Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 3rd October 2017 commencing at 1100

Venue: Large Meeting Room, Institute in the park

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY						
Board Business						
1.		**1115**	**Apologies**	Chair	Catherine McLaughlin, Anita Marsland	--
2.	**17/18/133**	**1116**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**17/18/134**	**1117**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **5th September 2017**	Read Minutes
4.	**17/18/135**	**1120**	**Matters Arising**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate	Verbal
5.	**17/18/136**	**1140**	**Key Issues/Reflections**	All	The Board to reflect on key issues.	Verbal
Strategic Update						
6.	**17/18/137**	**1150**	**External Environment** **Progress against strategic themes:** - **Liverpool Community Services** - **Liverpool Women's Reconfiguration Options/Neonatal** - **Congenital Heart Disease**	 L Shepherd L Shepherd S Ryan	To update the Board on progress.	Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Delivery of outstanding care						
7.	**17/18/138**	**1210**	**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.	**17/18/139**	**1220**	**Clinical Quality Assurance Committee: Chair's update**	A Marsland	To receive and review the approved minutes from the meeting held: July 2017	Read report
9.	**17/18/140**	**1230**	**Learning From Deaths** - **Guidance** - **Revised Trust Policy**	S Ryan	To present the latest national guidance on learning from deaths and the revised Trust Policy.	Read report
10.	**17/18/141**	**1240**	**Alder Hey in the Park update**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
Items for Approval						
11.	**17/18/142**	**1250**	- **NHS England EPRR Core Standards Audit/Self-Assessment**	H Gwilliams/ E Menarry	Items for approval following ratification at the Integrated Governance Committee.	Read reports
1300 – 1330 LUNCH						
The best people doing their best work						
12.	**17/18/143**	**1330**	**People Strategy Update**	M Swindell	To provide an update on the strategy and staff survey	Read reports
13.	**17/18/144**	**1340**	**Freedom to speak up survey 2017**	E Saunders/ S Igoe	To receive the survey recommendations.	Read report
14.	**17/18/145**	**1350**	**Listening into Action**	K Turner	Two Clinical teams from the current cohort to provide an update on progress to the Board	Presentation
Strong Foundations						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation	
15.	**17/18/146**	**1410**	**Winter Plan**	M Barnaby	To provide assurance on plans for the winter period.	Presentation	
16.	**17/18/147**	**1420**	**Programme Assurance update** - **Deliver Outstanding Care** - **Growing External Partnerships** - **Global Digital Exemplar** - **Park Community Estates and Facilities**	J Grinnell	To receive an update on programme assurance including the 2017/18 change programme	Read Report	
17.	**17/18/148**	**1430**	**Corporate Report**	J Grinnell/ H Gwilliams/ M Swindell	To note delivery against financial , operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of August 2017	Read report	
18.	**17/18/149**	**1450**	**Board Assurance Framework**	E Saunders	To receive the BAF report.	Read report	
19.	**17/18/150**	**1500**	**Resources & Business Development Committee: Chair's update**	I Quinlan	To receive and review the approved minutes from the meeting held on: 2017.	Read minutes	
Sustainability through external partnerships							**17/1**
20.	**17/18/151**	**1510**	**International Child Health**	S Falder/ B Pizer	To receive proposals on the vision.	Presentation/ Enclosure	
Game Changing Research and Innovation							**17/1**
21.	**17/18/152**	**1520**	**Global Digital Exemplar (GDE)**	P Young	To update the Board on the programme	Read report	
Any Other Business							
22.	**17/18/153**	**1530**	**Any Other Business**	All	To discuss any further business before the close of the meeting	Verbal	

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Date And Time Of Next Meeting: Tuesday 7th November 2017 At **10:00am, Institute In The Park, Large Meeting Room**						

REGISTER OF TRUST SEAL
The Trust Seal was not used during the month of **September, 2017**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the last meeting held on **Tuesday 5th September 2017 at 10:00am,**
Large Meeting Room, Institute in the park

Present:	Mr I Quinlan	Non-Executive Director (Chair)	(IQ)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mrs L Shepherd	Chief Executive	(LS)
	Dr S Ryan	Medical Director	(SR)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mr A Bateman	Acting Chief Operating Officer	(AB)
	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs C McLaughlin	Director of Integrated Community Services	
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator	(JT)
	Mr M Flannagan	Director of Communications	(MF)
Agenda item:	105.4 Mr Andrew Williams	Director of CAMHS	(AW)
	108 Mrs Anne Hyson	Complaints Manager	(AH)
	109 Mrs Jo Keward	Infection Control Nurse	(JK)
	117 Heidi Miller	Breastfeeding Lead	(HM)
	117 Cath Wardell	Associate Chief Nurse	(CW)
	117 Joan Mulvoy	Pharmacy Purchasing Manager	(JM)
	Mr Peter Young	Chief Information officer	(PY)
Apologies:	Mrs M Barnaby	Interim Chief Operating Officer	(MB)
	Sir D Henshaw	Chairman	(SDH)
	Mr C Duncan	Director of Surgery	(ChrD)
	Mrs C McLaughlin	Divisional Director of Community Services	(CMc)

Staff Story

The Board welcomed Julie Fitzpatrick Theatres Practitioner to the meeting. Julie had started at Alder Hey in 1994. In 2011 Julie was the first Health Care Assistant in the Country to complete a NVQ Level 3 qualification for a Scrub HCA. During this time Julie's sister was diagnosed with cancer; whilst this was a difficult period Julie said the support from her family and staff helped her to continue with the qualification. Later that year, Julie's husband passed away followed by her sister's death. Whilst this was an extremely difficult time Julie said the support from the Alder Centre and her management team helped her to come back to work.

Going forward Julie is going to visit Great Ormond Street Hospital and Birmingham Children's Hospital to provide advice on her role.

The Board thanked Julie for taking time to share her story as it is extremely valuable.

17/18/101 Declarations of Interest

None declared.

17/18/102 Minutes of the previous meetings held on 4th July 2017

Resolved:

The Board received and approved the minutes from the meeting held on 4th July 2017.

17/18/103 Matters Arising and Action Log

The Chair welcomed: Mark Flannagan, Adam Bateman and Adrian Hughes to their first Board meeting.

All actions from the previous meeting had been included on the agenda.

17/18/104 Key Issues/Reflections

On behalf of the Board the Chair congratulated Louise Shepherd on receiving her CBE in the Queen's announcements.

Erica Saunders reported the Trust had been shortlisted in the category of Provider Trust of the Year for the Health Service Journal Awards.

The Board received an update on recent changes to the Board at Liverpool Clinical Commissioning Group. Dr Simon Bowers has been appointed as the new Chair. A meeting with Simon and Board members from Alder Hey was to be scheduled.

Following concerns raised at Liverpool CCG both the Accountable Officer and Director of Finance had announced their decision to resign from the roles and replacements were being sought.

17/18/105 External Environment/STP/Progress against Strategic Themes

Following Louise Shepherd's resignation as STP Lead for Cheshire and Merseyside the role had now been appointed to; Mel Pickup, Chief Executive at Warrington and Halton NHS Trust would be the lead going forward. Both the Chief Executive and Chair Andrew Gibson are committed to developing an Accountable Care System for Cheshire and Merseyside.

Mark Flannagan agreed to communicate Louise Shepherd's resignation as the STP Lead for Cheshire and Merseyside to staff.

Action: MF

Liverpool Community Health Services

NHS Improvement has requested that bids for the Liverpool Community Services are submitted no later than Friday 8th September 2017. The decision as to which organisation is preferred bidder would be announced on 3rd October.

Neonatal Network
Regular meetings are being held locally to develop a single site Neonatal service. Adam Bateman noted that the Trust currently has nine beds and is planning to extend to a further 10 cots.

Liverpool Women's NHS Foundation Trust
Public consultation is due to commence in the Autumn.

Tier 4 CAMHS Cheshire and Merseyside Bid
Tier 4 (Specialised CAMHS) services include day and inpatient services for children and young people with the most complex mental health conditions. Within the inpatient element of CAMHS Tier 4 there are several different types of service including adolescent, eating disorder, learning disability, children's and low secure units. Alder Hey is commissioned to provide an inpatient service for children aged between 5-13 years at the Dewi Jones Unit (DJU).

The DJU is based in a facility away from the main hospital site and the Community Division is developing a case for change which would support the development of a purpose built facility within the Alder Hey Campus.

Jeannie France-Hayhurst asked for the Board to be regularly updated.

Resolved:
Board supports the intention to develop a full business case for the redevelopment of the Dewi Jones Unit on the Alder Hey campus, which will enable the service to be delivered in line with national service specification requirements and with the capacity to deliver against both current and future demand.

Congenital Heart Disease
Proposals are due to be submitted at the next NHS England Board meeting.

17/18/106 Serious Incidents Report
Hilda Gwilliams presented the report for July 2017. There had been six new SIRIs reported, four ongoing and one closed. Following feedback from the CQC the report format has been revised to include further detail.

The first SIRI had been a never event for wrong site surgery due to break down of communication with a trainee doctor. As trainee doctors' start at different times through the year it was agreed the introduction training pack would be reviewed to ensure information on site surgery is included.

The four ongoing incidents are all in progress within the timescales set. The Safeguarding Incident had been included for information.

Going forward Hilda Gwilliams agreed to include a lessons learnt section on each of the incidents as well as an annual review of themes.

Resolved:
The Board received the Serious Incident Report for July noting:

- Six new SIRIs, four ongoing and one closed. There had been one new safeguarding incident reported, one ongoing and none closed.

17/18/107 Clinical Quality Assurance Committee: Chair's Update
CQAC Minutes 21st June 2017
The first of the Quality Walkabouts has been scheduled for tomorrow.

Sepsis continues to be a focus for the committee.

Resolved:
The Board received and noted the approved minutes from the CQAC meeting held on 21st June 2017.

17/18/108 Complaints Quarter 1 report
The Trust received 18 formal complaints during this period. Two complaints from this quarter were subsequently withdrawn from the process at the complainant's request and two complaints also started as an informal concern (PALS), however due to dissatisfaction with informal outcome the complainant requested this progress to the formal complaint route.

Anne Hyson is working with the learning and development team to provide training to staff on giving realistic timescales to parents.

Six complaints where upheld within the quarter and five where not upheld. Four complaints are still ongoing as six had been received in June and two surgical complaints are extremely complex in nature and level of detail in the response.

All complainants are fully updated regarding any delays in response timeframes.

Q4 reported enquires to PALS saw a significant increase of 391. Further investigation looking at enquiries linked to activity, show a correlation between the two data sets.

In Q1 2017 - 2018 PALS contacts received have dropped to 308 contacts.

A compliments section had been included in the report. Anne Hyson advised compliments are captured through wards and departments.

Non-Executive Directors on the CQAC Committee had received a number of complaints to review. Anne Hyson agreed to arrange a follow up meeting.
Action: AH/JT

Resolved:
The Board received the Quarter 1 Complaints Report.

17/18/109 Infection and Control Quarter 1 report
The quarterly report provides the Board with the challenges for delivery of the Infection Prevention and Control Work Plan and progress to date.

At the end of Q1 53% (40/76) of the total of deliverables had been completed. 39% (30/76) of the total deliverables were in progress (amber); 8% (6/76) classified as red.

Plans are in place to recruit to the Director of Infection Prevention and Control role. Dr Cooke who retired from this role has agreed to return to cover a session per week.

Processes to review cases of MRSA/ MSSA/VRE and E Coli Bacteraemia are now in place.

An update on hand hygiene was received. A promotional campaign for hand hygiene would be held in national hand hygiene week, flu vaccinations would also be given during this time.

Resolved:
The Board received the Quarter 1 Infection, Prevention Control Report.

17/18/110 Mortality Quarter 1 report

The Board received the report noting the significant improvement in the completion of HMRG reviews. Julie Grice and the team are hoping to have worked through the rest of the backlog by the end of October 2017.

Anita Marsland reported on training recently provided by AQuA on Mortality noting it would be useful for Non-Executives to attend to have further understanding. As paediatric mortality is reported differently to adults it was agreed an in-house training session would be provided for NEDs.
Action: SR/JG

Resolved:
The Board noted their thanks to Julie Grice and the team for the significant improvement.

17/18/111 Alder Hey in the Park

David Powell updated the Board on the current position of projects within Alder Hey in the Park:

Demolition
Demolition of the old site is in progress.

Residential
Community engagement continues to progress.

Research and Education Phase II
The build remains on track and is hoped to be completed in September 2018.

Alder Centre
Building of the Alder Centre is due to commence next year. Cath Kilcoyne has been appointed as Commercial Advisor for this project.

Park
A review is currently place to agree on the extension.

Community/CAMHS Estate Strategy
Currently exploring a financial analysis of proposed developments and locations.

Resolved:
Board received an update on the current position.

17/18/112 Emergency Preparedness annual report and work plan
Resolved:
The Board received and approved the Emergency Preparedness annual report and work plan. The Non-Executive Lead is Steve Igoe.

17/18/113 People Strategy update
Melissa Swindell presented the July report.

Following on from the last Board, Melissa Swindell reported on progress made with internal engagement including the launch of employee of the month, the reward and recognition plans agreed in March are on track and Annual Awards are due to be launched later the year.

The Annual Staff Survey is to be launched later this month.

PDR rates have improved to 79% departments have agreed to be at 90% by the end of October.

The Alder Hey Nursery will be able to support the Government initiative of supporting 30 hours of nursery places per week.

Resolved Board Received:
a) The July report noting actions in place to improve internal communication and response rates to the annual staff survey.
b) Workforce and Organisational Development Committee approved minutes from the meeting held in June 2017.
c) Workforce and Organisational Development Committee Annual report 2016/17.

17/18/114 Internal Communications update
Resolved:
Mark Flannagan presented his findings and recommendations from the internal communications review he had taken since starting in post on 17th July 2017.

17/18/115 Listening into Action
Breast feeding Services
The Board welcomed Heidi Miller and Cath Wardell to the meeting.

Heidi provided an update on breastfeeding processes within Alder Hey highlighting gaps within the service including storage and inconsistencies in practices.

Following these findings next steps included:

- Secure a Breastfeeding co-ordinator role for 12 hours per week
- Implement e-learning training module for all clinical staff on safe management of EBM
- Implement training package for link nurses and HCAs initially
- Invest in waterless warmers to ensure EBM heated to safest standard. Policy and SOPs can then be ratified.

Heidi had included a cost breakdown for the waterless warmers, the reason why they are required and how many would be needed. Heidi noted the equipment is costly and how the Neonatal Network are working together to try to reduce the cost.

The training package referred to could be offered to external organisations at a cost.

Cath Wardell praised Heidi for work to date on ensuring breastfeeding services are safe.

Resolved:
The Board thanked Heidi and Cath for the presentation and supported the next steps. Hilda Gwilliams agreed to contact Heidi to move the service forward.
Action: HG

Revision of Homecare Staff Office space Sept 2017
The Board welcomed Joan Mulvoy to the meeting.

Joan reported on the space issues within pharmacy noting there are three Homecare admin staff who had not been allocated an office before the hospital move due to lack of space. The area allocated for these staff was in the dispensary near busy rooms and a high volume of staff traffic.

A 1:1 room had been identified as an appropriate office space with the 1:1 room being moved to a sundries storeroom and the stores being allocated to a separate room.

Benefits from the move included:

- Homecare staff now have an office.
- Chief Technician and Deputy will have an office
- A new One to One room is available to use
- Space is used effectively.
- Purchasing / Homecare teams can communicate better.

Going forward Phase 2 will be implemented.

Resolved:
The Board thanked Joan for her presentation.

17/18/116 Alder Hey Ventures

David Powell and John Grinnell updated the Board on the proposed development of Alder Hey Ventures Ltd, the purpose of which is commercialising and

operationalising innovation including governance, taxation, commercial and risk issues. KPMG in a light touch capacity have provided the required Taxation, Commercial and Legal support to Alder Hey NHS Foundation Trust to ensure a robust process is followed that provides the required assurances around an SPV set up and governance.

A draft report is due to be presented at the next Research Education and Innovation Committee this month. A final version will be presented at the November Board meeting.
Action: DP/JG

Resolved:
The Board received an update on Alder Hey Ventures Ltd.

17/18/117 Programme Assurance Update
Resolved:
The Board went through the dashboard noting medicine had made further progress than recorded.

17//18/118Corporate Report
The Board received the report for July 2017.

Financial, Growth & Mandatory Framework
For the month of July the Trust is reporting a trading deficit of £0.3m which is £0.1m behind plan.

Income is behind plan by £0.4m mainly due to income relating elective and outpatient activity. Elective activity is behind plan by 12% and outpatient activity is behind plan by 7%. These are offset by an overachievement on non-elective activity of 12%. Pay budgets are £0.2m overspent for the month relating to use of temporary staffing which has increased. The Trust is ahead with the CIP target to date by £0.1m. Cash in the Bank is £11.2m. NHSI Use of Resources rating of 3 in line with plan.

Performance
The Trust is compliant with all NHSI standards with the exception of the ED 4 hour standard, which was 93% for the month; August had seen improvement.

Diagnostics, incomplete pathway and cancer all achieved despite the high number of NEL and ED attendances. 28 day breaches have reduced to one. Activity has increased within the hospital against the same period last year. Backlog remained static, no patients waiting >52 weeks and clearance rates reduced. Corporate induction hit 100% for July.

A winter plan is being developed.

Patient Safety
Clinical incident reporting remains high (352 year to date compared to 188 last year). This reflects the continued open culture of reporting incidents.

Patient Experience
There were four formal complaints in July; this is the lowest in one month since January. PALS attendances are slightly lower than the previous month but are maintaining an increasing trend since April. Family and Friends responses have improved except in outpatients where there is a slight reduction in the percentage of families that would recommend Alder Hey. However there is a need to improve the number of responses in A&E and in Community. Inpatient survey metrics have all moved closer to their goal except 'patients knowing their planned date of discharge' which has deteriorated slightly.

Clinical Effectiveness
The marked reduction in hospital acquired infections has been maintained this month, with a cumulative 15 HAIs compared with 33 HAIs at this point last year. MRSA and C. difficile remain at zero for the year. Year to date there have been 3.8% (235) of surgical patients discharged later then their plan, compared to 5.4% at this point last year. The number of deaths in hospital has improved slightly at 23 cumulatively, compared to 27 last year

Resolved:
The Board received the Corporate Report for Month 4.

17/18/119 Board Assurance Framework
Resolved:
The Board received the content of the BAF, noting in particular the assurances with regard to the management contract at LCH.

17/18/120 Resource and Business Development Committee
Resolved:
The Board received the approved minutes from the meeting held on 28th June 2017.

17/18/121 Integrated Governance Committee: Chair's update
Resolved:
The Board received the approved minutes from the meeting held on 24th May 2017.

17/18/122 Global Digital Exemplar
The Trust received confirmation of the first tranche of PDC funding on Friday 16th June (approximately £2.5million), this was received and we were available to drawn down from on the 10th July.

The invoice request has been completed for the remaining revenue funding (approx. £800k) will also be made available via the CCG imminently.

The Alder Hey *Fast Follower* Trust, Clatterbridge, are currently undergoing 'due diligence' and a site visit has been arranged there for the 20th September 2017.
At the next Board update an overview of the Site Visit, copy of the Funding Agreement and Letter of intent will be circulated for formal agreement and sign off.

Peter Young highlighted difficulties with the new voice recognition system particularly in Orthopaedics. The teams were working through the issues being raised.

17/18/123 Research Education and Innovation Committee: Chair's update

Resolved:

The Board received the approved minutes from the meeting held on 28th April 2017.

It was agreed a presentation at the next Board would be given on projects within the Alder Hey Ventures LTD.

Action: DP

17/18/124 Any Other Business

No other business was reported.

Date and Time of next meeting: Tuesday 3rd October 2017, at 1:30pm, Large Meeting Room, Institute in the park.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd October 2017

Report of:	Chief Nurse
Paper Prepared by:	Chief Nurse and Clinical Risk Manager
Subject/Title:	Serious Incidents Requiring Investigation
Background Papers:	n/a
Purpose of Paper:	This report summarises all the open serious incidents in the Trust and identifies new serious incidents arising in the last calendar month.
Action/Decision Required:	For information regarding the notification and management of SIRI's.
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	

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1. Background:

All Serious incidents requiring investigation (SIRI) are investigated using a national Root Cause Analysis (RCA) investigation methodology.

Incidents are categorised as a Serious Incident Requiring Investigation (SIRI) using the definitions in the Trust "Management of Incidents including the Management of Serious Critical Incidents Policy". All new, on-going and closed SIRI incidents are detailed in Appendix A of this report.

Safeguarding children cases reported through StEIS are included in this report. Since June 2014 NHS England have additionally requested that the Trust report all Sudden Unexpected Deaths in Infancy (SUDI) and Sudden Unexpected Deaths in Childhood (SUDC) Cases onto the StEIS Database.

SIRI incidents are closed and removed from the table of on-going SIRI incidents following internal approval of the final RCA investigation report, in addition, an external quality assurance process is completed via Liverpool CCG as lead commissioners. The SIRI incident is then transferred to the Trust SIRI Action log until all actions are completed. Progress with implementation/completion of the SIRI action plans are monitored by the Clinical Quality Assurance Committee (CQAC).

2. SIRI performance data:

	SIRI (General)														
	2016/17										2017/18				
Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**
New	2	0	1	1	2	2	1	0	1	2	3	1	2	4	0
Open	2	4	2	3	3	2	2	1	1	2	2	4	4	6	8
Closed	2	0	2	0	1	3	2	2	0	0	2	1	0	1	2
Month	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**
New	1	0	1	1	2	0	0	1	2	2	0	0	0	1	0
Open	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total closed	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

3. Recommendations:

The Trust Board is asked to note new and closed incidents and progress in the management of open incidents.

New SIRI Incidents reported between the period 01/08/2017 to 31/08/2017:								
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**72 hour review completed/ immediate actions taken and shared learning**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
Nil								

New Safeguarding investigations reported 01/08/2017 to 31/08/2017: For information							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/ 19060	31/07/2017	Surgery	**Grade 3 Pressure Ulcer** - A 7 year old patient with a head injury sustained in a road traffic accident has a right sided below knee plaster of paris (POP) insitu. The patient has numerous abrasions from the accident including behind the right knee. The patient has now been confirmed as having a Grade 3 pressure ulcer behind the right knee thought to have been caused by friction from the plaster cast.	Kelly Black, Surgical Matron	Information gathered. RCA panel meeting being held 25/09/2017, following which RCA report is to be written.	Yes	Ongoing – numerous attempts made to contact family, which have been unsuccessful. Formal letter to be sent to family.
StEIS 2017/ 18792	26/07/2017	Medicine	**Grade 3 Pressure Ulcer** - Patient has nasopharyngeal airway (NPA) inserted into left nostril. Tissue Viability Nurse has reviewed and patient has a significant mucosal pressure ulcer to his left nostril.	Anne Hyson, Head of Quality	RCA panel meeting held, draft report written. Report Quality checked 25th September, submitted to CCG.	Yes	Yes
StEIS 2017/ 18783	26/07/2017	Business Support	**Delay in letters to GP's** - Following a Medisec update to	Martin Levine, Head of Clinical Systems	Following completion of 72 hour review and investigation report,	Yes	N/A – No harm known.

			facilitate the switch to electronic letters, it was identified that a software bug was introduced that resulted in letters not being sent to two GP practices for a period of 3 months. Any letters associated to patients of these practices were also not sent. No patient harm identified.		assurance provided that actions have been taken to mitigate the risk of reoccurrence. Liaised with CCG to agree to step this incident down from StEIS.		
2017/ 17986	17/07/2017	Surgery	**Unexpected death** of cardiac patient.	Rachael Hanger, Theatre Matron and Adam Donne, ENT Consultant	The baby's death was initially thought to be unexpected, and therefore reported to StEIS. Following review by clinical experts, it became apparent this was not an unexpected death. In view of that conclusion the team completed mortality reviews and a level 1 investigation. Liaised with CCG to agree to step this incident down from StEIS.	Yes	Verbal discussions have been held with the family. Duty of Candour letter not sent initially based on compassionate grounds. Following review, as patient's death was not unexpected, duty of candour not applicable.
StEIS 2017/ 14196	02/06/2017	Surgery	**Delay in patient being reviewed**. An unwell, query septic child was referred to the General Paediatric team for review by the Orthopaedic team. He had undergone	Sue Tickle, Clinical Nurse Manager ICU and Sarah Wood, Consultant Surgeon	RCA panel meeting held 29/08/17. Draft RCA report written and submitted for quality check on 25th September. Quality	Yes	Yes

			bilateral hip surgery 5 days prior. He was referred as he was febrile and tachycardic. He was referred to the paediatric team around 6.30pm on 24/5/2017.		check completed on 25th September, draft report returned to authors for further work to be completed.		
StEIS 2017/9937	12/04/2017	Surgery	**Sudden unexpected death** – patient had adenotonsillectomy with subsequent deterioration, admitted to HDU, subsequent cardiac arrest and sadly died.	Christine Murray, Sister, HDU	Further work required to finalise report. Report going through quality approval stage.	Yes	Yes
RCA 333 2016/17 **Internal**	28/03/2017	Community	**Potential missed opportunity to diagnose** - The patient was brought to ED in November 2016 as an emergency with seizures and hypertension. Despite resuscitation and intensive care she died 2 days later. Subsequent post-mortem has revealed previously undiagnosed structural kidney disease which is the likely cause of the malignant hypertension. The child had presented to ED in June 2013 and October 2015 with a diagnosis of Bell's Palsy. Blood pressure should have been recorded on each of these occasions but	Amanda Turton, ED Manager	Final draft report written, report going through quality approval stage.	Internal	Being open completed, level of harm unknown.

			was not recorded.				
RCA 332 2016/17 **Internal**	28/03/2017	Community	During a complaint investigation it became apparent that some elements of the child's inpatient stay had not been managed as robustly as they should have been. During the 4 days of the child's stay there were a number of times where his clinical condition and monitoring of vital signs triggered his PEWS score and required a review by a doctor - all required reviews do not appear to have taken place.	Dianne Topping, Senior Nurse	Final draft report written, report going through quality approval stage.	Yes	Being open completed, level of harm unknown.

On-going Safeguarding investigations							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

SIRI incidents closed since last report						
Reference Number	Date investigation started	CBU	Incident Description	RCA Lead Investigator	Outcome	Duty of Candour/Being open policy Implemented
StEIS 2017/ 12813	17/05/2017	Surgery	Grade 3 Pressure Ulcer - Acutely unwell patient stepped down from PICU to surgical ward. Patient was found to have a grade 2 pressure ulcer on left ear due to patient acuity and chest drain on right side. Limited options for re-positioning, impacting on deterioration of pressure ulcer to grade 3. Parents fully informed of pressure ulcer and acknowledge seriousness of patient acuity.	Kelly Black, Surgical Matron	Final RCA report sent to CCG 11/09/17 and family 15/09/17.	Yes
StEIS 2017/ 14923	12/06/17	Surgery	Never Event – wrong site surgery. Patient admitted for elective procedures to both arms- right sided osteotomy and fixation, and left removal of plate. 2 scars present on left arm, plan was to remove plate via the scar on the underside of the arm however the scar on the topside of the arm was incised first.	Neil Herbert – Deputy Theatre Manager	Final RCA report sent to CCG 05/09/17 and family 15/09/17.	Yes

Safeguarding investigations closed since last report
Nil

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee

Minutes of the last meeting held on Wednesday 19 July 2017
10.00 am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Jeannie France-Hayhurst	Non-Executive Director
	Mags Barnaby	Interim Chief Operating Officer
	John Grinnell	Director of Finance
	Erica Saunders	Director of Corporate Affairs
	Glenna Smith	General Manager – Medicine
	Lachlan Stark	Head of Planning and Performance
	Mark Peers	Public Governor
	Simon Hooker	Public Governor
	Catherine McLaughlin	Director of Community Services
	Cathy Umbers	Associate Director of Nursing & Governance
	Jo Williams	Non-Executive Director
	Paul Newland	Clinical Director for the Cancer & Laboratory Medicine Care Group
	Steve Ryan	Medical Director
	Rob Griffiths	Theatre Manager
	Richard Cooke	Director of Infection Prevention and Control
	Christian Duncan	Director - Surgery

In Attendance

Karen Critchley	Executive Assistant (Minutes)

Agenda Item

17/18/24 Apologies:

Hilda Gwilliams	Chief Nurse
Melissa Swindell	Director of HR
Joe Gibson	Programme Director

17/18/25 Declaration of Interest

None declared

17/18/26 Minutes of the previous meeting held on 21 June 2017

Resolved:

CQAC approved the Minutes of the last meeting held on 21 June 2017.

17/18/27 Maters Arising and Action Log

17/18/16 - **Visibility/Walkabout Process** – AM was disappointed that this programme was not yet in place. The previously agreed format for the visits, which would give teams the opportunity to showcase their services,

was reiterated. AM said that the programme must be in place by the end of August. CU said that diary pressures were challenging and asked for support in identifying dedicated time for this important activity. Feedback from the visits would be received by CQAC.

17/18/16 – CQC Report – ES said that the report had not yet been received but it was anticipated it would be available at the end of August.

17/18/16 – Equality Issues – It was noted that MS had met with Hannah Ainsworth. This item to remain on the action log awaiting an update from MS at the next meeting.

17/18/16 – Quality Impact Assessment Position Statement – To be shared with CQAC at next meeting on 16 August 2017.

17/18/19 – Sepsis – No update available on joint working with LCH. This to remain as an outstanding issue on the action log.

AM to review the action log outside of the meeting and to close those that had been completed.

17/18/28 CQC Action Plan

ES confirmed that whilst the CQC Inspection Team considered the Action Plan to be "live", most of the issues had been completed or were ongoing work. Audits had been undertaken and compliance rates of 90-100% had been demonstrated against most of the standards and areas.

Compliance with Mandatory Training – It was noted that MS would link with a colleague at LCH who had expertise in this area. It was anticipated that improvements to the ESR system would support improved reporting/monitoring. RG said that a task and finish group had been established to look at delivery of mandatory training. He agreed to provide an update to a future meeting.

Transition of Care for Young People – SR briefed CQAC on ongoing discussions taking place regarding the transition to adult services of a 22 year old in the care of Alder Hey.

Resolved : The updated Action Plan was noted.

CQAC received and noted the CQC's consultation document on the next phase of regulation. Discussion ensued on how Alder Hey would fit within this framework. It was agreed that ES would ask MIAA to expand the soon to be undertaken Well-Led Review to look at the wider quality determinants. Any comments on the CQC's consultation document to be directed to ES for transmission to the CQC.

17/18/29 Sepsis Update

GS updated CQAC on the work being undertaken within the Sepsis and Best in Acute Care Work Streams. She reported that the target of 60 minutes or less for the identification of Sepsis in ED and start of treatment had been achieved and reported to CQC. She described the results of the audit of inpatient care, which identified the timeframe as being 90 minutes. The challenges of reviewing patients across the hospital and the IT elements were described. In order to improve this, the IM&T team were looking at how manual processes could be translated to electronic solutions. Should this not be possible, escalation would be instigated to Meditech and the issue would be included on the risk register. AM said that the Board must be assured that the timescales and targets set around Sepsis were being achieved.

Resolved: That by 1 September all issues preventing the achievement of the 60 minute timeframe for identification/commencement of treatment for Sepsis be resolved. At that point, any outstanding barriers to be escalated as appropriate and included on the Risk Register.

CQAC thanked RC for his contribution to the Trust and this Committee over the past three years and wished him well in his retirement. As it had not been possible to recruit a DIPC it was noted that SR would be assuming the role of Infection Control Doctor and Valya Weston. Had been appointed Associate DIPC. A revised JD for DIPC was being developed and it was anticipated that the post would be advertised in September.

17/18/30 **Programme Assurance/Progress Update**

MB said that the programme was on track with work in progress against some of the gaps.

The Committee noted that Deteriorating Patient Project was now rated green.

Work was progressing on the improving patient and staff experience in outpatient project but lots of elements were yet to be completed.

Best in Operative Care – SR confirmed that the PID would be available by the end of July and in advance of the next CQAC meeting. It was noted that elective surgery activity in June was just below 90% and below target. Non-elective activity was above target. Whilst there was currently a financial gap, there was confidence that this would be closed by focussing on activity levels and improved controls around pay spend. Pay spend would continue to be monitored by RABD but AM would ask HG to provide regular recruitment reports for CQAC.

LS updated on progress with the Winter Plan which was being developed drawing on experience from last year. It was anticipated that this would be completed by the end of July.

JG was confident that now a Programme Board had been established and was meeting monthly, there would be improvements across all areas.

LS said that in response to guidance from the CCG, a PID Review Group had been established and would ensure that QIAs are completed as part of the programme documentation for any proposals.

17/18/31 Corporate Report – Quality Metrics

CU briefed the Committee on the clinical incidents reported for May. She said that of the 150, the majority were low level harm, with 4 being moderate/serious. The report reflected the culture of openness around incident reporting. Other measures reported:

- Medication errors – 7
- Pressure ulcers – 7 – Trust wide action plan in place
- Never Events – 0
- Readmission to PICU – 0
- Hospital Acquired Infections – 3
- Readmissions of patients with long-term conditions within 28 days of discharge - 3
- Surgical patients discharged later than planned – 107 – an improvement against the position at the same time last year.
- Noted a decrease in the number of patients who would recommend the Trust
- Other areas requiring improvement – availability of play resource and knowing planned date of discharge. These being addressed by Ward Managers. Recruitment of Play Lead is underway. MB said that planned date of discharge would be included as a quality metric in the Winter Plan. Kerry Morgan had also undertaken a detailed analysis around estimated date of discharge and her findings were being taken forward.

Whilst all of the above were below the target level, discussion ensued on the appropriateness of the quality metrics. JG suggested that a CQAC dashboard might be more meaningful. AM said she would welcome this approach.

Resolved: that LS would develop a bespoke CQAC dashboard for presentation, perhaps focussing a prototype/test on one area.

17/18/32 CQAC Terms of Reference

The Committee received the updated TOR. Discussion ensued on Membership and it was agreed that the following be included in the Membership:

- Head of Planning and Performance
- Clinical Director for the Cancer & Laboratory Medicine Care Group
- Heads of Quality (invitees)

Discussion ensued on how CQAC/the Board could be assured around service delivery within the Divisions. It was felt that this would evolve as divisions develop.

Resolved: To include members/invitees as noted above. Subject to that amendment the TOR were approved.

17/18/33 Board Assurance Framework

The Committee received the report. It was noted that the Matrons had now been recruited, with the exception of Critical Care.

17/18/34 Clinical Quality Steering Group – Key Issues Report

It was noted that 2 new serious incident action plans had been put in place (Surgical Division – inappropriate management of a deteriorating child; unexpected mortality and extravasation injury in elective orthopaedic patient). 41 actions on the SIRI action log remain overdue. Work was being undertaken with the divisions to resolve these issues quickly. CU said that she would be contacting the 3@Top within the divisions asking that this be given priority.

17/18/35 Any Other Business

Recruitment – the Committee discussed the impact on nurse recruitment of changes to nurse education. A workforce planning group would be looking at this. JF said that a potential source of nurse recruits might be Greece.

17/18/36 Date and Time of Next meeting

10.00 am – Wednesday 16 August 2017. (This might be subject to review).

National Guidance on Learning from Deaths

A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care

National Quality Board

First edition March 2017

National Guidance on Learning from Deaths

Contents

Foreword

Following events in Mid Staffordshire, a review of 14 hospitals with the highest mortality noted that the focus on aggregate mortality rates was distracting Trust boards "from the very practical steps that can be taken to reduce genuinely avoidable deaths in our hospitals".

This was reinforced by the recent findings of the Care Quality Commission (CQC) report *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England*. It found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. The report also pointed out that there is more we can do to engage families and carers and to recognise their insights as a vital source of learning.

Understanding and tackling this issue will not be easy, but it is the right thing to do. There will be legitimate debates about deciding which deaths to review, how the reviews are conducted, the time and team resource required to do it properly, the degree of avoidability and how executive teams and boards should use the findings.

This first edition of *National Guidance on Learning from Deaths* aims to kickstart a national endeavour on this front. Its purpose is to help initiate a standardised approach, which will evolve as we learn. Following the Learning from Deaths conference on 21st March 2017 we will update this guidance to reflect the collective views of individuals and organisations to whom this guidance will apply to ensure that it is helpful.

Professor Sir Bruce Keogh
National Medical Director
NHS England

Professor Sir Mike Richards
Chief Inspector of Hospitals
Care Quality Commission

Dr Kathy McLean
Executive Medical Director
NHS Improvement

On behalf of the National Quality Board.

Executive Summary

Introduction

1. For many people death under the care of the NHS is an inevitable outcome and they experience excellent care from the NHS in the months or years leading up to their death. However some patients experience poor quality provision resulting from multiple contributory factors, which often include poor leadership and system-wide failures. NHS staff work tirelessly under increasing pressures to deliver safe, high-quality healthcare. When mistakes happen, providers working with their partners need to do more to understand the causes. The purpose of reviews and investigations of deaths which problems in care might have contributed to is to learn in order to prevent recurrence. Reviews and investigations are only useful for learning purposes if their findings are shared and acted upon.

2. The following definitions apply for the purposes of this guidance:

(i) Case record review: The application of a case record/note review to determine whether there were any problems in the care provided to the patient who died in order to learn from what happened, for example Structured Judgement Review delivered by the Royal College of Physicians.

(ii) Investigation: The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence, including physical evidence, witness accounts, policies, procedures, guidance, good practice and observation - in order to identify the problems in care or service delivery that preceded an incident to understand how and why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events.

(iii) Death due to a problem in care: A death that has been clinically assessed using a recognised methodology of case record/note review and determined more likely than not to have resulted from problems in healthcare and therefore to have been potentially avoidable.

Governance and Capability

3. Learning from a review of the care provided to patients who die should be integral to a provider's clinical governance and quality improvement work. To fulfil the standards and new reporting set out in this guidance for **acute, mental health and community NHS Trusts and Foundation Trusts**, Trusts should ensure their **governance arrangements**

and processes include, facilitate and give due focus to the review, investigation and reporting of deaths, including those deaths that are determined more likely than not to have resulted from problems in care. Trusts should also ensure that they share and act upon any learning derived from these processes. The standards expected of Trust boards are set out at Annex A including having an existing **executive director** take responsibility for the learning from deaths agenda and an existing **non-executive director** take responsibility for oversight of progress. Guidance for non-executive directors is at Annex B.

4. Providers should review and, if necessary, enhance **skills and training** to support this agenda. Providers need to ensure that staff reporting deaths have appropriate skills through specialist training and protected time under their contracted hours to review and investigate deaths to a high standard.

5. Providers should have a **clear policy for engagement with bereaved families and carers**, including giving them the opportunity to raise questions or share concerns in relation to the quality of care received by their loved one. Providers should make it a priority to work more closely with bereaved families and carers and ensure that a consistent level of timely, meaningful and compassionate support and engagement is delivered and assured at every stage, from notification of the death to an investigation report and its lessons learned and actions taken.

Improved Data Collection and Reporting

6. The following minimum requirements are being introduced to complement providers' current approaches in relation to reporting and reviewing deaths:

A. POLICY ON RESPONDING TO DEATHS

- Each Trust should publish an **updated policy** by September 2017 on how it responds to, and learns from, deaths of patients who die under its management and care, including:

  i. How its processes respond to the death of an individual with a **learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) and a **stillbirth or maternal death** (Annex G).
  ii. **The Trust's approach to undertaking case record reviews**. Acute Trusts should use an evidence-based methodology for reviewing the quality of care provided to those patients who die. The Structured Judgement Review (SJR)

case note methodology is one such approach and a programme to provide training in this methodology for acute Trusts will be delivered by the Royal College of Physicians over the coming year (the current version of the SJR approach is available at https://www.rcplondon.ac.uk/projects/outputs/national-mortality-case-record-review-nmcrr-programme-resources Other approaches also exist, such as those based on the PRISM methodology. Methods like SJR were not developed for mental health and community Trusts but can be used as a starting point and adapted by these providers to reflect their individual service user and clinical circumstances. Annex J provides a case study of how SJR is being adapted for mental health Trusts. Case record reviews of deaths of people with learning disabilities by acute, mental health and community Trusts should adopt the methodology developed by the Learning Disabilities Mortality Review (LeDeR) programme in those regions where the programme is available (details of the programme are available from Annex D).

iii. **Categories and selection of deaths in scope for case record review:** As a minimum and from the outset, Trusts should focus reviews on in-patient deaths in line with the criteria specified at paragraph 14(ii). In particular contexts, and as these processes become more established, Trusts should include cases of people who had been an in-patient but had died within 30 days of leaving hospital. Mental Health Trusts and Community Trusts will want to carefully consider which categories of outpatient and/or community patient are within scope for review taking a proportionate approach. The rationale for the scope selected by Trusts will need to be published and open to scrutiny.

B. DATA COLLECTION AND REPORTING

- **From April 2017, Trusts will be required to collect and publish on a quarterly basis specified information on deaths. This should be through a paper and an agenda item to a public Board meeting in each quarter to set out the Trust's policy and approach (by the end of Q2) and publication of the data and learning points (from Q3 onwards).** This data should include the total number of the Trust's in-patient deaths (including Emergency Department deaths for acute Trusts) and those deaths that the Trust has subjected to case record review. Of these deaths subjected to review, Trusts will need to provide estimates of how many deaths were judged more likely than not to have been due to problems in care. The dashboard provided with this guidance shows what data needs to be collected and a suggested format for publishing the information,

accompanied by relevant qualitative information and interpretation.

- **Changes to the Quality Accounts regulations will require that the data providers publish be summarised in Quality Accounts from June 2018** (Annex L), including evidence of learning and action as a result of this information and an assessment of the impact of actions that a provider has taken.

Further Developments

7. In 2017-18, further developments will include:

- **The Care Quality Commission will strengthen its assessment of providers learning from deaths** including the management and processes to review and investigate deaths and engage families and carers in relation to these processes.
- **NHS England, led by the Chief Nursing Officer, will develop guidance for bereaved families and carers.** This will support standards already set for local services within the Duty of Candour[1] and the *Serious Incident Framework*[2] and cover how families should be engaged in investigations. Health Education England will review training of doctors and nurses on engaging with bereaved families and carers.
- **Acute Trusts will receive training to use the Royal College of Physicians' Structured Judgement Review case note methodology.** Health Education England and the Healthcare Safety Investigation Branch (Annex L) will engage with system partners, families and carers and staff to understand broader training needs and to develop approaches so that NHS staff can undertake good quality investigations of deaths.
- **NHS Digital is assessing how to facilitate the development of provider systems and processes** so that providers know when a patient dies and information from reviews and investigations can be collected in standardised way.
- **The Department of Health is exploring proposals to improve the way complaints involving serious incidents are handled** particularly how providers and the wider care system may better capture necessary learning from these incidents[3].

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[1] Further information is available from: http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf

[2] https://improvement.nhs.uk/resources/serious-incident-framework/

[3] This follows the Parliamentary and Health Service Ombudsman's report *Learning from Mistakes* (July 2016) and the Public Administration and Constitutional Affairs Committee hearings on this report.

Chapter 1 - Mortality Governance

Context

8. In December 2016, the Care Quality Commission (CQC) published its review *Learning, candour and accountability: A review of the way NHS trusts review and investigate the deaths of patients in England.* The CQC found that none of the Trusts they contacted were able to demonstrate best practice across every aspect of identifying, reviewing and investigating deaths and ensuring that learning is implemented.

9. The Secretary of State for Health accepted the report's recommendations and in a Parliamentary statement[4] made a range of commitments to improve how Trusts learn from reviewing the care provided to patients who die. This includes regular publication of specified information on deaths, including those that are assessed as more likely than not to have been due to problems in care, and evidence of learning and action that is happening as a consequence of that information in Quality Accounts from June 2018.

Accountability

10. Mortality governance should be a key priority for Trust boards. Executives and non-executive directors should have the capability and capacity to understand the issues affecting mortality in their Trust and provide necessary challenge.

11. This *National Guidance on Learning from Deaths* should be read alongside the *Serious Incident Framework*. Trust boards are accountable for ensuring compliance with both these frameworks. They should work towards achieving the highest standards in mortality governance. However, different organisations will have different starting points in relation to this agenda and it will take time for all Trusts to meet such standards. Over time this guidance is likely to be updated to include wider providers of NHS care and whole healthcare systems.

Responding to Deaths

12. Each Trust should have a policy in place that sets out how it responds to the deaths of patients who die under its management and care. The standards expected of Trusts are set out at Annex C.

13. Boards should take a systematic approach to the issue of potentially avoidable mortality and have robust mortality governance processes. This will allow them to identify any areas of

[4] https://www.gov.uk/government/speeches/cqc-review-of-deaths-of-nhs-patients]

failure of clinical care and ensure the delivery of safe care. This should include a mortality surveillance group with multi-disciplinary and multi-professional membership, regular mortality reporting to the Board at the public section of the meeting with data suitably anonymised, and outputs of the mortality governance process including investigations of deaths being communicated to frontline clinical staff.

Death Certification, Case Record Review and Investigation

14. There are three levels of scrutiny that a provider can apply to the care provided to someone who dies; (i) death certification; (ii) case record review; and (iii) investigation. They do not need to be initiated sequentially and an investigation may be initiated at any point, whether or not a case record review has been undertaken (though a case record review will inform the information gathering phase of an investigation together with interviews, observations and evidence from other sources). For example, the apparent suicide of an in-patient would lead to a Serious Incident investigation being immediately instigated in advance of death certification or any case record review. The three processes are summarised below:

(i) Death Certification: In the existing system of death certification in England, deaths by natural causes are certified by the attending doctor. Doctors are encouraged to report any death to the coroner that they cannot readily certify as being due to natural causes. Reforms to death certification, when implemented in England (and Wales), will result in all deaths being either scrutinised by a Medical Examiner or investigated by the Coroner in prescribed circumstances. Additionally, Medical examiners will be mandated to give bereaved relatives a chance to express any concerns and to refer to the coroner any deaths appearing to involve serious lapses in clinical governance or patient safety.

(ii) Case Record Review: Some deaths should be subject to further review by the provider, looking at the care provided to the deceased as recorded in their case records in order to identify any learning. At a minimum, providers should require reviews of:

i. all deaths where **bereaved families and carers, or staff, have raised a significant concern about the quality of care provision**;
ii. all in-patient, out-patient and community patient deaths of those with **learning disabilities** (the LeDeR review process outlined at Annex D should be adopted in those regions where the programme is available otherwise Structured Judgement Review or another robust and evidence-based methodology should be used) and

with **severe mental illness**;

iii. all deaths in a **service specialty, particular diagnosis or treatment group where an 'alarm' has been raised** with the provider through whatever means (for example via a Summary Hospital-level Mortality Indicator or other elevated mortality alert, concerns raised by audit work, concerns raised by the CQC or another regulator);

iv. all deaths in areas where people are **not expected to die**, for example in relevant elective procedures;

v. deaths where **learning will inform the provider's existing or planned improvement work**, for example if work is planned on improving sepsis care, relevant deaths should be reviewed, as determined by the provider. To maximise learning, such deaths could be reviewed thematically;

vi. **a further sample of other deaths** that do not fit the identified categories so that providers can take an overview of where learning and improvement is needed most overall. This does not have to be a random sample, and could use practical sampling strategies such as taking a selection of deaths from each weekday.

The above minimum requirements are additional to existing requirements for providers to undertake specific routes of reporting, review or investigations for specific groups of patient deaths, such as deaths of patients detained under the Mental Health Act 1983 (Annex E).

Providers should review a case record review following any linked inquest and issue of a "Regulation 28 Report on Action to Prevent Future Deaths" in order to examine the effectiveness of their own review process.

Providers should apply rigorous judgement to the need for deaths to be subject to a Serious Incident reporting and investigation. For example, there may be instances where deaths clearly meet Serious Incident criteria and should be reported as such (whether or not a case record review has already been undertaken). Equally, problems identified in case record review may lead to the need for investigation whether this is an investigation under the Serious Incident Framework or other framework/procedure (see section iii)

(iii) Investigation: Providers may decide that some deaths warrant an investigation and should be guided by the circumstances for investigation in the Serious Incident Framework.

Some deaths will be investigated by other agents, notably the coroner. Indeed, the coroner has a duty to investigate any death where there are grounds to suspect that the death may have been avoidable. While care should be taken not to compromise such investigations, equally waiting until other investigations are completed may cause unacceptable delay. A good working relationship and close communication are needed to avoid problems.

Providers should review an investigation they undertake following any linked inquest and issue of a "Regulation 28 Report to Prevent Future Deaths" in order to examine the effectiveness of their own investigation process. If an inquest identifies problems in healthcare, providers may need to undertake additional investigation and improvement action, regardless of the coroner's verdict.

Consistency and Judgement in Case Record Review

15. All Trusts currently undertake some form of mortality review. However there is considerable variation in terms of methodology, scope, data capture and analysis, and contribution to learning and improvement. To generate learning for improvement in healthcare, clinicians and staff should engage in robust processes of retrospective case record review to help identify if a death was more likely than not to have been contributed to by problems of care.

16. The Structured Judgement Review (SJR) case note methodology is an approach being rolled out by the Royal College of Physicians. Other methodologies exist and Trusts may already be using them. Trusts need to be assured that the methodology they are using is robust and evidence-based, that it will generate the information they are now being required to publish and that their staff are trained and given sufficient time and resources to undertake case record reviews and act on what they learn.

17. Case record review assessment is finely balanced and subject to significant inter-reviewer variation. It does not support comparison between organisations and should not be used to make external judgements about the quality of care provided.

18. The judgement of whether a problem may have contributed to a death requires careful review of the care that was provided against the care that would have been expected at the time of death. Research has shown that when case record review identifies a death that may have been caused by problems in care, that death tends to be due to a series of problems none of which would be likely to have caused the death in isolation but which in

combination can contribute to the death of a patient[5][6]. Some of these elements of care are likely to have occurred prior to the admission and providers should support other organisations, for example in primary care, to understand and act on areas where care could be improved.

19. Trusts should acknowledge and cooperate with separate arrangements for the review (and where appropriate investigation) of certain categories of deaths, for example suicides, homicides, and child and maternal deaths.

Objectivity in Case Record Review

20. To ensure objectivity, case record reviews should wherever possible be conducted by clinicians other than those directly involved in the care of the deceased. If the specific clinical expertise required only resides with those who were involved in the care of the deceased, the review process should still involve clinicians who were not involved in order to provide peer challenge. Objectivity of reviews should be a component of clinical governance processes. Providers may wish to consider if their review processes should additionally be the responsibility of a designated non-executive director who could do this by chairing the relevant clinical governance committee.

Investigations

21. This *National Guidance on Learning from Deaths* and the *Serious Incident Framework* are complementary. This guidance sets out what deaths should be subject to case record review (paragraph 14(ii)), which is inevitably a wider definition than deaths that constitute Serious Incidents. Equally, when a death meets Serious Incident criteria there is no need to delay the onset of investigation until case record review has been undertaken. A review of records will inevitably be undertaken as part of an investigation process. However, immediate action to secure additional information and evidence to support full investigation should not be lost due an inappropriate requirement for all deaths (regardless of nature) to first undergo a case record review.

[5] Hogan et al. Preventable deaths due to problems in care in English acute hospitals: a retrospective case record review study. *BMJ Qual Saf2012*: 21: 737-45.
[6] Hogan et al. Avoidability of hospital deaths and association with hospital-wide mortality ratios: a retrospective case record *BMJ* 2015; 351:h3239.

22. Inquiries by the coroner[7] and investigations by providers are conducted to understand the cause of death and contributing factors. However provider investigations are not conducted to hold any individual or organisation to account. Other processes exist for that purpose including criminal or civil proceedings, disciplinary procedures, employment law and systems of service and professional regulation, including the General Medical Council and the Care Quality Commission. In circumstances where the actions of other agencies are required then those agencies must be appropriately informed and relevant protocols must be followed.

Medical Examiners

23. The introduction of the Medical Examiner role will provide further clarity about which deaths should be reviewed. Medical Examiners will be able to refer the death of any patient for review by the most appropriate provider organisation(s) and this new mechanism should ensure a systematic approach to selecting deaths for review, regardless of the setting or type of care provided in the period before a patient's death. NHS Improvement and the Department of Health are commissioning research to explore whether Medical Examiners are best placed to select which deaths need further review and ensure they do not inadvertently miss or over-refer certain types of cases. Prior to the implementation of the Medical Examiner system, Trusts are advised to allow for any doctors undertaking the certification of death to refer cases for case record review to the most relevant organisation.

Learning

24. Providers should have systems for deriving learning from reviews and investigations and acting on this learning. The learning should be shared with other services across the wider health economy where they believe this would benefit future patients, including independent healthcare services and social care services. Recommendations within any "Regulation 28 Report on Action to Prevent Future Deaths" from the coroner should also be integral to a provider's systems to support learning within and across their organisation and local system partners.

25. Regardless of whether the care provided to a patient who dies is examined using case record review or an investigation, the findings should be part of, and feed into, robust clinical governance processes and structures. The findings should be considered alongside

[7] Coroner investigations, A short guide (February 2014) is available from: https://www.gov.uk/government/publications/guide-to-coroner-services-and-coroner-investigations-a-short-guide

other information and data including complaints, clinical audit information, mortality data, patient safety incident reports and data and outcomes measures etc. to inform the Trust's wider strategic plans and safety priorities.

26. Where case record review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this should be reported via local risk management systems to the National Reporting and Learning System (NRLS).

27. All patient safety incidents reported as resulting in death or severe harm to a patient are clinically reviewed by the National Patient Safety Team at NHS Improvement to determine if there are implications for national learning and if a response is appropriate. Any deaths that are identified via case record review as due to problems in healthcare would meet the criteria for NRLS reporting. More information on the national process is available at https://improvement.nhs.uk/resources/patient-safety-alerts. All serious incidents that relate to patients should be reported to the NRLS for the same reason.

Cross-system Reviews and Investigations

28. In many circumstances more than one organisation is involved in the care of any patient who dies. Guidance in relation to cross-system reviews and investigations is at Annex H.

Roles and Responsibilities of National Bodies and Commissioners

29. Guidance is provided at Annex I. The lead roles with overall responsibility for the learning from deaths programme at each of the relevant national organisation are provided at Annex K.

Chapter 2 - Bereaved Families and Carers

Key Principles

30. Providers should engage meaningfully and compassionately with bereaved families and carers in relation to all stages of responding to a death and operate according to the following key principles below.

BEREAVED FAMILIES AND CARERS - KEY PRINCIPLES:

- bereaved families and carers should be treated as **equal partners** following a bereavement;
- bereaved families and carers must always **receive a clear, honest, compassionate and sensitive response** in a sympathetic environment;
- bereaved families and carers should receive a **high standard of bereavement care** which respects confidentiality, values, culture and beliefs, including being offered appropriate support. This includes providing, offering or directing people to specialist suicide bereavement support;
- bereaved families and carers should be informed of their **right to raise concerns about the quality of care** provided to their loved one;
- bereaved families' and carers' views should **help to inform decisions about whether a review or investigation is needed**;
- bereaved families and carers should receive **timely, responsive contact and support in all aspects of an investigation process**, with a single point of contact and liaison;
- bereaved families and carers should be **partners in an investigation** to the extent, and at whichever stages, that they wish to be involved, as they offer a unique and equally valid source of information and evidence that can better inform investigations;
- bereaved families and carers who have experienced the investigation process should be supported to work in partnership with Trusts in **delivering training for staff in supporting family and carer involvement** where they want to.

Context

31. Dealing respectfully, sensitively and compassionately with families and carers of dying or deceased patients within the NHS is crucially important. The principles of openness, honesty, and transparency as set out in the Duty of Candour should also be applied by

providers in all their dealings with bereaved families and carers. Yet the Care Quality Commission's report *Learning, candour and accountability* identified that NHS providers are continuing to fail too many bereaved families and carers of those who die whilst in their care.

32. When a patient dies under the management and care of a Trust, bereaved families and carers should be informed immediately after the death. People who are bereaved need others to recognise and acknowledge their loss. Recognition by professionals, appropriately expressed, may be particularly valued. Communication at the time of a death, and afterwards, should be clear, sensitive and honest. Bereaved families and carers should be given as much information as possible in line with the Duty of Candour for providers. Every effort should be made to hold these discussions in a private, sympathetic environment, without interruptions. Providers should ensure that their staff, including family liaison officers where available, have the necessary skills, expertise and knowledge to engage with bereaved families and carers. This includes recognising and dealing with common issues such as family members feeling guilty about their loss.

33. All too often the terms of the conversation people have with the NHS about a concern or complaint are set by the organisation. Organisations can often be too quick to dismiss or explain away concerns, compounding the grief of bereaved families and carers with obfuscation and a lack of openness. Paying close attention to what bereaved families and carers say can offer an invaluable source of insight to improve clinical practice. Listening to them goes hand in hand with the Duty of Candour. In particular, bereaved families and carers should be asked if they had concerns about the quality of care received by the deceased to inform decisions about the need to undertake a case record review or investigation.

34. When reviewing or investigating possible problems with care, involvement of bereaved families and carers begins with a genuine apology. Saying sorry is not an admission of liability and is the right thing to do. The appropriate staff member should be identified for each case, including to explain what went wrong promptly, fully and compassionately. This may include clinicians involved in the case but this may not always be appropriate and should be considered on a case by case basis.

35. Depending on the nature of the death, it may be necessary for several organisations to make contact with those affected. This should be discussed with the bereaved families and carers and a co-ordinated approach should be agreed with them and the

organisations involved. If other patients and service users are involved or affected by the death they should be offered the appropriate level of support and involvement.

36. The provider should ensure that the deceased person's General Practitioner is informed of the death and provided with details of the death as stated in the medical certificate at the same time as the family or carers. The GP should be informed of the outcome of any investigation.

Bereavement Support

37. Bereavement can influence every aspect of well-being. Providers should offer a bereavement service for families and carers of people who die under their management and care (including offering or directing people to suicide bereavement support) that offers a caring and empathetic service at a time of great distress and sadness. This includes offering support, information and guidance. This should include bereavement advisors to help families and carers through the practical aspects following the death of a loved one such as:

- arranging completion of all documentation, including medical certificates;
- the collection of personal belongings;
- post mortem advice and counselling;
- deaths referred to the coroner;
- emotional support, including counselling;
- collection of the doctor's Medical Certificate of Cause of Death and information about registering a death at the Registrar's Office;
- details of the doctor's Medical Certificate of Case of Death (this is needed to register a death at the Registrar's Office).

