	117	1,018	937	98	2,200
Park, Community Estate & Facilities		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	-23	0
Global Digital Exemplar (GDE)	Peter Young	83	0	-83	83	0	-83	1,000	0	-1,000	1,000	0	-1,000	0	0	0	0	1,000	1,000
Subtotal: Strategic Workstreams		**667**	**26**	**-640**	**667**	**26**	**-640**	**8,000**	**1,385**	**-6,615**	**8,000**	**1,572**	**-6,428**	**205**	**117**	**1,063**	**1,299**	**5,316**	**8,000**
Divisional Business		-290	102	393	-290	102	393	-1,043	1,904	2,947	-1,043	1,838	2,881	1,230	339	335	838	-3,785	-1,043
Unidentified		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**376**	**129**	**-248**	**376**	**129**	**-248**	**6,957**	**3,289**	**-3,668**	**6,957**	**3,410**	**-3,547**	**1,435**	**456**	**1,397**	**2,137**	**1,532**	**6,957**

Programme Assurance Summary
Strong Foundations

Alder Hey Children's NHS
NHS Foundation Trust

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

Inventory Management and Procurement Projects have now updated the project documentation on SharePoint and the ratings positively reflect that work.

The 'Model Hospital' and 'Coding and Capture' projects need to be completed in terms of the full suite of project documentation.

The mobilisation of the 'Catering' project needs to be completed.

Claire Liddy, Director of Operational Finance – 16 May 2018

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

Ratings for three projects are now 'red' and the executive sponsors should identify what support the project teams need to bring them to the assurance standard.

The two 'Amber' rated projects should also be the subject of further detailed work to prevent them sliding into 'red' status and bring them up to the required level of project evidence.

Joe Gibson, External Programme Assessment – 16 May 2018

Programme Assurance Framework

Strong Foundations (Completed by Assurance Team)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	R&BD	Report Date	16 May 2018
Work stream Name	Strong Foundations	Executive Sponsor	John Grinnell/ David Powell

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, benefits profile also needs to feed into Trust CIP numbers (not yet reflecting procurement benefits as tracked on SharePoint). Evidence of stakeholder engagement uploaded although this appears relatively narrow. EA/QIA now signed off. **Last updated 16 May 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 9 May 18. Evidence of stakeholder engagement now uploaded but not extensive. EA/QIA signed off. **Last updated 9 May 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, needs to show phasing of savings across the year to allow coherent feed into Trust CIP tracking. Plan uploaded, needs completion; deadlines for actions and benefits to be clear. EA/QIA complete. **Last updated 14 May 2018.**
RABD 7.4	Model Hospital	To support the Trust to rationalise their corporate and administration functions to ensure their cost do not exceed 7% of their income by April 2018 and 6% of their income by 2020	Claire Liddy										Submitted Project Initiation Slide packs to Financial Sustainability Board. **Last updated October 2017.**
RABD 7.5	Coding and Capture	To ensure the AH delivers a above average depth of coding and complies with the business rules whilst maximising income	Claire Liddy										Gaps remain to be filled in project team structure. POD uploaded with benefits baselines still to be established. Detailed benefits tracker uploaded but no savings to date in 2018 and baselines to be finalised. Partial Milestone Plan uploaded needs completing with project actions over the full project cycle. Need assurance that the QIA signed of at end of 2017 applies to the 18/19 programme. **Last updated 10 May 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										Evidence of thorough team meetingsPOD available available on SharePoint but describes no planned benefits for 2018/19. Precision required on benefits sought and delivered. More detail required in the project plan. Evidence provided concerning risks. Need assurance that the QIA signed of at end of 2017 applies to the 18/19 programme. **Last updated 11 May 2018.**
RABD 7.7	Catering	To implement the recommendations from the Independent Catering review to improve the overall food service delivery at Alder Hey whilst reducing the financial loss current operating within the Catering Department.	Hilda Gwilliams										Submitted Project Initiation Slide packs to Financial Sustainability Board. **Last updated 3 May 2018.**

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	16 May 2018
Work stream Name	Strong Foundations	Executive Sponsor	John Grinnell

Programme Assurance Framework

Strong Foundations (Completed by Assurance Team)

Financial Benefits Profile - at Month 1:

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Division	Director	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Recurrent Target £000's
Community	Catherine McLaughlin	92	11	-81	92	11	-81	1,104	363	-741	1,104	357	-747	134	0	229	314	428	1,104
Medicine	Adrian Hughes	94	35	-58	94	35	-58	2,193	1,065	-1,129	2,193	1,123	-1,070	423	133	509	1,182	-53	2,193
Surgery	Christian Duncan	111	74	-37	111	74	-37	2,363	1,514	-849	2,363	1,547	-816	685	323	506	641	208	2,363
Subtotal: Clinical Divisions		297	120	-176	297	120	-176	5,660	2,941	-2,719	5,660	3,027	-2,633	1,241	456	1,244	2,137	582	5,660
Alder Hey in the Park	David Powell	30	1	-29	30	1	-29	364	12	-352	364	12	-352	12	0	0	0	352	364
Facilities	Hilda Gwilliams	10	2	-8	10	2	-8	206	150	-56	206	171	-35	112	0	38	0	56	206
Nursing & Quality	Hilda Gwilliams	8	0	-8	8	0	-8	158	0	-158	158	0	-158	0	0	0	0	158	158
Finance	John Grinnell	8	6	-2	8	6	-2	134	70	-64	134	70	-64	70	0	0	0	64	134
IM&T	Peter Young	11	0	-11	11	0	-11	150	73	-77	150	80	-70	0	0	73	0	77	150
Human Resources	Melissa Swindell	4	0	-4	4	0	-4	95	43	-53	95	50	-45	0	0	43	0	53	95
Corporate Other Dept	Erica Saunders	0	0	-0	0	0	-0	90	0	-90	90	0	-90	0	0	0	0	90	90
Subtotal: Non-Clinical Divisions		71	9	-63	71	9	-63	1,197	348	-849	1,197	383	-814	194	0	153	0	849	1,197
Innovation		8	0	-8	8	0	-8	100	0	-100	100	0	-100	0	0	0	0	100	100
Academy		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Research & Development		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		376	129	-248	376	129	-248	6,957	3,289	-3,668	6,957	3,410	-3,547	1,435	456	1,397	2,137	1,532	6,957
															27%	*20%*	*31%*	*22%*	

		In Month			Year to Date			In Year Forecast			Recurrent Savings			Risk Rating (In Year)					
Workstream	Exec Sponsor	Target £000's	Achieved (Posted) £000's	Gap £000's	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	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	208	7	-201	208	7	-201	2,500	87	-2,413	2,500	87	-2,413	87	0	0	229	2,184	2,500
Sustainability Through External Partnerships	Margaret Barnaby	67	0	-67	67	0	-67	800	0	-800	800	0	-800	0	0	0	0	800	800
The Best People Doing Their Best Work	Melissa Swindell	83	16	-67	83	16	-67	1,000	132	-868	1,000	132	-868	87	0	45	110	758	1,000
Game Changing Research and Innovation	David Powell	42	0	-42	42	0	-42	500	0	-500	500	0	-500	0	0	0	0	500	500
Strong Foundations	John G/Claire L	183	3	-180	183	3	-180	2,200	1,166	-1,034	2,200	1,353	-847	31	117	1,018	937	98	2,200
Park, Community Estate & Facilities		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	23	-23	0
Global Digital Exemplar (GDE)	Peter Young	83	0	-83	83	0	-83	1,000	0	-1,000	1,000	0	-1,000	0	0	0	0	1,000	1,000
Subtotal: Strategic Workstreams		667	26	-640	667	26	-640	8,000	1,385	-6,615	8,000	1,572	-6,428	205	117	1,063	1,299	5,316	8,000
Divisional Business		-290	102	393	-290	102	393	-1,043	1,904	2,947	-1,043	1,838	2,881	1,230	339	335	838	-3,785	-1,043
Unidentified		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		376	129	-248	376	129	-248	6,957	3,289	-3,668	6,957	3,410	-3,547	1,435	456	1,397	2,137	1,532	6,957

Corporate Report

Apr 2018

Corporate Report

Alder Hey Children's NHS
NHS Foundation Trust

Table of Contents

Executive Summary

Apr 2018

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

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

Highlights

Despite the operational challenges we have achieved the 4 hour, diagnostic, incomplete pathway and cancer standards. This has been a major achievement for the hospital despite the difficulties experienced by the Trust. Cancelled ops on the day and 28 day breaches have increased slightly however we have continued to see robust operational performance despite the challenges. Winter plan remains in place to support Flow and maintain hospital activity and will conclude from M2.

Challenges

Ongoing challenges remain around the maintenance of flow and ED attendance. Despite the demand we have achieved our 4hr standard. Significant challenges remain with maintaining primary care streaming with a number of shifts remaining unfilled. Team continue to backfill with non-GP medical staff and APNP but gaps remain. Maintaining operational focus has been a challenge due to challenges from within PICU. Collectively we have managed this and achieved our NHSI targets.

Patient Centred Services

Plateauing of metrics noted for April. The Trust team have had to manage sever operational challenges from the 12th April which will have impacted upon metrics such as DNA for OP due to adverse publicity. a small number of specialties have seen significant increased and require review. Despite these challenges the Trust has achieved its core NHSI standards for April. The winter plan has been running down in April and will conclude from May going forward. EL activity has started to increase; cancelled ops on the day have decreased but we have seen a modest increase with 28 day breaches. Theatre utilisation has increased predominantly in surgery but DOM utilisation remains low and requires improvement.

Excellence in Quality

There were zero grade 3 and above pressure ulcers, zero never events and zero readmissions to PICU in April. There were 85 incidents with associated minor harm reported in month. There were 4 medication errors resulting in harm, (a slight improvement on the previous month). There was 1x E.coli Blood Stream Infection reported, and there were zero MRSA bacteraemia, and zero C. difficile infections. The percentage of ED patients receiving antibiotics within 1 hour increased to 66.7%, whilst for in-patients this was 76%. There were 6 hospital deaths in April.
There were 9 formal complaints in April and 151 PALS attendances, which is a marked increase in month. Family and Friends Test results are behind target except in CAMHS who achieved 100% positive responses, although number of respondents was small. Three of the inpatient survey questions showed worsening in month, and 'knowing the planned date of discharge' remains the poorest performing measure.

Financial, Growth & Mandatory Framework

The Trust is reporting a trading deficit for April of (£1.1m) which is £0.4m behind plan.

Income is ahead of plan by £0.2m. Shortfalls in elective income (£0.5m) and outpatients (£0.1m) are offset by over performance in non elective activity (£0.4m). Elective activity is behind plan by 9%, non elective is ahead by 12% and outpatient activity is behind by 6%.

Expenditure budgets are 0.6m overspent for the month relating to non pay expenditure and the impact of unachieved savings targets. The Trust underachieved the CIP target for the month by £0.2m. Cash in the Bank is £12.4m. Monitor Use of Resources rating of 3.

