Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 2nd October 2018 commencing at 10:00

Venue: Large Meeting Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY (10.00 am-10.15am)						
1	**18/19/174**	**10:15**	**Apologies.**	Chair	To note apologies.	For noting
2	**18/19/175**	**10:16**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
3	**18/19/176**	**10:17**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **4th September 2018.**	Read Minutes
4	**18/19/177**	**10:20**	**Matters Arising:** - **Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Read Attachment
5	**18/19/178**	**10:25**	**Key Issues/Reflections.**	All	Board to reflect on key issues.	Verbal
Strategy Update						
6	**18/19/179**	**10:40**	**Research Strategy**	M Peak/ M Beresford	To review and refine the Trust's Research Strategic Plan.	Presentation
Delivery of Outstanding Care						
7	**18/19/180**	**10:55**	**Serious Incidents Report.**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report
8	**18/19/181**	**11:05**	**Mortality Report, Q 1.**	C Duncan	To receive the quarterly report.	Read report
9	**18/19/182**	**11:15**	**Global Digital Exemplar (GDE).**	P Young	To update the Board on the programme.	Read report
10	**18/19/183**	**11:25**	**Alder Hey in the Park Site Development update.**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
11	**18/19/184**	**11:40**	**Clinical Quality Assurance Committee: Chair's update:** - **Chair's verbal update from the meeting that took place on the 19.9.18.** - **Approved minutes from the meeting took place on the 18.7.18.**	A Marsland	To receive the approved minutes from the 18.8.18.	Read approved minutes
12	**18/19/185**	**11:45**	**Integrated Governance Committee:** - **Approved minutes from the meeting that took place on the 11.8.18.**	S Igoe	To receive the Integrated Governance Committee approved minutes from the 11.8.18.	Read report and approved minutes
The Best People Doing Their Best Work						
13	**18/19/186**	**11:50**	**People Strategy; including an update on the 2018 NHS Staff Survey:** - **Chair's update from the Workforce Organisational Development Committee meeting that took place on the 5.9.18.** - **Approved minutes from the Workforce Organisational Development Committee meeting that took place on 26.6.18.**	M Swindell	To provide an update and receive the approved minutes from the 26.6.18.	Read report Read Highlight Report Read approved minutes
14	**18/19/187**	**12:00**	**Listening into Action.** - **Reward and Recognition.**	K Turner C Caine J Fitzpatrick	For information and discussion.	Presentation
Sustainability Through External Partnerships						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
15	**18/19/188**	**12:10**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital.**	A Bateman	To update the Board on progress.	Presentation
Game Changing Research and Innovation						
16	**18/19/189**	**12:20**	**Governance Arrangements for Innovation.**	E Saunders/ J Grinnell	For ratification.	Report and presentation
Lunch (12:30-13:00)						
Strong Foundations						
17	**18/19/191**	**13:00**	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	J Grinnell	To receive an update on programme assurance including the 2018/19 change programme.	Read Report
18	**18/19/192**	**13:10**	**Corporate Report.** - **Monthly update by Executive Leads.**	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 August 2018	Read report
19	**18/19/193**	**13:25**	**Board Assurance Framework**	Executive leads	To receive an update.	Read report
Any Other Business						
20	**18/19/194**	**13:35**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting: Tuesday 6th November 2018 at 10:00am, Large Meeting Room, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust Seal was not used during the months of September

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 4th September 2018 at 10:00am,**
Large Lecture Theatre, Institute in the Park

Present:	Mr I Quinlan	Vice Chair (Chair)	(IQ)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	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)
	Ms L Cooper	Director of Community Services	(LC)
	Mr C Duncan	Director of Surgery	(ChrD)
	Mr M Flannagan	Director of Communications	(MF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs K McKeown	Committee Administrator (minutes)	(KMc)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr A Williams	Director of CAMHS	(AW)
Observing:	Ms K Byrne	Non-Executive Director Designate	(KB)
Agenda item: 10	Ms. A. Hyson	Head of Quality	(AH)
12	Mr P Young	Chief Information Officer	(PY)
14	Mr. G. Lamont	Consultant Paediatric Surgeon	(GL)
18	Mr J Gibson	External Programme Assurance	(JG)
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs C Dove	Non-Executive Director	(CD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Sir D Henshaw	Chairman	(SDH)
	Prof L Kenny	University of Liverpool	(PLK)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)

Patient Story

The parent of a patient who was given a 1% chance of survival at birth was invited to September's Trust Board to share her son's experience.

Mum, Caroline explained that baby Phoenix has a rare condition that only 1 in 30 million people are diagnosed with. Caroline gave an account of the birth at Liverpool Women's Hospital (LWH) and the actions that were taken to keep her son alive. Caroline told the Board that there wasn't much hope for him as a result of his prognosis, however following a meeting with Mr Simon Kenny to discuss Phoenix's condition and an ante-natal visit to LWH from Mr Matthew Jones, it was agreed that Phoenix would be transferred to Alder Hey to undergo surgery. Caroline advised of the improvement in her son, so much so that he was able to come off the ventilator at 21 days old. An operation took place at 23 weeks to drain Phoenix's bladder. Since then Phoenix has been allowed to go home with 12 hour PD dialysis and is thriving.

The Chief Executive thanked Caroline for sharing her son's story with the Board. Louise Shepherd pointed out that Simon Kenny and Matthew Jones are very focussed on the work that is taking place between the Trust and LWH and asked Caroline if there was anything that could have been done differently to improve her experience.

Caroline commended the nursing staff at LWH, the doctor who came back at 2.00am to deliver her son and the Priest who baptised Phoenix out of hours. Upon reflection, Caroline felt that once you have made a decision to continue with a pregnancy, regardless of how difficult the circumstances, the focus should be upon providing full support to families.

The Vice Chair thanked Caroline taking the time to come along.

18/19/140 Apologies

The Vice Chair noted the apologies received from Professor Michael Beresford, Claire Dove, Sir David Henshaw, Professor Louise Kenny and Jo Minford.

18/19/141 Declarations of Interest

Kerry Byrne highlighted her affiliation with Liverpool John Moores University (LJMU) in reference to the funding agreement/agreement to lease between Alder Hey and LJMU which was reported in the register of use of the Trust seal.

18/19/142 Minutes of the previous meetings held on 3rd of July 2018

Resolved:

The Board received and approved the minutes from the meeting held on the 3rd July 2018, pending the following amendment:

- **18/18/111:** *Care Quality Commission* – The minute should reflect that the Trust Board approved the CQC action plan due to it being completed.

18/19/143 Matters Arising and Action Log

Action Log

The action log was submitted to the Trust Board for information purposes. All relevant actions have been completed.

18/19/144 Key Issues/Reflections

Louise Shepherd informed the Board of the discussions that have taken place between the five specialist trusts in Liverpool, including Alder Hey, to look at a more structured collaboration. A meeting had taken place on the 9th August between the CEOs and Chairs of the five trusts from which the outcome had been very positive; a further meeting was planned once the proposal had been considered by all boards. A report has been compiled in broad terms but further work is required around the governance element of the proposal. It was pointed out that innovation and research are strategically significant for all five trusts. A more detailed report will be submitted to the Trust Board at October's meeting before making a formal announcement. Louise Shepherd drew attention to the great opportunities that will come about as a result of this positive move.

18/19/144.1 Action: LS

John Grinnell reported that the STP has appointed a lead for the implementation of the Carter review. Meetings have commenced and progress is anticipated to be rapid in areas such as financial services.

Jeannie France-Hayhurst informed the Board that she will be in a better position to provide an update following September's Charity Trustees' meeting, as there are a number of issues that the Chairman of the Charity is in the process of addressing at the present time.

Jo Williams informed the Board of her recent attendance at the Children's Forum. It was reported that one longstanding member is going to study at Brighton University and that research has been taking place in association with Edge Hill University to help children cope better with clinical interventions; Jo Williams gave the example of one little boy who thought he had to have his skin removed before he could have an x-ray.

Erica Saunders reported that Alder Hey had hosted a visit from the new Chief Executive of CQC, Ian Trenholm, and that a very positive discussion had taken place regarding the nature of the current inspection process and his thoughts to date on the next steps for regulation. Mr Trenholm also undertook a tour of ward 3B.

Anita Marsland advised the Board of an invitation that she received from NHS Improvement asking her to Chair the Sefton Transformation Board. She reported that she had accepted this role and did not feel there was inherent conflict in doing so but that she would raise potential issues as they arose.

Steve Ryan drew attention to the commencement of level 1 cardiac surgery for all ages from the morning of 4th September. The Trust had participated in a stringent assurance process and passed with flying colours. There are still some issues that require attention but the organisation will be looking to begin adult surgery from October 2018.

It was reported that the NHS National Medical Director, Steven Powis and the Northern Regional Medical Director, Mike Prentice had visited Alder Hey on the 3rd August. Both parties were very complimentary about the Trust and the way it provided care to patients whilst experiencing difficult circumstances earlier in the year. It was reported that the development of a national response will continue and that a meeting has been scheduled for early October.

18/19/145 Serious Incident Report

The Board received and noted the contents of the Serious Incidents report for July 2018. It was reported that there was one new Serious Incident in July and two that are on-going. The following points were highlighted and discussed:

StEIS 2018/18741: This patient was treated at Alder Hey and was discharged on the 26th April. The patient was admitted to Warrington Hospital on the 27th April with active bleeding from an unknown source. Escalation, treatment and blood products were given. The patient was stabilised and admitted on to a children's ward. There was subsequent deterioration and the patient died on the 28th April. An independent review had taken place and it was found that there was no gap in care provided by Alder Hey. The treatment was entirely appropriate and the death certificate was aligned to the patient's complex health issues.

StEIS 2018/15654: This patient deteriorated overnight following a Norwood Sano procedure. Delayed intervention took place but the patient went into cardiac arrest.

The patient was intubated on the ward and transferred to PICU; the patient was in Pulseless Electrical Activity (PEA) on arrival to PICU and put on Extracorporeal Membrane Oxygenation (ECMO). A full review of this case is taking place and it was confirmed that the patient is still on PICU.

StEIS 2018/11892: This report is due to be closed. Lessons have been learnt from this case.

The Board was advised of the three Never Events that have taken place during the last three weeks:

- Incorrect tooth extraction
- Incorrect administration of drugs: the CCG has since reduced this event to a Serious Incident.
- Incorrect K-wire inserted into an orthopaedic patient. It was confirmed that there was no harm to the patient but further discussions are taking place regarding this incident.

Hilda Gwilliams pointed out that the Trust has been open and transparent with regard to these incidents and confirmed that they are all in different areas of practice.

A question had been raised as to why the extraction of the wrong tooth was classed as a Never Event if there was no harm. Steve Ryan pointed out that it is necessary to have the right system in place as it could impact on more serious events in the future. If systems aren't strong enough there is a chance of serious harm. Clinicians have reported in an open and timely way and we have thanked them for this.

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

18/19/146 CQC

CQC Action Plan

The Board received the action plan associated with the inspection by CQC in February 2018. It was reported that all key actions have been assigned owners and all target completion dates are in place.

Must do and should do actions have been addressed and Erica Saunders commended the Divisions for the level of detail incorporated in the action plan. Monthly monitoring will form part of the CQAC agenda.

The Board was advised of the quarterly engagement session that is due to take place on the 11th September with the new CQC Inspector, Katherine Lamb.

Resolved
The Board noted the most recent version of the CQC action plan.

18/19/147 Position Statement for Complaints and PALS, Q1

The Trust Board received the Complaints and PALS position statement for quarter 1. The following points were highlighted and discussed:

- It was reported that the Trust has received 53 formal complaints in the year to date across the three Divisions; Medicine 19, Surgery 17 and

Community 17; 7 of the Community complaints have been received from MPs. A discussion took place around the lack of regular forums between the Trust and local MPs and it was felt that this is a deficit which needs to be addressed.

18/19/147.1 **Action: LS**

- Treatment remains the top category of complaints and consent, communications and confidentiality is the second highest category with attitude of Medical staff and communication failure of Medical staff being the subject areas complained about the most. It was pointed out that the cancellation of appointments has improved thus reducing complaints relating to this area. Adrian Hughes informed the Board that the summer period doesn't help but felt that the Divisions need to ensure that all gaps are filled.
- The Board was advised of the PALS concerns received in relation to car parking issues with regard to concessionary tickets. Ann Hyson reported that posters have been put up around the hospital to provide patients, parents and carers with appropriate information.
- It was confirmed that three complaints training sessions have taken place which 33 staff have attended from a wide variety of specialities and designations within the Trust. It was reported that the feedback has been very positive.
- Currently the Trust has 21 live first stage complaints and 1 second stage complaint. 1 complaint is being reviewed by the Ombudsman pending a judgement to investigate or not. The Board was advised that 3 of the complaints have breached their initial agreed timeframe for responding.

  A discussion took place around the increase in complaints and the reason for this, for which, Adrian Hughes reported that there is no apparent theme. Louise Shepherd pointed out that the Trust tends to uphold more complaints than not.

  Attention was drawn to the flurry on out of time complaints and the amount of time it takes to address an influx of complaints. Hilda Gwilliams informed the Board that complaints can be registered in month but may relate to incidents that occurred many years ago and pointed out that trusts tend to see a rise in complaints following high profile cases. The Board was advised of the increase in letters being received by the Trust from legal firms and the importance of ensuring that all relevant documentation relating to these cases is of a high standard.

  Anita Marsland informed the Board that the NEDs who sit on the Clinical Quality Assurance Committee is in the process of reviewing a number of complaints received by the Trust.

Resolved:

The Trust Board noted the Complaints and PALS position statement for Q1.

18/19/148 Infection, Prevention and Control Report, Q1

The Board was advised of the challenges for delivery of the Infection Prevention and Control work plan for 2018/19. The following points were highlighted and discussed:

- A review of the 2017/18 work plan was conducted in order to plan for new areas of work and carry forward existing work. It was reported that the CCG

has adopted the mapping system used by the Trust as part of the health app and have asked other trusts to do this across Liverpool.

- *Hand Decontamination* – It was reported that the Trust is working alongside an industry partner on a children's hand hygiene initiative with the prospects of trialling the process on identified wards and rolling it out across the Trust on the 15th of October during 'Infection Control Week'.

  The Trust is also going to approach a hand hygiene industry partner to scope the feasibility of developing new signage. Discussions are taking place with Comms to look at how and where in the hospital signs would be best positioned to promote hand-hygiene.

  The Board was advised of the plans to develop an isolation app for mobile phones. Hilda Gwilliams suggested including patients in the development of the app and queried the governance process for patient data. Erica Saunders recommended that a conversation take place with Joanne Fitzpatrick re the data protection element of this innovative piece of work

18/19/148.1 **Action: VW**

Valya Weston drew attention to the plans in place to ensure that hand hygiene technique assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR. Mags Barnaby queried the process for managing consistent non-compliance. Hilda Gwilliams reported that conversations take place directly with individuals. Steve Ryan pointed out that these conversations are not always easy and confirmed that the Trust is looking at training for managers to provide them with skills to address these matters.

A discussion took place around the large amount of red RAG ratings in the annual work plan and it was felt that the further narrative was required in order to offer the Board assurance of the work that is taking place along with the progress, together with a different pictorial approach to highlight new actions that had not yet commenced.

18/19/148.2 **Action: VW**

Louise Shepherd highlighted the work that has begun to ensure that a high quality Infection Prevention Service is delivered to Community Services and informed the Board of the appointment of the new Infection Control Consultant who commenced in post on the 3rd July.

Resolved:
The Board received and noted the Infection, Prevention and Control update for Q1

18/19/149 Alder Hey in the Park site Development Update

The Trust was provided with an update on the Alder Hey in the Park Site Development. The following points were highlighted and discussed:

- *Residential* – This scheme is on hold pending further discussions with the City Council.
- *R&E2* – Building completion and handover took place on the 24th August. Conversations are taking place around the opportunities available as a result of this project.
- *Alder Centre* – This scheme cannot commence until final costs are fully covered. Discussions have taken place with an alternative building partner to

look at reducing building costs in order to match available funding. A revised offer is due to be submitted to the Trust on the 12th September. It was agreed to provide the Board with an update on the 2nd October.
Action: DP

- *Community Cluster Building* – Discussions to take place with an alternative building partner in order to look at reducing building costs.
- *Springfield Park* – Meetings continue with universities to consider the development of an outdoor research lab in Springfield Park utilising the space and park for environmental and health and well-being research within university semester subjects. Work on developing the interactive interpretation boards in the forest area continues.
- *International Design and Build Consultancy* – the Jersey hospital design work continues to bring income into the Trust thus enhancing the organisation's reputation. A desk top review of the Schedule of Accommodation for Leeds Trust is also being carried out within the Development Team to earn income for the Trust.

The Board discussed the positive outcome of the relocation of Sefton Community CAMHS to Burlington House and congratulated the team for their input to enable a smooth transition. Andrew Williams reported that patients and staff were really happy with the new location of the service.

Louise Shepherd felt that the opportunities available to the Trust as a result of the new R&E2 building are enormous and suggested that Board members reflect upon this and feedback their ideas on future opportunities during November's meeting. It was confirmed that the formal opening of the R&E2 building will take place on the 22nd January.

A discussion took place around the naming of the building and the sensitivities regarding this matter. Jeannie France-Hayhurst drew attention to the amount of enquiries that she receives from members of the public and groups who would like to promote/participate in activities in the park but are unsure of what amenities are available. Mags Barnaby suggested producing a brochure to provide relevant information for the community.

Resolved:

The Board noted the update.

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18/19/150 Clinical Quality Assurance Committee

The Board noted the Chair's verbal update from the Clinical Quality Assurance Committee meeting that took place on the 18th July. It was reported that a discussion had taken place around clinical ethics and it was agreed to provide greater support to this area of work. It was requested that the minutes from the 20th June be amended as there is reference to a comment made by Louise Shepherd when her apologies had been noted.

18/19/150.1 Action: AM

Resolved:
The Board received and noted the approved minutes from the Clinical Quality Assurance Committee meeting that took place on the 20th June.

18/19/151 Integrated Governance Committee

The Board noted the Chair's verbal update from the Integrated Governance Committee meeting that took place on the 11th July. The Board was advised of the positive work that continues across the organisation to ensure risk management systems and processes are embedded but attention was drawn to medium risks/mitigation plans where there are still some issues in terms of ensuring all risks have action plans associated and are regularly reviewed.

Resolved:
The Board received and noted the approved minutes from the Integrated Governance Committee meeting that took place on the 24th May.

18/19/152 GDE

The Board was provided with an update on the progress of the Trust's Global Digital Exemplar (GDE) Programme along with the achievement of milestone 4 and the commencement of milestone 5.

Peter Young informed the Board that the team are struggling to cover all elements of work due to the lack of a Programme Manager but confirmed that the team have agreed to offer their support on an interim basis until the organisation is able to fill the post.

Louise Shepherd reported that the Trust has been asked by the Department of Health to host an international visit as a result of the GDE work that is taking place.

Resolved:

The Board noted the GDE Programme update.

18/19/153 People Strategy Update

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

- *New Pay Deal* - Payment of the new Agenda for Change pay increases for staff were made in July's salary and back pay will be made in the August payment. Work has commenced on the removal of the Band 1 salary scale and the Trust is working in partnership with Trade Union colleagues to deliver this project. Work is commencing on a review of the appraisal system in light of the changes to incremental progression which will come into force on the 1st April 2019. Mags Barnaby queried the cost of the Agenda for Change pay increase. John Grinnell reported that feedback has been submitted in respect to a £300k gap for the Trust, regarding which, the organisation is awaiting a response from NHS Improvement.
- *Staff Survey* - The 2018 NHS Staff Survey is due to be launched on the 9th July. Communications have been circulated to staff and it was confirmed that the Divisions are sighted on this. An update will be provided to the Trust Board on the 2nd October.
  Action: MS
- *Apprenticeships* – The expectation is that 49 learners will be signed up to an Apprenticeship before the end of the year and at least 22 will commence their learning in September 2018. It was reported that an internal assessor has been appointed to help increase capacity to deliver, thus allowing the Trust to receive monies directly from the Levy into the organisation. The next steps will be to focus on the pipelines that will generate income.

- *Sickness Rates* – Melissa Swindell informed the Board that sickness rates have increased slightly in June to 5.23% and reported on the national work that the Trust is participating in to address sickness absence rates.
- *Mandatory Training* – Mandatory training compliance remains at 92%.
- *PDRs* – As of the 28th August and PDR compliance is 82.38%.

A discussion took place around the forthcoming Staff Survey. Melissa Swindell reported that the Trust is hoping to receive raw results data back from the Centre towards the middle of December. Anita Marsland highlighted the importance of receiving this information as soon as possible in order to address the issues that are raised in the survey. It was also pointed out that the Trust needs to look at possible hotspots. It was agreed that a conversation should take place at the next Executive Team meeting to look at ways of addressing hotspots.

18/19/153.1 Action: MS

Melissa Swindell informed the Board of the positive feedback from staff in respect to the Star of the Month initiative.

Resolved:

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

18/19/154 Revalidation

The Board received the 2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation.

It was reported that there were 295 doctors with a prescribed connection to the Trust. The number of completed appraisals is 214, 76 appraisals were either not due or deferred for valid reasons. There are still five doctors who have not completed their appraisal for 2017/18.

A discussion took place around the governance arrangements for this area of work.

The Trust through the Associate Medical Director provides annual assurance on the quality assurance. However this year due to a technical issue the Trust has not managed to have as comprehensive a level of feedback and so it was necessary to conduct a further analysis of portfolios via a smaller but purposeful sample of records from completed appraisals. The Associate Medical Director advised that the samples were good and the individual conversations around quality were positive. In assessing the quality of appraisals for 2018/19 it is the intention of the team to capture feedback via a Survey Monkey tool so that we can get feedback on a larger sample of appraisals.

A query was raised around the gaps highlighted in the appraisal and revalidation performance data table in section 5 of the report. Graham Lamont highlighted the difficulties experienced around the management of new recruits for short term contracts as their appraisal status was frequently in poor order on arrival, so that the Trust required a significant period of practice here to occur to provide adequate evidence to ensure the quality of enhanced appraisal. Louise Shepherd highlighted the importance of addressing this issue and suggested that a discussion take place with Melissa Swindell, Medical HR and the Medical Education Team to look at a way to remedy this problem.

18/19/154.1 Action: GL/MS

Steve Ryan suggested a number of options that may help in assessing the quality of the appraisal process:

- Where possible, new doctors in post should bring their most recent appraisal with them from their previous organisation. The Trust needs to acknowledge/measure this and report back to the NHS England Responsible Officer where this is the case.
- Engaging with patients and their families as part of the appraisal process would assist doctors to reflect upon their work. Trusts are not doing this at the present time but it might be something that Alder Hey could look into.
- Gain access to complaints, incidents and PALS concerns and use the information for the reflective element of the appraisal process. Graham Lamont highlighted some of the difficulties in accessing this information since incidents are deliberately and properly reported without identifiers. It was suggested that Graham Lamont liaise with Sian Falder, Jo Minford and the Governance Team to triangulate this information. In any case such information can be shared around a team or service and not just the individual as this would be very useful for quality improvement work to be undertaken by the individual and their team

18/19/154.2 **Action: GL**

- Aggregated information would enable Line Managers to have a view of what the team has done as a whole. Hilda Gwilliams highlighted the potential for out of hour doctors to slip through the net from an induction/appraisal perspective.

Louise Shepherd informed the Board that Graham Lamont would be retiring from the Trust and his role as Director of Medical Education and took the opportunity to offer sincere thanks for his hard work and dedication to the Trust.

18/19/155 Listening into Action

Harvey's Gang @ Alder Hey

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Tracey Shackleton provided the Board with a number of slides to provide an overview of an initiative that was founded by the Chief Biomedical Scientist (BMS) at Worthing Hospital, Malcolm Robinson, in memory of Harvey Baldwin, a young boy who suffered from leukaemia who wanted to be a scientist.

Arrangements were made for Harvey to spend a day in the laboratory at Worthing Hospital and it was found that there were lots of other children who would like to do the same. As a result of this, a nationwide programme had commenced which received international recognition and won awards. The programme is charity led and free to run.

In 2015 Malcolm Robinson approached the Trust with regard to Alder Hey running the programme. This was revisited earlier in 2018 following a request from a patient visiting a relative in Worthington Hospital but who is treated at Alder Hey.

Following Senior BMS approval for the running of the programme at Alder Hey, stakeholder meetings have taken place and a risk assessment of the laboratories has been conducted. The Trust has identified champions who will lead on the tours which will hopefully commence in October 2018 and a meeting has been scheduled for the 4th September in order to discuss the comms for the Harvey's Gang initiative.

The aim is to make the visit a memorable experience for children and make pathology more integrated. A discussion took place around additional funding/support for

Harvey's Gang outside of the Trust and it was agreed to liaise with the Charity to see if they are able to support the programme.

18/19/155.1 Action: JG

NHSBT on Site at Alder Hey

Tracey Shackleton advised the Board of the continuous queries received from parents in respect to giving blood at Alder Hey. A survey was conducted and it was found that 95% of people would donate blood if there were facilities on site. Following on from this, rooms have been identified in the Institute and plans have been made for NHSBT to revisit the site to look at the suitability of these rooms.

NHSBT are planning to conduct visits twice a year for a full day and bookable appointments will be made available for staff and parents so there will be no waiting in queues.

Louise Shepherd commended Tracey Shackleton for the tireless work that has taken place to promote the Trust and make Alder Hey visible.

18/19/156 Joint Neonatal Partnership

Adam Bateman advised the Board that the Memorandum of Understanding between the Trust and Liverpool Women's Hospital has been agreed and had been signed by both parties in August 2018.

A joint project manager and a neonatologist have been appointed in order to move forward with the partnership. It was reported that the project is in its implementation mode and the Trust will receive updates from the Partnership Board on a regular basis.

The Board discussed the financial element of the partnership. John Grinnell drew attention to the STP capital bid that has been submitted by the Trust for this area of work and confirmed that further information on the progress of the bid will be available in October 2018. The Board was advised that the Trust is moving forward on intent with this scheme at the present time and it was agreed to submit the organisation's 10 year Capital Investment plan to provide an overarching view of potential investment moving forward. Kerry Byrne queried the outcome of the partnership in the event that the Trust fails to secure the funding. John Grinnell pointed out that the Joint Neonatal Partnership is a strategic investment that the commissioners are supporting from a quality perspective.

Resolved:

The Board noted the update provided on the Joint Neonatal Partnership.

18/19/157 Register of Shareholder Interest

Claire Liddy provided the Board with an overview on the definition of 'spin off' company structures, the implication for the Trust Board/Directors and the governance process.

It was reported that over the last 12 months the Trust has become shareholders in a total of 13 separate legal entities and as a result of this there is a requirement for a register to be maintained and visible to the Trust Board on a regular basis in order to provide key information.

Alder Hey received a visit in July 2018 by the HMRC NHS National Tax Compliance Officer as the Trust had one of the highest number of shareholder interested entities on companies house. The Board was advised that all of Alder Hey`s current subsidiaries are related to Innovation commercial activities.

Following the presentation conducted by Claire Liddy, a number of queries were raised by the Board which it was agreed the Innovation Board would be able to respond to:

- How many companies will become subsidiaries?
- Do we have to have an overarching company for each app?
- Is there a possibility of reputational damage as a result of companies using the Alder Hey brand?

18/19/157.1 Action: CL

Louise Shepherd pointed out that the organisation wants to be very open and transparent about this area of work and it was agreed that a further update will be provided to the Trust Board as this work progresses.

18/19/158 Programme Assurance Update

The Board received and noted the update on the assurance status of the change programme for July 2018.

Joe Gibson reported that the overall ratings have improved and commended the Executive Sponsors and their teams for the hard work that has taken place to achieve this position. Attention was drawn to the DMO and the fantastic work that the team are doing to support staff and the change programme

A discussion took place around the value of having an assurance framework and the importance of maintaining it and embedding it across the organisation. Joe Gibson advised on the handover process of the assurance work to Natalie Deakin who will report into the Trust Board by January 2019.

Resolved:
The Board received and noted the update on the assurance status of the change programme for July 2018.

18/19/159 Corporate Report

Resolved:
The Board received and noted the content of the Corporate Report for month 4.

18/19/160 Board Assurance Framework (BAF)

The Board received the BAF update for August 2018. The following points were highlighted and discussed:

- Mitigating actions have taken place to assist with the recovery of the Transcription Service, which was approaching a clinical risk.
- Attention was drawn to the stand alone IT risk in respect to the infrastructure. Louise Shepherd informed the Board of the forthcoming refresh to the existing IT Strategy.
- A reset around innovation is in the process of being addressed.

Resolved:

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

18/19/161 Governor Election Results
Resolved:
The Board noted the 2018 governor election results.

18/19/162 Proposed Constitutional Change

The Board was advised that at the end of July the Trust's Chief Executive received notification from NHS Improvement that following a review of foundation trust constitutions they had identified a number of trusts that are not strictly compliant with good governance as set out in the Code of Governance for FTs and Best Practice Guidance on Director-Governor interactions.

Alder Hey is one of a number of trusts that the review identified as having a constitution which allows for the CEO to be a formal member of the Nominations Committee. NHS Improvement has therefore requested that these trusts amend their constitution ahead of the publication of the new guidance to come into line with best practice.

The proposed amendment was considered. Steve Igoe highlighted the importance of the relationship between the Chair and CEO for the success of the organisation and that it is imperative to get the appointment process right with regard to the Chair in particular. The Non-Executive Directors agreed to have a discussion outside of the meeting before approving the proposed constitutional change, particularly in light of the fact that the guidance had not yet been published. An update will be provided on the 2nd October.
Action: NEDs

18/19/163 Any Other Business

There was none to discuss.

Date and Time of next meeting: Tuesday 2nd October 2018, 10:00am, Large Meeting Room, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Alder Hey Children's NHS Foundation Trust

	A	B	C	D	E	F	G	H
1	**Meeting date**	**Ref**	**Item**	**Action**	**By whom?**	**By when?**	**Status**	**Update**
2	**Actions for May 2018**							
3	**Actions for October 2018**							
4	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	2.10.18.		27.9.18 - This action is in the process of being addressed. An update will be provided on the 2.10.18.
5	3.7.18.	18/19/113.1	GDE	Look into the possibility of arranging time on the agenda of other Trust Boards to promote Alder Hey's GDE programme.	Sir David Henshaw	2.10.18.		18.8.18 - An update will be provided on the 2.10.18.
6	4.9.18.	18/19/144.1	Key Issues/Reflections	Board to receive the proposal for the Specialist Trust Alliance.	Louise Shepherd	2.10.18		27.9.18 - This item has been included on October's Trust Board agenda. **ACTION CLOSED**
7	4.9.18.	18/19/147.1	Position Statement for Complaints and PALS	Arrange for regular meetings to take place between the Trust and MPs.	Louise Shepherd	2.10.18		27.9.18 - An update will be provided on the 2.10.18.
8	4.9.18.	18/19/149.1	Alder Hey in the Park Site Development Update.	Provide an update on the submitted estimates for the Alder Centre.	David Powell	2.10.18		27.9.18 - This item will be included in October's update. **ACTION CLOSED**
9	4.9.18.	18/19/150.1	CQAC	Amend the minutes from the meeting that took place on the 20.6.18 to reflect Louise Shepherds apologies.	Anita Marsland	2.10.18		27.9.18 - This action has been addressed. **ACTION CLOSED**
10	4.9.18.	18/19/157.1	Register of Shareholder Interest	Submit the following questions to the Innovation Board and feedback on the outcome: How many companies will become subsidiaries? - Do we have to have an overarching company for each app? - Is there a possibility of reputational damage as a result of companies using the Alder Hey brand?	John Grinnell/ Claire Liddy	2.10.18		18.8.18 - An update will be provided on the 2.10.18.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Alder Hey Children's NHS Foundation Trust

	A	B	C	D	E	F	G	H
1	**Meeting date**	**Ref**	**Item**	**Action**	**By whom?**	**By when?**	**Status**	**Update**
11	**Actions for November 2018**							
12	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	6.11.18		27.9.18 - It was confirmed that there would be a significant financial cost to turn decommissioned rooms into anything other than storage rooms. The working group is looking into this matter and an update will be provided in November.
13	1.5.18.	18/19/47.1	Arts Programme and Next Steps.	Discussion to take place between Vicky Charnock and Michael Beresford around the possibility 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	6.11.18		27.9.18 - Vicky Charnock is in the process of contacting Michael Beresford regarding this matter. An update will be provided on
14	3.7.18	18/19/103.1	Quality Improvement Update	Submit the draft Inspiring Quality business case to the Trust Board in October.	Adam Bateman/ Sian Falder/ Jo Minford	6.11.18		27.9.18 - This item will be addressed during November's Trust Board.
15	3.7.18	18/19/118.1	Listening into Action	*Disability Network Groups* - Provide an update to the Trust Board in November 2018.	Chairs of the Network Groups	6.11.18.		
16	3.7.18	18/19/120.1	Freedom to Speak Up Guidance	Incorporate timelines and metrics against actions in reports.	Kerry Turner	6.11.18		27.9.18 - This item will be addressed during November's Trust Board.
17	3.7.18	18/19/120.2	Freedom to Speak Up Guidance	Conduct a piece of work to look at Freedom to Speak Up as a whole to ensure that the Trust is robust in its approach and reporting processes are fit for purpose.	Kerry Turner	6.11.18		27.9.18 - This item will be addressed during November's Trust Board.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Alder Hey Children's NHS
NHS Foundation Trust

	A	B	C	D	E	F	G	H
1	**Meeting date**	**Ref**	**Item**	**Action**	**By whom?**	**By when?**	**Status**	**Update**
18	4.9.18.	18/19/153.1	NHS Staff Survey	Look at potential hotspots that may affect the outcome of the 2018 NHS Staff Survey and discuss this matter at Execs.	Melissa Swindell	6.11.18		27.9.18 - This action will be addressed on the 4.10.18 and an update will be provided during November's Trust Board meeting.
19	4.9.18.	18/19/155.1	Listening into Action	Liaise with the charity to see if they are able to offer support with funding for the 'Harvey's Gang' Initiative.	Jo Williams/ Tracey Shackleton	6.11.18.		18.8.18 - An update will be provided on the 2.10.18.
20	**Actions for December 2018**							
21	4.9.18.	18/19/148.1	Infection, Prevention and Control Report, Q1	Liaise with the Governance Department when developing the Isolation App.	Valya Weston	4.12.18.		27.9.18 - An update will be provided during December's Trust Board meeting on the 4.12.18.
22	4.9.18.	18/19/148.2	Infection, Prevention and Control Report, Q1	Include additional narrative in the report to provide the Board with assurance on actions and progress.	Valya Weston	4.12.18.		27.9.18 - An update will be provided during December's Trust Board meeting on the 4.12.18.
23	**Actions for March 2019**							
24	4.9.18.	18/19/154.1	2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation	Liaise with Melissa Swindell, Medical HR and the Medical Education Team to look at resolving the issue around the management/inputting of data relating to new recruits.	Graham Lamont	5.3.19.		27.9.18 - An update will be provided during March's Trust Board meeting on the 5.3.19.
25	4.9.18.	18/19/154.2	2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation	Discuss the possibility of accessing/triangulating information relating to complaints, incidents and PALS concerns to enable doctors to use this data as part of the reflective element of the appraisal process.	Graham Lamont	5.3.19.		27.9.18 - An update will be provided during March's Trust Board meeting on the 5.3.19.
26	**COMPLETED ACTIONS**							
27	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 4.9.18

Alder Hey Children's NHS Foundation Trust

	A	B	C	D	E	F	G	H
1	**Meeting date**	**Ref**	**Item**	**Action**	**By whom?**	**By when?**	**Status**	**Update**
28	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**
29	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.		16.8.18 - Following a three day audit the level of support was increased for clinicians. This action has been moved into the OPD
30	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.		**3.7.18 -** An update was provided during July's Trust Board. **ACTION COMPLETE**
31	1.5.18.	18/19/46.1	Joint Neonatal Partnership - 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.		**22.5.18 -** This item has been included on July's agenda. **ACTION COMPLETE**
32	22.5.18	18/19/75.1	Key Issues	*Quality Summit* - Provide an update to the Board on the agreed process for implementing the Quality Summit learning to support the delivery of quality improvements.	Sian Falder/ Jo Minford	3.7.18.		**3.7.18 -** An update was provided during July's Trust Board. **ACTION COMPLETE**
33	22.5.18	18/19/75.2	Key Issues	Discuss the issues with the national NHS structure in more detail, outside of the meeting.	Sir David Henshaw/ Mags Barnaby	3.7.18.		16.8.18 - An initial discussion took place around integrated care going forward.
34	22.5.18	18/19/82.1	GDE	Provide a more granular report on the details of the patient portal during July's meeting.	Peter Young	4.9.18.		**3.7.18 -** An update was provided during July's Trust Board. **ACTION COMPLETE**
35	22.5.18	18/19/82.2	GDE	Liaise with Mark Flannagan to discuss the showcasing of the patient portal outside of the organisation.	Peter Young	3.7.18.		18.8.18 - Joe Fitzpatrick is liaising with Peter Young regarding this matter. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Alder Hey Children's NHS
NHS Foundation Trust

	A	B	C	D	E	F	G	H
1	**Meeting date**	**Ref**	**Item**	**Action**	**By whom?**	**By when?**	**Status**	**Update**
36	22.5.18	18/19/83.1	People Strategy Update	Submit the action plan for the diversity agenda, during July's meeting.	Melissa Swindell	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**
37	22.5.18	18/19/85.1	Freedom to Speak Up	Submit the completed self-review tool for Freedom to Speak Up, during July's Trust Board.	Erica Saunders	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**
38	22.5.18	18/19/90.1	Board Assurance Framework	Circulate the outcome of the discussion at May's IGC in respect to the pipe corrosion risk and the water contamination risk.	Adam Bateman/ David Powell	3.7.18		3.7.18 - An update was provided on the 3.7.18 during part 2 of the Trust Board meeting. **ACTION COMPLETE**
39	22.5.18	18/19/91.1	CQC Action Plan	Submit an exception report during July's meeting.	Erica Saunders	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**
40	22.5.18	18/19/93.1	Research Education and Innovation Committee	Meeting to be scheduled in order to discuss a way forward for the Research, Education and Innovation Committee.	Ian Quinlan/ Sir David Henshaw/ Louise Shepherd	2.10.18.		27.9.18 - This action has been superseded by the work taking place to address Research, Education and Innovation. **ACTION CLOSED**
41	22.5.18	18/19/94.1	Any Other Business	*Trust Board Documentation* - Include page numbers on the agenda for each item.	Karen McKeown	3.7.18.		**22.5.18** - July's Board pack will include page numbers on the agenda for each item. **ACTION COMPLETE**
42	3.7.18	18/19/107.1	Matters Arising	Update the action log outside of the meeting and circulate it to Board members.	Karen McKeown	4.9.18		16.8.18 - **ACTION COMPLETE**
43	3.7.18	18/19/108.1	Key Issues/ reflections	*New Pay Deal* - Provide an update on the mechanism for applying increments.	Melissa Swindell	4.9.18.		16.8.18 -This action has been included on September's agenda. **ACTION COMPLETE**
44								

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Alder Hey Children's NHS Foundation Trust

	A	B	C	D	E	F	G	H
1	**Meeting date**	**Ref**	**Item**	**Action**	**By whom?**	**By when?**	**Status**	**Update**
45	3.7.18	18/19/115.1	CQAC	Arrange for Matthew Peak to meet with the Non-Executive Directors to explain the issues being experienced by the Trust from a research perspective.	Karen McKeown	4.9.18.		18.8.18 - A meeting took place on the 24.7.18. **ACTION COMPLETE**
46	3.7.18	18/19/117.1	People Strategy Update	Circulate the 'Wellbeing at Work' presentation to Board members.	Melissa Swindell	4.9.18.		16.8.18 - **ACTION COMPLETE**
47	3.7.18	18/19/121.1	Joint Neonatal Partnership	Confirm as to whether a Non-Executive Director from Alder Hey should sit on the Joint Board for the Neonatal Partnership.	Adam Bateman	4.9.18.		16.8.18 - This has been built into the MOU. **ACTION COMPLETE**
48	3.7.18	18/19/122.1	Provider Alliance Plan	*Children's Transformation Plan* - Include Finance when scoping out investment for 2019/20.	Mags Barnaby/ Julie Heywood.	4.9.18.		18.8.18 - This request has been actioned. **ACTION COMPLETE**
49	3.7.18	18/19/122.2	Provider Alliance Plan	Discuss the governance element of the Children's Transformation Plan with colleagues outside of the meeting.	Mags Barnaby	4.9.18.		18.8.18 - The governance element of the Children's Transformation Plan was discussed with the Exec Team and the Divine 9. **ACTION COMPLETE**
50								
51								
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53	**Status**	
54	Overdue	
55	On Track	
56	Closed	
57		

Roadmap to Resilience: A Framework for Sustainable, World Class Research in Alder Hey

A. Abstract

A key strategic aim for Alder Hey is to be renowned for *'Game Changing Research…'*. The Trust's integrated research strategy has an overarching ambition for world class, internationally competitive research through partnership with key stakeholders. To achieve world leading status for research it is essential to create the best possible supporting structures and organisation in an environment culturally supportive of research. To maximise the benefits of existing and potential partnerships for research with a range of stakeholders, it is imperative that the Trust further professionalises and industrialises its research function and services through a whole organisation approach. This requires the organisation's clinical and corporate functions to meet world class standards to deliver world class research. This paper summarises the key domains and the specific actions needed to ensure Alder Hey continues its progression to a world class research institution.