38. The following should also be considered:

- timely access to an advocate (independent of the Trust) with necessary skills for working with bereaved and traumatised individuals;
- support with transport, disability, and language needs;
- support during and following an investigation. This may include counselling or signposting to suitable organisations that can provide bereavement or post-traumatic stress counselling, with attention paid to the needs of young family members, especially siblings;

- further meetings with the organisations involved or support in liaising with other agencies such as the police.

Review

39. If the care of a patient who has died is selected for case record review providers should:

- have formed that decision based on the views of the family and carers. Providers should require reviews in cases where family and carers have raised a significant concern about the quality of care provision (paragraph 14 (ii)(i));
- communicate to the family and carers the findings of the review if any problems with care are identified and any lessons the review has contributed for the future.

Investigations

40. If a provider feels that an investigation into a death is needed, early contact should have been made with bereaved families and carers so that their views helped to inform the decision.

41. Bereaved families and carers will expect to know: what happened; how; to the extent possible at the time, why it happened; and what can be done to stop it happening again to someone else. If a provider proceeds with an investigation, skilled and trained investigators need to be able to explain to bereaved families and carers the purpose of the investigation which is to understand what happened. If problems are identified, the investigation should be clear why and how these happened so that action can be taken to prevent the same mistakes from occurring again.

42. Provided the family or carer is willing to be engaged with regarding the investigation, an early meeting should be held to explain the process, how they can be informed of progress, what support processes have been put in place and what they can expect from the investigation. This should set out realistic timescales and outcomes. There should be a named person as a consistent link for the families and carers throughout the investigation, for example a family liaison officer.

43. Bereaved families and carers should:

- be made aware, in person and in writing, as soon as possible of the purpose, rationale and process of the investigation to be held;

- be asked for their preferences as to how and when they contribute to the process of the investigation and be kept fully and regularly informed, in a way that they have agreed, of the process of the investigation;
- have the opportunity to express any further concerns and questions and be offered a response where possible, with information about when further responses will be provided;
- have a single point of contact to provide timely updates, including any delays, the findings of the investigation and factual interim findings. This may disclose confidential personal information for which consent has been obtained, or where patient confidentiality is overridden in the public interest. This should be considered by the organisation's Caldicott Guardian and confirmed by legal advice in relation to each case;
- have an opportunity to be involved in setting any terms of reference for the investigation which describe what will be included in the process and be given expectations about the timescales for the investigation including the likely completion date;
- be provided with any terms of reference to ensure their questions can be reflected and be given a clear explanation if they feel this is not the case;
- have an opportunity to respond on the findings and recommendations outlined in any final report; and,
- be informed not only of the outcome of the investigation but what processes have changed and what other lessons the investigation has contributed for the future.

Guidance

44. NHS England will develop guidance for bereaved families and carers, identifying good practice for local services on the information that families say they would find helpful. It will cover what families can expect by way of local support in relation to investigations and what to expect when services have identified the death as complex or needing an independent investigation so potentially involving longer timeframes and multiple agency involvement.

45. Public Health England has published guidance which provides advice to local authorities and the NHS on developing and providing suicide bereavement support[8].

8 https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

Annexes

Annex A - Board Leadership

BOARD LEADERSHIP - KEY POINTS

The board should ensure that their organisation:

- has an existing board-level leader acting as **patient safety director** to take responsibility for the learning from deaths agenda and an existing **non-executive director** to take oversight of progress;
- pays particular attention to the care of patients with a **learning disability or mental health needs**;
- has a systematic approach to **identifying those deaths requiring review** and selecting other patients whose care they will review;
- adopts a robust and **effective methodology for case record reviews** of all selected deaths (including engagement with the LeDeR programme) to identify any concerns or lapses in care likely to have contributed to, or caused, a death and possible areas for improvement, with the outcome documented;
- ensures **case record reviews and investigations are carried out to a high quality**, acknowledging the primary role of system factors within or beyond the organisation rather than individual errors in the problems that generally occur;
- ensures that **mortality reporting in relation to deaths, reviews, investigations and learning is regularly provided to the board** in order that the executives remain aware and non-executives can provide appropriate challenge. The reporting should be discussed at the public section of the board level with data suitably anonymised;
- ensures that learning from reviews and investigations is **acted on** to sustainably change clinical and organisational practice and improve care, and **reported in annual Quality Accounts**;
- **shares relevant learning** across the organisation and with other services where the insight gained could be useful;
- ensures sufficient numbers of **nominated staff have appropriate skills** through specialist training and protected time as part of their contracted hours to review and investigate deaths;
- **offers timely, compassionate and meaningful engagement with bereaved families and carers** in relation to all stages of responding to a death;
- acknowledges that an **independent investigation** (commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may in

some circumstances be warranted, for example, in cases where it will be difficult for an organisation to conduct an objective investigation due to its size or the capacity and capability of the individuals involved; and,

- **works with commissioners to review and improve their respective local approaches** following the death of people receiving care from their services. Commissioners should use information from providers from across all deaths, including serious incidents, mortality reviews and other monitoring, to inform their commissioning of services. This should include looking at approaches by providers to involving bereaved families and carers and using information from the actions identified following reviews and investigations to inform quality improvement and contracts etc.

Annex B - Non-Executive Directors

Context

1. The board of directors of an NHS Trust or Foundation Trust is collectively responsible for ensuring the quality and safety of healthcare services delivered by the Trust, and in the case of a Foundation Trust taking into consideration the views of the board of governors.

2. Boards must ensure robust systems are in place for recognising, reporting, reviewing or investigating deaths and learning from avoidable deaths that are contributed to by lapses in care. Providers should ensure such activities are adequately resourced. Commissioners are accountable for quality assuring the robustness of providers' systems so that providers develop and implement effective actions to reduce the risk of avoidable deaths, including improvements when problems in the delivery of care within and between providers are identified.

3. All Trust directors, executive and non-executive, have a responsibility to constructively challenge the decisions of the board and help develop proposals on strategy. Non-executive directors, in particular, have a duty to ensure that such challenge is made. They play a crucial role in bringing an independent perspective to the boardroom and should scrutinise the performance of the provider's management in meeting agreed goals and objectives and monitor the reporting of performance. Non-executive directors should satisfy themselves as to the integrity of financial, clinical and other information, and that clinical quality controls and systems of risk management, for example, are robust and defensible.

Learning from Deaths

4. Executive and non-executive directors have a key role in ensuring their provider is learning from problems in healthcare identified through reviewing or investigating deaths by ensuring that:

   - the processes their organisation have in place are robust, focus on learning and can withstand external scrutiny, by providing challenge and support;
   - quality improvement becomes and remains the purpose of the exercise, by championing and supporting learning, leading to meaningful and effective actions that improve patient safety and experience, and supporting cultural change; and

- the information the provider publishes is a fair and accurate reflection of its achievements and challenges.

5. From April 2017, providers will start to collect and publish new data to monitor trends in deaths. Alongside this, they will need to establish an ongoing learning process. Board oversight of this process is as important as board oversight of the data itself. As a critical friend, non-executive directors should hold their organisation to account for its approach and attitude to patient safety and experience, and learning from all deaths, particularly those assessed as having been avoidable. The roles and responsibilities of non-executive directors include:

   i. **Understand the process: ensure the processes in place are robust and can withstand external scrutiny, by providing challenge and support. For example:**
      - be curious about the accuracy of data and understand how it is generated; who is generating it, how are they doing this, is the approach consistent across the Trust, are they sufficiently senior/experienced/trained?
      - seek similar data and trend information from peer providers, to help challenge potential for improvements in your own organisation's processes, but understand limitations of any direct comparisons;
      - ensure timely reviews/investigations (what is the interval between death and review or investigation?), calibre of reviewer/investigator and quality of the review or investigation;
      - is the Care Record Review process objective, conducted by clinicians not directly involved in the care of the deceased?
      - how was the case-record review selection done? For example, does selection reflect the evidence base which suggests older patients who die or those where death may be expected are no less likely to have experienced problems in healthcare that are associated with potentially preventable death? Does it ensure all vulnerable patient groups (not just those with learning disabilities or mental health needs) are not disadvantaged?
      - are deaths of people with learning disabilities reviewed according to the LeDeR methodology?
      - for coordination of responses to reviews/investigations through the provider's clinical governance processes, who is responsible for preparing the report, do problems in care identified as being likely to have contributed to a death feed into the organisation's Serious Incident processes?

ii. **Champion and support learning and quality improvement such as:**

- ensuring the organisation has a long-term vision and strategy for learning and improvement and is actively working towards this;
- understanding the learning being generated, including from where deaths may be expected but the quality of care could have been better;
- understanding how the learning from things going wrong is translated into sustainable effective action that measurably reduces the risks to patients - ensuring that learning and improvements are reported to the board and relevant providers;
- supporting any changes in clinical practice that are needed to improve care resulting from this learning;
- ensuring families and carers are involved reviews and investigations, and that nominated staff have adequate training and protected time to undertake these processes;
- paying attention to the provision of best practice and how the learning from this can be more broadly implemented.

iii. **Assure published information; ensure that information published is a fair and accurate reflection of the provider's achievements and challenges, such as:**

- ensuring that information presented in board papers is fit for publication i.e. it is meaningful, accurate, timely, proportionate and supports improvement;
- checking that relevant team are working towards a timely quarterly publication, in line with the Quality Accounts regulations and guidance;
- checking that arrangements are in place to invite, gather and act on stakeholder feedback on a quarter by quarter basis;
- ensuring the organisation can demonstrate to stakeholders that "this is what we said we would do, and this is what we did" (learning and action), and explain the impact of the quality improvement actions.

Annex C - Responding to Deaths

Trusts should have a policy in place that sets out how they respond to the deaths of patients who die under their management and care.

POLICY FOR RESPONDING TO DEATHS - KEY POINTS

The policy should include how providers:

- **determine which patients are considered to be under their care and included for case record review if they die** (it should also state which patients are specifically excluded);
- **report the death within the organisation and to other organisations who may have an interest** (including the deceased person's GP), including how they determine which other organisations should be informed;
- **respond to the death of an individual with a learning disability** (Annex D) or **mental health needs** (Annex E), **an infant or child death** (Annex F) **and a stillbirth or maternal death** (Annex G) and the provider's processes to support such deaths;
- **review the care provided to patients who they do not consider to have been under their care at the time of death but where another organisation suggests that the Trust should review the care provided to the patient in the past**;
- **review the care provided to patients whose death may have been expected**, for example those receiving end of life care;
- **record the outcome of their decision whether or not to review or investigate the death**, which should have been informed by the views of bereaved families and carers;
- **engage meaningfully and compassionately with bereaved families and carers** - this should include informing the family/carers if the provider intends to review or investigate the care provided to the patient. In the case of an investigation, this should include details of how families/carers will be involved to the extent that they wish to be involved. Initial contact with families/carers are often managed by the clinicians responsible for the care of the patient. Given that providers must offer families/carers the opportunity to express concerns about the care given to patients who have died, then the involvement of clinicians who cared for the patient may be considered a barrier to raising concerns. Providers should therefore offer other routes for doing this;
- **offer guidance, where appropriate, on obtaining legal advice for families,**

carers or staff. This should include clear expectations that the reasons, purpose and involvement of any lawyers by providers will be communicated clearly from the outset, preferably by the clinical team, so families and carers understand the reasons and are also offered an opportunity to have their own advocates.

Annex D - Learning Disabilities

Context

1. Since the 1990s, there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) reported that for every one person in the general population who died from a cause of death amenable to good quality care, three people with learning disabilities would do so[9]. Overall, people with learning disabilities currently have a life expectancy at least 15 to 20 years shorter than other people[10].

2. A concerning finding from CIPOLD was that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable, because that person had learning disabilities. As with the CQC report of 2016[11], CIPOLD also identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews and to the coroner.

3. The lives of people with learning disabilities often involve a complex array of service provision with multiple care and support staff. If we are to improve service provision for people with learning disabilities and their families, and reduce premature deaths, we need to look wider than NHS-related circumstances leading to a person's death, in order to identify the wider range of potentially avoidable contributory factors to their death. A cross-sector approach to reviewing deaths of people with learning disabilities is imperative; one that includes families, primary and secondary healthcare, and social and third sector care providers. Such a balanced approach across acute and other settings is needed from the outset of a review process, in order to accurately determine if there are any concerns about the death, or to identify examples of best practice that could lead to service improvement.

[9] Heslop P, Blair P, Fleming P, Hoghton M, Marriott A, Needleman D, Russ L. (2013) Confidential Inquiry into premature deaths of people with learning disabilities. Bristol: University of Bristol.
[10] Glover G,et al, 2017. Williams R. Heslop P, Oyinlola J, Grey J. (2016) Mortality in people with intellectual disabilities in England. *Journal of Intellectual Disabilities Research, 61, 1, 62-74; Health and Care of People with Learning Disabilities, 2014-15*, NHS Digital, 9 December 2016.
[11] *Learning, candour and accountability: A review of the way NHS Trusts review and investigate the deaths of patients in England*, Care Quality Commission December 2016.

4. There is unequivocal evidence that demands additional scrutiny be placed on the deaths of people with learning disabilities across all settings. This work has already been started by the Learning Disabilities Mortality Review (LeDeR) programme, commissioned by Healthcare Quality Improvement Partnership (HQUIP) for NHS England. Once fully rolled out, the programme will receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be conducted by trained reviewers.

5. The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

Scope

6. A conceptual definition of learning disabilities is used in the Learning Disabilities White Paper 'Valuing People'[12] (2001).

7. At present, NHS England is working with NHS Digital to explore the options and potential of 'flagging' the records of people with learning disabilities on the NHS Spine[13]. Over time, this could provide an access point for identifying that a person who has died had learning disabilities.

8. The LeDeR programme currently supports local reviews of deaths of people with learning disabilities aged 4 years and over. The lower age limit is set at 4 years of age because before that age, it can be difficult to be sure that a child has learning disabilities as defined above.

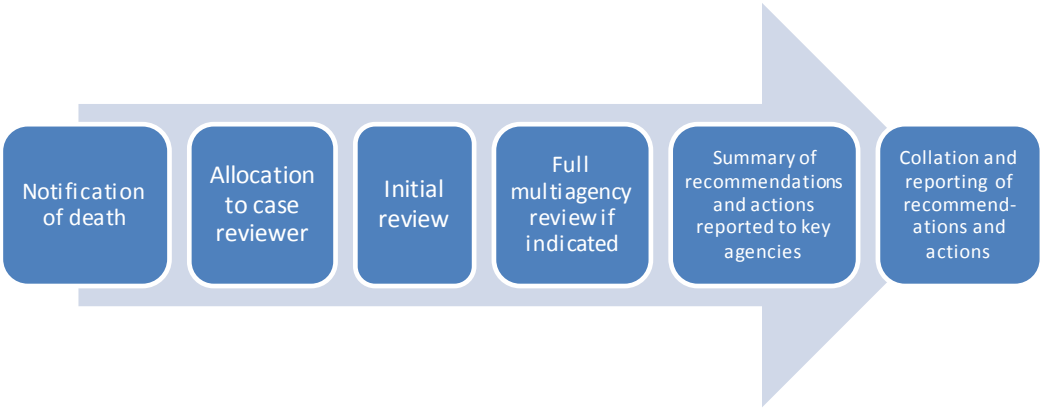
Operationalising Mortality Reviews of People with Learning Disabilities

9. The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities.

[12] Valuing People: A New Strategy for Learning Disability for the 21st Century, Department of Health, 2001. LeDeR briefing paper.

[13] Spine supports the IT infrastructure for health and social care in England, joining together over 23,000 healthcare IT systems in 20,500 organisations.

Current process



10. All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer.

11. The standardised review process involves discussing the circumstances leading up to the person's death with someone who knew them well (including family members wherever possible), and scrutinising at least one set of relevant case notes. Taking a cross-agency approach, the reviewer develops a pen portrait of the individual and a comprehensive timeline of the circumstances leading to their death, identifies any best practice or potential areas of concern, and makes a decision, in conjunction with others if necessary, about whether a multi-agency review is indicated.

12. A full multi-agency review is required if the criteria for the current themed priority review are met (death of a person from a Black and Minority Ethnic background or aged 18-24), or where an assessment of the care received by the person indicates deficiencies in one or more significant areas. A full multi-agency review is recommended if there have been any concerns raised about the death, if any 'red flag alerts'[14] have been identified in the initial review, or if the reviewer thinks that a full multi-agency review would be appropriate. The purpose of the multi-agency review is to gain further learning which will contribute to improving practice and service provision for people with learning disabilities, so the review process concludes with an agreed action plan and recommendations that are fed back to the regional governance structures for the programme.

[14] 'Red flag' alerts are those identified in the initial review that may suggest potential problems with the provision of care e.g. no evidence that an assessment of mental capacity has been considered when this would have been appropriate; delays in the person's care or treatment that adversely affected their health.

13. The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes. This enables an integrated approach to initial reviews of deaths of people with learning disabilities to be taken whenever possible, so as to avoid unnecessary duplication but ensure that the specific focus of the different review or investigation processes is maintained.

14. Alignment of LeDeR with SJR for example will enable a balanced approach to be taken to reviewing deaths of people with learning disabilities that draws on contributions from across acute and other settings. Deaths of people with learning disabilities that occur in hospital settings should be subject to the LeDeR review process in order that insights from families, primary and secondary healthcare, and social and third sector care providers are all included in the mortality review.

15. The LeDeR programme provide annual reports on its findings, collating learning and recommendations at the regional and national level on how best to take forward the learnings across the NHS.

16. Because of the different methodology adopted by the LeDeR programme, it would not be appropriate to use the same definition of 'avoidable death' as used by the SJR, nor to compare rates of avoidable deaths across and between the two review processes. The LeDeR programme will continue to use the Child Death Review Process terminology of 'potentially avoidable contributory causes of death' and the Office for National Statistics definition of avoidable deaths using ICD-10 coding of the underlying cause of death[15].

Integration of the LeDeR Process into National Level Mortality Review Structures

17. When a death of a person with learning disabilities occurs, mandatory review processes need to take precedence, working with the LeDeR programme reviewers to ensure that a coordinated approach is taken to the review of the death in order to minimise duplication and bring in the learning disabilities expertise of the LeDeR reviewers, whilst recognising that some investigatory processes will be more focused than that of LeDeR which is cross-agency in nature and may require the provision of additional information.

[15] Office for National Statistics (2016) Revised Definition of Avoidable Mortality and New Definition for Children and Young People. https://www.ons.gov.uk/aboutus/whatwedo/statistics/consultationsandsurveys/allconsultationsandsurveys/reviewofavoidablemortalitydefinition

18. Learning and recommendations from LeDeR reviews will identify opportunities for improvement at the local, regional and national level. Governance structures that can support the cross-agency implementation of recommendations from mortality reviews are required at all levels, but in particular for the reviews of deaths of people with learning disabilities. Such structures exist in the form of regional steering groups for the LeDeR programme, and these are usually best placed within the safeguarding framework. Not all deaths of people with learning disabilities are safeguarding issues; however the existing multi-agency framework and statutory responsibility mean that this is a natural 'home' for governance of mortality reviews.

Guidance for Providers

19. Key points to note are:

- All deaths of people with learning disabilities aged four years and older are subject to review using LeDeR methodology;
- The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017. If there is a death of a person with learning disabilities in an acute setting in an area that is not yet covered by the LeDeR programme, Trusts are recommended to use the SJR process or a methodology of equivalent quality that meets the requirements for the data that must be collected as an interim measure;
- If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at: http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed;
- Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred;
- Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers would be expected to conduct reviews independent of the Trust in which they work.

Annex E - Mental Health

1. Physical and mental health are closely linked. People with severe and prolonged mental illness are at risk of dying on average 15 to 20 years earlier than other people[16]. In addition, people with long term physical illnesses suffer more complications if they also develop mental health problems.

2. Reporting and reviewing of any death of a patient with mental health problems should consider these factors i.e. premature death of those with a mental disorder and the increased risk of complications for those with physical and mental health difficulties.

Inpatients detained under Mental Health Act

3. Regulations[17] require mental health providers to ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission without delay. In 2015, the Care Quality Commission reported concern that providers were failing to make this notification in 45% of cases. The Commission has since updated its notifications protocols to ensure that providers ensure they report in a timely way.

4. Under the Coroners and Justice Act 2009, coroners must conduct an inquest into a death that has taken place in state detention, and this includes deaths of people subject to the Mental Health Act. Providers are also required to ensure that there is an appropriate investigation into the death of a patient in state detention under the Mental Health Act (1983).

5. In circumstances where there is reason to believe the death may have been due, or in part due to, to problems in care - including suspected self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should also be given to commissioning an independent investigation as detailed in the *Serious Incident Framework*.

People with Mental Health Disorders in Prisons

6. Evidence shows that there is a high incidence of mental health problems in prisons: 72% of adult male and 71% of female prisoners may have 2 or more mental disorders (e.g.

[16] *The Five Year Forward View For Mental Health* (NHS England, 2016) is available at: https://www.england.nhs.uk/wp-content/.../Mental-Health-Taskforce-FYFV-final.pdf

[17] Regulation 17, Care Quality Commission (Registration) Regulations 2009

personality disorder, psychosis, anxiety and depression, substance misuse); 20% have 4 or more mental disorders.

7. There have been large increases in the number of natural and non-natural deaths in prisons over the most recent five-year reporting period. The increase in recent years in non-natural deaths in prisons are due to a number of factors. Prisons contain a high proportion of vulnerable individuals, many of whom have experienced negative life events that increase the likelihood of suicide or self-harm. Issues that increase risk include drug/alcohol abuse, family background, social disadvantage or isolation, previous sexual or physical abuse, and mental health problems. The increase in part reflects an ageing prison population. Prisons are also very challenging environments particularly so for those prisoners who have a learning disability. Average estimates of prevalence of learning disabilities amongst adult offenders in the UK is thought to be between 2-10%. This figure is much higher for children who offend[18]. Prisoners with learning disabilities are also more likely than other prisoners to suffer mental ill health. As such, the mental wellbeing of prisoners with learning disabilities should be a key consideration for healthcare staff of NHS providers along with all other prison staff.

8. The *Serious Incident Framework* states that in prison and police custody, any death will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. Guidance published by the PPO[19] must be followed by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO.

[18] *Equal Access Equal Care*, Guidance for Prison Healthcare Staff treating Patients with Learning Disabilities (2015) *available at* https://www.england.nhs.uk/.../equal-access-equal-care-guidance-patients-ld.pdf

[19] Guidance is available online: http://www.ppo.gov.uk/updated-guidance-for-clinical-reviews/

Annex F - Children and Young People

Infant and Child Mortality

1. Over the last 20 years, the UK has gone from having one of the lowest mortality rates for 0 to 14 year olds in Europe to one of the highest[1.] In 2014, 4, 419 children and young people aged 0 to 18 years old died in England and Wales. 24% of deaths in children and young people are thought to be preventable[2.] In the year ending March 2016, 68% of all deaths occurred in hospital, 22% in the home, 4% in a public place, and 4% in a hospice. In the year ending March 2016, 32% of all deaths occurred following a perinatal or neonatal event, 26% in children with chromosomal, genetic and congenital anomalies, 8% in children with 'sudden unexpected and unexplained' death, 7% in children with malignancy, 6% in children with acute medical or surgical illnesses, 6% in children with infection, 5% in children suffering trauma, 3% in young people taking their life, and 2% following deliberately inflicted injury, abuse or neglect[2].

2. In child mortality review, professionals have moved away from defining 'avoidability' to instead using the language of 'a preventable death' where the latter is defined as a death in which 'modifiable factors may have contributed to the death and which, by means of nationally or locally achievable interventions, could be modified to reduce the risk of future child deaths'[3]. In the year ending March 2016, 54% of deaths in hospital and 31% of death in the home were identified as having modifiable factors. Most modifiable factors are found in children dying from perinatal/neonatal events, followed by trauma, followed by those with chromosomal, genetic and congenital anomalies[2.].

National Data on Causes of Death and International Comparisons[4]

3. The UK ranks 15 out of 19 Western European countries on infant (under one year of age) mortality and has one of the highest rates for children and young people in Western Europe[5]. There is a strong association between deprivation and mortality; for example infant mortality is more than twice as high in the lowest compared with the highest socio-economic groups[6].

Infants (under 1 year)

4. Around 60% of deaths during childhood occur in infancy. Infant mortality can be split into neonatal mortality (deaths 0–27 days) and post-neonatal mortality (28–365 days). Births without signs of life (stillbirths if after 24 weeks of pregnancy) do not contribute to infant mortality but are also an important indicator of maternal and child health. The Infant

Mortality Rate (IMR) is an indicator of both population health and the quality of healthcare service. It is also a key international indicator in the United Nation's Sustainable Development Goals and in UNICEF international comparisons.

5. Neonatal mortality accounts for between 70% and 80% of infant deaths. The great majority of neonatal deaths are due to perinatal causes, particularly preterm birth, and are strongly related to maternal health, as well as congenital malformations. The remainder of infant deaths are post-neonatal and are due to a broad range of causes including sudden infant death syndrome (SIDS). Stillbirths (defined in the UK as a baby born without signs of life after 24 completed weeks of pregnancy) account for half of all deaths during the perinatal period. In 2014, the IMR across the UK was 3.9 deaths per 1,000 live births. Although there has been an overall decline in the IMR across the UK over the past 45 years, in recent years the reduction in infant mortality in the UK has not equalled the gains observed in comparable countries. An international study of mortality in the UK compared with similar wealthy countries in Europe and elsewhere showed the UK to have IMR in 1970 similar to the average of the group, but that the UK had become among the worst performing 10% by 2008[7].

6. Social inequalities play a role in almost all the leading causes of infant death. The mechanisms underlying this social gradient are related to increased risk of preterm delivery in more deprived groups, as well as to maternal health during pregnancy (for example, smoking, poor nutrition, substance abuse) and uptake of recommended practices such as breastfeeding and safe infant sleeping positions[8]. Maternal age is also associated with infant mortality[6]. Many of the causes of infant mortality are preventable and necessitate actions at both a population and individual level[9]:

    - maximising the health and wellbeing of women before conception and during pregnancy (smoking cessation programmes, promotion of breastfeeding and promoting healthy weight in women of childbearing age)
    - protecting and supporting health promotion and early intervention services (universal midwifery and health visiting services for new mothers)
    - promoting evidence-based research into maternal and infant health, and translating findings into improved practice, standards of care, and ultimately policy
    - identifying best practice and reducing variations in outcomes across health care services

Children (1-9 years)

7. The main factors that contribute to death during childhood are different to those that contribute to death during infancy or adolescence. The common causes of death amongst 1 to 9 year-olds are cancer, injuries and poisonings, congenital conditions and neurological and developmental disorders. Injuries and poisonings from external causes are the leading cause of death in boys aged one to four years, whilst cancer is the leading cause of death in girls of the same age[5]. For both girls and boys five to nine years of age, cancer is the leading cause of death. Very early life also still has an impact on mortality in later childhood; children who were born preterm remain more likely to die before age 10 years compared to children born at term.

8. In the period 2012-2014, the mortality rate in children aged 1-9 years in the U.K. was 12.1 per 100,000 population. Although the mortality rate has declined across the UK since the 1970s, the UK's recent progress has been significantly lower than in other wealthy European countries, and concerningly the incidence of death due to diseases such as asthma and diabetes is higher than equivalent high-income countries. The scale of difference between the UK child mortality rate and the average suggests there are around 130 excess deaths of 1- to 9-year-olds each year in the UK[10].

9. Many childhood deaths are preventable. As with infants there is a strong association between deprivation, social inequality, and mortality. Causes amenable to interventions include environmental and social factors as well as health service factors and key actions include the following[9]:

    - creating safe environments, including access to information and safety equipment schemes to promote safety in the home;
    - reduce road speed limits in built-up areas to 20mph;
    - ensuring that clinical teams looking after children with long-term conditions such as asthma, epilepsy and diabetes deliver care to the highest standards, incorporating good communication, open access for patients and families, use of established tools such as the epilepsy passport and asthma plan, adherence to the components prevalent in the best practice tariff for diabetes, and address early the optimal conditions for safe transition to adult services. Implicit in this is teaching self-management and ownership of the condition;
    - increasing the provision of high-quality end-of-life care and access to appropriate palliative care;

- delivering integrated health systems across primary and secondary care; whilst providing the optimal configuration of specialist services for children with complex conditions needing tertiary care, such as cardiac, renal conditions and children's cancer.

Young People (10-19 years)

10. After the first year of life, adolescence is the life stage when children are most likely to die. The factors leading to death in adolescence are different to those in earlier childhood, and differ between males and females. The most common causes of death in this age group are injuries, violence and suicide, followed by cancer, substance misuse disorders and nervous system and developmental disorders.

11. Although the mortality rate in young people has decreased across the UK since the 1970s, progress recently has been slower than that seen in other wealthy countries[10]. The UK's 'average' adolescent overall mortality today is a mixed picture. Whilst our injury mortality rate is amongst the lowest, we have a higher rate of deaths due to 'non communicable diseases' such as asthma than other equivalent wealthy countries. Social inequalities are important since injury and illness are associated with poor environmental conditions and hazards such as smoking, alcohol, and drug use[8].

12. Many deaths are preventable and key actions include[9]:

- reducing deaths from traffic injuries through the introduction of graduated licensing schemes;
- improving adolescent mental health services;
- improving services for children with long term conditions, and especially those transitioning to adult care;
- increasing the involvement of young people and their families with rare and common long-term conditions in developing guidelines, measuring outcomes, service design and research trials.

13. Underpinning all efforts to reduce child mortality in England lies an urgent need to collect high-quality data to better understand the reasons why children die, to allow accurate international comparisons, and to inform health policy. This requires a national system for the analysis of child mortality data, as well as improved child death review processes.

Historical Background to the Process of Child Mortality Review

14. Since 1st April 2008, Local Safeguarding Children's Boards in England have had a statutory responsibility for Child Death Review (CDR) processes. The relevant legislation underpinning such responsibility is enshrined in the Children's Act 2004 and applies to all children under 18 years of age. The processes to be followed when a child dies are described in Chapter 5 of the statutory guidance document, *Working Together to Safeguard Children*[11]. The overarching purpose of child death review is to understand how and why children die, to put in place interventions to protect other children, and to prevent future deaths. *Working Together* describes two interrelated processes:

    i. a "Rapid Response" multi-professional investigation of an individual unexpected death; and,
    ii. a Child Death Overview Panel (CDOP) review of all deaths in a defined geographical area. The purpose of the CDOP is to establish the exact cause of death, identify patterns of death in community and remedial factors, and to contribute to improved forensic intelligence in suspicious deaths. The family should be kept central to the process.

Drivers for Change including new Legislation

15. The review of child deaths has been, to date, far more comprehensive than that for adults. However the following drivers for change exist:

    i. *Variation in process.* There is significant variation across the system in how child deaths are reviewed, which deaths are reviewed, and the quality of the review. Specifically:

        - 'unexpected' deaths in the community are generally reviewed as per the Sudden Unexpected Deaths in Infancy (SUDI) process. However there is variation in when a death is considered "unexpected" and in the timing of triggering investigations.
        - hospital deaths are usually reviewed at a Mortality and Morbidity (M&M) meeting. However there is wide variation, across the NHS, in how these meetings are convened, no standardisation on terminology, and a confused array of investigations (root cause analysis, serious incident inquiry, mortality review) that follow certain types of deaths.

- there is wide variation in CDOP processes (size, structure and functioning) and many CDOP panels are dislocated from governance processes within their local children's hospital.

ii. *The Wood Review*[12]. In 2016, Alan Wood recommended that national responsibility for child death reviews should move from the Department for Education to the Department of Health, that DH should re-consider how CDOPs should best be supported within the new arrangements of the NHS, and that DH should determine how CDOPs might be better configured on a regional basis with sub-regional structures to promote learning. He also recommended that child deaths be reviewed over a population size that allowed a sufficient number of deaths to be analysed for patterns and themes. He went further to recommend that the NHS consider the role CDOPs should play in the process for achieving a common national standard for high quality serious incident investigations. Finally, he supported the intention to introduce a national child mortality database, and urged DH to expedite its introduction.

iii. *The National Adult Case Review programme*[13]. This programme uses a very different structured judgment review (SJR) methodology to that used in child mortality review. It focuses on problems in heath care processes within an organization rather than trying to understand the cause of death. Cases in which care is judged to be poor are scored according to an 'Avoidability of Death' scale. It is important to recognise that many 16 and 17 year olds die in adult ITU's and therefore it is important to understand what processes should take precedence in the review of such patients.

iv. *Medical Examiner process*. The Medical Examiner will be introduced across England. This appointee will link with bereaved families as well as the Coroner and their involvement will affect all mortality review processes.

v. *CQC report: Learning, Candour, and Accountability*[14]. This report identified inconsistencies in: the involvement of families and carers; the process of identifying and reporting the death; how decisions to review or investigate a death was made; variation in the quality of reviews and investigations; and variation in the governance around processes and questionable demonstration of learning and actions.

vi. *Legislative change (Children and Social Work Bill 2017)*. The Wood Review recommendation that national responsibility for child death reviews should move from the Department for Education to the Department of Health is being enacted through

the Children and Social Work Bill 2017. Under the new legislation, local authorities and clinical commissioning groups are named as 'child death review partners' and must make arrangements for the review of each death of a child normally resident in the local authority area. They may also, if they consider it appropriate, make arrangements for the review of a death in their area of a child not normally resident there. The proposed legislation also states that the 'child death review partners' must make arrangements for the analysis of information about deaths reviewed and identify any matters relating to the death or deaths in that area a) relevant to the welfare of children in the area or to public health and safety and b) to consider whether it would be appropriate for anyone to take action in relation to any matters identified.

National Child Mortality Programme

16. NHS England is undertaking a national review of child mortality review processes both in the hospital and community. A key aim is to make the process easier for families to navigate at a very difficult time in their life. Central to the programme is the creation of a National Child Mortality Database, which is currently being commissioned. The effective functioning of the national database requires high-quality, standardised data arising from simplified and standardised local mortality and CDOP review processes. NHS England have therefore established 3 work streams:

- the simplification and standardisation of mortality review processes in the community and hospital;
- a review of the governance arrangements and standardisation of CDOP processes;
- the creation of the national child mortality database.

17. The goals of the NHS England's child mortality review programme are to:

- establish, as far as possible, the cause or causes of each child's death;
- identify any potential contributory or modifiable factors;
- provide on-going support to the family;
- ensure that all statutory obligations are met;
- learn lessons in order to reduce the risk of future child deaths;
- establish a robust evidence base to inform national policy across government to reduce avoidable child mortality across the UK nations.

18. NHS England, the Department of Health and the Department for Education are working together to produce new statutory guidance for child death review. This guidance will cover the processes which should take place following the death of a child, and in particular how the death should be reviewed at local mortality meeting and child death overview panel. This new guidance will be published in late 2017.

Reporting

19. The definitions used within the adult Case Review programme for record review and to identify problems in care are not recognised within *Working Together*. NHS England's work programme intends to identify best practice and standardise processes across deaths in hospital and the community, to improve the experience of families and professionals. The deaths of children who are treated in acute, mental health and community NHS Trusts should be included by Trusts in quarterly reporting from April 2017. The information should come from child death review processes, and should include reporting problems related to service delivery.

Board Leadership

20. Hospital Trust, Local Authority, Community Trust, Mental Health Trusts, and CCG boards should ensure that learning is derived from the care provided to children who die, by the appropriate application of the child mortality review process, and that learning is shared and acted on.

21. Many of the points around board leadership relating to adult deaths (set out in the main body of this guidance) also apply for child deaths. For example, providers must ensure that they have a board-level leader designated as patient safety director to take responsibility for the learning from deaths agenda (Annex A) and he or she should also have specific responsibility for the learning from child mortality processes. The director should ensure that the reviews are delivered to a high quality, with sufficient numbers of trained staff to lead the child mortality review process.

22. Particular attention should be paid to the deaths of children and young people with learning disabilities or mental health conditions, as these present with frequent co-morbidities and are often a more vulnerable group.

23. Providers should acknowledge that an independent investigation (one commissioned and delivered entirely separately from the organisation(s) involved in caring for the patient) may be required where the integrity of the investigation is likely to be challenged.

Best Practice in responding to Death of a Child who dies under a Trust's Care

24. All Trusts should have a policy in place that sets out how they respond to the deaths of children who die under their care. In doing this they should be mindful of current expectations described within *Working Together to Safeguard Children* (2015) and of NHS England's current review of child mortality review processes. New statutory guidance on child death review will be published in late 2017.

25. That policy should also set out how Trusts:

- communicate with bereaved parents and carers. This should include providing an honest and compassionate account of the reasons for death and knowledge of any potential problems in care that may need further review, ensuring initial contacts are managed by clinicians responsible for the care of the patient, and offering support to express concerns about the care given to patients who have died;
- achieve independence (where relevant) and objectivity in the child mortality review process, as well as lay membership within wider clinical governance systems.

Cross-system Reviews and Investigations

26. When the death of a child involves treatment across the health care pathway (primary: secondary: tertiary care) it is expected that child mortality review processes will not be duplicated and that a single overarching meeting will be convened. Child mortality review processes should interface with existing organisational governance systems. The NHS England child death review programme is mindful of expectations arising from the Serious Incident Framework, which sets out the circumstances in which further investigation is warranted in certain situations. It is therefore anticipated that when a review identifies a problem in care that meets the definition of a patient safety incident (any unintended or unexpected incident which could have or did lead to harm to one or more patients receiving NHS care) then this is reported via local risk management systems to the National Reporting and Learning System (NRLS). Regardless of the type of review, its findings must form an integral part of and feed into the organisation's clinical governance processes and structures. Review findings should be considered alongside other information and data including complaints, clinical audit information, patient safety incident reports and other outcomes measures to inform the Trust's wider strategic plans and safety priorities.

Bereaved Families and Carers

27. *Working Together* places the family at the heart of its processes. However it is recognised that the multitude of investigations that may unfold following a child's death can cause great confusion and distress to parents. The national bereavement group and bereavement charities are closely involved with developing NHS England's child death review programme – both in the co-design of systems and public guidance that explains processes.

28. The national Child Death Review programme recognises the following principles:

- bereaved families and carers should be treated as equal partners both in the delivery of care and following a bereavement;
- bereaved families and carers should receive a high standard of bereavement care, including being offered appropriate support;
- bereaved families and carers must always receive an honest, caring and sensitive response;
- bereaved families and carers should receive timely, responsive contact and support in all aspects of any review process, with a single point of contact and liaison.

Learning Disabilities and Mental Illness

29. NHS England's National Child Mortality Review programme fully recognises the unique challenge in reviewing the deaths of children with learning disabilities and mental health disorders. The Programme is working closely with the Learning and Disabilities Mortality Review (LeDeR) programme, and also aims to align itself with the Children and Young People's (CYP) Mental Health Programme and Specialised Commissioning particularly with regard to deaths in Tier 4 inpatient CAMHS Units. It will also work closely with the National Programme on Suicide in Young People. Going forward, the programme will ensure that there are appropriate mechanisms in place to allow data flows to occur unencumbered between all these systems and the national Child Mortality Database.

Conclusion

30. This section highlights the very different circumstances that pertain to the death of a child in acute, mental health and community organisations. Although infant and child mortality has declined in the UK, these improvements have not been sustained in comparison to other European countries. While poverty and inequality have a major impact on child mortality, we can nonetheless do much in front line service delivery to improve outcomes

for children, and experiences for both bereaved parents and the professionals who deliver care. Sadly, deaths in childhood are often an inevitable consequence of congenital malformations, birth events, and long-term conditions or chronic illness. Many, however, have preventable factors, and there is therefore an absolute imperative to scrutinise all deaths both locally and nationally to ensure that learning always occurs.

31. NHS England is seeking to address this by establishing a National Child Mortality Database to allow analysis and interpretation of child mortality data. The programme will also seek to improve, standardise and simplify the processes that follow the death of a child. This is predominantly to improve the experience of bereaved parents at such an overwhelming time, but also to enable uniformly robust data collection, to ultimately lead to a reduction in infant and child mortality in this country.

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Annex G - Maternity

1. In England, maternity care is generally safe and for the majority of women and their babies there is a good outcome. However, when things go wrong, the impact is devastating and has a profound effect on the parents, partners, siblings and extended family members.

2. Dr Bill Kirkup was tasked by the Secretary of State for Health to investigate and report on maternity services at Morecambe Bay NHS trust. The Report of the Morecambe Bay Investigation in 2015[20] highlighted a number of failures over a number of years at the Trust which resulted in poor care and the tragic deaths of mothers and babies. The report makes recommendations for mandatory reporting and investigation of serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. It recommends a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review. In *Learning not Blaming*[21] the Government accepted this recommendation.

3. In October 2016, *Safer maternity care: next steps towards the national maternity ambition* was published setting out an action plan for the Government's vision for making NHS maternity services some of the safest in the world, by achieving the national ambition to halve the rates of stillbirths, neonatal deaths, brain injuries that occur during or soon after birth and maternal deaths, by 2030 with an interim measure of 20% by 2020. The plan details the actions needed at national and local level that build on the progress already made to improve the safety of maternity services.

4. Currently MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquires across the UK)[22], appointed by Health Quality Improvement Partnership and funded by NHS England, run the national Maternal, Newborn and Infant

[20] The report of the Morecambe Bay Investigation (March 2015): https://www.gov.uk/government/news/morecambe-bay-investigation-report-published

[21] The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation (July 2015).

[22] 'MBRRACE-UK' is the collaboration appointed by the Healthcare Quality Improvement Partnership (HQIP) to continue the national programme of work investigating maternal deaths, stillbirths and infant deaths, including the Confidential Enquiry into Maternal Deaths (CEMD). The aim of the MBRRACE-UK programme is to provide robust information to support the delivery of safe, equitable, high quality, patient-centred maternal, newborn and infant health services.

Clinical Outcomes Review to conduct surveillance of all late fetal losses, stillbirths and neonatal deaths, biennial topic-specific confidential enquiries into aspects of stillbirth and neonatal death or serious neonatal morbidity and surveillance and confidential enquiries of all maternal deaths.

5. Surveillance reports on stillbirths and neonatal deaths are published annually. Reports on maternal deaths are published on a triennial basis, because the number of maternal deaths from individual causes is small, and thus three years' worth of data is required to identify consistent lessons learned for future care and to maintain anonymity and confidentiality.

6. A maternal death is defined internationally as a death of a woman during or up to six weeks (42 days) after the end of pregnancy (whether the pregnancy ended by termination, miscarriage or a birth, or was an ectopic pregnancy) through causes associated with, or exacerbated by, pregnancy. Deaths are subdivided on the basis of cause into: direct deaths, from pregnancy-specific causes such as preeclampsia; indirect deaths, from other medical conditions made worse by pregnancy such as cardiac disease; or coincidental deaths, where the cause is considered to be unrelated to pregnancy, such as road traffic accidents. Maternal deaths are very rare. The MBRRACE-UK report 'Saving Lives, Improving Mothers Care highlights that for 2012-14, the maternal death rate was 8.5 per 100,000 women. Overall, 241[23] women among 2,341,745 maternities in 2012–14 died during or within 42 days of the end of pregnancy in the UK.

7. Better Births (2016)[24], the report of the NHS England commissioned National Maternity Review, set out a five year forward view for improving outcomes of maternity services in England. The report highlighted the lack of a standard approach to investigating when things wrong during before, during or after labour: Reviews and investigation are currently undertaken using different protocols and processes by different organisations. The Report recommended there should be a national standardised investigation process for when things go wrong, to get to the bottom of what went wrong and why and how future services can be improved as a consequence. Work has now begun on the development of a Standardised Perinatal Mortality Review Tool that will enable maternity

[23] Of these 41 deaths were classified as coincidental
[24] https://www.england.nhs.uk/wp-content/.../02/national-maternity-review-report.pdf

and neonatal services to systematically review and learn from every stillbirth and neonatal death in a standardised way.

8. Maternal deaths, neonatal deaths and stillbirths occurring in acute, mental health and community Trusts should be included by Trusts in quarterly reporting from April 2017.

9. It should be borne in mind that in addition to hospital obstetric units, maternal deaths can occur in a local midwifery facility (for example, a local midwifery unit or birth centre) or during home births. The definition also covers up to 42 days after the end of pregnancy.

Annex H - Cross-system Reviews & Investigations

1. In many circumstances more than one organisation is involved in the care of any patient who dies, with the most common combinations being primary care and acute care, ambulances services and acute care, or mental health services combined with any of these. Case record reviews typically have to rely on the records held by a single organisation, but even these records can provide indications of possible problems in earlier stages of the patient pathway.

2. Where possible problems are identified relating to other organisations, it is important the relevant organisation is informed, so they can undertake any necessary investigation or improvement. Most trusts already have effective systems to notify other organisations when concerns are raised via incident reports, and are likely to be able to adapt these to address potential problems identified in case record review.

3. Trusts should consider whether they can routinely arrange joint case record reviews or investigations for groups of patients where more than one organisation is routinely providing care at the time of death - for example, for older people with dementia and frailty receiving frequent input from their GP and from community mental health nurses. Commissioners have a role in encouraging appropriate routine collaboration on case record review.

4. Where the provision of care by multiple providers, and particularly the coordination of that care, is thought to have potentially contributed to the death of a patient, investing the significant resources required to coordinate major and complex investigations must be considered. For example, the Serious Incident Framework outlines the principles which underpin a serious incident investigation process and the relevant content is set out in paragraphs 5 to 10 below.

5. The organisation that declares the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.

6. All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate. Commissioners should help to facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process. Commissioners themselves should provide support in complex circumstances. For example, where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, the commissioner may lead this process. If commissioners do not have the capability or capacity to manage this type of activity this should be escalated to ensure appropriate resources are identified. This may be something to consider escalating through the relevant Quality Surveillance Group or through specific review panels and clinical networks. This should ensure the cumulative impact of problems with care can be resolved.

7. In some circumstances the local authority or another external body may be responsible for managing and co-ordinating an investigation process. Where this is the case, providers and commissioners must contribute appropriately and assure themselves that problems identified will be addressed.

8. Often in complex circumstances, separate investigations are completed by the different provider organisations. Where this is the case, organisations (providers and commissioners and external partners as required) must agree to consider cross boundary issues, such as gaps in the services that may lead to problems in care. The contributing factors and root causes of any problems identified must be fully explored in order to develop effective solutions to prevent recurrence. Those responsible for coordinating the investigation must ensure this takes place. This activity should culminate in the development of a single investigation report.

9. To determine oversight of an investigation, the RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model supports the identification of a single 'lead commissioner' with responsibility for managing oversight of serious incidents within a particular provider. This means that a provider reports and engages with one single commissioning organisation who can then liaise with other commissioners as required. This approach is particularly useful where the 'accountable commissioner' is geographically remote from the provider (and therefore removed from other local systems and intelligence networks) and/or where multiple commissioners' commission services from the same provider. It facilitates continuity in the management of serious incidents, removes ambiguity and therefore the risk of serious incidents being

overlooked and reduces the likelihood of duplication where there is confusion regarding accountability and/or responsibility and general management of the serious incident process.

Healthcare Safety Investigation Branch

10. The Healthcare Safety Investigation Branch (HSIB) will provide capability at national level to offer support and guidance to NHS organisations on investigations, and to carry out up to 30 investigations itself per year where there is a deeper learning opportunity for the NHS. Through a combination of setting exemplary practice and structured support to others, the HSIB is expected to make a decisive difference to the NHS, promoting a culture of learning and a more supportive relationship with patients, families and staff.

11. Providers will benefit from the HSIB, and their expert advice on safety improvement. It should mean timely investigations, with a genuine commitment to openness, transparency and engagement with staff and patients and their families and carers that adopt an ethic of learning and continuous improvement. The HSIB will contribute strongly to the culture change that is needed in the NHS.

Annex I - Roles and Responsibilities of National Bodies and Commissioners

1. Each national organisation will have a single lead at executive level who has accountability, internally and externally for that organisation's support of delivering against the national programme on learning from deaths. This will include ensuring progress is reported to the National Quality Board and ensuring that learning from deaths remains a priority area in future developments. A list of the lead roles for each national organisation is at Annex K and will be made available on each organisation's website.

2. As the independent regulator of health and social care, the **Care Quality Commission** will use this national guidance on learning from deaths to guide its monitoring, inspections and regulation of services. Inspectors will use new key lines of enquiry in relation to safety and governance, set out in the Care Quality Commission's assessment framework, to assess learning from deaths, collect evidence and identify good practice. Where specific concerns are identified, the Care Quality Commission can use its powers to take action with individual providers and will report its findings of good and poor progress in individual inspection reports or national publications to help encourage improvement.

3. **NHS Improvement** will continue to provide national guidance for managing serious incidents. Local processes setting out what deaths should be subject to case record review will inevitably use a wider definition than deaths that constitute Serious Incidents. Equally, when a death clearly meets Serious Incident criteria there is no need for an initial stage of case record review to be completed before work to initiate and support a full investigation is undertaken. Serious Incident guidance provides the framework upon which the Care Quality Commission and commissioners (including CCGs and NHS England) will assess the quality of investigations undertaken across the NHS. NHS Improvement will, alongside the Healthcare Safety Investigation Branch and others, support implementation of best practice in investigations by Trusts.

4. As the revised inspection regime of the Care Quality Commission will assess providers' ability to learn from deaths as a key component of high quality care, work to address this will be factored into NHS Improvement's work to support providers in achieving good or outstanding Care Quality Commission care ratings. Regional teams will work with

providers, their commissioners and NHS England to identify areas where improvements can be made and the strategies which can help deliver the change required.

5. Nationally, NHS Improvement commissions (via the Healthcare Quality Improvement Partnership) the work of the Royal College of Physicians to develop and roll-out the Structured Judgement Review methodology, which will be providing a national training programme for acute Trusts to support them to carry out the methodology for adult inpatient deaths.

6. **NHS England** has a direct commissioning role as well as a role in leading and enabling the commissioning system. This national guidance on learning from deaths will guide its practice in both of these areas.

7. The **National Institute for Health and Care Excellence (NICE)** has produced best practice guidelines on the care of the dying, covering adults and children. These guidelines are supported by measurable quality standards that help Trusts demonstrate high quality care, and by information for the public describing the care that should be expected in the last days of life.

Annex J - Structured Judgement Review in Mental Health Trusts

Background

1. Some mental health providers have seen a missed opportunity in not learning more widely from deaths by reviewing the safety and quality of care of a wider group of people. This is despite research showing that people with mental health problems have greater health care needs than the general population and may suffer unnecessarily with untreated or poorly managed long-term conditions.

Where Next - Making a Decision on the Review Method

2. Since 2014 hospitals in Yorkshire and the Humber have been working together with the AHSN Improvement Academy to refine a mortality review method called Structured Mortality Review (SJR), a method proposed for all acute hospitals in England. The acute sector methodology reviews phases of care appropriate to their settings, such as initial assessment and first 24 hours, care during a procedure, discharge/end of life care and assessment of care overall. Written explicit judgements of care and phase of care scores form the basis of the reviews. This now forms the basis of the national acute hospitals mortality review programme.

3. This methodology and review format was seen as potentially valuable by three regional Mental Health trusts and they have individually worked to create phase of care headings more appropriate to mental health care, with the support of the Improvement Academy and Professor Allen Hutchinson. These three trusts are at different stages of implementation. In the early adopter trust the tool was also adapted to include a pen picture to enable the reviewer to understand both the life and death of the person, considering this fundamental to understanding areas for learning that may include review of physical health and lifestyle choices. In the same trust this approach was used within Learning Disability services prior to the introduction of the Learning Disability Review of Deaths (LeDeR) programme. In another trust both the mental health care and community care facilities have been using the methods.

Introducing the Review Process

4. Just as with the acute services, future reviewers require initial training in how to make explicit judgements of the quality and safety of care and how to assess care scores for

each phase of care. Assessments are made of both poor and good care and it is common to find that good care is far more frequent than poor care.

5. One of the findings from introducing the methods into mental health care is that many of the reviewers naturally have a focus on the mental health care component of the services. But review teams have found that using this review method they also identify common long-term conditions such as diabetes and heart disease that do not appear to have been well managed. For example, in one hospital it became evident that many people had a number of co-existing comorbid/long term conditions, yet it was unclear from the records whether or not the person was receiving support and or review from primary care and or secondary care services for their physical health. There is value, therefore, in also training up review staff who have an understanding of what good care looks like in long-term conditions within the context of mental health facilities.

6. Scoring of the phases of care is a new approach for many clinical staff in mental health care (just as has been the case in acute care) and scoring was initially felt to be very daunting by some reviewers. Nevertheless, as staff become more confident with its use, scoring can often be seen as a natural outcome of their judgements on the level of care provided. Some of the hospital teams have set up a mortality-reviewers support group to provide peer review and guidance. Feedback of the good care may be shared with both the individual staff and the wider teams - this is often well received. Of course, concerns also have to be discussed with services to identify areas for improvement.

Where Next

7. The use of the structured judgement method often receives very positive feedback from staff trained in this methodology and so in one centre SJR is being rolled out for wider use to review the quality of care being received whilst people are currently receiving services. Looking forward, it has been recognised that whilst services can learn from each case, more can be learnt from the aggregation of cases, where patterns of poor care and good care emerge. In one case study that has sought for such patterns it is of note that where patterns exist of poorer care, these have been in the main linked to the management of physical ill health within mental health and learning disability services.

8. For further details please contact Allyson Kent allyson.kent@nhs.net , or Professor Allen Hutchinson allen.hutchinson@sheffield.ac.uk Yorkshire and The Humber AHSN Improvement Academy.

Annex K - National Leads

The list below provides the lead role with overall responsibility for the learning from deaths programme at relevant national organisations:

- NHS Improvement - Executive Medical Director
- Care Quality Commission - Chief Inspector of Hospitals
- Department of Health - Director of Acute Care and Workforce
- NHS England - National Medical Director

Annex L - Background and Links

Learning Disabilities Mortality Review (LeDeR) programme

Background is available at http://www.bristol.ac.uk/sps/leder

Quality Accounts

Background is available at:

http://www.nhs.uk/aboutNHSChoices/professionals/healthandcareprofessionals/quality-accounts/Pages/about-quality-accounts.aspx

Healthcare Safety Investigation Branch

The new Healthcare Investigation Branch (HSIB) will offer support and guidance to NHS organisations on investigations, and carry out certain investigations itself. It is envisaged that the HSIB will be established to:

i. generate investigation findings and recommendations which drive action on the reduction or prevention of incident recurrence;
ii. conduct investigations and produce reports that patients, families, carers and staff value, trust and respect; and,
iii. champion good quality investigation across the NHS, and lead on approaches to enhance local capability in investigation.

The HSIB will be hosted by NHS Improvement and will undertake a small number of investigations annually. It will focus on incident types that signal systemic or apparently intractable risks in local healthcare systems. The HSIB and the role of Chief Investigator will play a crucial part in developing the culture of safety, learning and improvement in the NHS that will be one of the key elements of national policy and cross-system action in the years ahead.

Alder Hey Children's NHS
NHS Foundation Trust

RM57 – HOSPITAL MORTALITY REVIEW POLICY

Version:	1
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Date ratified:	20th September 2017
Name of originator/author:	Julie Grice, Chair of Hospital Mortality Review Group / Sarah Stephenson, Head of Quality
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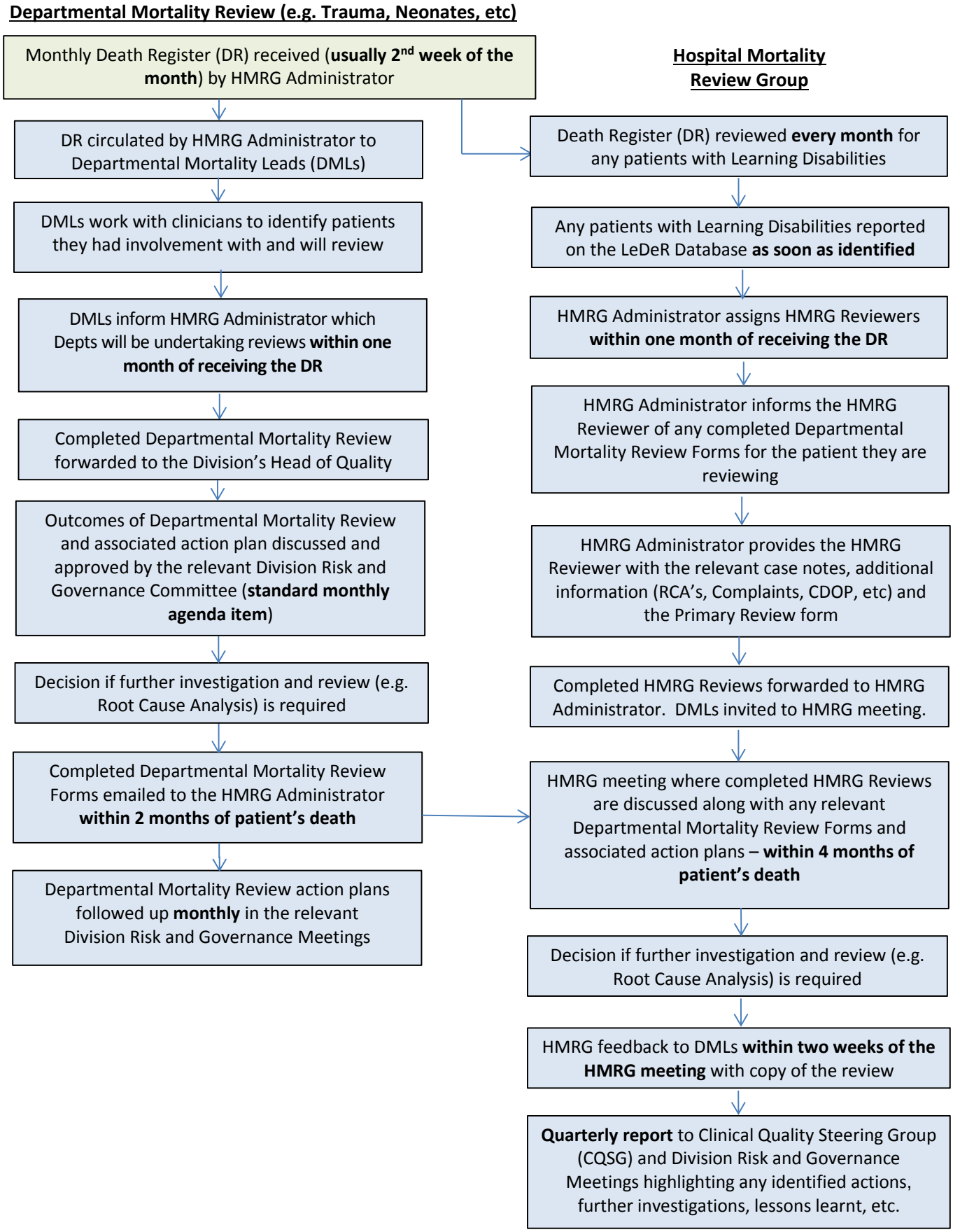
Quick Reference Guide – Hospital Mortality Review Policy

Please refer to the full policy for further guidance.