Great Talented Teams

Leading Metrics

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Mar 2018	Apr 2018	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	97.2 %	95.3 %	▼	
RTT: 90% Admitted within 18 weeks		88.5 %	87.5 %	▼	
RTT: 95% Non-Admitted within 18 weeks		91.0 %	90.1 %	▼	
RTT: Open Pathway: % Waiting within 18 Weeks		92.1 %	92.1 %	▲	
Diagnostics: Numbers waiting over 6 weeks		1	1	–	
Average LoS - Elective (Days)	3.0	3.2	2.8	▼	
Average LoS - Non-Elective (Days)	2.0	2.1	2.0	▼	
Daycase Rate		71.3 %	70.3 %	▼	
Theatre Utilisation - % of Session Utilised	90.0 %	86.2 %	88.1 %	▲	
28 Day Breaches	0.0	6	7	▲	
Clinic Session Utilisation	90.0 %	84.3 %	82.8 %	▼	
DNA Rate	12.0 %	11.0 %	11.7 %	▲	
Cancelled Operations - Non Clinical - On Same Day		28	22	▼	

Excellence in Quality

Metric Name	Goal	Mar 2018	Apr 2018	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	95.0 %	93.1 %	94.8 %	▲	
IP Survey: % Treated with respect	100.0 %	99.8 %	97.7 %	▼	
IP Survey: % Know their planned date of discharge	90.0 %	60.1 %	60.5 %	▲	
IP Survey: % Know who is in charge of their care	95.0 %	91.6 %	91.3 %	▼	
IP Survey: % Patients involved in play and learning	90.0 %	75.0 %	74.9 %	▼	
Pressure Ulcers (Grade 3 and above)		0	0	–	
Total Infections (YTD)		84	1	▼	
Medication errors resulting in harm	2.0	6	4	▼	
Clinical Incidents resulting in minor harm & above	54.0	95	83	▼	

Great and Talented Teams

Metric Name	Goal	Mar 2018	Apr 2018	Trend	Last 12 Months
Corporate Induction	90.0 %	96.7 %	87.0 %	▼	
PDR		82.0 %	1.4 %	▼	
Medical Appraisal	95.0 %	67.6 %	69.0 %	▲	
Sickness	4.5 %	4.9 %	4.5 %	▼	
Mandatory Training	90.0 %	93.3 %	92.3 %	▼	
Staff Survey (Recommend Place to Work)		64.0 %	64.0 %	–	
Actual vs Planned Establishment (%)		93.9 %	94.2 %	▲	
Temporary Spend ('000s)		1067	977	▼	

Financial, Growth and Mandatory Framework

Metric Name	Mar 2018	Apr 2018	Last 12 Months
CIP In Month Variance (£'000s)	864	-248	
NHSI Use of Resources	1	3	
Control Total In Month Variance (£'000s)	21571	-426	
Capital Expenditure In Month Variance (£'000s)	-887	1090	
Cash in Bank (£'000s)	12244	12406	

Exceptions

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	Last 12 Months
Diagnostics: Numbers waiting over 6 weeks	0	0	0	0	0	0	0	0	1	0	3	1	1	
Average LoS - Elective (Days)	3.0	3.6	2.7	3.2	2.9	3.1	2.6	3.0	3.6	3.0	3.0	3.2	2.8	
Theatre Utilisation - % of Session Utilised	87.2%	87.3%	88.3%	86.1%	87.5%	86.5%	86.4%	84.4%	86.0%	87.2%	85.6%	86.2%	88.1%	
Sickness	4.5%	4.6%	4.6%	5.1%	5.0%	4.9%	5.5%	5.3%	5.8%	6.3%	5.5%	4.9%	4.5%	
Total Infections (YTD)	6	9	13	15	20	26	36	49	58	68	80	84	1	

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

Metric Name	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	Last 12 Months
RTT: 90% Admitted within 18 weeks	89.6%	90.3%	88.8%	89.1%	89.0%	86.8%	89.6%	90.4%	89.6%	89.7%	88.3%	88.5%	87.5%	
RTT: 95% Non-Admitted within 18 weeks	90.2%	88.3%	88.7%	88.6%	89.5%	89.4%	90.3%	90.3%	89.7%	89.3%	91.3%	91.0%	90.1%	
IP Survey: % Treated with respect	98.5%	100.0%	98.8%	99.4%	99.3%	99.5%	99.3%	99.8%	99.4%	100.0%	99.4%	99.8%	97.7%	
Actual vs Planned Establishment (%)	94.8%	94.9%	94.8%	97.4%	92.9%	93.2%	94.4%	93.2%	92.8%	93.2%	94.9%	93.9%	94.2%	
Cash in Bank (£'000s)	6,180	5,243	3,738	11,263	10,405	9,116	10,872	6,753	8,171	6,712	10,201	12,244	12,406	

Challenge (Top 5 based on % change)

Metric Name	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	Last 12 Months
28 Day Breaches	4	2	5	1	9	0	8	5	5	0	2	6	7	
Clinic Session Utilisation	86.7%	85.9%	85.0%	85.7%	84.8%	83.9%	85.4%	86.7%	83.0%	85.9%	84.2%	84.3%	82.8%	
IP Survey: % Know their planned date of discharge	79.4%	69.1%	65.5%	64.0%	53.9%	65.0%	57.4%	61.9%	62.5%	52.1%	59.0%	60.1%	60.5%	
IP Survey: % Patients involved in play and learning	81.4%	75.8%	71.3%	74.0%	65.7%	73.0%	72.6%	76.7%	76.4%	78.3%	79.6%	75.0%	74.9%	
Clinical Incidents resulting in minor harm & above	60	70	78	97	65	73	72	88	51	85	80	95	83	

Patient Safety

Apr 2018

Alder Hey Children's NHS Foundation Trust

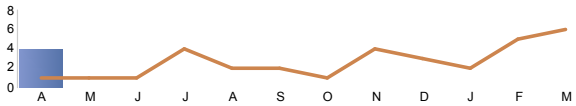
Summary

There were zero grade 3 and above pressure ulcers, zero never events and zero readmissions to PICU in April. There were 85 incidents with associated harm reported in month, none of which were moderate harm or higher. Plus there were zero Serious Incidents Requiring Investigation (SIRI's) for the third consecutive month. There were 4 medication errors resulting in harm, which is equivalent to the previous month.

18/19 17/18 Threshold

Medication Errors

Medication errors resulting in harm — 4 (goal: 2.0)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	4											
17/18	1	1	1	4	2	2	1	4	3	2	5	6

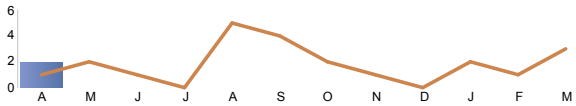
Pressure Ulcers

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

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	0											
17/18	0	1	0	2	0	0	0	0	1	2	0	0

Readmissions to PICU within 48 hrs

Readmissions to PICU within 48 hrs — 2



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	2											
17/18	1	2	1	0	5	4	2	1	0	2	1	3

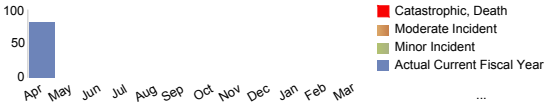
Never Events

Never Events — 0 (goal: 0.0)

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	0											
17/18	0	0	1	0	0	0	0	0	0	0	0	0

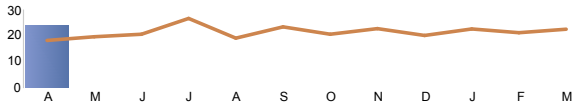
Incidents

Clinical Incidents resulting in minor harm & above — 83 (goal: 54.0)



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	83											
17/18	60	70	78	97	65	73	72	88	51	85	80	95

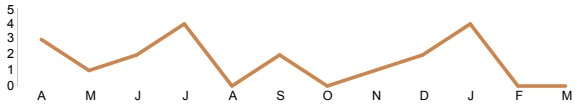
% of Total Clinical Incidents that resulted in Minor Harm & above — 24.4 %



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	24											
17/18	18	19	20	21	21	21	21	21	21	21	21	22

Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) — 0



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	0											
17/18	3	1	2	4	0	2	0	1	2	4	0	0

Clinical Incidents resulting in moderate harm, major/severe harm or death — 0

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	0											
17/18	2	2	0	3	0	3	0	3	2	3	0	1

Patient Experience

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Summary

There were 9 formal complaints in April and 151 PALS attendances, which is a marked increase in month. Family and Friends Test results are behind target except in CAMHS who achieved 100% positive responses, although number of respondents was small. Three of the inpatient survey questions showed worsening in month, and whilst 'knowing the planned date of discharge' showed a slight improvement, this remains the poorest performing measure.

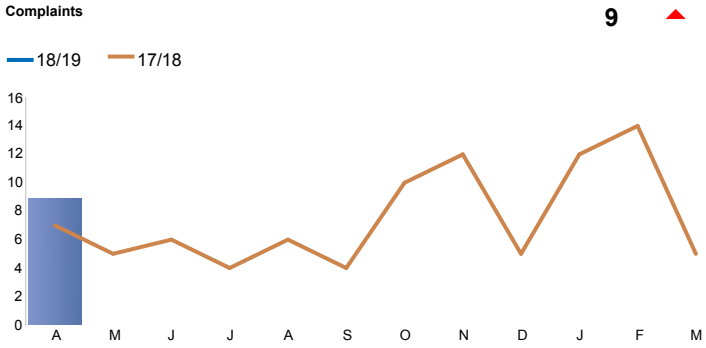
Inpatient Survey

Metric Name	Goal	Mar 2018	Apr 2018	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	91.6 %	91.3 %	▼	
% Patients involved in play and learning	90.0 %	75.0 %	74.9 %	▼	
% Know their planned date of discharge	90.0 %	60.1 %	60.5 %	▲	
% Received information enabling choices about their care	95.0 %	93.1 %	94.8 %	▲	
% Treated with respect	100.0 %	99.8 %	97.7 %	▼	

Friends and Family

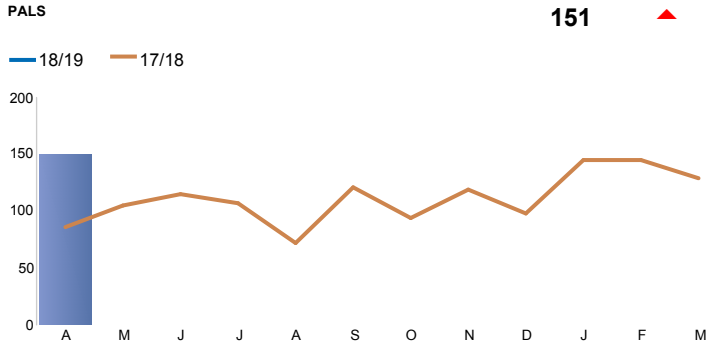
Metric Name	Goal	Number of Responses	Mar 2018	Apr 2018	Trend	Last 12 Months
A&E - % Recommend the Trust	87%	198	86.4 %	85.4 %	▼	
Community - % Recommend the Trust	96%	12	97.7 %	100.0 %	▲	
Inpatients - % Recommend the Trust	96%	652	96.8 %	93.7 %	▼	
Mental Health - % Recommend the Trust	88%	8	100.0 %	87.5 %	▼	
Outpatients - % Recommend the Trust	94%	857	89.3 %	90.3 %	▲	

Complaints



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	9											
17/18	7	5	6	4	6	4	10	12	5	12	14	5

PALS



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	151											
17/18	86	105	115	107	72	121	94	119	98	145	145	129

Clinical Effectiveness

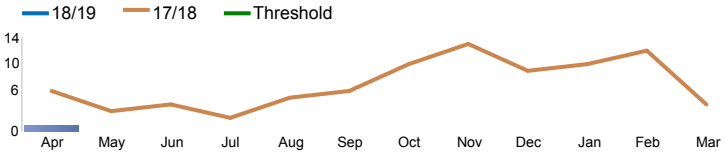
Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Summary

There was 1 infection recorded in April, this was a Blood Stream Infection with E. coli. There were zero MRSA bacteraemia, and zero C. difficile infections in month. The percentage of ED patients receiving antibiotics within 1 hour increased to 66.7%, whilst for in-patients this was 76%. There were 6 hospital deaths in April.