B. Background

Within the past decade, there has been an expansion of child health research in Liverpool evidenced by a number of objective markers, including:

- An increase in the numbers of senior child health clinical academic posts in the University of Liverpool and other academic institutions.
- Several successful National Institute for Health Research (NIHR) Academic Clinical Lecturer paediatric awards (University of Liverpool)
- Extended research partnerships between Alder Hey and a range of academic institutions, embodied by the multi-institutional Alder Hey Institute in the Park.
- Award of £4m for the NIHR Alder Hey Clinical Research Facility for Experimental Medicine.
- Establishment of the Children's Nursing Research Unit and the Liverpool Paediatric Medicines Research Unit, multi-partner research groups both led by Alder Hey.
- Acquisition of a significant number of NIHR programme and project awards across a range of schemes.
- Over 41,000 children and babies recruited to NIHR Clinical Research Network portfolio studies.
- An increase in the number of Chief Investigators and Principal Investigators for child health research based in Liverpool.
- An increase of 660% in the research operating budget within Alder Hey from c. £0.7m to £4.5m.

The Integrated Research Strategy for Child Health published in 2012 offered a ten year vision for the forward trajectory of collaborative research between Alder Hey and the University of Liverpool. This strategy was refined in 2015 following a consultation exercise led by the Trust Director of Research and the University of Liverpool Brough Chair in Child Health (Figure 1). The original and revised strategies both recognised that further research progression is dependent on critical factors including: targeted resourcing, talent development and integration of the research endeavour within the body of the Trust and its overall business.

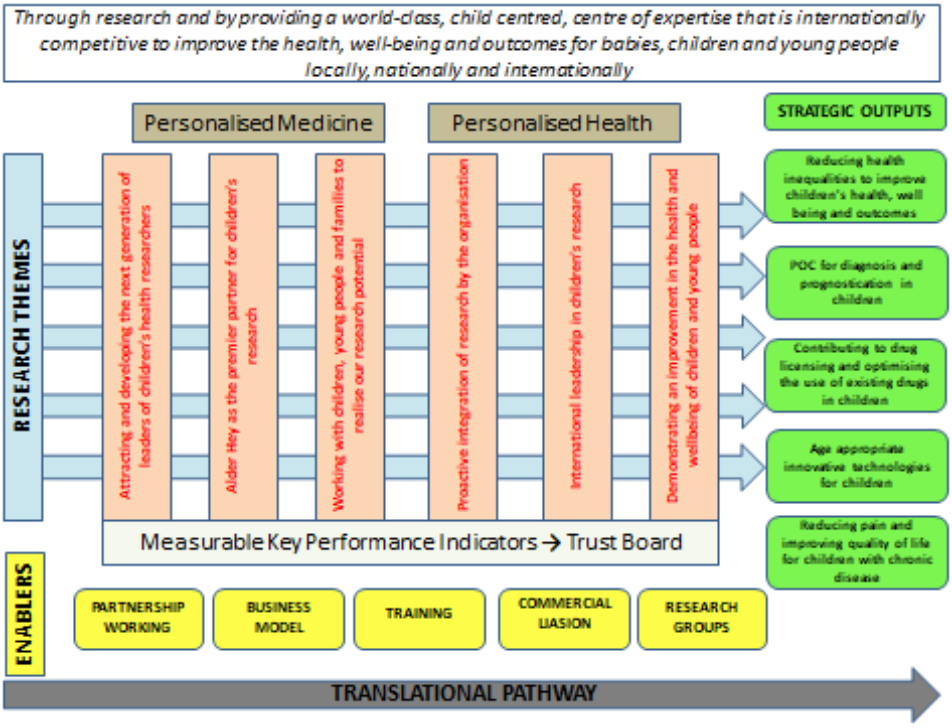

Figure 1: Summary of the Integrated Research Strategy for Child Health (2015)

Within Alder Hey, the research function is currently crystallised within the Clinical Research Division (CRD) as a cogent entity within the organisation. The CRD provides functions to oversee the safety, quality, performance management, financial management and delivery of clinical research. It is recognised that the expansion of child health research in Liverpool has not been matched by a similar growth in some core functions/resource within the CRD. In addition, the CRD has assumed the risk and burden associated with the delivery of clinical research and the need for a distributed model throughout the clinical divisions is increasingly required. The centralised model for research will be challenged by the Care Quality Commission's guidance on Research will form part of a NHS Trust's 'Well Led' category from late Autumn 2018.

Research remains a key domain within the Alder Hey corporate strategy. Following the Review of Clinical Research in Liverpool and a review of the strategic themes within the University of Liverpool, the prospects for significant developments in the city within the sphere of child health research are extremely promising. Alder Hey will be an essential partner in these developments, in particular through its collaborations with academic institutions. In order to capitalise on these possibilities, the Trust needs substantial reformation in its leadership of, organisation of and business model for sustainable clinical research.

C. Purpose

To summarise the objectives, requirements and resources within Alder Hey needed to achieve a resilient, sustainable and world class research function which can meet the expectations of external stakeholders/partners and consistent with the integrated research strategy and opportunities within for child health research Liverpool.

D. Domains of Need

i. Leadership

The existing leadership for clinical research is primarily reliant on two to three individuals each with limited capacity to exert their influence and to generate momentum. This narrow leadership is confined to the premier researchers within the CRD (Director of Research and Clinical Lead) and clinical academic body (Brough Chair) and is not supported by a distributed critical mass of clinical research leaders within the Alder Hey Clinical Divisions and the academic grouping from partner institutions. This is neither sustainable nor effective. A distributed model of clinical research leadership is needed, drawing on a wider pool of individuals, increasing leadership capacity and broadening the interaction within Alder Hey itself and its academic partners. This will be a virtual body also with some representation on a senior Research Strategy Partnership Group.

Overall Aim: A cadre of collegiate clinical research leaders across the clinical divisions which supports the forward momentum of the research strategy and integration of research within the Trust.

Specific Objectives:

1. Formalise the role of **Clinical Lead for Research** within the Clinical Research Division.
2. Identify and appoint **Associate Directors of Research (Clinical)** within the three other Clinical Divisions (x3; NHS professionals) who will work alongside the Director of Research and Clinical Lead for Research.
3. Appoint the first **Alder Hey Consultant Pharmacist** post with a major focus on research and leadership.
4. Designate a **research lead** for each department (primarily a link role).
5. Formalise the NIHR Alder Hey **Clinical Research Facility Theme/Cluster Lead roles**.
6. Ensure that the **NIHR NW Coast Clinical Research Network Speciality Leads for Children and Cancer (Paediatric)** are included in the clinical research leadership group.
7. Review the **Associate Chief Operating Officer for Research** role in respect to balance between divisional and corporate leadership and research specialty management.
8. Convene a **Research Strategy Partnership Group** comprising key clinical research leaders (1-2), senior faculty leaders from academic partner institutions, Alder Hey Director of Research, the UoL Brough Chair in Child Health and selected members of the Alder Hey Executive.
9. Convene a **Research Management Board** (see also Section iii) with senior divisional management representation to oversee effective cross-divisional research integration.

Key processes and enablers: Job planning to formalise specific roles; accountability structures (to Director of Research and Medical Director)

Resources: 8 x Consultant PA (2 x Clinical Lead; 3 x Divisional Leads; 3 x CRF Theme/Cluster Leads); See also section v (clinical research nurse leadership).

ii. Talent (Growing the Next Generation of Child Health Researchers)

Growing the next generation of child health researchers is a key pillar within the Integrated Research Strategy for Child Health (Figure 1). This represents a complex array of issues including, talent spotting at early career stage development across the professions, strategic collaboration with partner academic institutions to create clinical academic posts and career pathways, Alder Hey Clinical Division support for flexible academic career development, engagement with Deaneries and Health Education England and supporting NHS healthcare professionals in the pursuit of honorary

research track appointments with partner universities. While the circumstances and needs may vary between individuals, there is institutional development needed within Alder Hey to create a systematic approach and infrastructure so that repetition and 're-inventing the wheel' on a case-by-case basis is avoided.

Overall Aim: *Develop a systematic approach to identify and proactively support multi-professional established NHS researchers and junior academics to achieve their research potential.*

Specific Objectives:

1. Support NHS clinicians who successfully compete for **UoL honorary appointments** (Honorary Clinical Associate Professor; Honorary Professor) with protected time/resource for personal research progression and contingent upon defined leadership **responsibilities for the collective research endeavour**.
2. **Co-design research roadmaps with NHS clinicians** who have potential for UoL honorary status.
3. Introduce **flexibility within Divisions** to respond to and support opportunities for new Senior Lecturer appointments, NIHR Academic Clinical Lecturers and Local Clinical Lecturer appointments (across all professions).

Key processes: Team job planning and redistribution of DCCs where required to meet the research needs and potential of individuals and teams. Contingency planning within Divisions each financial year to introduce flexibility for support of academic trainees and junior researchers. Agreement with NW Deanery regarding out of programme opportunities for clinical trainees.

Resources: PAs (from Divisions) for NHS clinicians who meet the criteria of honorary UoL Professors commensurate with their personal research plans and contribution to the research strategy.

Priority and designated funding from the **Alder Hey Charity** to provide seed corn resource for researchers in categories 1-3 above.

iii. Infrastructure/Integration

Successful and effective clinical research is dependent on an organisation-wide approach to its delivery. Each NHS Trust has a central R&D function which will vary in its scale, organisation and resourcing. Irrespective of structural variances, the essential core functions of the management and governance of safe, high quality and efficient clinical research are consistent between organisations. It has been demonstrated through peer reviewed scientific publications[1,2] that the volume of clinical research within an organisation is associated with improved patient outcomes and organisational CQC ratings. This has prompted the CQC to explore integration of research into its 'Well Led' category, and a national group is developing this for implementation in 2018.

However, despite these compelling drivers many challenges also exist in adopting research at pace and scale within Alder Hey. Clinical services and specialities, and non-clinical support functions, are all needed to successfully deliver clinical research. The extent to which the clinical research endeavour is embedded within the organisation itself is related to the ability to deliver clinical research at pace and at volume.

Overall Aim: *Design and resource a model of research integration commensurate with the standards declared by the Care Quality Commission's Standards for Research.*

Specific Objectives:

1. Development of an **annual integrated operational business plan for research** which clearly identifies the resources within the Clinical Divisions available to support the research strategy and research delivery.
2. Re-design internal research governance and operational processes for best fit with the emergent **Liverpool Joint Research Service** (due to open in April 2019).
3. Implement the **'Research Integration' plan** (supported by Joe Gibson).
4. Set up a **Research Management Board** (see also Section i) with cross-divisional representation (supporting the research integration agenda)
5. Identify and implement research specific priorities for IM&T within the **GDE programme/IT Strategy**.
6. Ensure **corporate services** and their annual plans include clear objectives to support research and are resourced accordingly.
7. Identify the need and create the policy for **research specific-processes** which deviate from the institutional norm: e.g. recruitment processes for research posts funded by time limited external awards.

Key Processes and Enablers: Project management of the Research Integration plan; production of an annual integrated operational business plan for research led by the four divisional ACOOs, and accountable to the Chief Operating Officer for its delivery and completion; Standard Operating Procedures SOPs for research specific processes and/or amendment of existing policies; Constitute and implement the Research Management Board.

Resources: to be defined through integrated operational business planning.

iv. Growth

In line with the majority of clinical services in the organisation, there is a focus on growth. This can be considered in at least two paradigms: (1) research delivery volume; (2) the research economy.

With respect to delivery of clinical research at volume, there is a direct association with the resources provided by the NIHR Clinical Research Network, although this is overlaid by several factors including the efficient use of resources available, clinical motivation and incentivisation (at individual and team level), effectiveness of research delivery staff (e.g. research nurses) the capability of infrastructure systems and processes (e.g. IT) to support research delivery. With respect to the overall research economy within the Trust (and in collaboration with academic and commercial partners), this is dependent on the inherent business model for research and its ability to support growth and re-investment in activities which support the research endeavour. A simplified synopsis of the financial principles of the business of research is shown in Figure 2.

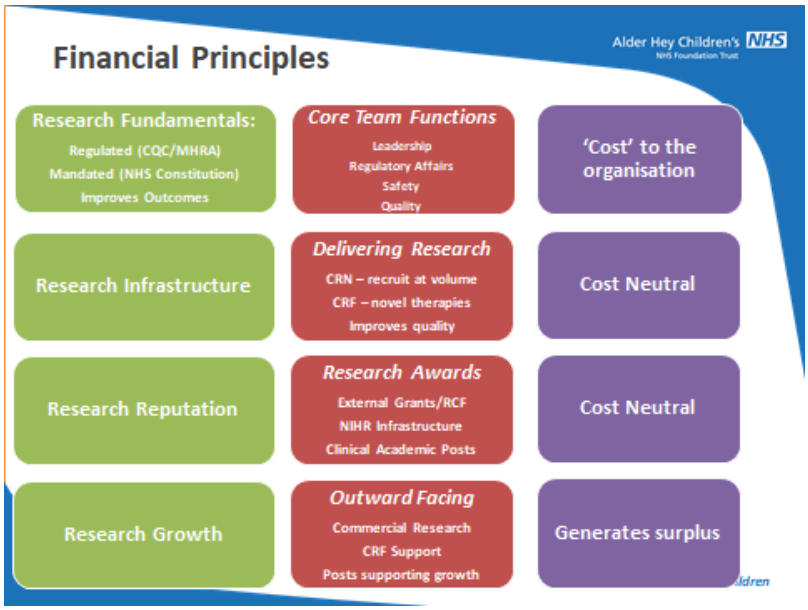

Figure 2: Financial principles underpinning the business of research

In order to operate a safe, high quality and effective research function, there are a number of essential posts (or variants of) which are needed within any NHS organisation. In the modern NHS, there is no income stream for such posts within the research funding landscape and in principle are borne by the organisation. Academic, non-commercial research (99% of research by volume at Alder Hey) is cost-neutral and, unlike commissioned clinical services, there is no opportunity to reduce the cost base to deliver a unit of activity. That leaves commercial research as the only means to generate a surplus through research.

Currently, the Trust has no reinvestment and redistribution component as part of its overall research business model. In the context of practice within other NHS Trusts, Alder Hey is an outlier in lacking any form of income redistribution and capacity building. From a survey of NHS Trusts within UK Research Directors and Leaders (UKRD), the R&D contribution/CIP at Alder Hey as a proportion of the overall R&D operating budget is almost four times greater than the mean within UKRD NHS Trusts. As a foundation for growth, an investment and incentivisation model needs to be implemented alongside a proportionate contribution to overheads and/or the cost improvement programme. The NIHR Alder Hey Clinical Research Facility has a focus on delivering commercial research and engagement with the commercial sector and its industry strategy is fundamental to the overall Trust business model for research.

Overall Aim: Implement a distributed research business model for growth and incentivisation which enables capacity building and resilience within departments while contributing to the Trust's overall wealth.

Specific Objectives:

1. Implement a **research business model** which is founded on recovery of base costs within Divisions (including CRD) and redistribution of commercial surplus within divisions and a proportionate contribution to the Trust's bottom line.

2. Create **incentivisation models** (resource and reward) which encourage the engagement of individual NHS professionals and/or departments in academic and commercial research delivery.
3. Co-create with the Alder Hey Charity a **capacity building investment plan for research** which is based on: (i) a commercial research growth plan based on the findings of the Duchenne Muscular Dystrophy (DMD) 'Newcastle Plan'; (2) growing and sustaining academic potential (section ii).
4. Ensure that research financial services are appropriately designed and managed to **recover commercial research income**, including coding of activity and system support.

Key Processes and Enablers: Detailed characterisation of the financial parameters of the DMD 'Newcastle Plan', led by the CRF Industry Manager; agree and implement a research business model developed by the four clinical divisions and Director of Finance; agree (within the business model) an income distribution model for commercial research.

Resources: Potential additional resource to support improved activity coding and real time invoicing to maximise commercial research income recovery.

v. Sustainability

The need for resilience and sustainability within the research function is essential, particularly as the entire research infrastructure within the Trust is supported through competitively awarded external funding. In this respect, the business continuity for research is exposed to external factors not within the control of the organisation. Sustainability is not only critical within the CRD, but also within other clinical divisions given the whole organisation approach to successful research delivery. The consideration of models for sustainability and contingency planning for eventualities driven by external factors is important. These considerations need to be addressed at the level of the whole organisation, sub-organisation (Division, Department) and key individuals/roles.

Overall Aim: Develop models for a sustainable future for clinical research at the level of the individual, teams and the organisation.

Specific Objectives:

1. Agree the optimal construct for the Trust Director of Research role and commence **succession planning**.
2. Implement a **clinical research nurse leadership** structure cogent with the findings from the recent external review of the Alder Hey clinical research nurse workforce and leadership.
3. Ensure research delivery professional roles each have a clear **career trajectory** enabling maturation and longevity in the roles and minimise loss to the clinical research workforce.
4. Develop a **five year research business plan for key departments** based on known and anticipated research profiling (including potential academic posts and research delivery growth).
5. Model the financial impact of **loss of NIHR infrastructure** (CRN, CRF, RCF) at 10%, 50% and 100%.

Key Processes and Enablers: Review of Research Director (and ACOO for Research) job description; implement recommendations of the Review of Clinical Research Nursing at Alder Hey (G Hewitt);

Divisional Research Leads (Section i) to support five year business plan development; ACOO for Research to model impact of NIHR infrastructure loss.

Resources: Predicted to be at the Senior Research Nurse Leadership level (potential new senior strategic nurse post and expansion of current AfC 7 leadership).

vi. Branding and Marketing

A consistent style and approach to how the Trust recognises clinical research as part of its services and functions is needed. This is relevant both to internal communications and visibility and to external stakeholders and the general public. Within the organisation, recognition of the CRD as a clinical entity and within the clinical architecture of the organisation is essential. The not infrequent categorisation of the CRD as a 'corporate service' is inappropriate and disabling in the drive for integration and meeting the CQC expectations for clinical research. Within the organisational branding and marketing media, it is important to promote the Trust as an organisation which not only offers but also invites children, young people and families to participate in clinical research studies.

Overall Aim: Ensure that the Clinical Research Division has an internal and external identity which explicitly recognises it as a core clinical function within the organisation.

Specific Objectives:

i. Ensure that the **CRD is appropriately represented** in corporate organograms, wall charts and other visual media.
ii. Ensure that the CRD is appropriately represented and described in **corporate literature** intended for the external market (e.g. recruitment brochures).
iii. Ensure senior **CRD leadership roles/titles** are consistent with other divisional leadership roles.
iv. Ensure that the **CRD is represented on relevant Trust committees**, in particular where clinical research division(s) are constitutional members.

Key Processes and Enablers: Refreshing key committee terms of reference; joint work with Communications Dept to adapt corporate literature and other visual media; liaison with Human Resources Dept to ensure clarity of leadership roles and titles.

Resources: To be confirmed.

vii. Performance Management

Measures of assessment will be needed to relate research productivity and output to the concept of 'world class' and 'internationally competitive'. To date, this has been a challenge because of the distributed nature of source data and lack of resource to engineer and maintain data collection processes. A high level suite of key performance metrics will be routinely monitored by the Research Management Board and reported to the Research Strategy Partnership Group. These metrics will also provide the Alder Hey Trust Board with high level assurance of progression against strategic objectives.

Research Professionalisation and Industrialisation
- Number of participants recruited into clinical research studies
- Number of research studies
- Number of Chief/Principal Investigators
Integrated Research Productivity
- Number of senior academic posts
- Number of trainee academic posts
- Number of PhD studentships
- Number and value of grant awards
Partnership and Sustainability
- Financial productivity
- Number of commercial partnerships

Table 1: Proposed domains of research performance metrics

While some of the domains/indicators of performance are available through internal source data, metrics in domains relevant to collegiate effort and partnership are from distributed data sources and will require combined institutional support to collect.

viii. References

[1]Downing et al. High hospital research participation and improved colorectal cancer survival outcomes: a population based study. *Gut*. 2016 Oct 19. pii: gutjnl-2015-311308. doi: 10.1136/gutjnl-2015-311308.

[2]Jonker & Fisher. The correlation between National Health Service trusts' clinical trial activity and both mortality rates and care quality commission ratings: a retrospective cross-sectional study. *Public Health.* 2018; **157:** 1-6. doi: https://doi.org/10.1016/j.puhe.2017.12.022

Professor Matthew Peak

Director of Research and Clinical Research Division

September 2018

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 2nd October 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' and updated 'Never Event' list in January 2018. The NHS England Serious Incident Framework (2015) defines the fundamental purpose of patient safety investigation, i.e. to learn from incidents, not to apportion blame (except in specific defined circumstances such as criminal activity, repeated same/similar errors) whilst identifying a system-based method for conducting investigations (root cause analysis).

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, 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 and Never Events,that relate to patient safety/patient harm. In addition, the Trust has a statutory duty to apply Duty of candour for all moderate and above harm incidents, and Never Events.

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

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 2018/19 performance for serious incidents requiring investigation (SIRI). All SIRI 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 three serious incidents, including two never events. There were no safeguarding incidents reported.

Table 2 shows the cumulative position, three new and two ongoing serious incident investigations in total, which comply with external requirements, including the regulatory requirement for 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 the regulatory requirement for duty of candour.

Table 4 shows the closed SIRIs for this reporting period.

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

	SIRI (General)											
	2017/18				2018/19							
Month	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**
New	2	0	1	2	4	0	0	0	1	1	1	1
Open	5	3	1	1	3	3	3	3	2	3	2	2
Closed	3	4	2	1	0	4	0	0	0	0	2	1
Safeguarding												
Month	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**
New	0	0	0	0	0	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0
Never Events												
Month	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**
New	0	0	0	0	0	0	0	0	0	0	0	2
Open	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0
Cumulative Position												
												5

Table 2 Ongoing serious incidents requiring investigation (cumulative):

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 2018/21325	31/08/2018	Surgery	**Never Event** (wrong implant) – Fixation of left supracondylar humerus fracture. Incident: 1.6mm wires taken in error rather than 2mm wires.	Paula Clements, Theatre Matron and Chris Talbot, Trauma and Orthopaedic Consultant	Information gathering commenced.	Yes	Yes – including Duty of Candour letter.

			Stable fixation achieved utilising 1 x 1.6mm and 1 x 2mm wire. Clinical decision made not to replace 1.6mm wire following check regarding stabilisation of joint. No harm to the patient.				
StEIS 2018/21324	31/08/2018	Surgery	Incident: Oral medication given via endotracheal tube which was mistaken for an orogastric tube. No harm to the patient.	Dianne Topping, Senior Nurse	Information gathering undertaken, RCA panel meeting being held 25/09/2018.	Yes	Yes – including Duty of Candour letter.
StEIS 2018/21323	31/08/2018	Surgery	**Never Event** (wrong site surgery) Incident: removal of wrong tooth. Patient seen in theatre for dental extractions as part of orthodontic treatment plan. Prior to the theatre date, she was seen in clinic for assessment/consent. The agreed treatment plan was confirmed when clerking prior to theatre. Initial plan was extraction of upper 4/4 and lower 5/5 + surgical removal of supernumerary tooth. While on the waiting list for theatre, patient saw a community dentist for restoration of UL6 under	Kate Holian, General Manager Surgical Division, Dr Madhavi Seshu, Consultant Orthodontist	Information gathering commenced.	Yes	Yes – including Duty of Candour letter.

			sedation. Her community dentist thought her UL6 had poor prognosis and queried with the orthodontist whether the UL6 was one of the teeth to be removed as a part of the orthodontic treatment plan before finishing final restoration. The Orthodontist then reviewed the treatment plan and sent a letter to the Trust requesting this change (to remove heavily restored UL6 instead of sound UL4). An outpatient appointment was booked in September after this letter was received by the Trust however the patient was listed and scheduled for theatre in July. After the theatre procedure was finished and the patient was in recovery, it was incidentally noticed that there were further letters from the orthodontist requesting the change in the treatment plan. The letters requesting a change to the original management plan were				

			sent after the patient was first seen for consultation and were not utilised as part of the preoperative planning leading to incorrect tooth extraction.				
StEIS 2018/18741	30/07/2018	Medicine	Patient treated at Alder Hey was discharged 26/04/2018 at 1700 and was admitted to Warrington Hospital on 27/04/2018 at 00:13. The patient was admitted with active bleeding from an unknown source. Escalation, treatment and blood products given and patient stabilised and admitted to children's ward. Subsequent deterioration and patient died on 28/04/2018 at 0400.	Andrew Riordan, Infectious Diseases Consultant and Jeanette White, Matron for Cancer Services and Laboratory Medicine	A review was undertaken by a Consultant Haematologist independent to the case; which found the advice given prior to discharge was correct and followed the most up to date UK guidance, there was no lapse in care identified. A request has been made to the CCG to stand the incident down from StEIS.	Yes	Yes – including Duty of Candour letter.
StEIS 2018/15654	25/06/2018	Surgery	The patient with an antenatal diagnosis of Hypoplastic Left Heart Syndrome (HLHS), Mitral Atresia, Ventricular Septal Defect and Hypoplastic Arch with Coarctation, born at 40 weeks of gestation in Burnley; was transferred to Ward 1C on day one of life. The patient was transferred to theatre on the 15/06/2018 for a Norwood-Sano	Ian Street, ENT Consultant Surgeon and Jan Taylor, Sister.	The RCA draft report has been written; the report is to be signed off by the Division by the 24/09/2018 for executive quality check.	Yes	Yes - including Duty of Candour letter.

			procedure and had an uneventful post-procedure recovery in the Paediatric Intensive Care Unit (PICU). The patient transferred from PICU to Ward 1C on 20/6/2018 at 19.00, 5 days post op Norwood-Sano procedure. The patient was clerked in by the SHO at 21.30 to do bloods, stop the Milrinone and take the Central Venous Line (CVL) out (due to the swollen leg). During the evening patient started to deteriorate (Paediatric Early Warning - PEW score 7 at 1.00 am) and the patient was reviewed at 1.30am by the cardiac registrar and an appropriate clinical plan was initiated; the patient made small improvements and the PEW score improved from 7 to 6. At 5.00am, the patient began to deteriorate again (PEW 7) and by 7.00am the PEW was				

			recorded as 9. The SHO was bleeped – the SHO spoke with the registrar; clinical plan outlined. The cardiac registrar reviewed the patient at 8.30am. The patient's temperature spiked and advice was taken from the Infectious Diseases (ID) Consultant by the ST2 doctor on the ward round. The patient then had a full septic screen, including a lumbar puncture (LP). Shortly following the LP, the patient became apnoeic and lost cardiac output. An arrest call was made at 9.58am. The patient was intubated on the ward and transferred to PICU; the patient was in Pulseless Electrical Activity (PEA) on arrival to PICU and put on Extracorporeal Membrane Oxygenation (ECMO).				

Table 3 Moderate harm incidents:

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**
30568	24/08/2018	RCA Level 1	Incident: Misdiagnosis of dislocated elbow joint. A 7 year old girl was seen in A&E and found to have an elbow injury. X-rays were performed and the patient examined. The findings on X-ray were an entrapped medial epicondyle fragment within the elbow joint as a result of a dislocation, and altered sensation in the distribution of the ulnar nerve. Unfortunately, the diagnosis made (undisplaced supracondylar fracture) and the management plan (discharge to fracture clinic) were not appropriate, and the actual diagnosis was missed. The patient has persistent ulnar nerve sensory loss and an entrapped fragment within the elbow joint.	Dr Charlotte Durand, Emergency Department Consultant	Investigation underway.	Yes	Duty of Candour completed including letter sent to family.

Table 4 Closed SIRIs:

Reference Number	Date investigation started	Division	Incident Description	Lead Investigator	Progress	60 working day compliance	Duty of Candour applied
StEIS 2018/11892	11/05/2018	Surgery	Incident: Grade 3 Pressure Ulcer. The patient was admitted to PICU at Alder Hey from Nobles Isle of Man on 30/03/2018 following high speed road traffic collision (RTC). The patient was a pedestrian and was hit by a car at 60mph. The patient sustained traumatic injuries. Patient reviewed by plastic surgery registrar 09/05/2018, pressure ulcer on heel identified as grade 3.	Paula Clements, Theatre Matron	Final report sent to CCG and family.	Yes	Yes - Final report and Duty of Candour letter sent to family.

END

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY
Medical Director's Mortality Report

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

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

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

Summary Table

2018

Number of deaths (Jan. 2018 – Dec. 2018)	32
Number of deaths reviewed	17
Departmental/Service Group mortality reviews within 2 months (standard)	22/28 (79%)
HMRG Primary Reviews within 4 months (standard)	11/14 (79%)
HMRG Primary Reviews within 6 months	7/7 (100%)

The HMRG is performing well with 79% of the reviews within the 4-month target that we set ourselves and 100% within 6 months. The 4-month target can be difficult/impossible to achieve if it is a coroner's case and if the RCA's are prolonged. The group is of the opinion that it is important to have all the relevant information to achieve a useful and complete review. Therefore, it is appropriate to wait, and it is unlikely that we will every achieve 100%. The standard of 4 month is useful so reviews are done in a timely manner and if there is a concerning trend it will be identified in a reasonable time period. The outstanding cases are related to RCA's or coroner's case.

Over the last few months a number of national guidelines have been realised impacting on the mortality review process is undertaken. The paediatric version of the learning from Deaths Guidance has been recently released and we are currently evaluating any changes are necessary to our current process. In addition, in July 2018 there was further guidance relating to Trusts

working with bereaved families and carers. In Alder Hey, we are extremely lucky to have an exceptional bereavement team and the work they do means that we are far exceeding the requirements. The only aspect that is being completed is the process of contacting the family and offering the opportunity to raise and issues they may wish to. We are aiming to have this process agreed very soon but it is vital that it is done correctly to prevent any further distress to the families concerned.

Internally there are still a number of improvements that are being made to our mortality review process:

1) We are still striving for engagement across the Trust in the process. The teams whose areas have the highest mortality rates for example PICU are very efficient in their review process, but it is the teams who only have an occasional death who we also need to ensure that they are aware and utilize the process correctly.

2) One aspect that we are focusing on is ensuring that the learning points raised from the monthly meetings are communicated effectively across the Trust.

3) The group is trying to improve engagement out of the Trust and improve communication. We plan to do this by inviting interested parties to our meetings and releasing our reviews to the GP's and DGH's involved.

4) The Community team are keen that any deaths involving their patients are reviewed by the HMRG and come under the mortality process. Currently this only happens if the children die in Alder Hey but more usually they are in the community or a hospice. This group would cover a number of the children with more complex issues and needs and often have had considerable input by the trust. It would be beneficial to us as a Trust to ensure that the care we are providing is the best that we can possibly achieve. It may be difficult practically due to the notes being in a number of different places, but we are working on the practical issues to make this and achievable goal.

2018

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2-month timescale	HMRG Reviews within 4-month timescale	HMRG Reviews within 6-month timescale	Discrepancies HMRG- Dept	HMRG Review - Death Potentially Avoidable
Jan	7	7	5	4	7	3	1
Feb	1	1	1	1		0	
March	6	6	6	6		0	
April	6	3	6			3	1
May	4		4				
June	4						
July	4						

Discordant Conclusions of the HMRG vs the Departmental/service group reviews

Since the previous mortality report there have been 5 cases where there have been discrepancies between the service group and HMRG reviews.
In 3 of the cases the care was rated by HMRG to be better than it was rated by the departmental review and in 2 it was considered to be examples of good practice.
In the other 2 cases, in one the care was rated as adequate whereas the HMRG considered that aspects of care were less than adequate and different management would not reasonably be expected to have altered the outcome.
In the last case the departmental review recorded the care as good practice but the HMRG review rated the care as adequate.

Potentially modifiable factors and actions

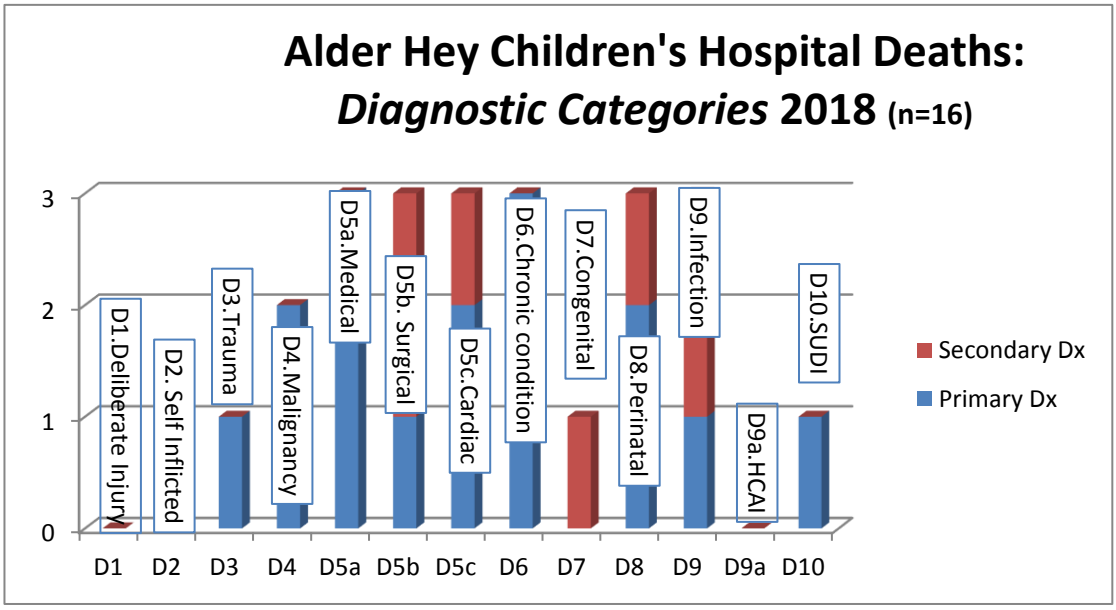
Since the last Trust Mortality report, there has been 1 in-hospital death. where there are issues with the care outside Alder Hey that the group believed could have been improved.

1) This was a toddler who had a week history of being unwell. She had developed a high temperature and she was lethargic. Since they were concerned they took her to their local DGH for assessment. She was discharged and returned later very unwell. There were

difficulties stabilising her and she deteriorated over a number of hours. By the time she arrived in AHCH she was extremely unstable and despite maximum treatment she unfortunately died. The HMRG considered that there were possible issues prior to arrival in AHCH.

Primary Diagnostic Categories

The chart below shows the deaths by primary diagnostic categories.

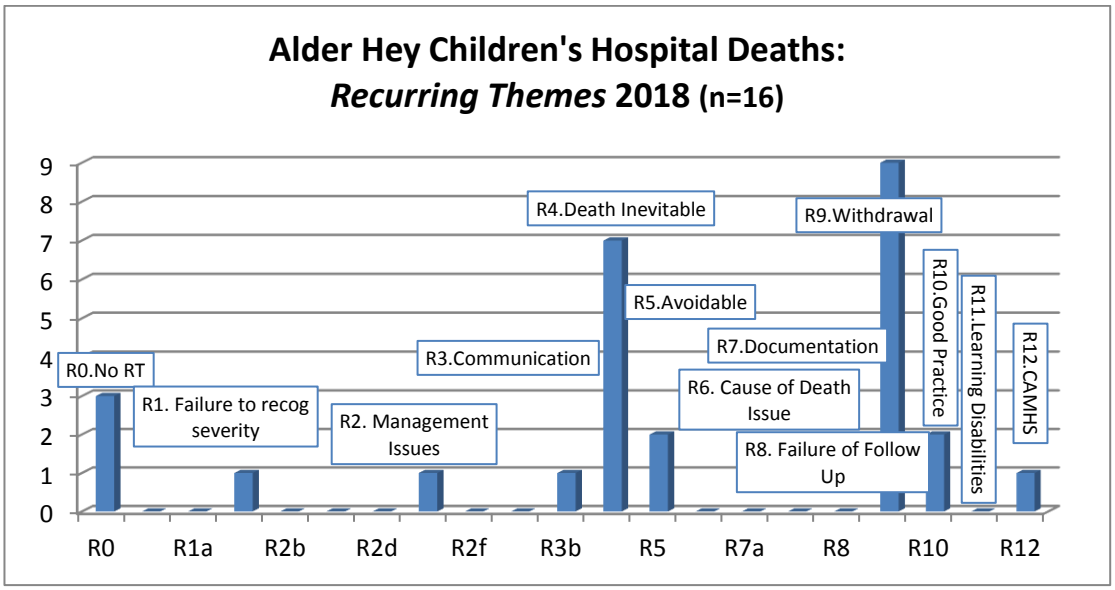


Diagnostic/Disease Categories (based on CEMACH categories - ref. *Arch Dis Child* 2011;96:922-6 + 927-31)

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

The numbers are low with only 16 at this stage so there are a number of diagnostic categories all clustered together. The commonest them is Acute medical or surgical causes with 3 cases (18.75%). Then there are 3 categories with 2 cases in each (12%) – malignancy, cardiac and perinatal. There are no hospital acquired infections and no worrying peaks.

Primary Recurrent Themes



Recurring Themes

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

The commonest theme is withdrawal of care in 56% of cases which shows that the intensive care team are providing the best possible care until they feel all treatment options are futile, then with full agreement of the family withdrawing intensive care.

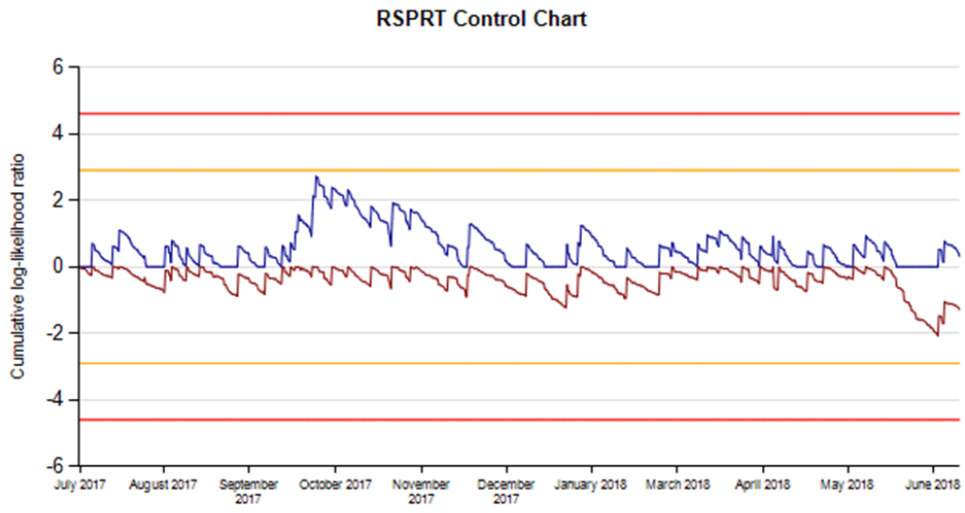
The next most common theme is death inevitable prior to admission, this occurred in 44% of cases. This is when even with optimum care there is nothing that the teams in AHCH can do to prevent death. This may not be apparent prior to transfer and may require investigations to be undertaken in AHCH to complete a full assessment and discuss all treatment options or lack of.

Section 2: Quarter 1 Mortality Report: April 2018 – June 2018

1) Statistical analysis of mortality:

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

In the RSPRT (Risk-adjusted resetting probability ratio test) Plots present the mortality of your unit cumulatively, based on what is predicted by PIM2 score. Between the orange lines is a 'safe zone' with the variability you might expect day to day. Between the red lines at the top of the chart can be regarded as a 'warning zone'.



Until there is a death, the top line stays flat and the bottom line gradually drops. When a death occurs, the top line moves up and the bottom line moves closer to zero. When either line touches the red line, the graph resets to zero.

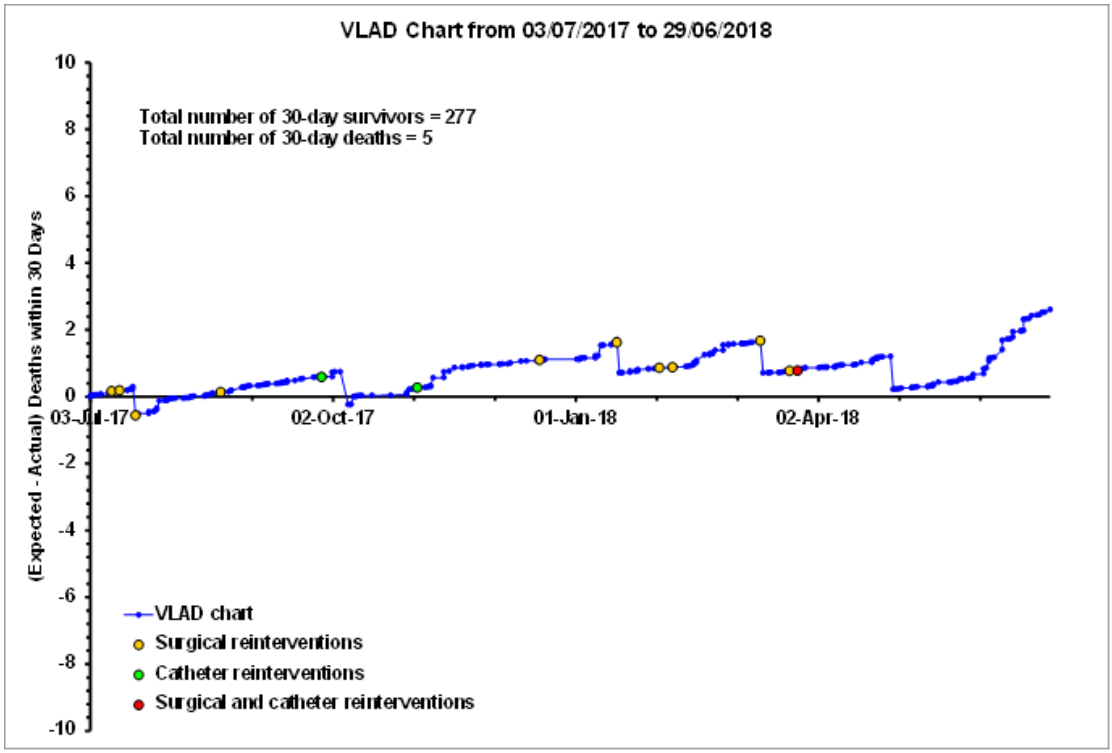
This data is nationally validated because generated by PICANet.