Version Control, Review and Amendment Logs

Version Control Table				
Version	**Date**	**Author**	**Status**	**Comment**
1	Sept 2017	Julie Grice, Chair of Hospital Mortality Review Group / Sarah Stephenson, Head of Quality	Current	Guideline updated to a Policy
-	October 2013	Kent Thorburn HMRG Chair	Archived	HMRG Guideline

Record of changes made to Hospital Mortality Review Policy – Version 1			
Section Number	**Page Number**	**Change/s made**	**Reason for change**
		Not applicable - New Policy	

Contents

1 Introduction

1.1 The death of any patient is incredibly difficult for the patient's family and also the staff involved.

1.2 The Care Quality Commission's 'Learning, Candour and Accountability' (December 2016) and the National Quality Board's 'National Guidance on Learning from Deaths' in March 2017, require all NHS Trusts to implement processes to ensure learning from deaths is integral to the Trust's clinical governance and quality improvement work.

1.3 It is essential that learning from mortality reviews is both shared and acted upon.

2 Definitions

2.1 Departmental Mortality Leads (DMLs) – Nominated mortality lead for a team / department.

2.2 Departmental Mortality Review – Review conducted at departmental level by the multidisciplinary team involved in the care of the patient. This can include mortality reviews for or by external bodies (e.g. Trauma mortality reviews, Neonatal mortality reviews).

2.3 Hospital Mortality Review Group (HMRG) – Committee established by the Clinical Quality Assurance Committee (CQAC) to conduct independent high quality mortality reviews following the death of any hospital inpatients.

2.4 Learning Disabilities Mortality Review (LeDeR) Programme – National programme delivered by the University of Bristol. It is commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England. The LeDeR Programme was established to support local areas to review deaths of people with learning disabilities, and to use the lessons learned to make improvements to service provision.

2.5 Mortality Ratio - Hospital Standardised Mortality Ratio (HSMR) is an indicator of healthcare quality that measures whether the number of deaths in a hospital is higher or lower than you would be expected in England. HSMR can be both a measure of safe, high-quality care and a warning sign that things are going wrong. HSMR is reported in the quarterly mortality report to Trust Board. The HSMR is the ratio of the observed number of in-hospital deaths divided by the number that is expected, and is based on 56 diagnoses. Although the scores are based on a basket of diagnoses that are more commonly found in adults, it allows a comparison of the performance of Alder Hey against other Trusts.

2.6 Sequential Probability Ratio Test (SPRT) – SPRT can be used to monitor the performance of Paediatric Intensive Care Unit (PICU) services in such a way as to give early warning of potentially irregular results. SPRT charts display

an upper warning limit and an upper action limit to help identify whether mortality is occurring at a higher level than expected. If these limits are triggered, this suggests that mortality is occurring higher than expected, and the deaths should be investigated to determine whether they could have been prevented. SPRT is reported in the quarterly reports to the Trust Board.

2.7 Death Register – Monthly report produced by the IM&T Department listing all inpatient deaths in the month.

2.8 Child Death Overview Panels (CDOP) – Local Safeguarding Children Boards (LSCB) are responsible for ensuring that a review of each death of a child normally resident in the LSCB's area is undertaken by a CDOP. The purpose of the child death review is to learn lessons and help prevent further such child deaths.

3 Duties

3.1 Chief Executive

- Has ultimate executive accountability for the quality of services in the Trust.

3.2 Medical Director –

- Executive Director responsibility for mortality review in the Trust.
- Provide the Trust Board with assurance regarding the Trust Mortality Review process.
- Provide support and guidance to the HMRG Chair and Departmental Mortality Leads as required.
- Take action where concern is raised through mortality ratio analysis and / or mortality reviews.

3.3 HMRG Chair –

- Chair the monthly Hospital Mortality Review Group
- Produce quarterly reports to the Clinical Quality Steering Group (CQSG)
- Produce quarterly reports to Trust Board
- Lead on developing the processes to ensure learning from deaths is shared widely across the Trust, with the support of the HMRG Group members.
- Ensure that HMRG cases are reviewed within 4 months of patient's death.
- Where HMRG reviews exceed the 4 month target, take action to increase the rate of reviews completed and bring reviews back to within target timescale.
- Liaise with the PICU Departmental Mortality Lead to ensure mortality ratio analysis is presented at the HMRG meetings.
- Ensure any concerns / questions raised by the patient's family are addressed as part of the HMRG review and acted on accordingly.

- Ensure families are given feedback which addresses any concerns / questions they have raised. The Bereavement Team can provide support to the family if requested.
- Share monthly report to monitor compliance with review timescales with HMRG members.

3.4 Departmental Mortality Leads (DMLs) –

- Share the Death Register with clinical teams (medical / nursing / AHPs)
- Inform the HMRG Administrator what teams / clinicians are taking responsibility for completing the departmental review.
- Inform other DMLs if a joint departmental review is indicated
- Ensure a departmental review is completed within two months by the team involved in the patient's care.
- Report to the relevant Division Risk and Governance Committee to highlight any teams not completing the departmental review in the two month timescale.
- Monitor completion of action plans following departmental reviews
- Ensure completed departmental reviews and action plans are submitted to the Division Risk and Governance Committee for review, discussion and approval.
- Circulate summary learning points following each HMRG meeting to share learning.

3.5 PICU Departmental Mortality Lead –

- Monitor the monthly Cumulative Sum of Mortality (CUSUM) and Sequential Probability Ratio Test (SPRT) produced by the Paediatric Intensive Care Unit (PICU), and highlight any concerns immediately to the Medical Director / HMRG Chair.

3.6 HMRG Administrator –

- Liaise with Departmental Mortality Leads (DMLs) to identify the departments / clinicians completing departmental mortality reviews.
- Where case notes are not scanned on Image Now, liaise with Medical Records Department to obtain the hard copy notes of deceased patients listed on the monthly Death Register.
- Assign the clinicians who will complete the Hospital Mortality Reviews for the cases listed on the Death Register within one month of the Death Register being published.
- Summary learning points sent to DMLs by the HMRG Administrator following each HMRG meeting.
- Produce monthly report to monitor compliance with review timescales for the HMRG Chair.

3.7 Heads of Quality (HoQ) –

- Ensure completed departmental mortality reviews and action plans are reviewed at the Division Risk and Governance Committee as a standing agenda item.
- Where a departmental mortality review raises concerns that a death was avoidable, instigate Trust risk management process to trigger a further detailed review (e.g. RCA). (Refer to the Management of

Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2))

- If required, and following the Trust process detailed in the Management of Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2), ensure the death is reported on the Strategic Executive Information System (STEIS) where applicable.
- Use Trust governance processes to ensure learning from deaths is shared widely and acted upon across the Divisions.

3.8 Learning Disabilities Clinical Lead -

- Following the publication of the Death Register, review all patients aged 4 years old and above, residing in England at the time of their death, to identify any patients with a Learning Disability.
- Ensure the Learning Disability Liaison Team are reporting the deaths of all patients with Learning Disabilities onto the Learning Disabilities Mortality Review (LeDeR) database.
- Attend HMRG meetings to raise appropriate questions in relation to patient's who had a Learning Disability.

3.9 CDOP Lead Nurse –

- Ensure where available that sudden unexpected death in infancy (SUDI) and sudden unexpected deaths in childhood (SUDiC) reports and Child Death Overview Panels (CDOP) reports are shared with the HMRG Administrator to aid HMRG reviewers in their review process.
- Attend monthly HMRG meetings. If CDOP Lead Nurse not available a Safeguarding Representative to attend where possible.

3.10 Bereavement Team –

- Will inform family members at an appropriate time that the policy of Alder Hey Children's NHS Trust is to review the deaths of all inpatients.
- Offer families the opportunity to raise any questions or concerns they may have in relation to the patient's last admission, or from an earlier stage in the patient's medical journey if the family feel it is relevant to the review of their child's death.
- Attend HMRG meetings to represent and share the questions and concerns of deceased patients' families.

3.11 Departmental Mortality Review Lead Clinician –

- When conducting the Departmental Mortality Reviews, lead clinicians should ensure all relevant staff are invited to attend the mortality review meeting to discuss the case.

4 Conducting HMRG Mortality Reviews

4.1 The HMRG mortality reviews should make use of all available data sources to enable a detailed and thorough review of events leading up to and following a patient's death. This includes, but is not limited to:

- Patient's case note on Image Now / Meditech / hard copy notes

- Clinic letters on Medisec
- Incident reports
- Any investigations (e.g. Root Cause Analysis (RCA) Reports)
- SUDI and SUDiC reports
- CDOP forms
- Post mortem reports
- Coroner's Reports
- Death Certificate
- PALS concerns
- Formal Complaints / Trust response
- External mortality reports (e.g. Trauma, Neonatal)
- Safeguarding reports
- Claim reports

4.2 Where available, this information will be made available to the HMRG reviewer by the HMRG Administrator.

4.3 The Structured Judgement Review documentation recommended in the National Quality Board's 'National Guidance on Learning from Deaths' (2017), is not currently being used at Alder Hey as it is not validated for children and young people. Until further national guidance for paediatrics is published, the Departmental and HMRG Mortality Review Forms in Appendix A and B will continue to be used.

4.4 For Departmental and HMRG Mortality Reviews, the Trust's Being Open and Duty of Candour Policy (RM47) may apply to the review of a patient's death, where a moderate or above incident is reported. Policy processes will be followed.

4.5 For Departmental and/or HMRG Mortality Reviews, where an incident is logged on Ulysses following a patient's death (e.g. due to the death being deemed avoidable), the Trust process detailed in the Management of Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2) will be followed. Advice will be taken from the Governance and Quality Assurance Team regarding the level of Root Cause Analysis (RCA) required. The Chair of the HMRG will be informed and the resulting RCA will form part of HMRG group's consideration. Where applicable, the death must be reported on the Strategic Executive Information System (STEIS).

5 Learning Disabilities

5.1 Following the preventable death of Connor Sparrowhawk in July 2013 at Southern Health NHS Foundation Trust, the independent Mazars (2015) review was commissioned by NHS England. The report highlighted that unexpected deaths of adult Mental Health and Learning Disability patients were not sufficiently reviewed or investigated. The report also highlighted the views and concerns of families were not actively sought, and where concerns were raised they were not responded to.

5.2 Many adult Trusts only conduct mortality reviews on cases where the death is unexpected or is flagged through an incident report. At Alder Hey Children's NHS Foundation Trust, all inpatient deaths are reviewed.

5.3 The Learning Disabilities Mortality Review (LeDeR) Programme was set up to ensure all deaths of patients with Learning Disabilities are comprehensively reviewed. Following notification of a patient's details to the LeDeR database, all deaths will receive an initial review by LeDeR. If any concerns are identified about the death by LeDeR, or it is felt that further learning could come from a fuller review of the death, a detailed, multiagency review will be held. Where possible this will be through the HMRG process, with a LeDeR representative present.

5.4 Since January 2017, all patients aged 4 years old and above, residing in England at the time of their death, are required to be reported to the LeDeR database. Further details of the LeDeR process can be viewed on their website: http://www.bristol.ac.uk/sps/leder/

5.5 Reviewers conducting Departmental Mortality Reviews and HMRG Reviews must consider the implications of a patient's Learning Disability.

6 Concerns of families

6.1 The publication 'National Guidance on Learning from Deaths' (2017), requires Trusts to ask bereaved families if they have any concerns about the quality of care received by the deceased patient.

6.2 At Alder Hey, this process will be led by the Bereavement Team who actively support families throughout the bereavement process.

6.3 The Bereavement Team will inform family members at an appropriate time that the policy of Alder Hey Children's NHS Trust is to review the deaths of all inpatients. The Bereavement Team will offer families the opportunity to raise any questions or concerns they may have in relation to the patient's last admission, or from an earlier stage in the patient's medical journey if the family feel it is relevant to the review of their child's death.

6.4 Any concerns raised should be notified by the Bereavement Team to the HMRG Administrator as soon as possible, in order that the concerns / queries can be incorporated into the HMRG review process.

6.5 Families raising concerns as part of the HMRG process, does not exclude families also raising these concerns through the Patient and Liaison Service (PALS) and Complaints process. In this situation, the processes in the Complaints and Concerns Policy (RM6) will be followed. If during the complaint investigation, it is found at any point that a patient safety incident has occurred, the Trust process detailed in the Management of Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2) will be followed.

(A patient safety incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care.)

6.6 Following completion of the HMRG review, where no further investigation is required (e.g. RCA), feedback should be provided to the family by clinicians. The Bereavement Team can provide support to the family if requested. The format of this feedback (e.g. face to face meeting, letter, phone call, etc.) will be led by the family.

6.7 If a moderate or above incident has been logged relating to the patients case, this feedback will be as part of the Trust's Being Open and Duty of Candour Policy (RM47). In this situation Senior Managers / Clinicians will feedback to the family in a face to face meeting if acceptable to the family. The Bereavement Team can provide support to the family if requested.

7 Learning Lessons from Mortality Reviews

7.1 The three reports: 'National Guidance on Learning from Deaths' (2017), 'Learning, Candour and Accountability' (December 2016) and 'Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015' (2015), all agree that more needs to be done to ensure learning from deaths is shared and acted upon.

7.2 The process for sharing information from mortality reviews needs to be managed in a number of ways to ensure the maximum number of staff have access to the information. These include, but are not limited to:

- Reports to key Trust committees (e.g. Division Risk and Governance Committees, Clinical Quality Steering Group (CQSG), Trust Board, Infection Control Committee, etc)
- Summary learning points sent to DMLs by the HMRG Administrator following each HMRG meeting.
- Trust internal communication methods (e.g. Trust intranet, Trust newsletter, etc)
- Presentations (e.g. Grand Round)

7.3 Monitoring actions arising from mortality reviews will be the responsibility of the action lead, with the Division's Head of Quality and the Chair of HMRG monitoring compliance.

7.4 Any opportunities to spread the learning from deaths further than Alder Hey should be taken (e.g. presenting at meetings and conferences, etc) .

8 Monitoring

8.1 The following monitoring will take place to confirm compliance with this policy:

Monitoring	Lead Responsible	Frequency	Responsible Committee
Report produced to monitor compliance with mortality review timescales	HMRG Administrator	Monthly	HMRG
Report produced summarising findings and learning points from all completed mortality reviews	HMRG Chair	Quarterly	Clinical Quality Steering Group (CQSG)
Report produced summarising findings and learning points from all completed mortality reviews	HMRG Chair	Quarterly	Trust Board

9 Further Information

9.1 National Quality Board (2017), *National Guidance on Learning from Deaths* https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

9.2 Care Quality Commission (2016), *Learning, Candour and Accountability - A review of the way NHS trusts review and investigate the deaths of patients in England* https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf

9.3 Mazars (2015), *Independent review of deaths of people with a Learning Disability or Mental Health problem in contact with Southern Health NHS Foundation Trust April 2011 to March 2015* https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/12/mazars-rep.pdf

9.4 Management of Incidents and Serious Incidents Requiring Investigation (SIRI) Policy (RM2)

9.5 Being Open and Duty of Candour Policy (RM47)

9.6 Policy for Supporting Staff Involved in Traumatic/Stressful Incidents, Complaints or Claims (E31)

9.7 Complaints and Concerns Policy (RM6)

9.8 Equality Analysis

Appendix A - Departmental Mortality Review Form

Alder Hey Children's NHS
NHS Foundation Trust

SERVICE GROUP / DEPARTMENTAL MORTALITY REVIEW FORM

Please complete electronically

SECTION A - PATIENT DETAILS

1) Hospital Number:
2) Date of Birth:
3) Date of Death:
4) Lead Clinician:
5) CBU:
6) Service Group:
7) Clinical Diagnosis:
8) Context of Involvement:
9) Patient Risk Factors:
10) Probable Cause of Death:
11) Did the patient have a Learning Disability (e.g. Developmental Delay, ASD)?
Yes ☐ Possibly / was on pathway ☐ No ☐
Details:

SECTION B - PLANNING FOR DEATH

1) Was the patient's death anticipated or not? *(please tick)* Yes ☐ No ☐
2) If the death was anticipated, at which stage in the patient's treatment was this the case?
3) Did the patient have a 'Life Plan' or 'Limitation of Treatment'? *(please tick)*
Yes ☐ No ☐

SECTION C – CLINICAL MANAGEMENT AND TREATMENT

Please consider each of the factors listed in this section and record whether the factor applies to this patient and, if relevant, what the consequences were.

1a) Appropriate and timely admission to Alder Hey on this occasion? *(please tick)* Yes ☐ No ☐
1b) If not, why not?
1c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

2a) Were medical / surgical reviews of a timely and senior enough nature, in relation to the patient's condition? *(please tick)* Yes ☐ No ☐
2b) If not, why not?
2c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

3a) If any procedures were performed, was the most senior practitioner present of suitable skill and experience for that procedure on that patient? *(please tick)*
Yes ☐ No ☐ Not applicable ☐

3b) If not, why not?
3c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

SECTION C – CLINICAL MANAGEMENT AND TREATMENT (cont.)

4a) Were there any deficiencies or errors in clinical management? *(e.g. failure of prescribing antibiotics / anticoagulation; admission of incorrect drug or dose; failure to refer to another specialty or PICU; etc.)* *(please tick)* Yes ☐ No ☐
4b) If 'yes', what were they?
4c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

5a) Were there any failings in technical skill undertaking the procedure? *(please tick)* Yes ☐ No ☐ Not applicable ☐
5b) If 'yes', what were they?
5c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

6a) Were any deficiencies in patient monitoring / observations / nursing care identified? *(please tick)* Yes ☐ No ☐
6b) If 'yes', what were they?
6c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

7a) Any delays in accessing support services at Alder Hey? (e.g. radiology, laboratory services, theatres, PICU, etc.) *(please tick)* Yes ☐ No ☐
7b) If 'yes', what were they?
7c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

8a) Any other concerns relating to the management of this patient? *(please tick)* Yes ☐ No ☐
8b) If 'yes', what were they?
8c) Did this contribute to the patient's death? *(please tick)* Yes ☐ No ☐ Possibly ☐

9) If you believe that the death was preventable in some way that is not covered above, please record what the major avoidable factors were:

10a) Has follow-up been offered or already undertaken? *(please tick)* Yes ☐ No ☐
10b) If not, why not?

SECTION D – CONCLUSION / ASSESSMENT

Please tick whichever one description best matches

1) Aspects of the care provided were less than adequate; and different management would reasonably be expected to have altered the outcome. ☐

2) Aspects of the care provided were less than adequate; and different management may have altered the outcome. ☐

3) Aspects of the care provided were less than adequate; and different management would not reasonably be expected to have altered the outcome. ☐

4) Adequate or above standard care provided ☐

SECTION E – ROOM FOR IMPROVEMENT

Please tick whichever one description best matches

1) Example of good practice ☐

2) Adequate / standard practice ☐

3) Aspects of clinical care could have been better ☐

4) Aspects of organisational care could have been better ☐

5) Aspects of clinical and organisational care could have been better ☐

6a) What aspects?
6b) ACTION PLAN:
6c) Timeframe of Action Plan:
6d) Lead for Action Plan:

SECTION F – FURTHER CONTACT DETAILS

Date of review:
Name of person completing form:
Designation of person completing form:
Preferred contact details for person completing the form:

Appendix B - Hospital Mortality Review Group (HMRG) Review Form

Alder Hey Children's NHS
NHS Foundation Trust

Audit No:

HOSPITAL MORTALITY REVIEW GROUP (HMRG) – REVIEW FORM

You have been nominated to complete a mortality audit primary review. Please complete the form below using the case notes and any supporting information provided. The first section has been completed for you.

Q1) Hospital number:

Q2) Gender: Male ☐ Female ☐

Q3) Date of admission:

Q4) Transferred from another hospital? Yes ☐ No ☐

If yes, where was the child transferred from?

Q5) Date of birth:

Q6) Date of death:

Q7) Place of death:

Q8) Admitting ward:

Q9) Admitting consultant:

Q10) Further information provided as part of Primary Review:

Incident report/s	☐	
Root Cause Analysis	☐	
Complaints	☐	
PALS	☐	
Legal	☐	
Bereavement Team	☐	
Child Protection	☐	
CDOP Form	☐	
Trauma Review	☐	

Q11) Name of reviewing consultant:

CLINICAL DIAGNOSIS

Q12) Brief clinical summary: see Death Summary letter

Q13) Clinical diagnosis:

Q14a) Did the patient have a Learning Disability (e.g. developmental delay, ASD)?

Yes ☐ Possibly / was on pathway ☐ No ☐

Details:

Q14b) Was the patient known to CAMHS? Yes ☐ No ☐

Details:

Q15) Was the lead consultant clearly identified in the case notes? Yes *(please select from list)*

Q16a) Other consultants involved:

Q16b) Other teams involved:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

PREVIOUS ADMISSION(S) TO ALDER HEY

Q17) Did the patient have a previous admission to Alder Hey? Yes ☐ No ☐

Q18) If yes, was the last admission a readmission with the same problem?

Yes ☐ No ☐ Not known ☐

Q19) Please detail any relevant previous admission/attendances:

Q20) Did the patient have a chronic illness? Yes ☐ No ☐ Not known ☐

If yes, please specify:

OPERATIONS / PROCEDURES PERFORMED IN THIS ADMISSION

Q21) Were any operations/procedures performed during the last admission?

Yes ☐ No ☐ (If no, go to Q22)

Q22) **1st operation / procedure:**
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

2nd operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

3rd operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

4th operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

5th operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

6th operation / procedure:
Date of operation/procedure:
Operation/procedure:
Grades of surgeon/anaesthetist:

CAUSE OF DEATH / POST MORTEM

Q23a) Case referred to coroner? Yes ☐ No ☐

If yes, name of consultant referring case:

Q23b) Case discussed with coroner? Yes ☐ No ☐ (If no, go to Q26)

If yes, name of consultant discussing case:

Q24) Discussion with coroner documented in medical record? Yes ☐ No ☐

Q25) Outcome of discussion with coroner:

Q26) Request for hospital post mortem? Yes ☐ No ☐ (If no, go to Q31)

Q27) If yes, request for post mortem made to parents by: Consultant ☐ Other ☐

If other, please state grade:

Q28) Permission for hospital post mortem given? Yes ☐ No ☐

Q29) Type of post mortem performed: Full hospital post mortem ☐

Limited hospital post mortem ☐

Q30) Findings of post mortem:

Q31) Death certificate issued? Yes ☐ No ☐

Q32) Cause of death:

1a)

b)

c)

2)

Q33) Do you agree with the probable cause of death on the Service Group Mortality Review form (Section B)?

Yes ☐ No ☐

If no, state reasons:

Q34) Death certificate correct? Yes ☐ No ☐

If no, why?

Q35) Any SUDC issues? Yes ☐ No ☐

Action: Referred to:

Q36) Healthcare associated infection related to death? Yes ☐ No ☐

FOLLOW-UP / DOCUMENTATION

Q37) Offer / arrangements for follow up documented? Yes ☐ No ☐

Q38) Follow up: Declined ☐ Awaiting ☐ Has occurred ☐
Done locally ☐ Unknown ☐

Q39) Has there been feedback / follow-up with the referral hospital?

Yes ☐ No ☐ Not applicable ☐

If no, should there have been? Yes ☐ No ☐

If yes, what aspects?

Q40) Overall evaluation of case note documentation of this admission:

Adequate – no issues ☐ Inadequate ☐

Comments on documentation:

SERVICE GROUP / DEPARTMENTAL MORTALITY REVIEWS

Q41) Service Group / Departmental review(s) of case? Yes ☐ No ☐

If no, which Service Groups / Departments?

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Divisions None *(please select from list)*

Service Group None *(please select from list)*

If 'other' please specify:

Q42) Departmental / Service Group Mortality Review – Minutes and action plans: (cut and paste)

Q43) Do you agree with the assessment (section C) of the clinical management and treatment issues?

Yes ☐ No ☐

If not, what are the areas of disagreement?

HMRG

Q44) How would you rate the care given?

1) Aspects of the care provided were less than adequate; and different management would reasonably be expected to have altered the outcome. ☐

2) Aspects of the care provided were less than adequate; and different management may have altered the outcome. ☐

3) Aspects of the care provided were less than adequate; and different management would not reasonably be expected to have altered the outcome. ☐

4) Adequate or above standard care provided ☐

Q45) Please tick whichever one description best matches:-

1) Example of good practice ☐

2) Adequate / standard practice ☐

3) Aspects of clinical care could have been better ☐

4) Aspects of organisational care could have been better ☐

5) Aspects of clinical and organisational care could have been better ☐

Q46) If your assessment from Q44 and Q45 above varies from the Service Group / Departmental Review, please explain why:

Q47) Requires formal HMRG discussion? Yes ☐ No ☐

Q48) Any further information / clarification required?

Q49) Any significant questions that remain unanswered?

Diagnostic Categories – *only one primary & no more than two secondary*

Diagnostic/Disease Categories

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 – subcategories:
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)*

Primary:

Secondary:

Recurring 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. External 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 – subcategories:
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 Coroner
R7. Documentation – subcategories:
R7a. Recording R7b. Filing
R8. Failure of follow-up
R9. Withdrawal / Limitation of care
R10. Example of Good Practice
R11. Learning disability
R12. Known to CAMHS

Recurring themes:

FOLLOWING DISCUSSION AT HMRG MEETING

Learning points identified:

Actions identified: Lead for action:

Lead for action:

Lead for action:

Outcome of primary review: No further action ☐

Need further information ☐

Diagnostic Categories:

Recurring themes:

HMRG Primary Review Form – Amended June 2017

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development	Date: 04/07/17 Report Number:	Period: June 2017 11	SRO: David Powell Author: Sue Brown
Programme 2017/18	Apr-17 | May-17 | Jun-17 | Jul-17 | Aug-17 | Sep-17		
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		
Decommissioning & Demolition (Phase 1 & 2)			Programme progressing on track and advance to demolish to M/N block now agreed as part of phase one. No issues with dust have arisen , monitoring continues as per plan. The management plan is in place covering both : 1. demolition of retained estate; 2. R&E II construction, levels have remained safe todate.
Residential			Community Engagment continues to progress in realtion to the scale of the scheme. once resolved the appointment of the prefferred bidder (Elect) will follow. Bidder working with LCC planners to ensure all consultation material is acceptable within the rules of the planning process to ensure that the final scheme has a high level of acceptance to all parties.Preffered bidder (elect) has submitted a planning pre-application. The Trust has placed the consultation process on hold until the Liverpool Community Health Bid process has concluded before dates are agreed.
Research & Education Phase II			Research and Education phase ll build remains on track, contract with Morgan Sindell still awaiting final agreement. University partners yet to sign sign off financial agreements although this was expected end of August beginning of september, it remains outstanding although all agreed in prinicipal.
Alder Centre			On Track. Dicussions and regular meetings in process and progressing with the Appointed Architect and users to refine the design. Tender for the construction due to go out end of October.
Park			Recently secured £28k of funding from a charity to develop accessible pathways in the park forest area. The Trust design was accepted fo rentry to the Chelsea flower show 2018, funding however has not been secured , so the plan will be to re-submit next year, feedback on the design from Chelsea was very positve. The Development team are confident that they have an interested partrner in M&G who may agree to be the major sponsor in 2019.
International Design & Build Consultancy			Contract prepared and exchanged with XI'AN, contract documents and drawings being translated via china centre prior to commencment of the design review and agreement on a timeline. Jersey review, they have agreed on a £60k design review exercise with DP, discussions and weekly input over 3/4 months to the Jersey team and this work is ongoing with weekly visits to jersey by team members. Possability this work will be extended beyond November and additional income achieved. Sharepoint documentation still to be fully developed.
Community Cluster Building			Design brief being prepared in order to lauch a RIBA design competition at the end of September, this includes , Neurological Assessment, Community Paeds, Psychology, orthotics and Police station in phase one. There is also the option for phase two which could include the Dewi Jones re locationfrom Alder Park and a new and separatley funded Sandfield Park School. Three will be potential in the future for additon of a small rehabilitation unit if the Trust wishes to pursue the option.Sharepoint documentation still to be fully developed.
Estates Strategy/Corporate Offices			Currently exploring and conducting a financial analysis of proposed developments and locations for Community services where current premisies have recieved notification of end of tenancy.Also financial analaysis of options for relocation to off site premeises for CAMHS and Corprate services due to conclude at the end of September.Sharepoint documentation still to be fully developed

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Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 3rd October 2017

Report of:	Chief Nurse
Paper Prepared by:	Emergency Preparedness & Business Continuity Manager
Subject/Title:	NHS England EPRR Core Standards Audit 2017/18
Background Papers:	• **Appendix A:** NHS England EPRR Core Standards Letter • **Appendix B:** (for viewing electronically, no printing required): Assurance Spreadsheet • **Appendix C:** 2017/18 Work plan • **Appendix D:** Statement of Compliance
Purpose of Paper:	The Board is asked to ratify the EPRR Self-Assessment Results
Action/Decision Required:	The Board is asked to ratify a 'substantial compliance' declaration.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• Deliver outstanding care • The Best People Doing Their Best Work
Resource Impact:	Funding for ED EPRR Clinical Lead to focus on CBRNE/Major incident 2017/18 work plan

1. Background:

In line with the Emergency Preparedness Resilience and Response (EPRR) Core Standards, the Trust is required to:

- Undertake an annual self-assessment of the core standards (**Appendix B**)
- Produce a work plan for the year ahead, based on any gaps in assurance (**Appendix C**)
- Complete a statement of compliance for ratification by the Trust Board (**Appendix D**)
- Present findings from the self-assessment/key lines of enquiry to NHS England during their visit to the Trust on Friday 27th October 2017.

Further detail regarding the audit/visit is available in the NHS England letter attached as **Appendix A**.

2. Key Issues:

2.1 Assurance Spreadsheet - Governance 'Deep Dive':

This year's assurance deep dive topic is organisational governance and is referenced in the attached core standards spreadsheet (**Appendix B**) in the section entitled 'governance'.

Core standard DD2 states 'the organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report'. The 16/17 results weren't published in the EPRR annual report however; was taken to the board last year for approval. Future annual reports will ensure that the results of the EPRR assurance process will be included.

Core standard DD3 states 'the organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation'. A report from the Emergency Preparedness Group is submitted to each Integrated Governance Committee (IGC) which is chaired by Steve Igoe, Non-Executive Director. Following receipt of the governance deep dive, the Non-Executive Director has agreed to formally hold the EPRR portfolio for the organisation.

2.2 2017/18 Workplan:

Attached is the 2017/18 EPRR work plan. The majority of the work plan refers to the Chemical, Biological, Radiological, Nuclear and Explosives (CBRNE)/Hazardous Materials (HAZMAT) planning and training required, which was identified in the 2016/17 work plan. The Emergency Department EPRR Clinical Lead took up post on 21st August 2017 and the Chief Nurse (Accountable Emergency Officer) has agreed that additional funding/hours can be provided for the clinical lead to complete these actions as a priority. A work plan is currently under development for review by the Chief Nurse.

2.3 Statement of Compliance:

Following completion of the core standards self-assessment spreadsheet, it is recommended that the Trust declares 'substantial' compliance. **The Board is asked to ratify this declaration.** The statement of compliance and associated documentation was returned to NHS England by the deadline of 22nd September 2017 and if the Board ratifies this level of compliance, then a signed copy of the statement will be submitted to NHS England.

2.4 NHS Strategic Asset Assurance Visit 27/10/17:

In light of recent incidents, this year's assurance process includes an emphasis on NHS Strategic Assets. Alder Hey as a Major Trauma Centre is considered to provide vital services and will this year receive a greater level of scrutiny in the form of a visit to Alder Hey on 27th October 2017. The following leads will be visiting the Trust:

- Paul Dickins, Regional Head of EPRR, NHS England
- Jim Deacon, Head of Emergency Preparedness, NHS England
- Joanne Richardson, EPRR Operations Manager, NHS England

There are key areas that the visiting team would like to visit while they are on site, these include, but not restricted to:

- The Emergency Department
- The location the organisation would manage an emergency from (Incident Coordination Centre)
- The store of CBRN equipment (Acute trusts)
- Location of any stockpiled equipment

The following staff will attend to represent the Trust:

- Chief Nurse (Emergency Preparedness Accountable Officer)
- Chief Operating Officer
- Director of Nursing
- Trauma Leads
- Emergency Department EPRR Clinical Lead
- Emergency Preparedness and Business Continuity Manager

An update will be provided to the Board on the outcome of this visit.

Publications Gateway Reference 06967

Simon Weldon
Director of NHS Operations and Delivery
NHS England
Skipton House
80 London Road
London SE1 6LH

10 July 2017

To: Provider Accountable Emergency Officers
CCG Accountable Emergency Officers
NHS England Regional Directors
NHS England Regional Directors of Assurance and Delivery
NHS England Directors of Commissioning Operations
NHS England LHRP Co-chairs

Cc: NHS England Heads of EPRR
NHS England Business Continuity team
CCG Accountable Officers
CCG Clinical Leads
CSU Managing Directors
Clara Swinson, Director General – Public Health, Department of Health
Helen Shirley-Quirk CB, Director Health Protection and Emergency Response, Department of Health
Dr Kathy McLean, Executive Medical Director, NHS Improvement
Dr Ruth May, Executive Director of Nursing, NHS Improvement

Dear colleague

Process for 2017-18 Emergency Preparedness, Resilience and Response (EPRR) Assurance

The last few months have been busy for us all in relation to NHS resilience and response. These events make the annual NHS EPRR Assurance process even more important and this letter starts this process for 2017-18. As in previous years, NHS England will lead the process via Local Health Resilience Partnerships (LHRP) in order to seek assurance that both the NHS in England and NHS England are prepared to respond to emergencies, and are resilient in relation to continuing to provide safe patient care. The format and process this year will follow that of 2016-17.

The purpose of this process is to assess the preparedness of the NHS, both commissioners and providers, against common NHS EPRR Core Standards which remain unchanged for this year. A task and finish group is currently reviewing the Core Standards ahead of the 2018/19 process and these will be published in the autumn.

The EPRR Core Standards are available on the NHS England internet site
http://www.england.nhs.uk/ourwork/eprr/

Local Health Resilience Partnerships continue to play an integral part of the process and constituent members are asked to support NHS England in conducting the process.

The NHS EPRR assurance process concludes with a submission to the NHS England Board in March 2018. Once this has been accepted by the Board, NHS England will be in a position to provide national EPRR assurance for 2017/18 to the Department of Health and the Secretary of State for Health.

In light of the current UK risks and threats, this year's process will include an additional element of assurance for NHS Strategic Assets. This additional element will include a site visit to meet with the relevant leaders within these organisations. This process is described in section 4 of this letter.

1. Timeframes

The timelines for this year's process will be in line with those for the 2016/17 process.

All organisations should commence their self-assessment immediately so as to give suitable time to undertake this in a measured and calculated manner.

Once organisations have taken their self-assessment results to their **Boards/Governing Bodies** there will be Local Health Resilience Partnership confirm and challenge process to provide organisations with a peer review.

Following this, Local Health Resilience Partnership Co-Chairs will submit their reports to the NHS Regional Teams where there will be a regional consolidation process, via confirm and challenge meetings. NHS England regions will determine the local arrangements and dates for submission.

By the 31 December 2017, Regional Teams will submit their consolidated data to the Central Team where national consolidation will take place. This will be complete by Wednesday 28 February 2018 so that the national report can be prepared and considered by the NHS England Board by 1 April 2018.

2. Actions

2.1 Providers of NHS funded care

The following organisations are required to undertake the 2017-18 NHS EPRR assurance process:

- Acute hospital service providers
- Specialist hospital providers
- Ambulance service providers (including patient transport organisations)
- Community service providers (this includes NHS Trusts, Foundation Trusts and social enterprises)
- Mental health service providers
- NHS111 providers

Local Health Resilience Partnerships may wish to include other organisations not mentioned above, at their discretion.

Provider organisations are asked to undertake a self-assessment against the relevant individual core standards and rate their compliance. These individual ratings will then inform the overall organisational rating of compliance and preparedness.

Once this process has taken place, organisations are required to take a statement of compliance to a public Board meeting. Provider organisations are also required to publish their statement of compliance in their annual report. This Board report, along with the Core Standards assurance ratings and rectification plans, should then form the submission to the Clinical Commissioning Group and Local Health Resilience Partnership. The Local Health Resilience Partnership will undertake a formal review via a confirm and challenge meeting.

Organisations which operate across Local Health Resilience Partnerships borders should present their self-assessment and supporting evidence to their lead commissioner and host Local Health Resilience Partnership. This documentation should also be shared with other relevant Local Health Resilience Partnerships /stakeholders as necessary.

2.2 Commissioners of NHS funded care

The following organisations are required to undertake the 2017-18 EPRR assurance process:

- Clinical commissioning groups
- NHS England regional and central teams.

Commissioning organisations (including NHS England) are required to undertake a self-assessment against the relevant individual NHS EPRR Core Standards and these individual ratings will then inform the overall organisational rating of compliance and preparedness.

Once this process has taken place commissioners are expected to take a statement of compliance to their Governing Bodies/Senior Management Teams. This report along with the Core Standards assurance ratings and rectification plan should then form the submission to the Local Health Resilience Partnership. The Local Health Resilience Partnerships will undertake a confirm and challenge meeting.

Commissioners which operate across Local Health Resilience Partnership borders should present their self-assessment and supporting evidence to their regular host Local Health Resilience Partnership. This documentation should also be shared with other relevant Local Health Resilience Partnerships s/stakeholders as necessary.

Clinical Commissioning Groups are asked to support NHS England in the additional assurance of the UK NHS strategic asset (Section 4).

2.3 Local Health Resilience Partnerships (LHRPs)

It is expected that Local Health Resilience Partnerships s will review and consider all relevant organisations self-assessments, Board or Governing Body papers (or equivalent) and rectification plans and provide a mechanism across their geography to facilitate confirm and challenge.

Local Health Resilience Partnerships are expected to:

- Ensure that commissioners of services are actively involved
- Seek further evidence where an organisation considers itself less than **Fully Compliant**.

- Conduct a 'deep dive' into core EPRR Governance in all organisations included in the assurance process
- Provide the NHS England Regional Director of Operations and Delivery with a report on the preparedness of all organisations in their Partnership.
- Actively monitor progress of those organisations reporting an overall rating of **Non-Compliant** until the Partnership is content that the organisation has attained an agreed level of compliance
- Actively engage with local NHS Improvement colleagues to support this process

Records should be kept of the reviews undertaken and include any evidence requested.

2.4 NHS England Regional Teams

NHS England Regional Teams will coordinate a submission to evidence their level of assurance and to help inform the national assurance assessment. Regional Teams will be asked to complete template(s) which will follow this letter and:

- Request any evidence of the work completed and/or plans put in place that they feel is necessary to support and/or challenge organisation(s)
- Be able to distinguish between the preparedness of NHS England and the preparedness of other organisations.
- Demonstrate where improvement is needed and the mitigation in hand at individual organisational/team level.
- Be able to identify and set out instances of good practice against the core standards so that this can be shared across regions to improve the overall preparedness and resilience of NHS England and the NHS in England.
- Actively engage with NHS Improvement colleagues to support this process
- Undertake the strategic asses assurance process (Section 4.)

Records should be kept of the reviews undertaken and include any evidence requested.
It is expected that all actions in section 2 above will be completed by 31st December 2016.

2.5 NHS England Business Continuity Assurance

NHS England business continuity assurance will be undertaken once and in conjunction with the NHS England Business Continuity Team, via the NHS EPRR Core Standards template.

The NHS England Business Continuity Team will liaise directly with NHS England Regional Teams alongside the NHS England central EPRR team to gain assurance of NHS England arrangements.

The NHS England Business Continuity Team will liaise directly with each Commissioning Support Unit (CSU) to gain their business continuity assurance, which will then be incorporated into the NHS England Board paper.

3. Assurance Deep dive

This year's EPRR assurance deep dive topic is core EPRR organisational governance. There has been a significant amount of organisational change over recent years and there is a need to ensure that EPRR is secured appropriately, within all our organisations. This deep dive will include

assurance of areas such as internal organisational EPRR accountability, regular reports to public Board meetings, a realistic work program and a solid training and exercise program.

Following on from the CBRN 'deep-dive' carried out during the 2014-15, the HAZMAT/ CBRN assessment remains incorporated into the NHS EPRR Core Standards.

Acute hospitals should expect ambulance service providers to work with them to assess and challenge their level of HAZMAT/CBRN preparedness (using the NHS EPRR Core Standards). NHS England continues to fund ambulance service providers, via the National Ambulance Resilience Unit (NARU), to undertake this. In addition to this assessment, ambulance service providers are funded to provide training to support the acute hospital response.

Specialist, community and mental health service providers should note that some HAZMAT/ CBRN core standards are relevant and pertinent to their organisations, and they also have a duty of care towards self-presenting patients who have been exposed to a HAZMAT or CBRN incident.

4. NHS Strategic Asset Assurance

In light of recent incidents, this year's assurance process will include an emphasis on NHS Strategic Assets. These are organisations that are considered to provide vital services and will this year receive a greater level of scrutiny. The organisations covered within the NHS Strategic Asset assurance process for 2017/18 are:

- Ambulance services
- Major Trauma Centres
- Burns Centres
- High level Isolation Units (infectious disease units)
- High Security Mental Health Facilities
- Geographically remote organisations

Ambulance services are receiving an enhanced assurance process which is being led by the National Ambulance Resilience unit and this program is well under way.

NHS England will lead the enhanced assurance process for all other strategic organisations. This will include a site visit to each organisation and the key lines of enquiry for these visits will be shared with the respective organisations, in advance. The visits will consist of representation from NHS England, NHS Improvement and the lead Clinical Commissioner. This team will expect to meet with the organisation's Accountable Emergency Officer and Emergency Preparedness Manager/Lead.

NHS England will work with these organisations to schedule these events.

5. Organisational Assurance Ratings

Organisations will be expected to state an overall assurance rating as to whether they are Fully, Substantially, Partially or Non-Compliant with the NHS EPRR Core Standards.

1. Acute, specialist, Community and mental health providers should calculate their overall organisation compliance level by using the 'EPRR Core Standards' and 'HAZMAT CBRN Core Standards' tabs together (therefore standards 1-66 as a single rating).

2. Patent Transport, 111, NHS England (regional and national), CCGs, CSUs and other NHS funded providers should calculate their overall organisation compliance level by using the 'EPRR Core Standards' tab only (therefore standards 1-52 only).

3. Ambulance providers should report 3 compliance levels:
   - Calculate EPRR Core Standards against Core Standards 1-66 as per No 1 above.
   - Calculate their overall compliance against 'MTFA Core Standards' and
   - Calculate their overall compliance 'HART Core Standards' separately applying the criteria in the national letter (gateway 05356) letter for each tab.

4. The deep dive results should be reported separately and should not be included in any overall organisational compliance rating.

The definitions of these ratings remain the same as the 2016/17 process and are detailed below:

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board has agreed.
Non-compliant*	Arrangements in place do not fully address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board and will be monitored on a quarterly basis in order to demonstrate future compliance.

* Should an organisation be Non-Compliant, the Local Health Resilience Partnership will regularly monitor progress throughout the year until it is has attained an agreed level of compliance.

6. Summary:

In summary, please can you:

1. Note that all organisations will undertake a self-assessment against the NHS EPRR Core Standards.
2. Note the approach to the 2017/18 EPRR assurance process that is expected to be followed by NHS England and Local Health Resilience Partnerships.
3. Note the timeframes for the delivery of the 2017/18 assurance process.
4. Liaise with local partners and stakeholders to achieve the outcomes required.
5. Note the additional implications of the NHS Strategic Asset assurance process for 2017/18 for the relevant organisations

Senior managers are asked to bring the contents of this letter to the attention of their emergency preparedness, resilience and response staff and disseminate to other organisations as applicable.

For further information, please see the NHS England EPRR web-page[1] or if you have any further queries, please contact Stephen Groves (National Head of EPRR) at stephengroves@nhs.net.

Yours sincerely,

Simon Weldon
Director of NHS Operations and Delivery

[1] http://www.england.nhs.uk/ourwork/eprr/

NHS England Core Standards for Emergency preparedness, resilience and response

v5.0

The attached EPRR Core Standards spreadsheet has 6 tabs:

EPRR Core Standards tab: with core standards nos 1 - 37 (green tab)

Governance tab:-with deep dive questions to support the EPRR Governance'deep dive' for EPRR Assurance 2017 -18(blue) tab)

HAZMAT/ CBRN core standards tab: with core standards nos 38- 51. Please note this is designed as a stand alone tab (purple tab)

HAZMAT/ CBRN equipment checklist: designed to support acute and ambulance service providers in core standard 43 (lilac tab)

MTFA Core Standard: designed to gain assurance against the MTFA service specification for ambulance service providers only (orange tab)

HART Core Standards: designed to gain assurance against the HART service specification for ambulance service providers only (yellow tab).

This document is V50. The following changes have been made :

• Inclusion of EPRR Governance questions to support the 'deep dive' for EPRR Assurance 2017-18

	Core standard	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance					
1	Organisations have a director level accountable emergency officer who is responsible for EPRR (including business continuity management)	Chief Nurse is the Accountable Officer. Letter confirming this sent to NHS England dated 13th April 2017	**N/A**		
2	Organisations have an annual work programme to mitigate against identified risks and incorporate the lessons identified relating to EPRR (including details of training and exercises and past incidents) and improve response.	Annual Report including workplan submitted to IGC on 24/07/17 and going to Trust Board on 05/09/17	**N/A**		
3	Organisations have an overarching framework or policy which sets out expectations of emergency preparedness, resilience and response.	Major Incident Policy, Major Incident Command & Control Plan. Also SOP for Strategic Commander and Tactical Commander. Trust Business Continuity Plan and Policy in place, along with local ward/department business continuity plans.	**N/A**		
4	The accountable emergency officer ensures that the Board and/or Governing Body receive as appropriate reports, no less frequently than annually, regarding EPRR, including reports on exercises undertaken by the organisation, significant incidents, and that adequate resources are made available to enable the organisation to meet the requirements of these core standards.	Update provided every 2 months to the Integrated Governance Committee, which is a sub Committee of the Board. EPPR annual report submitted to Trust Board for ratification.	**N/A**		
Duty to assess risk					
5	Assess the risk, no less frequently than annually, of emergencies or business continuity incidents occurring which affect or may affect the ability of the organisation to deliver its functions.	Risks recorded via the Trust Ulysses Risk Register with reference to the LHRP Risk Register included.	N/A		
6	There is a process to ensure that the risk assessment(s) is in line with the organisational, Local Health Resilience Partnership, other relevant parties, community (Local Resilience Forum/ Borough Resilience Forum), and national risk registers.	As above. LHRP Risk Register also reviewed at the LHRP Strategic and Practitioner EPRR meetings	N/A		
7	There is a process to ensure that the risk assessment(s) is informed by, and consulted and shared with your organisation and relevant partners.	Organisations notified as and when required and also discussed and monitored at LHRP meetings	N/A		
Duty to maintain plans – emergency plans and business continuity plans					
8	Effective arrangements are in place to respond to the risks the organisation is exposed to, appropriate to the role, size and scope of the organisation, and there is a process to ensure the likely extent to which particular types of emergencies will place demands on your resources and capacity.	Major Incident Policy and Major Incident Command & Control Plan			
9		Trust Business Continuity Policy and Plan. Local Ward/ Department business continuity Plans produced.			

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10	Have arrangements for (but not necessarily have a separate plan for) some or all of the following (organisation dependent) (NB, this list is not exhaustive):	CBRNE Plan available, however, requires refreshing	Refresh CBRNE/HAZMAT Plan	ED EPRR Clinical Lead	3/31/2018
11		Heatwave Plan, Cold Weather Plan in place, along witih developing Winter Plan			
12		Pandemic Flu Plan updated and approved at IPC Committee on 9/08/17			
13		Mass vaccination would be in consultation with PHE, CCG etc.			
14		Mass casualties is referenced in the Trust Major Incident Command & Control Plan. Mass Casualty exercise held on 21/08/17. Cheshire & Merseyside mass casualty matrix for receiving casualties. MRF/NHS E Mass Fatalities Plan			
15		Fuel Plan			
16		Escalation Plan approved and Winter Plan under development			
17		Infectious Diseases Plan undergoing update			
18		Evacuation Plan currently being updated to reflect whole hospital evacuation with a plan to be in place by December 2017			
19		Lockdown Plan and action cards available with further update to be considered regarding lockdown options			
20		Business Continuity Action cards available for utitliies, IT and communications failure			
21		MRF/NHSE Mass Fatalities Plan.			
22		Burns plan for large scale incidents currently under update following release of national document			
23		Not applicable			
24	Ensure that plans are prepared in line with current guidance and good practice which includes:	Plans prepared in line with current guidance along with verson control. Have asked peers to provide copies of their plans where required, using good practice examples.			
25	Arrangements include a procedure for determining whether an emergency or business continuity incident has occurred. And if an emergency or business continuity incident has occurred, whether this requires changing the deployment of resources or acquiring additional resources.	On Call policy and on call 24/7 rota, major incident/business continuity SOP for Strategic and Tactical Commander. Business Continuity Severity levels chart available to assist in determining level of business continuity incident. Definition of major incident and examples referenced.			

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26	Arrangements include how to continue your organisation's prioritised activities (critical activities) in the event of an emergency or business continuity incident insofar as is practical.	Local business continuity plans in place identifying critical services which must continue. Overarching list of critical areas will be finalised at EPG in September 2017.			
27	Arrangements explain how VIP and/or high profile patients will be managed.	VIPs managed in line with 'External Communications Policy (including VIP/Media Visits'			
28	Preparedness is undertaken with the full engagement and co-operation of interested parties and key stakeholders (internal and external) who have a role in the plan and securing agreement to its content	Planning meetings leading up to events take place with key areas affected e.g Meditech downtime, UPS electrical testing etc.			
29	Arrangements include a debrief process so as to identify learning and inform future arrangements	Debrief arrangements referenced in plans and debrief meetings organised following major incident or business continuity incidents			
Command and Control (C2)					
30	Arrangements demonstrate that there is a resilient single point of contact within the organisation, capable of receiving notification at all times of an emergency or business continuity incident; and with an ability to respond or escalate this notification to strategic and/or executive level, as necessary.	24/7 2nd and 1st On Call rota is available, and staff contactable via switchboard.			
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	Strategic Leadership is a crisis training is being organised. In addition, Strategic and Tactical Commanders have received local training from the Emergency preparedness & Business Continuity Manager regarding responding to major incidents and business continuity incidents - checklist to be developed to ensure this training covers everything listed in the National Occupational standards for Strategic, Tactical and Operational staff. Implement this as mandatory training.	**Develop core competency checklist for strategic, tactical and operational staff, in line with National Occupational Standards**	**EP&BC Manager**	3/31/2018
32	Documents identify where and how the emergency or business continuity incident will be managed from, ie the Incident Co-ordination Centre (ICC), how the ICC will operate (including information management) and the key roles required within it, including the role of the loggist .	Arrangements referenced in the Trust Major Incident Command and Control Plan and the Strategic and Tactical Major Incident/business continuity SOP. MRF contacts directory.			
33	Arrangements ensure that decisions are recorded and meetings are minuted during an emergency or business continuity incident.	Loggist list of staff available to record decisions made along with loggist books.			
34	Arrangements detail the process for completing, authorising and submitting situation reports (SITREPs) and/or commonly recognised information pictures (CRIP) / common operating picture (COP) during the emergency or business continuity incident response.	Arrangements for internal sitreps included in the Major Incident Command and Control Plan. External situation report requests from NHS England will be included in the next update of the plan			
35	Arrangements to have access to 24-hour specialist adviser available for incidents involving firearms or chemical, biological, radiological, nuclear, explosive or hazardous materials, and support strategic/gold and tactical/silver command in managing these events.	CBRNE/HAZMAT plan includes reference to contacting PHE for advice on a 24 hour basis			
36	Arrangements to have access to 24-hour radiation protection supervisor available in line with local and national mutual aid arrangements;	CBRNE/HAZMAT plan includes reference to contacting PHE for advice on a 24 hour basis			
Duty to communicate with the public					

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37	Arrangements demonstrate warning and informing processes for emergencies and business continuity incidents.	Communications Team liaise with NHS England during major incidents. Communications action card included in Major Incident Command & Control Plan.			

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38	Arrangements ensure the ability to communicate internally and externally during communication equipment failures	Radios available to communicate during communication failure. Recent cyber incident demonstrated need to develop continuity plan in the event of loss of IT network/external links which is being taken forward			
Information Sharing – mandatory requirements					
39	Arrangements contain information sharing protocols to ensure appropriate communication with partners.	The Trust Major Incident Policy includes reference to information sharing			
Co-operation					
40	Organisations actively participate in or are represented at the Local Resilience Forum (or Borough Resilience Forum in London if appropriate)	the Trust is represented at the LHRP Strategic Meeting and LHRP HRG meeting			
41	Demonstrate active engagement and co-operation with other category 1 and 2 responders in accordance with the CCA	Good networking arrangements in place at LHRP meeting and during exercises.			
42	Arrangements include how mutual aid agreements will be requested, co-ordinated and maintained.	Mutual aid would be requested via NHS England Strategic Coordinating Group/Tactical Coordinating Group			
43	Arrangements outline the procedure for responding to incidents which affect two or more Local Health Resilience Partnership (LHRP) areas or Local Resilience Forum (LRF) areas.	Direction would be sought from NHS England Strategic and Tactical Command, whilst following Trust Major Incident Command & Control Plan			
44	Arrangements outline the procedure for responding to incidents which affect two or more regions.	As above			
45	Arrangements demonstrate how organisations support NHS England locally in discharging its EPRR functions and duties	SITREPs would beprovided to NHS England in line with agreed battle rhythm as per recent cyber incident and Manchester Terrorism incident			
46	Plans define how links will be made between NHS England, the Department of Health and PHE. Including how information relating to national emergencies will be co-ordinated and shared	Major Incident Policy references different agencies and this would be coordinated via SGC/TCG arrangements			
47	Arrangements are in place to ensure an Local Health Resilience Partnership (LHRP) (and/or Patch LHRP for the London region) meets at least once every 6 months	Not applicable			
48	Arrangements are in place to ensure attendance at all Local Health Resilience Partnership meetings at a director level	The Accountable Director has delegated this requirement to the Director of Nursing, who chairs the Trust Emergency			
Training And Exercising					
49	Arrangements include a current training plan with a training needs analysis and ongoing training of staff required to deliver the response to emergencies and business continuity incidents	TNA produced, however, in line with Core Standard 31 additional action will be taken to ensure training is in line with meets National Occupational Standards for Strategic, Tactical and Operational staff and which of this training needs to be 'mandatory'. Last communication cascade test took place on 17/07. Desk top exercise held on 21/08/17. last live exercise held October 2016. Next live exercise being scheduled for November 2017, with joint Live/Hybrid exercise with Whiston Hospital to be held in July 2018.			