Infections



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	1											
17/18	6	9	13	15	20	26	36	49	58	68	80	84

Total Infections (YTD)

1

Hospital Acquired Organisms - MRSA (BSI) (YTD)

0 *(goal: 0.0)*

Hospital Acquired Organisms - C.difficile (YTD)

0 *(goal: 0.0)*

Outbreak Infections (YTD)

0

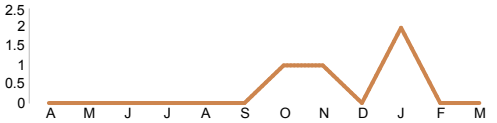
Cluster Infections (YTD)

0

Legend

18/19
17/18
Threshold

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



	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	0											
17/18	0	0	0	0	0	0	1	1	0	2	0	0

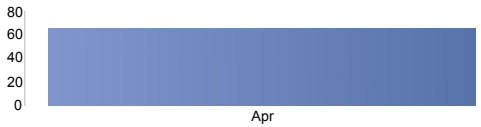
Hospital Acquired Organisms - C.difficile 0 *(goal: 0.0)*

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	0											
17/18	0	0	0	0	0	0	0	0	0	0	0	1

Acute readmissions of patients with long term conditions within 28 days 1 *(Est. Baseline)*

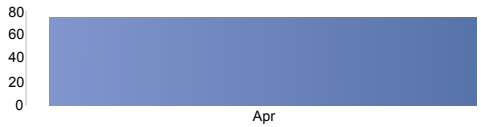
YTD	Apr
18/19	1

Sepsis: % Patients receiving antibiotic within 60 mins for ED



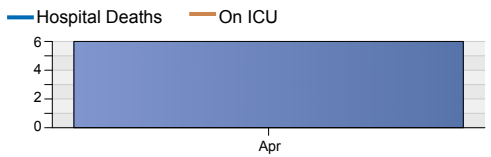
	Apr
18/19	66.7%

Sepsis: % Patients receiving antibiotic within 60 mins for Inpatients



	Apr
18/19	76.0%

Mortality in Hospital



Deaths in Hospital

Actual	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
18/19	6											
17/18	7	4	7	5	6	5	9	3	5	7	1	6

Access

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Summary

Incomplete, diagnostic, cancer and 4 hr access standard achieved for April. Elements of winter plan remain in place as emergency attendance continues in line with plan. Activity has reduced across some POD's due top service disruption from 12th April. Referrals into the hospital have increased against the same period last year; C&B availability 0.1% short against target. Hospital occupancy has increased as Elective activity has started to increase in line with plan.

18 Weeks

RTT: 90% Admitted within 18 weeks 87.5 %

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
89.5%	88.3%	89.9%	88.8%	87.5%

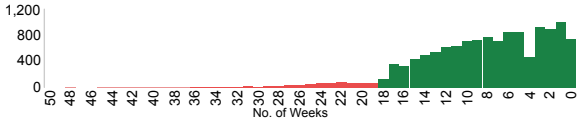
RTT: 95% Non-Admitted within 18 weeks 90.1 %

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
89.1%	89.2%	90.1%	90.6%	90.1%

RTT: Open Pathway: % Waiting within 18 Weeks 92.1 %

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
92.1%	92.1%	92.1%	92.1%	92.1%

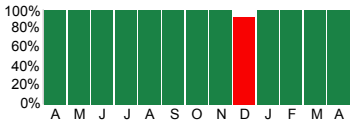
Open Pathways Weekly Profile Apr 2018



0-18 Wks	19-36 Wks	36-51 Wks
12,330	797	108

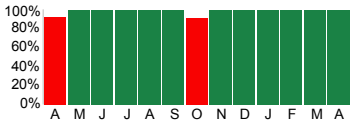
Cancer

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



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
100.0%	100.0%	97.4%	100.0%	100.0%

All Cancers: 31 day diagnosis to treament 100.0 % (goal: 100.0 %)



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
96.4%	100.0%	96.3%	100.0%	100.0%

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

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
100.0%	100.0%	100.0%	100.0%	100.0%

Diagnostics

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

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
100.0%	100.0%	99.9%	99.7%	99.8%

Waiting Times Failed 1

Waiting Times Passed 6

Number of Diagnostics
467

Admissions and Discharges

Bed Occupancy

Bed Occupancy (Accessible Funded Beds) 90.3 % (goal: 89.0 %)

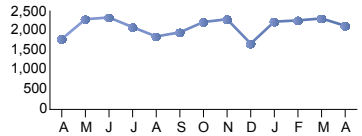
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
82.5%	82.0%	84.2%	89.1%	90.3%

Provider

Convenience and Choice: Slot Availability 94.9 % (goal: 96.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
98.0%	98.4%	98.8%	97.9%	94.9%

Referrals Received (GP)



Emergency Department

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Summary

ED

ED: 95% Treated within 4 Hours

95.3 % (goal: 95.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
96.0%	95.3%	93.8%	94.6%	95.3%

ED: Total Time in ED (95th Percentile)

240.0 mins (goal: 240.0 mins)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
717.0	753.0	824.4	810.2	240.0

ED: Longest Wait Time (Hrs)

18.5 (goal: 0.0)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
61.3	28.5	33.6	35.1	18.5

ED: Number Treated Over 4 Hours

234

ED to Inpatient Conversion Rate

17.6 %

Apr 2018

ED

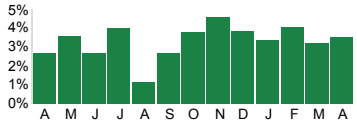
ED: 60 minute 'Time to Treat Decision' (Median)

93.0 mins (goal: 60.0 mins)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
247.5	206.0	266.5	291.0	93.0

ED: Percentage Left without being seen

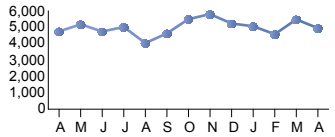
3.6 % (goal: 5.0 %)



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
3.0%	2.8%	4.1%	3.6%	3.6%

ED: Number of Attendances

4943 Apr 2018



Ambulance Services

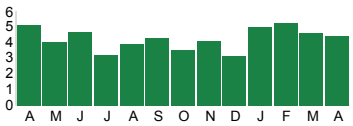
Ambulance: Acute Compliance

80.3 % (goal: 85.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
88.4%	84.2%	79.3%	81.4%	80.3%

Ambulance: Average Notification to Handover Time (mins)

4.5 mins (goal: 15.0 mins)



Ambulance: Patients Waiting between 30 and 45 minutes

4

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
9.0	4.0	10.2	6.0	4.0

Ambulance: Patients Waiting between 45 and 60 minutes

0

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
2.0	1.0	1.0	0.0	0.0

Productivity & Efficiency

Apr 2018

Alder Hey Children's NHS Foundation Trust

Summary

April continues with the winter plan in place and ongoing ED attendance & NEL challenges to manage. Ongoing issues arising from the incident on the 12th April have impacted in terms of DNA and cancellations despite assurances around business as usual. OP DNA's have increased across a range of specialties that will require further review. Theatre utilisation has increased within surgery but decreased in medicine. LOS has improved and likely due to residual impact of winter plan.

Length of Stay

Average LoS - Elective (Days) — 2.8 (goal: 3.0)

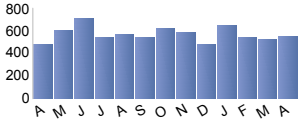
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
3.1	3.0	3.0	3.1	2.8

Average LoS - Non-Elective (Days) — 2.0 (goal: 2.0)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
2.1	2.1	2.0	2.1	2.0

Day Case Rate

Daycases (K1/SDCPREOP) — 559



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
1,819	1,674	1,724	1,737	559

Daycase Rate — 70.3 %

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
71.9%	70.9%	72.5%	72.7%	70.3%

Bed Refusals

Bed Refusals — 0 (goal: 0.0)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
0	0	0	1	0

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * — 88.1 % (goal: 90.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
87.6%	86.7%	85.6%	86.4%	88.1%

Cancelled Operations - Non Clinical - On Same Day (%) — 0.9 % (goal: 0.8 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
1.2%	1.4%	1.1%	0.9%	0.9%

Cancelled Operations - Non Clinical - On Same Day — 22

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
83	94	81	67	22

28 Day Breaches — 7 (goal: 0.0)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
11	10	18	8	7

Outpatients

Clinic Session Utilisation * — 82.8 % (goal: 90.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
85.8%	84.8%	85.2%	84.8%	82.8%

OP Appointments Cancelled by Hospital % — 12.6 % (goal: 5.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
13.4%	13.1%	13.6%	14.6%	12.6%

DNA Rate — 11.7 % (goal: 12.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
11.8%	12.4%	11.5%	10.6%	11.7%

OP: New/Follow Up — 2.5

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
2.6	2.6	2.7	2.8	2.5

Facilities

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Summary

At the end of April 2018 we have managed to audit most of the planned areas. This helps to focus on issues highlighted by the audits and what needs to be done to rectify them. High dusting has been an issue but we have now trialled a new high dusting tool and intend to purchase.

Facilities

Cleanliness Performance VH 98.7 % (goal: 98.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
99.7%	96.9%	98.2%	98.3%	98.7%

Cleanliness Performance H 97.2 % (goal: 95.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
94.6%	96.0%	96.3%	97.1%	97.2%

Cleanliness Performance S 98.7 % (goal: 85.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
90.3%	84.6%	91.8%	95.3%	98.7%

Cleanliness Performance L 76.0 % (goal: 75.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
90.0%	75.1%	75.0%	81.3%	76.0%

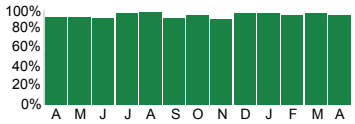
Facilities

Audit Compliance 90.0 % (goal: 85.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
6.7%	21.7%	66.7%	83.3%	90.0%

Facilities - Other

Routine Maintenance Resolution 94.8 % (goal: 85.0 %)



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
92.6%	95.7%	94.2%	96.5%	94.8%

PPM% 95.0 % (goal: 85.0 %)

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
94.8%	97.9%	97.5%	93.4%	95.0%

CAMHS

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Summary

EDYS average wait for urgent is 10.7 week and 3.6 weeks for routine. Breaches in month are due to limited capacity due to staff leaving and pre-booked annual leave. To mitigate this team have flexibility altered job plans/clinics to reduce the number of breaches.

Sefton CAMHS RTT 23 week, this has improved in month. Liverpool RRT has decreased in April, deep dive into referrals has indicated an issue with duplicate referrals.