The above RSPRT chart indicates that we have been in "Safe Zone" between June 2017 and June 2018. Between September 2017 and October 2017 there was a peak with 13 deaths in two months. Of the 13 deaths, 11 of them belonged to the "Death inevitable on PICU admission" group in retrospect. The other 2 deaths belonged to the group of chronic patients with multiple co-morbidities. All PICU deaths + RSPRT trends are discussed in the following month and monitored regularly.

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

A risk adjustment model Partial Risk Adjustment in Surgery (PRAiS) has been developed to calculate the estimated risk of death within 30 days of a primary paediatric cardiac procedure in children under 16. The PRAiS model uses the risk factors including specific procedure, age, weight, diagnoses and comorbidities. The National Institute for Cardiovascular Outcomes Research (NICOR) will use this information to produce funnel charts comparing the Standardised Mortality Ratio (SMR) across centres.

The PRAiS risk model has also been used to develop variable life-adjusted display (VLAD) charts for each centre. VLAD charts display the cumulative difference between expected and observed mortality over time. The plotted line goes up for a survival and down for a death; for higher risk patients who survive the line is steeper than low risk survivals; for low risk deaths the line is steeper than deaths for high risk patients. If the outcomes are as expected the line will be close to zero. The line will rise less steeply for a run of survivals than it will decrease for a run of deaths. Re-interventions are displayed as circles on the plotted line. Monitoring of VLAD charts provides additional quality assurance.

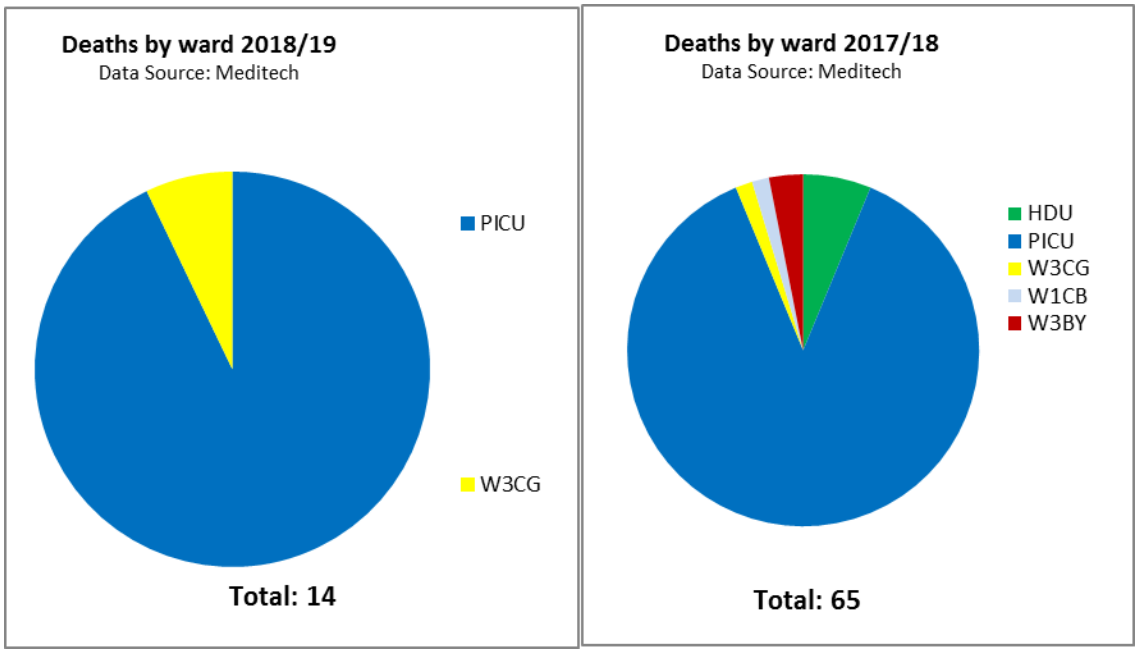


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from July 2017 to June 2018. The survival rate at 30 days was 98.2% against an expected rate of 97.3%.

2) Real time monitoring of mortality

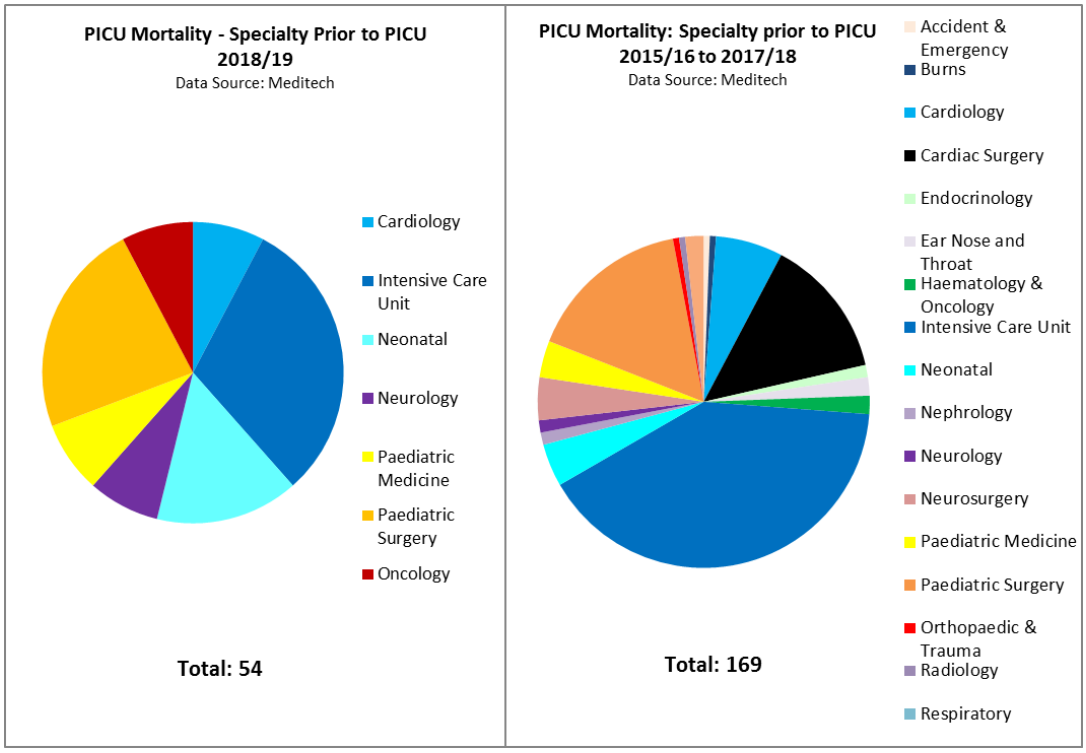
Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below are the charts showing mortality by ward for 2018/2019, and the previous year 2017/18.



The charts show the highest number of deaths occur in the PICU department. This enables observations of deaths in specific ward areas over time and thus identifies any potential unusual patterns, particularly in non PICU wards.

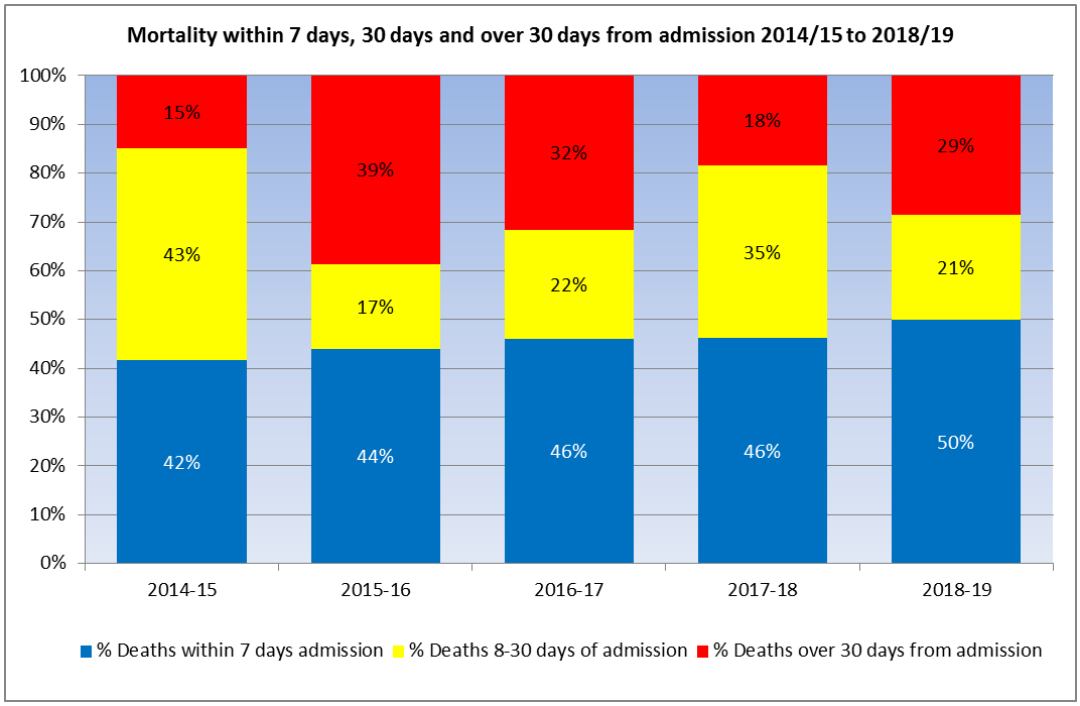
ii) Below are the charts showing mortality by specialty prior to PICU for 2017-18, and the previous 3 years 2014-15 to 2016-17.



These charts show the breakdown of PICU deaths by the specialty the patient was under during their episode before admission onto PICU. A large number of patients are regularly under PICU on their first episode.

For those whose first episode was not PICU, the largest numbers of patients have frequently been under the specialties Paediatric Surgery, Cardiac Surgery and Cardiology. This provides an opportunity for looking at unusual trends within specialties.

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

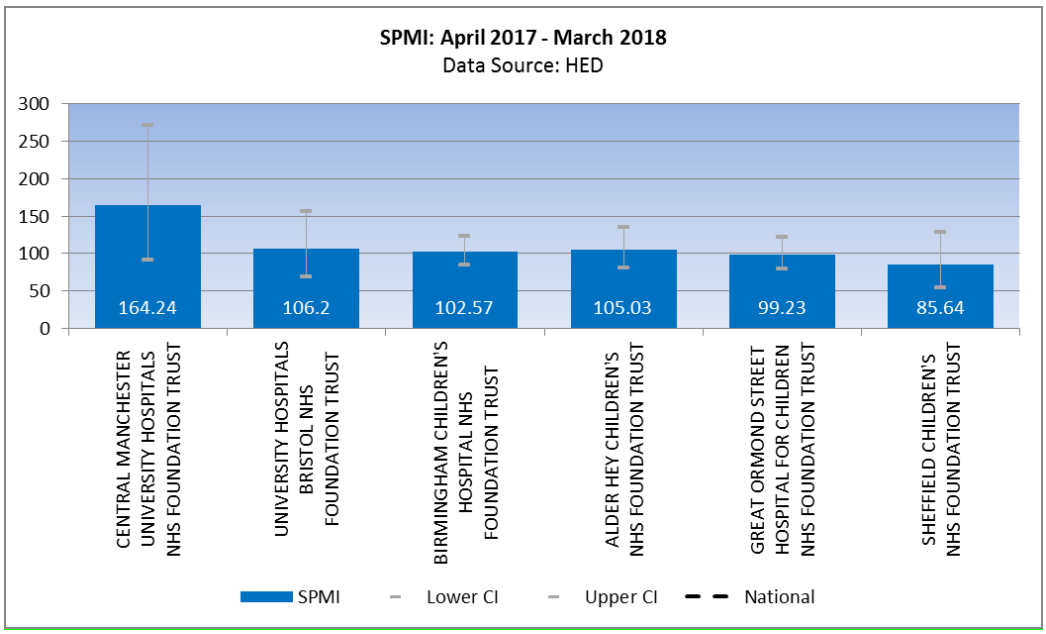


The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 44-46% of deaths occur within this time frame. In the current year (Apr - Jun) 50% occurred within 7 days of admission, 21% occurred within 8-30 days from admission, and 29% deaths occurred over 30 days from admission.

3. External Benchmarking

a) Standardised Paediatric Mortality Index (SPMI); – HED

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. The model is available in pre-release and the most recent data available is for the period 1st April 2017 to 31st March 2018.



The chart shows that Alder Hey has a higher mortality level than the average NHS performance with 60 deaths against 57.1 expected deaths. However Alder Hey's SPMI is similar to the hospital's with similar work load – Birmingham and Bristol.

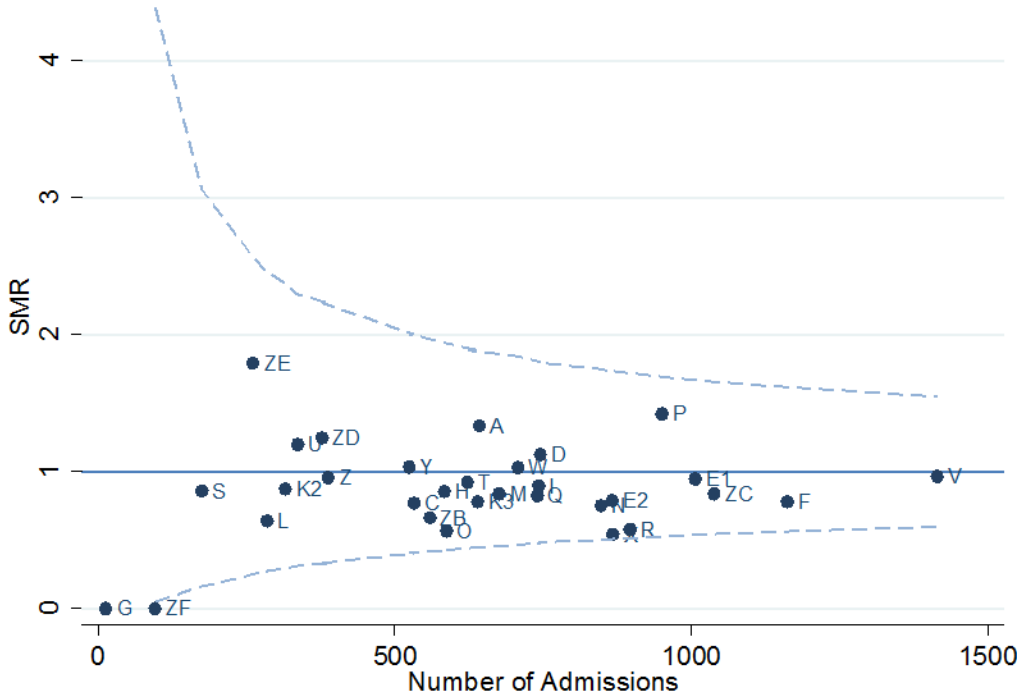
b) External benchmarking against comparator organisations for specific patient groups in addition to HED.

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

PICU

It is important to recognise that 85-90% of our deaths occur in PICU as in other children's trusts. In the most recent PICANet report (2017 Annual Report of the Paediatric Intensive Care Audit Network January 2014-December 2016), mortality is displayed in funnel plots. The Standardised Mortality Ratios (SMRs) for each organisation are plotted against the number of admissions. The risk adjusted SMR is the ratio of the observed number of deaths in the population against the expected number of deaths predicted by PIM3. Control limits are displayed on the funnel plots; variation within these limits is termed common-cause variation; variation outside of these limits is special-cause variation. Points above the upper control limit indicate higher than normal mortality; highlighting the need for further investigation into the mortality rate.

The chart below is taken from PICANet's most recent report, and shows the PICU SMRs by organisation with 99.9% control limits, 2016: PIM3 adjusted.



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

Conclusions

The HMRG is functioning well and is continuing to adapt and improve according to national recommendations. We continue to review every in-patient death in HMRG and the majority of deaths have at least one departmental/service group review in addition.

There is clearly considerable amount of work to be done to improve the process and increase engagement and communication across the Trust. Learning from deaths is the key goal and we are now trying to ensure that this occurs across the organisation.

The statistics relating to paediatric deaths are difficult as they are so many variables and different figures cover slightly different aspects.

The Trust that is the most comparable to AHCH is probably Birmingham children's Hospital NHS Foundation Trust and we are comparable to them with SPMI which is reassuring.

Alder Hey uses VLAD charts to monitor the trend in mortality in cardiac surgery; the latest chart shows observed mortality is lower than expected

mortality. All cardiac surgery patient deaths will be reviewed in the Cardiac M&M meetings and also the HMRG.

Reports have been produced to allow real time monitoring of mortality. Deaths will be analysed by year, ward, and specialty, deaths within 7 days, 30 days and over 30 days from admission. There are no current indications of patterns of concern.

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
2 October 2018

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Programme Director for Digital Kerry Morgan, GDE Risk and Benefits Lead
Action/Decision required	The Board is asked to note the updated progress of the Trusts GDE Programme the achievement of Milestone Four and the commencement of Milestone 5
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 Committee with an update on the progress of the Trusts Global Digital Exemplar (GDE) Programme; the achievement of Milestone Four and the commencement of Milestone 5.

2.0 Update of Progress

Since the previous update to the Committee on 25 July 2018 The Trust continues to show demonstrable progress against its GDE commitments. This progress brings with it the associated benefits of quality and patient care and taking both staff and patients on the digital journey experience. Recent GDE programme level achievements include:

- 3/7 funding milestones successfully met and funding made available
- Statement of planned benefits – highly commended
- Successful fast follower relationship
- Blueprinted our digital pathway approach
- Good support and clinical engagement across the Trust
- Effectively performing project and governance structure

Primary work has also included:

- Voice Recognition - open VR sessions held with clinicians as part of deployment work. Current system issues identified and plans in place to address
- Patient Portal - discussions held via Clinical Advisory Groups, good progress made with scope matrix based on clinical risks/benefits analysis
- PACS & Ologies - continued pre go-live and deployment work. 1 site now live
- e-Xchange - continued pre go-live and deployment work. 4 sites now live
- Bi-Directional Texting an Emailing of Letters – good go-live deployment work

During this reporting period the external assurance team were also given an insight into the impacts of milestone 4 deliverables on quality and patient care. There were visits to view the Rheumatology Speciality Package, hardware upgrades on Ward 3A along with Welch Allyn, the updated Electronic Whiteboards and Continuous Infusions in action.

These live demonstrations placed deliverables in a clear context for the assurance team who were given an opportunity for 'on the spot' discussions with a number of clinical staff to discuss their experiences of the systems being rolled out across the Trust. Feedback balanced, positive and demonstrated that the initiatives are led by clinicians with support from the informatics team.

3.0 Summary of Key Benefits

Category	Project	Aim	Measurement	Improvement	Current/Future
Safety	Community Matrons Specialty Package	Improve accessibility to Community Matrons clinical information. Move from EMIS to Hospital PAS system (Meditech)	Information stored in Meditech system.	Information now stored in Meditech; available to all clinicians	Current
Safety	Immunology & Infectious Diseases Specialty Package	Improve patient safety - timely administration of antibiotics following sepsis diagnosis	Percentage of patients receiving administration of antibiotics within 1 hour of diagnosis	Emergency Department: 25.6% in February 2017 to 57% in June 2018. Inpatients: 71% in September 2017 to 79% in June 2018.	Current
Safety/ Sustainability	Standard Documents Specialty Packages	Improve efficiency in clinics; increase patients seen in clinic	Shadowing; time savings in clinic and additional appointment slots	Respiratory specialist nurse; 30 min appointments reduced to 20. Urology consultant; 5 extra slots added per clinic.	Current
Safety/ Experience	Bronchiolitis Pathway Specialty Packages	Improve Patient Flow: Reduced length of stay for patients - Bronchiolitis	Length of stay	Length of stay has reduced from 3.6 to 3.1 days from 2016-17 and 2017-18.	Current
Experience	Bi-directional interface with kiosks in outpatients	Improve patient experience in booking in for outpatient appointments	Number outpatient appointments added on the day of appointment	2908 appointments added on the day were immediately available on the system in Feb-Jun 2018 improving patient experience	Current
Experience	PACs to Medical Photograph	Improve clinician experience	Number of requests for medical	50% increase in requests for medical	Current

Category	Project	Aim	Measurement	Improvement	Current/Future
	y		photography	photography	
Experience	Transition Specialty Package	Improve patient experience	Implementation of a visible and standard/structure process for transition	Standard visible process now in place for transition; will lead to an improvement in patient experience as clinicians are aware of the stage of transition a patient is at	Current
Experience	Specialty Packages	Improve user experience documenting/accessing clinical information	Survey: positive responses	83% positive responses during March 2018 for the Emergency Department	Current
Outcomes	Specialty Packages	Reduced variation in clinical practice	Number of pathways digitised	38 pathways developed	Current
Sustainability	Bi-directional texting	Improve efficiency in clinic; reduce DNA rates	DNA rate	Reduction of 1% Jan-Jun 2018 compared with Jan-Jun 2017.	Current
Sustainability	Bi-directional interface with kiosks in outpatients	Improve efficiency in booking in for outpatient appointments	Average time taken to add an outpatient appointment to the InTouch system.	Saving of 48.4 hours of time during Feb-Jun 2018 or £616	Current
Sustainability	Specialty Packages	Increased income from outpatient procedure coding	Actual income received above plan for outpatient procedures.	Increased income received of £394,387 during 2017-18.	Current
Sustainability	Specialty Packages	Increased income – Early Adopter site for the Emergency Care Data Set.	Income received for being an Early Adopter site.	£20,000 received for being an Early Adopter site.	Current
Sustainability	Bronchiolitis Pathway Specialty Packages	Improve patient flow: reduce length of stay	Average LOS – monitor usage of released bed days	Capacity released during 2017-18 enabled £312,000 of	Current

Category	Project	Aim	Measurement	Improvement	Current/Future
				additional activity to be undertaken	

5.0 Milestone Assurance

Planned assurance testing was undertaken on 25 July. It was reported there was a very high degree of confidence that Alder Hey will deliver to expectations, if not exceed them. The Trust's iterative approach taken in many of the initiatives, together with the proactive use of stakeholder reviews provided a high level of confidence.

4.0 Next deliverables

Work will now commence with the next tranche. By January 2019 Milestone 5 will deliver:

- Medical records electronic document production - patient summary report including 18 further specialities
- Observation device integration - Phillips
- Bedside medication verification - Pilot
- Review Paediatric Portal pilot
- Patient Portal phase one - Limited to complex patients
- Complete a total of 33 Speciality Package deployment
- GS1 Barcode deployment - Patient ID's & Pharmacy
- Deployment of MESH - National Requirement
- PDS Connectivity
- API/FHIR Interfacing - Wirral & Royal - Proof of concept

5.0 Recommendations

The Trust Board are asked note the progress of the Trusts GDE Programme; the finalisation of Milestone 4 commencement of Milestone 5.

Peter Young
Chief Information Officer

18 September 2018

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT **Site & Park Development**																									**SRO: David Powell** **Author: Sue Brown**
Programme 2018/19	**Apr-18**				**May-18**					**Jun-18**				**Jul-18**					**Aug-18**				**Sep-18**				
Week Commencing	**3**	**10**	**17**	**24**	**1**	**8**	**15**	**22**	**29**	**5**	**12**	**19**	**26**	**3**	**10**	**17**	**24**	**31**	**7**	**14**	**21**	**28**	**4**	**11**	**18**	**25**	
The Park																											Plans submitted for planning permission for the early reinstatement of the first phase of park near Oncology. Meetings continue with universities to consider the development of an outside research lab in Springfield park utilising the space and park users for environmental and health and well being research within university semester subjects. A recent friends of Springfeild park meeting was exceptionally well attended with a young person being voted as Vice Chair we are working hard to promote events and activites especially working in close collaboration with youth grouyps over the coming monthes. Further consultation is taking place for the design of the r-einstatement of the park . The team are arranging a Dragons den type of event in planning for the catering provision within the park of the future.
Future Site Development																											The residential scheme has been put on hold and the development team is exploring the full range of uses for the site and revisiting the DCP. Discussions are under way with the preferred partner secured through the OJEU process last year to explore uses other than residential including science, research and health and wellbeing.
New Schemes: Institute Phase II																											Building completion & handover on August 24th. University lease agreements to be signed by October3rd prior to any occupation. Furniture delivery commencied on 24th Sept together with minor works, AV installation in progress currently. Occupancy will commence from 3rd October and comnplete 21st October.
New Schemes:The Alder Centre																											Following the high cost within building tender returns; discussions and regular meetings have continued with architects AHMM and possible building partners to reduce building costs to match available funding. Design ready, site ready, but start of scheme on site delayed until final costs are fully covered. CIISC currently finalising its evaluation of costs and we are exprecting written confirmation that the building can be completed within the construction budget.
New Schemes: Community Cluster																											The Community Building and Dewi Jones Unit designs are held at stage 2 level whilst affordability is market tested following creeping building costs. The designs have all been well received by users, the parents and children's forum and the friends of Springfield park. Stage three will see the development of 1:50 room layouts and data sheets. Ground levels are being adjusted by demolition contractor in readiness for undercroft parking and commencement on site in spring of 2019
Site Clearance-Demolition Phase 1 & 2			**Completed**																								Programme progressed as plan and has completed on schedule. Additional work has been agreed within the budget to prepare land levels in preparation for the Alder centre, Community Cluster and temporary car park schemes. Next demolition phase not due to commence until 2019/20.
Site Clearance-relocation of on-site services/corporate teams																											The layout and occupancy of the Institute Phase 2 is agreed and all furniture and IT equipment ordered to allow successful agile working and accommodate staff numbers required. Following the Medical Records Review plans will be further discussed on the 26th September with the COO and service team. Plans have moved forward with a strong possibility of retaining the neuro building until 2020 this will mitigate the urgency to make a decision on the future location of medical records
Site Clearance: Temporary car park and new park phase 1																											Plans drawn up and planning submission submitted for temporary car park and new park phase 1. Land levels being reduced and prepared for car park under Community Cluster and temporary car park commencing 28th August
Community Sefton Services and CAMHS (Relocations)														**Completed**													Sefton Physio Services & CAHMS both moved into new lease premises on time and fully operational.

Alder Hey Children's NHS
NHS Foundation Trust

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

Present:	Anita Marsland	(Chair) Non-Executive Director
	Dame Jo Williams	Non-Executive Director
	Jeannie France-Hayhurst	Non-Executive Director
	Adam Bateman	Chief Operating Officer
	Steve Ryan	Interim Medical Director
	Cathy Umbers	Associate Director of Nursing & Governance
	Mags Barnaby	Interim Director of Strategy
	Tony Rigby	Deputy Director of Risk & Governance
	Erica Saunders	Director of Corporate Affairs
	Melissa Swindell	Director of HR
	Adrian Hughes	Director, Medicine Division
	Christian Duncan	Director, Surgical Division
	Rachel Greer	Associate Coo- Community Division
	Anne Hyson	Head of Quality - Medicine
	Sarah Stephenson	Head of Quality – Community Division
	Mark Flannagan	Director of Communications
	Stefan Verstraelen	Head of Quality, Surgery Division

In Attendance:

Natalie Deakin	Change Programme Manager
Sue Carter	Outpatient Operational Manager
Elaine Morgan	Head of Information & Clinical Coding
David Porter	Sepsis Lead Consultant
Glenna Smith	General Manager – Medicine
Jo Keward	Infection Control Nurse
Andy Darbyshire	Chair of Clinical Ethics Committee
Julie Creevy	Executive Assistant (Minutes)

18/19/061 Apologies:

Denise Boyle	Associate Chief Nurse, Surgery
Hilda Gwilliams	Chief Nurse
Mark Peers	Public Governor
Lachlan Stark	Head of Planning Performance
John Grinnell	Director of Finance
Pauline Brown	Director of Nursing
Steve Igoe	Non-Executive Director
Jacqui Ruddick	Head of Quality, Medicine Division
Matthew Peak	Director of Research
Cath McLaughlin	Director, Community Services Division
Julie Williams	Governor
Cathy Wardell	Associate Chief Nurse, Medicine
Jo McPartland	Consultant Paediatric Pathologist

18/19/62 Declaration of Interest
None declared

18/19/63 Minutes of the previous meeting held on 20th June 2018

Resolved:

CQAC approved the minutes of the previous meeting held on 20th June 2018.

18/19/64 Matters Arising and Action Log

18/19/43 – ART Business Case – Business Case is due for discussion at Exec Team meeting on 19th July 2018, prior to presenting to Investment Review Group. Further update to be received at CQAC in September 2018.

18/19/45 – Research – AM confirmed that a mtg had been scheduled for 24th July 2018, this item to be closed and removed from the log.

18/19/48 – CQC Action log – response to CQC will be submitted by 25th July 2018 , item to be removed from the action log.

18/19/49 – Quality metrics – work is ongoing with regards to quality metrics, update would be provided at September 2018 meeting.

18/19/65 Booking & Scheduling Update

AB presented an update on booking and scheduling which included the Brilliant Patient Booking Systems High level Plan which included key timescales for implementation; key issues as follows:-

- Operational Plan for 2018-2020 which included 5 improvement priorities, in order to provide a booking system that puts children and families first, and meets the need of clinicians that use it. In order to improve patient experience, reduce appointment cancellations, reduce the time from referral to first outpatient appointment, and improve clinician's experience of Trust systems.
- This will be achieved by capacity based booking system (Hybrid booking) Plan to complete by June 2019, E-booking and M-booking systems – plan to complete by December 2019 and 'My buddy' for patients with multiple appointments – plan to complete by June 2019).
- Digital approach will offer additional support to families allowing families to book an appointment via email.
- Admin support is required.
- Team are currently researching the market, and had been in liaison with colleagues from Milton Keynes in order to review a piece of kit, with the team at Alder Hey currently looking at bringing this piece of kit to Alder Hey.
- 25 Steps to Hybrid booking was noted.
- Next Steps for Hybrid booking implementation was noted.
- All referrals from GP's were now received electronically which had gone live during the last week.
- 3 Key risks to hybrid booking implementation were noted as follows:-

Risk: **-** Delay in recruitment could delay start of roll out plan
Mitigation Action: - Booking & Scheduling manager scoping various recruitment strategies to ensure roll out remained on track.

Risk: - Revised roll out plan based on capacity queues and hospital

cancellation could result in a negative impact on finances as the team had seen a number of blocked contracted specialties rise to the number with regards to priority.

Mitigation Action: - Potential for bi-directional texting to go live as a one off 'big bang' approach for all specialties to allow the back filling of short notice cancellations for all specialties to start as soon as recruitment is complete.

Risk – Lack of resource to clean data could result in a delay in roll out.

Mitigation Action: - Resource to assist with developing script to clean DNC lists and capacity queues agreed by GDE Programme Board.

Discussion took place regarding level of involvement with families. AB stated that the team are shortly to go live with updates for families. Dame Jo Williams stated the importance of regular communication updates to families and keeping families updated when appropriate.

AH highlighted the importance of capturing patient information feedback regarding patient preference i.e. – by text/phone comms etc.

AM thanked AB for his update.

Junior Doctor update

MS confirmed that the Sepsis E-Learning package had now been shared. James Ashton, Sepsis Nurse is in the process of testing and establishing reporting process. MS did not envisage any potential issues and stated that the system is now live for our staff, and live for Junior staff.
AM thanked MS for her update.

GDE Update

AH confirmed that he had attended a meeting with Nik Barnes on 13th July 2018, discussion had taken place regarding potential solution. Next version would be more flexible, however this would not be available until around 2 years' time. AH confirmed that there was a well-controlled sign off process at Alder Hey. There are improvements that could be made in the interim regarding cross cover function, the Trust have a pool team, in order to sign off results/investigations.
Team are working hard to ensure that this is not onerous for teams. With a plan to test with Rheumatology Team, prior to introducing to the wider group.
First meeting to progress issues further is scheduled in August. CQAC noted that this would take time to develop, and looked forward to receiving a further update at CQAC in September, once the meeting had taken place and testing with Rheumatology team had taken place.

18/19/66 18/19 Q1 Complaints Report & Annual PALS & Complaints Report

AH presented the Quarter 1 2018-2019 Complaints & PALS report, key issues as follows:-

Complaints:-

- The Trust received 32 formal complaints during the period. One complaint from this quarter was subsequently withdrawn from the Process by the Head of Quality.
- In 2017/18 Q1 the Trust received 18 formal complaints – this is therefore

an increase of 14 complaints received in Q1 2018-19.

- The main category of complaints received in this quarter are:-

- Access, Admission, Transfer, Discharge – 4 (13%)
- Consent, Communication, confidentiality – 3 (10%)
- Medication – 1 (3%)
- Staffing issues – 1 (3%)
- Treatment/Procedure – 22 (71%)

- Increase in complaints from MP's had been received, following recent high profile case.
- This quarter reviewing the main category in further detail, identified a shift from most of the complaints relating to questioning of medical management decision. There is now a greater mix including Nurse care, AHP care and additional other category types

  - Alleged Failure in Medical Care – 8
  - Alleged Failing in Nursing Care – 4
  - Operation – Adverse Outcome – 2
  - Operational Cancelled – 2
  - Alleged Failure in Care – AHP – 2
  - Operation (IP) Delay – 1
  - Diagnosis Delayed – 3

- In Quarter 1 all complaints were acknowledged within 2 days – 16% on the same day, all within target.
- There were no withdrawn complaints this month – one recorded as withdrawn on the system, but this is saved until parents want to respond back to the Trust for the Trust to progress further.
- AH stated that the team needed to consider how to report historical complaints : the Trust had recently received complaints dating back 34 years and 21 years ago. These will now be recorded in Ulysses as Out of Time complaints (OOT) in line with Complaints regulations 2009 that states a complaint relates to an incident or dissatisfaction that has occurred within the last 12 months. Alder Hey will however carefully consider all complaints received and investigate and feedback on a case by case basis. AH highlighted the time which is taken to investigate these complaints.
- 14 Complaints were upheld within this quarter, and 4 where not upheld. 1 complaint was partially upheld and 13 complaints are still ongoing.
- There are 4 second stage complaints and already have outcomes from the first stage. All complainants are fully updated regarding any delays in response timeframes.
- One contact from the Parliamentary & Health Service Ombudsman (PHSO), for this quarter – information had been sent and additional conversation with PHSO as this related to a very complex case – currently awaiting feedback from PHSO.

PALS

- In Quarter 1 2017-2018 PALS contacted received had reduced to 382. Within Quarter 1, however an additional 2236 concerned emails were received into the PALS inbox within a 2 week period, that had to be read and filed/archived as they also arrived in between concerns that required processing. The volume of

incoming emails was precedented, in addition to the hundreds of calls every day to the PALS team regarding the same high profile case.

- PALS concern are received in a variety of methods, phone call, email, written and face to face. Phone calls and face to face account for 63% of the contacts, whilst the written concerns account for 37%.
- PALS contacts received by Community Paediatrics within this quarter 69 – decreased from last month (99).
- The highest area of concern related to waiting time for appointments, with communication failure (medical) being the second highest category of concern.
- Key actions and lessons learnt from PALS during Quarter 2:-
  - Main issues identified within Quarter 1 related to appointments management – waiting times.
  - The specialities that have issues relating to these categories are:-
  - Waiting time for an appointment – Community Paeds, ENT, Opthalmology and Gastroenterology.
  - **Since Quarter 4 – concerns regarding cancellation of appointment** appears to have significantly reduced with only 24 people raising concerns, compared to 45 last quarter.
  - Further work is required to review these areas, and understand the root of the issues, and what actions could be implemented to reduce parents raising their concerns regarding appointments.
  - PALS and complaints are communicated and fed back to senior staff at the three Divisional integrated governance meetings in order to ensure appreciation of current trends are fully disseminated and actions can be taken to look at specific areas of concern.
  - Compliments are now recorded on the Ulysses system and shared with the relevant teams.
  - Zero complaints had been recorded this quarter on Ulysses.

AM thanked AH for her update.

Complaints & Annual Report

CQAC received and noted the contents of the Complaints and PALS Annual Report for 2017/18.

AM thanked AH for her update.

18/19/67 Programme Assurance – introducing the Delivery Management Office

N Deakin, Change Programme Manager presented the Evolution, Role and Vision of the Delivery Management Office (DMO), Key issues as follows:-

- Vision to create a project culture where project management is a valued competency embedded within the organisation and where product leaders and their teams embrace the project management processes to ensure the best possible chance of project success and delivery.
- ND shared the Strategy detail.
- Project initiation overview documentation had been established to demonstrate to Programme Board that appropriate teams are in place, and that a specific project is ready to be launched. DMO team are working with IT in order to display 'live' benefits and measures.
- A 5 week course 'Journey to Project Island' had been established, the 1 hour course held during lunchtime is a fun and interactive course for staff. Week 1 – Project Initiation led by DMO Leaders, Week 2 - Milestones & Benefits

Led by Kerry Turner, Week 3 – Communication, Engagement, EA and QIA led by Kerry Turner & Hannah Ainsworth, Week 4 – Risk & Issues led by Cathy Umbers, Week 5 – Engagement Question and Answers, enabling staff to raise any questions or concerns.

MS queried how the DMO were aligning the change programme with LIA and highlighted the importance of ensuring all staff are clear regarding the framework/fundamentals of the 7 step LIA methodology.

SV queried whether there was a visible database/log detailing small projects that were in process, or had been completed. in order to reduce any duplication when undertaking projects, ND agreed this was a sensible proactive approach and that she would follow this up.

CQAC welcomed the DMO update and looked forward to receiving further updates in due course.

AM thanked ND for her update.

18/19/68 Outpatients Programme Update

Sue Carter & Elaine Morgan presented the Outpatient Programme Update. Key issues as follows:-

SC & EM had been reviewing a number of projects in order to make improvements within OPD, to realise opportunities, key issues as follows:-

- Make better use of clinic schedules, as clinic schedules are not currently utilised as well as they could be – improved utilisation of rooms to 90% - potential to achieve (£900K).
- Review of clinic templates (move to standard/4 hour templates) – Potential to achieve - (£1.3M) – currently working with teams to develop standards and examine the detail.
- Improve recording of Out Patient procedures in clinic – potential to achieve (£400K).
- Ensure recording of ward based outpatient is consistent – potential to achieve (£335K).

Deliver Outstanding Care in patients

- Increase in Patient and Families Experience in Outpatients
- Improvement in Clinicians experience of Outpatients.
- Increase Clinic Utilisation in Outpatients
- Reduction in missing Outcome Forms in Outpatients – Patient Pathway Forms (e-PPF).

- Pilot – Clinic Co-ordinator – a Pilot over 2 days in G3 had recently been held which involved 25 clinical staff, with 2 clinic co-ordinators managing 8 rooms each. Trial of the e-PPF via InTouch with 3 Clinicians.
- All clinician's, with the exception of 2 clinicians were happy to use Intouch to manage their patient flow. 100% completion of all e-PPF's. Intouch Patient Pathway forms were the most efficient way to collect and action the appointment Outcome, for the clinicians and reception teams.
- Positive experience for all within the clinic.

- A further pilot would be held week commencing 23rd July 2018 on a different floor.

Recommendations

- Re-training programme on Intouch for all clinical teams working with OPD.
- Introduce a full bespoke training package for all future clinical staff working within OPD.
- Dedicated clinic co-ordinators managing clinics.
- Outcome forms (e-PPF's) move to Intouch.

MB queried the timeline for completion, SC confirmed that the timeline for completion is March 2019. MB queried whether community/mental health therapies were included within the project. SC confirmed that they were not included and that she & EM could follow this up with Divisional leads to progress further.

CQAC received and noted the Outpatient update and look forward to receiving further updates as appropriate.

JFH stated that this was a significant achievement and applauded the service and queried whether a similar approach could be adopted across further services.

AM thanked SC & EM for the Outpatient update.