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50	Arrangements include an ongoing exercising programme that includes an exercising needs analysis and informs future work.	Exercises referenced in annual work plan.			
51	Demonstrate organisation wide (including oncall personnel) appropriate participation in multi-agency exercises	Staff can attend multi agency exercises when there are sufficient spaces available to attend. Ambulance service, Trauma Leads, NHS England attended recent Trust Mass Casualty Exercise. Emergency Department Lead and Director of Nursing attended 'Exercise Elsa'. Large number of staff will be involved in joint 'Exercise Gemini' with Whiston in July 2018			
52	Preparedness ensures all incident commanders (oncall directors and managers) maintain a continuous personal development portfolio demonstrating training and/or incident /exercise participation.	This is held via the Emergency Preparedness Manager and Training Department			

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Patient Transport Providers	111	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & National	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
2015 Deep Dive																			
DD1	The organisation's Accountable Emergency Officer has taken the result of the 2016/17 EPRR assurance process and annual work plan to a public Board/Governing Body meeting for sign off within the last 12 months.	• The organisation has taken the LHRP agreed results of their 2016/17 NHS EPRR assurance process to a public Board meeting or Governing Body, within the last 12 months • The organisations can evidence that the 2016/17 NHS EPRR assurance results Board/Governing Body results have been presented via meeting minutes.	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Organisation's public Board/Governing Body report • Organisation's public website	The Core Standards spreadsheet and results along with the workplan were submitted to Integrated Governance Committee on 14/09/16 and then to Trust Board on 04/10/16 The EPRR annual report was submitted to Integrated Governance Committee on 24/07/17 and due to go to Trust Board on 05/09/17			
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report.	• There is evidence that the organisation has published their 2016/17 assurance process results in their Annual Report	Y	Y	Y	Y	Y	Y	Y			Y			Y	• Organisation's Annual Report • Organisation's public website	The results were not included in the annual report.	Reference the results from the core standards audit in future Annual Reports	EP&BC Manager	3/31/2018
DD3	The organisation has an identified, active Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio for the organisation.	• The organisation has an identified Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio. • The organisation has publicly identified the Non-executive Director/Governing Body Representative that holds the EPRR portfolio via their public website and annual report • The Non-executive Director/Governing Body Representative who formally holds the EPRR portfolio is a regular and active member of the Board/Governing Body • The organisation has a formal and established process for keeping the Non-executive Director/Governing Body Representative briefed on the progress of the EPRR work plan outside of Board/Governing Body meetings	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Organisation's Annual Report • Organisation's public Board/Governing Body report • Organisation's public website • Minutes of meetings	A report from the Emergency Preparedness Group is submitted to each Integrated Governance Committee (IGC) which meets every two months. IGC is a Trust Board sub committee and is chaired by a Non Executive Director who has agreed to be the active Non-executive Director who, following publication of governance deep dive, formally holds the EPRR portfolio for the organisation			
DD4	The organisation has an internal EPRR oversight/delivery group that oversees and drives the internal work of the EPRR function	• The organisation has an internal group that meets at least quarterly that agrees the EPRR work priorities and oversees the delivery of the organisation's EPRR function.	Y	Y	Y	Y	Y	Y	Y		Y	Y			Y	• Minutes of meetings	The Trust Emergency Preparedness Group is established and meets quarterly. Terms of Reference available.			
DD5	The organisation's Accountable Emergency Officer regularly attends the organisations internal EPRR oversight/delivery group	• The organisation's Accountable Emergency Officer is a regular attendee at the organisation's meeting that provides oversight to the delivery of the EPRR work program. • The organisation's Accountable Emergency Officer has attended at least 50% of these meetings within the last 12 months.	Y	Y	Y	Y	Y	Y	Y			Y			Y	• Minutes of meetings	The Trust Accountable Officer has delegated this responsibility to the Director of Nursing. The Director of Nursing reports to the Chief Nurse. This arrangement has been in place since June 2017 and will continue going forward.	The Director of Nursing will continue to chair the Emergency Preparedness Group, on behalf of the Chief Nurse. The Director of Nursing formally updates the Chief Nurse/EPRR Accountable Officer on at least a quarterly basis.	n/a	n/a
DD6	The organisation's Accountable Emergency Officer regularly attends the Local Health Resilience Partnership meetings	• The organisation's Accountable Emergency Officer is a regular attendee at Local Health Resilience Partnership meetings • The organisation's Accountable Emergency Officer has attended at least 75% of these meetings within the last 12 months.	Y	Y	Y	Y	Y	Y	Y	Y		Y			Y	• Minutes of meetings	The Trust Accountable Officer has delegated this responsibility to the Director of Nursing. The Director of Nursing reports to the Chief Nurse. This arrangement has been in place since June 2017 and will continue going forward.	The Director of Nursing will continue to attend the LHRP Strategic meetings and the Emergency Preparedness Manager will attend the practioner meetings. The Director of Nursing formally updates the Chief Nurse/ EPRR Accountable Officer on at least a quarterly basis.	n/a	n/a

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**				
	Preparedness					
53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	Arrangements include: • command and control interfaces • tried and tested process for activating the staff and equipment (inc. Step 1-2-3 Plus) • pre-determined decontamination locations and access to facilities • management and decontamination processes for contaminated patients and fatalities in line with the latest guidance • communications planning for public and other agencies • interoperability with other relevant agencies • access to national reserves / Pods • plan to maintain a cordon / access control • emergency / contingency arrangements for staff contamination • plans for the management of hazardous waste • stand-down procedures, including debriefing and the process of recovery and returning to (new) normal processes • contact details of key personnel and relevant partner agencies	There is a CBRNE/HAZmat plan, however, this requires refreshing and can be taken forward following appointment of ED EPRR Clinical Lead/HAZMAT trainer	The ED Emergency Preparedness Lead is in post from 21/08/17 and will refresh plan.	ED EPRR Clinical Lead	3/31/2018
54	Staff are able to access the organisation HAZMAT/ CBRN management plans.	Decontamination trained staff can access the plan	CBRNE/HAZMAT plan is available in Tactical Command Room			
55	HAZMAT/ CBRN decontamination risk assessments are in place which are appropriate to the organisation.	• Documented systems of work • List of required competencies • Impact assessment of CBRN decontamination on other key facilities • Arrangements for the management of hazardous waste	Dynamic Risk assessment is referenced in plan depending on the type of incident.			
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7.		Rotas need to be planned to ensure that there is adequate and appropriate decontamination capability available 24/7.	The ED emergency preparedness lead is in post from 21/08/17 and will review arrangements required going forward.	ED EPRR Clinical Lead	3/31/2018
57	Staff on-duty know who to contact to obtain specialist advice in relation to a HAZMAT/ CBRN incident and this specialist advice is available 24/7.	• For example PHE, emergency services.	This will be sourced via PHE and is referenced in the plan for staff to refer to			
	Decontamination Equipment					
58	There is an accurate inventory of equipment required for decontaminating patients in place and the organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff.	• Acute and Ambulance service providers - see Equipment checklist overleaf on separate tab • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf) • Initial Operating Response (IOR) DVD and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Equipment checklist completed			
59	The organisation has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required (NHS England published guidance (May 2014) or subsequent later guidance when applicable)	There is a plan and finance in place to revalidate (extend) or replace suits that are reaching the end of shelf life until full capability of the current model is reached in 2017				
60	There are routine checks carried out on the decontamination equipment including: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other decontamination equipment	There is a named role responsible for ensuring these checks take place	The Emergency Department clinical lead for EPRR carries out this role			

Hazardous materials (HAZMAT) and chemical, biological, radiolgocial and nuclear (CBRN) response core standards (NB this is designed as a stand alone sheet)			Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Q	**Core standard**	**Clarifying information**				
61	There is a preventative programme of maintenance (PPM) in place for the maintenance, repair, calibration and replacement of out of date Decontamination equipment for: A) Suits B) Tents C) Pump D) RAM GENE (radiation monitor) E) Other equipment					
62	There are effective disposal arrangements in place for PPE no longer required.	(NHS England published guidance (May 2014) or subsequent later guidance when applicable)	In line with NHS E guidance and clinical waste provider			
	Training					
63	The current HAZMAT/ CBRN Decontamination training lead is appropirately trained to deliver HAZMAT/ CBRN training		ED Clinical EPRR lead is the named officer who is appropriately trained			
64	Internal training is based upon current good practice and uses material that has been supplied as appropriate.	• Documented training programme • Primary Care HAZMAT/ CBRN guidance • Lead identified for training • Established system for refresher training so that staff that are HAZMAT/ CBRN decontamination trained receive refresher training within a reasonable time frame (annually). • A range of staff roles are trained in decontamination techniques • Include HAZMAT/ CBRN command and control training • Include ongoing fit testing programme in place for FFP3 masks to provide a 24/7 capacity and capability when caring for patients with a suspected or confirmed infectious respiratory virus • Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/	Now that the ED Clinical EPRR Lead is in post, this training programme will be re-established.	Provide 1 day CBRNE - HAZMAT Training	**ED EPRR Clinical Lead**	3/31/2018
65	The organisation has sufficient number of trained decontamination trainers to fully support its staff HAZMAT/ CBRN training programme.		ED Clinical EPRR lead is the named decontamination trainer and will be working towards training an additional 2 trainers			
66	Staff that are most likely to come into first contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	• Including, where appropriate, Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011) (found at: http://www.londonccn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf)	This is referenced in the CBRNE/HAZMAT plan			

HAZMAT CBRN equipment list - for use by Acute and Ambulance service providers in relation to Core Standard 43.

No	Equipment	Equipment model/ generation/ details etc.	Self assessment RAG Red = Not in place and not in the EPRR work plan to be in place within the next 12 months. Amber = Not in place and in the EPRR work plan to be in place within the next 12 months. Green = In place.
	EITHER: Inflatable mobile structure		
E1	Inflatable frame		N/A
E1.1	Liner		N/A
E1.2	Air inflator pump		N/A
E1.3	Repair kit		N/A
E1.2	Tethering equipment		N/A
	OR: Rigid/ cantilever structure		
E2	Tent shell		N/A
	OR: Built structure		
E3	Decontamination unit or room	Decontamination Shower Room	
	AND:		
E4	Lights (or way of illuminating decontamination area if dark)		
E5	Shower heads		
E6	Hose connectors and shower heads		
E7	Flooring appropriate to tent in use (with decontamination basin if needed)		
E8	Waste water pump and pipe		
E9	Waste water bladder		Waste water storage tank
	PPE for chemical, and biological incidents		
E10	The organisation (acute and ambulance providers only) has the expected number of PRPS suits (sealed and in date) available for immediate deployment should they be required. (NHS England published guidance (May 2014) or subsequent later guidance when applicable).		
E11	Providers to ensure that they hold enough training suits in order to facilitate their local training programme		Upon delivery of new CBRNE live suits, there will be sufficient training suits available
	Ancillary		
E12	A facility to provide privacy and dignity to patients		
E13	Buckets, sponges, cloths and blue roll		
E14	Decontamination liquid (COSHH compliant)		
E15	Entry control board (including clock)		
E16	A means to prevent contamination of the water supply		
E17	Poly boom (if required by local Fire and Rescue Service)		Not applicable
E18	Minimum of 20 x Disrobe packs or suitable equivalent (combination of sizes)		Not required
E19	Minimum of 20 x re-robe packs or suitable alternative (combination of sizes - to match disrobe packs)		Re-robe supplies available
E20	Waste bins		
	Disposable gloves		
E21	Scissors - for removing patient clothes but of sufficient calibre to execute an emergency PRPS suit disrobe		
E22	FFP3 masks		
E23	Cordon tape		
E24	Loud Hailer		
E25	Signage		This will be developed now ED clinical lead in post
E26	Tabbards identifying members of the decontamination team		
E27	Chemical Exposure Assessment Kits (ChEAKs) (via PHE): should an acute service provider be required to support PHE in the collection of samples for assisting in the public health risk assessment and response phase of an incident, PHE will contact the acute service provider to agree appropriate arrangements. A Standard Operating Procedure will be issued at the time to explain what is expected from the acute service provider staff. Acute service providers need to be in a position to provide this support.		Support will be provided as requested
	Radiation		
E28	RAM GENE monitors (x 2 per Emergency Department and/or HART team)		
E29	Hooded paper suits		
E30	Goggles		
E31	FFP3 Masks - for HART personnel only		
E32	Overshoes & Gloves		

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations have an MTFA capability at all times within their operational service area.	• Organisations have MTFA capability to the nationally agreed safe system of work standards defined within this service specification. • Organisations have MTFA capability to the nationally agreed interoperability standard defined within this service specification. • Organisations have taken sufficient steps to ensure their MTFA capability remains complaint with the National MTFA Standard Operating Procedures during local and national deployments.			Y													
2	Organisations have a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of MTFA staff to an incident requiring the MTFA capability.	• Deployment to the Home Office Model Response sites must be within 45 minutes.			Y													
3	Organisations have the ability to ensure that ten MTFA staff are released and available to respond to scene within 10 minutes of that confirmation (with a corresponding safe system of work).	• Organisations maintain a minimum of ten competent MTFA staff on duty at all times. Competence is denoted by the mandatory minimum training requirements identified in the MTFA capability matrix. • Organisations ensure that, as part of the selection process, any successful MTFA application must have undergone a Physical Competence Assessment (PCA) to the nationally agreed standard. • Organisations maintain the minimum level of training competence among all operational MTFA staff as defined by the national training standards. • Organisations ensure that each operational MTFA operative is competent to deliver the MTFA capability. • Organisations ensure that comprehensive training records are maintained for each member of MTFA staff. These records must include; a record of mandated training completed, when it was completed, any outstanding training or training due and an indication of the individual's level of competence across the MTFA skill sets.			Y													
4	Organisations ensure that appropriate personal equipment is available and maintained in accordance with the detailed specification in MTFA SOPs (Reference C).	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable. • All MTFA equipment is maintained to nationally specified standards and must be made available in line with the national MFTA 'notice to move' standard. • All MTFA equipment is maintained according to applicable British or EN standards and in line with manufacturers' recommendations.			Y													
5	Organisations maintain a local policy or procedure to ensure the effective identification of incidents or patients that may benefit from deployment of the MTFA capability.	• Organisations ensure that Control rooms are compliant with JOPs (Reference B). • With Trusts using Pathways or AMPDS, ensure that any potential MTFA incident is recognised by Trust specific arrangements.			Y													
6	Organisations have an appropriate revenue depreciation scheme on a 5-year cycle which is maintained locally to replace nationally specified MTFA equipment.				Y													
7	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any MTFA procedures, equipment or training that has been specified as nationally interoperable.				Y													
8	Organisations maintain an appropriate register of all MTFA safety critical assets.	• Assets are defined by their reference or inclusion within the National MTFA Standard Operating Procedures. • This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).			Y													
9	Organisations ensure their operational commanders are competent in the deployment and management of NHS MTFA resources at any live incident.				Y													
10	Organisations maintain accurate records of their compliance with the national MTFA response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
11	In any event that the organisations is unable to maintain the MTFA capability to the interoperability standards, that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
12	Organisations support the nationally specified system of recording MTFA activity which will include a local procedure to ensure MTFA staff update the national system with the required information following each live deployment.				Y													
13	Organisations ensure that the availability of MTFA capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
14	Organisations maintain a set of local MTFA risk assessments which are compliment with the national MTFA risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how MTFA staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
15	Organisations have a robust and timely process to report any lessons identified following an MTFA deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
16	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the MTFA service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
17	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for MTFA by NARU within 7 days.				Y													
18	FRS organisations that have an MTFA capability the ambulance service provider must provide training to this FRS	Training to include: • Introduction and understanding of NASMed triage • Haemorrhage control • Use of dressings and tourniquets • Patient positioning • Casualty Collection Point procedures.			Y													
19	Organisations ensure that staff view the appropriate NARU training and briefing DVDs	• National Strategic Guidance - KPI 100% Gold commanders. • Specialist Ambulance Service Response to MTFA - KPI 100% MTFA commanders and teams. • Non-Specialist Ambulance Service Response to MTFA - KPI 80% of operational staff.			Y													

	Core standard	Clarifying information	Acute healthcare providers	Specialist providers	Ambulance service providers	Community services providers	Mental healthcare providers	NHS England local teams	NHS England Regional & national	CCGs	CSUs (business continuity only)	Primary care (GP, community pharmacy)	Other NHS funded organisations	Evidence of assurance	Self assessment RAG Red = Not compliant with core standard and not in the EPRR work plan within the next 12 months. Amber = Not compliant but evidence of progress and in the EPRR work plan for the next 12 months. Green = fully compliant with core standard.	Action to be taken	Lead	Timescale
Governance																		
1	Organisations maintain a HART Incident Response Unit (IRU) capability at all times within their operational service area.	• Organisations maintain the four core HART capabilities to the nationally agreed safe system of work standards defined within this service specification. • Organisations maintain the four core HART capabilities to the nationally agreed interoperability standard defined within this service specification. • Organisations take sufficient steps to ensure their HART unit(s) remains complaint with the National HART Standard Operating Procedures during local and national deployments. • Organisations maintain the minimum level of training competence among all operational HART staff as defined by the national training standards for HART. • Organisations ensure that each operational HART operative is provided with no less than 37.5 hours protected training time every seven weeks. If designated training staff are used to augment the live HART team, they must receive the equivalent protected training hours within the seven week period (in other words, training hours can be converted to live hours providing they are re-scheduled as protected training hours within the seven week period). • Organisations ensure that all HART operational personnel are Paramedics with appropriate corresponding professional registration (note s.3.4.6 of the specification). • As part of the selection process, any successful HART applicant must have passed a Physical Competence Assessment (PCA) to the nationally agreed standard and the provider must ensure that standard is maintained through an ongoing PCA process which assesses operational staff every 6 months and any staff returning to duty after a period of absence exceeding 1 month. • Organisations ensure that comprehensive training records are maintained for each member of HART staff. These records must include; a record of mandated training completed, when it was completed. any outstanding training or training due and an indication of the individual's level of competence across the HART skill sets.			Y												
2	Organisaions maintain a HART Urban Search & Rescue (USAR) capability at all times within their operational service area.				Y													
3	Organisations maintain a HART Inland Water Operations (IWO) capability at all times within their operational service area.				Y													
4	Organisations maintain a HART Tactical Medicine Operations (TMO) capability at all times within their operational service area.				Y													
5	Organisations maintain a local policy or procedure to ensure the effective prioritisation and deployment (or redeployment) of HART staff to an incident requiring the HART capabilities.	• Four HART staff must be released and available to respond locally to any incident identified as potentially requiring HART capabilities within 15 minutes of the call being accepted by the provider. Note: This standard does not apply to pre-planned operations or occasions where HART is used to support wider operations. It only applies to calls where the information received by the provider indicates the potential for one of the four HART core capabilities to be required at the scene. See also standard 13. • Organisations maintain a minimum of six competent HART staff on duty for live deployments at all times. • Once HART capability is confirmed as being required at the scene (with a corresponding safe system of work) organisations can ensure that six HART staff are released and available to respond to scene within 10 minutes of that confirmation. The six includes the four already mobilised. • Organisations maintain a HART service capable of placing six competent HART staff on-scene at strategic sites of interest within 45 minutes. These sites are currently defined within the Home Office Model Response Plan (by region). Competence is denoted by the mandatory minimum training requirements identified in the HART capability matrix. • Organisations maintain any live (on-duty) HART teams under their control maintain a 30 minute 'notice to move' to respond to a mutual aid request outside of the host providers operational service area. An exception to this standard may be claimed if the live (on duty) HART team is already providing HART capabilities at an incident in region.			Y												
6	Organisations maintain a criteria or process to ensure the effective identification of incidents or patients at the point of receiving an emergency call that may benefit from the deployment of a HART capability.				Y													
7	Organisations ensure an appropriate capital and revenue depreciation scheme is maintained locally to replace nationally specified HART equipment.	• To procure interoperable safety critical equipment (as referenced in the National Standard Operating Procedures), organisations should have processes in place to use the national buying frameworks coordinated by NARU unless they can provide assurance through the change management process that the local procurement is interoperable.			Y													
8	Organisations use the NARU coordinated national change request process before reconfiguring (or changing) any HART procedures, equipment or training that has been specified as nationally interoperable.				Y													
9	Organisations ensure that the HART fleet and associated incident technology are maintained to nationally specified standards and must be made available in line with the national HART 'notice to move' standard.				Y													
10	Organisations ensure that all HART equipment is maintained according to applicable British or EN standards and in line with manufacturers recommendations.				Y													
11	Organisations maintain an appropriate register of all HART safety critical assets. Such assets are defined by their reference or inclusion within the National HART Standard Operating Procedures. This register must include; individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment).				Y													
12	Organisations ensure that a capital estate is provided for HART that meets the standards set out in the HART estate specification.				Y													
13	Organisations ensure their incident commanders are competent in the deployment and management of NHS HART resources at any live incident.				Y													
14	In any event that the provider is unable to maintain the four core HART capabilities to the interoperability standards,that provider has robust and timely mechanisms to make a notification to the National Ambulance Resilience Unit (NARU) on-call system. The provider must then also provide notification of the specification default in writing to their lead commissioners.				Y													
15	Organisations support the nationally specified system of recording HART activity which will include a local procedure to ensure HART staff update the national system with the required information following each live deployment.				Y													
16	Organisations maintain accurate records of their compliance with the national HART response time standards and make them available to their local lead commissioner, external regulators (including both NHS and the Health & Safety Executive) and NHS England (including NARU operating under an NHS England contract).				Y													
17	Organisations ensure that the availability of HART capabilities within their operational service area is notified nationally every 12 hours via a nominated national monitoring system coordinated by NARU.				Y													
18	Organisations maintain a set of local HART risk assessments which compliment the national HART risk assessments covering specific training venues or activity and pre-identified high risk sites. The provider must also ensure there is a local process / procedure to regulate how HART staff conduct a joint dynamic hazards assessment (JDHA) at any live deployment.				Y													
19	Organisations have a robust and timely process to reportany lessons identified following a HART deployment or training activity that may be relevant to the interoperable service to NARU within 12 weeks using a nationally approved lessons database.				Y													
20	Organisations have a robust and timely process to report, to NARU and their commissioners, any safety risks related to equipment, training or operational practice which may have an impact on the national interoperability of the HART service as soon as is practicable and no later than 7 days of the risk being identified.				Y													
21	Organisations have a proces to acknowledge and respond appropriately to any national safety notifications issued for HART by NARU within 7 days.				Y													

Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

Organisation: Alder Hey Children's NHS Foundation Trust

ACTIONS AND PROGRESS FROM 2016 / 2017

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
8	Evacuation Plan	Evacuation Plan requires update to consider secondary points of evacuation in the event of bomb threat	Continue with meetings to review arrangements update plan based on dynamic risk assessment	Identified that this would be based on dynamic risk assessment at the time, however, further consideration currently being given regarding arrangements for whole hospital evacuation – plan is under development, to be completed by March 2018.
8	Excess Deaths/Mass Fatalities	An additional area for holding bodies during excess deaths is currently being identified	Identify contingency area	Contingency area identified and agreed. Contingency plan detailing contingency arrangements to be developed.
23	Arrangements to ensure the ability to communicate internally and externally during communication equipment failures	Telephone-bleep system resilience needs to be clear with business continuity action cards available, long with sufficient resilience in place if telephones/ bleeps lost	Complete contingency action cards for telephone and bleep failure. Meet with key Executives regarding requirement for radios in event of communications failure	Complete
41/50	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7. The organisation has sufficient number of trained decontamination trainers to fully support its staffs HAZMAT/ CBRN training programme	New ED lead for Emergency planning to be identified (due to retirement). ED Lead was also a HAZMAT/CBRNE Trainer.	Appoint new ED lead and then take action to provide training to staff to allow decontamination capability. ED to identify additional HAZMAT/CBRNE trainers and organise attendance at the NWAS course, following in house training from Trust trainer.	The ED EPRR Clinical lead for Emergency Planning is in post from 21/08/17 (9.75 hrs per week) and one of their roles will be to review 24/7 decontamination capability. The ED EPRR Clinical Lead is also the trained decontamination trainer for the Trust.

Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Update on progress since last year
DD5	Fuel Plan	Update fuel plan to include reference to heating fuel	Reference heating fuel in the Fuel Plan	Complete

Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

ACTIONS ARISING FROM 2017 / 2018 ASSURANCE PROCESS

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
10/53	There is an organisation specific HAZMAT/ CBRN plan (or dedicated annex)	There is an organisation CBRNE/HAZMAT plan, however, due to the ED EPRR Clinical Lead only just being appointed, the plan requires update/refresh	Update/refresh CBRNE/HAZMAT plan Action Lead: ED EPRR Clinical Lead	31/03/18
31	Those on-call must meet identified competencies and key knowledge and skills for staff.	Whilst on call staff receive local major incident and business continuity training, this will be developed further to ensure the training meets the National Occupational Standards for Strategic, Tactical and Operational Staff.	Develop core competency checklist for strategic, tactical and operational staff, in line with National Occupational Standards.	31/03/18
56	Rotas are planned to ensure that there is adequate and appropriate decontamination capability available 24/7	Review of rotas to ensure decontamination capability 24/7	ED EPRR Clinical Lead is in post from 21/08/17 (9.75 hrs per week). Rotas will be reviewed this year in liaison with ED Manager	31/03/18
64	Internal HAZMAT/CBRNE training is based upon current good practice and uses material that has been supplied as appropriate	The HAZMAT/CBRNE one day training programme needs to be re-introduced.	ED EPRR Clinical Lead is in post from 21/08/17 (9.75 hrs per week) and will re-establish 1 day HAZMAT/CBRNE training for staff.	31/03/18

Cheshire & Merseyside EPRR Core Standards Improvement Plan 2017-18

Actions arising from Governance Deep Dive Standard (these actions aren't included as part of the main Core Standards Assessment, but will be taken forward):

Core standard reference	Core standard description	Improvement required to achieve compliance	Action to deliver improvement	Deadline
DD2	The organisation has published the results of the 2016/17 NHS EPRR assurance process in their annual report	Publish the results of future EPRR assurance processes in the Emergency Preparedness Annual Report	Publish the results of the 17/18 NHS EPRR assurance process in the 17/18 Annual Report	31/03/18

Cheshire & Merseyside Local Health Resilience Partnership (LHRP)
Emergency Preparedness, Resilience and Response (EPRR) assurance 2017-2018

STATEMENT OF COMPLIANCE

Alder Hey Children's NHS Foundation Trust has undertaken a self-assessment against required areas of the the NHS England Core Standards for EPRR v5.0.

Following assessment, the organisation has been self-assessed as demonstrating the Substantial compliance level (from the four options in the table below) against the core standards.

Compliance Level	Evaluation and Testing Conclusion
Full	Arrangements are in place and the organisation is fully compliant with all core standards that the organisation is expected to achieve. The Board has agreed with this position statement.
Substantial	Arrangements are in place however the organisation is not fully compliant with one to five of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Partial	Arrangements are in place however the organisation is not fully compliant with six to ten of the core standards that the organisation is expected to achieve. A work plan is in place that the Board or Governing Body has agreed.
Non-compliant	Arrangements in place do not appropriately address 11 or more core standards that the organisation is expected to achieve. A work plan has been agreed by the Board or Governing Body and will be monitored on a quarterly basis in order to demonstrate future compliance.

The results of the self-assessment were as follows:

Number of applicable standards	Standards rated as **Red**	Standards rated as **Amber**	Standards rated as **Green**
60	0	4	56
Acute providers: **60**** Specialist providers: **51**** Community providers: **50**** Mental health providers:**48**** CCGs: **38**			

Also includes **HAZMAT/CBRN standards** applicable to providers: **Standards:** Acutes **14** / Specialist, Community, Mental health **7
Ambulance Service are required to report statements for 3 compliance levels as stated on page 6 of the Gateway letter 06967

Where areas require further action, this is detailed in the attached core standards improvement plan and will be reviewed in line with the organisation's EPRR governance arrangements.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board / governing body along with the enclosed action plan and governance deep dive responses.

_____

Signed by the organisation's Accountable Emergency Officer

_____ _____

Date of board / governing body meeting Date signed

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

3rd October 2017

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for August 2017
Background Papers:	n/a
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	The Committee is asked to note the contents of the report.
Link to: **Trust's Strategic Direction Strategic Objectives**	The Best People Doing their Best Work
Resource Impact:	None

Section 1 - Engagement

Reward & Recognition

In response to the monthly Star Awards, 122 nominations were received during August. The winner was voted for by the panel (comprising a range of staff and staff side) and arrangements are being made for presentation by an Executive Director in early October. Nominations for September will be reviewed in October.

The annual staff awards will be launched at the beginning of October. Co-ordination is in progress, with categories identified and a separate independent judging panel to that on the monthly awards. The evening ceremony will be held in February 2018.

'Fab Change Week' in late October will be celebrated through a number of different staff engagement initiatives, and is being led by the LiA 'Reward and Recognition' group.

Staff Survey

The 2017 Staff Survey campaign was launched on 22nd September. The staff survey strategy group have developed a Trust wide communication program aimed at managers to promote and engage staff to complete the survey. The program includes face to face meetings with managers to promote survey completion; a pocket guide for managers with reminders about previous actions "you said…we did.." plus weekly statistics on departmental response rates. The strategy group will meet weekly throughout the survey timeline, until 1st December to support the on-going campaign, and will review the results early 2018, to inform future Trust wide and local conversations and action plans.

Section 2 - Availability of key skills

Employee Consultations

Trust Nursery

The recent Nursery consultation has concluded with one facilities post at risk. The post holder has been found a redeployment post and is currently undertaking a 4 week trial.

Hotel Services

Domestics and Portering staff (Portering and Portering Supervisors) organisational change programmes were initiated on 9 June 2017 which consisted of proposed reductions of staff (Portering Supervisors) and review of shift patterns/rotas in the other groups. The three consultations were due to conclude on 24 July 2017. A number of issues were raised by staff and staffside during the consultation in each of the staffing groups and further investigation is being undertaken by management requiring an extension to each of the consultations until 25th August 2017. A review meeting was undertaken on 8th September 2017 with key management stakeholders and union representatives to agree deliverables. The consultation period was extended to 30th September 2017 with further management/union meetings to be scheduled in early October 2017

Home Care Service – Community Division

An Organisational Change is in progress within the Home Care team for the following reasons: natural expiry of packages, progression of packages into adult services and having no further expansion of packages within the service since Nov 2016 commissioned by the CCG. This has resulted in seven Band 3 HCA staff being effected as displaced, four of whom area already displaced and are working temporarily within the Trust covering for agency, bank etc. These staff have been placed on the Trust's redeployment register and it is hoped that suitable alternative positions can be sort. A briefing paper has been submitted to Staff Side and signed off by Senior Management and formal consultations are in progress.

Formal consultation has been concluded with no additional comments from either staff or staff side, the final consultation paper is pending official sign off. In the duration, all staff affected have been allocated alternatives roles and are either currently undertaking trails or have completed and been accepted. One individual has been since identified as requiring further information before Home Care Organisation can be concluded.

C**omplex Care Team**

Organisational change process for services which were formally LCH, and are the same as Alder Hey Home Care Team affecting two individuals as a result of expiry of packages. Briefing paper completed and invite to consultation have been instigated.

Education, Learning and Development

Apprenticeships

The first cohort of internally delivered apprenticeship qualifications for our existing staff will commence in October 2017 with Healthcare Support and Team Leading. We have over 30 staff currently enrolled. Work is still ongoing to develop this qualification portfolio further with Blackburne House as a support to ensure the apprenticeship strategy remains on track. We are also supporting Liverpool Community Health with their apprenticeship planning.

Management & Leadership Development

A detailed paper has been presented to the Workforce and OD Committee with regards progress against the strategy, however for the purposes of this report, a brief overview of activity over the last 12 months is below:

- Delivery of Work based Coaching training (11 managers)
- Leading by Values programme (2 cohorts – 23 managers)
- New Managers Induction (34 since April 17)
- 360 degree feedback facilitation
- Individual coaching sessions

All activities have been rates highly by participants. September and October sees the roll out of the HR Management Skills programme, Team Leader apprenticeships and planning for the next work-based coaching programme.

Widening Participation

Schools Placement Support Programme

To date in 2016/17, 60 BTEC Health and Social Care students from local schools have completed a two week placement programme at Alder Hey. In September 2017, we have organised another induction and have 65 students attending who will commence their placement in October. The programme is very successful, with a number of students securing a place at Edge Hill or John Moores universities to study for degrees in Children's Nursing/Learning Disabilities/Child Studies/Child Health and Wellbeing/Social Work. The universities guarantee the students an interview if they have completed a placement at Alder Hey as they see this as valuable experience.

Pre-employment Programme

The Trust is working in partnership with Job Centre Plus, and we are now participating in various schemes which will allow us to develop a "grow our own "strategy. We have recently recruited 10 unemployed local people to participate in a pre-employment programme which consists of 1 week induction and 9 weeks work experienced based learning. Following the 10 weeks all learners who have successfully completed the program will be given the opportunity to apply for internal vacancies and join our bank.

Careers Events

Alder Hey hosted a careers event which was attended by 15 Year 10 students from a local school in June 2017. During the event the pupils were given the opportunity to listen to speakers from different professions describing their own personal career experiences and achievements. The students were also allowed to spend some time in our innovation hub learning about our 3D printing technology and attended basic life support session.

Alder Hey has signed up to collaborate with Merseyside Health Sector Career & Engagement Hub and Health Education England to enable strong links in the community and promote Alder Hey as an employer of choice. Human Resources and leads from our clinical areas will be attending a careers event on Tuesday 28th November based at the Titanic Hotel which will be co-ordinated by the Merseyside Health Sector Career & Engagement Hub. We will be promoting Ophthalmology, Theatres, and Radiology careers to year 10 pupils from several local schools.

We have also attended a number of high profile recruitment events, such as the RCN Jobs Fair at the Liverpool Echo Arena.

Section 3 - Structure & Systems

Employee Relations Activity

By the end of August the Trusts ER activity remains at 18 cases. These are 2 formal disciplinary cases, 4 formal Bullying and Harassment cases (2 cases have moved to informal mediation stages), 5 formal grievances, and 3 Employment Tribunal (ET) cases. In addition there are 2 final absence dismissal cases and 2 formal capability cases.

The senior HR team recently held an 'HR Case Summit' to review all cases and to look at best practice in case management. The summit demonstrated that we are managing all cases robustly, however the team will be introducing a 'lessons learned' session, in order to support more junior members of the HR team to increase their case management knowledge.

Employment Tribunal Cases

- The ET Claim relating to unfair dismissal and wrongful dismissal, due to be heard on 30th and 31st August was postponed at the Trusts request on compassionate leave grounds, has been rescheduled for 7th, 8th and 9th February 2018.

- An ET Claim relating to unlawful deduction of wages and breaches of the Agency Workers Regulations due to be heard on 7 and 8 June 2017 was postponed to allow for inclusion of an additional respondent. The Tribunal hearing is now scheduled to take place between 6th to 8th December 2017

- An ET claim relating to constructive / unfair dismissal and disability discrimination has been lodged. A pre-hearing was held in August and the case will be heard at Tribunal on 26th 27th 28th Feb and 1st March.

Corporate Report

The HR KPIs in the July Corporate Report are:

- Sickness has increased slightly to 5%
- Corporate Induction has increased to 100% compliance
- PDR compliance has increased to 79%
- Mandatory training compliance has remained the same at 76%

Actions to address shortfalls are being addressed by members of the HR & L&D team with the CBU management teams. Ongoing ESR training and support has been provided to managers by the HR Team to ensure accuracy in recording.

Payroll Key Performance Indicators

We are achieving the KPI of 99.5% payroll accuracy, and have done so now for the past three months. This has been achieved through good partnership working with our payroll provider, ELFS, and through increased training, support and focus for managers who were generating the majority of the errors.

Workforce Sustainability Group

A task and finish group has recently been set up to focus on improving spend on temporary staffing. This working group reports through the Change Programme. To date, the group have identified some quick wins in the top 20 areas for pay overspend, but are now looking at more detailed work around reasons for overspend, and the impact upon workforce resilience and sustainability.

NHS Professionals (NHSP)

NHSP are the Trust's provider of bank staff and flexible workers. Comparing Alder Hey Bank performance in August to the National & Northwest average statistics for the same period demonstrate very positive results, as Alder Hey has by far the highest Bank fill & lowest

Agency Fill compared to both the North West & National statistics, using only 0.2 WTE agency in August (nursing).

Enhancements to ESR

The HR team have been continuing to work on developments in ESR and the roll out of the ESR portal is progressing well- 1734 paper payslips went electronic by August payday.

The training on the ESR app has been well received and bespoke sessions have also been held across departments. Step by step guides have also been provided to managers and staff with many opting to follow the guides as opposed to full training, as they have found it very easy to access and use. To date the app and process has been well received amongst managers and staff. Further roll out of the portal and Manager Self Service will provide managers with a more user friendly platform for accessing their workforce data.

The Trust has also been undertaking a comprehensive data cleanse of 'position based competencies' and their alignment to job roles. As a result of this a full training matrix was revised to ensure that that the appropriate competences are aligned to positions correctly, which has now been captured in ESR. This has enabled the HR &OD team to run more accurate reports through BI.

Section 4 - Health & Wellbeing

Team Prevent

A Health Trainer is now working with the Trust providing stress management and relaxation/mindfulness training. These sessions have proved popular and will be scheduled and promoted accordingly. A session is being planned for management training in respect of how to recognise signs of stress with strategies on how to manage it. Further to the stress management sessions, the health trainer has confidentially supported a number of staff with stress symptoms to help them avoid absence from work where possible. The health trainer is working closely with theatres management team to consider a program of support for staff who may have experienced stress at work or signs of PTSD.

National Guardian

Freedom to Speak Up

Freedom to Speak Up Guardian Survey 2017

Findings and recommendations

The National Guardian's Office

Introduction

The requirement for trusts and foundation trusts to have a Freedom to Speak Up Guardian has been in place since October 2016, just as I took up post as National Guardian.

The National Guardian's Office set out its expectations about the role early on but I have been struck by the wide range of approaches that organisations have taken in implementing the role. This survey has given us the first opportunity to quantify some of this variation.

Enabling organisations to implement the role in a way that is right for them is important as no two organisations are the same. The new role allows for it to be integrated into the priorities of individual trusts. The diverse occupations and professional backgrounds of those in the guardian or champion / ambassador role has also proven to be a great source of strength. We have built up a unique network of individuals where traditional barriers between grade and profession simply do not exist and where everyone can draw upon the experience and expertise of everyone else. I am proud to lead this network and see it as a potentially powerful force for change and a source of skill, commitment, and knowledge that I hope others in and around the healthcare system can draw upon.

Consistency in approach does, however, have a part to play. I want everyone working in the health system to know that they can go to a Freedom to Speak Up Guardian for support and advice about speaking up and for their expectations to be met, no matter which organisation they are in. Some of the recommendations in this report therefore focus on ensuring that, amongst all the variation, a consistent core to the guardian role is maintained.

The guardian role is not an easy one. Our expectations are high and broad and, as patient safety and staff wellbeing are at its heart, we believe that it is a role in which it is well worth investing. Investment includes support and guardians need the support and commitment of their senior leaders to do their job and sufficient time to be reactive and proactive in culture change. The recommendations, drawn from the experience of guardians will enable trusts and foundation trusts to ensure that this role will meet the needs of all their staff.

I hope that senior leaders, guardians, champions, ambassadors and all those with an interest in speaking up will welcome this report. It is an honest reflection of how this new role is developing at the start of the Freedom to Speak Up journey, and I look forward to repeating this exercise next year to see how the recommendations have been implemented.

Dr Henrietta Hughes, National Guardian for the NHS

Background and summary

The development of the Freedom to Speak Up Guardian role was a recommendation made by Sir Robert Francis in "Freedom to Speak Up" in 2015. The standard NHS contract requires all trusts and foundation trusts to nominate a Freedom to Speak Up Guardian by October 2016.

Guidance on the role including a job description was issued by the National Guardian's Office, initially in April 2016, with a revised form being issued in June 2016. Support was given to guardians and trusts throughout 2016 /17, including foundation training and the development of regional networks to promote local learning and sharing of good practice.

Whilst the overall requirements of the role have been published, the role is not centrally funded, with trusts being expected to implement the role according to local need and resources. As this is a new initiative, and one that requires a broad range of skills and qualities, up until this point the National Guardian's Office has not issued detailed guidance on the grading of the role, where the role should fit in within organisational structures, or how the role should be resourced.

This survey is intended to provide a more systematic understanding of how the role has been implemented, who is being appointed to the role and, for the first time, ask the new network of guardians for their thoughts on Freedom to Speak Up within their trusts.

Ensuring that the needs of staff are met and that Freedom to Speak Up develops in a way that responds to local circumstances, are fundamental principles of the role. The results of this survey have helped identify some potential issues. These are highlighted and trust and foundation trust leadership teams are encouraged to reflect on these and, where necessary, make changes to ensure that the guardian role is properly resourced, embedded and used as the source of support, learning and improvement that it is intended to be.

The questions included in the survey can be found in the **Annex** to this report**.** These are divided into broad groups looking at how the guardian role has been implemented, who is in the role, and perceptions of Freedom to Speak Up. Respondents were also asked to consider what support they felt they needed from the National Guardian's Office and for examples of success and challenges that they face.

The survey was distributed to 493 email addresses and was open between 12 June and 30 June 2017. A total of 234 responses were received (a 47% response rate).

Key findings and recommendations (1-4)

#	AREA	RECOMMENDATION
1.	**Appointment**	We recommend that appointment of guardians is made in a fair and open way, and that senior leaders assure themselves that workers throughout their organisation have confidence in the integrity and independence of the appointee.
2.	**Potential conflicts of interest**	We recommend that all guardians / ambassadors / champions reflect on the potential conflicts that holding an additional role could bring and that they devise mechanisms to ensure that there are alternative routes for Freedom to Speak Up matters to be progressed should a conflict become apparent when supporting someone who is speaking up. We see particular potential for conflicts to arise where a guardian also has a role as a human resources professional and recommend that guardians do not have a role in any aspect of staff performance or human resources investigations.
3	**Local networks**	We recommend that all trusts consider developing a local network of ambassadors / champions, depending on local need, to help provide assurance that all workers have appropriate support and opportunities to speak up, and to give guardians alternative routes to pursue speaking up matters should they be faced with a real or perceived conflict. Members of a local network could also cover the guardian role when the guardian is absent, on leave etc.
4	**Diversity**	We recommend that all trusts take action to ensure that all workers, irrespective of their ethnicity, age, sexuality or other diversity characteristics, have someone they feel able to go to for support in speaking up. Guardians should consult with relevant representative groups in developing their approach on this matter. Guardians should also take action to assure themselves that any potential barriers to speaking up that particular groups face are understood and tackled.

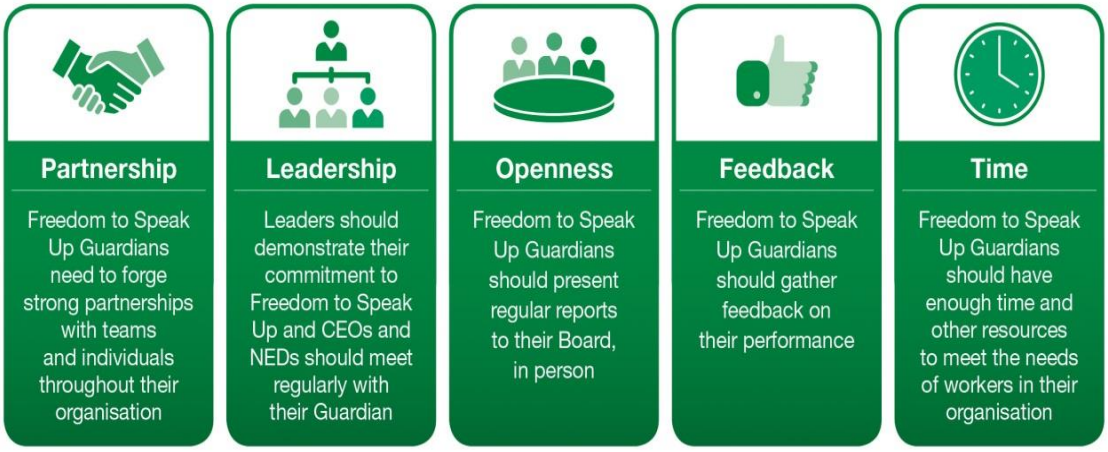
Key findings and recommendations (5-10)

#	AREA	RECOMMENDATION
5	**Communication and training**	We recommend that all guardians use all appropriate communication channels to ensure that all staff know of their role, and work with colleagues to ensure that Freedom to Speak Up is incorporated in all relevant staff training and development programmes, and particularly in staff inductions. In conjunction with the relevant parts of their organisation, guardians should monitor the effectiveness of their communication and training activities. Guardians should ensure that the language and message of communications and training are consistent with national guidance.
6	**Partnership**	We recommend that all guardians continue to develop working partnerships with all relevant parts of their organisation.
7	**Access to senior leadership**	We recommend that all guardians have direct and regular access to their chief executive and non-executive director with responsibility for speaking up.
8	**Board reporting**	We recommend that guardians or a representative from a local network of champions / ambassadors personally presents regular reports to their board. Board reports should include measures of activity and impact and, where possible, include 'case studies' describing real examples of speaking up that guardians are handling.
9	**Feedback**	We recommend that guardians always gather feedback on their performance, from their line managers, the partners they work with, and from those they are supporting.
10	**Time**	We strongly recommend that all trusts provide ring-fenced time for anyone appointed as a guardian / ambassador / champion to carry out their role and attend training, regional and national network meetings, and other events.

Freedom to Speak Up Guardian Survey 2017

10 principles for the role.

These principles are derived from the findings of our 2017 Freedom to Speak Up Guardian Survey.



Detailed findings and discussion

1. How the Freedom to Speak Up Guardian role has been implemented

Appointment to the role

At the time of the survey, the requirement to have nominated a guardian had been in effect for nine months, though we know that many trusts had taken early action in response to the Francis recommendations. It is not surprising, therefore, to note that **59%** of respondents had been in post for over 6 months, with **17%** being in post for 18 months or longer.

We asked how individuals were appointed to the guardian / champion / ambassador role. **60%** of respondents had been personally approached, volunteered, or were nominated. Whilst **56%** of this group were also interviewed as part of the process, this illustrates the 'personal' nature of many of the appointments.

The guardian role is one that requires a high degree of personal integrity, and the individual in the role needs to work alongside senior leaders whilst also capturing the confidence of staff throughout the organisation. In addition, the person needs to be able to act independently and under their own initiative. Given this, we see potential difficulties if appointments are made to the role without a transparent, fair and open process and we would always recommend that appointments are made in this way. To give further confidence that appointees have the confidence of workers, we know of some trusts where the appointment process has incorporated staff elections, values based recruitment, and other elements where staff representatives can be involved in the process.

#1. Appointment
We recommend that appointment of guardians is made in a fair and open way and that senior leaders assure themselves that workers throughout their organisation have confidence in the integrity and independence of the appointee

The survey did not specifically address the appointment of Freedom to Speak Up ambassadors / champions who usually play a supporting role to the guardian and who are often employed to increase the 'reach' of Freedom to Speak Up across a trust. Whilst appointments to these roles clearly need to meet local needs we would encourage them to be made upholding the same principles we recommend in relation to the appointment of guardians.

Who is in the role?

The vast majority of respondents (**84%**) indicated that they held another role alongside that of guardian or champion / ambassador. This 'other' role includes a broad range of clinical and non-clinical roles (table 1.1).

1.1 Other role	% respondents
Nurse	23%
Corporate Services	18%
Allied Healthcare Professional	11%
Administrative / clerical	7%
Human Resources	6%
Organisational Development	6%
Governor	6%
Doctor	5%
Safety	4%
Midwife	2%
Chaplaincy	2%
Healthcare Assistant	1%
Therapist	1%
Maintenance / ancillary	0.5%
Other*	28%

*responses include: company secretary, adult safeguarding lead, front of house manager, non-executive director, IT director, oral health promoter, listening into action lead, staff side chair

We think that this variety brings richness to the network of guardians and ensures that there is a wide range of peer-support available for guardians. This diversity brings a broad breadth of knowledge, insight and experience to bear on the guardian role, which will help ensure that it continues to develop to reflect the needs of all NHS workers.

However, carrying out two (or more) roles does not come without its challenges, both in terms of ensuring that enough time is given to the guardian role, and in managing potential conflicts of interest and perceptions of the ability of a guardian to act independently.

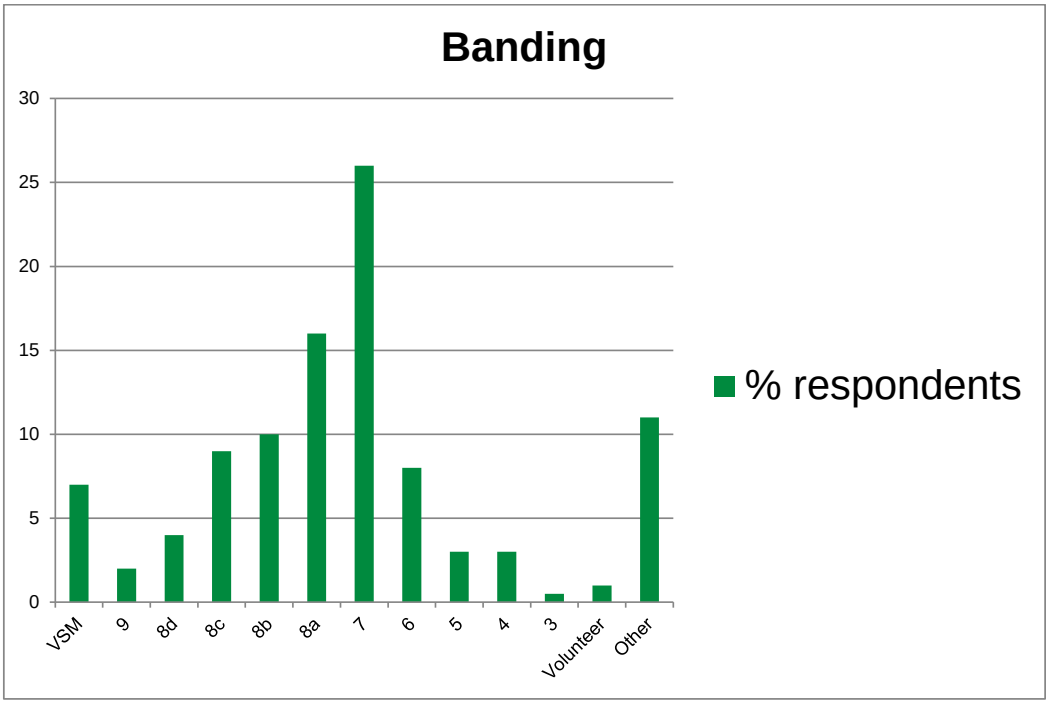
#2. Potential conflicts of interest

We recommend that all guardians / ambassadors / champions reflect on the potential conflicts that holding an additional role could bring and that they devise mechanisms to ensure that there are alternative routes for Freedom to Speak Up matters to be progressed should a conflict become apparent when supporting someone who is speaking up. We see particular potential for conflicts to arise where a guardian also has a role as an HR professional and recommend that guardians do not have a role in any aspect of staff performance or HR investigations.

The development of a local network of ambassadors / champions can help provide alternative routes to avoid conflict when a speaking up matter is being pursued, whilst also increasing 'reach' across larger or widely dispersed organisations. A network can also provide a diverse range of individuals for staff to seek support from. It is encouraging to see that **63%** of respondents said that they were part of a local network of this type.

#3. Local networks
We recommend that all trusts consider developing a local network of ambassadors / champions, depending on local need, to help provide assurance that all workers have appropriate support and opportunities to speak up, and to give guardians alternative routes to pursue speaking up matters should they be faced with a real or perceived conflict. Members of a local network could also cover the guardian role when the guardian is absent, on leave etc.

As with professional background, a similarly broad range of grading / band is also represented within the guardian network (see below)



1.2 Band / grade	% respondents
Very Senior Manager	7%
9	2%
8d	4%
8c	9%
8b	10%
8a	16%
7	26%
6	8%
5	3%
4	3%
3	0.5%
Volunteer	1%
Other*	11%

*responses include: non-executive director and independent / self-employed role

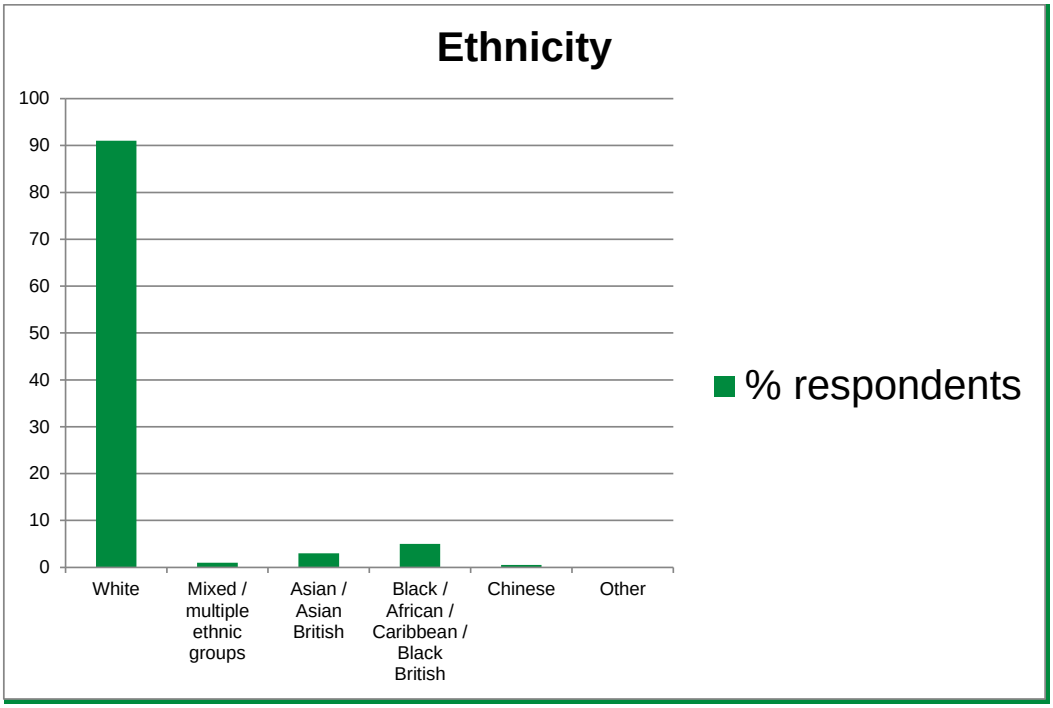
The guardian role is a broad one that requires reach and credibility from the frontline to the board and, most importantly, the ability to support, encourage, and capture the trust of any worker within an organisation (table 1.2). Given that, we see this wide range of banding as a strength. However, we do appreciate that it may be more difficult for individuals in lower banded roles to gain the confidence of, and challenge, senior leaders. Similarly, those in higher banded roles may be faced with barriers that being further up the 'hierarchy' can bring when trying to capture the trust and confidence of staff at lower grades. Nevertheless, we are reassured by the experiences of our guardians and those who are speaking up to them that these barriers are being overcome.

We continue to believe that appointments to a guardian role need to have the personal qualities of individuals front and centre, rather than focussing on banding. However, when this area is being considered we would encourage trusts to look at the job description in the round and ensure that whoever is in the role is appropriately rewarded for their work.

Building on this, it is clearly helpful if guardians have experience of speaking up themselves, and we note with interest that **42%** of respondents said that they had. Respondents provided us with a wide range of examples illustrating their experience, these included matters of abuse in a residential care setting, unsafe staffing levels, staff being pressurised to make decisions outside their area of competence, lack of support for vulnerable groups, challenging decisions made by senior leaders, fraud, and reports of bullying behaviour amongst senior colleagues.

It is essential that all workers in an organisation feel able to speak up and able to access the support of a guardian / ambassador / champion should they need it. To do this, they need to be able to turn to someone whom they can trust. We therefore note with interest the demographic profile of respondents to the survey.

91% of respondents are white (table 1.3), **79%** are women (table 1.4), **44%** are between 45 – 54 years old (table 1.5), **91%** did not consider themselves to have a disability (table 1.6), and **88%** are straight / heterosexual (table 1.7).



1.3 Ethnicity	% respondents
White	91%
Mixed / multiple ethnic groups	1%
Asian / Asian British	3%
Black / African / Caribbean / Black British	5%
Chinese	0.5%
Other	0%

1.4 Gender	% respondents
Male	20%
Female	79%
Prefer not to say	1%

1.5 Age	% respondents
16 – 34	6%
35 – 44	24%
45 – 54	44%
55+	24%
Prefer not to say	2%

1.6 Response to the question "Do you consider yourself to have a disability?"	% respondents
Yes	6%
No	91%
Prefer not to say	3%

1.7 Sexuality	% respondents
Bisexual	1%
Gay man	4%
Gay woman / lesbian	0.5%
Heterosexual / straight	88%
Prefer not to say	7%

Whilst none of these factors should present a barrier to workers speaking up to guardians, we are aware that they may do so for some and therefore recommend that all trusts take action to assure themselves that all staff have a range of individuals they can go to for support in speaking up, including individuals of differing diversity characteristics. We would also encourage guardians to forge close working partnerships with staff diversity networks and consider recruiting and training members of these groups as champions / ambassadors, or developing some other means of partnership working so that the trust has the assurance that all workers feel supported and able to speak up.

#4. Diversity
We recommend that all trusts take action to ensure that all workers, irrespective of their ethnicity, age, sexuality or other diversity characteristics, have someone they feel able to go to for support in speaking up. Guardians should consult with relevant representative groups in developing their approach on this matter. Guardians should also take action to assure themselves that any potential barriers to speaking up that particular groups face are understood and tackled.

2. Freedom to Speak Up Guardian activities

In addition to one-to-one support for people speaking up, guardians are engaged in a wide range of communication and engagement activities

2.1 Activity	% respondents
Communication of role internally	88%
Communication of role externally	11%
Involvement in staff induction	62%
Involvement in other staff training	52%
Attending team meetings	65%
Carrying out surveys	16%
Other*	25%

*responses include: developing steering and other working groups, back-to-floor visits, attending out-of-hours services, taking part in leadership programmes

A wide range of partnerships are also being forged

2.2 Partnership	% respondents
Senior leaders / the Board	83%
HR	82%
Organisational Development teams / similar	50%
Communications teams	73%
Training and Development teams	49%
Unions / staff-side	54%
Staff diversity networks	36%
Patient representative groups	18%
Internal Audit	15%
Other*	15%

*responses include: patient experience teams, safety and quality teams, occupational health, information governance and guardians in other trusts

We think this broad range of activities (table 2.1), and developing partnership working (table 2.2), is encouraging. We would advocate that all guardians continue to communicate their role, work with colleagues to ensure that Freedom to Speak Up messages are incorporated into staff training and development programmes (particularly staff inductions), and continue to forge working relationships throughout their organisation.

#5. Communication and training
We recommend that all guardians use all appropriate communication channels to ensure that all staff know of their role, and work with colleagues to ensure that Freedom to Speak Up is incorporated in all relevant staff training and development programmes, and particularly in staff inductions. In conjunction with the relevant parts of their organisation, guardians should monitor the effectiveness of their communication and training activities. Guardians should ensure that the language and message of communications and training are consistent with national guidance.

#6. Partnership

We recommend that all guardians continue to develop working partnerships with all relevant parts of their organisation.

The relationships between a guardian and their chief executive and non-executive director with responsibility for speaking up are particularly important ones. A guardian needs to support their senior leaders in creating a culture where speaking up can flourish whilst also maintaining their independence to enable confidential investigations to happen and, if appropriate, to step outside of their organisation's leadership altogether. We are therefore pleased to note that **86%** of respondents said that they had direct access to their chief executive (with **14%** saying that they did not), and **76%** of respondents said that they have direct access to their non-executive director with responsibility for speaking up (with **24%** saying that they did not). We believe, however, that all guardians should have this direct access.

#7. Access to senior leadership

We recommend that all guardians have direct and regular access to their chief executive and non-executive director with responsibility for speaking up.

Boards need to be kept abreast of all matters related to speaking up. This encompasses being sighted on both the issues being raised, and apparent barriers to speaking up. Board members also need to model speaking up behaviours, demonstrate their responsiveness and, in particular, provide feedback so that people who are speaking up are assured that they are being listened to and that action is being taken. In addition, so that Freedom to Speak Up messages can be taken to the board in an unfettered manner, and so that the independence of a guardian can be seen in practice, we believe it is important that guardians present regular reports to their board in person. We are therefore disappointed to note that only **55%** of respondents said that they present reports to board meetings in person.