Waiting Times

CAMHS: Avg Wait to Partnership Appt (Weeks)- Liverpool Specialist — 15.0

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
43.0	51.0	47.0	44.0	15.0

CAMHS: Avg Wait to Partnership Appt (Weeks)- Sefton Specialist — 19.0

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
43.0	51.0	47.0	44.0	15.0

Eating Disorder Pathway

Routine EDYS Pathway Average Wait in Weeks — 4

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
6.0	5.0	6.1	10.2	3.6

Urgent EDYS Pathway Average Wait in Weeks — 2

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
1.0	0.1	2.2	1.9	1.7

DNA Rates

CAMHS: DNA Rate - New — 8.7 % (goal: 10.0 %)

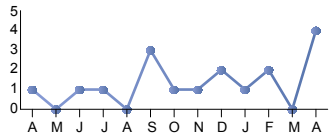
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
14.1%	18.9%	12.7%	11.5%	8.7%

CAMHS: DNA Rate - Follow Up — 21.7 % (goal: 14.0 %)

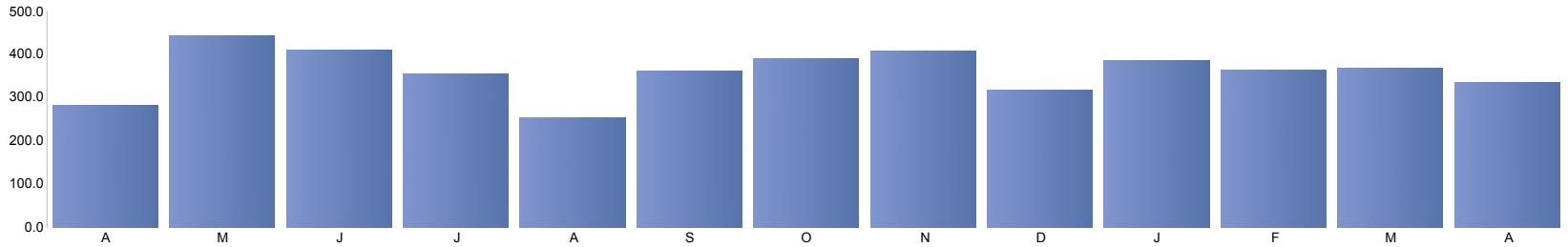
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
17.7%	20.9%	17.0%	15.6%	21.7%

Tier 4 Admissions

CAMHS: Total Admissions to DJU — 4



CAMHS: Referrals Received



External Regulation

Apr 2018

Alder Hey Children's NHS
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

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

NHSI - Risk Rating

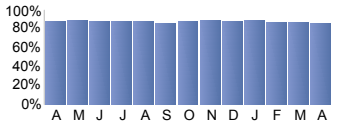
May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18
3	3	3	3	3	3	3	3	3	3	1	3

NHSI Apr 2018

Metric Name	Goal	Mar 18	Apr 18	Trend
ED: 95% Treated within 4 Hours	95.0 %	97.2 %	95.3 %	▼
RTT: 90% Admitted within 18 weeks		88.5 %	87.5 %	▼
RTT: 95% Non-Admitted within 18 weeks		91.0 %	90.1 %	▼
RTT: Open Pathway: % Waiting within 18 Weeks		92.1 %	92.1 %	▲
NHSI Use of Resources	3.0	1	3	▲
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day diagnosis 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	1	0	▼

NHSI - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
89.5%	88.3%	89.9%	88.8%	87.5%

RTT: 95% Non-Admitted within 18 weeks

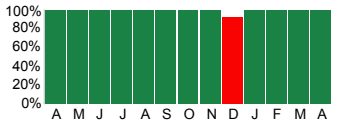
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
89.1%	89.2%	90.1%	90.6%	90.1%

RTT: Open Pathway: % Waiting within 18 Weeks

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
92.1%	92.1%	92.1%	92.1%	92.1%

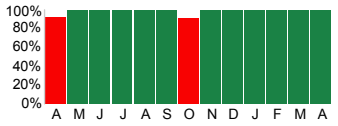
NHSI - All Cancers

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



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
100.0%	100.0%	97.4%	100.0%	100.0%

All Cancers: 31 day diagnosis to treament



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
96.4%	100.0%	96.3%	100.0%	100.0%

All Cancers: 31 day wait until subsequent treatments

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
100.0%	100.0%	100.0%	100.0%	100.0%

NHSI - A&E 4 Hour Target

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
96.0%	95.3%	93.8%	94.6%	95.3%

NHSI - C difficile

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
0	0	0	1	0

NHSI - Data Completeness

No Data Available

Workforce

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Summary

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Last 12 Months
Add Prof Scientific and Technic	3.6%	3.9%	4.6%	4.2%	4.9%	2.8%	3.7%	4.5%	3.5%	3.2%	3.4%	4.8%	
Additional Clinical Services	7.4%	7.3%	7.7%	6.1%	6.0%	7.5%	8.0%	8.7%	8.3%	7.1%	6.2%	5.4%	
Administrative and Clerical	2.3%	2.3%	3.7%	4.5%	4.3%	4.4%	4.3%	4.8%	5.2%	4.7%	3.9%	3.6%	
Allied Health Professionals	3.2%	3.8%	3.2%	2.8%	2.7%	3.0%	2.4%	2.4%	4.1%	4.0%	3.4%	2.4%	
Estates and Ancillary	9.2%	9.2%	10.8%	14.7%	12.3%	13.2%	11.4%	10.2%	12.8%	12.7%	10.6%	10.2%	
Healthcare Scientists	3.3%	4.0%	4.6%	1.5%	2.9%	2.0%	3.2%	2.2%	0.9%	1.8%	1.4%	0.9%	
Medical and Dental	1.7%	1.7%	2.0%	1.9%	1.7%	2.4%	2.1%	3.0%	2.9%	2.0%	1.0%	0.9%	
Nursing and Midwifery Registered	5.4%	5.3%	5.1%	4.8%	5.0%	6.1%	5.8%	6.7%	7.5%	6.2%	5.8%	5.5%	
Trust	4.6%	4.6%	5.1%	5.0%	4.9%	5.5%	5.3%	5.8%	6.3%	5.5%	4.9%	4.5%	

Staff in Post FTE (rolling 12 Months)

Staff Group	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Last 12 Months
Add Prof Scientific and Technic	199	201	200	197	199	199	196	197	198	199	200	200	
Additional Clinical Services	393	392	400	397	409	410	406	404	405	415	412	409	
Administrative and Clerical	623	620	626	628	626	624	626	628	635	635	631	641	
Allied Health Professionals	210	213	215	216	219	223	224	223	221	226	223	222	
Estates and Ancillary	185	184	184	183	182	182	180	180	180	180	180	179	
Healthcare Scientists	107	109	110	110	108	107	107	107	108	111	112	111	
Medical and Dental	243	247	241	248	249	251	247	247	251	253	255	260	
Nursing and Midwifery Registered	970	972	965	960	1,018	1,024	1,018	1,007	999	998	1,000	994	

Staff in Post Headcount (rolling 12 Months)

Staff Group	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	Mar 18	Apr 18	Last 12 Months
Add Prof Scientific and Technic	220	223	223	219	220	219	216	218	220	221	223	223	
Additional Clinical Services	470	468	477	473	486	488	484	481	483	493	490	488	
Administrative and Clerical	712	711	716	717	714	712	714	715	720	720	716	728	
Allied Health Professionals	259	262	264	265	267	271	272	271	269	274	271	269	
Estates and Ancillary	231	231	230	229	228	228	226	226	227	227	227	227	
Healthcare Scientists	117	119	119	119	119	116	116	116	118	121	121	120	
Medical and Dental	286	289	284	290	293	294	292	291	295	297	299	303	
Nursing and Midwifery Registered	1,095	1,097	1,091	1,086	1,145	1,151	1,145	1,133	1,122	1,121	1,122	1,119	

Finance

Temporary Spend ('000s) 977

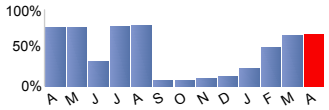
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
3	3	3	3	1

Actual vs Planned Establishment (%) 94.2 %

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
94.8%	94.3%	93.5%	94.0%	94.2%

Appraisals

Medical Appraisal 69.0 % *(goal: 95.0 %)*



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
76.9%	57.8%	11.1%	51.4%	69.0%

PDR 1.4 %

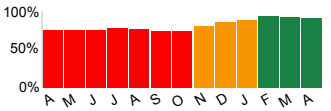
Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
21.1%	82.4%	86.3%	83.5%	1.4%

Training

Corporate Induction 87.0 % *(goal: 90.0 %)*

Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
82.6%	81.0%	80.6%	95.0%	87.0%

Mandatory Training 92.3 % *(goal: 90.0 %)*



Q1 17/18	Q2 17/18	Q3 17/18	Q4 17/18	Q1 18/19
76.2%	76.7%	81.0%	92.5%	92.3%

Performance by CBU

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	66.3%	87.1%	83.7%
Control Total In Month Variance (£'000s)	-108	127	-167
Convenience and Choice: Slot Availability	100.0%	92.3%	96.2%
DNA Rate (Followup Appts)	20.3%	9.8%	8.5%
DNA Rate (New Appts)	19.7%	11.3%	11.7%
Referrals Received (GP)	296	689	1,135
Referrals Received (Non GP)	510	993	2,469
Temporary Spend ('000s)	166	246	468
Theatre Utilisation - % of Session Utilised		76.1%	90.2%

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		3.2	2.4
Average LoS - Non-Elective (Days)		1.5	2.6
Cancelled Operations - Non Clinical - On Same Day	0	1	21
Daycases (K1/SDCPREOP)	0	70	484
Diagnostics: % Completed Within 6 Weeks		99.8%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	21	29	32
OP Appointments Cancelled by Hospital %	16.7%	14.4%	11.1%
RTT: 90% Admitted within 18 weeks		92.6%	86.6%
RTT: 95% Non-Admitted within 18 weeks	94.3%	88.9%	90.3%
RTT: Open Pathway: % Waiting within 18 Weeks	97.1%	90.0%	92.3%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores		98.1%	98.7%
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0
Medication Errors (Incidents)	3	18	37

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	75.0%	83.3%	92.3%
Mandatory Training	95.4%	92.7%	90.2%
PDR	0.4%	2.2%	1.1%
Sickness	4.3%	3.6%	4.7%

CBU Performance - Community

Apr 2018

Alder Hey Children's NHS Foundation Trust

Key Issues

DNAs and short notice cancellations of clinics are an issue across the division. Team to completed a targeted piece of work to improve this position.