18/19/69 Art Business Case Update

CU confirmed that this item was due to be presented and discussed at Exec Team meeting on 19th July 2018, following presentation at Exec Team meeting, the Business Case would be discussed at Investment Report Group. CQAC deferred a full update until September 2018 CQAC meeting.
AM thanked CU for her update**.**

18/19/70 Sepsis Update

D Porter & G Smith presented the Sepsis update, key issues as follows:-
Time to antibiotics:-

- ED mean time 59.2 minutes (median 56.5 minutes, n=60)
- Inpatients mean time – 55.4 minutes – (median 24 minutes, n=19)
- 60 mins to antibiotics

- In depth case review session
- Clinically-led session in July/August (Medicine, surgery, sepsis team, ED)
- Cases >90mins from diagnosis to antibiotics
- Varied locations & specialities
- More detailed assessment of causes
  - Sub-categories of cause where possible
  - Proportion where clinical justification
  - Suggested actions
- Aim for report in Sept 2018 CQAC meeting

Key issues: progress

- IT/Informatics

- Sepsis status development to continue for ED

- eLearning
  - Live on ESR. 90% compliance target of September
  - Accessible from Whiston – working on reports/matrix
- 128 staff trained to date
- Good numbers especially ED, 3C and 3B
- 8 medical staff
- CQUINs
  - Proposals provisionally accepted
- Replacement of NEWS2 with nursing concern (PEWS & NICE sepsis risk) *or* doctor concern

- DETECT/VitalPAC
  - Collaboration agreement
  - Phase I Dec 2018 / Phase II (full implementation) approximately Sept 2019
- Community & PICU
  - Face to face training sessions since mid-April 2018
  - Community Paeds: 109 trained (out of estimated 217)
  - PICU 107 trained (out of estimated 247) since March (training previously delivered within unit)

AM thanked DP & GS for the update.

18/19/71 CQC Action Plan Update

CU confirmed that the majority of the outstanding actions from the CQC action log from 2017 had been completed, with only 8 outstanding actions. The outstanding actions were discussed at Integrated Governance Committee meeting on 11th July 2018, 2 of those actions would be completed by the end of July 2018, which related to action 7 and action 10, with the remaining 5 actions being ongoing, and these actions would be tracked through relevant committees. Plan is to close down actions from 2017 and advise CQC accordingly. Following the publication of the CQC report in June 2018, A new action plan would be submitted to CQC by 25th July following the recent CQC recent inspection, the new action plan would be presented on a monthly basis at CQAC meetings from September 2018 onwards. There were some gaps regarding Ward co-ordinators – which would be followed up by nursing workforce remit. Cancelled operations would be tracked via the change programme.

Action: Receive CQC action plan at September CQAC meeting, receive and monitor action plan on a monthly basis thereafter.

AM thanked CU & ES for update.

18/19/72 Corporate Report – Quality metrics

CU presented the Corporate Report Quality metrics, key issues as follows:-

- **Patient Safety** – There was 1 pressure ulcer (Grade 3 and above), zero never events. There were 2 Medication errors resulting in harm, compared to 4 in the previous month. There were zero clinical incidents resulting in severe, permanent harm.

- **Patient Experience** – Friends & Family tests are ongoing, results from May 2018 are detailed as follows:-

- 96.5% Friends & Family Inpatients recommend the Trust
- 88.6% Friends & Family Outpatients recommend the Trust
- 82.6% Friends & Family A&E recommend the Trust
- 82.6% Friends & Family Mental Health recommend the Trust
- 96.8% Friends & Family Community recommend the Trust – scores were reviewed during the move from 3TC to Burlington house, therefore scores reflective – currently reviewing responses.

Responsive

- IP Survey 91.6% - Received information enabling choices about their care.
- 98.8% responded stating they had been treated with respect
- 76.1% Know their planned date of discharge
- 90.9% Know who is in charge of their care
- 77.8% Patients involved in play and learning

CU confirmed that the Safer Bundle would address some of the above issues.

- **Clinical Effectiveness** –There were zero Hospital Acquired infections – MRSA (BSI), there were zero C difficilie. There was 1 Hospital acquired MSSA. A panel meeting had been held and learning would be monitored. The was zero children that had suffered avoidable death. There had been 2 Central Line Associated Blood Stream infections (CLABSI) ICU only in May 2018. There was 1.2% readmission to PICU within 48 hours during May 2018, compared to 3.6% in April 2018.

  CU confirmed that incidents resulting in minor harm and above are monitored, and that the Heads of Quality are producing monthly reports to review initial risk scores. Further work is required regarding working with staff, to help staff fully understand incident reports and levels of harm. Further work is also required in order to ensure reports are fully robustly completed within the action section contained within the reports.

  AM queried whether the new Quality Metrics format was helpful and whether it addressed key information required. CQAC members were all in agreement that the improved format was appropriate and well received.

  AM thanked CU for her update.

18/19/73 DIPC Report

JK presented the DIPC report from 1st April 2018 – 30th June 2018).

Key issues as follows:-
The work plan for 2017/18 consists of 14 objectives and a total of 118 deliverables. At the end of Quarter 1, 59% (70/118) of the total of deliverables had been completed. 25% (29/118) of the total deliverables are in progress. 16% (19/118 are classified as outstanding/red.)
CQAC received an update regarding the 19 outstanding items.

Hospital acquired bacteraemia for Quarter 1
MRSA – 0
MSSA – 1 (3A)
E-Coli – 1 (3B)
Klebsiella 1 (HDU)

Pseudomonas 1 (PICU)
C Diff – 0
Outbreaks – O

MS referred IPC team to link in with Darren Shaw, e-learning manage in order to explore national agreed modules to review what is available nationally. MF referred IPC team to link with comms team in order to address signage issue.

CQAC received and noted the DIPC report.

AM thanked JK for her update.

18/19/74 Board Assurance Framework

CU presented the Board Assurance Framework. CQAC noted that the Executive Team had undertaken a refresh of the corporate report to ensure smarter content, which would be closely aligned to the strategic objectives within the corporate risk register. 1 change had been made to a building risk which had been escalated from moderate to high, which had been discussed at Trust Board meeting on 3rd July 2018.

HG/CU/Governance team had reflected on the current risk relating to BAF 1.1. 'Not having sufficiently robust, clear governance systems and processes and people in place supported by the expected culture and values that underpin learning and improvements'. CQAC noted the actions required to reduce risk to target rating.

BAF 1.2 – 'Failure to meet targets and internal performance metrics due to poor flow and lack of capacity to fulfil activity plans and respond to increasing demand.

As at June 2018 All external mandatory targets met, focus required to ensure elective programme remains on track given demand pressures.

CQAC noted the actions required to reduce risk to target rating.

BAF 1.3 – 'Sale of PFI Project Co, whilst a number of commissioning risks are still present could lead to a lack of focus and problems in maintaining safe environment'. This risk was being well managed. A consolidated report is in production, review meeting with Project Co and refresh of the action plan. Outcome to be reported on 24th July 2018.

Dame JW queried whether there was any update regarding pipework included within the business risk. AB confirmed that the Trust is in dialogue with them and the company are sharing engineering reports with our team.

18/19/75 Clinical Ethics Annual Report

AD presented the Clinical Ethics Annual Report.
Key issues as follows:-

- Clinical Ethics Committee had been established since 2011, under the leadership of Paul Baines in his capacity of Chair of Clincial Ethics Committee, PB retired in September 2017. Clinical Ethics Committee

comprises of 13 people, ranging from clinical representation, internal/external representation/lay member, who participate on a voluntary non/ funded basis.

- Currently the position of chair is resourced and paid at 4 hours per week. There had been access to funding for education and training.
- Principle functions of Clinical Ethics Committee

- Case consultation for individual medical consultants or clinical teams facing ethical dilemma's in relation to the care of treatment of a patient. Parent/patients will be informed ethical advice is being sought.
- Develop and promote education and training about clinical ethics within the Trust.
- Provide advice and guidance on clinical ethical issues to CQAC/Trust Board and Directorates/ in the development of standards and policies.
- Clinical Ethics Committee meet on a monthly basis (1st Wednesday of the month) during the last 12 months 4 meetings had been held.
- Preliminary discussion with Medical Director had taken place regarding ethical aspects of changing from biomass fuels to conventional fossil fuel.
- 3 cases had been discussed.
- A high profile media case in July 2017 – meeting held with parents with parents accompanied by legal representation – Trust provided advice, which was not different to advice provided by high courts.
- Sickle cell disease and non medical circumcision – at August 2017 meeting – Clinical Ethics could not justify the reasons being expressed by family to undertake surgery – no surgery was provided.
- 'Compassionate' use of unlicensed drugs – March 2018 - discussion took place regarding ethical issues surrounding a Phase 3 trial - Clinical Ethics requested further Discussion with Research Ethics team.

Challenges:-

- Change of leadership.
- Access to administrative support – which is currently organised and administered by the Chair of Clinical Ethics Committee.
- Training & education – courses are expensive and run on an annual basis
- Recruitment to group – Finding a balance between inclusivity/diversity/skills and effective functioning of the group.
- Confidentiality and sharing patient sensitive information with non-trust members – ES highlighted the need to link in with Caldicott Guardian/Jo Fitzpatrick re information governance issues.
- Resources – travel expenses/training cost – given there is no set budget for activity, although this has been funded by Trust board budget.
- Improving the profile of clinical ethics support within the Trust – lack of referrals reflective of the lack of profile and how to improve awareness and utilisation of the group.
- Improving the education aspects of the group activity.
- Hoping to plan a study day, however no resource at present.

- Currently unable to provide the ethical advice and guidance for standards and policy – need for identifiable resources to manage a more structured work plan for the group, whilst imposing further work on a volunteer workforce.

Future activity:-

- Hold a Trust study day regarding clinical ethics.
- Improve links within the NW UKCEN – including further exploration of links with LWH/GOSH.
- Provide support for increasing moral distress amongst Trust Workforce.
- Opportunity to have the ethics forum for wider discussion or moral dilemma's for all to attend.
- Schwartz rounds for individual clinician supervision and support.
- CESG for advice and support for individual cases.
- Explore the position of clinical ethics within a Trust process for dealing with cases such as the recent high profile case. In cases when parental opinion remains at odds with clinical opinion:-

- Parental opinion differs from medical opinion despite attempts to resolve and is not deemed to be in patients best interests – whether the Trust should seek 2nd opinion much earlier, then to progress to Clinical Ethics Best Interest discussion.
- Having a more diverse/inclusive ethics group would improve the ability to 'test' the moral validity of any clinical ethics support offered.

Discussion took place regarding the requirement for funding to support the Clinical Ethics Support Group. SR stated that a Business Case would need to be completed in order to outline requirements of support needed.

Discussion took place regarding admin support required for upcoming meetings prior to any business case being presented to Investment Review Group. MB queried whether Divisional PA's could each support a meeting each in the interim, MS confirmed that this did not sound too onerous. ES highlighted the importance of the right person, who fully understands the remit of Clinical Ethics/discussion matter attending the meeting, and the need to ensure consistency to support the Clinical Ethics Support Group.

MS offered support from Education Team and urged AD to link in with Catherine Kilcoyne for any support regarding training/study day and advised that Jo Pottier would support the team in terms of the Schwartz rounds

Action: ES/HG/PB to meet to discuss sharing sensitive information for Clinical Ethics Committee members.

Action: AD/SR & ES to meet to discuss clinical ethics admin requirements, - meeting to be diarised.

AM thanked AD for his update.

18/19/76 Clinical Quality Steering Group key issues report

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

- SIRI action log – Surgery currently had 9 current action plans in place and Medicine 5, with none in Community. In month there had been 3 new actions plans added in Surgery and 1 in Medicine and none in Community. Surgery and Medicine divisions had overdue actions.
- Monthly SIRI meetings continue with all Divisions to ensure improved compliance.
- EDS Goals 1 & 2 Summary report was agreed by CQSG. The Trust is working collaboratively with other Trusts, good progress had been made.
- Duty of Candour policy had been approved at Integrated Governance Committee on 11th July 2018. Non Medical Prescribing Policy was approved and had been through CDEG with some focus on AHP prescribing needing to be inputted to the policy in the near future.
- Divisional Quality Dashboards were discussed/noted at CQSG on 12th June 2018, some discrepancies in statistics within reports, therefore Business Intelligence Team are reviewing this further.

AM thanked CU for her update.

18/19/77 Any other business

JFH queried how eco friendly the Trust was. MF agreed to explore NHS Sustainability Plan.
Action: MF to explore NHS Sustainability plan.

18/19/78 Date and Time of Next meeting -

10.00 am – Wednesday 19th September 2018, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE
11th July 2018
Time: 10:00-12:00
Venue: Institute in the Park, Large Meeting Room

Present:

Mr S Igoe	Non-Executive Director **(Chair)**	(SI)
Mr J Grinnell	Director of Finance	(JG)
Mr S Ryan	Medical Director	(SR)
Mrs M Swindell	Director of HR & OD	(MS)
Mr P O'Connor	Deputy Director of Nursing	(PO)

In Attendance:

Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Miss L Calder	Quality Assurance Facilitator (Minutes)	(LC)
Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Ms K Morgan	Deputy Head of Information	(KM)
Mr G Dixon	Operational Lead (Building Services)	(GD)
Ms S Stephenson	Head of Quality (Community)	(SS)
Mrs C Barker	Chief Pharmacist	(CB)
Mr S Verstraelen	Head of Quality (Surgery)	(SV)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mrs J Ruddick	Head of Quality (Medicine)	(JR)
Miss G Smith	General Manager (Medicine)	(GS)
Mr D Reilly	Dept Head of Clinical Systems (IM&T)	(DR)
Ms J Noblett	Clinical Lead for EPRR	(JN)
Mrs C Orton	Assoc. Chief Operating Officer (Research)	(CO)
Mrs P Clements	Theatre Matron	(PC)

Apologies:

Mrs H Gwilliams	Chief Nurse	(HG)
Mrs V Weston	Infection Control & Prevention	(VW)
Mrs D Walker	Head of Pharmacy	(DW)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Mrs R Douglas	Assoc. Chief Nurse Community	(RD)
Ms E Saunders	Director of Corporate Affairs	(ES)
Mr A Bateman	Chief of Operations	(AB)
Mr D Powell	Development Director	(DP)
Mrs P Brown	Director of Nursing	(PB)
Mrs R Greer	Assoc. Chief of Operations (Community)	(RG)
Mrs S Owen	Head of Human Resources	(SO)
Ms J Gwilliams	Clinical Risk Manager	(JG)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mrs L Robinson	Quality Assur & Compliance Manager	(LR)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Mrs J Hutfield	Compliance, Risk & Contracts Manager	(JH)
Mr A Hughes	Director of Medicine Division	(AH)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Mr M Flannagan	Director of Communications	(MF)
Mrs C Liddy	Deputy Director of Finance	(CL)
Mr J Williams	Head of Estates and Capital Planning	(JW)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
18/19/01	**2.**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 24th May 2018. The Committee **APPROVED** the minutes as a correct record.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 24th May 2018.		SI/CU	
	3.	**Risk Register Management Reviews**				
18/19/27	**3.1**	**Surgery Division**	Stefan Verstraelen (SV) presented the risk management report for Surgery. SV focused on the high risks from the Surgical Division for this reporting period. Risks from the Surgical Divisions report were highlighted as follows: • Total number of risks = 69 • Number of new risks identified since the last reporting period = 3 • Number of risks closed and removed from the risk register =7 • Number of risks with an overdue review date = 30 • Number of risks with no agreed action plan = 6 • Number of high/extreme risks escalated to the Executive Team = 2		AM	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			There are 2 high risks with a score of 15: Risk 424 – risk of transmission of vCJD – The implementation date has been pushed back to 2nd week in July 2018 to ensure all correct instruments have arrived before this goes live, awaiting 5% of the instruments. The risk will continue to be monitored in line with policy until the issues have been resolved and the risk is eliminated. . Risk 1634 – Lack of portable IM&T equipment on 4A – Plan in place to mitigate. JG questioned if risks 1305/1308/964 patient access & cancellations, should this be a collective risk throughout the trust? CU advised that surgery/medicine/community should be working together to ensure no duplicated of risks are added to the risk register. Each risk should only be entered once onto the register. However if the issues identified show there are risks specific to individual areas then those risks need to be assessed and added to the relevant registers. SV advised the committee that they have a risk summit (risk purge) day booked within the division to look at all risks and to ensure they are at the correct risk rating. This will be led by the Division COO, associate chief nurse and the head of Quality. The team will meet with individual risk owners and managers to ensure that risk is being managed effectively going forward and that staff understand their responsibilities and accountabilities. In addition the Governance Team has put on additional Risk Management Training Sessions for more staff to be trained in risk management. SV advised the committee that although there is ongoing work required, the division are comfortable with the progress to date. SI advised the planned 'purge process' is a helpful initiative, and for other divisions to consider adopting similar processes and to update	Divisions to work together on collective risks (Heads of Quality) Divisions to feedback to IGC on progress with the purge process.	AM	Immediate

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			the committee at IGC on 12th September with progress. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/28	**3.2**	**Medical Division**	Jacquie Ruddick (JR) presented the risk management report for Medicine. Risks from the report were highlighted as follows: • Total number of risks = 116 • Number of new risks identified since the last reporting period = 3 • Number of risks closed and removed from the risk register = 15 • Number of risks with an overdue review date = 23 (20%) • Number of risks with no agreed action plan = 12 (9%) • Number of high/extreme risks escalated to the Executive Team = 1 JR focused on the high risks from the Medical Division for this reporting period. Risk no 1169 score 20 – Fragile medical workforce within the Haematology Service – Inability to run complex and acute care within the trust due to insufficient clinical cover caused by sickness or gaps in service. One consultant is on sick leave. One has just returned from sick leave, however will be going off on maternity leave. Single handed consultant covering the service was on annual leave for four weeks and had no consultant cover for June 2018. Glenna Smith (GS) advised a retired consultant from Royal Manchester Children's Hospital has been providing cover and this agreement is to be reviewed in September 2018. The recruitment advert that went out for a Consultant Haematologist was unsuccessful as no candidates applied. We have approached external recruiting agencies without	SR/GS/JR to document arrangement with Birmingham Children's	WW/CW	Immediate

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			success. Consultant Haematologists are hard to find. SR has spoken to Birmingham Children's hospital who has agreed to provide support as a backup if needed. GS is to meet with Manchester Children's Hospital in a few weeks for them to also provide support. SI also advised to have the reciprocal arrangement agreed documented with Birmingham Children's Hospital. Manchester is considered a much safer option as its closer to Alder Hey. JR advised the medicine division has been reviewing their risks to ensure they sit with the right owner and are being managed effectively. GS advised there are challenges within the division and we have will be on track within the next two months. JR advised the committee that the Medical Division are satisfied with progress, while recognising that ongoing work is required to enable assurance of effective management of risk across the division. **Resolved** that: the Committee NOTED the contents of the paper	Hospital.		
18/19/29	**3.3**	**Community Division**	SS presented the risk management report for Community. Risks from the report were highlighted as follows: • Total number of risks = 55 • Number of new risks identified since the last reporting period = 7 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 16 • Number of risks with no agreed action plan = 6 • Number of high/extreme risks escalated to the Executive Team = 1		RG/SS	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrate Governance Committee = 0 SS presented the risk management report and focused on the high risks identified for community. Risk 1524 – Lack of appropriate services to transition patients with ADHD. Risk of harm due to inappropriate care or advice provided to patients by paediatricians with lack of clinical knowledge about this age group. There are between 600-700 patients waiting to be transferred to adult services. There have been discussions around the shared care with GP's, however we are still looking for a resolution. The CCG are well sighted on the situation as the division has been working closely with them to address the problem. SS advised the committee that the division are confident they are keeping on top of all risks in terms of effective management. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/30	**3.4**	**Infection Control Service**	SR presented the risk management report for Infection Prevention Control. Risks from the report were highlighted as follows: • Total number of risks = 13 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 3 • Number of risks with an overdue review date = 1 • Number of risks with no agreed action plan = 0 • Number of high/extreme risks escalated to the Executive Team = 1		VW/JK	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			• Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrate Governance Committee = 0. Risk no 795 risk score 16 – Water Safety on CHP/Retained Estate (Legionella etc.). Trust should encourage further water usage across the Trust and increase flushing. The Water Safety Group has agreed to outsource help/advice for ADIPC on water safety. The Trust know what the risk is and it is being managed through filters fitted on the system and is being actively monitored and controlled. MS advised the Health & Safety team have demonstrated a lot of work is being completed to ensure mitigations are in place. Adam Bateman is leading on this and will liaise with AK to feed back to IGC in September 2018. SR advised the committee that although there is ongoing work required, the Infection Control team are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	AK to provide an update at next IGC Sept 18		Sept 18
18/19/31	**3.5**	**Facilities**	MD presented the risk management report for Facilities. Risks from the report were highlighted as follows: Total no of risks 7, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). MD advised the committee that there are no further developments to report for Facilities and he is satisfied with their progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		MD	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/32	**3.6**	**IM&T**	David Reilly (DR) presented the risk management report for IM&T. Risks from the report were highlighted as follows: Total no of risks 23, new risks since last report 3, risk closed and removed 4, risks overdue 4, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 1 (high risks). Risk no 1210 score 16 – Failure of data migration of legacy patient Pathology results and reports from meditech 5 to meditech 6 resulting in loss of patient data prior to June 2015. This is historical data not the current system and the functionality is not good however mitigations are in place to minimise the risk. DR advised that IT have a new plan and agreement in place which will enable IT to show risks are being managed and reduced consistently going forward. DR advised the committee that although there is ongoing work required, the IM&T are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		PY/LF	
18/19/33	**3.7**	**HR**	MS presented the risk management report for HR. Risks from the report were highlighted as follows: Total no of risks 4, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). MS advised the committee that HR have no new risks to escalate and they are on top of their risks and their current position is showing assurances are in place.		MS	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
18/19/34	**3.8**	**Finance**	JG presented the risk management report for Finance. Risks from the report were highlighted as follows: There are 5 risks identified on the finance risk register. 0 new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). JG advised the committee that Finance have no new risks identified and there are no risks out of review date or overdue. JG advised the committee that the Finance department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		JG	
18/19/35	**3.9**	**Estates**	Graeme Dixon (GD) presented narrative on the risk management report for **Estates** in the absence of representative from the team. Risks from the report were highlighted as follows: Total no of risks 22, new risks since last report 1, risk closed and removed 5, risks with a reduced risk score 7, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 1529 – Alarm panel showing disablement - Risk 1530 – Maintenance Records inaccurate and lacking in detail. Risk 1549 – Flammable store in very close proximity to the medical gas storage (Helium, Nitrogen and CO2) and the liquid o2 storage units.		DP/JW/SB	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/36		**Building Services**	Risk 1409 score 16 – Fire break glass - New Hospital. The fire safety officer John Spark (JS) to confirm if this remedial work has been completed once confirmed can be closed. In May 2018 100% of the Risks were reviewed and only 30% reviewed in June 2018, the reason for this was 70% of the risks were Fire Related these risks are being systematically reviewed. During this review period it has been identified that there should be a change of Risk Owner and Risk Manager for these risks and this is now being addressed. The majority of these risks will be managed by the Business Services Team in that teams risk management report SI advised Estates team to provide a clear outcome of where they are up to with outstanding risks and update IGC September 2018. **Resolved** that: the Committee NOTED the contents of the paper GD presented the risk management report for **Building Services**. Risks from the report were highlighted as follows: Risks on register for Building services. There are 12 risks identified - new risks since last report 1, risk closed and removed 1, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 2 (high risks). Risk no 1388 – (Score 20) – Pipe Corrosion. To date there are now confirmed 46 pin holes since occupation of CHP. Increased frequency of burst and subsequent issues has led to the risk being increased. David Powell to meet with the specialist consultant appointed by SPV. The pipe corrosion was discussed and minuted	Risk 1409 JS to confirm if works completed. JH/JW to provide clear outcome of where risks are up to.		Sept 18 Sept 18

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			at the recent Liaison Committee Meeting and will be taken to the next (RABD) Resource and Business Development Committee. Further mitigations are needed. GD to provide an update at the next IGC in September 2018. Risk no 825 – (Score 15) – Internal Balconies. On the horizontal handrail there is potential for climbing, resulting in the risk of potential fall from the balcony. The Trust are in talks with companies to look at the glass balustrades and removal of the handrails. The design of the glass balustrades didn't need the addition of handrails in situ. If the handrails are taken away this will remove the risk. Howard Davies 9Health and Safety) and Amanda Kinsella have reviewed the legislation which states there is no requirement for the handrails. JG advised could he and MS see the piece of work and email trail around the legislation and for this to be taken to the Exec Meeting. Report back to next IGC GD advised the committee that although there is ongoing work required, Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	GD to provide further update GD to send JG/MS email trail in relation to legislation		Sept 18 Immediate

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/37		**Development Directorate Projects**	Graeme Dixon presented narrative on the risk management report for **Development Directorate Projects** in the absence of representative from the team. Risks from the report were highlighted as follows: Risks on register for Development Directorate. There are 22 risks identified - new risks since last report 0, risk closed and removed 1, risks overdue 6, no of risks with no agreed action plan 3 (team to address), high risks need escalating to execs for their support 0 (high risks). GD advised the Development Directive reported there are financial implications due to the potential short fall in income to complete the Institute in the Park Building (phase 2). If the Universities do not sign the contracts this could have an impact on the overall estate strategy and the retained estate re-provision. GD advised this risk is relatively low and just needs finalisation. **Resolved** that: the Committee NOTED the contents of the paper		DP/JW/SB	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/38	**3.10**	**Health & Safety**	MS presented the risk management report for Health & Safety. Risks from the report were highlighted as follows: Total no of risks = 7, new risks since last report = 0 Risk closed and removed = 0. Risks with an overdue date = 0, No of risks with no agreed action plan = 0, No of high risks need escalating to execs for their support = 0 (high risks) Changes in the risk profile or categories in risk being reported that need to be brought to the attention of the Integrated Governance Committee = 1 MS advised risk 799 – Failure to control contractors. Works have proceeded on site without notification to H&S/Estates. MS advised the committee that she needs to speak to AK as this risk has been increased to a risk score of 16. MS advised AK will update IGC in September 2018 MS advised the committee that Health & Safety are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	AK to provide update on risk 799 at IGC Sept 18.	MS	Sept 18
18/19/39 **18/19/40**	**3.11**	**Business Preparedness & Associated reports**	CU presented the Business Preparedness & Associated reports. Risks from the risk management report were highlighted as follows: Total no of risks 15, new risks since last report 2, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk no 1376 score 12 – It was agreed that the CBRNE/HAZMAT training compliance report would be submitted to each IGC meeting		MS	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			until there is assurance that the Emergency Dept. staff are up to date with their training. Since the last IGC in May the staff training records have improved increase of 6.25%. The letter from Steve Ryan and Hilda Gwilliams to staff saying it is compulsory to attend the CBRNE/HAZMAT training has helped. Jo Noblett (JN) advised that ED Reception staff received ED specific EPRR training. 20 out of 21 reception staff attended the training over a 4 week period showing they are 95% compliant. New ED staffs are currently being recruited and another session will be delivered when the staffs are in post. CU is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/41	**3.12**	**Information Governance**	CU presented the risk management report for Information Governance. Risks from the report were highlighted as follows: Total no of risks 7, new risks since last report 0, risk closed and removed 2, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). CU advised that the new Information Governance Manager Joanne Fitzpatrick started this week and will submit the reports to the IGC meetings going forward. CU advised there has been no change since the last reporting period. The outstanding updates will be completed over the next few weeks. **Resolved** that: the Committee NOTED the contents of the paper		ES	
18/19/42		**Medicines Management & Pharmacy**	CB presented the risk management report for Medicines Management & Pharmacy. Risks from the report were highlighted as follows:		CB	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Total no of risks 28, new risks since last report 0, risk closed and removed 2, risks overdue 1 (10/06/18), no of risks with no agreed action plan = Unable to report due to current limitations of reporting system, high risks need escalating to execs for their support 0 (high risks). Risk no 1344 – Pharmacy and ASU cold stores failure. Funding of £55K secured via Capital Projects Group has been agreed at the Capital Projects Group and awaiting final system recommendation and implementation from manufacturer and Interserve. There is still no confirmation of timelines for fitting secondary backup refrigeration system. Risk no 944 – Trust security access to the laboratory – CB advised it is currently being considered which Trust staff members should have access.Inadequate security within pharmacy raises questions around the security of medicines. CB advised there is a meeting in the diary with AB to discuss and will feedback to C Gildea in Building Services. CB advised the committee she is satisfied with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/43		**Global Digital Excellence Programme**	KM presented the risk management report for Global Digital Excellence Programme reports. Risks from the report were highlighted as follows: Total no of risks 17, new risks since last report 2, risk closed and removed 6, risks overdue 2, no of risks with no agreed action plan 1 (mitigations in place), high risks need escalating to execs for their support 1 (high risks). Changes in the risk profile of categories of risk being reported that need to be brought to the attention of the		KM	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Integrated Governance Committee = 1 has increased to a score of 15. Risk no 1621 Score 15 – Patient records stored using two methods paper and digitally. There is a patient safety risk if patient information is not accessed. At the moment the clinicians have two places to look for information. As each specialty package goes live there has been communications to users via GDE newsletter and discrete communications. There is a timeframe of 3 years to ensure all digitisation of information is complete. Once all digitisation has been completed this will reduce the risk. KM advised that the overdue risks have been added by another trust member which KM will look into and update IGC September 2018. KM advised the committee GDE have some work to complete however happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper	Overdue risks KM to update IGC Sept 18		Sept 18
18/19/44		**Clinical Research Division**	CO presented the risk management report for Clinical Research Division. Risks from the report were highlighted as follows: Total no of risks 6, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Changes in risk profile or categories of risk being reported t need to be brought to attention of IGC = 0 CO advised that the Divisional Director Matthew Peak is taking 3 corporate risks to the Exec Meeting on 12th July 18 to ask for them to be moved to the Board Assurance Framework (BAF). The rest of the risks are to be managed through the division, these we can action and mitigate. We now have in the diary a monthly meeting within the			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			division to discuss all risks on our risk register. We are going to design a user guide for the research staff to understand which risks are to be added as the research risks are different to the Trust risks. CO advised now we have an understanding of what we should be reporting we can educate staff. CO advised it would be good if at the Exec Meeting they can Identify risks for the BAF and separate research risks from Innovation and Education. CO advised the committee Clinical Research have some work to complete however happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/45	**4.**	**Corporate Risk Register Review**	CU presented the Corporate Risk Register Review. CU informed the committee that there are 515 risks on the Trust risk register, and the detail is reflected in the Division and corporate functions risk registers. The total number of risks on the risk register is 515 compared to 532 for the previous reporting period. 19 (3.73%) of the Trusts risks are rated as' High/Extreme' risks compared to 24 (4.1%) for the previous reporting period. 347 (66.9%) of the Trusts risks are rated as 'Moderate', compared to 356 (67.3%) for the previous reporting period, of which 134 (26.01%) risk rated 12 (high moderate) compared to 150 (28%) for the previous reporting period. 123 (24.17%) of the Trust risks rated are as 'low risk' compared to for the 126 (23.7%) previous reporting period. 2 (4.52%) of the Trust risks rated as 'very low risk' compared to 24 (4.5%) for the previous reporting period. There are currently 19 high risks on the CRR;		CU	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			1 (5.26%) in the Medical Division, 2 (10.52%) in the Surgical Division. 1 (5.26%) in Community services. 0 (0%) in Research Division. 2 (10.52) in the BAF 13 (68.42%) in Corporate. Services. CU advised the committee there are assurance concerns both on the Trust and corporate risk register and has discussed and advised on these concerns with the risk owners and managers at the monthly risk validation meetings **Assurance concerns Trust risk register** • 164 (31.60%) risk assessments have an **overdue** review date, compared to175 (32.89%) for the last reporting period. • 61 (11.75%) risks do **not** have controls compared to 64 (12%) for the last reporting period. • 67 (12.91%) risks do **not** have actions compared to 83 (15.60%) for the last reporting period. • 314 (45.44%) **overdue** actions compared to 360 (48.32) for the same reporting period from last report. • **Assurance concerns corporate risk register (19 High risks)** 8 (42%) – overdue review 8 (42%) – overdue actions 5 (26.31%) – no controls identified 1 (5.26%) – no initial risk rating identified 4 (21%) – initial and current risk rating remain same, 3 with controls.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			CU advised that there are concerns as there is no significant reduction in risk scores except for many of the High risks, particularly in the case of moderate risks, consistently over 60% plus of all risks This is a significant concern for the Trust and needs to be addressed as a priority. Reviewing all the reports from 2017-2018 shows there are no significant movement for the moderate risks on the registers, including the high moderates. If these risks are not managed effectively, they could easily become high risks, with greater potential for the risks being realised and impacting on the Trust objectives. The management of risk and the evidence to support this via the risk registers needs to be prioritised by all concerned. Management of risk and providing assurance is a key part of everyone's role and cannot be treated as an add on to staff members jobs, on the contrary it is central to all roles and responsibilities. CU further advised the committee that our regulators (CQC) when considering compliance ratings with our legal obligations (regulation standards), they assess us using a risk based approach and our assurances via the risk register is key to their judgment of our compliance. CU advised the committee of the need for a more detailed update at the next IGC meeting in September 2018. **Resolved** that: the Committee NOTED the contents of the paper	All risk registers to show a more detailed update at IGC Sept 18		Immediate
18/19/46	**5.**	**Board Assurance Framework (BAF)**	JG presented the Board Assurance Framework. JG advised the committee that the BAF has gone through a refresh. E.g. looking at trends around flow to ensure they reflect the current position. There is works being completed around meeting access targets on the emergency pathway which is going through (RABD) Research and Business Development Committee at the moment. The operational risks, commercial risks which have come out of discussions today are awaiting further progress. ES will provide an update on the BAF at IGC September 2018. **Resolved** that: the Committee NOTED the contents of the paper	ES to update BAF	ES	Sept 18

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/47		**CQC Plan**	Phil O'Connor (PO) presented the CQC Plan. PO presented the CQC Action Plan and highlighted progress made since the last meeting for the Committee to be sighted on. PO advised the aim is to close down the CQC Action Plan for 2017/18 and any outstanding actions there will be a Trust risk assessment completed for those areas. Item 7 – Risk assessments - this will be closed the end of July 18 Item 10 – resuscitation roles - this will be completed and closed the end of July 18 Item 16&25 – Appraisals – will be completed through (WOD) Workforce Organisational Development Committee. Item 20 – Ward curtains – will be completed through (IPC) Infection Prevention & Control Committee. Item 22 – CD discard – will be completed through Medicines Management Committee. Item 23 – MAR - will be completed through (GDE) Global Digital Excellence. Item 24 – Ward Co-ordinators – will be completed through the nurse's workforce report at Trust Board. Item 26 – Cancelled operations – will be completed through the Change Programme. PO advised the committee that the 2017/18 action plan that has been presented to IGC will now be closed down but as outlined above will continue to be monitored via the relevant subject matter expert groups **Resolved** that: the Committee NOTED the contents of the paper		ES	
	7.	**Policies**				
18/19/48		Duty of Candour Policy	CU advised the committee that the policy has had a rewrite, to clarify roles, responsibilities and accountabilities; the process has been clarified further so there is no ambiguity. CU advised the committee of the legal duty to be candid with patients and what this means for	CU to meet with DS		Immediate

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			the Trust staff and patients. The 'Duty of Candour' flow chart within the policy is to be sent out to all clinical areas, to be used in conjunction with the policy. CU advised she will contact Learning & Development Manager Darren Shaw to discuss how this can be incorporated into staff induction as compliance is a statutory requirement. **Resolved** that: the committee RATIFIED the content of the paper			
18/19/49		Conflict of Interest Policy	CU advised the committee about the minor amendments contained within the conflict of interest policy with no changes to the guidelines. **Resolved** that: the committee RATIFIED the content of the paper			
18/19/50		Absconsion Policy and Equality Analysis	Elvina White (EW) presented the absconsion policy to the committee and advised that the policy does not show any significant changes since the last iteration. **Resolved** that: the committee RATIFIED the content of the paper			
	8.	**Ad Hoc Reports**				
	9.					
	10.	**Any other business**				
Date and Time of Next Meeting		The next meeting of the IGC will be held on Wednesday 12th September 2018, 10:00am. Institute, Large Meeting Room				

INTEGRATED GOVERNANCE COMMITTEE
ACTION LIST – July 2018

No	Item	Owner	When	Status
18/19/27	Collective Risks on Ulysses	Divisions	Immediate	CU advised that surgery/medicine/community should work together to ensure no duplicated of risks are added to the risk register.
18/19/28	Birmingham Children's Hospital arrangement	S Ryan/G Smith/J Ruddick	Immediate	SI advised to have the reciprocal arrangement agreed document in place with BCH.
18/19/29	Purge Process	Divisions	12th Sept	Divisions to report back to IGC on the Purge Process
18/19/30	Risk 795 Water Safety	A Kinsella	12th Sept	AK to liaise with AB and provide an update at next IGC Sept 18
18/19/35	Risk 1409 – Fire break glass Risks on Estates Risk Register	J Spark J Williams/J Hutfield	Immediate 12th Sept	JS to confirm if works completed on this risk and to close on register if completed. JW/JH to provide a clear outcome of where Estates risks are up to.
18/19/36	Risk 825 – Internal Balconies	G Dixon	Immediate	GD to send JG&MS the email trail in relation to legislation.
18/19/43	Overdue risks	K Morgan	12th Sept	KM to look into overdue risks added to GDE register by other trust member and provide an update to IGC Sept 18
18/19/45	Divisional and Corporate functions risk registers	Divisions	12th Sept	Divisions and corporate functions to provide a more detailed update to their risk registers at IGC Sept 18
18/19/48	Duty of Candour	C Umbers	Immediate	CU to discuss with D Shaw training need at Induction
18/19/38	Risk 799 - Failure to control contractors	A Kinsella	12th Sept	MS to speak to AK and AK to report back to IGC

				Sept 18

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

2nd October 2018

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for September 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 Star Awards for July once again have joint winners; the Communications Team and Maureen Mitchell, Ophthalmology. August nominations are being reviewed.

Discussions are underway to review the current monthly Star Award processes to ensure fit for purpose going forward. The reward and recognition group have allocated a task and finish group to review and improve the retirement and Long Service processes.

Plans continue in preparation of the NHS 'Fab Week' which is to run from 15th October to 19th October 2018.

Staff Survey

The 2018 Staff Survey launched on the 21st of September and we are working hard to ensure that we continue the theme of recent years in increasing completion rates.Last year we reached a completion rate of 54% (up 15% from the previous year) and are aiming to reach at least 60% this year.

To encourage staff to complete the 2018 survey, we are working closely with communications to ensure it is promoted throughout the Trust in a variety of ways, from poster campaigns, intranet pages, blogs from Louise and email campaigns. We will also be running incentives for staff who complete the survey in the form of prize draws and team awards.

The majority of staff will be completing an online survey this year which allows us to remind staff more frequently to complete their survey and report on completions in real time. At the time of writing, the response rate stands at 15% (26/09/18)

Improving Staff Wellbeing

The Trust will ensure particular focus over the coming year and beyond is given to improving the wellbeing of our staff. The wellbeing steering group has met monthly over the last 3 months and are generating excellent ideas and incentives to improve staff wellbeing and improving mental health. It is hoped the Trust will sign the 'time to change' pledge and recruit a number of mental health champions over the coming months.

The Trust continues to work NHSI on the national programme of improving employee health and wellbeing.

2. Workforce Sustainability and Capability

Agenda for Change New Pay Deal

Payment of the new Agenda for Change pay increases for staff was successfully made in July's salary, and back pay was made, again successfully, in the August payment. Work has now commenced on the removal of the Band 1 salary scale, and we are working in partnership with Trade Union colleagues to deliver this project. Work is commencing on a

review of the appraisal system in light of the changes to increment progression which will come into force on the 1st April 2019.

Education, Learning and Development

Apprenticeships

The Apprenticeship Team have appointed a new Assessor, giving us the ability to deliver internal apprenticeships and maximise the use of the levy funding. Our internal offer consists of Business Administration Level 2 and 3, Team Leading Level 2, Customer Service Level 2 and 3, Management Level 2 and 3 and Healthcare Support Services Level 2.

The table below shows apprenticeship starts in August and September:

	Medicine	Surgery	Corporate	Community
Leadership & Management L7	3	2	1	0
Biochemistry	2			
Nurse Associate	2	1		
Accountancy			2	
Business Administration	1	2	1	1
Leadership & Management L5	4	5		
Total	12	10	4	1

Mandatory Training

Mandatory training figures as of end of August have dropped to 89% for Core Mandatory Training and 86% for Overall Mandatory Training, below the 90% Trust target. This is below 90% for the first time in 6 months.

This is largely due to an extremely high number of staff competencies expiring throughout August and September due to it being 3 years since the move to the new hospital when a large piece of work was undertaken to train thousands of staff before the move.

To support compliance, the team have spent some time creating a system that allows us to email staff individual updates of their training compliance and upcoming expirations and are confident that compliance will swiftly improve again from October onwards and that we can achieve our trust target of 90%.

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, and improve the experience of our staff. The chairs of each of these networks are also active members in the Health and Wellbeing meetings, helping to identify areas of improvement particular for BAME staff and those staff with a disability.

The Diversity Action Plan was approved in the June Board, and we are exploring the use of some external expertise and advice to support this agenda.

Employee Consultations

Hotel Services

Portering:

Following a further review meeting with management and the trade unions that took place on 20th June 2018,it was provisionally agreed at that meeting that management would trial some proposed changes to working practises for a three month period with full staff engagement. Final preparations are taking place for the trial, anticipated to be the middle of October 2018.

Employee Relations Activity

The Trust's current ER activity has increased and stands at 38 formal cases. There are 8 disciplinary cases (3 through fast track); 4 Bullying and Harassment cases; 1 grievance; 20 final absence dismissal cases, 1 formal capability cases; 2 MHPS Capability cases and 2 Employment Tribunal (ET) cases.

An agreement has been reached with Staff side colleagues to commence bi-monthly case reviews; these will be carried out in partnership with HR and Trade Unions in order to learn from cases and improve processes and practice. This is a very positive step forward for partnership working across the Trust.