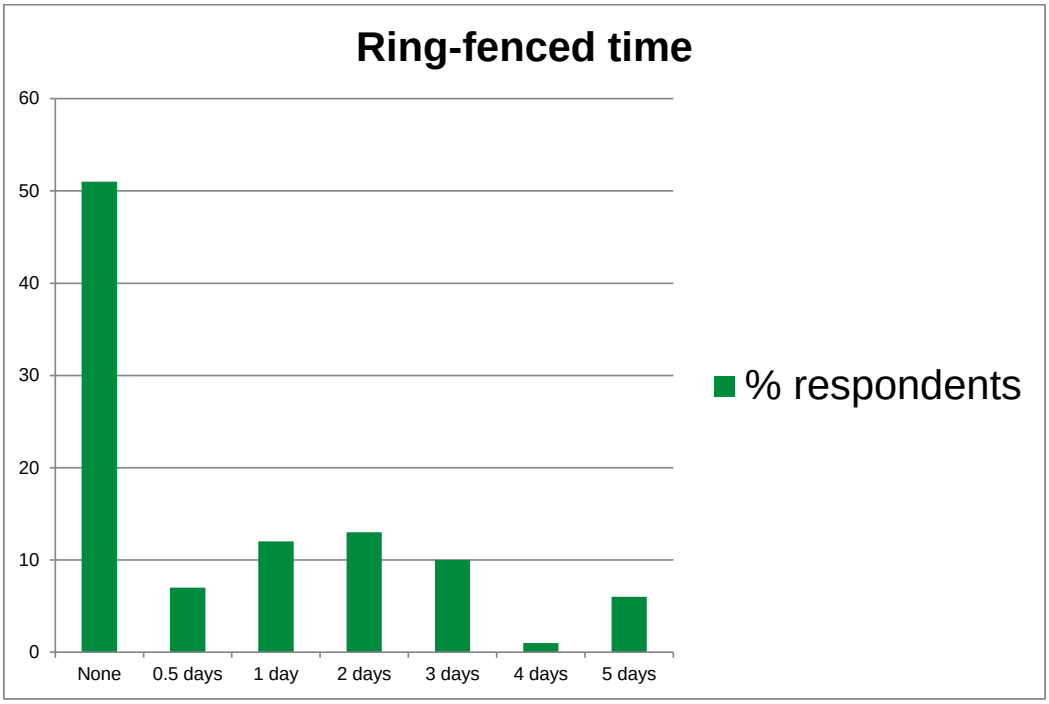
#8. Board reporting
We recommend that guardians or a representative from a local network of champions / ambassadors personally presents regular reports to their board.

Asking for, receiving, and acting on feedback is a central aspect of an effective speaking up process with a lack of feedback being a significant barrier to encouraging workers to speak up in the first place. We therefore see it as essential that guardians role-model this behaviour by always asking for feedback, both from the people who speak up to them (guardians have been provided with a standard from of wording to use when asking for this feedback), and from others who can comment on their performance more generally. However, only **46%** of respondents said that they gathered feedback on their performance (with **54%** saying that they don't).

#9. Feedback
We recommend that guardians always gather feedback on their performance, from their line managers, the partners they work with, and from those they are supporting

3. Implementation of and support for the role

51% of respondents said that they didn't have any ring-fenced time for the guardian role and the total proportion of respondents who had one day or less assigned to the role was **70%**.



3.1 Amount of ring-fenced time	% respondents
None	51%
Up to 0.5 days / week	7%
Up to 1 day / week	12%
Up to 2 days / week	13%
Up to 3 days / week	10%
Up to 4 days / week	1%
Up to 5 days / week	6%

Whilst we do see that some aspects of the role can be carried out alongside other work, and that many respondents are part of a local network of champions / ambassadors which widens the opportunities for speaking up, the general lack of time ring-fenced for the role is a cause for concern (table 3.1). The guardian role includes both proactive and reactive elements and time is needed to communicate the role, engage with staff, form partnerships across the organisation, consider and triangulate data that might indicate barriers to speaking up, and report to and engage with the board and the wider network of guardians. This is in addition to supporting

people who wish to speak up and ensuring that each issue that is brought up is properly handled, that feedback is given, and that any lessons that should be learnt are learnt. We therefore strongly recommend that every trust sets aside ring-fenced time for guardians to carry out their role.

#10. Time
We strongly recommend that all trusts provide ring-fenced time for anyone appointed as a guardian / ambassador / champion to carry out their role and attend training, regional and national network meetings, and other events.

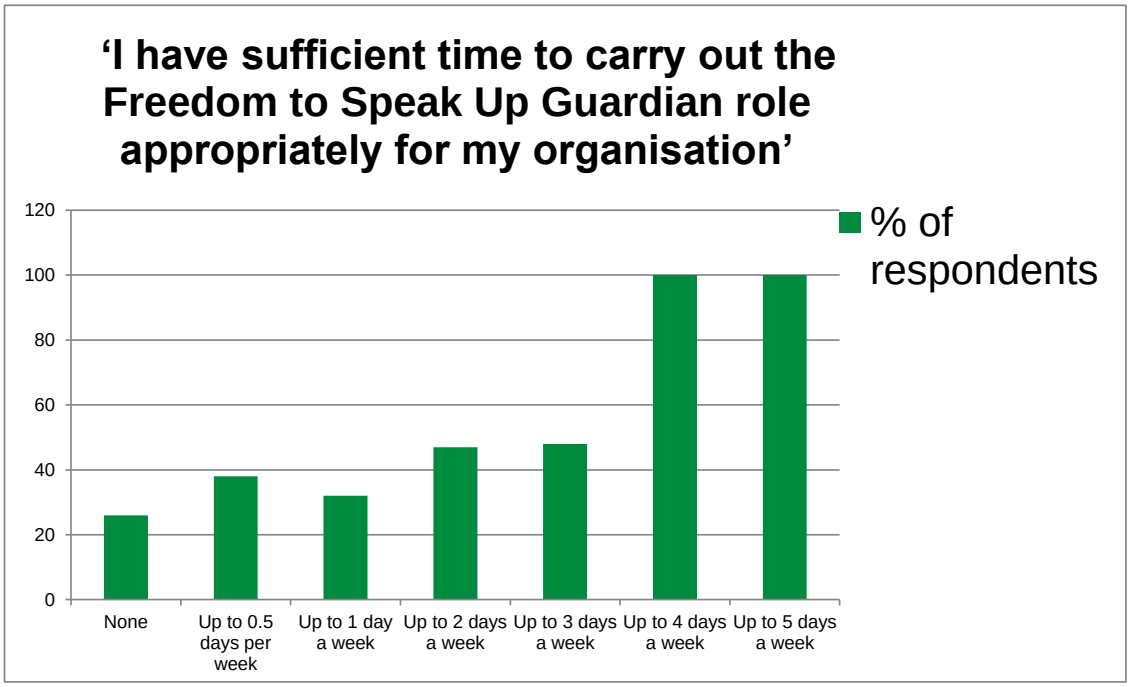
How much time that should be set aside will need to consider local circumstances and, of course, guardians / champions / ambassadors who are already in the role will be able to offer their own thoughts and advice.

We asked whether respondents felt that they had sufficient time for the guardian role (table 3.2). **38%** agreed or strongly agreed with the statement 'I have sufficient time to carry out the guardian role appropriately for my organisation', **38%** disagreed or strongly disagreed, and **25%** neither agreed nor disagreed.

3.2 Response to the question 'I have sufficient time to carry out the guardian role appropriately for my organisation'	**% respondents**
Strongly agree	12%
Agree	26%
Neither agree nor disagree	25%
Disagree	30%
Strongly disagree	8%

The proportion of respondents agreeing or strongly agreeing with this statement varied depending on how much time was ring-fenced for the guardian role (table 3.3).

3.3 Time ring-fenced for the guardian role	**Proportion of respondents agreeing or strongly agreeing with the statement 'I have sufficient time to carry out the guardian role appropriately for my organisation'**
None	26%
Up to 0.5 days per week	38%
Up to 1 day a week	32%
Up to 2 days a week	47%
Up to 3 days a week	48%
Up to 4 days a week	100%
Up to 5 days a week	100%



We also asked respondents for their thoughts on how confident they were about meeting the needs of their staff. Overall, **41%** of respondents agreed or strongly agreed with the statement ‘I am confident that I am meeting the needs of staff in my trust’, **37%** neither agreed nor disagreed, and **22%** disagreed or strongly disagreed.

3.4 Response to the question ‘I am confident that I am meeting the needs of staff in my trust’	**% respondents**
Strongly agree	4%
Agree	37%
Neither agree nor disagree	37%
Disagree	17%
Strongly disagree	5%

Again, the response to this question varied depending on the amount of time ring-fenced for the guardian role.

3.5 Time ring-fenced for the guardian role	Proportion of respondents agreeing or strongly agreeing with the statement 'I am confident that I am meeting the needs of staff in my trust'
None	36%
Up to 0.5 days per week	31%
Up to 1 day a week	36%
Up to 2 days a week	43%
Up to 3 days a week	50%
Up to 4 days a week	100%
Up to 5 days a week	64%

Whilst the numbers of respondents having 4 or 5 days a week ring-fenced for the role are low, and therefore the reliability of this analysis is limited, these apparent trends are interesting and not unexpected. Setting time aside to allow an individual to carry out Freedom to Speak Up work not only allows them to get that work done but, potentially, increases their confidence in their ability to meet the needs of staff.

Looking at budgets, **67%** of respondents indicated that there was no specific non-pay budget set aside for Freedom to Speak Up activities (though we do note that **24%** of respondents didn't know whether a budget had been set aside or not).

3.6 Non-pay budget for Freedom to Speak Up activities	% respondents
There is no specific budget set aside	67%
Less than £500	1%
Over £500 but less than £1,000	1%
Over £1,000 but less than £2,000	1%
Over £2,000 but less than £5,000	3%
Over £5,000 but less than £10,000	2%
Over £10,000	1%
Don't know	24%

We also asked whether respondents felt that they had access to the budget that they need. **28%** agreed or strongly agreed with the statement 'I have access to the budget I need', **44%** neither agreed nor disagreed and **29%** disagreed or strongly disagreed.

3.7 Response to the question 'I have access to the budget I need'	% respondents
Strongly agree	8%
Agree	20%
Neither agree nor disagree	44%
Disagree	21%
Strongly disagree	8%

Common sense suggests that Freedom to Speak Up activities require some budgetary investment though, given its cross-cutting nature, this may not always translate into the requirement to have a specific budget set aside and, depending on local change initiatives and other campaigns, Freedom to Speak Up messages can be incorporated in other activities.

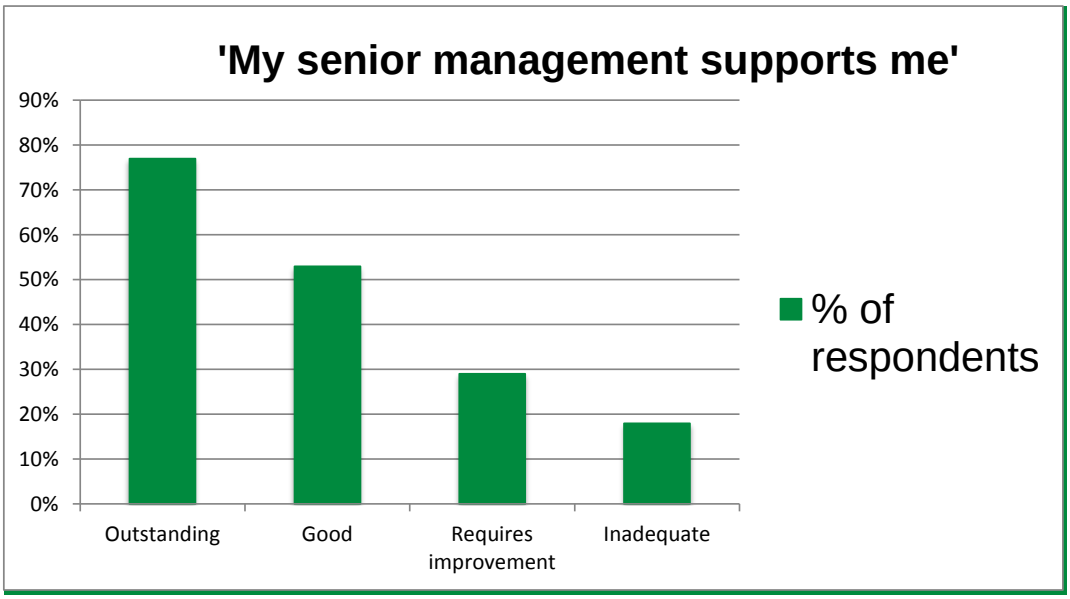
We asked respondents whether they felt supported by their chief executive and senior management team and the response was encouraging:

3.8	"My senior management team supports me"	"My chief executive supports me"
Proportion of respondents agreeing or strongly agreeing with the statement	81%	85%
Proportion of respondents neither agreeing nor disagreeing	16%	12%
Proportion of respondents disagreeing or strongly disagreeing	3%	3%

We hope this support continues. Whilst Freedom to Speak Up, by its nature, can be challenging and can shine a light on sometimes uncomfortable truths, we would encourage all senior leaders to think of the issues it raises as opportunities for improvement and for all those involved to seek to continue to pursue the agenda in an open and transparent way, acknowledging issues and promoting the changes that we know organisations can and do make in response to them.

Freedom to Speak Up is now an integral part of the well-led domain of Care Quality Commission (CQC) inspections. Whilst this is a recent initiative, listening and responding to people who speak up, and tackling the barriers to speaking up, is a natural ingredient of good leadership, which itself has always been a significant element of the CQC-rating process. It is therefore with interest that we observed the apparent correlation between CQC-rating and perceptions of the support that respondents felt they received from senior managers and chief executives.

3.9 CQC rating	Proportion of respondents agreeing or strongly agreeing with the statement "My senior management team supports me"	Proportion of respondents agreeing or strongly agreeing with the statement "My Chief Executive supports me"
Outstanding	92%	92%
Good	84%	89%
Requires improvement	83%	84%
Inadequate	54%	64%



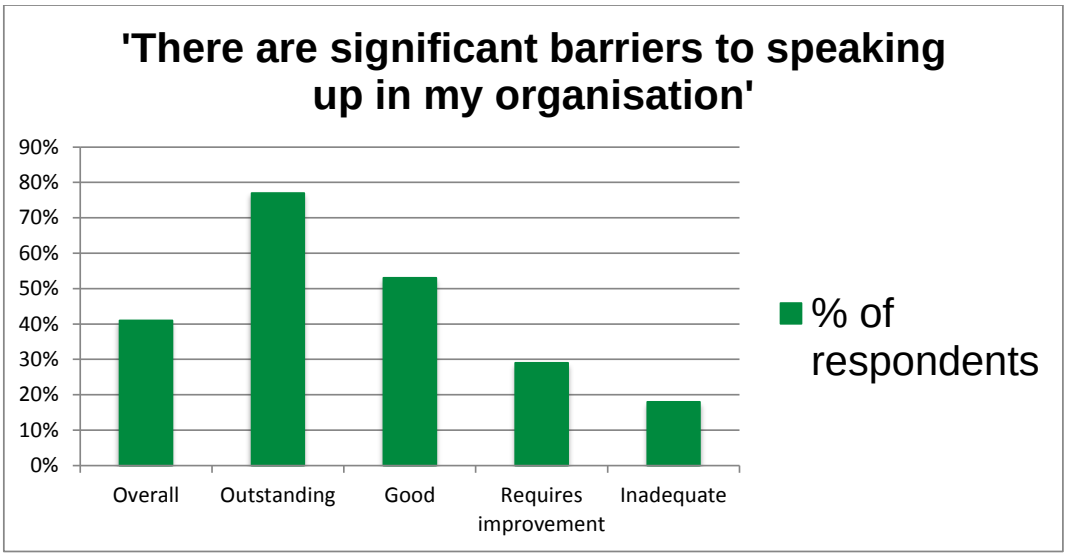
Whilst we have not carried out any analysis beyond looking at this simple trend, this result does suggest that trusts and foundation trusts which have higher CQC-ratings do tend to be the ones that support their guardians most, and emphasises the correlation between Freedom to Speak Up and the general quality of service that an organisation delivers.

With regard to support more generally, **78%** of respondents agreed or strongly agreed with the statement 'I have access to the support I need', **15%** neither agreed or disagreed, and **8%** disagreed or strongly disagreed.

3.10 Response to the question 'I have access to the support I need'	**% respondents**
Strongly agree	34%
Agree	44%
Neither agree nor disagree	15%
Disagree	8%
Strongly disagree	0%

Again, there may be a correlation between CQC rating and perceived levels of support with a higher proportion of respondents in outstanding trusts responding positively to this question:

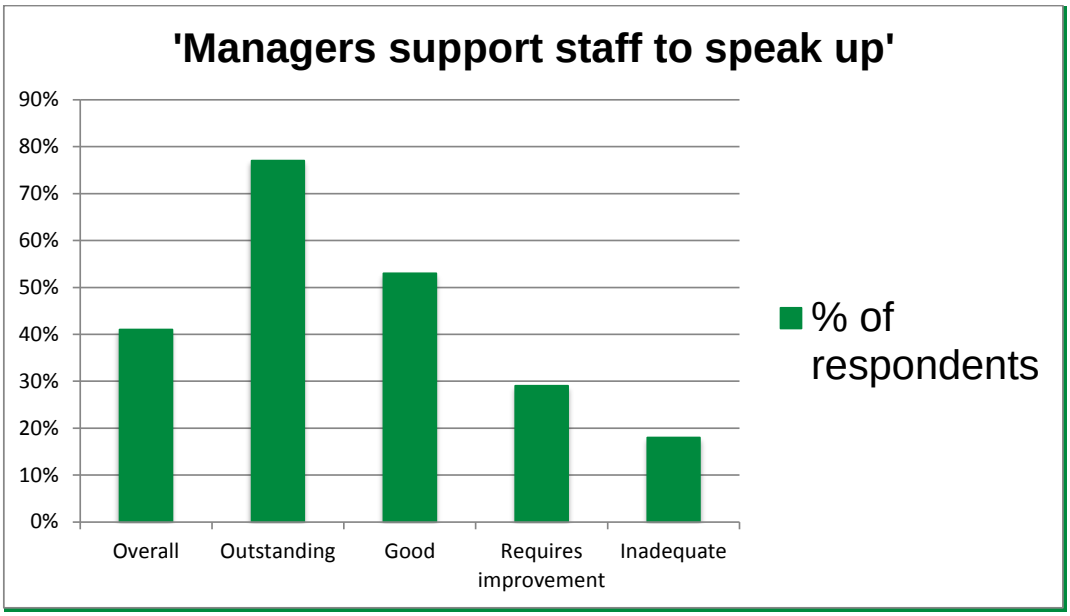
3.11 CQC rating	**Proportion of respondents agreeing or strongly agreeing with the statement "I have access to the support I need"**
Outstanding	92%
Good	77%
Requires Improvement	77%
Inadequate	72%



4. Perceptions of Freedom to Speak Up

We asked respondents for their opinions about a number of elements of speaking up

4.1 Statement	Proportion of respondents agreeing or strongly agreeing with the statement				
	CQC rating				
	Overall	Outstanding	Good	Requires improvement	Inadequate
The guardian role is making a difference	60%	70%	51%	66%	54%
My organisation has a positive culture of speaking up	55%	77%	65%	43%	45%
Speaking up is taken seriously in my organisation	72%	84%	81%	68%	36%
There are significant barriers to speaking up in my organisation (graph p.22)	25%	0%	21%	27%	45%
My organisation is actively tackling barriers to speaking up	70%	85%	72%	71%	45%
People in my organisation do not suffer detriment as a result of speaking up	43%	62%	54%	34%	27%
Managers support staff to speak up (graph p.24)	41%	77%	53%	29%	18%
Senior leaders support staff to speak up	67%	85%	78%	55%	45%
My organisation sees speaking up as an opportunity to learn and improve	75%	69%	81%	71%	64%



Overall these results indicate that there is a way to go in creating the culture change that we wish Freedom to Speak Up to generate, particularly in relation to perceptions of the support that managers give to speaking up. However, there are some encouraging responses: **72%** of respondents agree or strongly agree with the statement “speaking up is taken seriously in my organisation”; **70%** of respondents agree or strongly agree with the statement “my organisation is actively tackling barriers to speaking up” ; and **75%** agree or strongly agree with the statement “my organisation sees speaking up as an opportunity to learn and improve”. Our ambition is that responses to these questions will become more positive as the guardian role becomes embedded into the fabric of the NHS.

Whilst the trend towards more positive responses being given by trusts that are rated as ‘outstanding’ is of interest, we should note that the numbers of responses received from outstanding (and inadequate) trusts is small compared to trusts rated as good or requiring improvement.

Looking at these responses based on the services provided by an organisation, it is interesting to note that guardians / ambassadors / champions that work in organisations that provide mental health services tend to respond most positively to the questions we asked about Freedom to Speak Up culture, with those who work in ambulance services responding the most negatively.

4.2 Statement	Proportion of respondents agreeing or strongly agreeing with the statement				
	Services provided				
	Acute	Community	Mental Health	Ambulance	Specialist
The guardian role is making a difference	57%	65% **+**	65% **+**	61%	50% **-**
My organisation has a positive culture of speaking up	48%	59%	66% **+**	44% **-**	52%
Speaking up is taken seriously in my organisation	66%	73%	82% **+**	44% **-**	62%
There are significant barriers to speaking up in my organisation	25%	29%	23% **+**	39% **-**	32%
My organisation is actively tackling barriers to speaking up	68%	69%	74% **+**	50% **-**	64%
People in my organisation do not suffer detriment as a result of speaking up	35%	41%	44% **+**	23% **-**	28%
Managers support staff to speak up	36%	38%	39% **+**	33% **-**	36%
Senior leaders support staff to speak up	62%	69%	75% **+**	55% **-**	64%
My organisation sees speaking up as an opportunity to learn and improve	73%	76%	80% **+**	55% **-**	66%

+ most positive response

- least positive response

5. Successes and challenges

We asked respondents to provide examples of success and challenges. Whilst many respondents felt it was too early to give specific examples, there were some clear themes.

Successes: The most common examples of success were around communication where successful awareness campaigns had been run and messages sent out in corporate communications. There were also common themes around staff confidence and supporting staff with guardians having examples of feedback to suggest that they had given individuals more confidence to speak up and being thanked for the support they had given individuals at a difficult time.

Other successes included the emergence of strong leadership for speaking up amongst senior leaders, the development of good partnership working, a sense of achievement from making progress with individual cases, and comments about how Freedom to Speak Up has supported more general change in an organisation.

Challenges: By far the most cited challenge was around not having sufficient time to do all that that the role encompasses. Compounding challenges were ones of geography, where services are spread out and delivered in a large number of sites, and the need to balance the workload against pressures of another role that a guardian may hold.

Other sources of challenge were lack of support or general wariness of managers, potential conflicts with other responsibilities that a guardian may hold, general feelings of a lack of support (particularly amongst senior managers), and an existing lack of confidence amongst staff about speaking speaking up.

Other: We asked respondents whether they had been on the introductory / foundation training for the guardian role, how supported they felt by the National Guardian's Office, and what other training and support they felt that they needed. **70%** of respondents had attended introductory / foundation training, with **47%** of respondents also attending other training connected to the role. Respondents gave a range of opinions on their requirements for further training and guidance. The National Guardian's Office will continue to offer foundation training sessions and move to a model where initial training can be delivered at the regional level.

The National Guardian's Office will also work with Health Education England and the NHS Leadership Academy to source appropriate training and development to help to continually develop and improve the skills that individuals in the guardian network possess. Respondents gave a range of suggestions about how the National Guardian's Office can better support the guardian network. It will look into those suggestions and work with the network to ensure that all guardians receive the support they need.

Annex

Survey questions

A. ABOUT YOU AND WHAT YOU DO

B.

1. How were you appointed?

- I was personally approached and interviewed
- I was personally approached but was not interviewed
- I volunteered and was interviewed
- I volunteered but was not interviewed
- I was elected and interviewed
- I was elected but was not interviewed
- I was nominated and interviewed
- I was nominated but was not interviewed
- I was recruited internally through open competition
- I was recruited externally through open competition
- I work for an external provider
- Other (please specify)

2. How long have you been in post?

- Not yet started
- Less than 3 months
- 3 – 6 months
- 7 – 12 months
- 13 – 18 months
- 18 months or longer

3. Do you have another role?

- Yes
- No

4. If yes, please select from the following which best describes you

- Doctor
- Nurse
- Healthcare Assistant
- Midwife
- Dentist
- AHP
- Healthcare Scientist
- Therapist

- Admin & Clerical
- Maintenance / Ancillary
- Technician
- HR
- Corporate Services
- OD
- Safety
- Chaplain
- Governor
- Other (please specify)

5. What grade or band are you?

- VSM
- 9
- 8d
- 8c
- 8b
- 8a
- 7
- 6
- 5
- 4
- 3
- 2
- Volunteer
- Other (please specify)

6. How much time is ring-fenced for you to carry out the guardian role?

- None
- Up to 0.5 days per week
- Up to 1 day per week
- Up to 2 days per week
- Up to 3 days per week
- Up to 4 days per week
- Up to 5 days per week

7. Are you part of a network of guardian champions / ambassadors (or similar) in your organisation?

- Yes
- No
- Don't know

8. Do you have a Freedom to Speak Up Guardian 'buddy'?

- Yes
- No
- Don't know

9. What communication and training activities do you carry out as part of your role?

- Communication / publicity of your role through internal channels (e.g. staff newsletters)
- Communication / publicity of your role externally (e.g. local press, speaking engagements)
- Attending or incorporating Freedom to Speak Up messages in staff inductions
- Attending or incorporating Freedom to Speak Up messages in other staff training
- Attending team meetings
- Carrying out surveys about Freedom to Speak Up
- Other (please specify)

10. Which parts of your organisation do you regularly work with?

- Senior leaders / the Board
- HR
- Communication teams
- Organisational Development teams (or similar)
- Training and development teams
- Union / staff side representatives
- Staff diversity networks
- Patient representative groups
- Other (please specify)

11. Do you have direct access to my CEO?

- Yes
- No
- Don't know

12. Do you have direct access to the Non-Executive Director who has speaking up as part of their portfolio?

- Yes
- No
- Don't know

13. Do you present reports to Board meetings in person?

- Yes
- No
- Don't know

14. Do you gather feedback on your performance?

- Yes
- No

15. What non-pay budget is there for guardian activities in your trust (budget per annum)?

- There is no specific budget set aside for guardian actives
- Less than £500
- Over £500 but less than £1000
- Over £1000 but less than £2000
- Over £2000 but less than £5000
- Over £5000 but less than £10,000
- More than £10,000
- Don't know

16. Do you have personal experience of speaking up?

- Yes
- No

It would be helpful to know a little more of your experience if you are willing to describe it below. This information will be used to help the NGO understand the speaking up experience that exists within the guardian network

C. ABOUT YOUR ORGANISATION

17. What service/s does your trust provide (select all that apply)?

- Acute
- Community
- Mental Health
- Ambulance
- Specialist
- Other (please specify)

18. Approximately, how many staff are employed in your Trust?

19. On how many sites?

- 1
- 2 – 3

- 4 – 7
- 8 – 10
- More than 10 sites

20. What is your organisation's current CQC rating?

- Outstanding
- Good
- Requires improvement
- Inadequate

D. YOUR THOUGHTS ON YOUR ROLE AND YOUR ORGANISATION

21. How far do you agree or disagree with the following statements:

- I have sufficient time to carry out the guardian role appropriately for my organisation
- I am confident that I am meeting the needs of staff in my trust
- My senior management team supports me
- My Chief Executive supports me
- I have access to the support I need
- I have access to the budget I need

22. How far do you agree or disagree with the following statements:

- The guardian role is making a difference
- My organisation has a positive culture of speaking up
- Speaking up is taken seriously in my organisation
- There are significant barriers to speaking up in my organisation
- My organisation is actively tackling barriers to speaking up
- People in my organisation do not suffer detriment as a result of speaking up
- Mangers support staff to speak up
- Senior leaders support staff to speak up
- My organisation sees speaking up as an opportunity to learn and improve

E. TRAINING

23. Have you attended the introductory guardian-training workshop? (tick one)

- Yes
- No
- Don't know

24. Have you attended any other training connected to your guardian role? (tick one)

- Yes
- No

25. What other training and support would you find helpful

- None
- Influencing skills
- Equality / diversity training
- Presentation skills
- Listening skills
- Report writing / general writing skills
- Dealing with difficult conversations training
- Personal resilience
- Network building
- Other (please specify)

26. On a scale of 0 to 10 where 0 is 'not at all' and 10 is 'fully supported' please indicate your response to the following statement: I am sufficiently supported by the National Guardian's Office?

27. What further support from the National Guardian's Office would you find helpful?

F. SUCCESSES AND CHALLENGES

28. What success have you had in your guardian role? Please describe your achievements so far.

29. What are the most challenging aspects of your role?

G. PERSONAL DETAILS

30. What is your age?

- 16-34
- 35-44
- 45-54
- 55+
- Prefer not to say

31. Do you consider yourself to be disabled?

- Yes
- No

- Prefer not to say

32. What is your ethnic group? Please choose an answer that best describes your ethnic group or background

- White
- Mixed / multiple ethnic groups
- Asian / Asian British
- Black / African / Caribbean / Black British
- Chinese
- Other ethnic group

33. What is your religion or belief?

- No religion
- Buddhist
- Jewish
- Muslim
- Agnostic
- Christian
- Sikh
- Hindu
- Prefer not to say
- Other

34. What is your sexuality?

- Bisexual
- Gay man
- Gay woman / lesbian
- Heterosexual / straight
- Prefer not to say
- Other

35. Are you

- Single
- Separated
- Divorced
- Widowed
- Married or in a civil partnership
- Prefer not to say

36. What is your gender?

- Male

- Female
- Prefer not to say
- Other

37. Is your gender the same as the gender identity that you were born with?

- Yes
- No
- Prefer not to say

38. Are you currently pregnant or have you been pregnant in the last year?

- Yes
- No
- Prefer not to say

39. Have you been on maternity leave within the past year?

- Yes
- No
- Prefer not to say

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)

Half way though the year the level of progress across the programme (quality and financial) is not at an acceptable level. The financial plan in 17/18 assumed the transformation programme would ramp up from September and driving a stepped improvement in the financial run rate in the second half of the year; the current forecasts do not deliver the required step-up, which is manifesting as part of the over all control total risk. There continues to be a significant amount of projects with red or red/amber ratings and or low financial savings. The performance is similar across the workstreams particularly in the best people doing their best work and delivering outstanding care. The strong foundations workstream is beginning to pick up momentum.
Following a detailed Executive Team discussion the CEO has asked for a formal 6 month review of progress against our business plan objectives which will be brought to the November Board. This will shift the focus onto benefits tracking of the programme. The financial performance of the programme is incorporated into our financial recovery plan.

J Grinnell 26 Sep 17

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

1. This Board report contains assurance reports submitted to the following sub-Cttes: CQAC on 20 Sep 17 and R&BD on 28 Sep 17.
2. The scope of the programme and the contribution to CIP benefits are shown in the following slides; the financial contributions are of particular concern, being significantly below target (delivery at est. 50%), and will be the subject of a rigorous review during October 2017.
3. The overall assurance ratings continue to raise concern and in some key areas there is little or no current assurance evidence; this is particularly the case in the red rated projects in the 'Quality' and 'Workforce' work streams. Actions agreed to remedy these issues include Executive Sponsor focus and addressing the lack of applied capability to some key projects.

J Gibson 21 Sep 17

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

Overall for the year CiP has reporting a gap of £2m, this gap has not improved for two months. Fcous needs to be put into resolving this urgently .

Change Programme
30 August 2017_v12

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

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

Internal Delivery Group (CiP) ⟷ **Programme Assurance Framework** ⟷ **Programme Delivery Board**

27/40 = £ indicated projects

Deliver Outstanding Care
Hilda / Steve

1. **Deteriorating Patient**
2. **Experience in Outpatients £** SG
3. **Best in Operative Care £** SG
4. **GP Streaming**
5. **Best in Acute Care £**

Growing Through External Partnerships
John SG

1. **Establish Alder Hey as Leader of Children's Health across C & M**
   a) Single Service, 2 Site, Neonatal Service **£**
   b) Expand Mental Health Offering **£**
   c) Step Down Model for Patients with Complex Needs **£**
2. **Strengthen the Stoke Partnership £**
3. **International Health & Non-NHS Patients £**
4. **Transformation of New Community Services (SALT) £**
5. **CHD Liverpool Partnership £**
6. **Aseptics £**

The Best People Doing Their Best Work
Melissa/Hilda SG

1. **Staff Engagement & Development**
   a) Apprenticeships **£**
   b) Engagement & Communication
2. **Workforce Reviews**
   a) Specialist Nurse Review **£**
   b) AHP Review **£**
   c) Portering **£**
   d) Domestics **£**
3. **Agile Working**
4. **Temporary Staffing £**
5. **e-Rostering £**

Global Digital Exemplar
John/Steve

1. **Speciality Packages £** SG
2. **Voice Recognition £**

Strong Foundations
John

1. **Inventory Management £**
2. **Collaborative Procurement £**
3. **Energy £**
4. **Post-mobilisation Review**

Park, Community Estate & Facilities
David

1. **Decommission & Demolition** SG
2. **R&E 2**
3. **Alder Centre**
4. **Park**
5. **Residential Development**
6. **International Design & Build Consultancy £**
7. **Reprovision of Retained Estates**
8. **Neuro-Developmental Hub (TBC)**

RE&I

Game Changing Research & Innovation
David

1. **The Academy £**
2. **The Innovation Co £**
3. **Implement New Apps for Alder Hey**
4. **Expand Commercial Research £**

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

Alder Hey Children's NHS
NHS Foundation Trust

CIP Status at Month 05

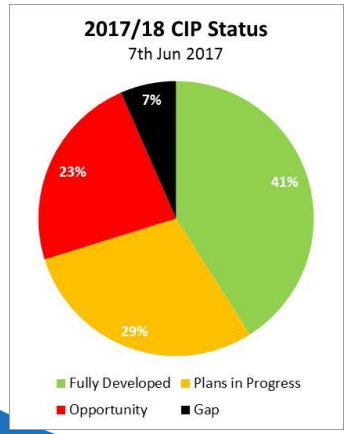
Trust Position

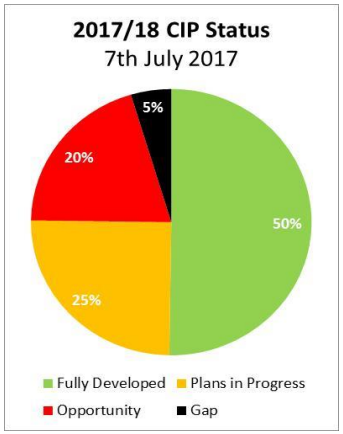
Risk Adjusted Forecast	at 6th Sep £000's
Implemented (Posted)	4,317
Fully Developed Plan	178
Plans in Progress	1,571
Subtotal: Forecast Delivery	6,067
Opportunity	903
Gap	1,031
Target	8,000

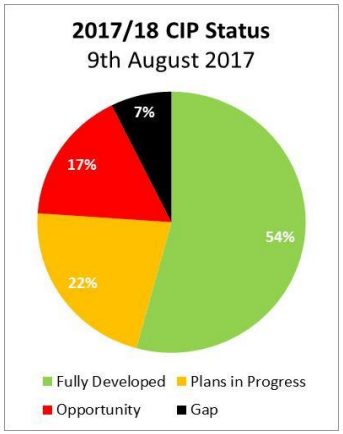
2017/18 CIP target is £8.0m:

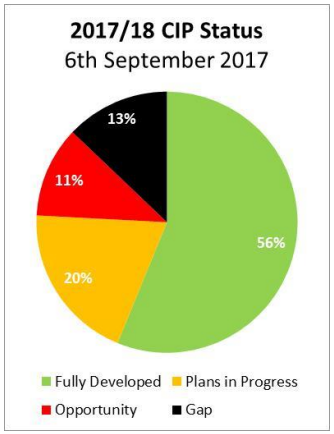
- In year forecast £6.1m (76%)
- **Current risk** **£1.9m** (24%)

Progress over the last 4 months









Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

CIP Status at Month 05

Performance, by Theme

Workstream	In Month			Year to Date			In Year Forecast		
	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Achieved (Posted) £000's	Gap £000's	Target £000's	Forecast £000's	Gap £000's
Deliver Outstanding Care	54	20	-34	210	64	-145	587	356	-231
Growing Through External Partnerships	13	6	-8	66	29	-38	159	129	-30
The Best People Doing Their Best Work	29	0	-29	111	0	-111	402	122	-280
Game Changing Research and Innovation	17	9	-8	85	43	-42	230	130	-100
Solid Foundations	0	0	0	0	0	0	142	0	-142
Subtotal: Strategic Workstreams	**113**	**34**	**-79**	**471**	**136**	**-335**	**1,520**	**737**	**-783**
Business as Usual	315	431	116	1,225	1,703	478	6,480	5,330	-1,150
Unidentified	0	0	0	0	0	0	0	0	0
Grand Total	**428**	**465**	**37**	**1,696**	**1,839**	**143**	**8,000**	**6,067**	**-1,933**

Workstream	Risk Rating (In Year)					
	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	157	0	198	0	231	587
Growing Through External Partnerships	69	0	60	30	0	159
The Best People Doing Their Best Work	0	0	122	95	185	402
Game Changing Research and Innovation	130	0	0	0	100	230
Solid Foundations	0	0	0	0	142	142
Subtotal: Strategic Workstreams	**356**	**0**	**381**	**125**	**658**	**1,520**
Business as Usual	3,961	178	1,191	777	373	6,480
Unidentified	0	0	0	0	0	0
Grand Total	**4,317**	**178**	**1,571**	**903**	**1,031**	**8,000**

Inspired by Children

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Delivering Outstanding Care

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

The latest forecast is savings of £0.4m, which is better than the previous update but still very low, and not sufficient to meet the financial objectives of the programme. The only projects currently forecasting savings are Best in Operative Care and Experience in Outpatients. The Executive sponsor is requested to review the saving potential as a matter of urgency, converting the opportunities into savings and increasing the value of the overall forecast.

Claire Liddy, Deputy Director of Finance – 12 Sep 17

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

Of the projects that have evidence lodged on the SharePoint site and are rated:

- 'Deteriorating Patient' – The 'Sepsis' project documentation on SharePoint is not currently being updated and the milestone plan is over two months out of date. This is a significant issue given the importance of this project and the gap was highlighted at the August Programme Board and September Trust Board. Resolution is required immediately.
- 'Outpatients' – is providing a high level of documentary evidence giving a sound assurance rating.
- 'Best in Operative Care' – is also being regularly updated and has a good suite of evidence.

Projects that are red rated, as highlighted at Programme Board/Trust Board, are:

- 'Best in Operative Care' – not updated since Programme Board/Trust Board and requiring benefits to be defined and a plan.
- 'GP Streaming' – awaiting a high level description of the project and any documentary evidence (nothing yet on SharePoint).

Joe Gibson, External Programme Assessment 12 Sep 17

Alder Hey Children's NHS
NHS Foundation Trust

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

Sub-Committee	CQAC	Report Date	12 Sep 17
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating:

1.0 Deliver Outstanding Care 17/18 £TBC														
CQAC 1.1	CQAC	Deteriorating Patient (Sepsis)	This project will ensure prompt recognition and management of the deteriorating patient and implementation of the Sepsis Pathway	Hilda Gwilliams										Project implementation meeting notes available but last record early June. PID complete. Benefits defined, tracking/reporting to commence. Milestone Plan is not being updated - actions from 26 June onwards to be updated. Comms/ Engagement Plan available, evidence to be provided where possible. Risks on Ulysses. EA/QIA complete. **Last updated 6 July 2017**
CQAC 1.2	CQAC	Experience in Outpatients	The project will improve patient & staff experience; understand demand and capacity; improve flow and environment	Hilda Gwilliams										SG meeting notes available to July. PID completed. Benefits defined - tracking/dashboard uploaded 29 Aug 17. Milestone Plans (Booking and Scheduling in particular) show some 'OM' tasks and requires populating with new actions. Comms/ engagement activities to be updated and evidence provided where possible. Risks available on Ulysses. **Last updated 6 September 2017**
CQAC 1.3	CQAC	Best in Operative Care	The "Best in Operative Care" strategy aims to deliver the best paediatric operative care in the world, as measured by low rates of mortality and harm, and high staff satisfaction rates	Steve Ryan										Steering Group notes available on SharePoint. PID available. Targets/benefits defined in PID, tracking/reporting to commence. Milestone Plan to be fully defined/populated and updated for September. Comms tracker available. Risks available on Ulysses. EA/QIA complete. **Last updated 11 September 2017**
CQAC 1.6	CQAC	GP Streaming		Mags Barnaby										**PID to be available at end of July. No documentation available on SharePoint.**
CQAC 1.7	CQAC	Best in Acute Care	The 'Best in Acute Care' strategy aims to deliver the best/safest paediatric acute care in the world, as measured by low rates of mortality and harm, and high staff satisfaction. We will achieve this through a strategy centered on patient safety, excellence and staffing wellbeing.	Steve Ryan (Hilda Gwilliams)										Draft PID uploaded and incorporates the following projects/workstreams: Resuscitation; Deteriorating Patient/Sepsis; 7 Day Services - inclusive of Out of Hours; PEWs/Deterioration; Outreach; Medical Management of Complex Surgical Patients). The PID includes the scope with benefits yet to be defined. Minutes/notes of meetings are present, as is identification of high level stakeholders. **Last updated 29 August 2017.**

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Deteriorating Patient	Black				No financial benefits identified to date
Reduce Variations by Developing Clinically Effective Pathways	Black				No financial benefits identified to date
Experience in Outpatients	Amber	180k	198k	-180k	Financial target based on 3% reduction in DNA rate in Medical specialities.
Best in Operative Care	Green	407k	157k	-250	Financial target based on indicative 2% growth in Elective and Daycase income in all Surgical specialties. Following detailed review and activity forecast, there is high confidence of increased income in Urology, Plastics and Pre-Op Assessment.
7 Day Services	Black				No financial benefits identified to date
Reduce Infections	Black				No financial benefits identified to date
Total		587k	356k	-231k	

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)

The majority of projects are now amber rated which is improving trend, however efforts must be put into delivering green ratings. The financial forecast for this work stream is particularly poor especially given the vast opportunity for business development. The Executive sponsor is requested to undertake a stock take of the finances and provide a re-forecast by October that will aid the trust financial position as a matter of urgency. Clear miles stones and profiling must be agreed with divisions.

Claire Liddy, Deputy Director of Finance – 19 September 2017

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

The work stream has made definite inroads to improve the assurance base since the previous sub-Committee review in June 2017. At that time only 5 projects were able to be assessed and the ratings were 3 red rated, 1 amber and 1 green. The latest position shows all 8 projects having commenced, with evidence on SharePoint, and of those 1 green rated, 6 amber and 1 red. This positive trend should be supported and continued.

Of particular concern is the continuing lack of evidence on SharePoint concerning the Liverpool CHD Partnership and the £90k shortfall in the financial contribution to the CIP programme.

The Executive Sponsor should work with all 'corporate leads 'of projects to attain green ratings as a matter of urgency.

Joe Gibson, External Programme Assessment – 19 September 2017

Programme Assurance Framework
Growing Through External Partnerships (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	19 September 2017
Workstream Name	Growing Through External Partnerships	Executive Sponsor	John Grinnell

Current Dashboard Rating:

Project Ref	Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG	An effective project team is in place (Explored)	Scope and Approach is	Targets / benefits defined/on track	Milestone plan is defined/on track (Established)	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment (Designed)	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee (Delivered / Sustained)
R&BD 2.1c	R&BD	Single Service, 2 Site, Neonatal Service	Lead services to review options to collaborate and maximise joint working across the NM LDS and C&M Footprint including a single Neonatal Service with LWH	Steve Ryan		Y	Y	Y	Y	G	Y	R	R	Now in implementation planning phase. Outline PID available. Milestone plan in development with further definition required. Definition of benefits in 'working draft' fromat with further work needed to establish SMART metrics. Comprehensive evidence of wide stakeholder engagement. Risk Register commenced and QIA/EA to be uploaded when signed off. **Last updated 25 August 2017.**
R&BD 2.1di	R&BD	STP AH @ C&M Strong Community Services Offer - Transition of New Community Services	To ensure safe and efficient transfer of selection of Specialist Paediatric Community Services from LCH	John Grinnell		Y	Y	Y	Y	Y	R	G	G	Team have requested closure of this project. Closure Report to be presented to July RABD meeting was not submitted, **Executive Sponsor is requested to ensure closure at 28 September R&BD meeting .** **Last updated 18 August 2017**
R&BD 2.1d	R&BD	STP AH @ C&M Transforming Mental Health Services	Improvements to primary and specialist mental health services locally. Improve access to 24/7 crisis resolution and secure Alder Hey as a provider of Tier 4 childrens services.	John Grinnell		R	Y	Y	Y	Y	R	R	R	PID to be presented to Steering Group meeting in **September 2017.** **Last updated 25 August 2017**
R&BD 2.2	R&BD	Strengthen the Stoke Partnership	Lead services to review options to collaborate and maximise joint working with Stoke partners	John Grinnell										**DRAFT Business Case on SharePoint - any eventual project subject to outcome of current discussions; meeting with NHSE 12 Sep 17.** **Last updated 30 August 2017**
R&BD 2.3	R&BD	International Health & Non-NHS Patients	Establish International service offer including: International Health Partnerships and non-NHS patients	John Grinnell		G	G	G	Y	Y	G	G	G	Steering Group meeting notes available. PID complete. Milestone Plan is defined and on SharePoint shows slippage with Dubai workstream and PP privileges. Details/evidence of comms/engagement to be provided where possible. Risks now on Ulysses. EA/QIA complete. **Last updated 17 July 2017**
R&BD 2.4	R&BD	Improving Pathways for Children with Complex Needs between Hospital and Home	To improve the experience of patients with complex needs between hopsital and home, reducing length of stay and delivering high quality, community based, services.	John Grinnell		Y	Y	Y	G	R	R	R	R	Draft PID in evideince with more work required, particularly on benefits and measures. Some evidence of team working but attendees at meetings, as well as action logs, need to be documented. A detailed action plan is in place and would benefit from a 'red line' showing the date of the latest amnedments/changes. Evidence of stakeholder engagement, confirmation of risks registred and EA/QIA are all outstanding. **Last updated 18 August 2017.**
R&BD 2.5	R&BD	CHD Liverpool Partnership		Steve Ryan										**PID to be available at end of July.** **No documentation available on SharePoint.**
RABD 2.6	R&BD	Aseptics	Validate and commission aseptic unit. To provide internal service which reduces outsourcing to minimal levels. Take unit to licence to offer income generating opportunities.	John Grinnell										DRAFT Business Case on SharePoint: Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit. **Executive Sponsor of Assurance Framework to decide if other project documents are required in evidence.** Current issues include no evidence of live tracking of milestones / risks / benefits and no documented evidence of meetings.

Programme Assurance Framework
Growing Through External Partnerships (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	**R&BD**	**Report Date**	**19 September 2017**
Workstream Name	Growing Through External Partnerships	**Executive Sponsor**	**John Grinnell**

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
High Quality Acute and Emergency Care	Black				No financial benefits identified to date
Develop Clinical Services Support Offer	Black				No financial benefits identified to date
Strong Specialist Services Offer	Black				No financial benefits identified to date
Strong Community Services Offer	Green	159k	69k	-90k	
Expand Mental Health Offering	Black				No financial benefits identified to date
Intermediate Care Unit	Black				No financial benefits identified to date
Strengthen Existing Partnerships	Black				No financial benefits identified to date
International Health & Non NHS Patients	Red				
Total		159k	69k	90k	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Global Digital Exemplar

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

The work stream is making strong progress and the assurance ratings are green. Work must now commence to identify and quantify the financial and non-financial benefits. The executive sponsor needs to agree a deadline of when this work will complete and the benefits will realise in 17/18 initially. A comprehensive update to RABD should be provided in Q3..

Claire Liddy, Deputy Director of Finance – 16 June 2017

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

The work stream has made significant efforts to improve the assurance base since the previous sub-Committee review in June 2017. At that time only 1 project was able to be assessed and the rating was red. The latest position shows all 3 strategic level projects (it having been decided that the more granular work streams will be assured at the project level) have comprehensive evidence on SharePoint and are all green rated. This is an high standard of assurance evidence and the team should be commended.

Of current concern is the lack of evidenced financial contribution to the CIP programme.

Joe Gibson, External Programme Assessment – 19 September 2017

Programme Assurance Framework
Global Digital Exemplar (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	19 September 2017
Workstream Name	Solid Foundations	Executive Sponsor	John Grinnell/ Steve Ryan

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG	An effective project team is in place (Explored)	Scope and Approach is (Explored)	Targets / benefits defined/on track (Established)	Milestone plan is defined/on track (Established)	Stakeholders engaged (Established)	Risks are identified and being managed (Designed)	Quality Impact Assessment (Designed)	Equality Analysis (Delivered)	Comments for attention of the Project Team, Steering Group and sub-Committee
4.0 Global Digital Exemplar 17/18 £TBC													
R&BD 4.1	GDE	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	Steve Ryan/ John Grinnell		●	●	●	●	●	●	●	●	Overall benefits profile and schedule still to be finalised. Further stakeholder evidence to be uploaded and register maintained. Risk protocols vis-à-vis national and Trust sytsems have been harmonised and are in the process of being finalised. **Last updated 23 August 2017**
R&BD 4.1a	Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Steve Ryan/ John Grinnell		●	●	●	●	●	●			Overall benefits profile and schedule still to be finalised. Risk protocols vis-à-vis national and Trust sytsems to be harmonised and finalised. **Last updated 21 August 2017.** 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. Detailed milestone plan available, shows actions on track. Comms/engagement activities detailed in PID, evidence required where possible. Risks detailed in workbook. EA/QIA to be signed by Project Team and uploaded. **Last updated 21 August 2017.**

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
GDE	Black	0	0	0	
	Black				
Total					

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 workstream has mostly improved in terms of ratings, however more work needs to happen before the next committee to improve the ratings for red rated projects.
The International D&B consultancy needs to be financially appraised and included in the figures.

Claire Liddy, Deputy Director of Finance – 19 September 2017

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

The work stream has made significant efforts to improve the assurance base since the previous sub-Committee review in June 2017. At that time only 3 projects were able to be assessed and the ratings were 3 red rated and one amber. The latest position shows all 8 projects having commenced, with evidence on SharePoint, and of those 2 green rated, 3 amber and 3 red. This positive trend should be commended and continued.

Of particular concern are the lack of an EA/QIA for the R&E 2 development and the overall lack of a financial contribution to the CIP programme.

The Executive Sponsor should work with all 'corporate leads 'of projects to attain green ratings as a matter of urgency.

Joe Gibson, External Programme Assessment – 19 September 2017

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

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	R&BD	Report Date	19 September 2017
Workstream Name	Park, Community Estate and Facilities.	Executive Sponsor	David Powell

Project Ref	Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG	An effective project team is in place (Explored)	Scope and Approach is	Targets / benefits defined/on track	Milestone plan is defined/on track (Established)	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment (Designed)	Equality Analysis (Delivered / Sustained)	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 17/18 £TBC														
R&BD 5.1	R&BD	Decommission & Demolition	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell		G	G	A	G	A	G	G	G	PID available, however details of benefits requires review in line with revised/ updated dates. Milestone plan shows slippage (car park demolition). Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses, some require review. **Last updated 2 August 2017**
R&BD 5.2	R&BD	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		G	A	A	A	A	A	R	R	Team action notes available to May. PID available, benefits to be confirmed. Milestone Plan shows some delays (space allocation & design). Details of comms/engagement activities to be confirmed and evidence provided where possible. Issues Log uploaded, risks to be entered on Ulysses. EA/QIA to be prepared and signed. **Last updated 24 August 2017**
R&BD 5.3	R&BD	Alder Centre	To plan, develop and construct the new Alder Centre within the park setting	David Powell		G	G	G	G	G	G	G	G	Steering Group meeting notes available. Scope/approach defined in PID (revised recently). Benefits defined in PID. Milestone Plan has been revised recently - shows initial actions on track. Evidence of Comms/ Engagement activities. Risks to be confirmed on Ulysses. EA/QIA complete. **Last updated 30 August 2017**
R&BD 5.4	R&BD	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		G	A	A	A	G	A	G	G	Updated PID on SharePoint - confirmation of updates required/approval at Steering Group. Benefits defined in PID, tracking/reporting of delivery required. Milestone plan shows actions on track, however clarification required eg re LCC sign-off/financial contribution which shows as missed (August 2017). Risks on Ulysses - need confirmation these are up to date. EA/QIA complete. **Last updated 26 August 2017**
R&BD 5.5	R&BD	Residential Development	To create a high quality residential scheme that co-ordinates with the themes and activities within the wider park site	David Powell		A	G	G	A	A	G	G	G	Scope/approach and benefits defined in PID. Plan shows delays - consultation pushed back to September. Evidence required of comms/engagement activities. Risks on Ulysses and require review (last review May 2017). EA/QIA complete. **Last updated 8 August 2017**
R&BD 5.6	R&BD	International Design & Build Consultancy		David Powell		A	A	R	R	R	R	R	R	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. **Last updated 24 August 2017**
R&BD 5.7	R&BD	Reprovision of Retained Estates		David Powell		R	A	R	A	R	R	R	R	Some statistics available on numbers for whom estate/space is needed. A high level critical path has been uploaded as well as an option for external provision of space. All project documentation to be fully developed. **Last updated 24 August 2017**
R&BD 5.8	R&BD	Neuro-Developmental Hub (TBC)		David Powell		R	A	R	R	R	R	R	R	SOA' available. All project documentation to be fully developed. **Last updated 24 August 2017**

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
International Design and Build Consultancy	Black	0	0	0	No financial savings identified to date
Total					

Corporate Report

Aug 2017

Corporate Report

Alder Hey Children's NHS
NHS Foundation Trust

Table of Contents

Executive Summary

Aug 2017

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17
N	N	N	N	N	N	N	N	N	N	N	N

Highlights

The Trust is compliant with all NHSI standards following on from the challenge of delivering the ED 4hr standard in July. Winter Plan currently in development to support flow. Cancellations on the day reduced from 30 in July to 15 which will help with 28 day breach management. Activity has increased within the hospital against the same period last year, no patients waiting >52 weeks

Challenges

Lower levels of elective activity with higher levels of NEL demand and increased LOS have driven occupancy over 83%; the challenge is not the overall occupancy but how to manage the NEL surges that take place. 28 day relist breaches have increased from 1 to 9; analysis identifies HDU, management of emergency patients and list over-runs being the top 3 for failing to treat within the timescale. Surgical Division to review management of this cohort. OP actual utilisation has increased however DNA's have also increased. DQ issues persist notably with cashing up clinics which skews data. 18 week Backlog has increased slightly and needs input to manage.

Patient Centred Services

Improvement noted in metrics from July to August with the exception of CAMHS. This is due to increasing levels of DNA's for new & Follow Up patients. The division are currently investigating.4 core NHSI core standards achieved for August; key deterioration noted in July was the ED 4hr standard following high levels of NEL/ED attendance however strong performance noted for August. 28 day breaches have also deteriorated following cancellation in July (patients will now be treated FOC as the commissioner "fine" within the standard contract) which will require management action via the Division.

Excellence in Quality

The reduction of medication errors associated with harm continues with only 2 in the month of August. Reporting of pressure ulcers continues to increase with improved education. A deeper analysis of clinical incidents with harm is being undertaken.
All inpatient survey measures deteriorated in August. Friends and Family responses from A&E and Community still needs to be improved . The number of complaints remains similar to last year. The overall trend in PALS attendances is lower than last year, reflecting an improvement in addressing concerns locally.
There were 5 recorded hospital infections in August, i.e. 20 year to date compared with 41 at this time last year. MRSA and C difficile infections remain at zero. There were 7 in month readmissions of patients with long term conditions within 48 hours. For surgical patients with an Estimated Date of Discharge (EDD), 3.9% were discharged later than the EDD. This is an improvement against 5.4% last year and equates to 66 patients.

Financial, Growth & Mandatory Framework

For the month of August the Trust is reporting a trading deficit of £1.6m which is £0.1m ahead of plan.

Income is ahead of plan by £0.9m mainly due to income relating to non elective and outpatient activity. Elective activity is ahead of plan by 5%, non elective is ahead by 3% and outpatient activity is ahead by 8%.

Pay budgets are 0.3m overspent for the month relating to use of temporary staffing. The Trust is on plan with the CIP target to date. Cash in the Bank is £10.4m. Monitor Use of Resources rating of 3 in line with plan.

Great Talented Teams

The Trust position on sickness absence saw a small increase in August to 5.10%. Medical Appraisals continue to increase in line with the window to 81%. Mandatory Training remains at 75%, work on the OLM data cleanse in ongoing and the roll out of the ESR portal will see the Trust paperless with payslips at the end of September with all staff being able to access their own personal information, mandatory training compliance and payslip from their mobile device.