Support Required

NA

Operational

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	78.8%	81.8%	79.6%	79.1%	76.9%	79.9%	83.1%	80.3%	73.0%	77.5%	75.9%	71.8%	66.3%	
DNA Rate (New Appts)	15.9%	16.1%	19.2%	17.7%	18.4%	13.2%	15.8%	13.4%	15.8%	14.3%	15.8%	16.1%	19.7%	
DNA Rate (Followup Appts)	15.1%	14.3%	15.8%	15.1%	19.8%	17.5%	13.7%	13.6%	15.9%	12.2%	12.8%	13.6%	20.3%	
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)	230	387	324	321	232	331	405	394	270	338	344	355	296	
Referrals Received (Non GP)	698	834	749	654	561	508	802	703	698	798	684	628	510	
Temporary Spend ('000s)	67	103	116	146	169	195	141	167	131	146	136	202	166	
Control Total In Month Variance (£'000s)	38	95	6	-69	-136	-55	-64	-72	-86	-161	43	119	-108	

Patient

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	87.9%	85.4%	91.8%	91.4%	93.1%	87.3%	87.9%	83.2%	90.0%	89.1%	90.6%	93.8%	94.3%	
RTT: Open Pathway: % Waiting within 18 Weeks	94.0%	97.4%	94.3%	94.6%	96.5%	96.1%	96.3%	96.8%	97.3%	97.3%	96.5%	96.7%	97.1%	
Average LoS - Elective (Days)						14.00				20.00				
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	15	3	12	5	13	8	19	17	19	10	10	30	21	
Daycases (K1/SDCPREOP)	0	2	0	1	0	0	1	3	0	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 %	22.8%	14.5%	18.8%	13.3%	17.3%	16.1%	15.2%	16.9%	16.9%	12.3%	13.5%	17.7%	16.7%	
Diagnostics: % Completed Within 6 Weeks														

Quality

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
Medication Errors (Incidents)	3	2	3	2	7	9	11	7	2	2	8	7	3	
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	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
Corporate Induction	82.9%		88.9%	100.0%	57.1%	100.0%	33.3%	100.0%	100.0%		100.0%	100.0%	75.0%	
PDR	0.0%	5.7%	26.5%	71.0%	82.8%	87.4%	90.4%	88.8%	90.4%	90.4%	83.9%	83.9%	0.4%	
Sickness	5.1%	5.6%	5.7%	6.4%	6.3%	7.0%	5.8%	5.6%	6.7%	6.0%	5.6%	5.8%	4.3%	
Mandatory Training	57.1%	56.1%	55.2%	74.5%	75.3%	74.6%	75.1%	80.3%	86.7%	89.8%	96.8%	95.7%	95.4%	

CBU Performance - Medicine (Part 1)

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Clinic Utilisation increased in April, despite challenging operational issues and we saw a return to our DNA rate for f/up under 10%. We has seen slot availability deteriorate, but this reflects the work on the eRS CQUIN with all GP referrals to be electronic as well as reducing our polling ranges. This will need to be closely managed.

Sickness is under 4% for the first time which is excellent, and whilst our mandatory training remains above 90% we have seen a drop for the last two months which needs review.

Support Required

Operational

Metric Name	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	Last 12 Months
Theatre Utilisation - % of Session Utilised	81.1%	83.6%	84.6%	76.9%	81.8%	82.0%	81.5%	79.6%	82.5%	79.9%	80.6%	83.5%	76.1%	
Clinic Session Utilisation	86.5%	87.1%	84.8%	87.1%	87.1%	86.6%	86.9%	88.5%	86.5%	88.0%	89.1%	87.1%	87.1%	
DNA Rate (New Appts)	15.0%	12.6%	12.7%	12.9%	12.3%	10.5%	13.4%	10.6%	14.0%	11.3%	11.1%	10.7%	11.3%	
DNA Rate (Followup Appts)	12.1%	11.9%	10.5%	10.6%	11.2%	11.2%	11.2%	8.9%	10.3%	8.5%	8.6%	11.0%	9.8%	
Convenience and Choice: Slot Availability	98.0%	96.3%	100.0%	100.0%	98.0%	91.4%	99.4%	97.8%	100.0%	99.7%	96.3%	92.3%	92.3%	
Referrals Received (GP)	577	746	792	729	636	635	724	758	564	744	772	816	689	
Referrals Received (Non GP)	944	1,279	1,087	1,137	957	956	1,065	1,102	929	1,106	1,022	1,073	993	
Temporary Spend ('000s)	290	322	222	323	326	250	186	242	207	211	276	316	246	
Control Total In Month Variance (£'000s)	-225	-72	-370	-649	155	-21	-464	529	-52	611	461	-855	127	

Patient

Metric Name	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	Last 12 Months
RTT: 90% Admitted within 18 weeks	96.4%		95.7%	90.5%	95.5%	100.0%	94.2%	92.7%	85.3%	83.2%	93.4%	90.4%	92.6%	
RTT: 95% Non-Admitted within 18 weeks	90.9%	86.2%	88.8%	89.1%	87.3%	86.8%	89.0%	90.1%	85.2%	80.6%	88.7%	89.6%	88.9%	
RTT: Open Pathway: % Waiting within 18 Weeks	94.9%	94.5%	94.0%	93.6%	93.3%	94.2%	92.7%	91.2%	92.6%	92.9%	93.0%	89.8%	90.0%	
Average LoS - Elective (Days)	3.50	3.40	2.94	3.05	2.90	3.06	2.89	3.33	4.06	3.54	3.22	3.17	3.23	
Average LoS - Non-Elective (Days)	1.62	1.60	1.51	1.65	1.49	1.63	1.39	1.41	1.50	1.75	1.57	1.50	1.52	
Hospital Initiated Clinic Cancellations < 6 weeks notice	20	18	23	17	16	21	32	30	41	26	55	67	29	
Daycases (K1/SDCPREOP)	58	70	103	70	71	63	76	74	49	58	66	73	70	
Cancelled Operations - Non Clinical - On Same Day	1	3	1	2	1	2	2	5	2	0	1	0	1	
OP Appointments Cancelled by Hospital %	17.8%	11.5%	13.7%	14.8%	13.7%	13.6%	14.3%	13.5%	15.4%	15.4%	18.0%	17.7%	14.4%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.8%	

Quality

Metric Name	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	Last 12 Months
Medication Errors (Incidents)	25	34	27	25	31	19	29	22	27	28	30	33	18	
Cleanliness Scores		97.0%			96.0%	96.0%	97.6%	95.4%	97.8%		98.0%	97.0%	98.1%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	1	0	2	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Nov 2017	Dec 2017	Jan 2018	Feb 2018	Mar 2018	Apr 2018	Last 12 Months
Corporate Induction		81.8%	61.5%	100.0%	50.0%	80.0%	70.0%	100.0%	70.0%		96.2%	100.0%	83.3%	
PDR	2.9%	15.4%	41.3%	73.8%	79.7%	82.2%	84.0%	85.0%	84.0%	84.0%	81.5%	81.5%	2.2%	
Sickness	4.0%	4.8%	4.3%	4.7%	3.8%	4.1%	5.0%	5.3%	5.1%	5.6%	4.8%	4.3%	3.6%	
Mandatory Training	80.1%	80.0%	80.5%	79.0%	78.3%	75.7%	77.3%	82.2%	86.6%	88.9%	94.7%	93.8%	92.7%	

CBU Performance - Medicine (Part 2)

Apr 2018

Alder Hey Children's NHS Foundation Trust

Key Issues

Patient: Turnaround times in ED, Inpatient and MRI dipped again and will be monitored.
Quality: Turnaround times for urgent requests under one hour improved as predicted. Significant dip in reporting times for perinatal autopsies in 56 calendar days. To be investigated.

Support Required

Patient

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	96.0%	91.0%	92.0%	90.0%	90.0%	86.0%	97.9%	88.4%	97.0%	99.0%	99.0%	99.0%	99.0%	
Imaging - % Reporting Turnaround Times - ED	80.0%	64.0%	76.0%	83.0%	82.0%	85.0%	96.7%	96.7%	78.0%	99.0%	86.0%	88.9%	84.0%	
Imaging - % Reporting Turnaround Times - Inpatients	78.0%	74.0%	79.0%	85.0%	85.0%	79.0%	97.8%	94.4%	78.0%	94.0%	79.0%	85.0%	84.0%	
Imaging - % Reporting Turnaround Times - Outpatients	92.0%	90.0%	92.0%	98.0%	98.0%	92.0%	89.5%	90.0%	95.0%	96.0%	93.0%	97.0%	92.0%	
Imaging - Waiting Times - MRI % under 6 weeks	71.0%	81.0%	67.0%	68.0%	77.0%	79.0%	93.7%	96.8%	96.0%	73.0%	88.0%	89.0%	80.0%	
Imaging - Waiting Times - CT % under 1 week	95.0%	89.0%	87.0%	87.0%	89.0%	87.0%	93.3%	94.4%	84.0%	85.0%	81.0%	88.0%	90.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	93.0%	94.0%	93.0%	94.0%	92.0%	91.0%	98.9%	100.0%	91.0%	92.0%	89.0%	91.0%	91.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	84.0%	88.0%	90.0%	91.0%	90.0%	87.0%	95.6%	93.3%	85.0%	84.0%	87.0%	87.0%	86.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	88.0%	95.0%	89.0%	100.0%	93.0%	72.0%	100.0%	96.8%	83.0%	92.0%	90.0%	82.0%	94.0%	
BME - High Risk Equipment PPM Compliance	80.2%	91.7%	91.6%	91.2%	90.1%	84.6%	90.2%	90.1%	89.2%	87.6%	84.7%	88.0%	86.9%	
BME - Low Risk Equipment PPM Compliance	100.0%	82.0%	81.9%	80.4%	75.5%	74.6%	70.9%	76.0%	77.7%	80.4%	81.5%	84.0%	84.9%	
BME - Equipment Pool - Equipment Availability	91.4%	99.8%	100.0%	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	57.0%	37.0%	60.0%	65.0%	63.0%	57.0%	61.0%	60.0%	61.0%	58.0%	51.0%	50.0%	54.0%	
Pharmacy - Dispensing for Out Patients - Complex	98.0%	100.0%	100.0%	96.0%	97.0%	100.0%	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%	54.3%	54.5%	80.0%	90.0%	100.0%	100.0%	100.0%	100.0%	94.1%	92.9%	100.0%	

Quality

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	89.7%	89.9%	91.0%	88.1%	88.1%	91.0%	89.1%	87.4%	87.6%	87.7%	88.0%	87.8%	89.7%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	
Reporting times for perinatal autopsies in 56 Calendar Days	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.3%	100.0%	100.0%	100.0%	100.0%	71.4%	
Blood Traceability Compliance	99.4%	100.0%	100.0%	99.5%	99.8%	99.8%	99.2%	99.5%	100.0%	99.8%	99.6%	99.6%	99.2%	

CBU Performance - Surgery

Apr 2018

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Cancelled operations on the day of surgery - This remains high; most common cancellation reason is due to no available ward bed. This is contributing to multiple patient cancellations and breach of 28 day relisting target. Work commencing with patient flow and SAFER project to reduce these cancellations.

Clinic Utilisation -Planned utilisation across Surgery for April is 102%, however DNA's & particularly short notice cancellations reduces this. Actions to resolve include rollout of bidirectional texting for all surgical specialties.

Support Required

Rapid and effective implementation of Black Marble and SAFER programme will assist in facilitation of timely discharges and delivery of planned elective care.
Continued progress with brilliant booking systems workstream to improve access and attendance in outpatients.