Employment Tribunal Cases

- A tribunal is 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 will be heard at the Liverpool Employment Tribunal in November 2018.

Corporate Report

The HR KPIs in the August Corporate Report are:

- Sickness rates have decreased slightly this month compared to last month to 4.98% in month.
- Core Mandatory training compliance is at 89%, just below the target of 90%.
- The PDR window opened in April. Compliance at the end of August was 82%. The latest report (as of 24/9/18) now shows compliance at 86%, just short of the 90% target.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

3rd September 2018

Workforce & Organisational Development Committee (WOD) – Chairs Note

1. Purpose of the Report

The purpose of this report is to update the Board on the key issues raised at the WOD Committee held in September 2018.

2. Key Issues

The following issues were raised and discussed at the Workforce & Organisational Development Committee on the 3rd September 2018; the minutes of the meeting will be submitted to the November 2018 Board for noting.

- The Committee **noted** the ratings (Apprenticeship & Portering Service) for The Best People Doing Their Best Work – Programme Assurance.
- The Committee received a report and action plan outlining the latest developments to support the NHSI Health & Wellbeing Improvement Programme and **noted** the progress made.
- The Committee received a presentation outlining the latest developments to support the Health & Wellbeing Strategy and **noted** the advances made.
- The Committee received the updated annual EDS2 summary report for 2018/19 and **approved** the document.
- The Committee received the Workforce Race Equality Standard (WRES) and Equality Diversity Inclusion Action Plan for 2018/19 and **approved** the documents.
- The Committee received the Workforce Equality Objectives for 2018-21, generated from EDS2/WRES metrics and **approved** the content.
- The Committee received a verbal update on the latest developments to support Education Governance and **noted** the progress made.
- The Committee received a Staff Survey report and **noted** the progress made to support the launch.
- The Committee received a report outlining the latest developments in Apprenticeship scheme and **noted** the progress made.
- The Committee received a report outlining the latest developments for Mandatory Training and **noted** the significant progress made.
- The Committee received the Board Assurance Framework August 18 and **noted** the content.
- The Committee received an update of the Workforce Leading Indicators for July 18 and **noted** the content.
- The Committee received the following policies and agreed to issue virtually for ratification:
  Consultant and SAS Doctors Procedure for Leave Policy
  Consultant and SAS Doctor Job Planning Policy
  Special Leave Policy
  The Committee is awaiting receipt of EIA's for the above policies.
- The Committee noted the content of the following Committee notes:
  Joint Consultation Negotiation Committee 5th June 2018
  Joint Consultation Negotiation Committee 11th July 2018
  Local Negotiation Committee 22nd March 2018
  Local Negotiation Committee 23rd May 2018

3. Recommendations

It is recommended that the Board note the contents of the Chairs Update relating to the key issues from the Workforce and Organisational Development Committee held on 3rd

September 2018.

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Alder Hey Children's NHS
NHS Foundation Trust

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
26th June 2018

Present:	Ms C Dove	Non-Executive Director (Chair) (Part attendance)	(CD)
	Mrs M Swindell	Director of HR & OD	(MKS)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mr M Flannagan	Director of Communications & Marketing	(MF)
	Mr A Bateman	Chief Operating Officer	(AB)
	Mr S Ryan	Medical Director (Part Attendance)	(SR)
In Attendance:	Mrs S Owen	Acting Deputy Director of HR&OD	(SO)
	Mrs K Turner	Trust LiA Lead	(KT)
	Ms H Ainsworth	Equality & Diversity Manager	(HA)
	Mr A McColl	Associate COO (Part Attendance)	(AMc)
	Mr P O'Connor	Deputy Director Nursery	(POC)
	Ms G Thomas	Apprenticeship Delivery Manager	(GT)
	Mr J Gibson	External Programme Assurance (Part Attendance)	(JG)
Apologies:	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Ms Dot Brannigan	Patient Governor (Parent & Carer)	(DB)
	Mr T Johnson	Staff Side Chair	(TJ)
	Mrs H Gwilliams	Chief Nurse	(HG)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
18/29 **Minutes of the Previous Meeting & Meeting Protocol**	The Committee considered the minutes of the meeting held on 21st May 2018 and they were **approved** as an accurate record.			
18/30 **Matters Arising, Actions**	The Committee considered the following under matters arising: **16/33 & 17/20 Review of Key Performance Indicators** MKS confirmed that the following reviews had taken place: • Review of Trust KPIs • Review Against the Workforce Plan to ensure they reflect the workforce strategy Noted as **complete** on the action log. **18/21 BME Chair Update** MKS advised that the BME Chair will be joining July's Trust Board to update on developments.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
18/31 **Programme Assurance 'The Best People Doing Their Best Work'**	**Programme Assurance Framework – June 2018** The Committee received a regular summary prepared by the Executive Sponsors of the Assurance Framework, External Programme Assessor and Assurance Team. The purpose of this assurance framework is to ensure the monitoring of robust processes for progression. All papers supporting Programme Assurance for the work stream 'The Best People Doing Their Best Work' are recorded as read prior to the meeting. External Programme Assurance representative gave a breakdown of latest developments to the Committee. JG advised that the current dashboard shows improved ratings for both projects 'Apprenticeship' and 'Improving the Portering Service'. Particular attention was brought to the Apprenticeship Project being well run, with evidence reported on SharePoint and supported by the dedicated productivity/diligence of the project team and DMO project management. JG acknowledged that the amber rating for 'Improving Portering Services Project' does not reflect the progress made, but reflects the delay of proceedings. MKS confirmed that it had proved difficult to meet with all TU's at one time to progress proposals, following discussions will see the project move onto the next stage. MKS acknowledged that 'E-rostering' project was now at the feasibility stage, whilst 'Agile Working' project – R&E2 is running live and whether it's formally taken on needs to be decided. JG added that work remains to fully define the schemes to deliver the £1M target in 2018/2019. The Committee **noted** the comments made.			
18/32 **Progress against the People Strategy**	**LiA Update** The Committee received a presentation outlining the LiA progress to date, undertaken by the Trust LiA Lead. KT reflected on the journey so far and an overview of the work that is completed/underway was presented. KT acknowledged that the format of the 'Big Conversations' that began in 2016 and continued through 2017 will be reviewed for 2018. KT went on to itemise the projects completed by Cohorts 1 & 2 along with the teams that currently have projects underway. This process is still supported using the LiA '7 steps methodology'. Particular attention was brought to the following: • Quick wins – 230 raised, recent wins are: a database created for HDU and TV installed, fitness classes with 2 sessions a week - hugely attended, Atrium wheelchairs in place. • Division drop-ins – open forums to raise ideas, issues and concerns; have been arranged with Medical & Surgical divisions.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	• Executive Shadowing – over 63 visits in just over a year, with feedback from Executives taken back to Division drop-ins. • Celebrating Alder Hey Staff – initiatives outlined that had taken place i.e. Staff Awards, Fab staff day – this year's Fab staff day will take place in October. • Inspiring Quality Summit – inspired by Children – a great event supported by LiA. • Freedom to Speak Up – an NHS England programme that encourages staff to identify issues and to find ways to resolve them. This programme is run by FTSU champions and supported at board level by FTSU guardian. KT advised that she is one of the champions and the group meet monthly. The Trust has seen a steady flow of cases, none being anonymous, which explains the support and culture we have at Alder Hey. FTSU has been integrated into Alder Hey's already established channels, including 'Raise It, Change It'. The Committee **noted** the progress made.			
18/33	**Equality Monitoring Process – EDS2** The Committee received an annual report prepared by the Equality & Diversity Manager. HA reminded the Committee that EDS2 Summary Report for 2018/19 is a requirement by both NHS Commissioners/Providers and is designed to give an overview of the Trusts most recent EDS2 implementation. Organisations are encouraged to follow the implementation of EDS2 in accordance with the '9 Steps for EDS2 Implementation' as outlined in the 2013 EDS2 guidance document. Once completed and grading approved, the summary report is published on the Trust website and shared with Commissionaires. Goals are linked to the evidence drawn upon by 7 Equality Objectives. HA advised that the goals relevant to Workforce are Goal 3 'A Representative and Supported Workforce' and some elements of Goal 4 'Inclusive Leadership'. HA advised that the outcome of the grading links into the Equality Objectives. The suggested grading was 'developing' for all workforce elements of Goal 3 and 4. As indicated in the EDS2 Summary Report under 'headlines of good practice for workforce' the report notes Goal 3 – the development of staff networks for disabled and black and minority ethnic (BME) staff has resulted in action plans that identify workplace priorities.. In-depth discussion took place, the Committee noted that the tool kit was difficult to use and complex to understand. The grading against the '9 protected characteristics' was challenging to provide if you do not monitor in the same way. The Committee noted that the submission date for this data was end April 2018.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	HA advised that in terms of Patients Goals (reported at CQAC), collaboration approach has been adopted with several Trusts in the area to identify priorities with AH Trust taking the lead for the protected characteristics of 'age' and 'religion and belief'. Once findings have been collated and shared each, Trust/Commissioner will convene a panel including key strategic leads. The panel will develop actions that will form the basis of the Trust Equality Objectives plan, mapped to the outcomes of EDS2. CD requested that a similar approach be put in place for the Workforce elements of EDS2 Summary Report and suggested the appropriate key strategic leads be invited to a panel to agree/inform/verify the self-assessment grading and workforce equality objectives. Outcomes will inform the CQC how the workforce is developing. CD further requested that a robust action plan be put in place to include timelines for completion. HA concurred with this approach for workforce and will set up meetings to agree the Trust self-assessment grading and verify outcomes. MKS suggested that HA meet with the Acting Deputy Director of HR&OD to progress this week. The Committee **noted** the progress made.	Arrange meetings to agree self-assessment grading's. Produce robust action plan progressing EDS2 outcomes	HA HA	ASAP ASAP
18/34	**Apprenticeship Update** The Committee received a report prepared by the Apprenticeship Delivery Manager. The report outlined the progress made to support apprenticeships at the Trust since the last update to the Committee in February 2018. The report was noted as read. GT advised that to support apprenticeships at the Trust, a new Learning & Development Co-ordinator and an Apprentice Assessor have been recruited. The Apprentice Assessor will take on a cohort of up to 40-learners to deliver apprenticeships in Management, Customer Service, Business Administration and Health Care Support Services. A further 2 assessors have been identified to support expansion of Apprenticeships at the Trust. GT advised that work continues with colleges and that this development will also allow the new Assessors a resource to tap into for support around Standardisation and Ofsted requirements. The Committee noted that Programme Assurance had seen a rag rating of green overall and is overachieving against the in year targets. The Committee acknowledged the Trust has considerable growth plans over the coming years and a strong strategy is required to support the challenges the Trust will encounter. The Committee noted importance of Ofsted grading requirements to ensure we can carry on drawing down of the Levy. GT advised that work continues to increase the awareness of the apprenticeships at			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	the Trust and support diversity via a number of avenues; such as meetings with Divisional Managers to spread the word to staff; further awareness session will be held in September in the Atrium; NHS job site sign post has been located in the Atrium. The Committee **noted** the progress made.			
18/35	**Sickness Absence** The Committee received a presentation prepared by the Acting Deputy Director of HR&OD. As part of the focus to see improvements of the Health & Wellbeing of our staff, the presentation outlined the action plan in place to support the reduction sickness absence rates at the Trust (hard copy included in Committee papers for reference). SO shared the analysis of Trust sickness data trends over the last 3 years benchmarked against our peers and charted the effects on associated costs. SO outlined an overview of the action plan for improvement to support health and wellbeing priorities for 2018. This includes the establishment of H&W Steering Group and sub working groups to cover the areas of Health, Work, Values/Principles, Collective/Social and Personal Growth to review solutions. SO advised that HR were one of seventy eight Trusts invited to attend a workshop at the end of May arranged by NHSI (Staff Health & Wellbeing – Reducing Sickness Absence). SO noted it was perfect timing for the Trust as workshop was found to be helpful in supporting the development of our local health and wellbeing improvement plans. Following further support from NHSI, the Trust will be required to submit a plan to NHSI by 3rd September 2018. Further progress on the action plan will be brought back to the Committee. The Committee **noted** the advances made.			
18/36	**Mandatory Training Update** The Committee received the mandatory training report prepared by the Acting Deputy Director of HR&OD. The purpose of the report is to outline the Trusts commitment to address low levels of compliance with a target of 90% compliance for all recognised mandatory training subjects. SO advised that core mandatory training compliance is at 92% (as of end of May 2018) and this has remained above 90% for the last 4 months. SO acknowledged that this is a positive achievement. Slightly less at 89% has been achieved for overall mandatory training, which contains specific mandatory training (as of end of May 2018). SO outlined the compliance percentage for each mandatory subject and advised that a breakdown of the Divisions will be brought to a future Committee. Going forward the HR&OD Team will continue to work with subject matter experts and managers			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	and detailed reports to divisions and depts. will continue to be issued. The new ESR and Learning & Development managers are working together to manage the system effectively and improve compliance. The ongoing development of e-learning packages continues to support the increased learning options for all mandatory training. The Committee **noted t**he significant progress made.			
18/37	**Medical Education Report** The Committee received the medical education report, prepared by the Medical Education department. The purpose of the report is to provide the Committee with an overview of the current highlights and challenges within Medical education. The report is noted as read. In the absence of the Medical Education and Revalidation Manager, MKS gave a brief overview of the challenges impacting upon the educational and training activity and the plans in place to establish improved processes to support governance and transparent funding for training. MKS brought particular attention to the Quality Visit that took place in May lead by the Deanery. A report will be received outlining risk categories and this report will be presented at Trust Board. The Committee noted that Education governance remains a priority in the coming year. MKS advised an update will be brought to the Committee in September and Medical Education will be a regular agenda item. The Committee **noted** the content of the report.	Education Governance Update	HB	September 2018
18/38	**Marketing & Communications Update** The Committee received a presentation outlining the Marketing & Communications Objectives. The purpose of the Marketing and Communications Team is to support the Trust's plans to build a healthier future for children and young people. MF reflected on the key objectives that support the Trust Vision under the following themes: 'The Best People doing their Best Work', 'Delivery of outstanding care', Sustainability through external partnerships' and Game-changing research and innovation'. The Committee noted the importance of 'Staff Engagement' to support positive feedback from staff about the Trust and their role in achieving our goals. MF charted the planned undertakings/outcomes for 2018-19 covering a wide range of activities as outlined in the presentation. A number of observations/opportunities were raised: • SR asked what opportunities could be put in place to support diversity at the Trust via the utilisation of comms/media within the local community, asset			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	groups/leaders. MF advised that we could look to review and put a framework in place to support jobs board. • AMc asked how we join up the individual divisions – how do we keep individual identities. MF said that we need to develop a common look and within the Trust, but within a wide pallet that allows us to communicate what different parts do. To help colleagues we will produce templates that can be used to drop information into, to allow for better, but more consistent communications. • AMc asked if the handbook would be in the form of an App for phones to make it easier to work with. MF said that, yes, eventually an App would be great, but we need to not neglect hard copy collateral and materials. For example, newly recruited nurses need hand held information, even before they arrive at the Trust to help orientate them and support them, and we need to develop this within the context of the handbook. We also need something that matches the user experience and standards that they are used to outside of the NHS – i.e. high quality, very user friendly, very "slick" • CL asked how we plan to engage with children in this work. MF said that working with children more formed part of the Inspiring Quality work and the Comms team would work within this and be inspired and helped by this in ensuring children are part of how we communicate. That said, we "use" children as our voices routinely, through videos for example, and will do more of this going forward. The Committee **noted** the update received.			
18/39	**Staff Support – Action Plan** The Committee received an action plan to support staff presented by the Director of HR&OD. The action plan is part of a wider piece of work to support improving the wellbeing of our staff. The purpose of the action plan is to outline areas of focus and the actions/outcomes required to support staff. MKS brought specific attention to ICU and the additional psychological support made available for staff and families. The Committee **noted** the content of the action plan.			
18/40 **Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks**	**Key Workforce Risks KPIs – May 2018** The Committee received a regular report prepared by the Acting Deputy Director of HR concerning the key risks relating to workforce monitoring for May 2018. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. Key headlines are: SO advised that work has taken place to develop the new dashboard with feedback received from the 3 x Associate Chief of Operations in terms of sickness reporting. The Equality & Diversity Manager is working with the HR team to increase BME			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	recruitment by1% annually over the next 5 years. Core mandatory training is in a healthy position at 92% above target. Apprenticeship headcount and Trust target has been added to the dashboard to monitor progress. PDR's look low at 11%, but it was noted that there is a window of 5 more weeks and feedback from Divisions have indicated that they are scheduled. MKS initiated a discussion about the requirement to understand the trajectory around the completion of PDR's within Corporate and the Divisions and understand what is causing the delays. SO advised that the information is getting out there from HR with some managers completion rates at 80/90% and others coming in at 10%. The Committee noted the requirement to focus the mind of some managers to progress completion of PDR's with active support from senior managers. The Committee **noted** the content of the report.			
18/41	**Board Assurance Framework – May 2018** The Committee received the (BAF) for May 2018. The risks are: • Failure to always have the right people, with the right skills and knowledge, in the right place, at the right time. • Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims. • Failure to proactively develop a future workforce that reflects the diversity of the local population. The Committee **noted** the content of the Board Assurance Framework.			
18/42	**CQC Action Plan May 2018** The Committee received workforce elements of the CQC Action Plan for monitoring purposes (full plan is monitored at CQAC). The purpose of the CQC action plan is for the Trust to address issues raised, ensure the appropriate action is taken and monitor progress through to completion. MKS advised that all but one of the workforce elements have been completed, the version received today also includes tasks that are completed. The Committee **noted** the progress made.			
18/43 **Legislation, terms & conditions, employment policies/EIA's – review & ratification/approval**	The Committee considered the following Policies and Equality Impact Assessments for formal ratification and approval. **Flexible Working Policy & EIA** SO advised the policy was discussed at the Policy Review Group on 15th May, quick reference guide and appendices have been removed, following feedback from the			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Disability Network some of the wording has been updated. The Committee **ratified** the Policy and **Approved** the EIA. **Organisational Change policy & EIA** SO advised the policy was discussed at the Policy Review Group on 15th May, the policy has been reduced in length and aligned to other policies/legislation, clear processes has been introduced via the toolkit and clarification on the redundancy process added. The Committee **ratified** the Policy and approved the EIA. SO recognised that good feedback has been received from Staff Side at the Policy Review Groups and wanted to acknowledge the productive support of received in updating the Trusts policies. **First Aid Policy & EIA** The Committee noted that the policy has been approved at the Resuscitation Committee. As this policy is workforce related, ratification was sought by either WOD or CQAC. MKS to ask Resuscitation what implementation plan and resource has been put in place. The Committee **ratified** the Policy and **approved** the EIA.	Speak to Resus re resource plan	MKS	ASAP
18/44	**Sub Committee Minutes** The Committee received the minutes of the following for information. Joint Consultation Negotiation Committee – 5th April 2018 Joint Consultation Negotiation Committee – 27th April 2018 The Committee **noted** the content.			
18/45 AOB	None.			
Date of Next Meeting	**Monday 3rd September 2018, 2pm-4pm, Room 8, Mezzanine.**			

Action List

Minute Reference	Action	Who	When	Status
Meeting Protocol				
	Terms of Reference			
16/33 17/20	• Review of key performance indicators required against the workforce plan to ensure they reflect the workforce strategy. • Head of Planning & Performance revising Trust KPI's, Updated HR KPI's to be presented.	MKS/CD MKS	June 2018 June 2018	Complete Complete
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
17/21	• Feedback on outcomes of Change Programme Framework • Update on identified resource for Projects AHP, Temporary Staffing and E-Rostering	JG MKS		Ongoing Ongoing
People Strategy Overview & Progress Against Strategic Aims				
	LiA			
16/38 17/52	• Present Communications Plan • LiA update	KT/Communications KT	December 2017 June 2018	Complete Complete
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CL	Ongoing	Ongoing
	Equality & Diversity			
15/03	• Align E&D deliverables with people strategy	HA	Ongoing	Update at future meetings
17/13	• Equality Objectives Plan for 2017/18 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee	HA HA/SM	1/4ly Update 6 monthly Review **September 2018**	Ongoing
18/05	• **Corporate Induction** – review current practice of holding on a set day as opposed to the 1st day of commencement in post. The Committee noted on 21st May that the new Learning & Development Manager will be reviewing in conjunction with Communications	MKS	TBC	Ongoing
18/21	• Following discussion about the annual workforce profile – invite the BME Chair and Apprenticeship to next meeting to update the Committee. Noted on 26th June 2018 that the BME Chair will be updating on development at the Trust Board on 3rd July 2018.	MKS	June 2018	
18/34	• EDS2 - Arrange meetings to agree self-assessment grading's and produce a robust action plan for progressing EDS2 outcomes.	HA	ASAP	

	Education Governance Update			
18/38	• To be a regular item on the Committee Agenda.	HB		Ongoing
Legislation, Terms & Conditions, Employment policies/EIA's				
18/43	• Ratified First Aid Policy enquire with Resuscitation what implantation and resource plan is in place.	MKS	ASAP	
AOB				
18/28	• Present a Communication update to the Committee	**MF**	**June 2018**	**Complete**

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board Of Directors

Tuesday 2nd October 2018

Report of:	Innovation
Paper Prepared by:	Rachel Lea Jason Taylor
Subject/Title:	Innovation Co Corporate Governance Manual
Background Papers:	n/a
Purpose of Paper:	To propose the Corporate Governance arrangements for Innovation Co.
Action/Decision Required:	The Board are asked to: 1) Note the contents of the Manual 2) Approve the proposed Corporate Governance arrangements
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Game Changing Research and Innovation
Resource Impact:	n/a

Alder Hey Children's NHS
NHS Foundation Trust

Innovation Governance
October 2018

Background

As part of the Innovation reset process the governance of Alder hey innovation activity has been reviewed and strengthened to ensure robust and best practice assurance and process, with suitable Executive Director and Non-Executive oversight and scrutiny. The required governance is stipulated in the Innovation corporate Governance Manual and Terms of Reference

Innovation Corporate Governance Manual

On the 24th September 2018 the Innovation Board approved the new Innovation Co Corporate Governance Manual. The manual follows Trust standard form and is required to;

provide guidance on how Innovation Co corporate governance arrangements work in practice.

This Corporate Governance Manual explains how:

- the various formal governance documents such as the Standing Orders and the Scheme of Delegations; and
- the various Board Committees of the Company are each implemented in Innovation Co's corporate governance arrangements

Terms of reference

The Terms of reference details the membership, authority, duties and reporting of the innovation Board to that of the Trust Board of Directors of Alder Hey NHS Foundation Trust.

Recommendation

It is recommended that the Innovation governance is approved.

NHS
Alder Hey Children's
NHS Foundation Trust

Innovation Co

Corporate Governance Manual

Contents

1 Introduction

Alder Hey Children's NHS Foundation Trust is a public benefit corporation established in accordance with the provisions of the National Health Service Act 2006 ("the 2006 Act") and The Health and Social Care Act 2012. The Health and Social Care Act 2012 sets out the legal framework within which the Foundation Trust operates. The Constitution set out who can be members of the Foundation Trust and how it should conduct its business.

The Provider Licence is issued by the regulator and identifies the conditions of operation. The Accountable Officer Memorandum requires Foundation Trust boards to adopt schedules of reservation and delegation of powers and to set out the financial framework within which the organisation operates.

Innovation Co Ltd is wholly owned by Alder Hey Children`s NHSFT and is responsible for ensuring that the activities undertaken are carried out:

- to the satisfaction of Alder Hey Children`s NHSFT and
- in the long term interests of Innovation Co, its Employees, the local community and business partners,

The purpose of this manual is to provide guidance on how Innovation Co corporate governance arrangements work in practice.

This Corporate Governance Manual explains how:

- the various formal governance documents such as the Standing Orders and the Scheme of Delegations; and
- the various Board Committees of the Company

are each implemented in Innovation Co's corporate governance arrangements.

2 Corporate Governance

2.1 What is Corporate Governance?

Innovation Co aligns its Corporate Governance process to the UK Corporate Governance Code (the Code) to the extent that it is considered by the Board to be applicable to Innovation Co. The Code describes Corporate Governance as follows:

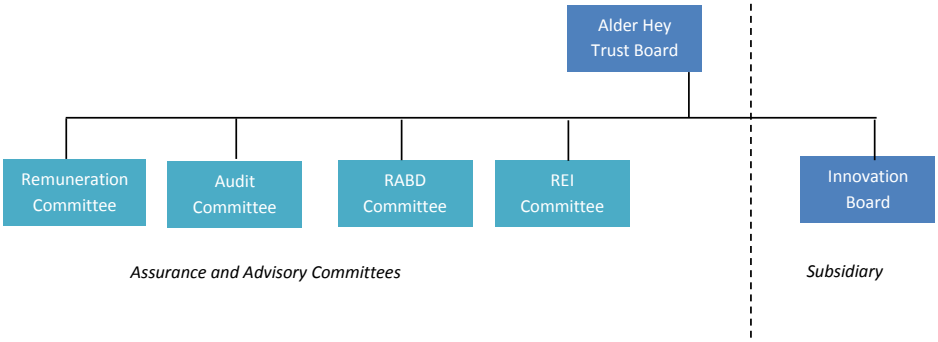
> *"Corporate Governance is the system by which companies are directed and controlled. Boards of directors are responsible for the governance of their companies. The shareholders' role in governance is to appoint the directors and the auditors and to satisfy themselves that an appropriate governance structure is in place. The responsibilities of the board include setting the company's strategic aims, providing the leadership to put them into effect, supervising the management of the business and reporting to shareholders on their stewardship. The board's actions are subject to laws, regulations and the shareholders in general meeting."*

Corporate Governance should not be confused with accountability for day-to-day management of the business which is held by the Chief Executive Officer (CEO) supported by the Board of Directors

2.2 Corporate Governance Structure

The Corporate Governance structure for Innovation Co is shown below. This structure should not be confused with the management structure for Innovation Co which is defined separately.

Corporate Governance Framework



The committees identified on the above structure have implemented terms of reference which set out the scope of their role.

As shown above, the structure comprises four Trust Board sub-committees, each of which will provide assurance to the Alder Hey Trust Board and will be central in assisting the Innovation Board to maintain good governance. Although other committees will support the work of these committees, final accountability and responsibility for the operation and management of Innovation Co rests directly with the Innovation Board. Decisions may be taken by these committees in line with their delegated authority as set out in the terms of reference (otherwise it is their responsibility to make recommendations to the Board).

*The **Innovation Board*** of Innovation Co **is authorised to:**

- Consider, for 'decision', all actions/schemes that are brought to the meeting by the members or invitees;
- Direct, monitor and control the actions/schemes and hold those accountable for delivery by agreed dates;
- Escalate issues outside its authority and any areas of concern, to the Trust Board on a monthly basis;
- Ensure the feasibility and sustainability of all actions/schemes at a regular interval;
- Ensure Value for Money is obtained for the Innovation Department

All other committees, whether formally appointed or not, are advisory unless either the Board or the Executive elects to further delegate any of its decision-making authority.

A Standard Operating Procedure for Innovation Co is in place which provides the detail on the due diligence and contract paperwork that will be completed before any project or contract is entered into.

2.3 Role of the Innovation Co Board

The Board provides leadership to Innovation Co within a framework of prudent and effective controls which enable risk to be assessed and managed.

The Innovation Board is required to:

- Monitor the development, implementation and delivery of all schemes/actions contributing to the delivery of the Work Plan.
- Ensure that all new schemes/actions have an accountable manager for delivery.
- Assure that each of the actions/schemes identifies the scope of benefit realisation.
- Report to the Trust Board actions/schemes that have been deferred/or discontinued or have not been sustained.

Its authority is derived from the Scheme of Delegations which is contained within Appendix 1.

The Innovation Board will meet on a monthly basis with a minimum of 10 meetings per year.

The Innovation Board Terms of Reference are contained in Appendix 3.

The Companies Act 2006

The Companies Act 2006 sets out the duties of a Director as follows:

- a duty to act in accordance with the company's constitution and only exercise powers for the purposes for which they are conferred;
- a duty to act in the way the director considers, in good faith, would be most likely to promote the success of the company for the benefit of its members as a whole and in doing so have regard to various matters:
  - a) the likely consequences of the decision in the long term;
  - b) the interests of the company's employees;
  - c) the need to foster the company's business relationships with suppliers, customers and others;
  - d) the impact of the company's operations on the community and the environment;
  - e) the desirability of the company maintaining a reputation for high standards of business conduct; and
  - f) the need to act fairly as between members of the company;[1]
- a duty to exercise independent judgment;
- a duty to exercise reasonable care, skill and diligence;
- a duty to avoid a situation in which the director has, or can have, a direct or indirect interest that conflicts, or possibly may conflict, with the interests of the company;
- a duty to not accept a benefit from a third party conferred by reason of the director being a director, or his doing (or not doing) anything as director; and
- a duty for the director to declare if he is in any way, directly or indirectly, interested in a proposed transaction or arrangement with the company, and the nature and extent of

that interest, to the other directors.

The role of a Director is separate and distinct from the role of an Executive or Senior Manager, even if (as is the case of certain Directors who are also members of the Innovation Executive) the roles are held by the same person.

Each Executive Director's role is to put aside the interests they may have in an executive capacity and act in a way which meets the duties of a director.

Non-Executive Directors are recognised as playing a key part in good governance in terms of independent oversight of Board decision making.

Non-Executive Directors' roles should be developed to ensure that they provide the appropriate level of oversight and challenge to the decisions of the Board and they should be provided with suitable and sufficient information and briefings to enable them to fulfil this role in full.

It is good practice to review the overall effectiveness of the Board on an annual basis and to keep under consideration the role and appointment of Directors.

The key accountabilities and responsibilities of the Board, together with the matters reserved to the board are set out in Appendix 1.

2.4 Roles of the Board Members

The members of the Innovation Board are:

Trust Chair

Chief Executive

Director of Corporate Affairs

Non-Executive Director

Development Director (Executive Lead for Innovation)

Clinical Director of Innovation

Director of Finance

Operational Director of Finance

Alder hey Charity Chair

In addition there will be individuals who will be expected to attend each of the Board meetings which are included in the Terms of Reference in Appendix 3.

2.5 Role of the Innovation Executive

The Executive membership comprises a combination of the Executive Directors and other non-board executive leads. Each member is authorised to undertake activities and manage their accountabilities within their respective areas of accountability.

They may carry out these duties on their own authority or via delegation through the management chain. They may also seek advice from other individuals or management bodies to support them in decisions that they take under their own authority. The authority of the Innovation Executive members is derived through delegation by the Innovation Board

.

Issues that do not require approval at Board will usually be taken by Directors or other managers within the authority delegated to them by virtue of their appointment, or at a designated meeting such as the Innovation Executive.

2.6 Formalities

The formalities supporting and recording decisions taken by Innovation Co, either by the Board or its committees vary depending upon the nature of the issue, the level at which the decision should be taken and the committee concerned.

Appendix 2 contains details on the formalities surrounding content and submission of papers, decision process and the recording of decisions.

2.7 Audit and Assurance

An independent audit and assurance review will be performed annually and will be reported through the Trust Audit Committee.

Any modifications or improvements to the governance process of Innovation Co identified through either the self-assurance or the independent assurance/audit will firstly be addressed by the relevant Innovation Co Process Owner and any modifications/actions required will be taken in conjunction with the relevant Committee Chair(s).

2.8 Annual review of effectiveness

In line with Corporate Governance best practice, except where there is a clear overriding reason to do otherwise, the Board and the formal committees will review their performance and effectiveness on an annual basis and where appropriate develop an action plan for improvement.

An annual report will be produced and reported to the Trust Board on activities of the Innovation Board and if it has fulfilled the duties defined in the Terms of Reference.

The Innovation Board will develop a Work Plan with specific objectives which will be reviewed regularly and formally on an annual basis.

2.9 Process Owner Responsibilities

The Process Owner for Corporate Governance is the Trust Director of Corporate Affairs.

Appendix 1 – Scheme of Delegation

The Innovation Board remains accountable for all of its functions, even those delegated to individual committees, sub-committees, directors or officers and would therefore expect to receive information about the exercise of delegated functions to enable it is maintain a monitoring role.

MATTERS RESERVED TO THE BOARD

	A) Matters required by the Board itself:
Policy	The setting of Innovation Co Policies, approval of material changes to policies and oversight of the implementation of the policies and procedures.
Risk Review	To set the risk 'appetite' within Innovation Co and monitor its application and effectiveness through the risk management system, and to identify and review Board-level risk.
Safety	To consider recommendations from the Innovation Executive in connection with any matters relating to significant safety risks managed by Innovation Co.
Strategy	To define the strategic aims and objectives of Innovation Co.
Business Plans and Budget	To approve business cases for investment or contract which has a financial value of between £100k and £500k
Security	To consider recommendations from the Innovation Executive in connection with any matters relating to significant security risks managed by Innovation Co.
Annual Report & Accounts	To consider and approve the Annual Report and Accounts for Innovation Co.
Delegations	To receive for approval recommendations in respect of the Innovation Co Delegation of Financial Authorities to the CEO.
Stakeholder Engagement	To approve the strategy for stakeholder engagement and its enactment by the Innovation Executive.
Compliance & Ethics	To consider Innovation Executive recommendations in connection with any matter the Board considers pertinent to its responsibilities, including reporting of Employee concerns.
	B Matters required through the Scheme of Delegations to have Board approval (not included in the above):
	Approval of Work Plan

It is a matter for the Board to decide which matters are exclusively reserved to it and as such it will review and may amend the above list from time to time.

The Innovation Co Board (whilst retaining overall accountability) will delegate authority for other issues to the Innovation Executive. Day to day management of the business will be overseen by the Innovation Executive.

DELEGATED FINANCIAL LIMITS

All thresholds are inclusive of VAT irrespective of recovery arrangements. Details of procurement thresholds are provided (net of VAT)

	Proposed Financial Limits	Delegated Officer
1. GIFTS AND HOSPITALITY - Any gifts or hospitality which exceed £50 threshold must be declared	Up to the value of £50	Director of Corporate Affairs
2. INVESTMENT PROPOSALS	Over £500k	Trust Board
	Up to £500k	Innovation Board of Directors
	Up to £100k	Innovation Executive
3. REQUISTIONING GOODS AND SERVICES AND APPROVING PAYMENTS **3.1 Non Pay Expenditure**	Above £250k	Innovation Board
	Up to £250k	Director of Finance
	Up to £10k	Head of Innovation
3.2 Agency/Consultancy Expenditure	Above £100k	Innovation Board
	Up to £100k	Director of Finance
	Up to £5k	Head of Innovation

Appendix 2 - Formalities

a) *Innovation Board and Executive meetings:* In the case of a formal decision taken at a Board or Executive meeting, the process will typically involve:

i) A briefing paper. This paper addresses all the issues which the Directors are likely to take into account in making their decision, including the strategic rationale for the proposal, the financial effects, the level of risk inherent in the proposal, a summary of legal and regulatory issues, issues relating to employees, reputational issues and other relevant considerations under the Companies Act 2006.

The paper must clearly identify the nature of the decision or action required and the authorisation upon which it is requested e.g. a decision by the Executive Team to proceed with a proposed strategy that does not require Board approval. The detail depends on the type of proposal. The paper is to be circulated in advance of any meeting, unless the circumstances are exceptional, and is to be considered thoroughly by Directors. Arguably it forms the most important documented support to the decision process but its purpose should not be misunderstood; that is to assist Directors in reaching a decision through exercising their own judgement – it should not be construed as the decision or a record of the Directors' views. All papers must be formally submitted and will be logged and retained.

ii) A presentation. This may be used to supplement the briefing paper. This is a significant opportunity for Senior Management to present their position in relation to major matters to support the Board or Executive Team in reaching its decision.

iii) A discussion amongst Board/Executive Team supported by professional advisors, leading to a decision.

iv) A minute. The minute should summarise the main points of any Board or committee meeting. It must at a minimum record any decision, but should also, where appropriate, briefly describe the process of discussion which led to that decision.

v) The Administration or nominee shall minute the proceedings and resolutions of all Board meetings, including the names of those present and in attendance. Draft minutes of Board Meetings shall be circulated promptly to all members of the Board for approval.

vi) Minutes of all meetings of the Board shall be signed by the person acting as Chairman of the proceedings to which the minutes relate, or of any subsequent proceedings in the course of which the minutes are approved as a correct record.

The process for full Board meetings is likely to be more formal, the process for Executive meetings less so.

b) *Decisions taken by individual Directors or formally constituted sub committees on matters specifically delegated to them:* Where decisions are taken by individual Directors or their committees, the process may, legitimately, involve much less formality, although in order to show that internal processes have been followed, there may be some form of briefing paper and/or record of the decision concerned.

c) *Other decisions not taken under a) or b) above:* The way other decisions are supported or recorded varies as widely as the nature of the decisions concerned. When recommendations are taken by committees in circumstances other than at a formal Board Meeting, those recommendations should be recorded in accordance with the terms of reference of the particular committee. Where a decision is made, it must be recorded on whose authority that decision is made.

Creation and retention of records

The Company Secretary is responsible for the creation, retention and archive of appropriate records of business transacted during any Corporate Governance meeting following general site policy on retention and safe keeping of documents. This will include terms of reference, agenda, actions, minutes, and papers for each committee.

In order to maintain a suitable record of the meeting, the Company Secretary must produce appropriate formal minutes depending on the nature of the decision; and as instructed by the chair:

- Simplest – e-mail or note recording actions or decisions from a meeting.
- Fuller – record of the decision taken and a summary of the rationale behind that decision.
- Fullest – fully minuted note detailing the decision, recording the debate and any specific issues or caveats.

Access to Board minutes, papers, presentations and all other documents is strictly controlled by the Chair. Documents may only be released both internally and to external with the explicit written permission of the Chair, acting under advice from Legal Service

Appendix 3 – Terms of Reference Innovation Board

Constitution	The Board hereby resolves to establish a Committee of the Board of Directors to be known as the Innovation Board.
Membership	Trust Chair Chief Executive Director of Corporate Affairs Non-Executive Director Development Director (Executive Lead for Innovation) Clinical Director of Innovation Director of Finance Operational Director of Finance Alder Hey Charity Chair
Attendance	The following would be expected to attend each meeting: Non-Executive Director (Audit Committee) Associate Director of Finance – Strategic and Commercial Finance Head of Innovation – Insight and Engagement Head of Innovation – Commercial and Delivery The following would attend as required by the agenda: Innovation Consultants Innovation Project Manager
Representation	Chair or Nominated Deputy. At least one representative from Innovation, Finance and Executive.
Frequency/ Duration	Meetings shall normally take place on a monthly basis with a minimum of 10 meetings per year.
Authority	The Innovation Board is authorised to: • Consider, for 'decision', all actions/schemes that are brought to the meeting by the members or invitees; • Direct, monitor and control the actions/schemes and hold those accountable for delivery by agreed dates; • Escalate issues outside its authority and any areas of concern, to the Trust Board on a monthly basis; • Ensure the feasibility and sustainability of all actions/schemes

	at a regular interval; • Ensure value for money is obtained by the Innovation Department
Duties	The Innovation Board is required to: • Monitor the development, implementation and delivery of all schemes/actions contributing to the delivery of the Work Plan • Review progress against Key Performance Indicators. • Ensure that all new schemes/actions have an accountable manager for delivery. • Assure that each of the actions/schemes identifies the scope of benefit realisation. • Report to the Trust Board actions/schemes that have been deferred/or discontinued or have not been sustained. • Approve business cases for investment and contracts up to the value of £500,000 and advise the Trust Board for all cases above £500,000.
Reporting	The Innovation Board will ensure that the minutes of its meetings are formally recorded and submitted to the Board along with a Chair's report identifying key areas. Any items of specific concern or which require Board of Directors approval will be the subject of a separate report. The Committee will prepare and submit an annual report on its activities to the Board of Directors. The Committee will receive regular reports on performance metrics.
Conduct	The Innovation Board will develop a Work Plan with specific objectives which will be reviewed regularly and formally on an annual basis. The Committee will also review its performance against the "effective committee" checklist after six months and thereafter on an annual basis. Agendas, papers and minutes to be distributed not less than 4 working days prior to meetings. Papers to be tabled in exceptional circumstances. Any other business to be notified to the Chair of the meeting in advance.

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. This month some key projects have seen a dip in the assurance ratings - Sepsis, GDE, The Academy – and it is vital that Executive Sponsors support those project teams to bring the ratings back to an acceptable level as soon as possible.
2. The Change Programme totals towards the CIP effort are shown at slide 3; there has been real progress but further work is required to ensure that the full extent of benefits realisation is captured, for example from the GDE programme.
3. Now that we have entered the second half of the 2018/19 Financial Year, we will be starting the process of looking ahead to the 19/20 change programme and decide - notwithstanding several of our work streams are multi-year programmes – what additional projects we need to initiate to make the changes in safety, effectiveness, experience and sustainability that we aspire to deliver next year.

J Grinnell 25 Sep 18

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

1. This Board report comprises extracts from the assurance dashboard covering the 7 themes of the change programme as reporting to the Board sub-Committees: WOD 3 September; RE&I 13 September; CQAC 19 September; and R&BD 26 September.
2. The 28 projects continue to show around 37% green rated; however, the number of red rated projects had more than doubled in the past month to some 27%. Executive sponsors should focus on expediting the measures required to put these projects onto a sounder footing.
3. The weekly 'Financial Sustainability Board' is the forum – aligned with the Programme Board – that provides the challenge and support required to monitor and advance the CIP programme towards its target. The overall level of contribution from the change programme remains a risk.