Leading Metrics

Aug 2017

Alder Hey Children's NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Jul 2017	Aug 2017	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	93.1 %	98.3 %	▲	
RTT: 90% Admitted within 18 weeks		89.1 %	89.0 %	▼	
RTT: 95% Non-Admitted within 18 weeks		88.6 %	89.5 %	▲	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.0 %	92.0 %	▲	
Diagnostics: Numbers waiting over 6 weeks		0	0	–	
Average LoS - Elective (Days)		3.2	2.9	▼	
Average LoS - Non-Elective (Days)		2.1	2.2	▲	
Daycase Rate	0.0 %	70.9 %	70.3 %	▼	
Theatre Utilisation - % of Session Utilised	90.0 %	86.1 %	87.5 %	▲	
28 Day Breaches	0.0	1	9	▲	
Clinic Session Utilisation	90.0 %	85.6 %	83.6 %	▼	
DNA Rate	12.0 %	10.2 %	11.4 %	▲	
Cancelled Operations - Non Clinical - On Same Day		31	15	▼	

Excellence in Quality

Metric Name	Goal	Jul 2017	Aug 2017	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	90.0 %	95.7 %	92.1 %	▼	
IP Survey: % Treated with respect	100.0 %	99.4 %	99.3 %	▼	
IP Survey: % Know their planned date of discharge	80.0 %	64.0 %	53.9 %	▼	
IP Survey: % Know who is in charge of their care	95.0 %	92.9 %	91.2 %	▼	
IP Survey: % Patients involved in play and learning	80.0 %	74.0 %	65.7 %	▼	
Pressure Ulcers (Grade 2 and above) YTD		20	23	▼	
Total Infections (YTD)	35.0	15	20	▲	
Medication errors resulting in harm (YTD)	25.0	13	15	▼	
Clinical Incidents resulting in harm (YTD)	245.0	352	433	▼	

Great and Talented Teams

Metric Name	Goal	Jul 2017	Aug 2017	Trend	Last 12 Months
Corporate Induction	100.0 %	100.0 %	55.6 %	▼	
PDR	90.0 %	78.7 %	84.7 %	▲	
Medical Appraisal	100.0 %	79.2 %	81.0 %	▲	
Sickness	4.5 %	5.0 %	4.9 %	▼	
Mandatory Training	90.0 %	78.2 %	77.2 %	▼	
Staff Survey (Recommend Place to Work)		39.6 %	39.6 %	–	
Actual vs Planned Establishment (%)		97.4 %	92.9 %	▼	
Temporary Spend ('000s)		1092	1166	▲	

Financial, Growth and Mandatory Framework

Metric Name	Jul 2017	Aug 2017	Last 12 Months
CIP In Month Variance ('000s)	-72	37	
Monitor Risk Ratings (YTD)	3	3	
Trading Surplus/(Deficit)	-270	-1691	
Capital Expenditure YTD % Variance	22.4 %	-58.5 %	
Cash in Bank (£M)	11.3	10.4	

Exceptions

Aug 2017

Alder Hey Children's NHS
NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	86.3%	88.9%	88.1%	89.2%	87.9%	87.5%	88.9%	87.9%	89.6%	90.3%	88.8%	89.1%	89.0%	
RTT: 95% Non-Admitted within 18 weeks	88.8%	87.5%	86.7%	85.8%	87.2%	90.5%	86.7%	89.5%	90.2%	88.3%	88.7%	88.6%	89.5%	
Cancelled Operations - Non Clinical - On Same Day	14	16	22	28	12	17	29	31	7	57	19	31	15	
Never Events	0	0	0	1	0	0	0	0	0	0	1	0	0	
Cash in Bank (£M)	2.9	4.5	6.5	5.4	6.2	5.2	7.2	6.5	6.2	5.2	3.7	11.3	10.4	

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

Metric Name	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Last 12 Months
RTT: 92% Waiting within 18 weeks (open Pathways)	92.1%	92.0%	92.1%	92.1%	92.1%	92.4%	92.1%	92.1%	92.1%	92.1%	92.1%	92.0%	92.0%	
Theatre Utilisation - % of Session Utilised	85.9%	87.8%	85.1%	85.1%	84.1%	86.6%	87.0%	86.8%	87.2%	87.3%	88.2%	86.1%	87.5%	
DNA Rate	14.6%	12.9%	11.5%	11.9%	14.6%	12.9%	12.7%	10.7%	12.7%	12.7%	11.1%	10.2%	11.4%	
Actual vs Planned Establishment (%)	90.7%	91.8%	87.0%	91.8%	87.7%	89.0%	92.3%	95.1%	94.8%	94.9%	94.8%	97.4%	92.9%	
Trading Surplus/(Deficit)	-695	2,293	500	1,104	-776	535	470	5,972	-1,905	-448	-127	-270	-1,691	

Challenge (Top 5 based on % change)

Metric Name	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Last 12 Months
28 Day Breaches	3	5	4	4	3	2	4	2	4	2	5	1	9	
Corporate Induction	65.4%	85.5%	100.0%	74.1%	81.5%	77.8%	77.8%	82.4%	82.9%	85.7%	79.3%	100.0%	55.6%	
Sickness	4.8%	5.1%	5.4%	5.4%	5.5%	5.4%	5.3%	4.7%	4.5%	4.6%	4.6%	5.0%	4.9%	
IP Survey: % Know their planned date of discharge	69.0%	71.2%	71.6%	73.5%	73.1%	78.7%	72.0%	75.7%	79.4%	69.1%	65.5%	64.0%	53.9%	
IP Survey: % Patients involved in play and learning	30.7%	31.0%	55.9%	55.1%	56.1%	55.6%	77.1%	75.7%	81.4%	75.8%	71.3%	74.0%	65.7%	

Patient Safety

Aug 2017

Alder Hey Children's NHS Foundation Trust

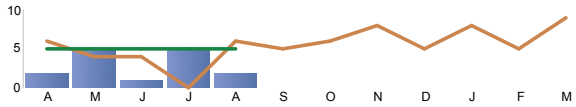
Summary

Medication errors resulting in harm show continued improvement with only 2 in month. There were 3 pressure ulcers, increasing the year to date position to 23 compared to 11 last year. This is felt to be associated with improved education and reporting. There were zero never events in August. Clinical incidents with harm remains significantly higher at 433 compared to 234 last year. A deeper analysis is being undertaken to explore if this is simply improved reporting or if there are any trends or areas causing a real increase in harm caused. There were no incidents resulting in moderate or higher harm in August, and there were no Serious Incidents Requiring Investigation (SIRIs) in month.

17/18 16/17 Threshold

Medication Errors

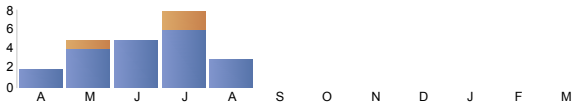
Medication errors resulting in harm (YTD) 15 (goal: 25.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	7	8	13	15							
16/17	6	10	14	14	20	25	31	39	44	52	57	66

Pressure Ulcers

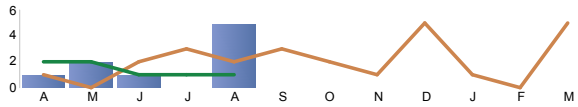
Pressure Ulcers (Grade 2 and above) YTD 23 (Est. Baseline)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	7	12	20	23							
16/17	3	6	8	9	11	16	18	22	26	28	29	32

Readmissions to PICU within 48 hrs

Readmissions to PICU within 48 hrs (YTD) 9 (goal: 7.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	3	4	4	9							
16/17	1	1	3	6	8	11	13	14	19	20	20	25

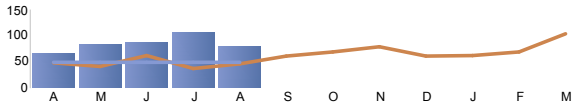
Never Events

Never Events 0 (goal: 0.0)

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

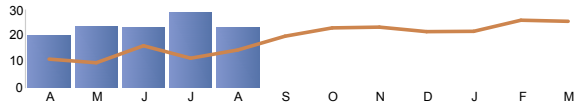
Incidents

Clinical Incidents resulting in harm (YTD) 433 (goal: 245.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	68	154	243	352	433							
16/17	48	89	151	188	234	295	364	443	504	566	635	739

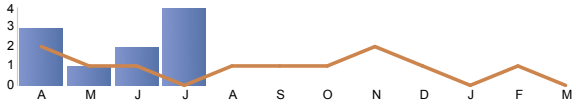
% of Total Clinical Incidents that resulted in Harm 23.8 %



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	21	22	23	24	24							
16/17	11	10	12	12	12	13	15	16	16	17	17	18

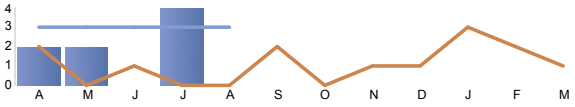
Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) 0



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3	4	6	10	10							
16/17	2	3	4	4	5	6	7	9	10	10	11	11

Clinical Incidents resulting in moderate, severe harm or death (YTD) 8 (goal: 15.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	4	4	8	8							
16/17	2	2	3	3	3	5	5	6	7	10	12	13

Patient Experience

Aug 2017

Alder Hey Children's NHS
NHS Foundation Trust

Summary

There were 5 formal complaints in month, i.e. 27 year to date - very similar to last year's position. PALS attendances have reduced, with only 72 in August. The overall trend is lower than last year, reflecting an improvement in addressing concerns locally immediately and avoiding the need to refer to PALS.
Patients knowing their EDD has reduced from 64% to 53.9%, as has 'patients involved in play and learning', down from 74% to 65.7% in month. All other inpatient survey results have also deteriorated, and Friends and Family responses from A&E and Community still needs to be improved.

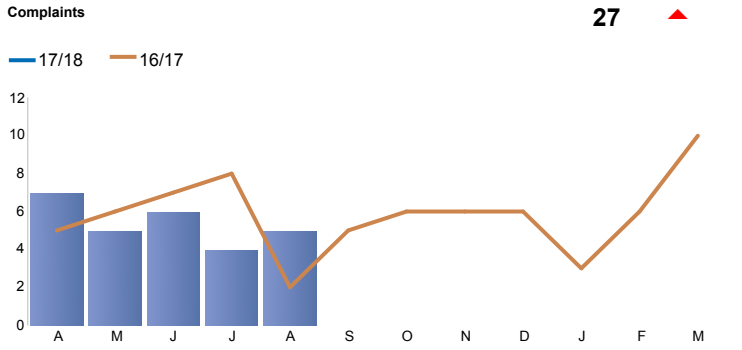
Inpatient Survey

Metric Name	Goal	Jul 2017	Aug 2017	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	92.9 %	91.2 %	▼	
% Patients involved in play and learning	80.0 %	74.0 %	65.7 %	▼	
% Know their planned date of discharge	80.0 %	64.0 %	53.9 %	▼	
% Received information enabling choices about their care	90.0 %	95.7 %	92.1 %	▼	
% Treated with respect	100.0 %	99.4 %	99.3 %	▼	

Friends and Family

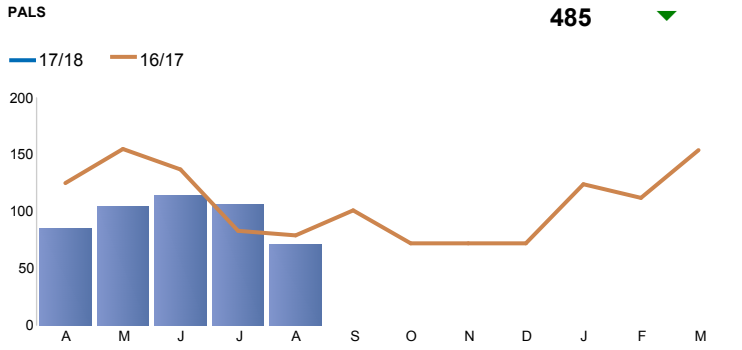
Metric Name	Required Responses	Number of Responses	Jul 2017	Aug 2017	Trend	Last 12 Months
A&E - % Recommend the Trust	250	26	100.0 %	92.3 %	▼	
Community - % Recommend the Trust	29	1	100.0 %	100.0 %	–	
Inpatients - % Recommend the Trust	300	517	97.6 %	94.2 %	▼	
Mental Health - % Recommend the Trust	27	60	93.3 %	96.7 %	▲	
Outpatients - % Recommend the Trust	400	490	92.8 %	92.0 %	▼	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	12	18	22	27							
16/17	5	11	18	26	28	33	39	45	51	54	60	70

PALS



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86	191	306	413	485							
16/17	125	280	417	500	579	680	752	824	896	1,020	1,132	1,286

Clinical Effectiveness

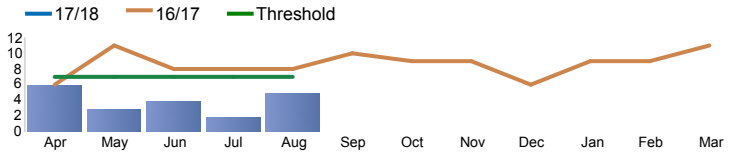
Aug 2017

Alder Hey Children's NHS Foundation Trust

Summary

There were 5 recorded hospital infections in August, resulting in 20 infections year to date compared with 41 at this time last year. MRSA and Clostridium difficile infections remain at zero year to date. There were 7 in month acute readmissions of patients with long term conditions within 48 hours of discharge, a slight increase on the previous month. For surgical patients with an Estimated Date of Discharge (EDD), 3.9% were actually discharged later than the EDD. This is an improvement against 5.4% last year and equates to 66 patients.

Infections



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

Total Infections (YTD)

20 (goal: 35.0) ▲

Hospital Acquired Organisms - MRSA (BSI) (YTD)

0 (goal: 0.0) –

Hospital Acquired Organisms - C.difficile (YTD)

0 (goal: 0.0) –

Outbreak Infections (YTD)

2 –

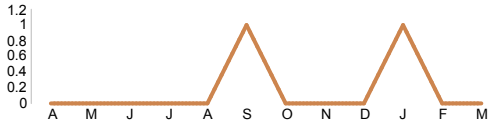
Cluster Infections (YTD)

0 –

Legend

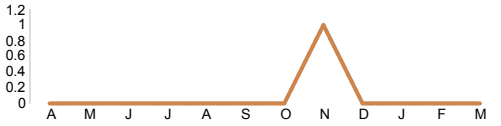
17/18
16/17
Threshold

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



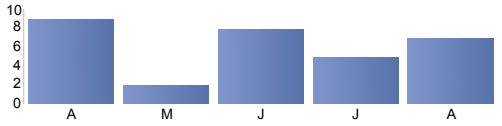
YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	0	0	0	0	0							
16/17	0	0	0	0	0	1	1	1	1	2	2	2

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



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

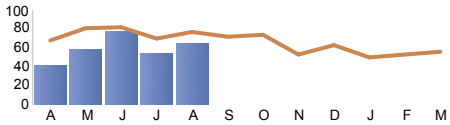
Acute readmissions of patients with long term conditions within 28 days 31 (Est. Baseline)



YTD	Apr	May	Jun	Jul	Aug
17/18	9	11	19	24	31

Admissions & Discharges

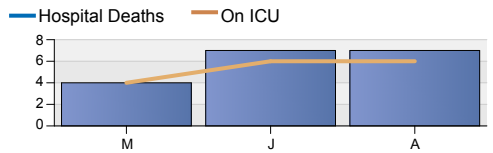
Patients with an estimated discharge date discharge later than planned (only surgical) 301 (Est. Baseline)



% of patients with an estimated discharge date discharge later than planned (only surgical) 3.9 % (Est. Baseline)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3.3%	3.6%	4.0%	3.8%	3.9%							
16/17	5.1%	5.4%	5.5%	5.4%	5.4%	5.3%	5.3%	5.1%	5.1%	4.9%	4.8%	4.7%

Mortality in Hospital



Deaths in Hospital

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

Access

Aug 2017

Alder Hey Children's NHS Foundation Trust

Summary

4 hour, Incomplete pathway, diagnostic & cancer standards achieved. Activity (spells) has increased against same period last year but reduced in line with seasonal variation. GP referrals have increased above 2016 levels and in line with seasonal trends with C&B available to meet current demand. Capacity continues to be monitored via Divisions & daily bed meetings. No patients waiting greater than 52 weeks

18 Weeks

RTT: 90% Admitted within 18 weeks 89.0 %

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
87.6%	88.4%	88.0%	89.5%	89.0%

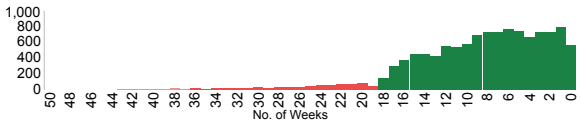
RTT: 95% Non-Admitted within 18 weeks 89.5 %

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
87.9%	86.6%	88.9%	89.1%	89.1%

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

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
92.1%	92.1%	92.2%	92.1%	92.0%

Open Pathways Weekly Profile Aug 2017



0-18 Wks	19-36 Wks	36-51 Wks
11,168	746	116

Cancer

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

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
100.0%	94.4%	100.0%	100.0%	100.0%

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

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

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

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

Diagnostics

Diagnostics: % Completed Within 6 Weeks 100.0 % *(goal: 99.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
99.9%	99.3%	99.8%	100.0%	100.0%

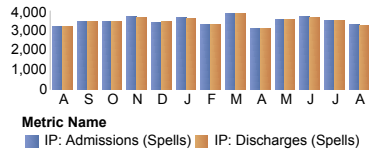
Waiting Times Failed 0

Waiting Times Passed 7

Number of Diagnostics

430

Admissions and Discharges



Bed Occupancy

Bed Occupancy (Funded Beds) 73.9 %

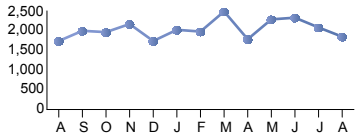
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
76.6%	80.2%	83.9%	80.1%	78.6%

Provider

Convenience and Choice: Slot Availability 99.3 % *(goal: 96.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
97.5%	99.2%	97.0%	98.0%	99.3%

Referrals Received (GP)



Emergency Department

Aug 2017

Alder Hey Children's NHS Foundation Trust

Summary

Significant improvement in 4 hour target since last month when the Trust underachieved for the first time since December 2016. Fewer attendances (4031 compared with 5016 in July) and reduced vacant GP shifts have allowed for better flow through the Department. Conversion rate also slightly lower than last month (16.0%). Median time to treat this month has vastly improved on last month (July: 86 minutes).

ED

ED: 95% Treated within 4 Hours — 98.3 % ▲ (goal: 95.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
96.7%	93.1%	96.7%	96.0%	95.4%

ED: Total Time in ED (95th Percentile) — 232.0 mins ▼ (goal: 240.0 mins)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
705.0	838.8	714.0	717.0	513.0

ED: Longest Wait Time (Hrs) — 7.9 ▼ (goal: 0.0)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
27.6	36.0	30.6	61.3	18.8

ED: Number Treated Over 4 Hours

67

ED to Inpatient Conversion Rate

15.6 %

Aug 2017

ED

ED: 15 minute 'Time to Initial Assessment' (95th Percentile) — 0 –

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

ED: 60 minute 'Time to Treat Decision' (Median) — 50.0 mins ▼ (goal: 60.0 mins)

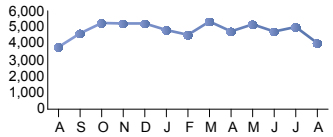
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
184.0	239.0	227.0	247.5	136.0

ED: Percentage Left without being seen — 1.2 % ▼

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
2.2%	3.1%	2.3%	3.0%	2.8%

ED: Number of Attendances

4031 Aug 2017



Ambulance Services

Ambulance: Acute Compliance — 86.2 % ▼ (goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
86.5%	83.3%	90.1%	88.4%	86.6%

Ambulance: Average Notification to Handover Time (mins) — 3.9 mins ▲ (goal: 15.0 mins)

Ambulance: Patients Waiting between 30 and 45 minutes — 1 –

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
16.0	5.0	11.0	9.0	2.0

Ambulance: Patients Waiting between 45 and 60 minutes — 1 ▲

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
3.0	4.0	2.0	2.0	1.0

Productivity & Efficiency

Aug 2017

Alder Hey Children's NHS Foundation Trust

Summary

Planned activity levels have reduced in line with seasonal variation. Elective LOS has reduced and NEL LOS has increased accordingly impacting upon overall hospital occupancy. On the day cancellations have reduced however 28 day relist breaches have increased predominantly due to lack of HDU capacity and managing emergencies. Theatre utilisation has increased with general improvements noted across all areas. Out Patient utilisation has also decreased slightly spread across a number of specialties despite lower DNA rates that will require further analysis and action to address.

Length of Stay

Average LoS - Elective (Days) 2.9 ▼

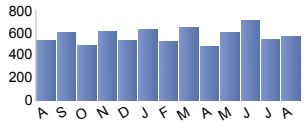
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
2.8	3.0	2.9	3.1	3.0

Average LoS - Non-Elective (Days) 2.2 ▲

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
1.8	1.9	2.0	2.1	2.2

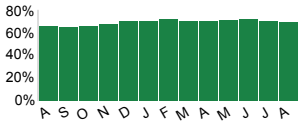
Day Case Rate

Daycases (K1/SDCPREOP) 575 ▲



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
1,721	1,653	1,820	1,819	1,124

Daycase Rate 70.3 % ▼ *(goal: 0.0 %)*



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
66.7%	68.6%	71.2%	71.9%	70.6%

Bed Refusals

Bed Refusals 0 – *(goal: 0.0)*

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

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 87.5 % ▲ *(goal: 90.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
86.2%	84.8%	86.8%	87.6%	86.8%

Cancelled Operations - Non Clinical - On Same Day (%) (YTD) 1.1 % ▼ *(goal: 0.8 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
0.8%	0.9%	1.1%	1.2%	1.0%

Cancelled Operations - Non Clinical - On Same Day 15 ▼

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
50	62	77	83	46

28 Day Breaches 9 ▲ *(goal: 0.0)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
12	11	8	11	10

Outpatients

Clinic Session Utilisation * 83.6 % ▼ *(goal: 90.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
83.0%	85.4%	85.9%	85.8%	84.6%

OP Appointments Cancelled by Hospital % 13.5 % ▲ *(goal: 5.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
14.7%	14.6%	14.5%	13.3%	13.3%

DNA Rate 11.4 % ▲ *(goal: 12.0 %)*

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
13.5%	12.6%	12.0%	12.1%	10.8%

OP: New/Follow Up 2.6 ▲

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
2.4	2.5	2.7	2.6	2.6

Facilities

Aug 2017

Alder Hey Children's NHS Foundation Trust

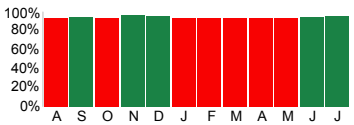
Summary

Facilities

Cleanliness Performance VH

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
97.5%	96.7%	97.7%	99.7%	98.2%

Cleanliness Performance H



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
94.4%	95.7%	94.0%	94.6%	96.8%

Cleanliness Performance S

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
93.0%	96.3%	96.5%	90.3%	84.0%

Cleanliness Performance L

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
98.2%	100.0%	100.0%	90.0%	75.2%

Facilities

Audit Compliance

TBC
(goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
100.0%	77.0%	40.0%	6.7%	20.0%

Facilities - Other

Routine Maintenance Resolution

98.5 % ▲
(goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
97.4%	99.7%	96.6%	92.6%	97.8%

PPM%

98.6 % ▲
(goal: 85.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
97.8%	94.4%	96.1%	94.8%	98.5%

CAMHS

Aug 2017

Alder Hey Children's NHS Foundation Trust

Summary

Waiting times for choice continue to raise due to lack of capacity. A remedial action plan has been produced and additional resource identity. DNAs for the CAMHS Service had increased, the service will undertaken a deep dive to identify the cause.

Waiting Times

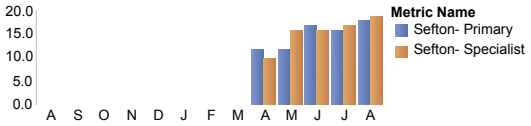
CAMHS: Avg Wait to Choice Appt (Weeks) 0.0

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
6.0	0.0	0.0	0.0	0.0

CAMHS: Avg Wait to Partnership Appt (Weeks)- Liverpool Specialist 18.0

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
0.0	0.0	0.0	43.0	31.0

CAHMS: Avg Wait to Partnership Appt (Weeks)- Sefton Primary and Specialist



DNA Rates

CAMHS: DNA Rate - New 21.7 % ▲ *(goal: 10.0 %)*

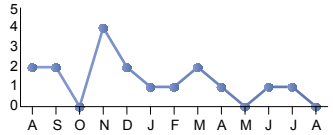
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
15.2%	13.4%	13.4%	13.0%	18.5%

CAMHS: DNA Rate - Follow Up 17.2 % ▲ *(goal: 14.0 %)*

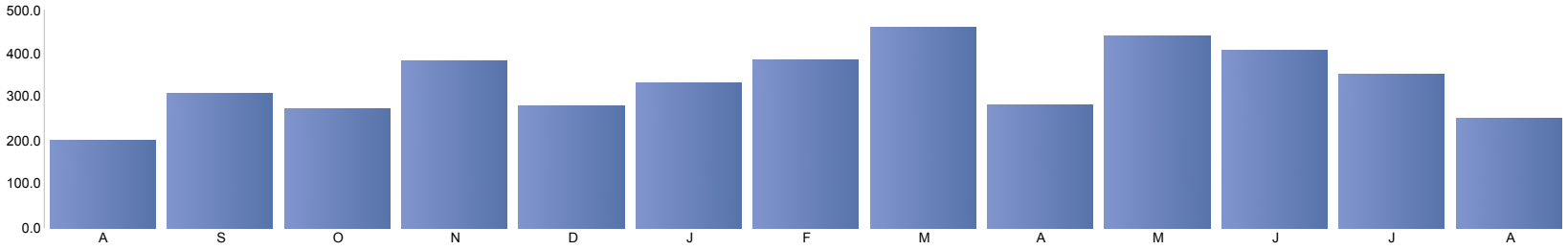
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
15.7%	16.1%	17.6%	16.9%	14.8%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 0 ▼



CAMHS: Referrals Received



External Regulation

Aug 2017

Alder Hey Children's NHS Foundation Trust

Summary

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

Monitor - Governance Concern

Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17
N	N	N	N	N	N	N	N	N	N	N	N

Monitor - Risk Rating

Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17
2	3	3	3	3	3	2	3	3	3	3	3

Monitor Aug 2017

Metric Name	Goal	Jul 17	Aug 17	Trend
ED: 95% Treated within 4 Hours	95.0 %	93.1 %	98.3 %	▲
RTT: 90% Admitted within 18 weeks		89.1 %	89.0 %	▼
RTT: 95% Non-Admitted within 18 weeks		88.6 %	89.5 %	▲
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.0 %	92.0 %	▲
Monitor Risk Ratings (YTD)	2.0	3	3	–
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait until subsequent treatments	100.0 %	100.0 %	100.0 %	–
Hospital Acquired Organisms - C.difficile	0.0	0	0	–

Monitor - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
87.6%	88.4%	88.0%	89.5%	89.0%

RTT: 95% Non-Admitted within 18 weeks

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
87.9%	86.6%	88.9%	89.1%	89.1%

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

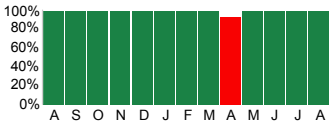
Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
92.1%	92.1%	92.2%	92.1%	92.0%

Monitor - All Cancers

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

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
100.0%	94.4%	100.0%	100.0%	100.0%

All Cancers: 31 day wait referral to treament



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

All Cancers: 31 day wait until subsequent treatments

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

Monitor - A&E 4 Hour Target

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
96.7%	93.1%	96.7%	96.0%	95.4%

Monitor - C difficile

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

Monitor - Data Completeness

No Data Available

Workforce

Aug 2017

Alder Hey Children's NHS Foundation Trust

Summary

The Trust position on sickness absence saw a small increase in August to 5.10%. Medical Appraisals continue to increase in line with the window to 81%. Mandatory Training remains at 75%, work on the OLM data cleanse in ongoing and the roll out of the ESR portal will see the Trust paperless with payslips at the end of September with all staff being able to access their own personal information, mandatory training compliance and payslip from their mobile device.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Last 12 Months
Add Prof Scientific and Technic	5.5%	5.0%	5.8%	5.2%	5.0%	5.9%	4.9%	3.6%	3.6%	3.9%	4.6%	4.4%	
Additional Clinical Services	6.1%	7.0%	6.9%	7.0%	6.6%	5.5%	5.7%	7.2%	7.4%	7.3%	7.7%	6.0%	
Administrative and Clerical	5.0%	5.2%	4.5%	4.7%	4.6%	5.0%	3.3%	2.9%	2.3%	2.4%	3.7%	4.1%	
Allied Health Professionals	3.4%	3.1%	3.3%	4.3%	2.3%	2.2%	3.5%	2.9%	3.2%	3.8%	2.9%	2.8%	
Estates and Ancillary	7.9%	8.4%	8.6%	10.9%	9.1%	7.4%	8.9%	10.7%	9.2%	9.1%	10.8%	14.3%	
Healthcare Scientists	2.8%	2.2%	1.9%	2.0%	1.7%	3.7%	2.3%	1.0%	3.3%	4.0%	4.6%	2.3%	
Medical and Dental	2.7%	2.7%	2.0%	1.6%	2.3%	2.4%	1.6%	1.1%	1.3%	1.3%	1.6%	1.6%	
Nursing and Midwifery Registered	5.1%	5.7%	6.2%	6.1%	6.4%	6.1%	5.5%	5.1%	5.5%	5.4%	5.2%	5.0%	
Trust	5.0%	5.4%	5.4%	5.6%	5.4%	5.2%	4.7%	4.5%	4.6%	4.6%	5.0%	4.9%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Last 12 Months
Add Prof Scientific and Technic	196	200	199	198	198	197	201	197	199	201	200	201	
Additional Clinical Services	369	365	368	367	370	373	376	391	393	392	400	397	
Administrative and Clerical	560	568	574	573	586	589	586	611	621	617	623	626	
Allied Health Professionals	125	126	126	130	132	132	131	208	209	212	214	214	
Estates and Ancillary	192	192	190	190	189	189	189	187	185	184	184	183	
Healthcare Scientists	105	105	106	108	107	107	107	107	107	109	110	110	
Medical and Dental	248	245	246	245	245	246	243	243	242	246	241	245	
Nursing and Midwifery Registered	975	973	971	970	972	981	970	968	971	971	964	960	

Staff in Post Headcount (rolling 12 Months)

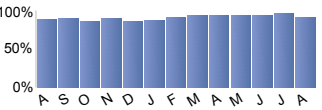
Staff Group	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Last 12 Months
Add Prof Scientific and Technic	217	221	220	218	218	217	221	218	220	223	223	221	
Additional Clinical Services	431	430	431	430	434	439	442	469	470	468	477	473	
Administrative and Clerical	658	666	671	670	677	679	673	700	709	707	713	715	
Allied Health Professionals	154	155	155	161	163	163	161	257	258	261	263	263	
Estates and Ancillary	241	241	238	238	236	236	236	234	231	231	230	229	
Healthcare Scientists	114	114	116	118	117	117	117	117	117	119	119	119	
Medical and Dental	286	283	285	284	284	287	284	285	285	288	284	288	
Nursing and Midwifery Registered	1,099	1,099	1,097	1,093	1,095	1,105	1,094	1,093	1,095	1,096	1,090	1,085	

Finance

Temporary Spend ('000s) 1166

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
3	2	3	3	2

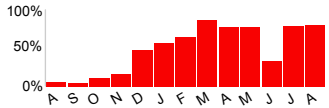
Actual vs Planned Establishment (%) 92.9 %



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
90.9%	88.8%	92.2%	94.8%	95.0%

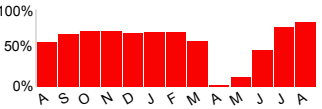
Appraisals

Medical Appraisal 81.0 % (goal: 100.0 %)



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
5.2%	25.5%	68.5%	76.9%	80.1%

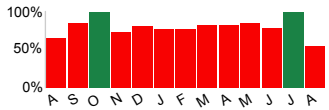
PDR 84.7 % (goal: 90.0 %)



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
62.7%	72.3%	67.2%	21.0%	81.6%

Training

Corporate Induction 55.6 % (goal: 100.0 %)



Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
81.5%	84.0%	79.5%	82.6%	78.9%

Mandatory Training 77.2 % (goal: 90.0 %)

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
76.1%	75.6%	77.1%	76.1%	77.7%

Health and Safety

RIDDOR 0

Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18
3	1	3	2	2

Performance by CBU

Aug 2017

Alder Hey Children's NHS
NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	64.6%	86.9%	84.8%
Convenience and Choice: Slot Availability	100.0%	98.0%	100.0%
DNA Rate (Followup Appts)	15.9%	10.4%	10.0%
DNA Rate (New Appts)	17.6%	13.0%	10.8%
Referrals Received (GP)	228	641	977
Temporary Spend ('000s)	169	326	554
Theatre Utilisation - % of Session Utilised		81.8%	88.6%
Trading Surplus/(Deficit)	145	-302	2,574

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		2.9	2.9
Average LoS - Non-Elective (Days)		1.5	3.0
Cancelled Operations - Non Clinical - On Same Day	0	1	14
Daycases (K1/SDCPREOP)	0	71	499
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	13	16	32
OP Appointments Cancelled by Hospital %	18.5%	13.9%	12.6%
RTT: 90% Admitted within 18 weeks		95.5%	87.8%
RTT: 92% Waiting within 18 weeks (open Pathways)	96.5%	93.3%	91.2%
RTT: 95% Non-Admitted within 18 weeks	93.1%	87.3%	90.2%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores			
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0
Medication Errors (Incidents)	17	139	243

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	57.1%	50.0%	60.0%
Mandatory Training	75.3%	78.3%	77.0%
PDR	82.8%	79.7%	91.1%
Sickness	5.7%	4.0%	4.6%

CBU Performance - Community

Aug 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Clinic utilisation is below required level despite increases in clinic booking rates. Increases in DNA rates have been observed and so further investigation is required to understand if there is a data reporting issue or real increase in DNA rates.

The division is reporting a deficit financial position at M5 related to increases in agency spend to cover medical staff vacancies and additional costs for services transferred from LCH which was not planned.

The division has worked hard to increase rates of PDRs to above 80% and further work is planned during September to get to 90%.

Support Required

Sickness rates are higher than the Trust average and so further work with local managers required to understand trends and what additional support is required to help bring rates down.

Operational

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	75.9%	73.1%	78.4%	80.6%	74.1%	75.9%	80.3%	83.0%	79.0%	81.9%	79.8%	78.7%	64.6%	
DNA Rate (New Appts)	15.8%	12.9%	15.6%	12.8%	18.9%	15.3%	11.8%	11.8%	15.9%	16.4%	14.4%	14.6%	17.6%	
DNA Rate (Followup Appts)	16.7%	15.9%	14.0%	12.3%	17.8%	16.5%	15.7%	13.3%	15.3%	14.4%	13.7%	11.2%	15.9%	
Convenience and Choice: Slot Availability	92.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	
Referrals Received (GP)	200	313	307	393	298	268	336	385	229	387	322	319	228	
Temporary Spend ('000s)	149	144	37	60	47	77	72	150	67	103	116	146	169	
Trading Surplus/(Deficit)	371	244	355	341	415	410	256	442	343	414	299	224	145	

Patient

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	80.9%	87.5%	77.4%	78.0%	80.2%	75.3%	73.1%	88.4%	87.9%	85.4%	91.8%	91.4%	93.1%	
RTT: 92% Waiting within 18 weeks (open Pathways)	89.6%	88.5%	82.5%	85.9%	92.3%	92.8%	93.1%	94.4%	94.0%	97.4%	94.3%	94.6%	96.5%	
Average LoS - Elective (Days)				22.00										
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	18	29	23	29	1	9	19	8	15	3	12	5	13	
Daycases (K1/SDCPREOP)	2	0	0	0	3	0	0	0	0	2	0	1	0	
Cancelled Operations - Non Clinical - On Same Day	0	0	0	0	0	0	0	0	0	0	0	0	0	
OP Appointments Cancelled by Hospital %	23.2%	22.9%	22.3%	17.0%	15.4%	14.2%	20.3%	20.8%	23.1%	14.7%	19.4%	14.3%	18.5%	
Diagnostics: % Completed Within 6 Weeks	100.0%													

Quality

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
Medication Errors (Incidents)	19	20	24	26	27	29	30	31	3	5	8	10	17	
Cleanliness Scores														
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
Corporate Induction	60.0%	86.7%	100.0%	72.7%	87.5%	87.5%	87.5%	100.0%	82.9%		88.9%	100.0%	57.1%	
PDR	68.3%	77.1%	82.1%	81.4%	75.4%	77.2%	76.4%	67.0%	0.0%	5.7%	26.5%	71.0%	82.8%	
Sickness	5.5%	6.2%	7.6%	8.8%	7.1%	7.1%	6.9%	5.9%	5.1%	5.6%	5.6%	6.0%	5.7%	
Mandatory Training	75.4%	73.2%	71.1%	70.9%	72.1%	75.8%	78.0%	57.1%	57.1%	56.1%	55.2%	74.5%	75.3%	

CBU Performance - Medicine (Part 1)

Aug 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Overall Month 5 was positive in terms of delivery of activity within Medicine where they were 4% ahead of plan; Daycase, A&E and Outpatients performed well. It was a better month for Nephrology where we had previously identified coding issues, and we saw an improved performance in month. Division is reviewing activity compared with 2016/17 and identifying in more detail where the challenged specialties any case mix opportunities.

Support Required

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Operational

Metric Name	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Last 12 Months
Theatre Utilisation - % of Session Utilised	75.8%	85.0%	80.1%	79.1%	80.1%	82.9%	79.1%	85.4%	81.1%	83.6%	84.6%	76.9%	81.8%	
Clinic Session Utilisation	81.0%	84.0%	86.6%	86.9%	83.8%	85.4%	86.9%	89.6%	86.8%	86.7%	84.7%	86.7%	86.9%	
DNA Rate (New Appts)	17.5%	14.6%	14.8%	12.5%	14.6%	14.1%	12.4%	10.0%	15.0%	12.6%	12.6%	12.8%	13.0%	
DNA Rate (Followup Appts)	18.7%	15.4%	13.6%	16.1%	18.5%	16.3%	16.8%	13.0%	16.6%	15.8%	11.4%	9.9%	10.4%	
Convenience and Choice: Slot Availability	93.7%	99.4%	98.1%	100.0%	99.6%	96.1%	86.5%	99.4%	98.0%	96.3%	100.0%	100.0%	98.0%	
Referrals Received (GP)	566	627	653	733	563	681	594	821	577	747	791	728	641	
Temporary Spend ('000s)	272	272	230	229	164	499	341	302	290	322	222	323	326	
Trading Surplus/(Deficit)	-307	525	321	491	212	74	-113	1,012	-298	108	-152	-390	-302	

Patient

Metric Name	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	95.8%	100.0%	89.6%	93.1%	87.6%	92.6%	100.0%	91.5%	96.4%		95.7%	90.5%	95.5%	
RTT: 95% Non-Admitted within 18 weeks	86.4%	85.4%	88.6%	83.2%	84.7%	92.4%	89.3%	90.9%	90.9%	86.2%	88.8%	89.1%	87.3%	
RTT: 92% Waiting within 18 weeks (open Pathways)	93.3%	93.2%	95.1%	96.0%	96.7%	96.9%	96.0%	94.8%	94.9%	94.5%	94.0%	93.6%	93.3%	
Average LoS - Elective (Days)	3.01	2.72	3.27	3.25	3.66	3.64	3.22	3.20	3.50	3.40	2.96	3.05	2.92	
Average LoS - Non-Elective (Days)	1.28	1.34	1.29	1.54	1.53	1.44	1.69	1.57	1.62	1.60	1.51	1.65	1.49	
Hospital Initiated Clinic Cancellations < 6 weeks notice	14	27	22	41	29	41	37	27	20	18	23	17	16	
Daycases (K1/SDCPREOP)	68	86	52	46	65	68	63	70	58	70	103	70	71	
Cancelled Operations - Non Clinical - On Same Day	1	4	1	8	4	6	6	3	1	3	1	2	1	
OP Appointments Cancelled by Hospital %	14.6%	13.4%	14.7%	13.6%	14.2%	14.6%	15.0%	14.1%	17.4%	11.3%	13.5%	14.8%	13.9%	
Diagnostics: % Completed Within 6 Weeks	99.5%	100.0%	76.9%	99.1%	99.5%	100.0%	99.7%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Last 12 Months
Medication Errors (Incidents)	114	146	168	198	228	251	270	305	25	58	84	109	139	
Cleanliness Scores	95.0%	96.5%	95.8%	97.5%	97.0%	96.8%	96.8%	99.0%						
Hospital Acquired Organisms - MRSA (BSI)	0	1	0	0	0	1	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Last 12 Months
Corporate Induction	69.2%	80.0%	100.0%	85.0%	83.3%	75.0%	75.0%	68.8%		81.8%	61.5%	100.0%	50.0%	
PDR	78.9%	81.6%	79.7%	79.4%	77.6%	76.7%	75.7%	69.7%	2.9%	15.4%	41.3%	73.8%	79.7%	
Sickness	4.5%	4.7%	4.9%	4.6%	4.8%	4.9%	5.3%	4.5%	4.0%	4.7%	4.3%	4.6%	4.0%	
Mandatory Training	80.1%	76.6%	76.9%	76.3%	76.4%	77.3%	79.2%	79.7%	80.1%	80.0%	80.5%	79.0%	78.3%	

CBU Performance - Medicine (Part 2)

Aug 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

All patient metrics are consistent or improved, with the exception of equipment availability, which will be investigated. MRI waiting time under 6 weeks at 77% and still a concern. Looking at possibility of extra MR sessions at weekends to reduce the MR waiting-list backlog.
All quality metrics consistent or improved.

Support Required

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Patient

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	91.0%	89.0%	96.0%	95.0%	93.0%	96.0%	97.0%	87.0%	96.0%	91.0%	92.0%	90.0%	90.0%	
Imaging - % Reporting Turnaround Times - ED	89.0%	89.0%	88.0%	87.0%	88.0%	88.0%	93.0%	90.0%	80.0%	64.0%	76.0%	83.0%	82.0%	
Imaging - % Reporting Turnaround Times - Inpatients	84.0%	85.0%	87.0%	76.0%	80.0%	86.0%	89.0%	90.0%	78.0%	74.0%	79.0%	85.0%	85.0%	
Imaging - % Reporting Turnaround Times - Outpatients	97.0%	89.0%	93.0%	93.0%	94.0%	97.0%	98.0%	94.0%	92.0%	90.0%	92.0%	98.0%	98.0%	
Imaging - Waiting Times - MRI % under 6 weeks	94.0%	90.0%	88.0%	90.0%	92.0%	92.0%	86.0%	85.0%	71.0%	81.0%	67.0%	68.0%	77.0%	
Imaging - Waiting Times - CT % under 1 week	92.0%	90.0%	86.0%	84.0%	81.0%	81.0%	77.0%	87.0%	95.0%	89.0%	87.0%	87.0%	89.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	94.0%	95.0%	95.0%	94.0%	94.0%	94.0%	92.0%	93.0%	93.0%	94.0%	93.0%	94.0%	92.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	89.0%	88.0%	86.0%	85.0%	83.0%	83.0%	81.0%	87.0%	84.0%	88.0%	90.0%	91.0%	90.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	81.0%	91.0%	85.0%	100.0%	88.0%	88.0%	84.0%	93.0%	88.0%	95.0%	89.0%	100.0%	93.0%	
BME - High Risk Equipment PPM Compliance	90.0%	90.0%	90.4%	89.7%	93.0%	91.0%	91.1%	88.0%	80.2%	91.7%	91.6%	91.2%	90.1%	
BME - Low Risk Equipment PPM Compliance	80.0%	78.0%	77.0%	79.0%	80.0%	81.0%	80.8%	79.0%	100.0%	82.0%	81.9%	80.4%	75.5%	
BME - Equipment Pool - Equipment Availability	100.0%	100.0%	99.8%	100.0%	100.0%	99.8%	100.0%	100.0%	91.4%	99.8%	100.0%	100.0%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	64.0%	44.0%	45.0%	50.0%	51.0%	55.0%	50.0%	45.0%	57.0%	37.0%	60.0%	65.0%	63.0%	
Pharmacy - Dispensing for Out Patients - Complex	100.0%	100.0%	100.0%	97.7%	98.0%	100.0%	98.0%	98.0%	98.0%	100.0%	100.0%	96.0%	97.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	63.0%	63.0%	63.0%	54.3%	54.5%	80.0%	

Quality

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	90.0%	91.3%	90.2%	89.0%	87.9%	87.5%	88.7%	87.9%	89.7%	89.9%	91.0%	88.1%	88.1%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	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%	
Reporting times for perinatal autopsies in 56 Calendar Days	83.0%	100.0%	94.7%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Blood Traceability Compliance	100.0%	99.5%	100.0%	99.6%	99.8%	99.7%	98.8%	99.6%	99.4%	100.0%	100.0%	99.5%	99.8%	

CBU Performance - Surgery

Aug 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

We are delighted that more than 90% of staff have received a PDR this year. We are now turning our focus to supporting staff with access to mandatory training.

On a positive note, our theatre utilisation has improved and is near to the standard. Of concern is our persistent under-utilisation of clinics; in response Divisional Board will receive a report on clinic utilisation in neurosurgery and plastic surgery, which are the departments with the lowest utilisation.

Support Required

Operational

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
Theatre Utilisation - % of Session Utilised	87.6%	88.3%	86.0%	86.1%	84.8%	87.2%	88.5%	87.1%	88.3%	87.9%	88.9%	87.7%	88.6%	
Clinic Session Utilisation	84.3%	84.0%	86.6%	87.9%	84.2%	85.5%	85.3%	88.0%	87.7%	86.1%	85.9%	86.3%	84.8%	
DNA Rate (New Appts)	12.1%	11.3%	10.1%	11.7%	13.3%	12.4%	11.9%	9.8%	10.3%	11.7%	11.7%	9.6%	10.8%	
DNA Rate (Followup Appts)	11.8%	10.5%	8.7%	9.0%	11.2%	8.7%	9.4%	8.3%	9.9%	10.1%	8.9%	9.3%	10.0%	
Convenience and Choice: Slot Availability	99.6%	99.1%	97.4%	100.0%	98.7%	100.0%	99.8%	95.3%	98.2%	99.5%	96.0%	99.0%	100.0%	
Referrals Received (GP)	971	1,055	1,002	1,041	876	1,072	1,046	1,280	976	1,151	1,215	1,033	977	
Temporary Spend ('000s)	436	453	529	426	331	504	475	443	516	402	456	511	554	
Trading Surplus/(Deficit)	1,992	1,921	1,806	2,721	1,539	2,008	2,181	2,821	1,826	2,930	3,321	2,980	2,574	

Patient

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
RTT: 90% Admitted within 18 weeks	85.4%	87.7%	87.9%	88.9%	88.0%	86.8%	87.0%	87.2%	86.9%	90.3%	87.8%	88.8%	87.8%	
RTT: 95% Non-Admitted within 18 weeks	90.8%	88.7%	87.0%	88.6%	89.7%	92.8%	88.1%	89.1%	90.1%	89.8%	88.2%	88.1%	90.2%	
RTT: 92% Waiting within 18 weeks (open Pathways)	91.9%	92.0%	92.1%	91.3%	90.4%	90.6%	90.6%	90.9%	90.9%	90.8%	91.3%	91.2%	91.2%	
Average LoS - Elective (Days)	2.93	2.43	2.87	2.88	2.73	2.17	3.26	2.62	2.58	3.57	2.57	3.10	2.90	
Average LoS - Non-Elective (Days)	2.58	2.27	2.65	2.64	2.55	3.02	2.78	2.64	2.84	3.06	2.57	2.86	2.96	
Hospital Initiated Clinic Cancellations < 6 weeks notice	45	56	34	72	20	30	54	22	19	23	28	35	32	
Daycases (K1/SDCPREOP)	463	515	442	570	471	562	461	582	426	540	609	472	499	
Cancelled Operations - Non Clinical - On Same Day	13	12	21	20	8	11	23	28	6	54	18	29	14	
OP Appointments Cancelled by Hospital %	14.4%	13.8%	14.8%	14.6%	13.8%	14.0%	14.2%	13.7%	13.2%	11.2%	12.7%	12.0%	12.6%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
Medication Errors (Incidents)	233	264	295	336	367	396	430	477	40	97	146	188	243	
Cleanliness Scores	96.6%	96.6%	95.1%	97.9%	96.0%	96.1%	96.2%	97.7%						
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	1	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Last 12 Months
Corporate Induction	64.0%	85.7%	100.0%	65.2%	71.4%	71.4%	71.4%	94.1%		90.0%	100.0%	100.0%	60.0%	
PDR	51.4%	64.2%	63.4%	63.3%	61.1%	63.4%	64.2%	45.1%	1.9%	11.2%	63.0%	87.6%	91.1%	
Sickness	5.2%	5.7%	5.7%	5.8%	5.5%	5.6%	4.9%	4.4%	4.5%	4.5%	4.8%	4.9%	4.6%	
Mandatory Training	78.5%	75.0%	75.3%	75.7%	77.0%	77.5%	78.7%	79.3%	80.6%	80.7%	81.5%	79.1%	77.0%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended August 2017

	In Month			Year to Date			Full Year		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000	Variance £'000
Clinical Income									
Elective	3,678	3,648	(29)	19,771	18,749	(1,023)	48,861	48,861	0
Non Elective	2,211	2,690	479	12,021	13,769	1,748	29,204	29,204	0
Outpatients	2,081	2,243	162	11,559	11,593	34	28,628	28,628	0
A&E	394	399	5	2,479	2,357	(122)	6,036	6,036	0
Critical Care	2,003	2,114	111	10,314	10,851	537	25,222	25,222	0
Non PbR Drugs & Devices	1,796	2,472	676	8,892	9,913	1,021	21,243	21,243	0
Excess Bed Days	388	221	(167)	1,941	1,851	(89)	4,658	4,658	0
CQUIN	261	179	(82)	1,306	1,308	2	3,134	3,134	0
Contract Sanctions	(10)	(4)	6	(52)	(36)	16	(125)	(125)	0
Private Patients	15	58	43	73	126	53	176	176	0
Other Clinical Income	2,914	2,725	(189)	14,862	15,278	416	37,489	37,489	0
Non Clinical Income									
Other Non Clinical Income	2,033	1,961	(72)	9,881	10,342	460	25,181	25,181	0
Total Income	17,763	18,706	943	93,046	96,100	3,053	229,707	229,707	0
Expenditure									
Pay Costs	(12,267)	(12,530)	(263)	(61,136)	(62,022)	(887)	(144,985)	(144,985)	0
Drugs	(1,638)	(2,139)	(501)	(8,111)	(9,511)	(1,400)	(19,368)	(19,368)	0
Clinical Supplies	(1,568)	(1,564)	5	(7,973)	(8,044)	(71)	(18,524)	(18,524)	0
Other Non Pay	(2,203)	(2,378)	(175)	(11,357)	(12,375)	(1,018)	(25,542)	(25,542)	0
PFI service costs	(329)	(346)	(17)	(1,645)	(1,540)	105	(3,948)	(3,948)	0
Total Expenditure	(18,005)	(18,956)	(951)	(90,222)	(93,493)	(3,272)	(212,367)	(212,367)	0
EBITDA	(242)	(250)	(8)	2,825	2,607	(218)	17,340	17,340	0
PDC Dividend	(114)	(114)	0	(569)	(569)	0	(1,365)	(1,365)	0
Depreciation	(548)	(495)	53	(2,677)	(2,475)	202	(6,409)	(6,409)	0
Finance Income	0	2	2	2	9	7	5	5	0
Interest Expense (non-PFI/LIFT)	(92)	(89)	2	(445)	(441)	4	(1,087)	(1,087)	0
Interest Expense (PFI/LIFT)	(675)	(675)	0	(3,374)	(3,374)	0	(8,098)	(8,098)	0
MASS/Restructuring	(62)	(62)	0	(247)	(284)	(37)	(247)	(247)	0
Gains/(Losses) on asset disposals	0	65	65	0	71	71	0	7	7
Control Total Surplus / (Deficit)	(1,732)	(1,618)	114	(4,486)	(4,456)	30	138	145	7
One-off normalising items									
STF Funding	0	0	0	0	93	93	0	93	93
Government Grants/Donated Income	712	196	(516)	5,101	1,970	(3,131)	12,750	12,750	0
Depreciation on Donated Assets	(176)	(172)	4	(871)	(853)	17	(2,089)	(2,089)	0
Fixed Asset Impairment	0	0	0	0	0	0	(1,536)	(1,536)	0
Reported Surplus/(Deficit)	(1,196)	(1,594)	(398)	(256)	(3,246)	(2,990)	9,263	9,363	100

Key Metrics	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income £000	17,763	18,706	943	93,046	96,100	3,053	229,707	229,707	0
Expenditure £000	(19,495)	(20,324)	(829)	(97,532)	(100,556)	(3,024)	(229,569)	(229,562)	7
Control Total Surplus/(Deficit) £000	(1,732)	(1,618)	114	(4,486)	(4,456)	30	138	145	7
WTE	3,223	3,191	(32)	3,223	3,191	(32)			
CIP £000	428	465	37	1,696	1,839	143	8,000	6,067	(1,933)
Cash £000	2,883	10,405	7,522	2,883	10,405	7,522			
CAPEX FCT £000	1,344	558	786	9,112	4,015	5,097	28,972	28,972	0
Use of Resources Risk Rating	3	3	0	3	3	0	3	3	0

Activity Volumes	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Elective	2,116	2,223	107	11,904	11,213	(691)	29,307	29,307	0
Non Elective	1,026	1,056	30	5,600	6,025	425	13,769	13,769	0
Outpatients	14,924	16,111	1,187	83,971	86,905	2,934	206,735	206,735	0
A&E	3,697	4,011	314	23,197	23,645	448	56,463	56,463	0

Alder Hey Children's NHS Foundation Trust
CAPITAL PROGRAMME 2017/18

	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	FULL YEAR FORECAST	FULL YEAR VAR TO REV BUDGET
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ESTATES	**128**	**42**	**86**	**640**	**655**	**(15)**	**1,536**	**1,552**	**(16)**
RESEARCH & EDUCATION	**644**	**116**	**528**	**4,532**	**1,585**	**2,947**	**13,120**	**8,902**	**4,218**
ESTATES TOTAL CAPITAL	**772**	**158**	**614**	**5,172**	**2,240**	**2,932**	**14,656**	**10,454**	**4,202**
GDE, NETWORKING, INFRASTRUCTURE & OTHER IT	250	249	1	1,305	948	**357**	3,431	2,828	603
ELECTRONIC PATIENT RECORD	0	39	(39)	151	174	**(23)**	604	539	65
IM & T TOTAL CAPITAL	**250**	**288**	**(38)**	**1,456**	**1,121**	**335**	**4,035**	**3,367**	**668**
MEDICAL EQUIPMENT	104	86	18	821	342	**479**	1,529	1,598	(69)
NON-MEDICAL EQUIPMENT	0	5	(5)	220	109	**111**	220	278	(58)
CHILDRENS HEALTH PARK	80	(22)	102	743	83	**660**	5,347	5,268	79
ALDER HEY IN THE PARK TOTAL	**184**	**69**	**115**	**1,784**	**534**	**1,250**	**7,096**	**7,144**	**(48)**
OTHER	138	43	95	700	119	**581**	3,185	2,879	306
OTHER	**138**	**43**	**95**	**700**	**119**	**581**	**3,185**	**2,879**	**306**
CAPITAL PROGRAMME 17/18	***1,344***	***558***	***786***	***9,112***	***4,015***	***5,097***	***28,972***	***23,844***	***5,128***