Operational

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
Theatre Utilisation - % of Session Utilised	88.3%	87.9%	88.9%	87.7%	88.6%	87.3%	87.3%	85.2%	86.6%	88.3%	86.4%	86.8%	90.2%	
Clinic Session Utilisation	87.9%	86.0%	85.9%	86.2%	84.8%	83.2%	85.2%	87.0%	82.9%	86.2%	83.6%	85.0%	83.7%	
DNA Rate (New Appts)	10.2%	11.7%	12.4%	11.6%	12.6%	11.8%	12.3%	12.6%	12.7%	11.6%	11.8%	12.3%	11.7%	
DNA Rate (Followup Appts)	9.9%	10.1%	9.7%	10.6%	11.5%	11.3%	10.9%	9.1%	11.1%	9.6%	9.0%	8.9%	8.5%	
Convenience and Choice: Slot Availability	98.2%	99.5%	96.0%	99.0%	100.0%	100.0%	99.8%	97.4%	98.7%	97.1%	99.2%	100.0%	96.2%	
Referrals Received (GP)	977	1,153	1,215	1,035	981	988	1,087	1,134	833	1,143	1,141	1,135	1,135	
Referrals Received (Non GP)	2,235	2,972	2,875	2,485	2,424	2,438	2,428	2,394	1,831	2,189	2,338	2,506	2,469	
Temporary Spend ('000s)	516	402	456	511	554	429	479	383	331	408	434	514	468	
Control Total In Month Variance (£'000s)	-198	157	650	82	532	-167	-506	-610	-489	-634	-715	-215	-167	

Patient

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
RTT: 90% Admitted within 18 weeks	86.9%	90.3%	87.8%	88.8%	87.8%	85.0%	88.5%	90.0%	90.5%	90.7%	87.1%	88.0%	86.6%	
RTT: 95% Non-Admitted within 18 weeks	90.1%	89.8%	88.2%	88.1%	90.2%	90.7%	91.2%	91.2%	91.6%	92.9%	92.6%	91.4%	90.3%	
RTT: Open Pathway: % Waiting within 18 Weeks	90.9%	90.8%	91.3%	91.2%	91.2%	90.9%	91.6%	92.0%	91.3%	91.4%	91.3%	92.6%	92.3%	
Average LoS - Elective (Days)	2.58	3.57	2.57	3.10	2.91	3.03	2.36	2.76	3.30	2.62	2.88	3.14	2.41	
Average LoS - Non-Elective (Days)	2.84	3.06	2.57	2.86	2.96	2.74	2.90	3.17	3.18	2.67	2.89	3.31	2.59	
Hospital Initiated Clinic Cancellations < 6 weeks notice	19	23	28	35	32	26	27	26	37	24	58	41	32	
Daycases (K1/SDCPREOP)	426	540	609	472	499	485	552	521	435	590	472	454	484	
Cancelled Operations - Non Clinical - On Same Day	6	54	18	29	14	46	24	35	13	19	19	28	21	
OP Appointments Cancelled by Hospital %	13.2%	11.2%	12.7%	12.0%	12.8%	11.8%	12.3%	13.2%	13.2%	12.9%	13.9%	12.6%	11.1%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	92.6%	94.7%	100.0%	

Quality

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
Medication Errors (Incidents)	40	56	48	42	55	32	30	46	25	39	44	44	37	
Cleanliness Scores				97.6%	93.9%		95.5%	97.4%	98.3%	97.7%	98.4%	98.4%	98.7%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	1	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	1	0	

Workforce

Metric Name	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	Last 12 Months
Corporate Induction		90.0%	100.0%	100.0%	60.0%	71.4%	85.0%	88.9%	77.8%		88.2%	91.7%	92.3%	
PDR	1.9%	11.2%	63.0%	87.6%	91.1%	90.1%	89.5%	88.1%	89.5%	89.5%	83.3%	83.3%	1.1%	
Sickness	4.5%	4.4%	4.7%	4.8%	4.7%	4.6%	5.1%	4.8%	6.0%	6.3%	5.1%	4.4%	4.7%	
Mandatory Training	80.6%	80.7%	81.5%	79.1%	77.0%	73.0%	73.8%	80.9%	85.8%	89.3%	93.5%	91.5%	90.2%	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 22 May 2018

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, Governance Manager
Subject/Title	2018/19 Board Assurance Framework Update (May 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 – May 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

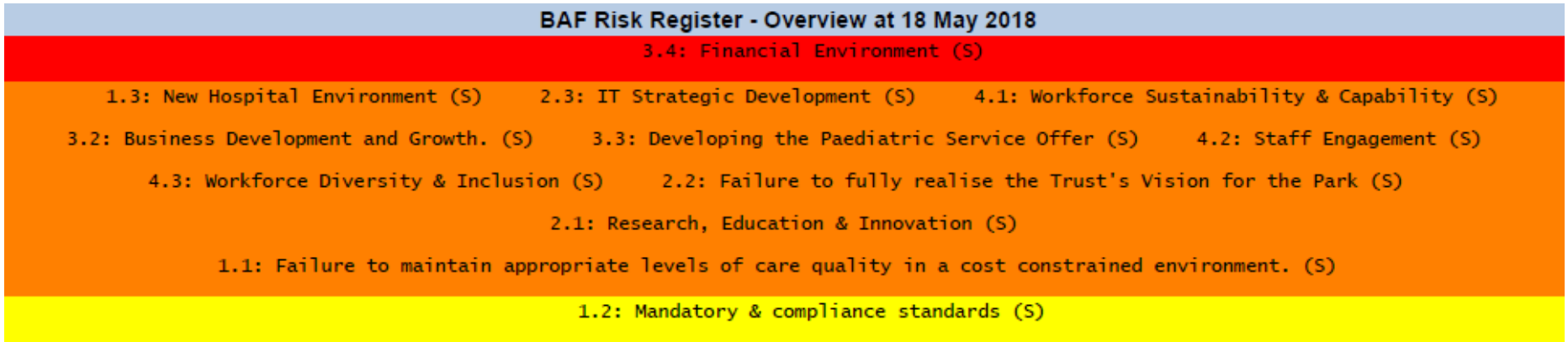
Board Assurance Framework 2018/19

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.



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**	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation						
2.1 DP	**Research, Education & Innovation**		3-3	3-2	WORSE	STATIC
2.2 DP	**Failure to fully realise the Trust's Vision for the Park**		3-3	3-2	BETTER	STATIC
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 1 May 2018 Board meeting

The diagram above shows that the majority of the risks on the BAF remained static.

External risks

- ***Business development and growth (MB)***
  Detailed discussion at Execs (17 May). Further work up of detailed proposals for 18/19 to be completed by end of June and for July Trust Board..

- ***Mandatory and compliance standards (ES)***
  No compliance concerns at this stage in the month

- ***Developing the Paediatric Service Offer (MB)***
  Workshop held on 17 May and next steps agreed.

Internal risks:

- ***New Hospital Environment (DP)***
  Interim report on Pipework received. Commercial plan meeting in diary for June. Fire-stopping review under way.

- ***Maintain care quality in a cost constrained environment (HG)***
  Recruitment drive underway following agreement of the clinical educator business case due to number of roles a staggered approach to recruitment has been adopted.

- ***Financial Environment (JG)***
  Key risks highlighted as delivery of efficiency programme and elective run-rates, financial sustainability board charged with oversight which is being tracked through RABD.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Meeting arranged with Friends of Springfield Park to agree 1st park extension

- ***IT Strategic Development (JG)***
  No material changes to report in-month

- ***Workforce Sustainability & Capability (MS)***
  The Trust has been invited to be part of a national staff health and wellbeing improvement programme being led by NHS Improvement in order to improve the health and wellbeing of our workforce and to reduce sickness absence rates. Sickness absence rates have fallen for the 3rd consecutive month. Training compliance remains above 90%

- ***Staff Engagement (MS)***
  Team discussions re staff survey outputs are taking place across the divisions. PDR refresher training for managers has been provided by L&D, to assist managers in having meaningful conversations with staff during their PDR. The PDR window is currently open until July 2018.

- ***Workforce Diversity & Inclusion (MS)***
  The Trust is currently scoping out a targeted pre-employment programme specifically for BME applicants, with an imminent roll out.

- ***Research, Education & Innovation (DP)***
  Revised plan for 2017/18 innovation activity

Erica Saunders
Director of Corporate Affairs
22 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.	We have 2 Nurse Associates in training qualify 2019. Apprenticeship lead has met with EHU programme lead and agreed provisional date of March 19 for us to input to the programmes dependent on our agreed nursing workforce strategy
Recruit nurse education lead to support delivery of nursing workforce	Job description being developed. To be sent for desk top matching prior to

strategy	advertising.

Executive Lead's Assessment
APRIL 2018: Successful recruitment, nurse leadership OPD MAY 2018: Recruitment drive underway following agreement of the clinical educator business case due to number of roles a staggered approach to recruitment has been adopted

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 1. No governance concerns
MAY 2018: No compliance concerns at this stage in the month

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	
Whole Hospital review of fire stopping	
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. MAY 2018: Interim report on Pipework received. Commercial plan meeting in diary for June. Fire-stopping review under way	

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: STATIC

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**
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 re-launched MAY 2018: Revised plan for 2017/18 innovation activity

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: STATIC

Risk Description	
Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations	
Existing Control Measures	
• 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**
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)
Executive Lead's Assessment	
APRIL 2018: New Park manager appointed MAY 2018: Meeting arranged with Friends of Springfield Park to agree 1st park extension.	

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
MAY 2018: No material changes to report in-month

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.
MAY 2018: Detailed discussion at Execs (17 May). Further work up of detailed proposals for 18/19 to be completed by end of June and for July Trust Board.

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.
MAY 2018: Workshop held on 17 May and next steps agreed

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 Sefton CCG contract negotiaitions	Base contract agreed. Discussions on-going regarding targeted investment in the community / CMAHS services
Develop fully worked up CIP programme	Action needs accelerating as gap is currently larger than anticipated at this stage in the year

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.
MAY 2018: Key risks highlighted as delivery of efficiency programme and elective run-rates, financial sustainability board charged with oversight which is being tracked through RABD.

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**
Working with Trade Unions to refresh the policy, understand further the drivers for high sickness absence	
ensure a minimum of 50 learners enrolled on apprenticeship pathways.	

Executive Lead's Assessment

APRIL 2018: Progress continues with apprenticeship programme. Training compliance still above 90%. Sickness Absence Task and Finish project defined.
MAY 2018: The Trust has been invited to be part of a national staff health and wellbeing improvement programme being led by NHS Improvement in order to improve the health and wellbeing of our workforce and to reduce sickness absence rates. Sickness absence rates have fallen for the 3rd consecutive month. Training compliance remains above 90%

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
L&D manager to undertake a review of the methodology, with a view to launching new system in June 18	
Group to be established and to roll-out the approach to HWB across the organisation	

Executive Lead's Assessment

APRIL 2018: Local Staff Survey data shared with all teams to discuss locally. Alder Hey Life staff magazine published.
MAY 2018: Team discussions re staff survey outputs are taking place across the divisions. PDR refresher training for managers has been provided by L&D, to assist managers in having meaningful conversations with staff during their PDR. The PDR window is currently open until July 2018.

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	
APRIL 2018: Workforce Profile Report developed ready for publication in May. Data analysed to identify areas of focus. MAY 2018: The Trust is currently scoping out a targeted pre-employment programme specifically for BME applicants, with an imminent roll out.	