J Gibson 25 Sep 18

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

See CIP status at slide 3 of this pack. Since the previous report, the 18/19 change programme forecast outturn CIP achievement at 4th September has increased by £400k to £5.5m; however, there remains a gap – black/red rated – of some £1.4m.

Change Programme 18/19

Trust Board

Programme Assurance Framework, DMO & Delivery Board

Alder Hey Children's NHS
NHS Foundation Trust

R&BD

Growing Through External Partnerships

John

1. CHD Liverpool Partnership — SG
2. Aseptics

Imminent Pipeline

- Neonatal Services

WOD

The Best People Doing Their Best Work

Melissa/Hilda

1. Portering — SG
2. Apprenticeships

Imminent Pipeline

- E-Rostering
- AHP Review

CQAC

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

Imminent Pipeline

- Models of Care

Park, Community Estate & Facilities

SG — *David* — R&BD

1. Decomm. & Demolition
2. R&E 2
3. Alder Centre
4. Park
5. Design & Build Consultancy
6. Hospital Moves
7. Community Cluster

Game Changing Research & Innovation

David — RE&I

1. The Academy
2. Developing Apps and Products with Acorn Partnership
3. Expand Commercial Research
4. The Innovation Co. Project

Strong Foundations

SG — *John* — R&BD

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

Global Digital Exemplar

John/Steve — R&BD — PB

1. Speciality Packages
2. Voice Recognition

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

Programme Contribution to CIP Status – as at 4th September 18

Weekly CIP Tracker as at 4th September 2018 by work stream

Workstream	Exec Sponsor	In Year Forecast				Recurrent Savings				Risk Rating (In Year)					
		Target £000's	Forecast Current £000's	Forecast Last Week £000's	Improvement £000's	Target £000's	Forecast Current £000's	Forecast Last Week £000's	Improvement £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	2,500	1,458	1,458	0	2,500	1,770	1,770	0	866	117	475	0	1,042	2,500
Growing Through External Partnerships	Margaret Barnaby	800	0	0	0	800	0	0	0	0	0	0	0	800	800
The Best People Doing Their Best Work	Melissa Swindell	1,000	578	578	0	1,000	20	20	0	428	0	150	80	342	1,000
Game Changing Research and Innovation	David Powell	500	0	0	0	500	0	0	0	0	0	0	0	500	500
Strong Foundations	John G/Claire L	2,200	1,638	1,689	-51	2,200	1,842	1,867	-25	962	80	596	327	235	2,200
Park, Community Estate & Facilities	David Powell	0	18	18	0	0	18	18	0	18	0	0	0	-18	0
Global Digital Exemplar (GDE)	Peter Young	1,000	0	0	0	1,000	0	0	0	0	0	0	0	1,000	1,000
Subtotal: Strategic Workstreams		**8,000**	**3,692**	**3,743**	**-51**	**8,000**	**3,650**	**3,675**	**-25**	**2,274**	**197**	**1,221**	**407**	**3,901**	**8,000**
Divisional Business		-1,043	1,801	1,721	80	-1,043	1,409	1,330	79	1,557	73	171	331	-3,175	-1,043
Unidentified		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**6,957**	**5,492**	**5,464**	**28**	**6,957**	**5,059**	**5,005**	**54**	**3,832**	**270**	**1,391**	**739**	**726**	**6,957**

Key points to note:

- CIP Schemes identified as at 1TH September 2018 as fully developed (green) is £3.8m or 60%.
- The forecast outturn is £5.5m or 79%
- Value of schemes in progress (amber) is at £1.4 m or 20% that present a risk and scheme need to be reviewed to establish when they can be turned to green.
- The gap (red/ black element) of £1.4m or 27% is same as previous weeks and represents the underachievement of CIP.

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)

The 'e-Rostering' and 'AHP' projects remain in the imminent pipeline; the prospective executive sponsors should bring the planned starting dates to the next Programme Board.

The ratings for the two live projects are a credit to the project teams and the support offered by the DMO.

Work remains to fully define the schemes to deliver the £1m target in 2018/19, the most recent CIP Summary contributions shows this work stream has a gap of some £353k. The WOD sub-Committee should be considering this challenge, together with the Director of HR/OD and Director of Nursing to examine what other schemes might be brought forward to mitigate this shortfall.

John Grinnell, Director of Finance 28 Aug 18

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

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

The 'Apprenticeships' project continues to be particularly well run and this is evidence of consistently good project management (on the SharePoint site) by the project team and the application of their partners from the DMO.

The 'Improve Portering Services' project continues to be amber rated due to the ongoing and is subject with ongoing discussions with staff side.

Joe Gibson, External Programme Assurance 28 Aug 18

The Best People doing their Best Work – as at 9 Aug 18

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 apprentisehip qualitifcations following introduction of the Apprenticeship Levy.	Melissa Swindell		●	●	●	●	●	●	●	●	Weekly project leads meeting notes are available on SharePoint to 3 Aug 18 and Steering Group to 2 Jul 18. A PID is available at v6 dated 28 May 18. A detailed Milestone Plan is available and is being closely tracked; some milestones have slipped and several open entries (left of the date line) need to be categorised as 'complete' or 'missed'. Comms/Engagement activities detailed in PID and a comms plan is in place with extensive stakeholder engagement materail in evidence. Evidence that risks are up-to-date on Ulysses is now on SharePoint. EA/QIA complete. **Last updated 6 Aug 18.**
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 to 24 September 2018. The project is now subject to negotiations with Unions following rejection of the proposals by ballot on 20 Apr 18. The Trust will be meeting imminently with the Unions to try to agree a trial period and the project work will await the outcome of those discussions. Evidence available of Comms/ Engagement activities. Risks uploaded as per Ulysses Risk Log of 7 Aug 18. EA/QIA complete. **Last updated 7 Aug 18.**

Alder Hey Children's NHS
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Programme Assurance Summary
Game Changing Research & Innovation

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

The inclusion of these projects in the assurance framework is a decision of the Programme Board, on behalf of the Trust Board; therefore, the assurance observations (overleaf) should prompt the action of the Project Teams, Steering Groups and RE&I sub-Committee.

It follows, that the lack of assurance evidence for both projects in this work stream should be addressed by the sub-committee on behalf of the Trust Board.

The standards of project working and evidence issues now require the personal attention of the executive sponsor.

Claire Liddy, Director of Operational Finance – 5 Sep 18

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

The 'Academy' project is suffering from what appears to be a hiatus in project management; there has been no substantive addition to the assurance evidence since the Mar-May 2018 period, including an absence of minutes from any forum 'managing' the project. The forecast of income for 18/19 continues to fall well short of target and there is no clear link between the activity plans and the delivery of benefits.

The 'Developing Apps' project is encountering the same issues (as above) in that there is a lack of a timely flow of assurance evidence. Again, the solution here is to tighten the sense of project 'grip' and ensure that the documents are uploaded to SharePoint. Benefits measurement in particular should have commenced in Sep 18 but there is no sign yet of this happening.

Joe Gibson, External Programme Assurance – 5 Sep 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	5 Sep 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		🔴	🔴	🔴	🟡	🟡	🟡	🟡	🟡	There is evidence of an 'Academy' team meeting up to 12 Apr 18 in so far as agendas have been uploaded; however, there is no evidence of the action notes that are required under the meetings ToRs. The PID remains out of date and needs to be refreshed. Benefits are off-track according to the tracker and last updated March 2018. Milestone Plan has been updated but only out to Mar 19 (so does not support delivery of revised benefits). Comms/ Engagement activities to be tracked with evidence provided where possible. Risks transferred to Ulysses and evidence is on SharePoint but most recent upload May 2018. EA/QIA signed by Execs, confirmation required that 2017 certificate relates also to 18/19 programme. **Last updated 7 Aug 18.**
RE&I 6.3	**Developing Apps and Products with Acorn Partnership**	To set up the Acorn Partnership charged with creating a pipeline for developing the Innovation Machine's Apps	David Powell		🟢	🟢	🟡	🟡	🟡	🟢	🟢	🟢	Evidence of meetings of a 'Project Delivery Group' to 5 July 2018. A revised PID has now been uploaded with key benefits and timelines updated. A high level Milestone Plan has been uploaded and is being tracked (last update May 18). No explicit measurement of financial benefits could be found even though these are due to commence in Sep 18 (£450k Sep 18 and £450k Mar 19). Comms/Engagement activities have a plan but this should be updated regularly (weekly), no indication of whether 18 events since early June have been completed. Risks on Ulysses with evidence uploaded, the team need to check that these do encompass all the main risks to the Trust. EA/QIA has been completed and signed but needs reviewing and updating. **Last updated 5 Jul 18.**

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)

While there is a sustained improvement in at least half of the project dashboard ratings, the ratings for 'benefits identification and delivery' - for both quality and sustainability benefits – need to be improved to reduce the risk (given the assurance ratings overleaf). The sustainability gap is some £1m against the target of £2.5m for FY 18/19.

There continue to be issues with the Sepsis project being able to evidence all of the work in progress on the programme SharePoint site; however, the 'Plan' has been updated and the shortfalls in the other areas now need to be remedied.

It is requested that the relevant Executive Sponsors discuss what further clarity and/or support may be required to put the projects on the right assurance footing.

Claire Liddy, Director of Operational Finance – 11 Sep 18

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

The overall ratings from the 'Delivering Outstanding Care' continue to improve this month, with the May 2018 ratings of 4 red rated and 2 amber rated projects now superseded by 3 green rated, 2 amber and a single red rated project. However, there remain concerns around the tracking and attainment of benefits for 5 out of the 6 projects and this trend should be discussed by the sub-Committee.

Moreover, with some further effort the 'Patient Flow' and 'DETECT' projects will be able to further improve the assurance picture and Executive Sponsors should engage with the teams to this end. Turning to the Sepsis project, it is essential the revised approach formulated by the Executive Sponsor starts to improve the evidence across all of the assurance domains.

Joe Gibson, External Programme Assessment – 11 Sep 18

Programme Assurance Framework

Delivering Outstanding Care (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	CQAC	Report Date	11 Sep 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating (sheet 1 of 2):

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 now fully in place and good minutes of Steering Group available (to July 2018) and Project Leads meeting (to 16 Aug 18) with action notes tracked; a future schedule of meetings has been planned. The PID is detailed and clear but at least two of the targets are trending in a negative direction; the project team should consider these results and the update of clinician satisfaction metric (last reported April 18). There is a comprehensive milestone plan being tracked. A risk register is held and is up to date. There is a planned approach to stakeholder engagement. **Last updated 4 Sep 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 and documented (attendance lists would add value). The PID still requires work to fully define benefits. Benefits tracking plans are comprehensive but with some baselines still to be established. The Gantt Project Plan is now complete and being tracked but with several milestones delayed. There is a comprehensive suite of stakeholder engagement. The risk register is detailed with risks last reviewed on 7 Aug 18. EA/QIA signed off and uploaded. **Last updated 5 Sep 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										Comprehensive Mental Health project team meetings: the Steering Group forms part of the CAMHS board agenda on first Thursday of each month while meetings to discuss each work stream and the milestones happen on a fortnightly basis; evidence of both meetings is on SharePoint; the Steering Group ToRs need to be clear about whether thay apply to the CAMHS Board or the 'Fortnighly Meetings' - this is currently unclear (and perhaps not sustainable). There is a comprehensive PID (although the PID high level milestones should project out to the end of the project cycle) and benefits are defined. A good milestone plan is in place and being tracked. There is still no evidence of wider stakeholder engagement (the folder currently holds project team minutes). A Ulysses risk log has been completed but needs the risk review dates to be completed. A signed EA/QIA has been uploaded. **Last updated 3 Sep 18.**

Programme Assurance Framework

Delivering Outstanding Care (Completed by Assurance Team)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	CQAC	Report Date	11 Sep 18
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating (sheet 2 of 2):

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	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 SAFER Task Force minutes up to 30 August 2018. The PID needs further work on benefits and high level milestones. A detailed milestone plan has been uploaded for SAFER but milestones need further additions to due dates. Stakeholder engagement evidence is limited to a 'Black Marble' presentation and a 'SAFER FSB' presentation, additional evidence is now required. A rcomprehensive risk register has been prepared but target risk scores are missing and also actions to reduce risk for some entries. An EA/QIA has been drafted for signature. **Last updated 5 Sep 18.**
CQAC	Sepsis	This project will ensure prompt recognition and management of the deteriorating patient and implementation of the Sepsis Pathway	Hilda Gwilliams		🟡	🟢	🔴	🟢	🟡	🟡	🟢	🟢	Sepsis Steering Group minutes available to 13 Jun 18 with next meeting due 15 Aug. PID complete. Benefits defined, tracking/reporting of benefits has commenced but last up-dated figures are December 2017. From the benefits tracker on SharePoint: 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. However, there is also data to August 2018 showing time to prescription for High Risk at 71.8% and for Low/Mod/High at 72.2%. Training records for nurses were at 91% overall at February 2018. Milestone Plan for 2018/19 has been uploaded and last updated 10 Sep but needs further milestones beyond October 2018. Evidence has been provided for certain stakeholder engagement activities but there is no tracked communications plan (since 2017). Evidence now on SharePoint of risks on Ulysses system (last update May 2017). EA/QIA complete. **Last updated 10 Sep 18.**
CQAC	DETECT Study	Using smart technology to reduce critical deterioration	Hilda Gwilliams		🟢	🟡	🟡	🟢	🟡	🟡	🟡	🟡	Evidence of project team meetings has been uploaded to SharePoint. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed; however, the metrics are still required for the measurement of benefits. A detailed Gantt Chart is available (uploaded 17 Jul 18) and will now need tracking on SharePoint. There are materials uploaded which indicate stakeholder engagement but there is no communications plan in evidence. There is a risk register and it would benefit from being in Trust standard format. An EA/QIA has been drafted and needs sign-off. **Last updated 2 Aug 18.**

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)

The Monday 'Sustainability Delivery Group', by exception, needs to play a role in discussing the status of GDE benefits realisation across the Trust. The CIP tracker (here at slide 3) is showing £0 achievement and £0 forecast for 2018/19. Work needs to be completed by Divisions to urgently reconcile the tracker and include all relevant benefits.

As agreed at the GDE Programme Board, the evidence of the progress of the operational divisions taking ownership of, and managing through, the 'potential benefits' being reported by the GDE programme, needs to become visible to the assurance framework (SharePoint) and the wider organisation.

Claire Liddy, Director of Operational Finance – 18 Sep 2018

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

The lack of realised benefits, compared to the 'Statement of Projected Benefits' estimating £2.08m cash realising for 2018/19, has resulted in a red rating for GDE benefits and – at month 6 – the overall rating has now moved to 'red'; moreover, the uploading of evidence for other aspects of the programme governance to SharePoint has fallen by the wayside and needs to be addressed.

Furthermore, the 'Speciality Packages' project is now 'red' rated due to a lack of updates to the documentation on SharePoint. The 'Voice Recognition' project (see previous reports) remains 'amber' rated, due to the difficulty in realising the planned benefits, albeit there continues to be a high standard of project management.

Joe Gibson, External Programme Assessment – 18 Sep 2018

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	18 Jun 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										Programme Board Minutes and Agenda only in evidence up to April 2018. GDE Action Log uploaded to 14 Aug 18. PID of 28 Jun 17 v8 available. 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 or forecast in 2018 while SoPB proposes £2.08m cash realising benefits in 2018/19 (VfM Tracker). Milestone Plan on Dashboard, uploaded 10 Sep 18, shows some delivery dates missed; several milestones have RAG ratings that do not reflect the delivery dates. Stakeholder evidence has been uploaded with a register updated to May 2018 with Newsletters to 8 June 2018. Risk protocols vis-à-vis national and Trust sytsems have been harmonised but not updated on SharePoint since 14 Mar 18. **Last updated 10 Sep 18.**
R&BD 4.1a	Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Steve Ryan/ John Grinnell								N/A	N/A	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 on SharePoint 24 weeks ago, 27 March 2018, and many milestones outstanding are unreported. Stakeholder engagements entered to 8 Jun 18. Risk protocols vis-à-vis national and Trust systems are now harmonised and finalised. Risks and issues aggregated at GDE programme level but not updated since 4 May 18. **Last updated 13 Jun 18.** 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 10 Sep 18.**

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 fully green ratings.

The expected benefits from the CHD Liverpool Partnership need to be more fully described and the evidence uploaded to the programme SharePoint site.

The estimated contribution to the CIP effort from this work stream is still showing zero at month 6; this should be taken up by the Sustainability Delivery Group as an exception for discussion.

Claire Liddy, Director of Operational Finance – 18 Sep 2018

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

The lack of comprehensive evidence from the CHD Liverpool Partnership is of concern and the programme team, under the guidance of the executive sponsor, is requested to discuss how the governance of this partnership programme will feed into the Alder Hey assurance framework. It is suggested that updated plans (and associated programme documentation) could easily be shared and uploaded to the SharePoint site.

The exception report for the Aseptics project, to re-baseline the milestone Plan, was endorsed Programme Board in June 2018; the current ratings show that the project is now being managed to a satisfactory standard.

Joe Gibson, External Programme Assessment – 18 Sep 2018

Sub-Committee	R&BD	Report Date	18 Sep 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		🟢	🟢	🟡	🔴	🟡	🟡	N/A	N/A	Minutes of meetings and governance structure now uploaded to SharePoint. Following NHSE decision on 30 Nov 17, project documentation has been developed to provide a mobilisation plan. Milestone Plan uploaded, with tabs for various work streams, but is not being tracked on SharePoint since June 2018. Benefits need to be further refined with evidence on SharePoint. Risk Register uploaded and risks not reviewed since 5 Apr 18. **Last updated 18 Jun 18.**
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.	Mags Barnaby		🟢	🟡	🟡	🟢	🟢	🟢	🟢	🟢	Minutes of the Quality Management Meeting of the Aseptics Services Department are available and up to date to 2 Aug 18. Scope is decribed by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' now dated 16 March 2018'. Targets and benefits are being closely tracked but not yet reaching aspired thresholds. A Gantt chart is in place and being tracked in accordance with the 'Exception Report' uploaded on 22 Jun 18; there are some minor delays to milestones and it as 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. **Last updated 6 Sep 18.**

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)

The executive Sponsor for the 'Community Cluster' project needs to provide a date by which the project will be fully mobilised so that ratings of all domains can be conducted.

Elsewhere, the improvement in ratings for the 'Park' and 'Hospital Moves' projects is noted and thanks to the project teams concerned for moving these onto a better assurance footing. The remaining projects on amber/red ratings need to now show a similar improvement.

Claire Liddy, Director of Operational Finance – 18 Sep 2018

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

The work stream ratings are now showing signs of improvement: in June 2018, of the 7 projects with evidence on SharePoint, 3 were amber rated and 4 red; at September 2018, with 6 projects 'live', 2 are green rated, 2 amber and 2 red,

The 'Decommission & Demolition' project needs to be addressed and the 'International design and Build Consultancy', not having the attributes of a 'project' should be considered by the programme Board for removal from the assurance framework.

Joe Gibson, External Programme Assessment – 18 Sep 2018

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

Programme Assurance Framework

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

Alder Hey Children's NHS
NHS Foundation Trust

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 18/19													
R&BD 5.1	**Decommission & Demolition**	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell										PID available, however details of benefits requires review in line with revised/ updated dates. Milestone plan shows that all planned activities have now completed; confirmation required of the milestones dates for future activity. Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses but no updates to SharePoint. **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 April 2018. The R&E Commissioning Plans and notes of the related 'Agile' meeting are also available. PID available, benefits to be confirmed. Milestone Plan continues to show some significant delays with key milestones running late but is being tracked as recently as 11 Sep 18. There is a key dependency on the 'Agile' working project which remains in 'pipeline' status; however, detailed evidence of the work of the 'Agile' group is now on SharePoint and stakeholders are being engaged with a 'Handbook' and FAQs. Issues Log uploaded to 11 Sep 18, risks to be entered on Ulysses. Deatils of Catering options are also on SharePoint. EA/QIA completed and signed off. **Last updated 11 September 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); it is understood that construction that was due to start at the beginning on June (according to plans on SharePoint) has not yet commenced. Finalisation of design has been completed with start of build scheduled 2 months later than showing on the plan. Evidence of Comms/ Engagement activities. Risks to be confirmed on Ulysses. EA/QIA complete. **Last updated 4 Jun 18.**
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										Steering Group reports available to 31 July 2018 and governance structure in place (notes from Steering Group should also be uploaded). Updated PID on SharePoint showing comprehensive suite of benefits and high level milestones through to end of project life cycle. An indication of progress against benefits targets (RAG rating or % confidence level achieved would be useful). There is a detailed Milestone Plan which would benefit from some further precision on re-scheduling of missed dealines; there is also an extremely informative 'Springfield Park Update' available. A comprehensive 'Engagement Ops Plan' is in evidence (this would benefit from status indicators). A Risk Register has been uploaded and risks last reviewed on 22 Jun 18. EA/QIA complete. **Last updated 29 Aug 18.**
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								N/A	N/A	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 4 Jun 18.**
R&BD 5.7	**Hospital Moves**	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										A list of 'Commissioning Meeting' membership is available as well as project governance structure; however, there is no evidence of meetings available on SharePoint apart from the 'Records and Transcriptions' meeting. The PID dated 9 Jan 18 is available on SharePoint and provides a comprehensive summary of scope and approach. A high level critical path has been uploaded as well as an option for external provision of space. There is now a detailed Milestone Plan now uploaded onto SharePoint. A risk register is being maintained (important to have dates for 'risk raised' and 'last reviewed'). EA/QIA signed, important to review during the project as different accommodation options are decided upon. **Last updated 10 Sep 18.**
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.**

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)

The ratings across this work stream have improved again this month and the efforts of the project teams should be commended; the focus should remain on bringing all the SharePoint ratings into the green zone.

The 'Energy' project needs to be completed in terms of the full suite of project documentation.

The mobilisation of the 'Catering' project is now fully underway and the operational progress in encouraging. The financial recovery process now needs to follow swiftly.

Claire Liddy, Director of Operational Finance – 18 Sep 2018

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

The project teams have improved and now sustained the majority of the assurance evidence – in terms of working project documents - and this trend is reflected in the ratings.

The two 'Energy' project should be considered by the Programme Board for it's inclusion in the assurance framework as it lacks (according to the SharePo0int documentation) both depth and breadth of ambition.

The Catering project has now been launched and the assurance evidence is showing good early progress.

Joe Gibson, External Programme Assessment – 18 Sep 2018

Programme Assurance Framework

Alder Hey Children's NHS Foundation Trust

Strong Foundations (Completed by Assurance Team) - Current Dashboard Rating:

Sub-Committee	R&BD	Report Date	18 Sep 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 shows project is on track to realise full benefits as projected. Evidence of stakeholder engagement has been uploaded (albeit relatively narrow). EA/QIA now signed off. **Last updated 7 Sep 18.**
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 2 Aug 18. Evidence of stakeholder engagement now uploaded but not extensive. EA/QIA signed off. **Last updated 7 Sep 18.**
RABD 7.3	Medicine Optimisation	To deliver the trust MO strategy and deliver quality improvements and financial benefits	Steve Ryan										Team structure now complete and actions notes of Steering Group available up 13 Jul 18. POD now uploaded, needs to show phasing of savings across the year to allow coherent feed into Trust CIP tracking. Plan uploaded, needs completion; tracking and completion of milestones for actions and benefits needs to be clear. Good stakeholder engagement evidence is emerging. A risk register has been uploaded. EA/QIA complete. **Last updated 13 Aug 18.**
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										Project team structure now complete. Minutes of Steering Group available up 26 Apr 18. POD uploaded and benefits baselines still to be established. Detailed benefits tracker uploaded, with savings starting to flow and forecast to meet target. Detailed Milestone Plan in evidence, tracked and up to date, with project actions over the full project cycle. Detailed evidence of stakeholder engagement has now been uploaded. Risk register in place and last reviewed on 1 Aug 18. It has been confirmed that the QIA signed of at end of 2017 applies to the 18/19 programme (and will be reviewed in Dec 18). **Last updated 12 Sep 18.**
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 team meetings is available to June 18. The POD available available on SharePoint gives no details of financial benefits expected for 2018/19. The project plan for 18/19 contains only 6 actions (2 of these relate to usage monitoring and 2 relate to a compensation claim; more detail is required if this is to be considered a project). Evidence provided concerning risks is limited to the single BAF entry. QIA signed off for the 18/19 programme. **Last updated 1 Aug 18.**
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										Evidence is available for the initial project team meeting that took place on 15 Aug 18. The extensive and detailed 'Review of Catering Services – Final Version' dated January 2018 is serving as a detailed PID. There is a 'Catering Project Benefit Tracker 2019/20' in development. A comprehensive Gantt chart plan has been prepared arising from the review, it is being monitored, and is largely on track. More evidence will be required in terms of stakeholder engagement. Risks have been identified and are being managed. An EA/QIA has been drafted for signature. **Last updated 11 Sep 18.**

NHS
Alder Hey Children's
NHS Foundation Trust

Corporate Report August 2018

How Did We Do?

Executive Summary **Month: August** **Year: 2018**

Alder Hey Children's NHS
NHS Foundation Trust

Delivery of Outstanding Care

Safe

- Never Events
  The Trust has seen 2 Never Events reported during this period of which none have resulted in moderate or above harm. Initial 72 hour review reflects system and process failure, with immediate action and ongoing investigation underway.

Highlight

- Sustained performance in relation to no grade 3 or above pressure ulcers in month.

Challenges

- Reduction in minor harm incidents remains a challenge, divisional focus including action plans. The issue forms part of the monthly calendar risk and governance meetings.

The Best People Doing their Best Work

Caring

- Friends and Family positive test results in relation to, '% who would recommend the Trust' approximately ranges between 90-100%.

Highlight

- Focused F&F work stream in ED has led to a steady increase in performance over the past 5 months.

Challenges

- 14 complaints received in month, highest recorded in previous 12 month period. On further analysis the complaints span 13 different services with no particular trend identified.

Delivery of Outstanding Care

Effective

- The sepsis team are developing improved electronic documentation to enhance accuracy of data recording and extraction and improve clarity and management prompts to medical staff and Live 'status boards' to display on wards time to ABs for individual patients and to help sepsis nurses and acute care team provide support
- New weekly performance meetings systematically checks and oversees the re-booking patients' operations within 28 days of cancellation.
- To improve clinic utilisation we are auditing the impact of bi-directional texting to inform its roll-out, perhaps in a revised form, and from 1 October 2018 we will have in place an administrative service to book appointments to replace appointments cancelled at short-notice.

Highlight

- Emergency department waiting times
- Transcription turnaround times

Challenges

- Providing antibiotic treatment within 60 minutes for sepsis patients
- Patients' operations booked within 28 days of cancellation

Delivery of Outstanding Care

Responsive

- In August a business case was approved to invest in a multi-professional team to manage complex patients. We expect the enhanced team to be in place for Winter 2018 which will focus on delivering this standard.
- The SAFER project focuses on the communication of expected dates of discharge and we are tracking improvement in this measure through this group which are presently focused on Ward 3A and 4C.

Highlight

- National standards relating to cancer, diagnostics and waiting times are all delivered

Challenges

- Sustaining a reduction in the number of patients in hospital for over 21 days
- Increasing the number of patients who know their planned date of discharge

The Best People Doing their Best Work

Well Led

- In month financial performance was £400k behind plan largely driven by cost overspend on temporary staff spend and high non pay costs which are being further investigated. This has put pressure on our forecast position
- Whilst CIP was behind plan in month further progress has been made in bridging the full year gap.
- Mandatory training has dipped below target for the first time in 6 months. Some of this reduction relates to a large block of three yearly training that was completed as part of the move to the new hospital. Divisions are focussing on ensuring compliance is maintained.
- Consultant appraisal levels are being maintained at 95%. We are relooking at how this is reported in the main report

Highlight

- Elective target delivered
- Cash balances at £21.5m following payment of 17/18 STF bonus monies
- Short term sickness lower than plan

Challenges

- Financial performance in month £400k behind plan
- PDR performance is behind our target with a revised date of end of Sept for compliance
- Mandatory training has fallen behind plan

Game Changing Research and Innovation

Research and Development

- There is a small overall increase in the total number of open studies (academic and commercial) in the year to date. The current trajectory for annual patient recruitment is c.3,000 which is above the historic annual mean for the Trust but short of the target imposed by the NIHR Clinical Research Network (CRN).
- A bid of c. £40k has been submitted to the NWC CRN for additional resources in A&E to support recruitment to existing and upcoming trials which will require out of hours cover for maximum recruitment.

Highlight

- Global first recruit for commercial rheumatology study

Challenges

- Increasing number of studies with no increase in the research delivery establishment
- Ongoing difficulties in engaging some clinical services in support of commercial research in absence of income distribution/incentivisation models.

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Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG			Comments Available
Total no of incidents reported Near Miss & Above	417	406	426	464	326	453	456	514	413	447	490	434	451		>=418	>=375	<375	✔
Clinical Incidents resulting in minor harm & above	64	73	71	88	51	84	80	94	83	78	93	85	85		<=58	<=65	>65	✔
Clinical Incidents resulting in moderate, semi permanent harm	0	2	0	2	2	2	0	1	0	1	1	1	1		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	1	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Grade 3)	0	0	0	0	1	2	0	0	0	1	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Grade 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	2	2	1	4	3	2	5	6	4	2	4	3	4		<=2	N/A	>2	✔
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	2		0	N/A	>0	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	92.3%	93.2%	95.2%	89.1%	90.9%	89.8%	85.6%	86.4%	85.4%	82.6%	83.9%	86.3%	88.2%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	97.7%	100.0%	96.8%	96.4%	92.2%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	94.2%	98.5%	97.9%	97.5%	97.3%	97.3%	96.6%	96.8%	93.7%	95.5%	94.9%	97.0%	97.0%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	96.7%	96.3%	94.1%	96.0%	100.0%	77.8%	82.8%	100.0%	87.5%	82.6%	88.9%	100.0%	89.9%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	92.0%	91.4%	95.8%	92.0%	97.7%	96.1%	91.8%	89.3%	90.3%	88.6%	86.9%	85.5%	89.7%		>=95 % >=90 % <90 %	✔
Complaints	6	4	10	12	5	12	13	5	8	11	11	12	14		<=5 <=6 >6	✔
PALS	72	121	94	119	98	145	145	129	151	126	99	101	100		<=65 <=72 >72	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG			Comments Available
Sepsis: Patients treated for Sepsis - A&E	68.8%	44.4%	54.5%	60.0%	57.1%	60.0%	42.3%	60.9%	66.7%	55.6%	57.1%	65.5%	68.2%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis - Inpatients	82.6%	72.4%	83.7%	85.4%	70.3%	74.1%	86.4%	79.2%	76.0%	72.7%	78.9%	71.4%	72.5%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
% Readmissions to PICU within 48 hrs	6.0%	4.5%	2.9%	2.4%	0.0%	2.4%	1.5%	4.1%	3.6%	2.5%	2.7%	6.5%	0.0%		<=3 %	N/A	>3 %	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	1	1	0	2	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	1	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	1	3	2	0	2	0	3	0	0	1	0	0	0		<=1	N/A	>1	✔
Hospital Acquired Organisms - CLABSI - ICU Only	0	1	2	1	6	2	4	2	2	2	2	0	1		<=1	N/A	>1	✔
Hospital Acquired Organisms - Gram Negative BSI	1	0	2	3	2	1	1	3	2	0	1	0	1		<=1	N/A	>1	✔
Bed Occupancy (Accessible Funded Beds)	74.7%	85.0%	85.1%	88.8%	78.9%	88.2%	89.3%	89.6%	90.3%	84.9%	88.5%	83.9%	76.2%		<=89 %	<=93 %	>93 %	✔
ED: 95% Treated within 4 Hours	98.3%	95.0%	94.5%	92.8%	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%		>=95 %	N/A	<95 %	✔
Average LoS - Elective (Days)	2.86	3.07	2.61	2.97	3.60	2.94	2.98	3.21	2.79	2.87	2.89	3.13	2.80		<=2.9	N/A	>2.9	✔
Average LoS - Non-Elective (Days)	2.20	2.09	2.01	1.98	1.97	2.10	1.99	2.10	1.96	2.01	2.01	1.85	2.03		<=2.2	N/A	>2.2	✔
Theatre Utilisation - % of Session Utilised	87.5%	86.5%	86.4%	84.4%	86.0%	87.2%	85.6%	86.2%	88.2%	88.5%	87.9%	89.3%	86.6%		>=90 %	>=80 %	<80 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	15	48	26	40	15	24	25	37	26	33%	44	34	18		<=21	N/A	>21	✔
28 Day Breaches	9	0	8	5	5	0	3	8	10	5	6	6	7		0	N/A	>0	✔
Clinic Session Utilisation	84.2%	83.4%	85.0%	86.2%	82.5%	85.1%	83.7%	83.8%	83.3%	83.6%	84.8%	82.0%	82.6%		>=90 %	>=85 %	<85 %	✔
Did Not Attend Rate	13.1%	12.3%	12.0%	10.6%	12.2%	10.4%	10.7%	11.3%	10.7%	11.5%	11.8%	11.9%	13.3%		<=12 %	<=14 %	>14 %	✔
Transcription Turnaround (days)	8.50	8.50	12.50	13.00	18.50	23.00	26.00	28.50	15.00	6.00	4.50	4.00	1.00		<=3	<=5	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	92.1%	96.5%	96.1%	94.9%	94.7%	94.4%	94.7%	93.1%	94.8%	91.6%	96.2%	94.7%	94.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	99.3%	99.5%	99.3%	99.8%	99.4%	100.0%	99.4%	99.8%	97.7%	98.8%	99.7%	99.7%	99.6%		100 % >=95 % <95 %	✔
IP Survey: % Know their planned date of discharge	53.9%	65.0%	57.4%	61.9%	62.5%	52.1%	59.0%	60.1%	60.5%	76.1%	63.7%	65.7%	60.6%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	91.2%	92.8%	93.8%	94.9%	90.6%	93.6%	90.9%	91.6%	91.3%	90.9%	92.7%	94.7%	91.6%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in play and learning	65.7%	73.0%	72.6%	76.7%	76.4%	78.3%	79.6%	75.0%	74.9%	77.8%	74.4%	73.1%	74.8%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	92.0%	92.1%	92.2%	92.0%	92.0%	92.2%	92.1%	92.1%	92.1%	92.0%	92.1%	92.0%	92.0%		>=92 % >=90 % <90 %	✔
Waiting List Size									13,235	13,238	12,879	12,962	12,925		<=12905 N/A >12905	✔
Waiting Greater than 52 weeks	0	0	0	1	0	1	2	1	0	0	0	0	0		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day diagnosis to treament	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % N/A <100 %	✔
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.3%	99.8%	99.8%	99.8%	99.2%	99.3%	99.0%		>=99 % N/A <99 %	✔
Number of Super Stranded Patients (21+ Days)	31	27	26	33	29	35	26	32	34	27	32	29	33		<=32 N/A >32	✔
PFI: PPM%	94.0%	88.0%	88.0%	98.0%	100.0%	98.0%	100.0%	98.0%	98.6%	99.0%	99.0%	96.0%	98.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG			Comments Available
CIP In Month Variance (£'000s)	37	5	-459	-433	-149	54	-410	864	-248	104	153	-238	-137		>=0%	>=-20%	<-20%	✔
Control Total In Month Variance (£'000s)	100	45	-688	418	218	243	17		-426	154	285	29	-396		>=0%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	786	70	1,623	-141	2,329	1,184	3,161	-887	1,090	-333	1,701	-462	-129		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	10,405	9,116	10,872	6,753	8,171	6,712	10,201	12,244	12,406	10,455	9,455	23,910	21,519		>=0%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	995	133	-16	3,837	455	1,893	1,080	19,658	218	591	425	998	741		>=0%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	-263	-148	-647	-716	-426	-538	-605	546	-17	-7	-38	-111	-311		>=-1%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	-633	60	-24	-2,703	189	-1,111	-458	1,368	-627	-431	-102	-858	-825		>=0%	>=-20%	<-20%	✔
NHSI Use of Resources	3	3	3	3	3	3	3	1	3	3	3	3	3		<=3	N/A	>3	✔
AvP: IP - Non-Elective									190	124	112	134	149		>=0	N/A	<0	✔
AvP: IP Elective vs Plan									-86	-25	-103	-85	-47		>=0	N/A	<0	✔
AvP: Daycase Activity vs Plan									-97	-112	-96	-214	63		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Plan									709	388	586	299	1,408		>=0	N/A	<0	✔
PDR	75.9%	77.7%	79.7%	80.1%	79.6%	79.7%	76.1%	76.4%	1.3%	11.3%	31.1%	64.7%	82.3%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal	81.0%	8.0%	8.0%	11.6%	13.6%	24.0%	52.1%	67.6%	69.0%	69.0%	2.0%	4.0%	6.3%		>=95 %	>=90 %	<90 %	✔
Mandatory Training	74.8%	71.8%	73.6%	80.5%	86.2%	88.9%	94.1%	92.9%	92.1%	92.0%	92.1%	91.6%	88.6%		>=90 %	>=80 %	<80 %	✔
Sickness	5.0%	4.9%	5.4%	5.3%	5.9%	6.3%	5.5%	4.7%	4.4%	4.6%	4.8%	5.3%	5.2%		<=4.5 %	<=5 %	>5 %	✔
Short Term Sickness	1.3%	1.2%	1.7%	1.5%	1.7%	2.1%	1.7%	1.5%	1.3%	1.2%	1.3%	1.5%	1.2%		<=1.5 %	N/A	>1.5 %	✔
Long Term Sickness	3.6%	3.7%	3.7%	3.8%	4.2%	4.2%	3.8%	3.2%	3.1%	3.4%	3.5%	3.8%	4.0%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	1,166	999	918	938	761	833	926	1,067	977	973	947	901	1,082		<=800	<=960	>960	✔
% of Correct Pay Achieved	99.6%	99.6%	99.5%	99.6%	98.0%	99.6%	99.3%	98.9%	99.8%	99.4%	99.5%	99.5%	99.5%		>=99.5 %	>=99 %	<99 %	✔
Staff Turnover	11.0%	10.8%	10.9%	11.0%	11.5%	11.5%	11.5%	11.0%	10.8%	11.2%	11.0%	11.5%	10.8%		<=10 %	<=11 %	>11 %	✔
Safer Staffing (Shift Fill Rate)	92.8%	93.9%	93.2%	96.2%	93.9%	95.9%	94.2%	95.0%	96.4%	96.5%	94.8%	95.0%	93.9%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	20.0%	25.0%	75.0%	60.0%	65.0%	75.0%	85.0%	90.0%	90.0%	85.0%	65.5%	97.5%	85.0%		>=85 %	N/A	<85 %	✔
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

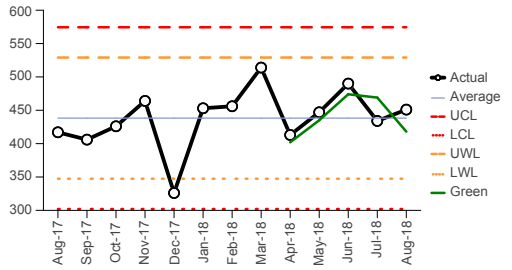
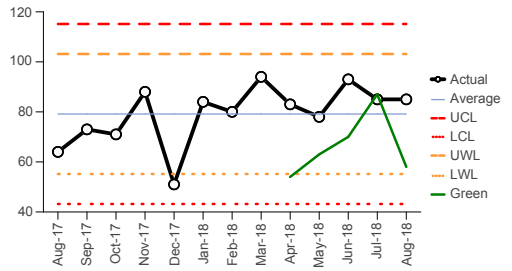
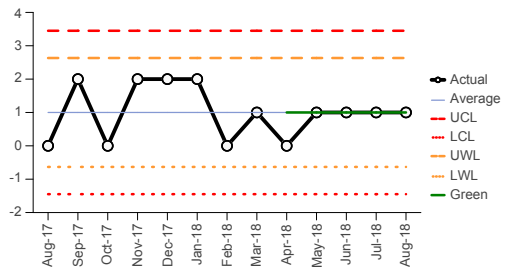
GROW THE FUTURE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic									148	153	159	159	156		>=50	N/A	<50	✔
Number of Open Studies - Commercial									34	33	34	34	37		>=5	N/A	<5	✔
Number of New Studies Opened - Academic									5	2	5	7	2		>=4	N/A	<4	✔
Number of New Studies Opened - Commercial									3	0	0	1	2		No Threshold			✔
Number of patients recruited									272	308	245	128	249		>=417	N/A	<417	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

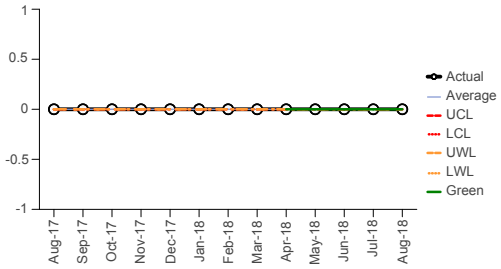
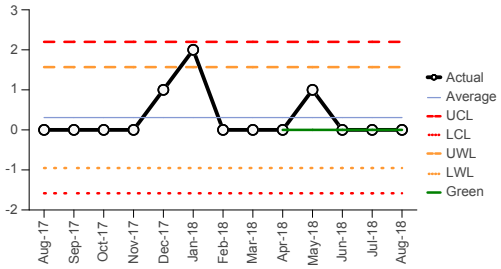
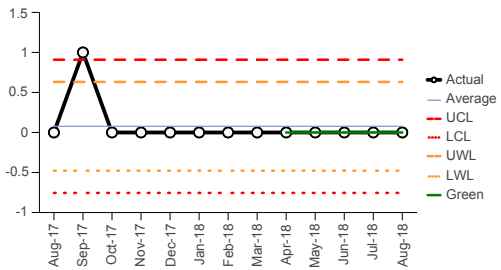
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Increasing Reporting	**Total no of incidents reported Near Miss & Above** Total number of Incidents reported. The threshold is based on increasing on last year for the period Apr 17 - Mar 18 (4,241) 18/19 aim is more than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	451	R <375 A >=375 G >=418		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in minor harm & above** Incidents reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (913). 18/19 aim is 10% less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	85	R >65 A <=65 G <=58		Weekly meeting of harm monitoring and action. Monthly Head of Quality analysis reports including lessons learned presented to Divisional Governance Assurance Committee and Clinical Quality Steering group.
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (16). 18/19 aim is 12 or less, annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

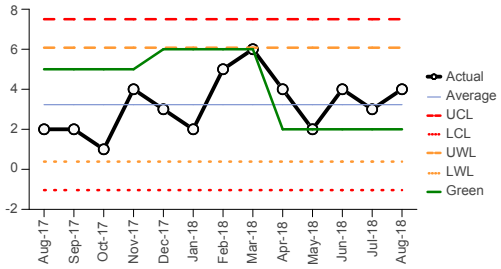
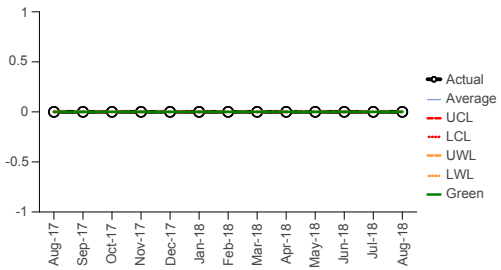
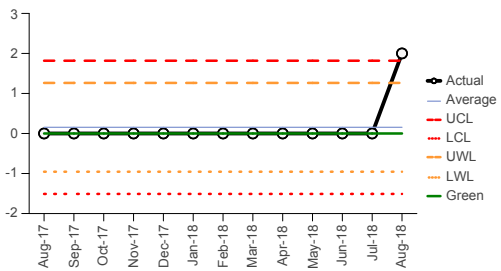
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Grade 3)** Pressure Ulcers of Grade 3. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

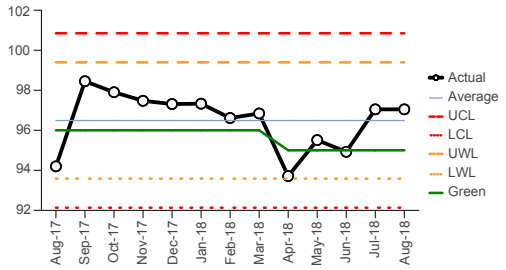
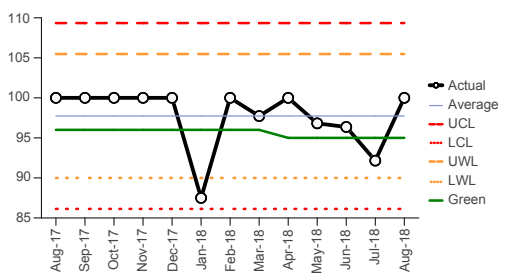
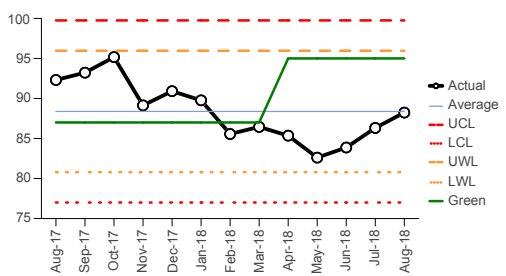
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Medication Errors	**Medication errors resulting in harm** Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (32). 18/19 aim is 2 avg per month, or less, per month (less than 24 annually) **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	4	R >2 A N/A G <=2		13/09 - All incidents minor, non-permanent harm. One reported incident was an adverse drug reaction. Bespoke training for affected ward areas organised for mid-September to provide re-training around medication safety issues. Increasing number of incidents discussed at Medicines Safety Committee. To ensure Ulysses can differentiate between clinical incidents and ADRs. Review of all incidents causing harm of any level currently being undertaken to ascertain trends and create action plan to prevent reoccurrence. AMR (MSO)
Reducing Pressure Ulcers	**Pressure Ulcers (Grade 4)** Pressure Ulcers of Grade 4. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Never Events	**Never Events** Never Events. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	2	R >0 A N/A G 0		NHS Serious Incident Framework and Never Event framework followed to assure standard of investigation's and lessons learned are implemented.