In-Month

Division	Specialty	POD	Activity Plan	Activity Actual	Activity Variance	Income Plan	Income Actual	Income Variance	Income Variance (case-mix)	Income Variance (volume)
Surgery	Anaesthetics	Outpatient New	3	2	-1	£2,431	£1,476	-£955	£1	-£956
		Outpatient Follow-up	102	56	-46	£12,487	£15,430	£2,944	£8,601	-£5,657
	Anaesthetics Total		**106**	**58**	**-48**	**£14,917**	**£16,906**	**£1,989**	**£8,602**	**-£6,613**
	Audiology	Daycase	3	0	-3	£2,930	£0	-£2,930	£0	-£2,930
		Outpatient New	429	420	-9	£40,682	£39,834	-£848	£5	-£853
		Outpatient Follow-up	316	354	38	£29,889	£33,490	£3,601	£31	£3,570
		OP Procedure	1	1	0	£108	£94	-£14	-£6	-£8
	Audiology Total		**750**	**775**	**25**	**£73,608**	**£73,417**	**-£191**	**£30**	**-£221**
	Burns Care	Daycase	4	2	-2	£4,750	£809	-£3,941	-£1,390	-£2,551
		Elective	1	0	-1	£4,919	£0	-£4,919	£0	-£4,919
		Non Elective	21	26	5	£135,874	£159,462	£23,588	-£11,535	£35,123
		Outpatient New	13	14	1	£2,509	£2,777	£268	£2	£266
		Outpatient Follow-up	59	65	6	£11,664	£12,892	£1,228	£11	£1,217
		Ward Attender	27	22	-5	£5,286	£4,363	-£923	£4	-£926
		Ward Based Outpatient	3	11	8	£584	£2,182	£1,598	£2	£1,596
		OP Procedure	0	0	0	£4	£0	-£4	£0	-£4
	Burns Care Total		**128**	**140**	**12**	**£165,591**	**£182,485**	**£16,895**	**-£12,906**	**£29,801**
	Cardiac Surgery	Elective	22	35	13	£359,955	£442,559	£82,604	-£119,844	£202,447
		Non Elective	12	16	4	£317,289	£382,449	£65,160	-£55,133	£120,294
		Excess Bed Days	75	29	-46	£38,217	£22,743	-£15,474	£8,031	-£23,505
		Outpatient New	8	17	9	£5,545	£12,252	£6,707	£11	£6,696
		Outpatient Follow-up	39	76	37	£27,961	£54,774	£26,813	£49	£26,763
		Ward Attender	0	5	5	£0	£3,604	£3,604	£0	£3,604
	Cardiac Surgery Total		**156**	**178**	**22**	**£748,966**	**£918,380**	**£169,414**	**-£166,885**	**£336,299**
	Cardiology	Daycase	18	26	8	£48,036	£73,530	£25,494	£3,841	£21,653
		Elective	18	16	-2	£59,529	£52,376	-£7,153	£685	-£7,838
		Non Elective	11	16	5	£43,114	£65,103	£21,990	£1,643	£20,347
		Excess Bed Days	20	6	-14	£9,256	£3,217	-£6,039	£417	-£6,456
		Outpatient New	157	151	-6	£31,970	£30,619	-£1,352	-£34	-£1,317
		Outpatient Follow-up	453	541	88	£56,696	£67,508	£10,812	-£222	£11,034
		Ward Attender	43	27	-16	£5,584	£3,369	-£2,215	-£112	-£2,102
		Ward Based Outpatient	7	0	-7	£924	£0	-£924	£0	-£924
		OP Imaging	610	622	12	£54,409	£55,498	£1,089	£18	£1,070
	Cardiology Total		**1,338**	**1,405**	**67**	**£309,518**	**£351,221**	**£41,702**	**£6,236**	**£35,467**
	Dentistry	Daycase	107	118	11	£64,853	£74,256	£9,404	£2,918	£6,486
		Elective	3	1	-2	£2,704	£653	-£2,051	-£408	-£1,642
		Non Elective	1	1	0	£981	£869	-£112	-£0	-£112
		Outpatient New	108	96	-12	£3,847	£3,418	-£428	-£1	-£427
		Outpatient Follow-up	100	121	21	£3,565	£4,308	£743	-£3	£746
		OP Procedure	27	18	-9	£3,592	£2,336	-£1,256	-£60	-£1,196
	Dentistry Total		**346**	**355**	**9**	**£79,541**	**£85,841**	**£6,300**	**£2,445**	**£3,855**
	ENT	Daycase	109	96	-13	£113,223	£104,616	-£8,607	£5,103	-£13,709
		Elective	82	60	-22	£109,876	£80,548	-£29,328	-£1	-£29,327
		Non Elective	23	27	4	£32,359	£44,991	£12,632	£7,404	£5,228
		Excess Bed Days	28	0	-28	£11,330	£0	-£11,330	£0	-£11,330
		Outpatient New	354	327	-27	£43,334	£40,834	-£2,499	£797	-£3,297
		Outpatient Follow-up	330	390	60	£20,727	£24,772	£4,045	£252	£3,793
		OP Procedure	226	124	-102	£27,863	£15,697	-£12,167	£426	-£12,593
	ENT Total		**1,152**	**1,024**	**-128**	**£358,712**	**£311,458**	**-£47,254**	**£13,981**	**-£61,235**
	Gynaecology	Daycase	2	6	4	£993	£3,797	£2,804	£235	£2,569
		Elective	1	0	-1	£1,190	£0	-£1,190	£0	-£1,190
		Outpatient New	31	20	-11	£5,189	£3,307	-£1,882	-£0	-£1,882
		Outpatient Follow-up	44	23	-21	£3,076	£1,626	-£1,450	£0	-£1,450
	Gynaecology Total		**78**	**49**	**-29**	**£10,448**	**£8,730**	**-£1,719**	**£235**	**-£1,953**
	Intensive Care	Elective	0	2	2	£0	£1,941	£1,941	£0	£1,941
		Non Elective	17	9	-8	£91,777	£21,463	-£70,314	-£28,051	-£42,262
		Excess Bed Days	18	0	-18	£11,109	£0	-£11,109	£0	-£11,109
		PICU	554	519	-35	£977,430	£936,620	-£40,810	£0	-£40,810
		HDU	382	369	-13	£454,931	£464,313	£9,382	£0	£9,382
		Cardiac HDU	247	242	-5	£238,388	£245,028	£6,641	£0	£6,641
		Cardiac ECMO	13	34	22	£45,104	£117,680	£72,576	£0	£72,576
		Respiratory ECMO	8	0	-8	£49,790	£21,944	-£27,846	£0	-£27,846
	Intensive Care Total		**1,237**	**1,175**	**-62**	**£1,868,527**	**£1,808,989**	**-£59,539**	**-£28,051**	**-£31,487**
	Maxillo-Facial	Outpatient New	49	62	13	£7,468	£10,419	£2,951	£915	£2,037
		Outpatient Follow-up	52	82	30	£9,459	£15,868	£6,409	£1,075	£5,335
		Ward Attender	0	0	0	£5	£0	-£5	£0	-£5
		OP Procedure	1	0	-1	£108	£0	-£108	£0	-£108
	Maxillo-Facial Total		**102**	**144**	**42**	**£17,040**	**£26,288**	**£9,248**	**£1,990**	**£7,258**
	Neurosurgery	Daycase	1	0	-1	£1,623	£0	-£1,623	£0	-£1,623
		Elective	20	19	-1	£185,044	£198,910	£13,865	£24,569	-£10,703
		Non Elective	25	27	2	£209,791	£180,835	-£28,956	-£44,788	£15,832
		Excess Bed Days	25	7	-18	£14,978	£4,254	-£10,724	£129	-£10,853
		Outpatient New	57	68	11	£5,102	£6,057	£955	£5	£950
		Outpatient Follow-up	148	200	52	£13,207	£17,814	£4,607	£14	£4,593
		Ward Attender	43	20	-23	£3,818	£1,781	-£2,036	£1	-£2,038
		Ward Based Outpatient	1	0	-1	£131	£0	-£131	£0	-£131
		Neuro HDU	217	187	-30	£195,356	£207,325	£11,970	£0	£11,970
	Neurosurgery Total		**539**	**528**	**-11**	**£629,049**	**£616,976**	**-£12,073**	**-£20,070**	**£7,997**
	Ophthalmology	Daycase	30	31	1	£36,877	£39,668	£2,790	£1,758	£1,032
		Elective	4	4	0	£8,289	£10,953	£2,664	£2,368	£296
		Non Elective	2	1	-1	£3,253	£1,830	-£1,422	-£165	-£1,257
		Outpatient New	265	296	31	£44,508	£42,784	-£1,723	-£6,968	£5,244
		Outpatient Follow-up	965	1,275	310	£76,841	£83,527	£6,686	-£17,950	£24,636
		OP Procedure	17	30	13	£5,009	£4,754	-£254	-£3,923	£3,669
	Ophthalmology Total		**1,283**	**1,637**	**354**	**£174,776**	**£183,516**	**£8,740**	**-£24,880**	**£33,620**
	Oral Surgery	Daycase	22	24	2	£19,367	£16,927	-£2,440	-£3,884	£1,444
		Elective	13	13	0	£47,421	£46,885	-£535	£154	-£690
		Non Elective	10	3	-7	£10,230	£3,390	-£6,839	£209	-£7,048
	Oral Surgery Total		**45**	**40**	**-5**	**£77,017**	**£67,203**	**-£9,815**	**-£3,521**	**-£6,294**
	Orthodontics	Outpatient New	5	8	3	£806	£1,298	£492	-£0	£492
		Outpatient Follow-up	25	66	41	£1,825	£4,736	£2,911	-£17	£2,928
		OP Procedure	19	17	-2	£2,111	£1,857	-£254	-£46	-£208
	Orthodontics Total		**49**	**91**	**42**	**£4,741**	**£7,890**	**£3,149**	**-£63**	**£3,212**
	Paediatric Surgery	Daycase	122	134	12	£133,038	£147,361	£14,322	£1,760	£12,562

In-Month

	Paediatric Surgery	Elective	36	54	18	£121,657	£152,493	£30,836	-£30,699	£61,536
		Non Elective	125	143	18	£347,508	£528,880	£181,371	£130,394	£50,977
		Excess Bed Days	126	92	-34	£57,431	£52,890	-£4,542	£10,797	-£15,338
		Outpatient New	161	149	-12	£27,474	£25,410	-£2,064	-£2	-£2,062
		Outpatient Follow-up	253	195	-58	£29,107	£22,555	-£6,552	£96	-£6,649
		Ward Attender	71	65	-6	£8,077	£7,435	-£642	-£5	-£637
		Ward Based Outpatient	9	0	-9	£1,061	£0	-£1,061	£0	-£1,061
		OP Procedure	0	2	2	-£0	£458	£458	£459	-£2
		Neonatal HDU	11	17	6	£132,920	£143,933	£11,013	£0	£11,013
	Paediatric Surgery Total		**913**	**851**	**-62**	**£858,274**	**£1,081,413**	**£223,139**	**£112,801**	**£110,338**
	Plastic Surgery	Daycase	72	76	4	£79,738	£87,372	£7,633	£3,344	£4,290
		Elective	10	12	2	£13,949	£19,777	£5,828	£2,301	£3,527
		Non Elective	85	116	31	£139,497	£173,026	£33,529	-£16,491	£50,020
		Excess Bed Days	11	5	-6	£6,344	£1,742	-£4,602	-£1,279	-£3,323
		Outpatient New	212	339	127	£28,835	£45,474	£16,640	-£701	£17,341
		Outpatient Follow-up	362	473	111	£38,388	£50,169	£11,782	-£2	£11,784
		Ward Attender	9	10	1	£909	£1,061	£152	-£0	£152
		Ward Based Outpatient	2	4	2	£187	£424	£238	£0	£238
		OP Procedure	105	188	83	£13,120	£23,795	£10,675	£372	£10,303
	Plastic Surgery Total		**867**	**1,223**	**356**	**£320,966**	**£402,840**	**£81,875**	**-£12,456**	**£94,331**
	Spinal Surgery	Daycase	1	3	2	£579	£16,520	£15,941	£13,650	£2,291
		Elective	11	8	-3	£328,044	£193,563	-£134,481	-£40,928	-£93,553
		Outpatient New	38	55	17	£7,891	£11,324	£3,433	-£0	£3,434
		Outpatient Follow-up	83	87	4	£6,326	£6,604	£278	-£13	£291
	Spinal Surgery Total		**133**	**153**	**20**	**£342,839**	**£228,011**	**-£114,828**	**-£27,291**	**-£87,537**
	Trauma And Orthopaedics	Daycase	37	34	-3	£71,586	£64,707	-£6,879	-£538	-£6,341
		Elective	53	69	16	£222,975	£253,309	£30,334	-£37,177	£67,511
		Non Elective	68	78	10	£185,631	£224,570	£38,938	£11,258	£27,680
		Excess Bed Days	31	35	4	£14,423	£15,188	£766	-£1,139	£1,905
		Outpatient New	623	729	106	£99,292	£114,533	£15,241	-£1,654	£16,895
		Outpatient Follow-up	1,328	1,391	63	£124,302	£127,622	£3,320	-£2,575	£5,896
		Gait New	26	30	4	£30,666	£35,164	£4,498	£0	£4,498
		Gait Follow-Up	23	20	-3	£26,533	£23,442	-£3,090	£0	-£3,090
		Ward Attender	2	2	0	£142	£179	£37	£0	£37
		OP Procedure	190	207	17	£23,408	£25,613	£2,204	£50	£2,154
	Trauma And Orthopaedics Total		**2,380**	**2,595**	**215**	**£798,957**	**£884,327**	**£85,370**	**-£31,774**	**£117,144**
	Urology	Daycase	169	219	50	£152,397	£225,981	£73,583	£28,572	£45,012
		Elective	11	13	2	£33,889	£48,714	£14,825	£7,922	£6,903
		Non Elective	3	6	3	£7,716	£25,184	£17,467	£10,417	£7,050
		Excess Bed Days	13	35	22	£6,748	£13,750	£7,002	-£5,019	£12,022
		Outpatient New	86	70	-16	£12,651	£10,336	-£2,315	-£1	-£2,314
		Outpatient Follow-up	174	208	34	£16,988	£20,331	£3,344	-£1	£3,344
		Ward Attender	3	14	11	£327	£1,369	£1,041	£0	£1,041
		Ward Based Outpatient	6	0	-6	£595	£0	-£595	£0	-£595
		OP Procedure	15	32	17	£3,334	£7,321	£3,986	-£34	£4,020
	Urology Total		**479**	**597**	**118**	**£234,646**	**£352,986**	**£118,340**	**£41,856**	**£76,484**
Surgery Total			**12,080**	**13,018**	**938**	**£7,088,135**	**£7,608,877**	**£520,742**	**-£139,723**	**£660,465**
Medicine	Accident & Emergency	Daycase	0	0	0	£163	£0	-£163	£0	-£163
		Elective	0	0	0	£98	£0	-£98	£0	-£98
		Non Elective	300	229	-71	£208,125	£161,218	-£46,907	£2,308	-£49,215
		Excess Bed Days	3	0	-3	£1,161	£0	-£1,161	£0	-£1,161
		Outpatient New	183	132	-51	£61,640	£44,613	-£17,026	£41	-£17,067
		Outpatient Follow-up	19	9	-10	£6,464	£3,042	-£3,422	£3	-£3,425
		Ward Based Outpatient	1	0	-1	£197	£0	-£197	£0	-£197
		A&E Attendance	3,697	4,011	314	£395,266	£392,093	-£3,173	-£36,701	£33,528
	Accident & Emergency Total		**4,203**	**4,381**	**178**	**£673,113**	**£600,967**	**-£72,146**	**-£34,350**	**-£37,796**
	Allergy	Daycase	34	15	-19	£18,689	£6,863	-£11,826	-£1,382	-£10,444
		Elective	0	2	2	£0	£767	£767	£0	£767
		Outpatient New	65	94	29	£13,951	£20,343	£6,392	£108	£6,284
		Outpatient Follow-up	87	114	27	£11,800	£15,736	£3,936	£206	£3,731
		Ward Attender	0	1	1	£0	£136	£136	£0	£136
		Ward Based Outpatient	0	0	0	£35	£0	-£35	£0	-£35
		OP Procedure	0	0	0	£40	£0	-£40	£0	-£40
	Allergy Total		**186**	**226**	**40**	**£44,515**	**£43,845**	**-£669**	**-£1,068**	**£399**
	Dermatology	Daycase	2	12	10	£1,328	£9,471	£8,143	-£125	£8,268
		Outpatient New	142	141	-1	£19,638	£19,501	-£137	-£1	-£136
		Outpatient Follow-up	314	260	-54	£28,148	£23,251	-£4,897	-£26	-£4,871
		Ward Attender	0	0	0	£3	£0	-£3	£0	-£3
		Ward Based Outpatient	4	3	-1	£351	£268	-£82	-£0	-£82
		OP Procedure	253	268	15	£29,532	£29,104	-£429	-£2,175	£1,746
	Dermatology Total		**715**	**684**	**-31**	**£79,000**	**£81,595**	**£2,595**	**-£2,327**	**£4,922**
	Diabetes	Outpatient New	26	1	-25	£5,277	£202	-£5,075	-£0	-£5,075
		Outpatient Follow-up	3	2	-1	£458	£354	-£104	-£0	-£104
		Ward Attender	0	1	1	£0	£177	£177	£0	£177
		Ward Based Outpatient	0	0	0	£6	£0	-£6	£0	-£6
	Diabetes Total		**29**	**4**	**-25**	**£5,741**	**£732**	**-£5,009**	**-£0**	**-£5,009**
	Endocrinology	Daycase	81	118	37	£62,331	£93,436	£31,106	£2,681	£28,424
		Elective	7	6	-1	£7,792	£4,408	-£3,384	-£2,723	-£660
		Non Elective	2	0	-2	£5,748	£0	-£5,748	£0	-£5,748
		Excess Bed Days	27	5	-22	£11,830	£1,934	-£9,896	-£263	-£9,633
		Outpatient New	57	73	16	£17,432	£22,242	£4,810	-£1	£4,810
		Outpatient Follow-up	253	363	110	£38,664	£54,817	£16,153	-£602	£16,755
		Ward Attender	17	12	-5	£2,491	£1,809	-£681	-£0	-£681
		Ward Based Outpatient	93	97	4	£13,992	£14,626	£634	-£0	£634
	Endocrinology Total		**536**	**674**	**138**	**£160,279**	**£193,273**	**£32,994**	**-£909**	**£33,902**
	Epilepsy	Outpatient New	10	17	7	£2,529	£4,313	£1,784	-£0	£1,785
		Outpatient Follow-up	23	10	-13	£4,595	£1,986	-£2,609	-£0	-£2,609
	Epilepsy Total		**33**	**27**	**-6**	**£7,124**	**£6,299**	**-£825**	**-£0**	**-£825**
	Gastroenterology	Daycase	126	145	19	£90,132	£106,972	£16,840	£3,255	£13,585
		Elective	36	14	-22	£49,446	£17,282	-£32,164	-£1,968	-£30,196
		Non Elective	9	12	3	£27,788	£36,850	£9,062	£735	£8,327
		Excess Bed Days	104	4	-100	£48,527	£1,755	-£46,772	-£110	-£46,662
		Outpatient New	90	140	50	£20,872	£32,553	£11,681	-£7	£11,687
		Outpatient Follow-up	281	246	-35	£40,852	£35,813	-£5,040	-£2	-£5,037
		Ward Attender	22	1	-21	£3,233	£146	-£3,088	£0	-£3,088
		Ward Based Outpatient	77	94	17	£11,234	£13,685	£2,451	-£0	£2,451
	Gastroenterology Total		**745**	**656**	**-89**	**£292,085**	**£245,055**	**-£47,030**	**£1,902**	**-£48,932**
	Haematology	Daycase	21	44	23	£16,428	£32,355	£15,927	-£2,291	£18,218

In-Month

	Haematology	Elective	3	8	5	£11,976	£35,512	£23,536	-£1,054	£24,590
		Non Elective	11	14	3	£13,981	£15,117	£1,137	-£2,517	£3,654
		Excess Bed Days	3	3	0	£879	£1,160	£281	£256	£25
		Outpatient New	19	34	15	£8,636	£15,309	£6,673	-£1	£6,674
		Outpatient Follow-up	53	82	29	£11,126	£17,310	£6,183	-£1	£6,184
		Ward Attender	150	192	42	£31,645	£40,531	£8,886	-£0	£8,886
		Ward Based Outpatient	0	0	0	£53	£0	-£53	£0	-£53
		OP Procedure	0	0	0	£22	£0	-£22	£0	-£22
	Haematology Total		**260**	**377**	**117**	**£94,746**	**£157,294**	**£62,548**	**-£5,607**	**£68,155**
	Immunology	Daycase	4	0	-4	£1,924	£0	-£1,924	£0	-£1,924
		Outpatient New	11	26	15	£2,417	£5,624	£3,207	£27	£3,180
		Outpatient Follow-up	8	25	17	£1,157	£3,424	£2,267	£19	£2,248
		Ward Attender	4	5	1	£581	£681	£100	-£0	£100
		Ward Based Outpatient	14	35	21	£1,856	£4,768	£2,912	£0	£2,912
	Immunology Total		**41**	**91**	**50**	**£7,934**	**£14,497**	**£6,563**	**£46**	**£6,517**
	LTV	Outpatient New	10	6	-4	£6,736	£4,428	-£2,308	£174	-£2,482
		Outpatient Follow-up	42	50	8	£29,119	£36,898	£7,779	£1,955	£5,824
	LTV Total		**51**	**56**	**5**	**£35,855**	**£41,326**	**£5,471**	**£2,129**	**£3,342**
	Metabolic Disease	Outpatient New	4	9	5	£1,686	£3,459	£1,774	£3	£1,770
		Outpatient Follow-up	24	45	21	£9,258	£17,297	£8,039	£15	£8,024
		Ward Based Outpatient	3	5	2	£1,056	£1,922	£866	£2	£864
	Metabolic Disease Total		**31**	**59**	**28**	**£12,000**	**£22,678**	**£10,678**	**£20**	**£10,658**
	Nephrology	Daycase	119	161	42	£212,418	£236,828	£24,411	-£50,608	£75,019
		Elective	27	30	3	£29,102	£19,842	-£9,260	-£11,968	£2,708
		Non Elective	4	1	-3	£12,337	£2,176	-£10,161	-£899	-£9,263
		Excess Bed Days	17	0	-17	£8,513	£0	-£8,513	£0	-£8,513
		Outpatient New	14	21	7	£1,635	£2,481	£846	£2	£844
		Outpatient Follow-up	124	160	36	£14,694	£18,906	£4,212	£18	£4,194
		Ward Attender	59	15	-44	£6,974	£1,654	-£5,320	-£117	-£5,203
		Ward Based Outpatient	47	50	3	£5,492	£5,908	£416	£6	£410
	Nephrology Total		**411**	**438**	**27**	**£291,165**	**£287,795**	**-£3,370**	**-£63,566**	**£60,196**
	Neurology	Daycase	23	9	-14	£25,240	£11,555	-£13,686	£1,663	-£15,349
		Elective	5	14	9	£9,776	£30,038	£20,261	£4,480	£15,781
		Non Elective	9	10	1	£46,325	£55,553	£9,228	£1,230	£7,999
		Excess Bed Days	81	43	-38	£49,084	£27,282	-£21,802	£1,251	-£23,054
		Outpatient New	79	67	-12	£21,917	£18,593	-£3,324	£18	-£3,342
		Outpatient Follow-up	209	193	-16	£57,892	£53,559	-£4,333	£49	-£4,382
		Ward Attender	12	9	-3	£3,373	£2,498	-£876	£2	-£878
		Ward Based Outpatient	16	0	-16	£4,349	£0	-£4,349	£0	-£4,349
	Neurology Total		**434**	**345**	**-89**	**£217,957**	**£199,077**	**-£18,880**	**£8,694**	**-£27,573**
	Oncology	Daycase	159	71	-88	£150,947	£58,097	-£92,850	-£9,414	-£83,437
		DCHEMO	121	168	47	£40,387	£55,862	£15,475	-£0	£15,475
		Elective	26	25	-1	£97,702	£119,357	£21,654	£24,705	-£3,050
		Non Elective	50	23	-27	£101,799	£61,797	-£40,002	£14,982	-£54,984
		Excess Bed Days	58	9	-49	£26,779	£3,327	-£23,452	-£853	-£22,600
		Outpatient New	9	7	-2	£2,302	£1,814	-£487	£2	-£489
		Outpatient Follow-up	196	276	80	£50,865	£71,280	£20,415	-£234	£20,649
		Ward Attender	44	46	2	£11,382	£11,923	£541	£11	£531
		Ward Based Outpatient	8	0	-8	£2,105	£0	-£2,105	£0	-£2,105
	Oncology Total		**671**	**625**	**-46**	**£484,268**	**£383,457**	**-£100,811**	**£29,198**	**-£130,009**
	Paediatrics	Daycase	13	8	-5	£7,324	£5,427	-£1,896	£1,030	-£2,926
		Elective	1	5	4	£619	£7,369	£6,750	£3,205	£3,545
		Non Elective	220	287	67	£255,359	£340,148	£84,789	£7,137	£77,653
		Excess Bed Days	72	16	-56	£29,670	£6,826	-£22,844	£272	-£23,116
		Outpatient New	271	258	-13	£58,397	£55,535	-£2,862	-£2	-£2,860
		Outpatient Follow-up	446	408	-38	£60,766	£55,579	-£5,187	-£3	-£5,184
		Ward Attender	8	5	-3	£1,112	£681	-£431	-£0	-£431
		Ward Based Outpatient	36	11	-25	£4,949	£1,499	-£3,450	-£0	-£3,450
		OP Procedure	0	0	0	£27	£0	-£27	£0	-£27
	Paediatrics Total		**1,069**	**998**	**-71**	**£418,222**	**£473,064**	**£54,842**	**£11,638**	**£43,204**
	Radiology	Daycase	99	126	27	£129,103	£134,346	£5,243	-£29,483	£34,726
		Elective	17	7	-10	£31,126	£17,167	-£13,959	£4,112	-£18,071
		Non Elective	2	1	-1	£25,224	£32,480	£7,256	£22,247	-£14,991
		Excess Bed Days	24	0	-24	£11,551	£0	-£11,551	£0	-£11,551
		OP Imaging	942	1,250	309	£124,966	£129,197	£4,231	-£36,716	£40,947
	Radiology Total		**1,084**	**1,384**	**300**	**£321,970**	**£313,191**	**-£8,779**	**-£39,840**	**£31,060**
	Respiratory Medicine	Daycase	9	29	20	£11,356	£30,206	£18,850	-£7,714	£26,564
		Elective	10	7	-3	£15,927	£29,269	£13,342	£17,564	-£4,222
		Non Elective	16	7	-9	£33,753	£39,966	£6,213	£25,229	-£19,016
		Excess Bed Days	23	33	10	£13,351	£23,271	£9,920	£4,456	£5,464
		Outpatient New	66	73	7	£17,099	£18,940	£1,841	-£68	£1,909
		Outpatient Follow-up	218	306	88	£31,254	£43,911	£12,658	-£3	£12,660
		Ward Attender	3	3	0	£460	£431	-£29	-£0	-£29
		Ward Based Outpatient	121	8	-113	£17,319	£1,148	-£16,171	-£0	-£16,171
		OP Procedure	52	1	-51	£11,050	£77	-£10,973	-£136	-£10,837
	Respiratory Medicine Total		**517**	**467**	**-50**	**£151,568**	**£187,220**	**£35,651**	**£39,328**	**-£3,677**
	Rheumatology	Daycase	151	105	-46	£95,709	£68,557	-£27,152	£1,871	-£29,022
		Elective	18	2	-16	£22,959	£1,891	-£21,069	-£726	-£20,343
		Non Elective	2	3	1	£2,610	£5,333	£2,722	£130	£2,593
		Excess Bed Days	26	0	-26	£10,695	£0	-£10,695	£0	-£10,695
		Outpatient New	49	61	12	£7,307	£9,183	£1,876	£8	£1,868
		Outpatient Follow-up	172	205	33	£25,819	£30,861	£5,042	£85	£4,957
		Ward Attender	14	6	-8	£2,040	£903	-£1,136	£1	-£1,137
		Ward Based Outpatient	9	10	1	£1,385	£1,505	£120	£1	£119
		OP Procedure	0	0	0	£14	£0	-£14	£0	-£14
	Rheumatology Total		**439**	**392**	**-47**	**£168,539**	**£118,233**	**-£50,305**	**£1,370**	**-£51,675**
	Sleep Studies	Daycase	0	1	1	£0	£654	£654	£0	£654
		Elective	22	16	-6	£26,465	£23,630	-£2,834	£4,027	-£6,861
	Sleep Studies Total		**22**	**17**	**-5**	**£26,465**	**£24,284**	**-£2,180**	**£4,027**	**-£6,207**
Medicine Total			**11,476**	**11,901**	**425**	**£3,492,547**	**£3,393,884**	**-£98,663**	**-£49,316**	**-£49,347**
Community	CAMHS	Elective	0	0	0	£259	£0	-£259	£0	-£259
		Outpatient New	170	104	-66	£0	£0	£0	£0	£0
		Outpatient Follow-up	846	1,294	448	£11,358	£4,776	-£6,582	-£12,596	£6,014
	CAMHS Total		**1,016**	**1,398**	**382**	**£11,617**	**£4,776**	**-£6,841**	**-£12,596**	**£5,755**
	Community Medicine	Outpatient New	322	236	-86	£26,080	£28,826	£2,747	£9,710	-£6,964
		Outpatient Follow-up	632	410	-222	£3,191	£3,447	£256	£1,378	-£1,122
		Ward Attender	2	0	-2	£0	£0	£0	£0	£0
		OP Procedure	0	0	0	£12	£0	-£12	£0	-£12

In-Month

Community	**Community Medicine Total**	**957**	**646**	**-311**	**£29,283**	**£32,274**	**£2,990**	**£11,088**	**-£8,098**
Community Total		**1,973**	**2,044**	**71**	**£40,900**	**£37,049**	**-£3,851**	**-£1,508**	**-£2,343**
Grand Total		**25,529**	**26,963**	**1,434**	**£10,621,582**	**£11,039,811**	**£418,228**	**-£190,547**	**£608,775**

Year to Date

Division	Specialty	POD	Activity Plan	Activity Actual	Activity Variance	Income Plan	Income Actual	Income Variance	Income Variance (case-mix)	Income Variance (volume)
Surgery	Anaesthetics	Outpatient New	16	21	5	£12,153	£14,884	£2,731	-£599	£3,330
		Outpatient Follow-up	512	226	-286	£62,433	£55,371	-£7,063	£27,808	-£34,871
	Anaesthetics Total		**528**	**247**	**-281**	**£74,586**	**£70,255**	**-£4,332**	**£27,209**	**-£31,541**
	Audiology	Daycase	17	12	-5	£14,650	£9,525	-£5,125	-£1,023	-£4,102
		Outpatient New	2,419	3,260	841	£229,399	£309,367	£79,968	£221	£79,747
		Outpatient Follow-up	1,783	1,554	-229	£168,538	£147,015	-£21,523	£138	-£21,661
		OP Procedure	6	7	1	£607	£673	£66	-£25	£91
	Audiology Total		**4,225**	**4,833**	**608**	**£413,194**	**£466,580**	**£53,386**	**-£689**	**£54,075**
	Burns Care	Daycase	24	13	-11	£26,785	£13,729	-£13,056	-£565	-£12,491
		Elective	8	5	-3	£27,738	£8,262	-£19,476	-£8,337	-£11,139
		Non Elective	127	96	-31	£837,336	£608,992	-£228,344	-£22,382	-£205,962
		Outpatient New	71	64	-7	£14,146	£12,694	-£1,452	£11	-£1,463
		Outpatient Follow-up	332	297	-35	£65,774	£58,709	-£7,065	-£148	-£6,918
		Ward Attender	150	168	18	£29,807	£33,321	£3,514	£29	£3,485
		Ward Based Outpatient	17	67	50	£3,293	£13,289	£9,996	£11	£9,984
		OP Procedure	0	31	31	£25	£3,809	£3,784	-£59	£3,843
	Burns Care Total		**731**	**741**	**10**	**£1,004,905**	**£752,804**	**-£252,101**	**-£31,440**	**-£220,661**
	Cardiac Surgery	Elective	126	145	19	£2,029,747	£2,257,345	£227,598	-£72,608	£300,206
		Non Elective	58	60	2	£1,588,713	£1,560,572	-£28,141	-£80,363	£52,222
		Excess Bed Days	377	127	-250	£191,083	£94,163	-£96,920	£29,736	-£126,656
		Outpatient New	43	61	18	£31,266	£43,963	£12,698	£40	£12,658
		Outpatient Follow-up	219	264	45	£157,671	£190,267	£32,597	£172	£32,425
		Ward Attender	0	21	21	£0	£15,135	£15,135	£0	£15,135
	Cardiac Surgery Total		**823**	**678**	**-145**	**£3,998,479**	**£4,161,446**	**£162,967**	**-£123,023**	**£285,990**
	Cardiology	Daycase	101	93	-8	£270,870	£254,276	-£16,594	£5,003	-£21,597
		Elective	104	87	-17	£335,679	£323,221	-£12,458	£42,151	-£54,610
		Non Elective	54	75	21	£215,876	£456,988	£241,112	£159,519	£81,593
		Excess Bed Days	99	42	-57	£46,280	£19,426	-£26,854	-£175	-£26,679
		Outpatient New	888	786	-102	£180,278	£159,380	-£20,898	-£179	-£20,719
		Outpatient Follow-up	2,554	2,901	347	£319,702	£361,997	£42,295	-£1,192	£43,487
		Ward Attender	244	167	-77	£31,487	£20,840	-£10,647	-£695	-£9,953
		Ward Based Outpatient	42	36	-6	£5,210	£4,492	-£717	-£0	-£717
		OP Procedure	0	1	1	£0	£185	£185	£0	£185
		OP Imaging	3,050	3,389	339	£272,047	£287,767	£15,720	-£14,517	£30,237
	Cardiology Total		**7,136**	**7,577**	**441**	**£1,677,429**	**£1,888,572**	**£211,143**	**£189,915**	**£21,228**
	Dentistry	Daycase	605	517	-88	£365,697	£324,051	-£41,646	£11,493	-£53,138
		Elective	14	6	-8	£15,246	£5,954	-£9,293	-£415	-£8,878
		Non Elective	6	5	-1	£4,912	£12,034	£7,121	£7,687	-£565
		Outpatient New	609	522	-87	£21,690	£18,586	-£3,104	-£8	-£3,097
		Outpatient Follow-up	564	514	-50	£20,103	£18,301	-£1,802	-£13	-£1,789
		OP Procedure	152	164	12	£20,253	£20,981	£728	-£845	£1,574
	Dentistry Total		**1,950**	**1,728**	**-222**	**£447,901**	**£399,907**	**-£47,994**	**£17,899**	**-£65,893**
	ENT	Daycase	616	535	-81	£638,450	£573,218	-£65,231	£18,640	-£83,871
		Elective	462	352	-110	£619,581	£478,449	-£141,132	£5,893	-£147,025
		Non Elective	116	128	12	£162,027	£217,491	£55,464	£39,300	£16,164
		Excess Bed Days	139	136	-3	£56,652	£56,729	£78	£1,200	-£1,123
		Outpatient New	1,996	1,540	-456	£244,354	£192,257	-£52,097	£3,703	-£55,801
		Outpatient Follow-up	1,859	1,873	14	£116,875	£118,957	£2,082	£1,200	£882
		OP Procedure	1,276	1,430	154	£157,119	£177,608	£20,489	£1,503	£18,985
	ENT Total		**6,463**	**5,994**	**-469**	**£1,995,058**	**£1,814,710**	**-£180,348**	**£71,439**	**-£251,787**
	Gynaecology	Daycase	9	16	7	£5,599	£9,232	£3,633	-£266	£3,899
		Elective	6	5	-1	£6,712	£7,240	£528	£1,914	-£1,386
		Outpatient New	177	143	-34	£29,258	£23,643	-£5,615	-£0	-£5,615
		Outpatient Follow-up	245	206	-39	£17,347	£14,566	-£2,781	£0	-£2,781
	Gynaecology Total		**438**	**370**	**-68**	**£58,917**	**£54,681**	**-£4,235**	**£1,647**	**-£5,882**
	Intensive Care	Elective	0	5	5	£0	£17,979	£17,979	£0	£17,979
		Non Elective	84	65	-19	£459,539	£431,368	-£28,171	£73,765	-£101,936
		Excess Bed Days	101	242	141	£62,643	£102,470	£39,827	-£48,090	£87,917
		PICU	2,769	2,808	39	£4,887,151	£4,948,740	£61,589	£0	£61,589
		HDU	1,910	2,050	140	£2,274,653	£2,404,519	£129,866	£0	£129,866
		Cardiac HDU	1,233	1,220	-13	£1,191,938	£1,206,591	£14,654	£0	£14,654
		Cardiac ECMO	63	74	12	£225,518	£302,472	£76,954	£0	£76,954
		Respiratory ECMO	38	47	10	£248,949	£286,661	£37,712	£0	£37,712
	Intensive Care Total		**6,197**	**6,511**	**314**	**£9,350,391**	**£9,700,801**	**£350,410**	**£25,675**	**£324,735**
	Maxillo-Facial	Outpatient New	275	302	27	£42,111	£49,005	£6,894	£2,708	£4,186
		Outpatient Follow-up	296	432	136	£53,338	£83,709	£30,371	£5,772	£24,599
		Ward Attender	0	2	2	£30	£291	£262	-£0	£262
		OP Procedure	5	1	-4	£610	£105	-£505	-£10	-£494
	Maxillo-Facial Total		**576**	**737**	**161**	**£96,088**	**£133,110**	**£37,022**	**£8,469**	**£28,553**
	Neurosurgery	Daycase	5	14	9	£9,152	£31,310	£22,158	£6,538	£15,620
		Elective	114	124	10	£1,043,444	£1,058,921	£15,478	-£78,881	£94,359
		Non Elective	126	140	14	£1,050,457	£849,675	-£200,782	-£320,225	£119,442
		Excess Bed Days	127	92	-35	£74,889	£36,736	-£38,153	-£17,479	-£20,674
		Outpatient New	323	347	24	£28,767	£30,907	£2,140	£24	£2,116
		Outpatient Follow-up	837	931	94	£74,471	£82,924	£8,454	£65	£8,388
		Ward Attender	242	141	-101	£21,527	£12,559	-£8,968	£10	-£8,978
		Ward Based Outpatient	8	0	-8	£741	£0	-£741	£0	-£741
		Neuro HDU	1,085	979	-106	£976,778	£960,750	-£16,028	£0	-£16,028
	Neurosurgery Total		**2,867**	**2,768**	**-99**	**£3,280,225**	**£3,063,783**	**-£216,442**	**-£409,947**	**£193,505**
	Ophthalmology	Daycase	170	166	-4	£207,947	£217,425	£9,478	£14,424	-£4,947
		Elective	22	16	-6	£46,742	£41,800	-£4,942	£7,459	-£12,401
		Non Elective	8	5	-3	£16,286	£5,523	-£10,763	-£4,453	-£6,310
		Excess Bed Days	0	1	1	£0	£574	£574	£0	£574
		Outpatient New	1,493	1,432	-61	£250,973	£206,983	-£43,991	-£33,708	-£10,283
		Outpatient Follow-up	5,444	6,202	758	£433,297	£407,447	-£25,850	-£86,170	£60,320

Year to Date

Surgery	Ophthalmology	OP Procedure	98	333	235	£28,243	£57,999	£29,756	-£38,321	£68,077
	Ophthalmology Total		**7,235**	**8,155**	**920**	**£983,488**	**£937,752**	**-£45,737**	**-£140,768**	**£95,032**
	Oral Surgery	Daycase	126	132	6	£109,208	£95,574	-£13,634	-£18,884	£5,250
		Elective	74	62	-12	£267,400	£202,738	-£64,662	-£20,134	-£44,529
		Non Elective	48	36	-12	£51,221	£42,978	-£8,243	£4,800	-£13,043
	Oral Surgery Total		**249**	**230**	**-19**	**£427,829**	**£341,290**	**-£86,539**	**-£34,218**	**-£52,322**
	Orthodontics	Elective	0	1	1	£0	£1,314	£1,314	£0	£1,314
		Outpatient New	28	36	8	£4,542	£5,840	£1,298	-£0	£1,298
		Outpatient Follow-up	143	313	170	£10,288	£22,557	£12,269	£18	£12,251
		OP Procedure	106	71	-35	£11,906	£7,800	-£4,106	-£149	-£3,957
	Orthodontics Total		**277**	**421**	**144**	**£26,736**	**£37,511**	**£10,775**	**-£132**	**£10,906**
	Paediatric Surgery	Daycase	690	696	6	£750,187	£750,215	£28	-£6,036	£6,064
		Elective	202	240	38	£686,009	£930,826	£244,817	£116,638	£128,179
		Non Elective	624	684	60	£1,740,028	£2,504,501	£764,474	£598,458	£166,016
		Excess Bed Days	628	663	35	£287,156	£311,954	£24,798	£8,612	£16,186
		Outpatient New	908	818	-90	£154,923	£139,503	-£15,421	-£7	-£15,414
		Outpatient Follow-up	1,425	1,202	-223	£164,132	£138,739	-£25,393	£304	-£25,697
		Ward Attender	398	334	-64	£45,545	£38,206	-£7,339	-£24	-£7,315
		Ward Based Outpatient	52	22	-30	£5,982	£2,517	-£3,466	-£0	-£3,466
		OP Procedure	0	3	3	-£0	£686	£686	£689	-£2
		Neonatal HDU	55	262	207	£664,602	£792,498	£127,896	£0	£127,896
	Paediatric Surgery Total		**4,983**	**4,924**	**-59**	**£4,498,564**	**£5,609,645**	**£1,111,081**	**£718,633**	**£392,448**
	Plastic Surgery	Daycase	407	486	79	£449,635	£611,146	£161,511	£73,810	£87,701
		Elective	54	41	-13	£78,658	£106,739	£28,080	£47,028	-£18,948
		Non Elective	428	538	110	£698,480	£984,401	£285,920	£105,434	£180,487
		Excess Bed Days	53	35	-18	£31,719	£17,014	-£14,706	-£4,133	-£10,573
		Outpatient New	1,194	1,525	331	£162,595	£204,773	£42,178	-£2,947	£45,126
		Outpatient Follow-up	2,041	2,191	150	£216,463	£232,391	£15,927	-£9	£15,936
		Ward Attender	48	105	57	£5,124	£11,137	£6,013	-£0	£6,013
		Ward Based Outpatient	10	42	32	£1,052	£4,243	£3,190	-£212	£3,402
		OP Procedure	594	1,123	529	£73,984	£142,835	£68,851	£2,920	£65,931
	Plastic Surgery Total		**4,827**	**6,086**	**1,259**	**£1,717,712**	**£2,314,678**	**£596,966**	**£221,891**	**£375,075**
	Spinal Surgery	Daycase	3	34	31	£3,266	£257,212	£253,946	£224,689	£29,257
		Elective	63	60	-3	£1,849,801	£1,399,059	-£450,743	-£359,624	-£91,119
		Non Elective	0	3	3	£0	£52,120	£52,120	£0	£52,120
		Excess Bed Days	0	10	10	£0	£5,014	£5,014	£0	£5,014
		Outpatient New	192	255	63	£39,453	£52,503	£13,049	-£2	£13,051
		Outpatient Follow-up	416	436	20	£31,630	£33,293	£1,663	£131	£1,532
		Ward Attender	0	5	5	£0	£380	£380	£0	£380
	Spinal Surgery Total		**674**	**803**	**129**	**£1,924,151**	**£1,799,581**	**-£124,570**	**-£134,806**	**£10,236**
	Trauma And Orthopaedics	Daycase	210	196	-14	£403,664	£376,182	-£27,482	£68	-£27,550
		Elective	299	318	19	£1,257,331	£1,248,157	-£9,174	-£90,604	£81,430
		Non Elective	339	335	-4	£926,258	£1,038,149	£111,891	£122,004	-£10,113
		Excess Bed Days	155	183	28	£72,115	£80,977	£8,863	-£4,394	£13,257
		Outpatient New	3,513	3,840	327	£559,895	£603,450	£43,555	-£8,563	£52,118
		Outpatient Follow-up	7,489	6,641	-848	£700,925	£609,100	-£91,826	-£12,498	-£79,328
		Gait New	148	147	-1	£172,921	£172,302	-£619	£1	-£620
		Gait Follow-Up	128	113	-15	£149,614	£132,450	-£17,164	£1	-£17,165
		Ward Attender	9	3	-6	£799	£179	-£620	-£89	-£530
		Ward Based Outpatient	0	1	1	£0	£0	£0	£0	£0
		OP Procedure	1,069	1,622	553	£131,998	£202,979	£70,981	£2,678	£68,303
	Trauma And Orthopaedics Total		**13,357**	**13,399**	**42**	**£4,375,519**	**£4,463,924**	**£88,405**	**£8,604**	**£79,802**
	Urology	Daycase	953	1,088	135	£859,351	£1,030,624	£171,274	£49,890	£121,383
		Elective	61	63	2	£191,098	£294,471	£103,373	£96,783	£6,590
		Non Elective	16	30	14	£38,637	£72,130	£33,493	-£1,704	£35,196
		Excess Bed Days	63	107	44	£33,741	£48,895	£15,154	-£8,487	£23,641
		Outpatient New	483	449	-34	£71,338	£66,300	-£5,038	-£4	-£5,034
		Outpatient Follow-up	980	927	-53	£95,791	£90,612	-£5,180	-£3	-£5,177
		Ward Attender	19	90	71	£1,845	£8,798	£6,953	£0	£6,953
		Ward Based Outpatient	34	20	-14	£3,353	£1,955	-£1,398	£0	-£1,398
		OP Procedure	82	205	123	£18,801	£46,898	£28,097	-£215	£28,312
	Urology Total		**2,691**	**2,979**	**288**	**£1,313,956**	**£1,660,682**	**£346,726**	**£136,261**	**£210,465**
Surgery Total			**66,228**	**69,181**	**2,953**	**£37,665,129**	**£39,671,710**	**£2,006,581**	**£552,620**	**£1,453,961**
Medicine	Accident & Emergency	Daycase	1	0	-1	£917	£0	-£917	£0	-£917
		Elective	1	1	0	£551	£947	£396	£269	£127
		Non Elective	1,502	1,418	-84	£1,042,114	£1,024,879	-£17,235	£40,887	-£58,121
		Excess Bed Days	15	0	-15	£5,803	£0	-£5,803	£0	-£5,803
		Outpatient New	1,029	778	-251	£347,578	£262,947	-£84,632	£239	-£84,871
		Outpatient Follow-up	108	46	-62	£36,449	£15,547	-£20,902	£14	-£20,916
		Ward Based Outpatient	3	0	-3	£985	£0	-£985	£0	-£985
		A&E Attendance	23,197	23,645	448	£2,479,903	£2,356,841	-£123,062	-£170,922	£47,859
	Accident & Emergency Total		**25,856**	**25,888**	**32**	**£3,914,299**	**£3,661,160**	**-£253,139**	**-£129,513**	**-£123,626**
	Allergy	Daycase	170	86	-84	£93,444	£36,643	-£56,801	-£10,629	-£46,172
		Elective	0	2	2	£0	£767	£767	£0	£767
		Outpatient New	365	381	16	£78,666	£81,992	£3,326	-£22	£3,348
		Outpatient Follow-up	488	483	-5	£66,537	£66,332	-£206	£532	-£738
		Ward Attender	0	1	1	£0	£136	£136	£0	£136
		Ward Based Outpatient	1	2	1	£198	£272	£74	£0	£74
		OP Procedure	2	5	3	£228	£733	£505	£109	£396
	Allergy Total		**1,027**	**960**	**-67**	**£239,074**	**£186,876**	**-£52,198**	**-£10,009**	**-£42,189**
	Dermatology	Daycase	9	46	37	£7,487	£33,124	£25,637	-£3,662	£29,298
		Outpatient New	801	713	-88	£110,735	£98,609	-£12,126	-£6	-£12,120
		Outpatient Follow-up	1,773	1,451	-322	£158,726	£129,937	-£28,789	£29	-£28,818
		Ward Attender	0	0	0	£18	£0	-£18	£0	-£18
		Ward Based Outpatient	22	38	16	£1,977	£3,398	£1,421	£0	£1,421
		OP Procedure	1,427	1,786	359	£166,530	£196,723	£30,193	-£11,721	£41,914
	Dermatology Total		**4,032**	**4,034**	**2**	**£445,473**	**£461,792**	**£16,319**	**-£15,359**	**£31,678**
	Diabetes	Outpatient New	147	6	-141	£29,754	£1,210	-£28,544	-£0	-£28,544
		Outpatient Follow-up	15	12	-3	£2,583	£2,121	-£461	-£0	-£461

Year to Date

Medicine	Diabetes	Ward Attender	0	6	6	£0	£1,061	£1,061	£0	£1,061
		Ward Based Outpatient	0	0	0	£34	£0	-£34	£0	-£34
	Diabetes Total		**162**	**24**	**-138**	**£32,371**	**£4,392**	**-£27,978**	**-£0**	**-£27,978**
	Endocrinology	Daycase	457	516	59	£351,475	£392,293	£40,817	-£4,568	£45,386
		Elective	37	23	-14	£43,936	£21,685	-£22,251	-£5,651	-£16,600
		Non Elective	8	7	-1	£28,780	£26,848	-£1,932	£2,750	-£4,682
		Excess Bed Days	135	211	76	£59,151	£93,128	£33,977	£391	£33,586
		Outpatient New	323	279	-44	£98,296	£85,006	-£13,291	-£3	-£13,288
		Outpatient Follow-up	1,428	1,655	227	£218,024	£250,776	£32,753	-£1,892	£34,645
		Ward Attender	93	43	-50	£14,044	£6,484	-£7,560	-£0	-£7,560
		Ward Based Outpatient	523	392	-131	£78,901	£59,108	-£19,793	-£2	-£19,792
	Endocrinology Total		**3,004**	**3,126**	**122**	**£892,608**	**£935,328**	**£42,720**	**-£8,975**	**£51,695**
	Epilepsy	Outpatient New	56	61	5	£14,261	£15,477	£1,216	-£1	£1,217
		Outpatient Follow-up	130	49	-81	£25,913	£9,732	-£16,181	-£0	-£16,181
	Epilepsy Total		**187**	**110**	**-77**	**£40,174**	**£25,209**	**-£14,965**	**-£1**	**-£14,963**
	Gastroenterology	Daycase	711	741	30	£508,245	£567,216	£58,971	£37,187	£21,784
		Elective	203	92	-111	£278,818	£123,487	-£155,331	-£3,013	-£152,318
		Non Elective	46	43	-3	£139,139	£156,160	£17,022	£26,748	-£9,727
		Excess Bed Days	520	143	-377	£242,634	£66,621	-£176,013	-£50	-£175,963
		Outpatient New	506	465	-41	£117,697	£108,288	-£9,409	£143	-£9,552
		Outpatient Follow-up	1,582	1,180	-402	£230,362	£171,785	-£58,577	-£11	-£58,566
		Ward Attender	125	23	-102	£18,233	£3,348	-£14,885	-£0	-£14,885
		Ward Based Outpatient	435	483	48	£63,349	£70,318	£6,969	-£2	£6,971
	Gastroenterology Total		**4,129**	**3,170**	**-959**	**£1,598,477**	**£1,267,224**	**-£331,253**	**£61,003**	**-£392,255**
	Haematology	Daycase	118	235	117	£92,636	£175,628	£82,991	-£9,414	£92,405
		Elective	15	32	17	£67,530	£145,743	£78,213	-£521	£78,734
		Non Elective	56	81	25	£70,003	£179,785	£109,782	£77,756	£32,026
		Excess Bed Days	15	5	-10	£4,396	£2,116	-£2,280	£609	-£2,889
		Outpatient New	108	128	20	£48,696	£57,633	£8,938	-£2	£8,940
		Outpatient Follow-up	297	310	13	£62,741	£65,439	£2,698	-£2	£2,700
		Ward Attender	845	970	125	£178,443	£204,767	£26,324	-£0	£26,324
		Ward Based Outpatient	1	1	0	£300	£211	-£89	-£0	-£89
		OP Procedure	1	0	-1	£127	£0	-£127	£0	-£127
	Haematology Total		**1,456**	**1,762**	**306**	**£524,871**	**£831,321**	**£306,450**	**£68,425**	**£238,025**
	Immunology	Daycase	18	17	-1	£9,619	£9,441	-£178	£97	-£275
		Non Elective	0	1	1	£0	£1,416	£1,416	£0	£1,416
		Outpatient New	63	111	48	£13,627	£24,083	£10,456	£189	£10,267
		Outpatient Follow-up	48	197	149	£6,527	£27,335	£20,809	£498	£20,311
		Ward Attender	24	46	22	£3,275	£6,267	£2,991	£0	£2,991
		Ward Based Outpatient	77	250	173	£10,465	£34,058	£23,593	£0	£23,593
	Immunology Total		**230**	**622**	**392**	**£43,512**	**£102,600**	**£59,088**	**£785**	**£58,304**
	LTV	Outpatient New	48	42	-6	£33,679	£30,994	-£2,684	£1,215	-£3,900
		Outpatient Follow-up	208	305	97	£145,596	£226,554	£79,482	£11,926	£67,556
	LTV Total		**256**	**347**	**91**	**£179,275**	**£257,548**	**£76,798**	**£13,141**	**£63,657**
	Metabolic Disease	Outpatient New	25	18	-7	£9,506	£6,919	-£2,588	£6	-£2,594
		Outpatient Follow-up	136	139	3	£52,205	£53,429	£1,224	£47	£1,176
		Ward Attender	0	1	1	£0	£384	£384	£0	£384
		Ward Based Outpatient	14	19	5	£5,281	£7,303	£2,023	£6	£2,016
	Metabolic Disease Total		**174**	**177**	**3**	**£66,992**	**£68,035**	**£1,043**	**£60**	**£983**
	Nephrology	Daycase	671	714	43	£1,197,799	£1,163,414	-£34,385	-£111,304	£76,920
		Elective	155	158	3	£164,102	£94,462	-£69,639	-£73,072	£3,432
		Non Elective	20	18	-2	£61,773	£57,870	-£3,903	£2,533	-£6,436
		Excess Bed Days	84	57	-27	£42,567	£20,836	-£21,731	-£8,135	-£13,596
		Outpatient New	78	159	81	£9,222	£18,787	£9,566	£17	£9,548
		Outpatient Follow-up	702	919	217	£82,856	£108,589	£25,733	£101	£25,632
		Ward Attender	333	56	-277	£39,326	£6,262	-£33,063	-£348	-£32,715
		Ward Based Outpatient	262	285	23	£30,969	£33,676	£2,707	£31	£2,675
	Nephrology Total		**2,305**	**2,366**	**61**	**£1,628,613**	**£1,503,897**	**-£124,717**	**-£190,177**	**£65,460**
	Neurology	Daycase	129	73	-56	£142,326	£98,196	-£44,130	£17,964	-£62,095
		Elective	30	55	25	£55,128	£137,541	£82,413	£37,137	£45,276
		Non Elective	43	38	-5	£231,956	£183,853	-£48,103	-£22,577	-£25,526
		Excess Bed Days	405	257	-148	£245,419	£151,818	-£93,601	-£3,757	-£89,844
		Outpatient New	446	421	-25	£123,590	£116,832	-£6,758	£114	-£6,872
		Outpatient Follow-up	1,177	1,123	-54	£326,448	£311,644	-£14,804	£283	-£15,088
		Ward Attender	69	67	-2	£19,021	£18,593	-£428	£18	-£446
		Ward Based Outpatient	88	122	34	£24,522	£33,856	£9,335	£33	£9,302
	Neurology Total		**2,388**	**2,156**	**-232**	**£1,168,409**	**£1,052,333**	**-£116,077**	**£29,216**	**-£145,292**
	Oncology	Daycase	895	326	-569	£851,174	£259,448	-£591,725	-£50,529	-£541,196
		DCHEMO	685	852	167	£227,735	£283,299	£55,563	£0	£55,563
		Elective	146	116	-30	£550,933	£524,560	-£26,372	£85,374	-£111,746
		Non Elective	250	216	-34	£509,724	£519,404	£9,680	£79,749	-£70,069
		Excess Bed Days	288	47	-241	£133,896	£20,552	-£113,344	-£1,274	-£112,070
		Outpatient New	50	41	-9	£12,979	£10,627	-£2,351	£9	-£2,361
		Outpatient Follow-up	1,107	1,303	196	£286,824	£337,478	£50,654	-£142	£50,796
		Ward Attender	248	336	88	£64,180	£87,091	£22,911	£77	£22,834
		Ward Based Outpatient	46	54	8	£11,869	£13,997	£2,127	£12	£2,115
	Oncology Total		**3,715**	**3,291**	**-424**	**£2,649,314**	**£2,056,457**	**-£592,857**	**£113,277**	**-£706,134**
	Paediatrics	Daycase	75	20	-55	£41,135	£13,027	-£28,109	£2,033	-£30,142
		Elective	4	24	20	£3,477	£42,356	£38,879	£22,367	£16,512
		Non Elective	1,448	1,946	498	£1,680,427	£2,414,696	£734,269	£156,713	£577,556
		Excess Bed Days	408	428	20	£167,308	£212,214	£44,907	£36,893	£8,014
		Outpatient New	1,530	1,336	-194	£329,293	£287,576	-£41,716	-£11	-£41,705
		Outpatient Follow-up	2,515	2,086	-429	£342,653	£284,159	-£58,494	-£17	-£58,477
		Ward Attender	46	17	-29	£6,272	£2,316	-£3,956	-£0	-£3,956
		Ward Based Outpatient	205	92	-113	£27,904	£12,533	-£15,371	-£0	-£15,371
		OP Procedure	1	0	-1	£152	£0	-£152	£0	-£152
	Paediatrics Total		**6,233**	**5,949**	**-284**	**£2,598,619**	**£3,268,877**	**£670,257**	**£217,978**	**£452,279**
	Radiology	Daycase	560	635	75	£727,996	£795,325	£67,329	-£30,322	£97,651
		Elective	94	39	-55	£175,518	£77,145	-£98,373	£4,409	-£102,783

Year to Date

Medicine	Radiology	Non Elective	12	7	-5	£126,301	£69,548	-£56,753	-£2,083	-£54,670
		Excess Bed Days	122	47	-75	£57,755	£26,856	-£30,900	£4,545	-£35,444
		OP Imaging	4,708	5,822	1,115	£624,831	£566,751	-£58,080	-£206,009	£147,929
	Radiology Total		**5,496**	**6,550**	**1,054**	**£1,712,401**	**£1,535,624**	**-£176,777**	**-£229,460**	**£52,682**
	Respiratory Medicine	Daycase	49	115	66	£64,035	£135,701	£71,665	-£14,673	£86,339
		Elective	54	25	-29	£89,809	£67,753	-£22,056	£25,950	-£48,006
		Non Elective	173	37	-136	£363,314	£267,515	-£95,799	£189,617	-£285,416
		Excess Bed Days	117	815	698	£66,755	£416,139	£349,384	-£48,533	£397,917
		Outpatient New	370	386	16	£96,422	£100,022	£3,601	-£488	£4,089
		Outpatient Follow-up	1,228	1,432	204	£176,236	£205,494	£29,258	-£13	£29,270
		Ward Attender	18	9	-9	£2,592	£1,292	-£1,301	-£0	-£1,301
		Ward Based Outpatient	681	170	-511	£97,662	£24,396	-£73,266	-£1	-£73,265
		OP Procedure	293	3	-290	£62,307	£452	-£61,855	-£186	-£61,669
	Respiratory Medicine Total		**2,982**	**2,992**	**10**	**£1,019,132**	**£1,218,763**	**£199,631**	**£151,672**	**£47,958**
	Rheumatology	Daycase	850	635	-215	£539,692	£408,094	-£131,599	£4,799	-£136,398
		Elective	99	17	-82	£129,466	£24,868	-£104,597	£2,626	-£107,223
		Non Elective	8	13	5	£13,071	£30,009	£16,937	£7,462	£9,475
		Excess Bed Days	128	174	47	£53,476	£67,164	£13,688	-£5,815	£19,503
		Outpatient New	274	333	59	£41,202	£50,130	£8,928	£43	£8,885
		Outpatient Follow-up	970	1,066	96	£145,588	£160,476	£14,887	£444	£14,444
		Ward Attender	76	31	-45	£11,502	£4,667	-£6,835	£4	-£6,839
		Ward Based Outpatient	52	43	-9	£7,812	£6,473	-£1,339	£6	-£1,344
		OP Procedure	1	0	-1	£80	£0	-£80	£0	-£80
	Rheumatology Total		**2,456**	**2,312**	**-144**	**£941,889**	**£751,880**	**-£190,008**	**£9,568**	**-£199,577**
	Sleep Studies	Daycase	0	1	1	£0	£654	£654	£0	£654
		Elective	122	89	-33	£149,231	£110,754	-£38,477	£1,710	-£40,187
	Sleep Studies Total		**122**	**90**	**-32**	**£149,231**	**£111,408**	**-£37,823**	**£1,710**	**-£39,533**
Medicine Total			**66,209**	**65,926**	**-283**	**£19,844,734**	**£19,300,723**	**-£545,487**	**£83,340**	**-£628,827**
Community	CAMHS	Elective	1	0	-1	£1,461	£0	-£1,461	£0	-£1,461
		Outpatient New	957	764	-193	£0	£0	£0	£0	£0
		Outpatient Follow-up	4,771	7,473	2,702	£64,046	£33,063	-£30,983	-£67,260	£36,277
		Ward Based Outpatient	0	1	1	£0	£0	£0	£0	£0
	CAMHS Total		**5,729**	**8,238**	**2,509**	**£65,507**	**£33,063**	**-£32,444**	**-£67,260**	**£34,816**
	Community Medicine	Outpatient New	1,816	1,452	-364	£147,061	£131,777	-£15,283	£14,166	-£29,449
		Outpatient Follow-up	3,565	3,460	-105	£17,996	£16,375	-£1,620	-£1,091	-£530
		Ward Attender	11	4	-7	£0	£0	£0	£0	£0
		OP Procedure	1	0	-1	£69	£0	-£69	£0	-£69
	Community Medicine Total		**5,392**	**4,916**	**-476**	**£165,126**	**£148,153**	**-£16,973**	**£13,075**	**-£30,048**
Community Total			**11,122**	**13,154**	**2,032**	**£230,633**	**£181,216**	**-£49,417**	**-£54,185**	**£4,768**
Grand Total			**143,559**	**148,261**	**4,702**	**£57,740,496**	**£59,153,648**	**£1,411,677**	**£581,775**	**£829,902**

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Thursday 28th September 2017

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, and Quality Assurance Officer
Subject/Title	2017/18 BAF Report
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF August report
Action/Decision required	The Board is asked to note the June position relating to the Board Assurance Framework
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be internationally recognised for the quality of our care ***(Excellence in Quality)*** ➢ be recognised for the exceptional care we provide to our children, that is technologically enabled and matched by exceptional facilities ***(Patient Centred Services)*** ➢ have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)*** ➢ be a world class, child focussed centre of research & innovation expertise to improve the health and wellbeing outcomes for babies, children & young people ***(International Research, Innovation & Education)*** ➢ have secured sustainable long term financial and service growth supported by a strong international business ***(Growing our Services and Safeguarding Core Business)***
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Alder Hey Children's NHS
NHS Foundation Trust

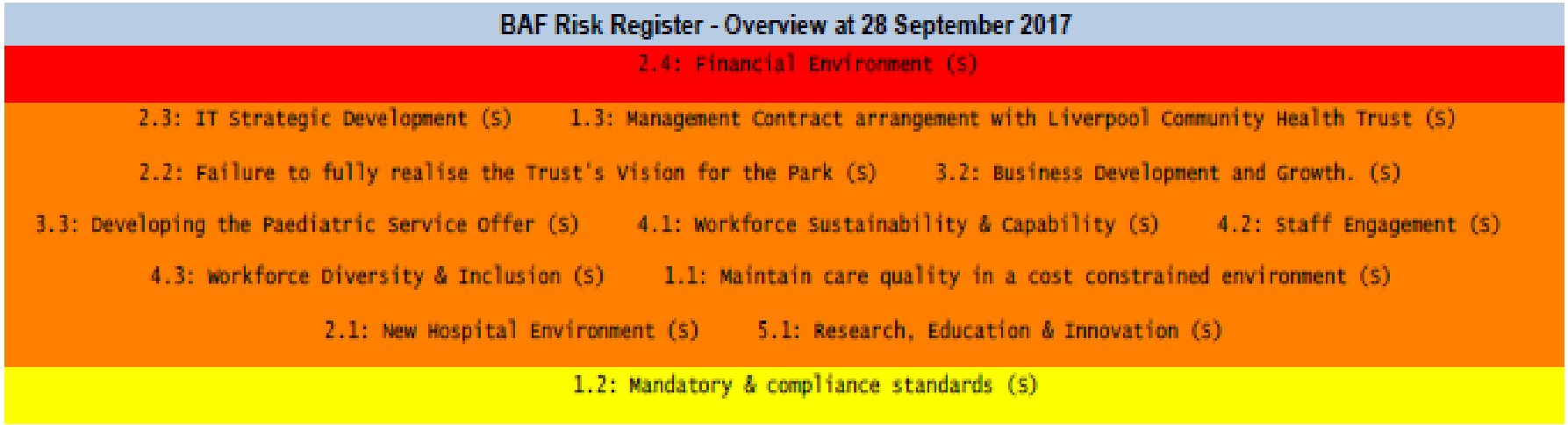
Board Assurance Framework 2017/18

1. Purpose

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

2. Review of the BAF

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



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

Changes since 30 May 2017 Board meeting

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

External risks

- ***Business development and growth (MB)***
  1) AH were awarded the Management Contract for Liverpool Community Health, (Liverpool Bundle) for May 2017. Future organisational structure being developed with NHSi, the 3 Acute Trusts, local authority, LCCG and local GP's. Opportunities for all to rationalise patient pathways.
  2) Partnership with Al Jalia now entering Phase 2. Specific deliverables identified and agreed. Work due to commence in Q2. Non NHS patient stretch target agreed and Q1 activity delivered.
  3) MOUs signed with two hospitals in China and work in progress to identifying workstreams and benefits.
  4) AH awarded contract for Design and Build Consultancy for Children's Hospital in Xian.