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 Incorporatir
				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 Incidents; 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			
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	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	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

			competencies for health care staff Intercollegiate Document (2014)	4.2 Monitor compliance with Level 3 safeguarding training across the Trust, within Divisions, and within specific departments			**Update beginning of May 2018:** Monthly monitoring continues. Figure for Level 3 Safeguarding as at 24 April 2018 93.79%	**Subject to Monthly monitoring**		No completion date as training compliance tasks will renew on an annual basis (or three yearly depending on training cycle)	
				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	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

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 Committee	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			
				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		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 May 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			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				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 Resuscitatio
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 beginning of May 2018:** As per action 12.4			Revised timescale: 19 June 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			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				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	
				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	

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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
				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			

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				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
				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 May 2018** First Audit taken completed – this will be ongoing.	Complete		~~31 January 2018~~ ~~28 February 2018~~ **Complete:** 30 April 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 :
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 May 2018:** Finalising policy and will go to next Policy Review Group meeting		In progress	~~31st January 2018~~ ~~31 March 2018~~ Revised timescale: 19 June 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			

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				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 of May 2018:** As per 12.1			~~31st March 2018~~ Revised timescale: 19 June 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 90%	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 team, devise specific and targeted actions in any areas with compliance less than 90%		Andy McColl Associate Chief Operating Officer Surgical Division				31st December 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		In progress	• **Complete** • **Complete** • ~~April 2018~~ Revised timescale June 2018 • Timescale July 2018	Divisional Risk and Governance Committee Clinical Quality Steering Group Clinical Quality Assurance Committee	Specific disease pathways will be in place Trust will be assured of patient safety during transition from paper to electronic pathways	Guidelines.pptx Newly Diagnosed Diabetes Pathway.pd

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							the summer.					
				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	**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	

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				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		Chief Operating Officer Surgical Division	**Update 30th October 2017:** Training in place	**Complete**	**Complete:** 31st October 2017 and ongoing		
				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 monitoring**	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 May 2018:** PDR sessions now diarised, divisions have started to make progress and HR will be updating the divisions with an end of month percentage in the next few days. July to be used as a 'mop up' of PDRs with most taking place in April, May and June.		~~30th November 2017 and ongoing~~ April to July 2018		
				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		

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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 May 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 Children's Nurses			Revised timescale: End of May 2018			
				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	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	**Update beginning of Apr 2017:** 'Risk Register review' added as a SAI of the Surgical Division's Integrated Governance & Quality Assurance Board meeting.	Complete	In progress	**Complete** April 2018	Integrated Governance Committee	Risk Registers will be up to date with appropriate review dates and evidence that actions	

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			services and surgical services		Christian Duncan Associate Medical Director for Surgery				identified to mitigate risk are in place in the Medical and Surgical Divisions	
				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	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 with actions, review completed in line with timeframes identified on risk assessment, and escalation completed in a timely manner. Corporate risk registers to include all high risks only and linked to corporate objectives	
				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 May 2018:** **Medicine:** 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 management expertise across the Trust, and a systematic cascade of training in each Division **Surgery:** Training session on risk management delivered at the Division of Surgical Care Governance & Quality Assurance Board meeting. Evidence attached.	Complete	**Complete:** April 2018		20180503 - risk training register.pdf 20180427 - Risk training for Division S
				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	Complete	**Complete:** 20th October 2017 and ongoing		

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							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	In progress				
				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 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:** 31st December 2017 **Remains 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			

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				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 first week of March.	Complete		31st January 2018			
				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 beginning of May 2018:** Action dependent on the results of the audit (22.3) which is running slightly behind (see below)		In progress	~~30 April 2018~~ Revised timescale End of May 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-			**Update beginning of May 2018:** Areas have been re-audited – final data collection awaited. Results will be sent out shortly.			~~30 April 2018~~ Revised timescale			

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				audit a month later to ensure actions implemented and compliance improved to acceptable standard			PICU/ HDU have ben trialling the Theatre style CD records books to see if that helps improve recording of waste			End of May 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 using the Theatre style CD books. Suitable ward CD registers are being looked into.			31st December 2017 – and ongoing			CD in theatre template.docx Controlled Drugs in Theatres_April2016 (. 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	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	In progress	**Complete:** October 2017	Global Digital Exemplar Programme Board Operational Delivery Board	Accurate recording of medication administration to reduce the risk of associated medication errors	

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			medication overdose	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			
				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		

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				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			

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				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

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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 May 2018:** See 16.5			April to July 2018			
				25.6 Annual review of PDR documentation and update as			**Update beginning of April 2018:** Appraisal window opens	Complete		**Complete:** 31st March			

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				required			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.			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			**Update beginning of May 2018:** No tangible progress to date with realigning the Operating Theatre schedules, due to clinics, consultant job plans etc. Pressures are currently alleviated by capping elective procedures. The Best in Operative Care Group have decided that a theatre schedule review would be one of their work streams in the coming year.			~~30th April 2018~~ Revised timescale: Aug 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			

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				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			
				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			

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

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
				27.2 Development of a Super SOP to incorporate the processes for risk assessment			**Update beginning of May 2018** Super SOP in draft for both Liverpool and Sefton.			~~28th February 2018~~ ~~April 2018~~ Revised timescale: June 2018			CAMHS Record Keeping Audit Tool.dc
				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			
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	

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

				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 beginning of May 2018** Policy being updated by Liz Edwards. Sheet to go out with correspondence letting families know letter can be translated. Action complete	Complete	In progress	~~30th November 2017~~ ~~31 January 2018~~ **Complete:** end of April 2018	CAMHS Clinical Governance	Ensure that people are provided with information in a language or format they understand	
				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 beginning of May 2018** This is in place for CAMHS Liverpool – just waiting confirmation from Sefton			~~31st December 2017~~ ~~31st January 2018~~ ~~End of April 2018~~ Revised timescale: End of May 2018			

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 May 2018:** The Transition team met with Transition leads at St Helens and Knowsley (Whiston) DON, and Chief Nurse from Aintree. A provisional date for the Aintree meeting has been set for the 22nd June 2018. A date for Whiston has been requested. Non clinical transition preparation is ongoing 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, we now have identified leads from Aintree, RLBUHT, Whiston, Wirral, Salford. A meeting is being planned for the next couple of weeks with NHSE to plan milestones for 2018-19 complex patient CQUIN Transition into Meditech 6 is designed and went live, although how we deliver transition/meditech training, this needs to be established 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. The Transition team with Edge Hill met this week, and have almost finalised the MCA, DOL's and Best interest patient and parent information leaflet. Sponsorship has been secured for the 3rd annual North West Collaborative Transition Conference, planned for the 29th June 2018, all delegates to attend free, the event is now advertised this week on Eventbrite.

Alder Hey Children's NHS
NHS Foundation Trust

Research, Education and Innovation Committee Annual Report 2017/18

The Research, Education and Innovation Committee

The Research, Education and Innovation Committee was established by the Board of Directors to operate under the broad aims of developing the Trust's Research Strategy, Education Strategy and Innovation Strategy and related activities, to provide assurance to the Board that delivery in these areas supports the Trust's strategic pillars, focusing on international research and education, excellence in quality and patient-centred care.

The Committee has authority on behalf of the Board to:

- Steer the development of a cohesive approach to these separate but interlinked agendas, ensuring that the Trust maximises the opportunities presented by its facilities, clinical expertise, partnerships and networks
- Make recommendations to the Board to pursue specific projects and initiatives that fall within the duties set out below
- Seek and commission external advice as deemed appropriate to the successful delivery of these agendas

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, the membership comprises:

- Non-Executive Directors x 2 [one of whom shall be the Chair]
- Chief Executive
- Medical Director
- Chief Nurse
- Director of Research
- Brough Chair, University of Liverpool
- Director of Medical Education
- Director of Innovation
- Lead for Innovation
- Director of Human Resources
- Director of Marketing and Communications
- Development Director
- Director of Corporate Affairs

The Committee may request the attendance of any Non-Executive Directors, any Executive Directors and any other persons by invitation. A schedule of attendance at the meetings is provided in Appendix A. The Committee has an annual work plan with meetings timed to consider and act on specific issues within that plan.

Minutes of the Committee were presented to the Board and are supported by a verbal report from the Committee Chair.

This was the first year of the committees operation; given its responsibilities in relation to non-patient facing activities, the Board has been satisfied with the different approach to assurance taken by the committee. This has involved a greater emphasis on maximising opportunity and potential benefit across the three key areas (research, education & innovation).

A thorough review of the Terms of Reference was undertaken in-year. The committee now has a strong refocus and is committed to regular meetings with consistent representation across its membership.

Achievements in 2017/18

In discharging its duties the Committee met its responsibilities through self assessment and review, requesting assurances from Trust officers and directing and receiving reports from relevant individuals.

The following areas were the main focus of the Committee's attention:

- Progress and achievement against the Trust's Integrated Research Strategy for Child Health in partnership with the University of Liverpool and other academic institutions.
- Oversight of the new model of pump-priming by Charities to increase access to commercial trials for patients
- Received updates on changes to NIHR requirements
- Alder Hey Ventures
- Innovation service updates including
    - ongoing activity including KPI's and the financial position.
    - Acorn project developed to identify entrepreneurs,
    - h:ours app developed to support Junior Doctors with remaining within their contracted hours and
    - Bloom to support nurses with revalidation
- Regular review of the Board Assurance Framework with a specific focus on risk 5.1 'Research, Education & Innovation' relating to delivery of the Trusts Strategic Objective 'Game-Changing Research & Innovation'.
- As part of the devolved governance structure, the Committee maintained a strong focus on maintaining a programme assurance function on the following element of the Framework:
    - Research, Education and Innovation
- Update on the International Child Health Programme
- Divisional Commercial Research Growth Plans

<u>Self-Assessment</u>

During the year the Committee has complied with 'good practice' recommended through:-

- Agreement and monitoring of an annual work programme.
- Prepared an Annual Report of its activities incorporating a review of the key elements of the Terms of Reference.

Committee Priorities for 2018/19

The Committee has identified a number of areas to focus on during 2018/19:

- Ensure a cohesive approach to the Trust's Research Strategy, Education Strategy and Innovation Strategy and related activities.

- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.
- Ensure that particular attention is given to the IP element of the Education/Research/Innovation Strategy in conjunction with the Business Development function.
- Continue to closely monitor key innovative growth opportunities.
- 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.