The Best People doing their best Work

8.1 - QUALITY - CARING

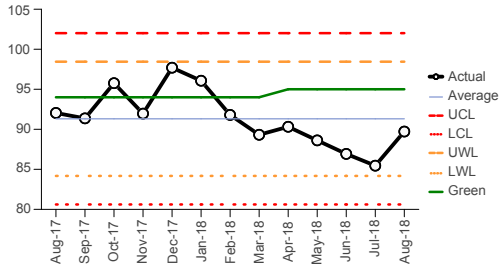
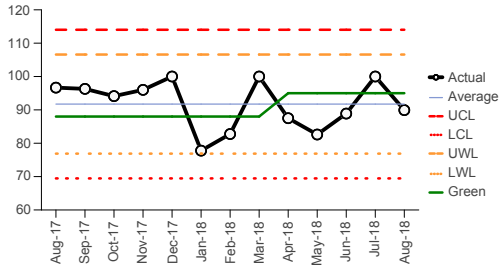
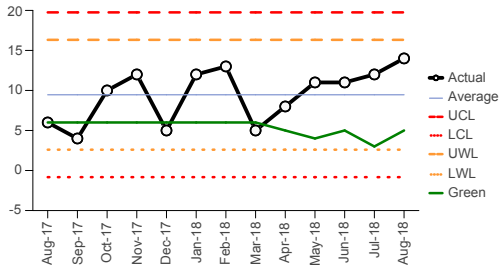
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	97.05 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family A&E - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on exceeding the National average in Nov 17. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	88.24 %	R <90 % A >=90 % G >=95 %		Positive responses for people recommending A&E have continued to increase since May 2018. Lack of communication around waiting times continues to be a source of frustration for our families. Processes have been put in place to address these issues, nobo board, triage nurse to communicate to families, discussions to use In Touch. FFT Feedback is sent for dissemination by senior managers to their divisions. Patient experience/quality lead will present the exception trends/themes action plan at the monthly divisional integrated governance meetings. The heads of quality will monitor for assuranc

The Best People doing their best Work

8.2 - QUALITY - CARING

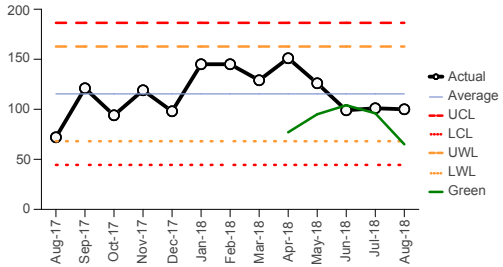
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	89.72 %	R <90 % A >=90 % G >=95 %		Feedback continues to show the same themes. 'The best positive care project' has been introduced to address the issues that arise each month. High level concerns are families having to stand when waiting for their appointment, lack of communication around waiting times in clinics. The patient experience/quality lead will discuss the feedback at the next divisional integrated governance meeting. Heads of quality will monitor actions for assurance.
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	89.92 %	R <90 % A >=90 % G >=95 %		Positive responses have increased from last year; concerns are the building is not nice, this is on retained estates. Actions have been put in place to collect higher numbers of family friend's test feedback to enable a broader measure of any ongoing trends or concerns. We are currently seeking to further develop a new innovative cost-effective approach to collect measure and evaluate FFT this will give us a real time patient experience solution using various methods of collecting feedback.
Complaints	**Complaints** Total complaints received. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (90). 18/19 aim is to reduce by 25% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	14	R >6 A <=6 G <=5		August – 14 new formal complaints received. 13 departments/specialties involved - 2 x CAMHS Sefton and 2 x Community Paediatrics. The remainder are all different areas/department/specialties therefore no link to the rise in Complaints can be highlited. 6x complaints relate to Alleged Failure of Care, 3x complaints relate to Staff Attitude, 2x complaints relate to Communication Failure, 1x complaint related to Appointment Waiting Time, 1x complaint related to Test Results not Available, 1x Complaint related to Medication Incorrectly Administered.

The Best People doing their best Work

8.3 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

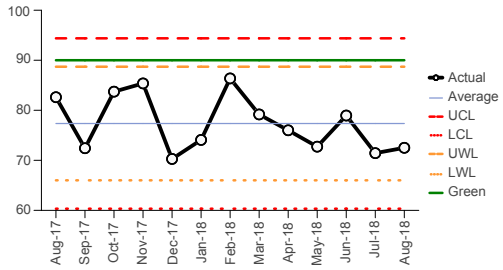
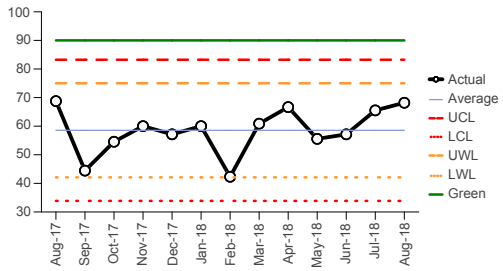
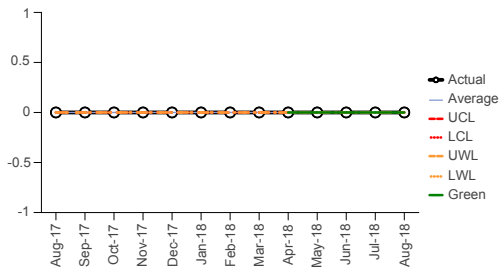
	Description	Performance	Threshold	Trend	Management Action (SMART)
PALS	**PALS** Total number of PALS contacts. Threshold is based on a 10% Reduction on 17/18 (1336). 18/19 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	100	R >72 A <=72 G <=65		PALS contact for the last three months has remained fairly static and is only three less than the same timeframe last year.

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

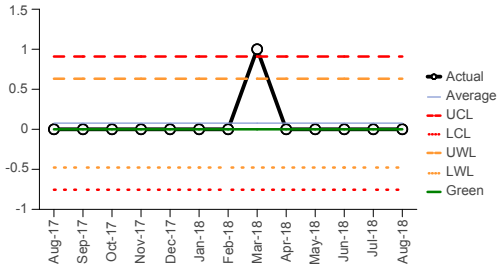
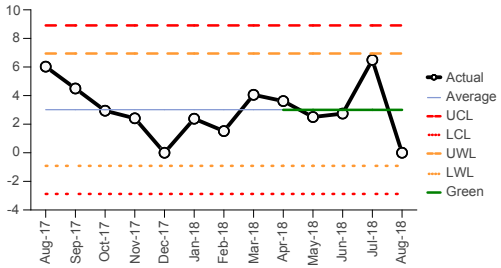
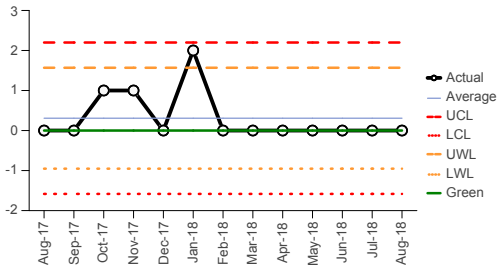
	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	72.50 %	R <90 % A N/A G >=90 %		With increased number of patients we have not dipped overall % yet. The next few months will be important to ensure training and education has been delivered/completed to raise awareness especially for winter months where we now there is an increased pressure (as shown last winter in the figures). All wards aware of training and responsibilities. Number of cases this month where there has been good support across precilaties and clinicians which will be key in busier times.
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	68.18 %	R <90 % A N/A G >=90 %		Education and training ongoing for all staff and clinicians. Lots of work to educate new clinicians and juniors regarding sepsis. Continued gradula increase in overall % now that we have changed data collection method. Positive for ED as a whole to show this improvement and also encouraging for winter months where we know there will be an increase in patients and clinical concerns about sepsis.
Mortality	**No of children that have suffered avoidable death - Internal** Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 18/19 is zero. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

9.2 - QUALITY - EFFECTIVE

BRILLIANT BASICS

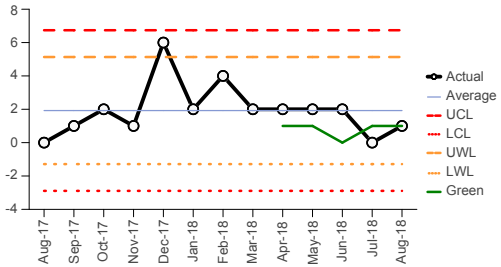
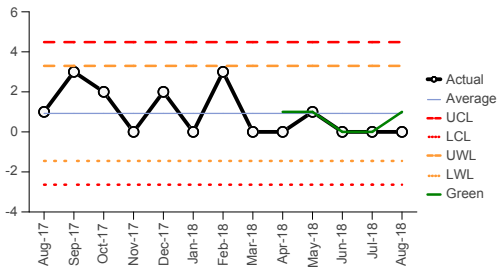
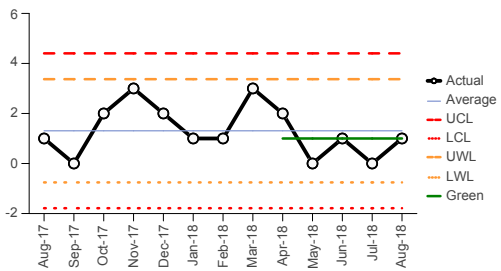
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - C.difficile** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0 %	R >3 % A N/A G <=3 %		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

9.3 - QUALITY - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

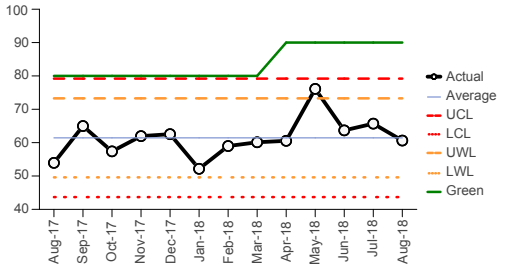
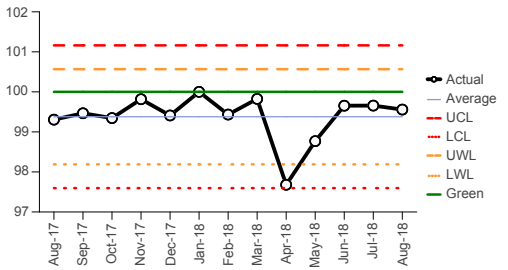
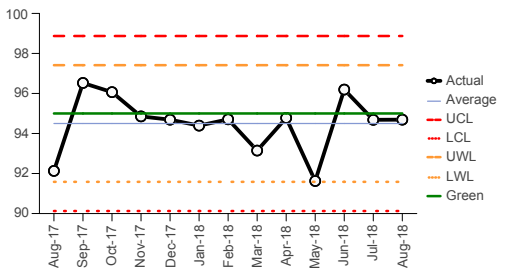
	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - CLABSI - ICU Only** Hospital Acquired Organisms - CLABSI on ICU Ward Only. 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MSSA** Hospital Acquired Organisms - MSSA . 18/19 aim is to reduce by 25% or more. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >1 A N/A G <=1		No Action Required
Reducing Infections	**Hospital Acquired Organisms - Gram Negative BSI** Gram - Negative BSI to include E Coli, Klebsiella and Pseudomonas . 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS Foundation Trust

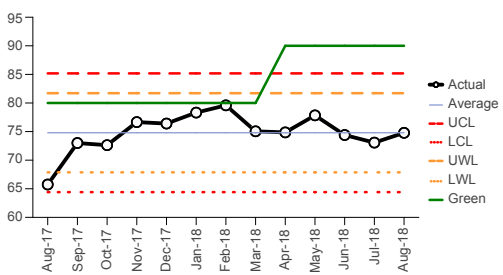
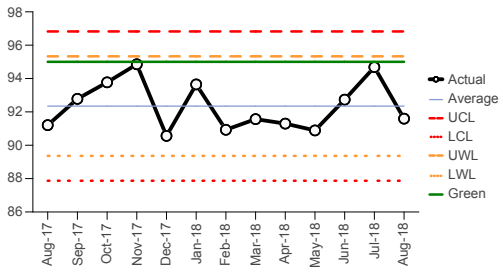
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	60.62 %	R <85 % A >=85 % G >=90 %		My Pads' have been rolled out across 3A, 3C and 4C, these are to track the patient's journey and contribute to the 'Road Home'. This concept includes EDD and is kept live by asking questions such as 'What my next steps' are, 'When is my next review' and 'who can help me outside of Alder Hey'. These are reviewed daily by nurses and named Consultants to keep in line with the EDD set. Complex Care team are also currently developing the GDE speciality package for complex care which will highlight EDD
Inpatient Survey: Respect	**IP Survey: % Treated with respect** Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 18/19 is 100%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	99.56 %	R <95 % A >=95 % G 100 %		No negative feedback around respect has been reported. This will continue to be monitored by the patient experience/quality lead and will be shared at the divisional integrated governance meeting in September.
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	94.69 %	R <90 % A >=90 % G >=95 %		Each patient has an allocated nurse; ongoing trends and themes have been added to the FFT exception action plan. The patient experience/quality lead will share with senior managers, and discuss at the next divisional integrated governance meeting. Heads of quality will monitor the plan for assurance and progress

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

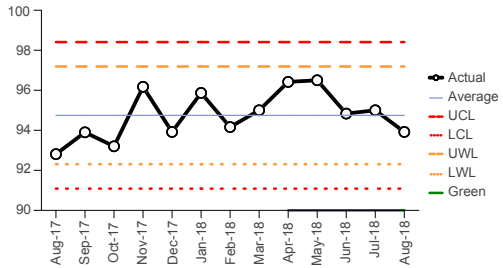
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Play and Learning	**IP Survey: % Patients involved in play and learning** % of children / families that report engaging in play / learning. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	74.78 %	R <85 % A >=85 % G >=90 %		An 18 month strategy plan is in the process of being developed to identify areas of concern and achievable actions to be in place. This will be led by the patient experience/quality lead and supported by the play manager, patient experience team and volunteers. Referrals are now being recorded which will see an increase in financial benefits; in return staff resources will increase and enable more engagement. Extra play materials will be sourced through the charity.
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	91.59 %	R <90 % A >=90 % G >=95 %		Each patient has an allocated nurse; issues have been put on the FFT Exception action plan and shared with senior managers, heads of quality will monitor for assurance and progress.

The Best People doing their best Work

11.1 - QUALITY - WELL LED

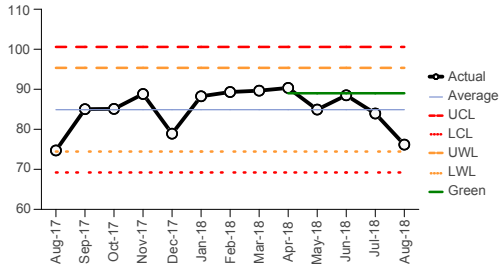
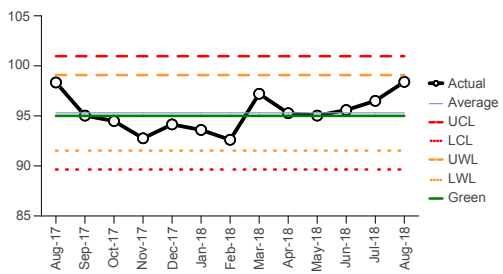
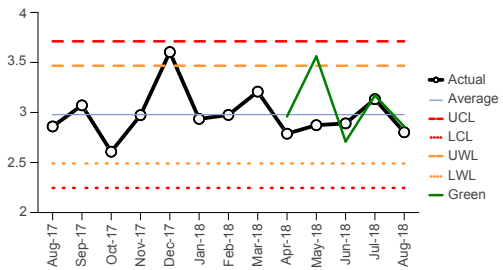
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	93.92 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

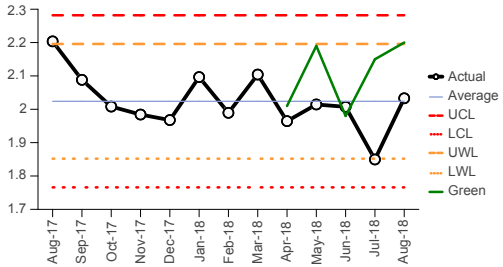
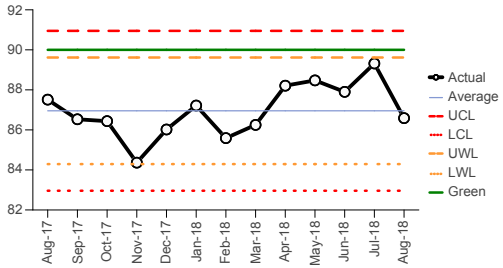
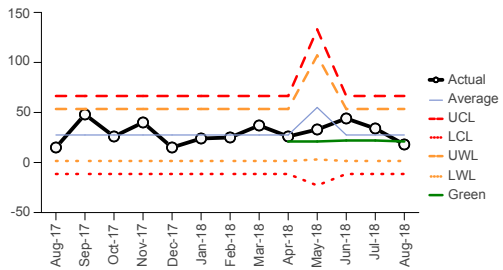
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Bed Occupancy	**Bed Occupancy (Accessible Funded Beds)** Percentage of funded beds that are occupied in accessible wards 3A, 4A, 3C and 4C, this is based on 3 occupnacy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	76.17 %	R >93 % A <=93 % G <=89 %		No Action Required
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	98.40 %	R <95 % A N/A G >=95 %		No Action Required
LoS: Elective	**Average LoS - Elective (Days)** Average Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	2.80	R >2.9 A N/A G <=2.9		No Action Required

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

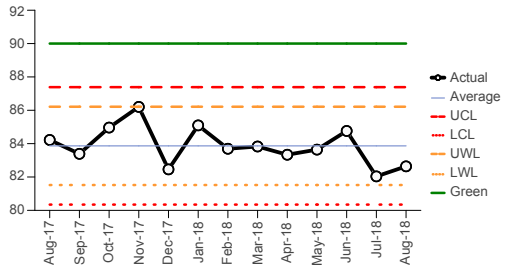
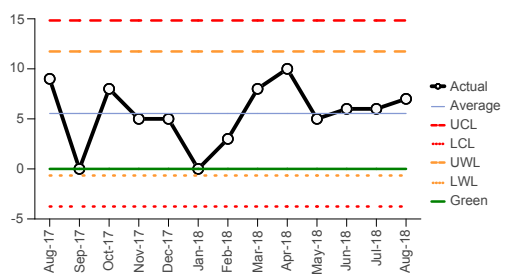
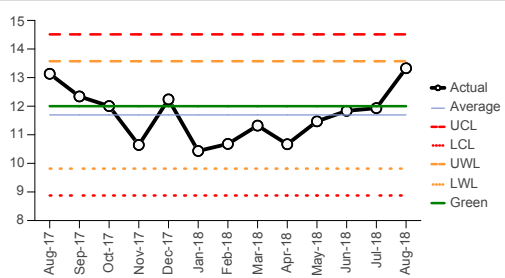
	Description	Performance	Threshold	Trend	Management Action (SMART)
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	2.03	R >2.2 A N/A G <=2.2		No Action Required
Theatre Utilisation	**Theatre Utilisation - % of Session Utilised** Threshold is based on the productive theatre improvement measures at greater than or equal to 90% utilisation of theatres. **Exec Lead:** Adam Bateman **Committee:** RABD	86.59 %	R <80 % A >=80 % G >=90 %		Detailed work for specialties with ongoing theatre utilisation is continuing. Forward planning on theatre list utilisation is being prioritised as one of the surgical winter planning actions - implementing a 6-4-2 model to ensure theatre lists are scheduled, booked and locked down with sufficient notice. A review of theatre downtime has also started to understand when and why delays are occurring.
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 25% based on 17/18 overall performance. **Exec Lead:** Adam Bateman **Committee:** RABD	18	R >21 A N/A G <=21		No Action Required

Delivery of Outstanding Care

12.3 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

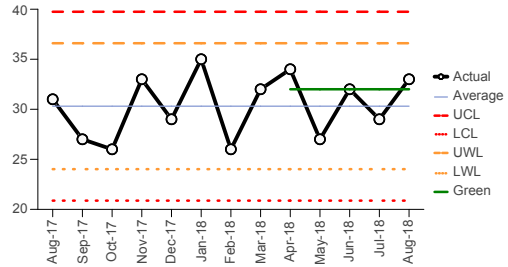
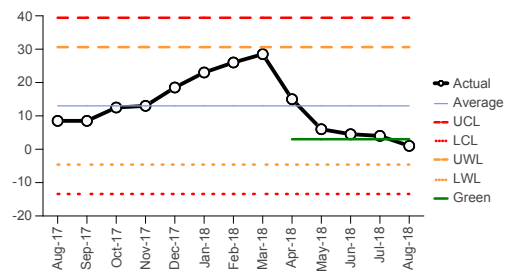
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and DNAs. **Exec Lead:** Adam Bateman **Committee:** RABD	82.64 %	R <85 % A >=85 % G >=90 %		Bi-Directional texting has commenced in number of specialties which improves a patient's parents/guardian's ability to cancel a clinic appointment via a text message. Whilst this improves the access for parents we need to counter this with a system to backfill the available slots. We have commenced a programme of recruitment which should us fully established from Sep.
Operation Breaches	**28 Day Breaches** Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	7	R >0 A N/A G 0		These breaches have occurred due to difficulty relisting patients because of surgeon and theatre list availability. This is a consequence of the high number of cancelled operations experienced from April - July. This has improved in August so the number of 28 day breaches are expected to reduce. We are revising the monitoring process for potential breaches to improve visibility and opportunity for rebooking.
DNAs	**Did Not Attend Rate** The target of 12% is a local target aligned to outpatient improvement workstreams (Hybrid Booking, Patient Demogrpahic Checking and bidirectional automate text reminders). **Exec Lead:** Adam Bateman **Committee:** RABD	13.33 %	R >14 % A <=14 % G <=12 %		Seasonal impact noted for DNA. Will reduce from September as summer holidays conclude. Brilliant Booking workstream working to improve DNA rates by improving chronological management. Planned rollout starting with community from September. Missing outcomes will also inflate the DNA rate. Patient details have been shared with the Divisions for validation so actual DNA rate will reduce.

Delivery of Outstanding Care

12.4 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

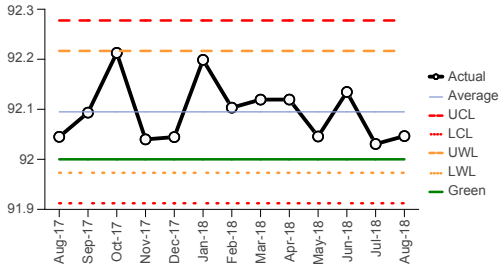
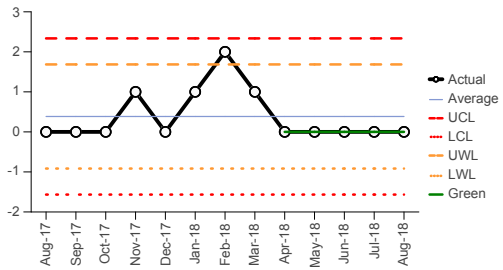
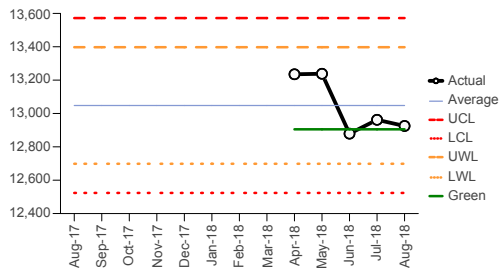
	Description	Performance	Threshold	Trend	Management Action (SMART)
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. This excludes patients on ICU/HDU/NEO and Cardiac HDU. **Exec Lead:** Adam Bateman **Committee:** RABD	33	R >32 A N/A G <=32		Business case approved for additional resource to support delayed discharges and reduced LoS above trim point. Ths will enable earlier planning and coordination for those CYP in hospital 10 days plus. Currently out to recruitment for posts. Numbers of patients 30 day plus impacted this month by requirment for patients to remain in AH as a place of safety pending social care decision making re: residence. Delay in care packages continues to impact on LoS and we are working with commissioners to address this.
Transcriptions	**Transcription Turnaround (days)** Days from dictation to typing clinic letters for services transcribed by Transcription service. Based on working day average. This is also monitored externally by our local commissioners. **Exec Lead:** Adam Bateman **Committee:** RABD	1	R >5 A <=5 G <=3		No Action Required

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

BRILLIANT BASICS

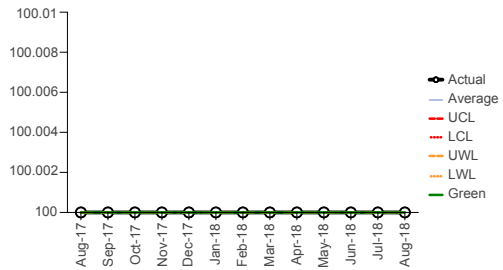
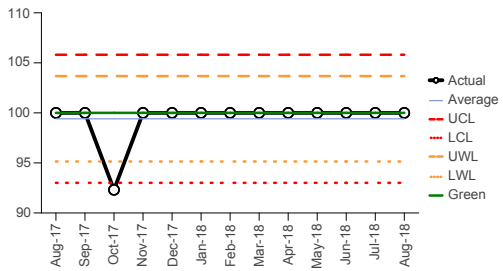
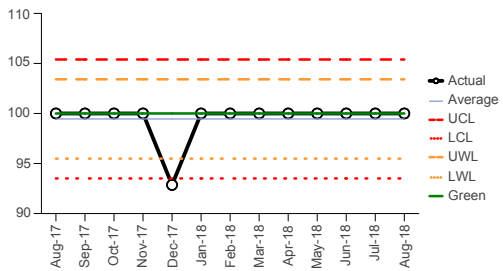
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.05 %	R <90 % A >=90 % G >=92 %		No Action Required
Waiting Times	**Waiting Greater than 52 weeks** Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 18/19 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Waiting Times	**Waiting List Size** National threshold as part of the 18/19 NHSI plan. The target is to reduced the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12925	R >12905 A N/A G <=12905		Despite flagging as red the current waiting list size is less than it was in March 18 which is the current core target. We have also imported 700 Audiology patients from N. Sefton which skews the aggregate figure. We are currently developing a process to manage DQ errors in the system which will also reduce the waiting list size. This is currently being developed with a go-live date circa November 18.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

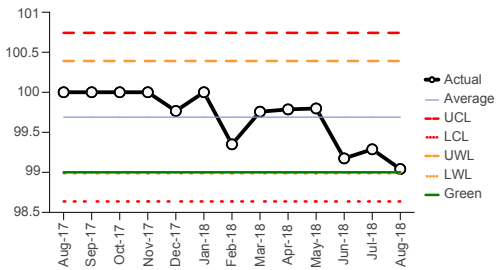
Alder Hey Children's NHS Foundation Trust

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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

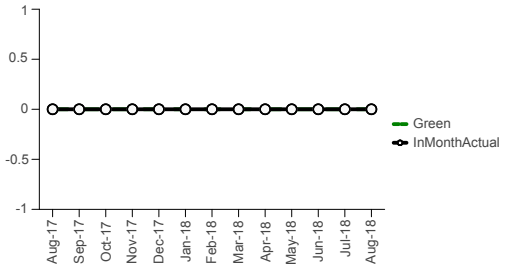
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	99.04 %	R <99 % A N/A G >=99 %		No Action Required

The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

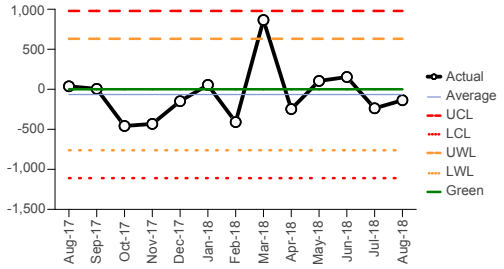
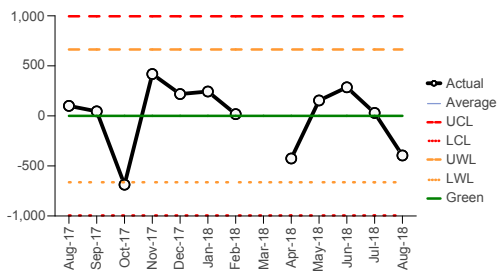
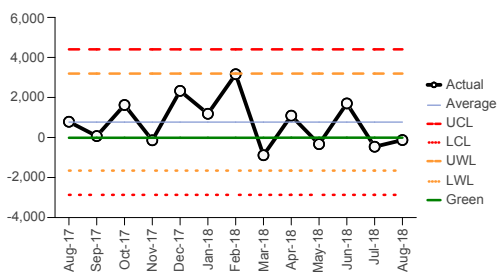
Alder Hey Children's NHS
NHS Foundation Trust

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

The Best People doing their best Work

15.1 - FINANCE - WELL LED

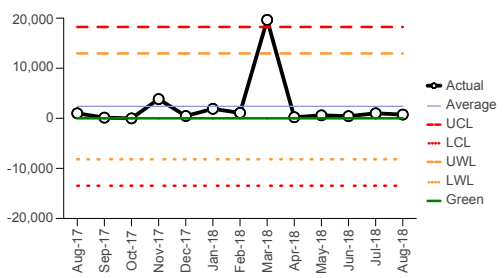
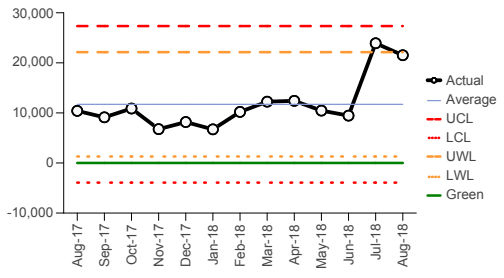
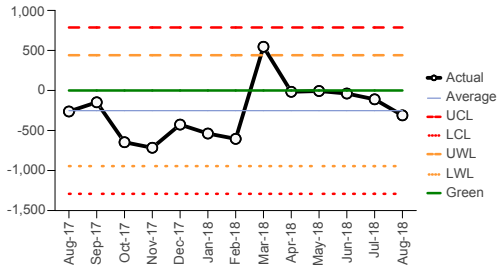
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**CIP In Month Variance (£'000s)** Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-137	R <-20% A >=-20% G >=0%		The CIP for the month of August was behind plan by £0.1m. This was mainly due to the Community and Medical Divisons. the Year to Date CIP is £0.4m behind the plan.
Finance	**Control Total In Month Variance (£'000s)** Variance from Control Total plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-396	R <-20% A >=-20% G >=0%		In August the Trust was behind the Control Total plan by £0.4m. Although income was ahead of plan by £0.7m this was offset by overspends of £1.1m. The overspends related expenditure on temporary staffing and non pay overspends which are currently under investigation.
Finance	**Capital Expenditure In Month Variance (£'000s)** Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-129	R <-10% A >=-10% G >=-5%		In August the capital programme was underspent by £0.1m. This related to slippage and delays on Estates Projects.

The Best People doing their best Work

15.2 - FINANCE - WELL LED

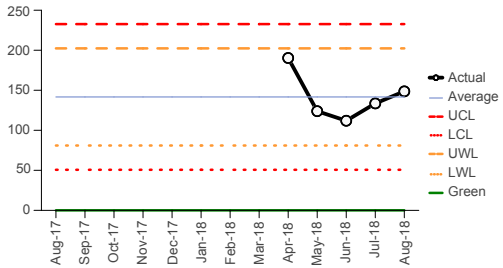
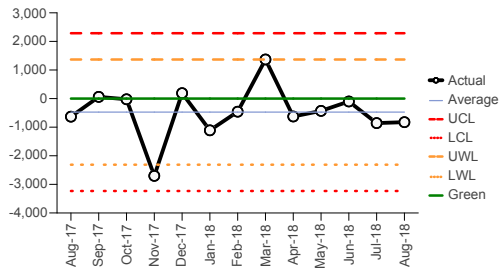
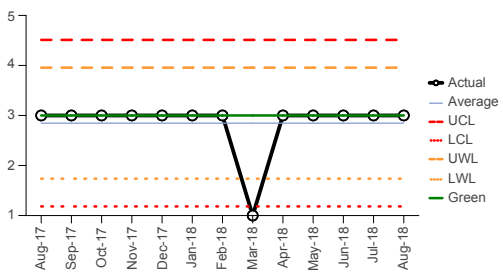
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Income In Month Variance (£'000s)** Variance from income plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	741	R <-20% A >=-20% G >=0%		No Action Required
Finance	**Cash in Bank (£'000s)** Variance from Cash plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	21,519	R <-20% A >=-20% G >=0%		No Action Required
Finance	**Pay In Month Variance (£'000s)** Variance from pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-311	R <-20% A >=-20% G >=-1%		The pay expenditure exceeded the budget in month by £0.3m. This was due to an increase in temporary staffing partly relating to activity. Therefore this overspend was partly offset by income.

The Best People doing their best Work

15.3 - FINANCE - WELL LED

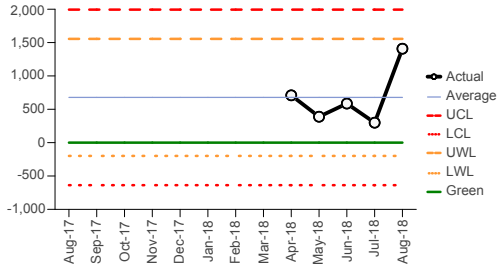
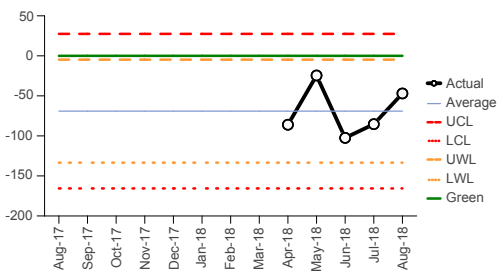
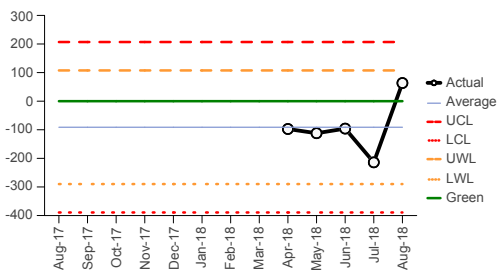
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	148.62	R <0 A N/A G >=0		No Action Required
Finance	**Non Pay In Month Variance (£'000s)** Variance from non pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-825	R <-20% A >=-20% G >=0%		The non pay expenditure in August exceeded the budget by £0.8m This related to expenditure on theatre consumable items, energy and drugs costs. Expenditure on non pay is currently subject to a comprehensive review.
Finance	**NHSI Use of Resources** NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	3	R >3 A N/A G <=3		No Action Required

The Best People doing their best Work

15.4 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

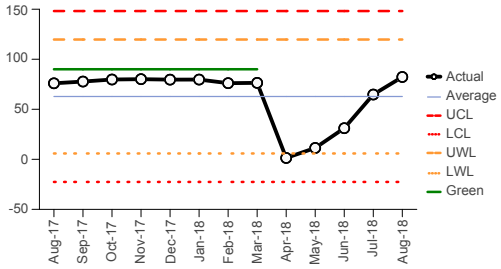
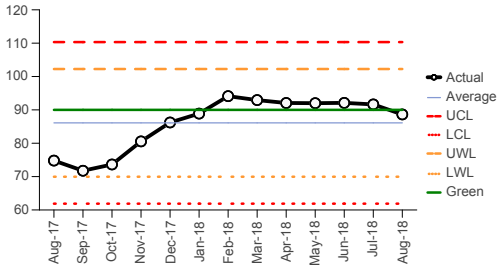
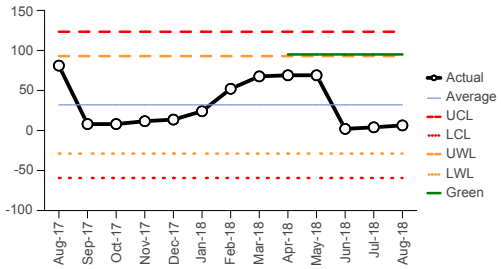
	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Outpatient Activity vs Plan** Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	1407.83	R <0 A N/A G >=0		No Action Required
Finance	**AvP: IP Elective vs Plan** Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-47.03	R <0 A N/A G >=0		The most significant adverse variance is in ENT (30 spells); considerably ahead of the next largest variance which is orthopaedics (16).
Finance	**AvP: Daycase Activity vs Plan** Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	63.42	R <0 A N/A G >=0		No Action Required

The Best People doing their best Work

16.1 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

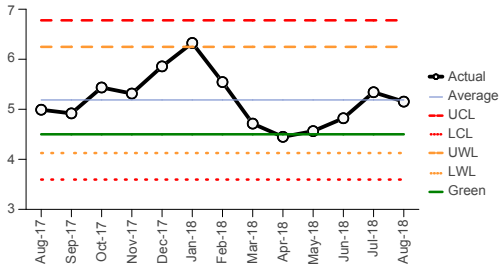
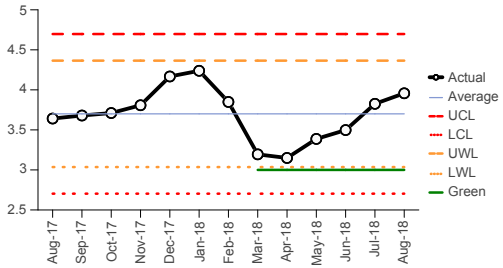
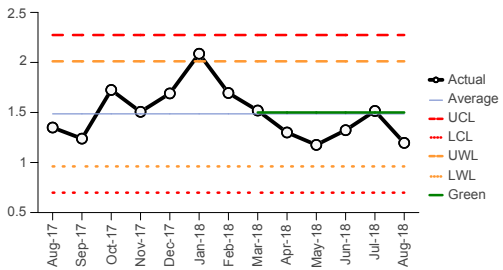
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Personal Development	**PDR** Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	82.26 %	R <85 % A >=85 % G >=90 %		Due to an exceptional agreement made with the Exec Team, the window for PDR completion has been extended to the end of September.
Training	**Mandatory Training** This is a Trust target that measures the 6 core mandatory training modules that are required of all staff (Safeguarding L1, Moving and Handling, Information Governance, Equality and Diversity, Fire Safety and Health and Safety) **Exec Lead:** Melissa Swindell **Committee:** WOD	88.63 %	R <80 % A >=80 % G >=90 %		Core mandatory training has dipped below 90% for the first time since January this year. This is due to Moving & Handling, Equality & Diversity and Health & Safety each falling between 4.2% - 4.7%. The team are continuing to work with SME's to ensure the hard work that has taken place to improve our position carries on.
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	6.33 %	R <90 % A >=90 % G >=95 %		The appraisal window is open from April –January 2019. We will only be reporting on substantive posts. We currently have 246 Consultants and SAS Drs in substantive posts. The numbers will begin to increase as we move forward. The majority of appraisals will take place between September –January

The Best People doing their best Work

16.2 - HR - WELL LED

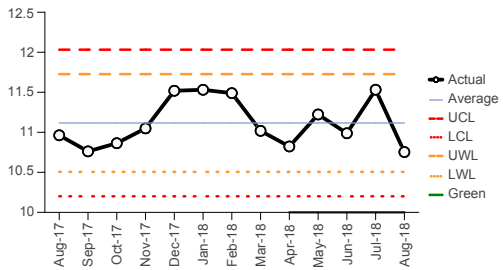
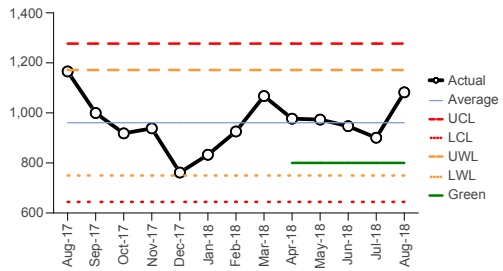
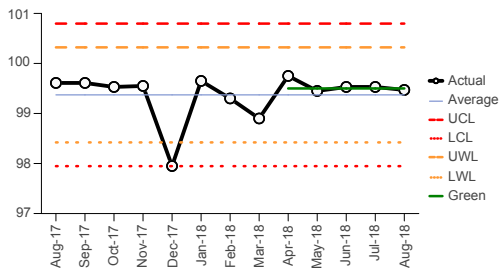
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.15 %	R >5 % A <=5 % G <=4.5 %		Sickness has started to decline since last month with the biggest reduction in the Division of Medicine, a positive step after the large spike in absences in July. Community has also seen a reduction in it's in month sickness which has contributed to the overall decrease in the Trust rate. The HR Team continue to work with managers to address any issues and support employees.
Sickness	**Long Term Sickness** % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	3.96 %	R >3 % A N/A G <=3 %		Please see comment for overall sickness percentage
Sickness	**Short Term Sickness** % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.20 %	R >1.5 % A N/A G <=1.5 %		No Action Required

The Best People doing their best Work

16.3 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

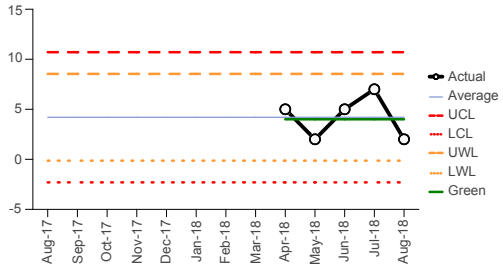
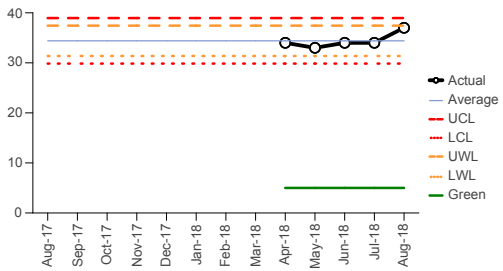
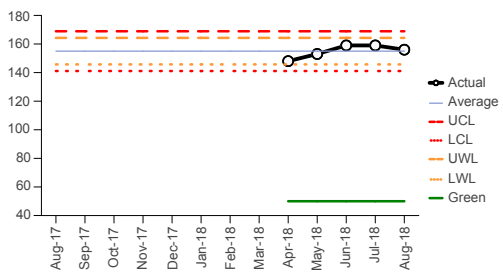
	Description	Performance	Threshold	Trend	Management Action (SMART)
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	10.75 %	R >11 % A <=11 % G <=10 %		Staff Turnover has dropped by 0.75% since last month's report, the staff group with the highest turnover continues to be nursing. As mentioned last month, NHS Improvement is holding Retention Masterclasses in October 2018 covering a range of retention themes/initiatives and offering networking opportunities with other NHS Trusts. Our Trust Lead Nurses have been invited to attend and feedback on some strategies to improve our staff retention rates.
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	1082.04	R >960 A <=960 G <=800		Temporary spend is being reported to weekly sustainability group. The main reason for temporary spend is sickness which remains higher than our target. A senior group facilitated by HR has been set up to review health and wellbeing which is expected over time to reduce rates of absence and in turn temporary spend. Other temporary spend is a result of hard to fill positions, the exploration of a Doctors bank is currently being looked into
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.47 %	R <99 % A >=99 % G >=99.5 %		Our % of correct pay achieved has fallen slightly below the threshold of 99.5% this month, regular meetings are held with our Payroll provider where our KPI's and any operational issues are discussed.

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

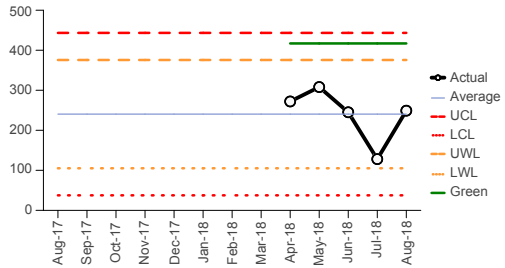
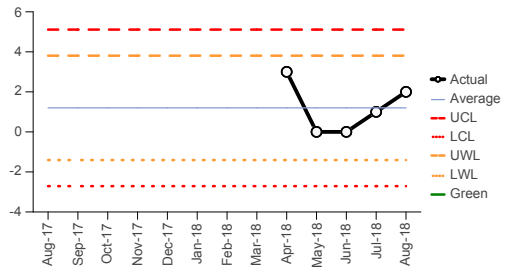
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Academic** Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	R <4 A N/A G >=4		There is significant variation in this metric month to month. The average over the months to date is green.
Clinical Research	**Number of Open Studies - Commercial** Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	37	R <5 A N/A G >=5		No Action Required
Clinical Research	**Number of Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	156	R <50 A N/A G >=50		August is a very quiet month for opening studies due to many sponsors taking a break. this is a normal and consistent pattern for august.

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

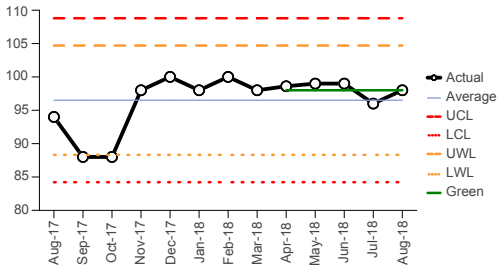
GROW THE FUTURE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of patients recruited** Number of patients recruited in month. **Exec Lead:** Matthew Peak **Committee:** REIC	249	R <417 A N/A G >=417		During school holidays or over the summer period recruitment tends to dip. However a large significant study (DETECT) is due to open this year which will boost recruitment figures. Some undulation is expected.
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	No Threshold		When analysing small numbers the whole year effect is more important. Not opening any commercial trials for a few months at a time is not unusual.

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

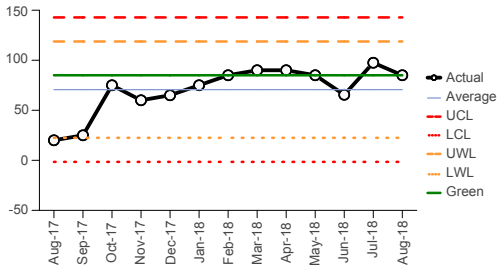
Alder Hey Children's NHS Foundation Trust

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

The Best People doing their best Work

19.1 - FACILITIES - WELL LED

Alder Hey Children's NHS Foundation Trust

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

All Divisions

SAFE

	COMMUNITY	MEDICINE	SURGERY	RAG
Total no of incidents reported Near Miss & Above	47	135	227	No Threshold
Clinical Incidents resulting in minor harm & above	2	27	47	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	1	0	No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0 N/A >0
Pressure Ulcers (Grade 3)	0	0	0	0 N/A >0
Pressure Ulcers (Grade 4)	0	0	0	0 N/A >0
Medication errors resulting in harm	1	0	3	No Threshold
Medication errors resulting in moderate, sever harm or death	0	0	0	0 N/A >0
Never Events	0	0	0	0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	3	0	No Threshold

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	5	3	3	No Threshold
PALS	26	23	22	No Threshold

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
Readmissions to PICU within 48 hrs	0	0	0	No Threshold
% of acute readmissions within 48 hrs of discharge (exc Oncology)	0.0%	0.9%	1.3%	<=1.1 % N/A >1.1 %
Readmissions within 48 hrs	0	17	20	No Threshold
Outbreak Acquired Organisms - Other	0	0	0	0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0 N/A >0
Hospital Acquired Organisms - MSSA	0	0	0	No Threshold

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
Hospital Acquired Organisms - RSV	0	0	0	No Threshold
Hospital Acquired Organisms - CLABSI - ICU Only			1	No Threshold
Outbreak Infections	0	0	0	No Threshold
Referrals Received (Total)	645	1,548	3,310	No Threshold
ED: 95% Treated within 4 Hours		98.4%		>=95 % N/A <95 %
Average LoS - Elective (Days)		2.82	2.75	No Threshold
Average LoS - Non-Elective (Days)		1.45	2.71	No Threshold
Theatre Utilisation - % of Session Utilised		77.6%	88.3%	>=90 % >=85 % <80 %
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.3%	1.3%	<=0.8 % N/A >0.8 %
On the day Elective Cancelled Operations for Non Clinical Reasons	0	4	14	No Threshold
28 Day Breaches	0	2	5	0 N/A >0
Clinic Session Utilisation	80.1%	80.9%	83.8%	>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	23.4%	15.7%	12.6%	<=5 % <=10 % >10 %
Did Not Attend Rate	15.8%	13.1%	12.7%	<=12 % <=14 % >14 %
Incomplete Pathway Forms in Outpatients	757	4,349	8,279	No Threshold
Referral Turnaround (days to log)	3.71	3.23	5.20	No Threshold
Referral Turnaround (Consultant to Action)	12.62	8.51	9.80	No Threshold
Coding average comorbidities	8.00	3.51	3.62	No Threshold
CAMHS: DNA Rate - New	9.5%			<=6 % <=8 % >8 %
CAMHS: DNA Rate - Follow Up	19.8%			<=10 % <=16 % >16 %

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Received information enabling choices about their care		92.4%	95.9%	>=95 % >=90 % <90 %
IP Survey: % Treated with respect		99.4%	99.7%	100 % >=95 % <95 %
IP Survey: % Know their planned date of discharge		54.8%	63.7%	>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care		91.7%	91.5%	>=95 % >=90 % <90 %

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Patients involved in play and learning		74.5%	74.9%	>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	92.7%	90.2%	92.7%	>=92 % >=90 % <90 %
Waiting List Size	974	3,402	8,549	No Threshold
Waiting Greater than 52 weeks	0	0	0	0 N/A >0
Diagnostics: % Completed Within 6 Weeks		99.0%	100.0%	>=99 % N/A <99 %
Number of Stranded Patients (7+ Days)		39	15	No Threshold
Number of Super Stranded Patients (21+ Days)		27	6	No Threshold
CAMHS: 2 Appointments within 6 weeks	0			No Threshold
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	21.00			No Threshold
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	4.00			No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	16.00	0.00	0.00	No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	31.00	0.00	0.00	No Threshold

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	-144	75	-63	>=0% >=-20% <-20%
Income In Month Variance (£'000s)	-67	533	294	>=0% >=-20% <-20%
Pay In Month Variance (£'000s)	-17	-79	-62	No Threshold
Non Pay In Month Variance (£'000s)	-60	-379	-295	>=0% >=-20% <-20%
AvP: IP - Non-Elective		106	43	>=0 N/A <0
AvP: IP Elective vs Plan	0	-24	-24	>=0 N/A <0
AvP: OP New	-95.03	-220.22	524.90	>=0 N/A <0
AvP: OP FollowUp	-33.58	-4.92	518.68	>=0 N/A <0
AvP: Daycase Activity vs Plan		108	-45	>=0 N/A <0
AvP: Outpatient Activity vs Plan	-129	-225	1,044	>=0 N/A <0

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
PDR	78.7%	85.5%	83.6%	>=90 % >=80 % <85 %
Mandatory Training	92.7%	87.9%	87.2%	>=90 % >=80 % <80 %
Actual vs Planned Establishment (%)	89.6%	91.6%	97.4%	No Threshold
Sickness	3.3%	5.1%	5.7%	<=4.5 % <=5 % >5 %
Attendance (HR)	96.7%	94.9%	94.3%	>=95.5 % >=90 % <90 %
Short Term Sickness	0.8%	1.2%	1.4%	<=1.5 % N/A >1.5 %
Long Term Sickness	2.5%	3.9%	4.3%	<=3 % N/A >3 %
Temporary Spend ('000s)	154	261	509	No Threshold
Staff Turnover	13.4%	10.4%	10.0%	<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	100.0%	99.0%	90.1%	>=90 % >=80 % <90 %

Alder Hey Children's NHS
NHS Foundation Trust

Medicine

SAFE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	7	8	4	4	6	3	3	0	1	1	4	0	3	No Data Available	No Threshold

CARING

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Complaints	3	0	1	5	2	3	4	3	0	7	4	3	3		No Threshold
PALS	21	25	20	27	30	37	30	39	51	31	27	28	23		No Threshold

EFFECTIVE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	1	0	2	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	1,602	1,611	1,813	1,894	1,520	1,895	1,846	1,958	1,834	1,942	2,004	1,886	1,548	No Data Available	No Threshold
ED: 95% Treated within 4 Hours	98.3%	95.0%	94.5%	92.8%	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%		>=95 % N/A <95 %
Average LoS - Elective (Days)	2.90	3.06	2.89	3.33	4.06	3.54	3.22	3.17	3.23	2.67	4.01	3.84	2.82		No Threshold
Average LoS - Non-Elective (Days)	1.49	1.63	1.39	1.41	1.50	1.75	1.57	1.50	1.52	1.55	1.59	1.28	1.45		No Threshold
Theatre Utilisation - % of Session Utilised	81.8%	82.0%	81.5%	79.6%	82.5%	79.9%	80.6%	83.5%	75.4%	75.6%	78.6%	83.0%	77.6%		>=90 % >=80 % <80 %
Clinic Session Utilisation	85.3%	84.7%	85.4%	86.6%	84.4%	85.3%	86.9%	85.2%	84.0%	82.4%	84.3%	81.3%	80.9%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	13.4%	13.4%	14.0%	13.3%	15.3%	15.2%	17.6%	17.5%	13.5%	14.1%	12.8%	16.3%	15.7%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	11.9%	11.1%	11.8%	9.7%	11.4%	9.5%	9.6%	11.1%	10.1%	11.0%	12.5%	12.0%	13.1%		<=12 % <=14 % >14 %
Coding average comorbidities	3.05	3.57	3.43	3.42	3.92	3.86	3.49	3.34	3.52	3.35	3.54	3.40	3.51	No Data Available	No Threshold

RESPONSIVE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	93.3%	94.2%	92.7%	91.2%	92.6%	92.9%	93.0%	89.8%	90.0%	90.2%	89.5%	89.7%	90.2%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.8%	99.8%	99.1%	99.3%	99.0%		>=99 % N/A <99 %

WELL LED

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	155	-21	-464	529	-52	611	461		127	122	408	223	75		>=0% >=-20% <-20%
AvP: IP - Non-Elective									130	53	63	93	106		>=0 N/A <0
AvP: IP Elective vs Plan									-29	-11	-43	-28	-24		>=0 N/A <0
AvP: OP New									-82.43	-195.04	-7.23	-245.27	-220.22	No Data Available	>=0 N/A <0
AvP: OP FollowUp									-56.36	-169.18	-57.63	-430.23	-4.92	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Plan									0	-13	-43	-83	108		>=0 N/A <0
AvP: Outpatient Activity vs Plan									-139	-364	-65	-676	-225		>=0 N/A <0
PDR	79.7%	82.2%	84.0%	85.0%	84.0%	84.0%	81.5%	81.5%	2.2%	13.4%	35.5%	67.2%	85.5%		>=90 % >=85 % <85 %
Mandatory Training	78.3%	75.7%	77.3%	82.2%	86.6%	88.9%	94.7%	93.8%	92.7%	92.8%	92.4%	91.3%	87.9%		>=90 % >=85 % <80 %
Sickness	3.8%	4.1%	5.0%	5.3%	5.1%	5.6%	4.9%	4.3%	3.8%	3.9%	4.3%	5.7%	5.1%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	326	250	186	242	207	211	276	316	246	276	196	227	261		No Threshold

Surgery

SAFE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Complaints	2	2	3	0	2	2	3	2	1	2	1	5	3		No Threshold
PALS	14	30	21	25	16	26	24	20	25	36	28	20	22		No Threshold

EFFECTIVE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	1	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	1	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	3,407	3,425	3,515	3,524	2,668	3,338	3,490	3,679	3,767	4,082	3,818	4,185	3,310	No Data Available	No Threshold
Average LoS - Elective (Days)	2.91	3.03	2.36	2.76	3.30	2.62	2.88	3.14	2.40	2.94	2.55	2.69	2.75		No Threshold
Average LoS - Non-Elective (Days)	2.96	2.74	2.90	3.17	3.18	2.67	2.89	3.31	2.63	2.78	2.63	2.61	2.71		No Threshold
Theatre Utilisation - % of Session Utilised	88.6%	87.3%	87.3%	85.2%	86.6%	88.3%	86.4%	86.8%	90.5%	90.5%	89.5%	90.4%	88.3%		>=90 % >=80 % <80 %
Clinic Session Utilisation	84.9%	83.2%	85.2%	87.0%	83.0%	86.2%	83.6%	85.1%	84.2%	85.0%	86.0%	82.8%	83.8%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	12.9%	11.9%	12.3%	13.2%	13.3%	13.0%	14.0%	12.7%	11.2%	12.2%	12.2%	12.3%	12.6%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	11.8%	11.5%	11.3%	10.2%	11.6%	10.2%	10.0%	10.3%	9.6%	10.7%	10.9%	11.7%	12.7%		<=12 % <=14 % >14 %
Coding average comorbidities	3.11	3.18	3.13	3.18	3.06	2.99	3.18	3.24	3.11	3.31	3.50	3.62	3.62	No Data Available	No Threshold

RESPONSIVE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	91.2%	90.9%	91.6%	92.0%	91.3%	91.4%	91.3%	92.6%	92.3%	92.5%	93.1%	92.9%	92.7%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	95.0%	100.0%	92.6%	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 % N/A <99 %

WELL LED

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	532	-167	-506	-610	-489	-634	-715		-167	32	-23	81	-63		>=0% >=-20% <-20%
AvP: IP - Non-Elective									60	70	48	40	43		>=0 N/A <0
AvP: IP Elective vs Plan									-58	-16	-61	-59	-24		>=0 N/A <0
AvP: OP New									399.34	536.63	450.48	236.35	524.90	No Data Available	>=0 N/A <0
AvP: OP FollowUp									148.57	-307.75	-467.28	-107.76	518.68	No Data Available	>=0 N/A <0
AvP: Daycase Activity vs Plan									-99	-101	-57	-132	-45		>=0 N/A <0
AvP: Outpatient Activity vs Plan									548	229	-17	129	1,044		>=0 N/A <0
PDR	91.1%	90.1%	89.5%	88.1%	89.5%	89.5%	83.3%	83.3%	1.1%	10.0%	33.5%	64.4%	83.6%		>=90 % >=85 % <85 %
Mandatory Training	77.0%	73.0%	73.8%	80.9%	85.8%	89.3%	93.5%	91.5%	90.2%	89.9%	90.9%	90.3%	87.2%		>=90 % >=85 % <80 %
Sickness	4.7%	4.6%	5.1%	4.8%	6.0%	6.3%	4.9%	4.0%	4.3%	4.8%	5.5%	5.5%	5.7%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	554	429	479	383	331	408	434	514	468	420	480	445	509		No Threshold

Community

SAFE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Complaints	0	1	3	1	1	3	2	0	2	2	3	4	5		No Threshold
PALS	13	35	28	28	14	33	50	33	32	28	20	22	26		No Threshold

EFFECTIVE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	812	878	1,231	1,122	974	1,150	1,033	1,001	857	1,091	847	1,076	645	No Data Available	No Threshold
Average LoS - Elective (Days)		14.00													No Threshold
Clinic Session Utilisation	76.9%	79.9%	82.9%	80.4%	73.3%	77.7%	75.7%	72.1%	75.2%	79.1%	78.2%	79.2%	80.1%		>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	17.1%	15.9%	15.2%	16.7%	17.0%	12.3%	13.6%	17.2%	16.1%	10.8%	16.9%	16.4%	23.4%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	19.5%	16.8%	14.2%	13.5%	15.7%	12.6%	14.2%	14.6%	14.6%	14.4%	13.2%	12.5%	15.8%		<=12 % <=14 % >14 %
Coding average comorbidities	4.50	2.00	3.00	3.50		5.00		3.33	5.00	2.33		2.33	8.00	No Data Available	No Threshold

RESPONSIVE

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	96.5%	96.1%	96.3%	96.8%	97.3%	97.3%	96.5%	96.7%	97.1%	96.1%	95.3%	92.2%	92.7%		>=92 % >=90 % <90 %

WELL LED

	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-136	-55	-64	-72	-86	-161	43		-108	-70	30	62	-144		>=0% >=-20% <-20%
AvP: IP Elective vs Plan									0	0	0	0	0		>=0 N/A <0
AvP: OP New									-25.37	-24.35	-35.17	-85.43	-95.03	No Data Available	>=0 N/A <0
AvP: OP FollowUp									275.02	345.12	345.57	219.44	-33.58	No Data Available	>=0 N/A <0
AvP: Outpatient Activity vs Plan									250	321	310	134	-129		>=0 N/A <0
PDR	82.8%	87.4%	90.4%	88.8%	90.4%	90.4%	83.9%	83.9%	0.4%	9.3%	31.9%	58.8%	78.7%		>=90 % >=85 % <85 %
Mandatory Training	75.3%	74.6%	75.1%	80.3%	86.7%	89.8%	96.8%	95.7%	95.4%	95.0%	94.1%	94.2%	92.7%		>=90 % >=85 % <80 %
Sickness	6.3%	7.0%	5.8%	5.8%	6.9%	6.2%	6.0%	6.1%	4.8%	5.2%	3.9%	3.5%	3.3%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	169	195	141	167	131	146	136	202	166	180	142	131	154		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 2 October 2018

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, Clinical Risk Manager
Subject/Title	2018/19 Board Assurance Framework Update (September 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 – August 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 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.

BAF Risk Register - Overview at 27th September 2018

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

Ref, Owner	Risk Title		Risk Rating: I x L		Monthly Trend	
			Current	Target	Last	Now
STRATEGIC PILLAR: Delivery of Outstanding Care						
1.1 HG	**Achievement of outstanding quality for children and young people**		3-3	2-2	STATIC	STATIC
1.2 ES	**Mandatory & Compliance Standards**		3-3	4-1	WORSE	STATIC
1.3 DP	**New Hospital Environment**		4-4	4-2	WORSE	WORSE
STRATEGIC PILLAR: The Best People Doing Their Best Work						
2.1 MS	**Workforce Sustainability & Capability**		3-3	3-2	STATIC	STATIC
2.2 MS	**Staff Engagement**		3-3	3-1	STATIC	STATIC
2.3 MS	**Workforce Diversity & Inclusion**		3-4	3-1	STATIC	STATIC
STRATEGIC PILLAR: Sustainability Through External Partnerships						
3.1 DP	**Failure to fully realise the Trust's Vision for the Park**		3-3	3-2	STATIC	STATIC
3.2 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**		4-4	4-3	STATIC	STATIC
STRATEGIC PILLAR: Game-Changing Research And Innovation						
4.1 DP	**Research, Education & Innovation**		3-3	3-2	STATIC	STATIC
4.2 JG	**IT Strategic Development**		3-3	3-3	STATIC	STATIC

Changes since September 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)***
  Trust Board agreed Clinical Sustainability Strategy which was re-named Strategic Plan 2018-2021.

- ***Mandatory and compliance standards (ES)***
  ED 4 hour target currently red (tracking at 93% for the month to date); mitigation plan agreed at Exec Comm Cell. Mitigation plans include: Staff an additional 11 beds for Winter (9 inpatient beds, 2 high-dependency beds) *enhanced staffing levels in ED- nurse practitioners and medical shift cover *investment of 0.5m in additional capacity and services such as mental health liaison team, in-reach community nursing team and rapid laboratory testing.

- ***Developing the Paediatric Service Offer (MB)***
  CEO now chair of Children's Transformation Board; Single Neonatal Service model moving to implementation phase. Level 1 CHD partnership in place and due to go live beginning of September 2018. Successful Go Live for CHD Partnership undertaken.

Internal risks:

- ***New Hospital Environment (DP)***
  Completion of fire action plan and 90% of fire-stopping works

- ***Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations (HG)***
  CQC action plan developed and shared with regulators, on-going monthly monitoring via CQAC and Trust Board. In addition, CQAC will receive the associated risk register in relation to the change programme from October 2018.

- ***Financial Environment (JG)***
  CIP identified increased identified to £5.5m with £6m a key next phase we aim to get to by end of Sept. Divisions have reduced forecast gap which now stands at £3.5m. Work on-going to further reduce this deficit. Key risks remains commissioner over performance which is material. A new risk related to estates capital spend overspends (unmitigated estimate £6m-£9m). Work has started to prepare a capital recovery plan and reduce value of risk.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Completion of residual estate retraction plan.

- ***IT Strategic Development (JG)***
  Progress with NHSE milestones remains positive with full funding schedule in place. Recent positives include the roll of out of a sepsis module in standard documentation and interoperability piece. Gap in Programme Manager a concern with plans in place to mitigate.

- ***Workforce Sustainability & Capability (MS)***
  Workforce Planning training delivered by NHSI in September. Launch of additional recruitment materials, including corporate video.

- ***Staff Engagement (MS)***
  Staff Survey launched. 15% response rate as at 27/09/18). Leadership strategy in development for presentation at the October WOD Committee.

- ***Workforce Diversity & Inclusion (MS)***
  Expert resource identified to support the diversity and race agenda.

- ***Research, Education & Innovation (DP)***
  Presentation of innovation re-set to Innovation Board.

Erica Saunders
Director of Corporate Affairs
27th September 2018

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.1	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: Achievement of Outstanding Quality for Children and Young People as defined by the Care Quality Commission (CQC) regulations.		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: Hilda Gwilliams	**Type:** Internal, Known		Current IxL: 3-3	Target IxL: 2-2	Trend: STATIC

Risk Description

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

Existing Control Measures

• 1. Quality impact assessment completed for all planned changes (NHSe). Change programme assurance reports monthly	• 2. Risk registers including corporate register inform Board assurance.
• 3. Quality section of Corporate Report including incidents, complaints, infection control including sepsis, friends and family test, best in acute care, best in surgical care, performance managed at Clinical Quality Assurance Committee and Trust Board.	• 4. Division and Corporate Quality & Safety Dashboards in place and monitored consistently via performance framework. This includes safety thermometer i.e. infections, falls, pressure ulcers, medication, workforce 'Hard Truths', sickness, appraisals, etc.
• 5. Weekly Meeting of Harm monitors incidents, including lessons learned, immediate actions for improvement and sharing Trust wide.	• 6. Programme of quality assurance rounds, developed and implemented across all services, aligned to Care Quality Commission, Key lines of enquiry (KLOE).
• 7. Annual clinical workforce assurance report presented to Board, aligned to Relevant Professional Standards.	•
• 8. Quality Strategy 2016/2021, Quality Improvement Change Programme established - associated workstreams subject to sub-committee assurance reporting.	• 9. Governance including risk processes from Ward to Board, linked to NHSI Single Oversight Framework
•	• 10. Acute Provider Infection Prevention and Control framework and associated dashboards and action plans for improvement.
• 11. Internal Nursing pool established and funded	• 12. Nursing leadership in alignment with Royal College of Nursing and Midwifery Standards.
• 13. Annual Patient Survey reports and associated action plans	• 14. Trust policies underpinning expected standards
• 15. CQC regulation compliance	

Assurance Evidence	Gaps in Controls/Assurance
1. Annual QIA assurance report and change programme assurance report 2. Risk assessments etc and associated risks monitored via the Integrated Governance Committee. Trust Board informed via Integrated Governance Committee minutes. Divisional Integrated Governance Committee minutes. 3. Clinical Quality Assurance Committee, Trust Board and Divisional Governance minutes 4. Corporate report/quality section, Trust Board and Divisional Quality Board minutes. 5. Minutes from Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly meeting of harm group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA audit report. 6. Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees. 7. Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes. 8. Board and sub-board committees minutes and associated reports. 9. TO BE ADDED 10. IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes. 11. Nursing Workforce report and associated Board minutes. 12. Nursing Workforce report and associated Board minutes. 13. Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes. 14. Audit committee reports and minutes. 15. CQC action plan monitoring via Board and sub board committees	2. High risks reporting to Clinical Quality Assurance Committee and Divisional Integrated Governance Committee minutes do not provide assurance of monitoring and risk reduction.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	

Executive Lead's Assessment

SEP 2018: CQC action plan developed and shared with regulators, on-going monthly monitoring via CQAC and Trust Board. In addition, CQAC will receive the associated risk register in relation to the change programme from October 2018.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.2	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: Achievement of national and local mandatory & compliance standards
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective			
Exec Lead: Erica Saunders	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 4-1	Trend: STATIC

Risk Description

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

Existing Control Measures

• 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. NHSI quality concern 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 Proactive management of patient flow making better use of trend analysis data

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitor the use of surgical beds to ensure full activity plan delivered	Elective programme being monitored on a weekly basis however significant pressure from NEL orthopaedic cases experienced during June has proved challenging.
Plans to ensure performance sustained across the year need to be embedded and maintained	New Models of Care review findings presented and agree at Ops Board September; action plan agreed.
New model to deliver required number of CCAD cases agreed at Board on 22/5/18. COO to lead implementation.	Additional HDU capacity to support new cardiac model planned for November

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
JUNE 2018: All external mandatory targets met; focus required to ensure elective programme remains on track given demand pressures
AUGUST 2018: All key national indicators met for the month; transcription issues resolved.
SEPTEMBER 2018: ED 4 hour target currently red (tracking at 93% for the month to date); mitigation plan agreed at Exec Comm Cell. Mitigation plans include: Staff an additional 11 beds for Winter (9 inpatient beds, 2 high-dependency beds); enhanced staffing levels in ED- nurse practitioners and medical shift cover; investment of 0.5m in additional capacity and services such as mental health liaison team, in-reach community nursing team and rapid laboratory testing.

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: 4-4	Target IxL: 4-2	Trend: WORSE

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	Report received from Project Co. Agreed to present at October Board
COO updating Action Plan to address key water safety issues	
Interserve developing water safety action plan	Project Co. agreement to scope out water cross-over test. Exercise planned for sept 2018
Whole Hospital review of fire stopping	
Review of various risk elements and consolidation into single report with external validation.	
Complete Fire Notice action plan	
Create action Plan for addressing ceiling tile falls	Proposed plan submitted to Project co. for consolidation
Complete fire stopping work	

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 JUNE 2018: Consolidated report in production; review meeting with Project Co and refresh of action plan. Outcome to be reported 24/07/2018 AUG 2018: review of consolidated report with sub plans for fire and ceilings Sept 2018: completion of fire action plan and 90% of fire-stopping works

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Workforce Sustainability		
Related CQC Themes: Safe, Effective, Responsive, Well Led, Well Led, Well				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description	
Failure to deliver consistent, high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place, at the right time.	
Existing Control Measures	
• Workforce KPIs tracked through the corporate report and divisional dashboards	• Bi-monthly Divisional Performance Meetings.
• Mandatory training fully reviewed in 2017, with a new system of reporting linked to competencies on ESR; enabling better quality reporting.	• Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.
• Permanent nurse staffing pool	• HR Workforce Policies
• Attendance management process to reduce short & long term absence	• Wellbeing Steering Group established
• Large-scale nurse recruitment event 4 times per year	• Training Needs Analysis linked to CPD requirements
• Apprenticeship Strategy implemented	• Engaged in pre-employment programmes with local job centres to support supply routes
• Engagement with HEENW in support of new role development	• People Strategy
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 level which supports Ward to Board Reporting to HEE People Strategy report monthly to Board Programme Board reporting	Not meeting compliance target in relation to mandatory training in some areas Sickness Absence levels higher than target. Lack of standard methodology to workforce planning across the organisation
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Undertaking a sickness absence review in 2018 Working with Trade Unions to refresh the policy, understand further the drivers for high sickness absence.	
L&D to undertake full review of mandatory training; comms, process and quality. See date for progress update.	
Undertake review of recruitment methods to support Community Division in recruiting hard to reach posts	
ensure a minimum of 50 learners enrolled on apprenticeship pathways.	
Training required for HR Business Partners and Advisers in workforce planning methodologies	
Executive Lead's Assessment	
SEPT 2018: Workforce Planning training delivered by NHSI in September. Launch of additional recruitment materials, including corporate video.	

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.2	**Strategic Objective:** The Best People Doing Their Best Work		Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
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	
• People Strategy	• Wellbeing Strategy implementation
• Action Plans for Staff Survey	• Values and Behaviours Framework
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action Guidance and Programme of work
• 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.
•	• BME and Disability Staff Networks
Assurance Evidence	**Gaps in Controls/Assurance**
Monthly People Strategy Report to Board Outcomes from Annual Staff Survey reported to the Board. Staff Survey local departmental conversations PDR completion rates Values and Behaviours Framework Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data 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 Wellbeing Strategy progress reported to WOD Board/sub-Board Committee minutes Minutes of Staff Networks Engagement through Editorial Board leadership for Alder Hey Life	Internal Communications Strategy and Plan Refreshed Leadership Strategy
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Further to last action email, complete strategy by end July.	
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	
Further to previous action email, please provide progress update.	
Please prepare outline strategy for discussion at away day on the 9th July 18.	
Executive Lead's Assessment	
SEPT 2018: Staff Survey launched. 15% response rate as at 27/09/18). Leadership strategy in development for presentation at the October WOD Committee.	

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.3	**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: 3-4	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

• Wellbeing Strategy	• WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.
• Wellbeing Steering Group	• Staff Survey results analysed by protected characteristics and actions taken by E&D Lead.
• HR Workforce Policies	• 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, and improving the experience of BME staff who work at Alder Hey	•
•	•

Assurance Evidence	**Gaps in Controls/Assurance**
Monthly recruitment reports provided by HR to divisions Diversity and Inclusion Action Plan reported to Board Bi-monthly reporting to 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 Equality Objectives	LGBTQ Network not yet in place
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Establish LGBTQ network	No progress due to capacity issues. Revised timeline for completion.

Executive Lead's Assessment

SEPT 2018: expert resource identified to support the diversity and race agenda

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.1	**Strategic Objective:** Sustainability Through External Partnerships		Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led					
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	• Monitoring reports on progress
• Heads of Terms agreed with LCC for joint venture approved	• Redevelopment 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	Planning for Park extension submitted 31/07/2018
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. JUNE 2018: 2nd round of user meetings on Community Cluster. Commissioning Programme for Institute under way. Implemented bi-weekly control group meetings on the Institute commissioning Aug 2018: Planning application for park extension. Handover of Institute Phase 2 Sept 2018: Completion of residual estate retraction plan	

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Risk to service sustainability development/growth due to NHS financial environment and constraints on internal infrastructure to deliver business as usual as well as maximise growth opportunities. External opportunities for partnership may not be fully optimised

Existing Control Measures

• Divisional Performance Management Framework.	• Clear trajectories for challenged specialities to deliver.
• Business Development Plan	• 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
• 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
Marketing and Business Development Committee has been refreshed as a Growth Through Sustainable Partnerships Group. First meeting planned July 2018 . 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 Growth through Partnerships to be included as part of Strategic elements of business planning in the next planning cycle
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Development of the international agenda	

Executive Lead's Assessment

APRIL 2018. Final Clinical and Sustainability Strategy to July Board.
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.
JUNE 2018: Clinical sustainability strategy to be finalised at Board meeting on 3rd July. AUG 2018: Trust Board agreed Clinical Sustainability Strategy which was re-named Strategic Plan 2018-2021

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 for working with key partners to develop children's services and reduce variation across the City region and beyond

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 refreshed 'Sustainability Through External Partnerships Steering Group'. Monthly to Board via RABD & Board Compliance with final national specifications Single Neonatal Services Business Case approved by NHS England	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. Go live due beginning of September 2018.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Development of a single neonatal service business case across Alder Hey & LWH	Governance model developed and agreed by both trusts and NHS England including delivery model and work streams. MoU drafted and due to be approved by both boards in July 2018.
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. In addition to support the Strategic Plan identify which existing and new Partnerships need to be strengthened and grown	

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
JUNE 2018: CEO now chair of Children's Transformation Board; Single Neonatal Service model moving to implementation phase. Level 1 CHD partnership in place and due to go live beginning of September 2018. Successful Go Live for CHD Partnership undertaken.

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 Weekly Financial Sustainability delivery meeting papers	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 CIP Position improved however Divisional forecasts still showing a potential £7m gap

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Tracking actions from Financial Recovery Board	on target
Develop fully worked up CIP programme - Progress has been made however still forecasting £1m under target	Reviewed at financial sustainability group 2.7.18 Further work to take place as part of Q1 review and in July. Review again at expected completion date

Executive Lead's Assessment

JUNE 2018: Key risks highlighted as delivery of CiP (£2.5m gap), elective run rates/winter plan delivery and other emerging cost pressures. Total Divisional risk equates to c£8m and will be through divisional recovery supported by an effective winter plan and identification of non-recurrent measures. Mitigation plan to be tracked through RABD
AUG 2018: CIP identified has plateau at £5m against £6.8m plan. Efforts continue with £6m looking deliverable. Main concerns now relate to Divisional forecast gap of £6.8m and level of Spec Comm over performance which is now subject to a formal activity notice.
SEPT: CIP identified increased identified to £5.5m with £6m a key next phase we aim to get to by end of Sept. Divisions have reduced forecast gap which now stands at £3.5m. Work on-going to further reduce this deficit. Key risks remains commissioner over performance which is material. A new risk related to estates capital spend overspends (unmitigated estimate £6m-£9m). Work has started to prepare a capital recovery plan and reduce value of risk.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.1	**Strategic Objective:** Game-Changing Research And Innovation		Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led					
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)	Legal work complete on Crucible Contract
Execute contract for RIE with back to back arrangements with the Charity and HEIs	Final Documentation with solicitors prior to completion before move in to Institute Phase 2
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
JUNE 2018: Innovation Refresh 2nd session
AUG 2018: Innovation prioritisation exercise
Sept 2018: presentation of innovation re-set to Innovation Board

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**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: 3-3	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	• Resilience of underlying infrastructure
• A plan is now in place to develop new strategy and roadmap to present to board in Autumn 2018 including plan for user engagement. Plan will include the current GDE programme and beyond, as well as review of Meditech offerings beyond current contract.	

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 GDE Programme Board tracking delivery - Chaired by MD Plan presented to Ops Board June 18	IM&T Strategy out of date - update work in progress to produce Roadmap for October 19 Resilience of underlying infrastructure - replacement being installed

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Replacement equipment procured - equipment is now installed however delay in ensuring appropriate electrical back up in place which is being rectified	
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
JUNE 2018: Replacement underlying infrastructure ordered; Excellent feedback from NHSE on benefits realisation
AUG 2018: Replacement infrastructure in situ. Continued positive feedback from NHSE. Programme on track with revised approached for VR in place.
SEPT: Progress with NHSE milestones remains positive with full funding schedule in place. Recent positives include the roll of out of a sepsis module in standard documentation and interoperability piece. Gap in Programme Manager a concern with plans in place to mitigate.