Ian Quinlan
Committee Chair
10 May 2018

RESEARCH, EDUCATION AND INNOVATION COMMITTEE - RECORD OF ATTENDANCE 2017/18

Quorum: Chair or nominated deputy, one Executive Director, one member from each area of business

Member/Date of Meeting	2017				2018		TOTAL
	25 May	*13 July*	*14 Sept*	*7 Dec*	*11 Jan*	*15 Mar*	
Mr Ian Quinlan (Non-Executive Director) **Chair**	Meeting cancelled	✓	Meeting cancelled	Meeting cancelled	X	Meeting cancelled	**1/2**
Sir David Henshaw (Non-Executive Director)		X			X		**0/2**
Louise Shepherd (Chief Executive)		X			✓		**1/2**
Dr Steve Ryan (Medical Director)		X			✓ **Chair**		**1/2**
Mrs Hilda Gwilliams (Chief Nurse)		X			X		**0/2**
Prof. Matthew Peak (Director of Research)		✓			✓		**2/2**
Prof. Michael Beresford (Brough Chair, University of Liverpool)		X			X		**0/2**
Mr Graham Lamont (Director of Medical Education)		X			✓		**1/2**
Mr Iain Hennessey (Director of Innovation)		✓			✓		**2/2**
Mr Jason Taylor (Lead for Innovation)		X			✓		**1/2**
Mrs M Swindell (Director of HR)		✓			✓		**2/2**
Mr M Flannagan (Director of Marketing & Communications)		X			✓		**1/2**
Mr David Powell (Development Director)		X			✓		**1/2**
Ms Erica Saunders (Director of Corporate Affairs)		✓			✓		**2/2**

Alder Hey Children's NHS
NHS Foundation Trust

Research, Education and Innovation Committee
Confirmed Minutes of the meeting held on **Thursday 11th January 2018,**
Meeting Room 1, Innovation Hub

Present:	Dr. S Ryan (Chair)	Medical Director	(SR)
	Mr M Flannagan	Director of Communications	(MF)
	Mr I Hennessey	Director of Innovation	(IH)
	Mr G Lamont	Director of Medical Education	(GL)
	Prof M Peak	Director of Research	(MP)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR	(MS)
	Mr J Taylor	Innovation Service General Manager	(JT)
In Attendance:	Mr J Grinnell	Director of Finance	(JGr)
	Mrs C Kilcoyne	Commercial Project Manager	(CK)
	Mrs R Lea	Assoc. Director Development Commercial	(RL)
	Dr C Orton	Clinical Research Unit Senior Manager	(CO)
	Mrs K McKeown	Committee Administrator	(KMc))
Agenda item: 32	Mr J Gibson	External Programme Assessor	(JG)
33	Mr J Gibson	External Programme Assessor	(JG)
Apologies:	Prof M Beresford	Brough Chair, University of Liverpool	(MB)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Sir David Henshaw	Chairman of the Trust	(SDH)
	Mr I Quinlan (Chair)	Non-Executive Director	(IQ)

17/18/29 **Declarations of Interest**
There were none to declare.

17/18/30 **Minutes of the previous meeting held on Thursday 13th July 2017**
Resolved:
The minutes from the previous meeting held on the 13th of July 2017 were agreed as an accurate record of the meeting.

17/18/31 **Matters Arising**

Action 17/18/05.1: *Programme Assurance (feedback on progress)* – This item has been included on January's agenda. **ACTION CLOSED**

Action 17/18/05.2: *Programme Assurance (16/17 Research Budget)* – It was confirmed that £160k of the commercial surplus was carried forward into 2017/18 and is available for investment in the Clinical Research Facility and Research Division.
ACTION CLOSED

Action 17/18/06.1: *Board Assurance Framework* (*REIC risk*) – This item has been included on January's agenda. **ACTION CLOSED**

Action 17/18/07.1: *Research Charity Pump-Priming Models for Increasing Commercial Research Capacity* – A presentation will be shared with the Committee in order to provide an update on this action. **ACTION CLOSED**

17/18/32 Programme Assurance - Research, Education and Innovation

Joe Gibson provided an update on the Programme Assurance for Game Changing Research and Innovation.

The Committee discussed the work stream summary and it was reported that the latest forecast attributed saving of £130k is not sufficient to meet the financial objective for this workstream which was set at £200k. Joe Gibson informed the Committee that work is taking place on the projects but it was pointed out that evidence is not being uploaded onto sharepoint hence plans appear as snapshots of activity at the present time.

Following discussion it was agreed to discuss this matter in further detail outside of the meeting.

17/18/32.1 Action: JG/CO

Resolved:
The Research Education and Innovation Committee received and noted the programme assurance report.

17/18/33 International Child Health

Joe Gibson informed the Committee of the forthcoming work that is due to take place over the next ten weeks on the International Child Health Strategy and confirmed that a paper is to be submitted to the Trust Board for approval on the 10.4.18. This report will address a number of areas, for example, governance, leadership, framework, benefits, a business plan, defined offer, key strategic aims and recognition and value. It was reported that the International Child Health agenda has five domains which could act as a conduit for innovation and research.

The Committee was advised that it has been proposed that Alder Hey designs and implements a procurement project that explores a strategic partnership with a private healthcare organisation as a solution to the Trust's gap in terms of market insight, additional capacity and operational capability. It is envisaged that an appropriately designed procurement process will enable the Trust to leverage market knowledge to ensure that it is an intelligent customer of such a partnership. Further growth in private patient activity for 2018/19 will benefit the Trust through an enhanced international reputation and increase of income to support financial sustainability. A brief paper on this area of work is due to be submitted to the Trust Board on the 6.2.18 in order to gain approval to progress with the procurement process for a Private Patient Partnership.

Joe Gibson reported on the benefits of having a shared marketing brand and confirmed that work is taking place to produce a single cohesive branding approach for Alder Hey which will be submitted to the Trust Board on the 6.3.18 for approval.

Joe Gibson informed the Committee of the promotional pack that is being compiled for Alder Hey which will be circulated on the 15.1.18 for feedback. Louise Shepherd highlighted the importance of providing Joe Gibson with feedback to enable leaflets etc. to be upgraded in preparation for international meetings that are scheduled for the end of March 2018.

17/18/33.1 Action: All

Resolved:
The Committee noted the presentation on International Child Health.

17/18/34 Board Assurance Framework

Erica Saunders presented the Board Assurance Framework for December 2017.

A discussion took place around the importance of capturing risks relating to research, education and innovation and ensuring controls, gaps and actions are up to date. It was felt that there is a need to refocus on the governance element of the Committee agenda, ensure that meetings take place on a regular basis and appoint an additional Non-Executive Director to address quoracy/continuity of meetings.

A discussion took place around the various boards that are being established to address innovation, International Child Health, etc. and the need to identify the operational /governance route for these boards. Louise Shepherd pointed out that work is being conducted around on research, education and innovation but felt that a separate discussion needs to take place around the integration of these three workstreams in order to refresh the agenda.

The Committee felt that the connectivity between the three arms along with the governance needs to improve from an internal perspective. Following discussion if was agreed to schedule a meeting to discuss a way forward.

17/18/34.1 Action: LS/JT/MB/MP

Steve Ryan reported that CQC is regulating innovation at the present time. Louise Shepherd informed the Committee that it is imperative that the organisation is prepared to be regulated and evidence the work that is being conducted in order to have a positive impact.

Resolved:
The Research, Education and Innovation Committee received the Board Assurance Framework update for December 2017.

17/18/35 Divisional Commercial Research Growth Plan

Charlie Orton submitted a number of slides to provide an update on commercial research growth. The Committee discussed the scope and baseline of activity and it was confirmed that growth has been achieved with income increasing by £100k which equates to fourteen new patients, in comparison to the set target of one to two patients per year. At the present time Alder Hey is engaging with seven of the ten biggest pharmaceutical companies in the world especially in relation to infection and immunity.

The Committee was provided with benchmarking information which compared Alder Hey against twenty other Trusts in the North West from a commercial research income perspective for 2016/17. It was reported that the Trust is progressing well in this field which is reflected in the size of the organisation's turnover. Following discussion it was agreed to bring back more sophisticated data to the next meeting to offer a more in-depth view of the proportion of income for each Trust.

17/18/35.1 Action: CO

Charlie Orton identified the challenges to growth from an internal and external perspective and reported on the next steps. It was pointed out that for the first time ever and without an explanation, Pfizer haven't chose Alder Hey to participate in a rheumatology trial. Charlie Orton reported that the Trust is going to start challenging pharmaceutical companies to facilitate Alder Hey's participation in appropriate clinical trials.

Louise Shepherd queried the effect that Brexit will have on the Trust. Charlie Orton reported that Brexit won't stop global companies delivering in the UK but felt that any forthcoming changes will be dependent on how the UK adopts the directive for clinical trials. Charlie Orton pointed out that the market will change but felt that by streamlining the organisation with Germany and adopting the same framework would put the Trust in a better positon.

A discussion took place around the need for re-investment in this area of work along with a change in culture to ensure research becomes business as usual. Louise Shepherd highlighted the importance of having clear indicators of success and getting metrics into the forum in the same way as the rest of the organisation. Steve Ryan pointed out that each service should be research active and conversation regarding this matter should be addressed across the whole of the Trust.

Resolved:

The Research, Education and Innovation Committee REIC received the latest position on increasing commercial research.

17/18/36 Innovation Service Overview

Jason Taylor provided the Committee with an update on the Innovation Service and ongoing activities, including KPI's and the financial position. The following points were highlighted and discussed:

- *New products* - It was reported that the Trust is adopting new products.
- *Increasing Alder Hey's Profile and Reputation* – The Committee was advised that Alder Hey is now a sponsor for NHS England Entrepreneur.
- *Grant Funding* – The Trust is awaiting feedback on six projects which if successful will provide development funds to align resources to move forward with the projects in the next six to twelve months.
- *Milestone Tracker* - Each live and validated project is now tracked against four key milestones; Partner Agreement, Funding, Resource and Commercialisation Plan. It was reported that negotiations are on-going with each partner.
- Work is taking place in association with John Moores University in relation to trials for hip dysplasia which is being funded by Arthritis UK. Proof of concept has been conducted and the Trust is looking to compile a business case.
- The Committee was advised of the progress that is being made around a variety of commercial partners. It was reported that the Trust is working with Philips to look at patient information in PICU, the Research and Development Team are working with the neonatal team at Alder Hey to help develop the department and virtual reality for cardiology is of interest too. Jason Taylor advised the Committee that Philips have recently become sponsors of Alder Hey.
- *ERDF Grant* – The ERDF funded Health Innovation Exchange project provides staffing and resources that underpin the operation of the wider team. The project is currently behind profile on delivering contracted outputs. The team has delivered 77% of the outputs to date with two rather than four staff, the forecast is that the project will return to profile in the second quarter of 2018 when the

final team members are in place. Jason Taylor confirmed that a further update will be provided in March 2018.

17/18/36.1 **Action: JT**

- David Powell informed the Committee of the Innovation Board workshop that is taking place to address a refresh to quality which will include Research, Education and Innovation. David Powell reported that the Innovation Board will be exploring a number of core innovation products and felt that it would be beneficial for the exceptional pieces to be discussed at a future Research, Education and Innovation Committee meeting.

Resolved:

The Committee noted the update.

17/18/37 **Innovation Service Projects**
Resolved:
This item was addressed under agenda item 17/18/37.

17/18/38 **Alder Hey Academy**

The Committee was informed of Cath Kilcoyne's appointment to post last year and the progress that has been made as a result of this appointment. It was reported that members of the team visited China in November 2017 which brought about positive opportunities. A bid has been submitted to China for a £1.3m Observership contract for Chinese medics. Progress is being made in respect to networking and it was reported that Cath Kilcoyne is responsible for Phase 2 of the Institute in the Park

The Committee discussed the formal piece of work that is taking place around a strategy and action plan for 2018/19 and it was agreed to provide an update on this area of work along with further information on the Observership contract for Chinese medics.

17/18/38.1 **Action: DP**

Resolved:

The Research, Education and Innovation Committee received an update on Innovation.

16/17/39 **Any Other Business**
No other business was reported.

Date and Time of next meeting: 15th March 2018, 1:00pm, Room 7 on the Mezzanine