- ***Mandatory and compliance standards (ES)***
  Complaint with all national targets in month. Registration of community services with CQC is resolved.

- ***Developing the Paediatric Service Offer (MB)***
  Work commencing on the Implementation of the single service, two site model;
  1) Neonatal service model with NHS England and LWH on 6/7/17
  2) CHD Public Consultation closes in July. Results not expected to be released until January 2018. In the meantime AHCH and LCH are providing support to deliver services for patients due to the collapse of the Manchester service following the departure of their last remaining surgeon in June.
  3) Out of Hours group has been merged with the other workstreams to design a sustainable 24/7 paediatric service in light of further reductions and gaps in rotation. This workstream is named best in Acute Care and is led by the MD and Chief Nurse.

Internal risks:

- ***Maintain care quality in a cost constrained environment (HG)***
  All nursing staff now trained in Sepsis triggers; medical staff training to take place in August & September. Re-introduction of matron role across the Trust over next three months.

- ***Management Contract arrangement with Liverpool Community Health Trust (LS)***
  Stock take report compiled for NHS I. Plans in place to ensure services at both AH & LCH are managed safely and effectively. Senior Roles and associated back fill confirmed and communicated to all AH staff.

- ***New Hospital Environment (DP)***
  Probation period ended. Main outstanding issue – energy.

- ***Financial Environment (JG)***
  £0.3m behind control total at month 2. Residual Forecast financial risk of circa £5m identified by Divisions. Action Plan Produced and delivery tracked via Internal Recovery and RABD.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Consultation strategy presented at July board.

- ***IT Strategic Development (JG)***
  GDE funding confirmed and agreements signed / returned by DoF. Cash not received 27.06.17. Overall GDE programme milestones have slipped but on track to deliver objectives.

- ***Workforce Sustainability & Capability (MS)***
  Temporary Staffing Project initiated

- ***Staff Engagement (MS)***
  Launch of the Big Conversations with staff from across the Trust. Executive Visibility Programme commenced

- ***Workforce Diversity & Inclusion (MS)***
  First BME Network meeting. HRD as Exec sponsor.

- ***Research, Education & Innovation (DP)***
  Academy model agreed.

Erica Saunders
Director of Corporate Affairs
September 2017

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• Quality impact assessment of all planned changes	• Risk assessment and utilisation of risk registers in responding to incidents and other drivers.
• Quality section of Corporate Report scrutinised at CQAC and Board.	• CBU and Corporate Dashboards in place and are part of updated Performance Framework.
• Weekly Meeting of Harm	• Programme of quality reviews (deep dives) planned across all departments. Implemented and being reported via the WMoH quarterly report.
• Refresh of CQAC to provide a more performance focussed approach	• Changes to ESR to underpin workforce information -
• New Change Programme established - associated workstreams subject to sub-committee assurance reporting	• Robust risk & governance processes from Ward to Board, linked to NHSI Single Oversight Framework
• Quality Strategy 2016-2020 implemented to deliver safe and effective services demonstrated via measurable Quality Aims and Sign up to Safety campaign	• External review on IPCC resulted in action plan to address issues identified and track improvements.
• "Our Patients at the Centre" projects subject to assurance committee monitoring (CQAC)	• Quarterly 'themes' report from Weekly Meeting of Harm shared within meeting & CQSG as multidisciplinary engagement and cross-organisational learning.

Assurance Evidence	Gaps in Controls/Assurance
Monthly reporting to CQSG. CQAC focus on performance. Analysis of incident reports. Monthly reporting of the Corporate Report to Board. Improved reporting - in the top 20% of NRLS nationally Ongoing national open recruitment exercise in Spring 2017 PEWS audit scores on improvement trajectory Sepsis implementation plan underway, overseen by project team; audit data showing improvement in recognition and escalation.	Reduced investment opportunity to respond to clinical development as a result of financial situation. Full electronic access to specialty performance results Meditech issues identified as key challenge to obtaining accurate Sepsis audit data without extensive manual analysis by clinical lead. Nursing maternity leave continues to rise - currently at 50 WTE per month.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Develop and build audit programme within Meditech to ensure continuous monitoring in place and deliver CQUIN	Key stakeholders working with IM&T to build audit programme
Heads of Quality to take forward Quality Ward Accreditation Programme in 17/18 (as part of devolved governance)	Revised framework agreed. On-going work in progress. Electronic sharing of information with the public - completed programme July.
Successfully implement all Change Programme workstreams to improve efficiency and flow	16/17 year-end reports to CQAC. Actions to carry forwards into 17/18 change programme in association with PIDs and milestone trackers.
Roll out PFCC model for all appropriate services	PFCC model now forms part of transformation toolkit
Continue to maintain nurse staffing pool	Recruitment on-going. Further analysis of maternity leave factors to be undertaken (July 2017)
Clinical lead for Sepsis in dialogue with Meditech team to develop solution to systems issues re data.	

Executive Lead's Assessment

APR 2017: no change in-month
MAY 2017: the Trust continues to maintain appropriate workforce levels ensuring care quality in a cost constrained environment. Achieving Monitor capped nursing agency targets
JUNE 2017: All nursing staff now trained in Sepsis triggers; medical staff training to take place in August & September. Re-introduction of matron role across the Trust over next three months.
JULY 2017: Staffing requirements for winter assessed as part of refresh of successful winter plan from 2016/17; also early consideration of flexing beds and surgical capacity. Trust has agreed support for development of an additional four ANPs as part of overall workforce plan.
August 2017: Measures being taken to address unexpected gaps in senior nursing leadership due to sickness and other personal issues. Preparatory work underway for new cohort of newly qualified nurses commencing September.
SEPTEMBER 2017: HEI new recruits commenced September 2017 aligned to staff vacancies and winter plan.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to deliver on all mandatory and compliance standards due to lack of engagement with internal throughput plans and targets

Existing Control Measures

• New Operational Delivery Group (July 2016) to take action to resolve non-compliance relating to performance. Reporting to RBD	• Emergency Planning & Resilience meetings in pace
• CBU Executive Review Meetings - now strengthened as of May 2016 and meeting regularly each month	• Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and CBU Dashboards.	• Risks to delivery addressed through RBD, CQAC, WOD & 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)	• Revised CBU leadership structure to implement clinically led leadership team for CBU
• Weekly Performance meetings	

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through CQSG, CQAC & Board. Monthly reporting to the Board via the Corporate Report. Monitor / NHSI governance risk rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against Monitor Provider Licence to go to Board CBU / Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly Report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. IG toolkit, MSE, evidence of compliance relating to learning disabilities declaration Assurance required to underpin CBU reporting on CQC standards 'Horizon scanning' to anticipate risks & issues now implemented through performance review meeting Work with CCG to manage demand & develop / fully utilise existing capacity across PC Junior Doctor Rotas

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Ensure divisional governance embedded and working effectively to reflect ward to board reporting	Awaiting the implementation of the Matron roles in each CBU
Plans to ensure performance sustained across the year need to be embedded and maintained	
Review bed capacity and staffing model for seasonal variation	The Winter Plan was effective. Planning for next winter to commence early

Executive Lead's Assessment

APR 2017: All access targets achieved at 31/3. Letter of congrats received from SoS for most improved ED 4 hour performance.
MAY 2017: Need to maintain grip on activity plan and ensure community waiting times are a focus in the short term especially CAMHS and SALT
JUNE 2017 Compliant with all national targets in month. Registration of community services with CQC is resolved.
JULY 2017: A&E performance slipped to 93% for the month due to unseasonal levels of activity and gaps in medical cover; this has been recovered in August. All other national standards on track/on plan.
AUGUST 2017: Month end position not known at time of writing but no significant issues reported in-month.
SEPTEMBER 2017: ED performance back on track in August but dipping again in September; all other targets met.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

BAF 1.3	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Management Contract arrangement with Liverpool Community Health Trust		
Related CQC Themes: Well Led, Responsive, Safe				
Exec Lead: Louise Shepherd	**Type:** External, New	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

- Risk to senior leadership team visibility & capacity
- Risk to operational delivery at Alder Hey (quality & performance standards)
- Financial risk to achieving the AH control total
- Risk to delivery of AH strategic plan and associated brand and reputation
- Impact on staff morale at AH

Existing Control Measures

• Backfill arrangements for some key members of Exec Team in place & gaps actively being backfilled	• MIAA due diligence process undertaken at LCH
• Cross agency Transition Board place at LCH to oversee safe transfer of remaining services	• Interim Provider Group in place to retain oversight of the Management Contract

Assurance Evidence	Gaps in Controls/Assurance
Interim governance arrangements in place including Exec Team meetings	Financial package not yet agreed with NHSI & Liverpool CCG Some senior and support posts not yet filled Potential for further quality risks to emerge Staff engagement & motivation across the two sites
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Develop plans to ensure services at both AH & LCH are managed safely and effectively	

Executive Lead's Assessment

MAY 2017: Plans continue to be developed to ensure services at both AH & LCH are managed safely and effectively
JUNE 2017: Stock take report compiled for NHS I. Plans in place to ensure services at both AH & LCH are managed safely and effectively. Senior Roles and associated back fill confirmed and communicated to all AH staff.
JULY 2017: Sustained levels of performance across majority of areas; assurance committees continue to have oversight of all key KPIs and plans including change programme
AUGUST 2017: A&E trajectory back on track following unseasonal levels of activity and concerted work by team. All corporate risks being validated through a structured process agreed by IGC at its meeting in July, led by Associate Director of Nursing and Governance. New Quality Ward round process to commence early September.
SEPTEMBER 2017: Performance against key metrics within both organisations receiving appropriate levels of scrutiny through Executive team and assurance processes; AH Quality Ward Rounds commenced and running effectively; risk revalidation exercise nearing completion; IGC receiving additional assurance from revised reporting.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** Strong Foundations	Risk Title: New Hospital Environment		
Related CQC Themes: Safe, Effective, Well Led				
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 4-2	Target IxL: 4-1	Trend: STATIC

Risk Description

Failure to deliver world class healthcare due to constraints of new environment

Existing Control Measures

• Regular Fix-It Team reports to Execs, CQAC & IGC	• Interserve Reports & representation at Health & Safety Committee
• Monitoring & Fix-It Team in place responsible for day to day management of PFI Contractor ensuring services are delivering the required standards	• Fix-It Team governed by a Steering Group (meets monthly)
• Joint Energy Committee to monitor performance & compliance	• Joint Water Committee to monitor performance & compliance
• Survey of all departmental users to assess quality of service	• Review of Charter compliance or liaison committee

Assurance Evidence	Gaps in Controls/Assurance
Tracker in place. Reporting compliance of PFI Services against contract to Trust Board. Confirmation that invoices and sums are charged correct (Finance Lead to approve all invoices and expenditure). Number of reported faults is falling. The items on the 'red list' i.e. main snags have reduced significantly. Further meeting arranged to review energy performance Partnership Charter Liaison Committee - meeting minutes	Delay in commissioning external Health & Safety Review. Gap in reporting from Project Co. and inconsistencies in description of faults

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Reviewing Health & Safety interface with Estates and Building Services Team	Recommendation issued to Dir. of HR fro consideration
review of probation items	Review postponed due to issues with energy
conduct series of surveys (1 per quarter) to assess progress.	Second survey results received
Implement recommendations in external H&S Review	
Assess issues with energy and agree action plan.	Interim report received at Energy Committee.

Executive Lead's Assessment

APR 2017: Review of progress at Liaison Committee
MAY 2017: Review and agree actions from H&S Report
JUNE 2017: Probation period ended. Main outstanding issue - energy
JULY 2017: Review of outstanding issues
AUGUST 2017: Agreement on Deed of variation to correct retrospective faults e.g. theatre floors
SEPTEMBER 2017: New ENR.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

BAF 2.2	**Strategic Objective:** Strong Foundations	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: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

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

Existing Control Measures

• Business Cases developed for various elements of the Park & Campus	• Alignment with the 'Alder Hey in the Park' vision and the 'Alder Hey Campus' visions
• Heads of Terms agreed with LCC for joint venture approved	• Redeveloped Steering Group
• Monthly reports to Board & RABD	

Assurance Evidence	Gaps in Controls/Assurance
Establishment of a Community Interest Charity to operate the park for AHCH and the local community 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 Representation at Springfield Park Shadow Board Stakeholder events held Representation at Friends of Springfield Park Group	Fully reconciled budget with Plan. Risk quantification around the development projects. Joint business case approval with LCC

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	dependent upon residential scheme (target date no Sept 2017)
Income generation opportunities to be thoroughly explored (grant applications) and reconcile requirement for funding versus available	Draft Business Case prepared. Final requirement will depend upon contribution from residential scheme
Develop a Planning Process Communication Strategy	Strategy to be presented at July board
Confirm arrangements for the CIC to run the Park.	Awaiting discussions with LCC Mayor

Executive Lead's Assessment

APR 2017: Shortlisted - first step as preferred bidder
MAY 2017: Compile draft Consultation Strategy. Consultation process held for purdah.
JUNE 2017: Consultation strategy presented at July board
JULY 2017: Pre planning process considered with LCC
AUGUST 2017: Evaluation of options with LCC Mayor
SEPTEMBER 2017: Public consultation delayed until outcome of LCH bid known.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

Existing Control Measures	
• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Investment in IM&T Team (2016/17 budget)

Assurance Evidence	**Gaps in Controls/Assurance**
Regular progress reports presented to RABD and Operational Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews	IM&T Strategy out of date - update work in progress Internal Programme Assurance Reports Resources required to deliver Strategy proposed and aspirations of Trust - review Oct 2016 - Strategy update deferred pending consultation with new restructure CBU leadership teams and outcome of Global Digital Excellence bid.

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Link to innovation partnerships in paediatric healthcare	
Conclude the review of IM&T Infrastructure	currently being reviewed in relation to GDE bid and business case
IM&T Strategy development & approval	Trust GDE bid submitted and approved by Board and NHSE Nov / Dec 2016. NHSE undertaking due diligence review pre sign off and approval of funding agreement. Full I&MT strategy to be updated Q4 2016/17
Continual improvement of MEDITECH and other clinical systems as prioritised by the Clinical Systems Informatics Steering Group	changes to software tracked by and reported to the Clinical Informatics Steering Group
Engage with iLinks programme to progress interoperability	

Executive Lead's Assessment
APR 2017: email confirmation from NHSE highlighting treasury approval - awaiting final confirmation MAY 2017: escalated NHSE funding for GDE by FD as impacting on programme delivery JUNE 2017: GDE funding confirmed and agreements signed / returned by DoF. Cash not received 27.06.17. Overall GDE programme milestones have slipped but on track to deliver objectives. JULY 2017: £2.5m capital funding received 10th July. AUGUST 2017: £0.8m revenue funding invoiced. Not yet paid as at 24th Aug. Overall GDE programme milestones have slipped but remain on track to deliver objectives. SEPTEMBER 2017: funding is now up to date, GDE project is green rated over all. The main risk that Board need to be aware of is the pace of realisation of benefits of the programme including specialty packages and VR.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

BAF 2.4	**Strategic Objective:** Strong Foundations		Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: John Grinnell	**Type:** Internal, Known		Current IxL: 5-4	Target IxL: 3-4	Trend: STATIC

Risk Description	
Failure to deliver Trust control total and Risk rating 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 CBU Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• Weekly meeting with CBUs 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	• COO Task & Finish Group targeted at increasing activity in line with planned levels
• 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 RBDC. Specific Reports (i.e. Monitor Plan Review by RBDC) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support CBU 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	Improved financial control and effective recovery required in identified CBU's where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff CBU recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP Based on month 7 run rate performance (£0.3m adrift in month overall from recovery profile) and update projections and risks reported by Clinical Business Units, heightened risk of failure to deliver target control. In order to address emerging risk CBU control targets issued to address risk profile gap of circa £2.7m. (£3.7m gross but £1m mitigation identified).
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Focus on activity delivery	Recovery plans under development and review
Improve delivery of clinical business developments to meet local CCG outsome needs, e.g. as part of Healthy Liverpool, to achieve and exceed financial targets	COO task & finish group established; targeted at increasing activity in line with planned levels
Plans to address CIP shortfall - scheme PIDs to be complete by end of May - progressing against milestones agreed	Trust in discussions with NHSI re. formal approval of required £8m interim cash support
implement divisional recovery plan	

Executive Lead's Assessment
APR 2017: 16/17 control overachieved. 17/18 risks remain as CIP £4m, Activity run rate £3m, pay cost pressures (ward related) £3m MAY 2017: key risks highlighted: pay, activity & CIP. Individual Exec Leads in place. Tracking of internal improvements through Internal Recovery Team JUNE 2017: £0.3m behind control total at month 2. Residual Forecast financial risk of circa £5m identified by Divisions. Action Plan Produced and delivery tracked via Internal Recovery and RABD. JULY 2017: Achieved Q1 control total of (£2.6m) deficit. Forecast financial risk of circa £6m identified by the Divisions. AUGUST 2017: £0.1m behind year to date control total at month 4. Forecast financial risk now £6.3m. Delivery of the action plan continues to be tracked at the Internal Delivery Group and RABD. SEPTEMBER 2017: year to date on track. Forecast risk remains at £6.3m, largely driven by variances in medicine, facilities, estates and surgery. Recovery process implemented.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Workshop held in June to identofy options for bridging business development gap	Alternative schemes being developed. Report to RABD
Identify models and services to provide to non NHS patients / commercial offers	Trust currently progressing tender application for LCH paediatric community services. Timeframe: June - end Aug 2016. Financial assessment will be part of due diligence. Report to RABD and through to Board. Duscussions with surgical teams and Stoke to accelerate increase in cardiac cases

Executive Lead's Assessment

APR 2017: No change in-month.
MAY 2017: No change
JUNE 2017: 1) AH were awarded the Management Contract for Liverpool Community Health, (Liverpool Bundle) for May 2017. Future organisational structure being developed with NHSi, the 3 Acute Trusts, local authority, LCCG and local GP's. Opportunities for all to rationalise patient pathways.
2) Partnership with Al Jalia now entering Phase 2. Specific deliverables identified and agreed. Work due to commence in Q2. Non NHS patient stretch target agreed and Q1 activity delivered.
3) MOUs signed with two hospitals in China and work in progress to identifying workstreams and benefits.
4) AH awarded contract for Design and Build Consultancy for Children's Hospital in Xian.
JULY 2017: Indication to bid to acquire LCH services NHS Trust.
AUGUST 2017: Bid to go to Trust Board on 5th September 2017.
SEPTEMBER 2017: Decision on bid expected early October 2017. Awaiting to hear from Dubai regarding phase 2 extension.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Key developments monitored through CBU Boards. Risks highlighted to CRC. Monitored at Performance Management Group. Monthly to Board via RABD & Board Compliance with final national specifications	Inability to recruit to highly specialist roles due to skill shortages nationally. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date. Potential elective underperformance due to cancelled sessions. Awaiting final results re. CHD service at national level. Working with partners including CMFT to progress transfer of adult CHD services and to support partners during transition

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitoring of action plans.	Now working with NHS England to secure a resolution for the North
Clear plan for delivery of strategic services (cardiac, neonatal, rehab, community care, primary care, Vanguard, CAMHS)	
Pro-active recruitment in identified areas.	Trust in discussion with Liverpool Women's re future service models for neonates and in discussion with Liverpool Heart and Chest re future model for cardiac service
Develop a strong Community Service offering for Children in Liverpool.	Alder Hey has been awarded a Management Contract for 6 months to deliver the LCH Community Services
Strengthening the paediatric workforce	Now part of Change Programme and 7 day service as Best in Acute Care led by Steve Ryan.

Executive Lead's Assessment

APR 2017: The ODN recommendation single service, single workforce, two site model has been accepted by NHS England and AH and LWH are now working on an implementation plan together with Alder Hey leading. There will be a need for some Capital funding to support the reconfiguration of the ICU and the number of cots required. This is a key work stream of the Trusts Change Programme for 2017/18.
Alder Hey has been awarded a Management Contract for 6 months to deliver the LCH Community Services.
MAY 2017:
JUNE 2017:
JULY 2017:
AUGUST 2017: Agreement that Liverpool Heart & Chest NHS Trust and Alder Hey provide Cardiac Services for Liverpool patients. This has not yet resulted in a change to the flow of cardiac patients to Liverpool.
SEPTEMBER 2017: No change since last update.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• Compliance tracked through the corporate report and CBU dashboards	• Performance Review Group
• CBU Performance Meetings.	• Mandatory Training reviewed in February 2017.
• Mandatory training records available online and mapped to Core Skills Framework	• Permanent nurse staffing pool
• 'Best People Doing our Best Work' Steering Group implemented	• Attendance management process to reduce short & long term absence
• Positive Attendance Policy	

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Sickness Policy refreshed	Training for managers on Sickness Absence Policy ongoing
Recruitment & Retention Strategy to focus on specific groups	Currently being refreshed with action plan to support
Develop and support talent identified within the organisation and via local supply routes e.g. apprenticeships by leveraging networks via HEE and HENW to address future workforce supply challenges	Apprenticeship Strategy ratified and under implementation. Corporate objective agreed to support a succession planning process for business critical roles by end Dec 17

Executive Lead's Assessment

APRIL 2017: planning underway to support apprenticeship roll out. successful Recruitment Day for nursing, resulting in over 40 nurses being appointed.
MAY 2017: Task & Finish Group with staff side reviewing approach and sickness absence
June 2017: Temporary Staffing Project initiated
JULY 2017: Plans in place to increase support for development of ANP's
AUGUST 2017: Apprenticeship activity increased, with over 30 learners now registered for an apprenticeship.
SEPTEMBER 2017: New nurse pool cohorts commenced their induction period. Recruitment team engaged with national RCN jobs fair.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** The Best People Doing Their Best Work		Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: Melissa Swindell	**Type:** Internal, Known		Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description

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

Existing Control Measures

• Internal Communications Strategy.	• Refine Trust Values.
• Roll out of Leadership Development and Leadership Framework	• Action Plans for Engagement, Values and Communications.
• Medical Leadership development programme	• Staff Temperature Check Reports to Board (quarterly)
• Values based PDR process	• People Strategy Reports to Board (monthly)
• Listening into Action methodology	• Staff surveys analysed and followed up (shows improvement)

Assurance Evidence	Gaps in Controls/Assurance
Outcomes from Annual Staff Survey reported to the Board. PDR completion rates Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data now sent to CBUs 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	Reward & Recognition schemes embedded

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Revised governance arrangements that underpin effective assurance mechanisms utilising the discipline and systems provided by Programme Management methodology	Change programme monitors Listening into Action deliverables

Executive Lead's Assessment

APR 2017: Progress continues with LiA and development of C&E Project. Quarterly Temperature Check launched.
MAY 2017: Local staff survey conversations continue
JUNE 2017: Launch of the Big Conversations with staff from across the Trust. Executive Visibility Programme commenced
JULY 2017: Local staff survey conversations continue
AUGUST 2017: launch of the monthly 'Star Awards'. Preparation for the Staff Survey underway.
SEPTEMBER 2017: Medicine 100% compliance with local staff survey conversations, others on their way to full compliance. Staff Survey launched. 84% PDR compliance as at 25/09/16.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to proactively develop a future workforce that reflects the diversity of the local population

Existing Control Measures

• Equality, Diversity & Human Rights Group	• Workforce Committee re-enforced and includes recruitment and education
• Workforce Plan established	• Staff Survey results
• Workforce Planning Poilcy signed off at WOD June 2015	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	

Assurance Evidence	Gaps in Controls/Assurance
Monthly recruitment reports provided by HR/Payroll provider Quarterly reports to the Board via WOD on the Workforce Strategy and Workforce Plan 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	Recruitment Strategy to focus on specific groups

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Workforce Planning Policy	Draft policy produced, however future work is to focus on identifying priority workforce needs in light of current financial position
Deliver on our new Recruitment and Retention Strategy to ensure an optimum workforce is in place and that the workforce reflects the diversity of the local community	Currently being drafted with action plan to support
Proactively utilise the EDS2 results to establish the composition of our workforce in order to target areas for improvement	Currently being refreshed with action plan to support

Executive Lead's Assessment

APR 2017: scoping apprenticeship opportunities for local communities as part of our strategy development.
MAY 2017: Recruitment Policy reviewed. EDS2 scoring agreed and equality objectives approved
JUNE 2017: First BME Network meeting. HRD as Exec sponsor.
JULY 2017: BME Network meetings continue with some success, bespoke work undertaken in ICU
AUGUST 2017: Disability network in development. Apprenticeship recruitment planning underway.
SEPTEMBER 2017: Job Centre Plus initiative to support long term unemployed on work placements underway. 65 BTEC students from a range of local schools commenced induction.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

BAF 5.1	**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: 4-2	Target IxL: 4-1	Trend: STATIC

Risk Description

Failure to develop a cohesive approach to research, innovation & education.

Existing Control Measures

• Establishment of RIEC Steering Board	• 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	Lack of integration with other academic partners Commercial research offer not quantified Education Strategy needs to be refreshed

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Educational Partnerships to be cemented	Academy proposals agreed at execs
Develop a robust Academy Business Model	Agreed
Establish pipeline structure for sensors including finances	Proposal agreed in principle
Appoint Academy Leadership Team	Appointment made
Launch Innovation Co. and secure funding	Funding plan agreed at Innovation Board
Execute plan to increase research portfolio	Outline plan develped
Execute contract for RIE with back to back arrangements with the Charity and HEIs	

Executive Lead's Assessment

APR 2017: Issue around charitable commitment now resolved - letter of intent to be re-issued.
MAY 2017: Institute Phase 2 building commenced
JUNE 2017: Academy model agreed
JULY 2017: Agreed funding plan for Innovation
AUGUST 2017: Approved Head of Academy
SEPTEMBER 2017: Head of Academy now in post.

Alder Hey Children's NHS
NHS Foundation Trust

Resource and Business Development Committee
Minutes of the meeting held on: **Tuesday 1st August 2017**, **at 1330**
Room 5, Level 1, Mezzanine

Present:	Ian Quinlan (Chair)	Non-Executive Director	IQ
In Attendance:	Mags Barnaby	Interim Chief Operating Officer	MB
	Sue Brown	Project Manager and Decontamination Lead	SB
	Claire Liddy	Deputy Director of Finance	CLi
	Sharon Owens	Head of HR	SP
	Steve Ryan	Medical Director	SR
	Erica Saunders	Director of Corporate Affairs	ES
	Julie Tsao	Executive PA	JT
Agenda item:	Peter Young	Chief Informatics Officer	CF
	Steve Begley	Head of Procurement	SB
	Alan Burgess	Procurement Team Manager (observing)	AB
	Joe Gibson	External Programme	JGi
	Mark Flannagan	Director of Communication	MF
Apologies:	Claire Dove	Non-Executive Director	CD
	Rob Griffiths	Service Manager Theatres	RG
	John Grinnell	Director of Finance	JGr
	Graham Dixon	Head of Building	GD
	Christopher Gildea	Operational Lead PFI	CG
	David Powell	Development Director	DP
	Lachlan Stark	Head of Planning and Performance	LS
	Melissa Swindell	Director of HR	MS

As Claire Dove had been unable to attend the meeting was not quorate. Items would still be approved subject to Claire's agreement.

17/18/50 Minutes of the previous meeting held on 28th June 2017
Resolved:
RABD received and approved the minutes of the previous meeting.

17/18/51 Matters Arising and Action log
All items for discussion had been included on the agenda.

17/18/52 Global Digital Excellence Programme
Peter Young reported the first tranche of PDC funding £2.5m had been received. A discussion was held on Meditech upgrade taking place next Wednesday. Mags Barnaby noted the downtime may cause some areas to fall behind with activity however they would be able to get back on track by the end of the financial year.
Resolved:
RABD received and noted the content of the GDE report.

17/18/53 Performance
Service Level Agreement Monitoring (SLAM) summary identifies continued mixed performance finish M3 at -£350k. Division continues to report significant challenges with medical staff sickness; maintenance of medical rota's and vacancies as major factors affecting their ability to deliver plan. A&E attendance was low for the month and significant underperformance noted within gastro, endocrinology and neurology. Division continues to develop plans to mitigate this where possible and improve their forecast.
Resolved:
RABD received and noted the content of the performance report.

17/18/54 Finance report

For the month of June the Trust is reporting a trading deficit of £0.2m which ahead of plan by £0.3m. Income is ahead of plan by £0.9m but expenditure is higher than budgeted by £0.6m. The year to date position is a deficit of £2.6m which is ahead of plan by £0.1m. The Use of Resources risk rating is 3 which is in line with plan and cash in the bank of £3.7m.
Elective and day cases had both achieved the forecasted plan for the month. RABD congratulated Surgery on achieving this noting the vacancies they currently have and the extra sessions completed to achieve this.

A Workforce Sustainability Task and Finish group has been created which is chaired by the Director of HR and includes representation from the divisions, Finance, HR and nursing. This is meeting fortnightly and overseeing specific actions in relation to pay expenditure. One of the aims was to reduce temporary spend by a £1m at the end of the financial year, it was agreed an update would be received in October.
Action: CL/MS

Due to changes with agency targets the Trust is currently in breach of NHSI in relation to the number of Medical Locums. The Workforce group are reviewing this to bring the Trust back in line.

The Trust Control Total is a surplus of £0.1m and it is imperative that all Divisions meet their financial objectives, so that the Trust achieves agreed Control Total, and secures the full £4.4m STF funding which is cash-backed. The Divisions have prepared a forecast which totals a £7.7m deficit and although this is a £1.6m improvement from last month none of the forecasts have been accepted. The expectation is that all divisions and departments will:

- Deliver activity plans
- Control Pay Expenditure
- Achieve full CIP target
- Break even against budget control totals

CIP
The month 3 CIP performance across the Trust showed an overachievement of £0.2m. For the year the Trust is forecasting savings of £6m against a target of £8m. The main gaps are in Medicine (£1.1m), Surgery (£0.2m) and Community (£0.4m) divisions.

Resolved RABD:
Received and noted the content of the Finance report for month 1.

Contracts
CCG Contract
The acting as one agreement for North Merseyside is worth 25m, the agreement had been made to provide security on income. It was noted the agreement would provide opportunities in quarter 3.
Action: MB/CL

Welsh Contract
As reported at the last meeting the Welsh contract had not yet been signed. This is due to a dispute between the Welsh Commissioners and English hospitals as the new contract increases the value of Welsh activity. As Alder Hey's contract would reduce in value it was agreed a memorandum of understanding would be written to the Welsh Commissioners to confirm Alder Hey would continue to providing services to the Welsh Commissioners unless otherwise advised.

Action: MB/AMc

Resolved:
RABD noted the content of the contacts report.

Capital report Quarter 1
Following submission to NHS Improvement on the approved capital programme of £29.092m a paper summarising risks and issues in quarter 1 was presented.

Potential Emerging Risks at Q1

- Following a CQC assessment one of the recommendations was to replace the current defibrillators to the same brand and replace the trolleys with a fleet expansion for the total of £419k for approval, to be funded in part by bringing forward 18/19 and in part as cost pressure. A discussion was held on the current defibrillators and whether they could be used for community. Claire Liddy agreed to discuss this with Barry Laithwaite.
- Audiology Booth Costs £50k, overage costs from PFI quote for approval.
- Capital Medical Equipment – The Trust would need to allocate a further £0.4m to as contingency to ensure appropriate levels of service provision for noting.
- Health and Safety Building review estimates £60-£300k for noting.

During July and August an exercise will be completed by the Capital Programme Group to assess how much of this pressure can be handled via slippage and how much will result in an increased capital spend during 2017/18.
Resolved RABD:
Noted the contents of the report.
Approve the additional funding for Defibrillators and Audiology Booth.
Agreed further quarterly updates

Reference Cost
RABD received the reference cost report in relation to the combined reference costs/Education and Training prior to submission.
RABD requested an update at the September meeting on next steps for the service review.
Action: Laurence Murphy

Resolved:
RABD approved the recommendations:
(a) the costing process ahead of the collection;
(b) information, data and systems underpinning the return are reliable and accurate;
(c) there are proper internal controls over the collection and reporting of the information included in the collection, and these controls are subject to review to confirm that they are working effectively in practice; and
(d) costing teams are appropriately resourced to complete the return, including the self-assessment quality checklist and validations accurately within the timescales set out in the reference costs guidance.
(e) they have, on behalf of the board, approved the final return prior to submission;
(f) the return has been prepared in accordance with NHS Improvement's Approved Costing Guidance, which includes the combined costs collection guidance.

Corporate report
Resolved RABD:
Received and noted the contents of the CR report for June.

17/1855 CIP

The month 3 CIP performance across the Trust showed an overachievement of £0.2m. For the year the Trust is forecasting savings of £6m against a target of £8m. The main gaps are in Medicine (£1.1m), Surgery (£0.2m) and Community (£0.4m) divisions.

Resolved:

RABD received the content of the report.

18/18/56 Procurement

Steve Begley gave a presentation on procurement's stocktake for 17/18 noting at month 4 the team are forecasting £722k against £1m target. This target is one of the highest in the North West. A slide on £37m expenditure scope was presented.

Steve Begley reported on the requirement for clinical engagement and the clinical procurement group that had been arranged. As Steve Ryan had previously supported reduction of procurement prices at a previous Trust it was agreed a meeting would be arranged for this to be discussed further outside of the meeting.

One of the aims when building the new hospital was to use natural sources or reused recycled energy. It was highlighted that whilst the Trust is trying to be environmentally friendly it is not a cost effective option, this was currently being reviewed.

RABD noted the reduction in waivers for items over £5k.

Resolved:

RABD received an update on Procurement and agreed to receive further quarterly updates.

Action: SB

17/18/57 Programme Assurance

As Joe Gibson had on leave at the time of the submission of papers his summary had not been included however he advised he agreed with the Executive Sponsor summary for all three of the workstreams.

Following the second meeting of the Programme Board (PB) an action list had been circulated for completion prior to the next (PB).

As Debbie Herring had now left the Trust John Grinnell is now Executive Sponsor for Growing Through External Partnerships.

Jeannette Richardson Programme Assurance support had left the Trust due to this Joe Gibson, John Grinnell and Claire Liddy are reviewing the process over the next 12 months to ensure the programmes are embedded.

Resolved:

RABD noted the report and the work being undertaken to increase pace and benefit opportunities.

17/18/58 Weekly waiting times update

All core access standards have been achieved for June CAMHS waits have increased due to staffing shortages in key areas and impact of reduced funding to 3rd sector.

Resolved:

RABD noted the report.

17/18/59 Marketing and Communication Activity report

The chair welcomed Mark Flannagan to his first RABD meeting. Overall media coverage for June had decreased from last month: this was in relation to two local incidents that had occurred in May.

Mark advised since starting the Trust last month a review of internal communications has taken place and a review of external coms was to follow. Mark agreed to include further information on internal communications within the report once the review had been completed.
Action: MF
Resolved:
RABD noted the report.

17/18/60 Quarter 1 Monitoring report
Resolved:
RABD received the Q1 Monitoring report for submission.

17/18/62 Monthly Debt Write Off
Resolved:
RABD approved June's write offs for £366.43.

17/18/63 PFI Contract Monitoring report
As Graeme Dixon and Chris Gildea had not been available to attend RABD asked for a response on the following queries:

- When is the deal expected to be settled.
- Have Theatres been updated with arrangements for changes to the floor?
- An energy update was requested for the August or September meeting.

17/18/64 Any Other Business
August RABD
A discussion was held on whether an August meeting was required, it was agreed Julie Tsao would confirm if there was a substantive agenda for the meeting to go ahead.

Date and Time of the next meeting: Wednesday 27th September 2017 at 09:30, Room 5, Level 1 Mezzanine.

NB: Meeting moved to Thursday 28th September at 3:30pm Room 8, Level 1 Mezzanine.

International Child Health at Alder Hey

Briefing Paper for Trust Board

Purpose

This paper seeks Board support for our vision for International Child Health (ICH) at Alder Hey and how this can be brought about. The paper summarises the current position in Alder Hey with respect to involvement in health activities abroad and proposes the development of a Department of International Child Health. If supported, we can work collaboratively on implementation and associated governance arrangements. This umbrella unit would be responsible for implementing a comprehensive strategy for ICH, coordinating all aspects of international work within a cohesive framework, and contribute to Alder Hey becoming recognised as one of the best children's hospitals in the World.

Executive Summary

- Alder Hey has a long history of engagement with International Child Health, encompassing a wide range of activities by both individuals and departments.
- The Trust supported an initial vision statement (2011) and a proposed strategy (2012) regarding global child health and commissioned an independent review of ICH activities by Ernst Young in 2014.
- EY recognised benefits of pursuing ICH activities including reputational, recruitment and retention, research and educational and bringing in revenue.
- There has been progress with some business development opportunities particularly with Al Jalila Hospital, Dubai but it is proposed that there is great scope for significant expansion with the resultant benefits of a major income stream and enhanced standing of our organisation.. A clear business plan for commercial activities is required.
- Many activities overseas (including humanitarian, research and education) have taken place and are ongoing, driven by committed individuals. There is, however, only one formal partnership existing between Alder Hey and a developing country partner.
- A comprehensive ICH strategy would incorporate five key themes: international health partnerships (particularly with low-income countries); humanitarian 'mission' operations; education and training; research and commercial/business development.
- Alder Hey has many strengths in each of these areas with potential to fulfil its vision of being a world-leading children's hospital by developing all aspects of ICH.
- However, the existing ICH group has only met sporadically, suffered from inconsistent leadership and has not developed or delivered a cohesive strategy.
- Overall, engagement with international child health to date is patchy and, at present, there is no clearly defined Alder Hey "offer" with respect to any of the five areas of ICH.
- A department of ICH will provide the recognition and the key functions required to realise the vision of ICH being both truly valued and a key strategic aim.
- ICH is an area where Alder Hey can stand out from its competitors and move towards the status of an internationally-recognised children's hospital of excellence.

Background

- In 2011, Barry Pizer was asked by Ian Lewis, on behalf of the Trust Board, to develop a vision statement for international child health (ICH). An ICH group was established and developed a strategy which was shared with the Board. This encompassed broad areas of work including commercial consultancy, treating overseas private patients, research and education, as well as international humanitarian and partnership work in resource-poor countries.
- An exercise was conducted (2013) to map out the areas of activity by Alder Hey staff around the World, that highlighted the scope and value of international collaboration and training (Appendix 1).
- EY (formerly Ernst Young), a London-based multinational professional services firm, were commissioned in 2014, to conduct a free-of-cost scoping exercise in ICH activity, which identified benefits as the 'four R's':
    - ***Reputation***: One of Alder Hey's five key strategic aims, expressed in the Strategic Plan 2014-2019, was to "*to grow existing operations and brand name beyond the domestic region by growing our international footprint.*" We provide excellent secondary and tertiary level services for our patients. However we do not hold the status as an internationally recognised children's hospital of excellence. Examples of such institutions include Great Ormond Street Hospital, the Hospital for Sick Kids, Toronto and Boston Children's Hospital. Enhanced participation in international activities will greatly enhance our ambition to be recognised as a world leading children's hospital.
    - ***Recruitment and Retention:*** 'We look to attract world-leading medical professionals and researchers and we recruit from a limited global pool of such individuals. We also want to retain our current world-leading professionals. Working internationally will improve our retention rate and improve satisfaction levels.
    - ***Research and Education:*** Our clinical academics and other staff have a very strong portfolio of research in ICH. Our research activities and our reputation as a leading centre for research will be enhanced by increasing engagement with research activities overseas. Increased international networks will support us to maintain our role as a leading education centre and enhance the development of the Alder Hey Academy.
    - ***Revenue:*** Our international work will lead to additional revenue for us, forecast at ~£8.7m over 5 years. This will be achieved through enhanced delivery of care provision to international patients both at our hospital and at the overseas partner institutions. It is envisaged that educational activities may also attract significant income-generation.
- EY outlined strategic steps but the original ICH strategy was not fully endorsed by the Board at that time, possibly due to competing priorities.
- With the Department of Health's support, Alder Hey started to explore more commercial-based initiatives which led to the appointment of Angie May as lead nurse and Esme Evans as accountant for international business.
- The ICH group continued to meet but suffered from inconsistency in leadership with a succession of different chairpersons (Sir David Henshaw, Therese Patten, Jon Stevens, Louise Dunn, Debbie Herring) and focus on the business aspect of ICH has taken precedence over other aspects.

The Vision for International Child Health at Alder Hey

Our vision is that Alder Hey will be contributing to improving the health of the world's children, have an established, international paediatric brand with a reputation for excellence, be a proven partner with a track record of international delivery and have a balanced portfolio of income-generating and philanthropic activities in all areas of paediatric health delivery.

International Child Health will be fully integrated into strategic planning and Trust development, leading to Alder Hey establishing a reputation as a truly global organisation, rather than just a very good children's hospital.

The international child health portfolio will encompass the following five themes:

1. **Health Partnerships :**

   These are established, formal and equitable two-way health partnerships between institutions in high income and those in low income settings, with clear benefit to both partners. Examples at Alder Hey include our longstanding relationships in Malawi (currently informal), our 21 year association with Kanti Children's Hospital, Kathmandu (underpinned by a formal MOU) and several other links that are of somewhat shorter duration.

2. **Humanitarian work:**
   There is an incredible amount of humanitarian work being undertaken by Alder Hey staff which has largely gone unrecognised. Examples include Ram Dhannapuneni's regular cardiac surgery health camps in India, Caron Moores' engagement with charities providing health camps in Nepal and Andrew Curran's links with India, among many others. Many of these activities involve wider teams of staff.

3. **Commercial activities :**
   Some progress has been made towards developing commercial activities overseas, including our relationship with Al Jalila. However, current plans fall short of what was initially anticipated when the Trust embarked on this area of work.

4. **Research :**
   World leading research is a corporate aim and, historically, much of Alder Hey's research has been carried out on a global basis: internationally-based clinical trials in oncology and other areas; world-leading research being conducted by high-profile individuals such as Enitan Carroll, Atif Rahman and Nigel Cunliffe.

5. **Education:**
   This area offers tremendous potential to benefit Alder Hey with respect to global reputation, staff benefits and income generation. There are multiple opportunities for development, including formal visiting fellows programme, MSc and higher degree programmes.

Why a Department of ICH?

- The five key themes of ICH have a degree of overlap between them. For example, international health partnerships may contain educational and/or research elements. Business development opportunities may well include a strong health partnership component and have education and training and research opportunities.
- There is potential for cross-subsidization principles between international private patient activity and other activities, including work in low income nations, as well as the core business.
- However, currently, there is no clear understanding of Alder Hey's "offer" in any of these areas. Where we have pursued opportunities, they have often been reactive in nature. We do need to fully understand what our offer is, why and how we are in the best position to deliver it and what are our comparative advantages over our competitors.
- Without this, we cannot maximise opportunity and are unable to describe and therefore realise expected commitments and benefits.
- The fragmented ICH group has not been able to devise and deliver the cohesive strategy described above. The establishment of a department recognises the importance of defined roles and responsibilities in key areas for the effective delivery of the above vision.
- This includes strong clinical leadership and experience in this field, which may mean recruiting external individual(s) with a proven track record.
- Additional core functions such as administration / financial / communications / legal / HR / IM&T support are required.
- The department's responsibilities will be devising and delivering Alder Hey's offer, taking into account a resourcing plan and due diligence. There must also be a formal review process for all international working with robust governance and commercial systems. Some of these "offers" may also be extended to UK opportunities, e.g. 'design and build' or research and education.
- A department of ICH provides a central point of information and contact, coordinating overseas work and links with other organisations.

Should the Board support this vision?

Working internationally fully supports all aspects of our strategic plan: the Trust vision: "building a healthier future for children and young people"; the Trust aspiration: "to be World leading" and our goals for: delivery of outstanding care, the best people doing their best work, sustainability through external partnerships and game-changing research and innovation.

Historically, the Board has supported the principles of ICH and pursued some aspects of it.

Can we afford the investment now?

Significant investment in time and effort has already been made; there needs to be a focus on the return on investment from activities against previously defined strategic goals. It is not clear that there has been a routine approach to either tracking time and effort on international work or on the net returns.

Many staff throughout the Trust invest their own time and resources in overseas working, emphasising the value that is placed on this work by individuals throughout the organisation. This work has not been celebrated, meaning opportunities to promote our reputation, and potentially generate income, may have been missed.

Is there political support?

The UK government recognises the importance of addressing global health issues (see Appendix 2) and its commitment to do so is summarised in a DH paper entitled "The Framework for NHS Involvement in International Development" (March 2010). This document addresses issues including the UK policy context, the key principles for effective involvement in international development, the benefits of NHS involvement in international development, the architecture for NHS activity to support developing countries and good practice for organisations, individuals and employers.

What are the benefits to Alder Hey?

There are well described benefits of global child work to NHS organisations which apply across all health provider roles. These include:

- Provision of better return on investment in training: staff return from visits abroad with a wide range of skills and a better ability to work in a challenging environment, and in teams, for minimal cost to the organisation.
- Enhanced leadership and professional skills for NHS clinicians and managers.
- Enhanced reputation of the organisation amongst the public, staff and the media
- Greater staff satisfaction and improved retention and productivity. Staff return refreshed.
- Greater understanding and sensitivities of the needs of individual patients.
- Greater organisation cohesion, innovation and corporate social responsibility which can embed key NHS values set out in the NHS constitution and can potentially lead to higher sustainable organisational performance and cultural competence.
- Education and research opportunities that can benefit patients in all communities.
- A greater understanding of social and ethnic diversity
- Greater understanding of global health issues and knowledge of diseases not routinely seen in the UK.
- Income generation

Current strengths

1. Existing strong UK partnerships
    - University of Liverpool: the University of Liverpool sees internationalisation as a key priority. Many Alder Hey staff members hold academic positions at the University of Liverpool, and many clinical academics from the University are based at Alder Hey.
    - Liverpool School of Tropical Medicine (LSTM): historic links include courses delivered at Alder Hey, clinical and research work. The journal 'Paediatrics and International Child Health' is based there. Tropical Health and Education Trust: this NGO co-manages the International Health Links Funding scheme (in which Alder Hey partnerships have been successful) and has built up considerable experience in developing, managing and evaluating links. International Health Links Centre, Liverpool: a one-stop shop resource centre set up in 2009 and based at LSTM.

- RCPCH (Royal College of Paediatrics and Child Health): has an International Board.
- The British Council
- Global Health NHS, North of England, Northwest Office

2. Long-standing successful international partnerships, in both low income countries (e.g. Nepal (formal link with MOU) and Malawi, as well as in the Middle East
3. Track record of successful grant applications for partnership work with potential to apply for larger grants.
4. Committed and enthusiastic staff: many people already engaged in overseas work through their own initiatives or with other organisations
5. Education: We have existing strong training and education programmes, recognised nationally and internationally, with particular strengths in infectious diseases, CAHMS, paediatric neurology and epilepsy, orthopaedics, pharmacy and medicines.
6. Research: Alder Hey staff have led the way in many fields, e.g. vaccinations adopted by WHO, Infectious Diseases and Child and Maternal Mental Health.

Conclusion:

- Alder Hey has many strengths in international child health and a real opportunity to promote this aspect of working as a key part of its brand
- There is activity in all domains of ICH but this is not coordinated and there is little governance or accountability in some aspects.
- Establishment of a Department of International Child Health is an opportunity to coordinate and reduce inconsistency in these activities, develop strong and realistic offers within a clear framework, maximise income generation and mitigate risks.
- This paper seeks Board level support to adopt this vision as an organisational ambition.
- The next steps would be:
  - the identification of key personnel to take this forward
  - the formal establishment of a Department of ICH
  - a formal Alder Hey ICH strategy
  - a clear communications strategy for ICH
  - describing and mapping out work undertaken to date
  - identifying barriers and blockages to progress
  - designing realistic / aspirational future offers: high-level draft offers in each domain
  - outlining the risk and governance management framework that is needed for these offers

  See the Timeline in Appendix 3.

Appendix 1: Map of overseas activities (2013)

Appendix 2: Department of Health documentation addressing overseas working

International Humanitarian and Health Work Toolkit to Support Good Practice (2003).

http://www.fph.org.uk/uploads/international_humanitarian_and_healthwork_toolkit.pdf

Working together for better health (2007)

http://www.who.int/pmnch/activities/advocacy/workingtogether.pdf

Global Health Partnerships: the UK contribution to health in developing countries, the Government Response (2008)

http://www.wales.nhs.uk/documents/DH_083510.pdf

Evaluation of links between north and south healthcare organisations (2008)

https://www.eldis.org/document/A72431

Health is Global: a UK Government strategy 2008-13 (2008)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215656/dh_125671.pdf

Eliminating World Poverty: Building our Common Future (2009)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/229029/7656.pdf

UK Government's Institutional Strategy for working with WHO (2009)

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/67475/Building-stability-overseas-strategy.pdf

The Framework for NHS Involvement in International Development (2010)

http://www.severndeanery.nhs.uk/assets/Internationalisation/TheFrameworkforNHSInvolvementinInternationalDevelopmenttcm79-26838.pdf

Appendix 3: International Child Health at Alder Hey – 2 year Plan

	Year 1	Year 2
Overarching	Appointment of ICH Group Chair and identification of membership Appointment of ICH Administrator Planning for Department of ICH Development of ICH Strategy (describing 'offers' in each domain) Mapping Process of AH ICH Activities Develop and Implement Risk assessment Tool	 Department of ICH in place Completion and Implementation of ICH Strategy Review with respect to 'offers' Review and refine Risk assessment Tool
Communications	Appointment of part-time ICH Communications Officer Develop communication framework Development of ICH Webpages Develop Alder Hey International Brand Grand Round updates x 2	 Review and refine communications framework Refinement of ICH Webpages Role out Alder Hey International Brand Grand Round progress reports x 2 Report activities in other media
Health Partnerships	MOU with Queen Elizabeth Central Hospital, Blantyre, Malawi; scoping visit 1 (AH team to Malawi). Outline plan for collaborative activities.	Scoping visit 2 (QECH team to AH). Finalise activity plan; start first activity. Other MOUs / Engagement dependent on mapping process
Commercial	Fully establish Overseas Business Unit (constitution/TOR) Discussions with Trust Board - Breath of Commercial Activities Second Contract with Al Jalila Hospital Expansion of collaboration with Al Jalila [Neurosurgery/Neurosciences] Visiting Clinician programme Telemedicine	Review Overseas Business Unit Expansion of Commercial Activities Expansion of collaboration with Al Jalila (3rd Contract)
Education	Development of ICH Education Strategy Host 3-4 RCPCH Visiting Fellows 1 or 2 LSTM MSc Students (Nepal +/- other)	 Host 3-4 RCPCH Visiting Fellows 1 or 2 LSTM MSc Students (Nepal +/- Malawi)

	Engagement with Partners re Education (e.g. RCPCH) Development of Alder Hey International Fellowship Programme Business plan for joint AH/LSTM Leadership in Global Child Health 6 week course Business plan for ETAT+ course (Emergency Triage Assessment and Treatment + continued care)	 Start of Fellowship Programme Deliver first course and review Deliver first course and review (Innovation Hub)
Research	Engagement with HEI Partners Mapping and prioritisation of research themes Exploring opportunities through the Global Challenges Research Fund	PhD Studentship Implementation plan Review activities
Humanitarian	Review mapping process and Implementation plan Developing a theme to our humanitarian work	Collaboration with Commercial Partners re humanitarian work

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board of Directors

05 October 2017

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Associate Director of IM&T Jenny Wood, GDE Programme Manager
Action/Decision required	The Trust Board is asked to note the updated progress towards participation in NHS England's GDE Programme and subsequent initiation of the Programme.
Background papers	N/A
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	IM&CT Strategy Significant contribution to the strategic objectives for:- - Clinical Excellence - Positive patient experience - Improving financial strength - World class facility

Summary of progress in last month

Funding

The Trust received confirmation of the first tranche of PDC funding on Friday 16th June (approximately £2.5million), this was received and we were available to drawn down from on the 10th July.

The remaining revenue funding (approx. £800k) has been made available via the CCG.

Fast Follower

The Alder Hey *Fast Follower* Trust, Clatterbridge, are currently undergoing 'due diligence' A site visit was conducted successfully on the 20th September 2017 and approval was given and Clatterbridge are now completing their funding agreement.

At the next Board a copy of the Funding Agreement and Letter of intent will be circulated for formal agreement and sign off

Programme Assurance

NHS Digital has attended Alder Hey and completed their assurance testing for the second milestone.

The final assurance report is due and will be provided to the Board for overview.

Programme Delivery

Work remains underway in preparations for the achievement of the phase 3 milestones:-

- Recruitment to all approved posts. It is anticipated the full team will be in place by the end of September.
- Revision of milestones has now been completed to take into account the delays to the funding at national level; this includes the movement of milestone three from March to February 2018 for financial reasons.
- The Statement of planned benefits has been completed and submitted for NHS Digital to review.
- Internal organisational engagement work ongoing with good progress.
- System development has been completed for two speciality packages, with development commencing on six "specialty packages"
- The additional eight specialities are mapping their requirements
- A "speciality package launch" is scheduled for seven specialities on the 9th October.
- The Voice Recognition project has now trained circa 250 users and is now live within Gen Paeds, Ortho, Ophthalmology, Amb and Neph.
- The average turnaround time has reduced from 16 days to 8.5 days.
- Scoping and development of the Paediatric Portal is underway with a launch being planned for key stakeholders
- Emergency Theatre List System (ELIS) is now live

- TCI – Theatre Pathway re-design has commenced and is being led by Serive Manager, Sian Calderwood.
- IMO Clinical Terminology software implementation underway.

A copy of the GDE Programme Dashboard which summarises the status of all individual workstreams is included.

Next Steps

- Continue working towards the delivery of milestone three (February 2018) respectively.

- Assurance testing results to be returned by NHS Digital for milestone two.

Recommendation

The Trust Board is asked to:-

1. Note the progress with the GDE Programme and ongoing work to progress towards the third milestone due on 28th February 2017.

Peter Young

Chief Information Officer 22th August 2017

GDE Programme Dashboard - Assurance

Version 0.1 10/04/17

Project Ref	GDE?	Project Title	Project Description	Delivery Date	PROJECT RAG OVERALL PROJECT RAG status	% Progress	Comments for attention of the Project Team, Steering Group and sub-Committee
Workstream 1 - HIMSS level 7 EPR - System wide projects							
1B(a)	GDE	Voice recognition deployment	Deploy voice recognition solution in MEDITECH	30 September 2017 - Stage 1		Stage 1 100%	Live in Opthalmology. Video user guide created. FAQ pulled together.
1B(b)	GDE	Voice recognition deployment	Deploy voice recognition solution in Medisec	30 September 2017 - Stage 1		Stage 1 100%	Live in Opthalmology. Video user guide created. FAQ pulled together.
1C(a)	IM&T	Prescribing and Medicines Administration Enhancements	Warfarin	Thursday, March 1, 2018		75%	Review of resources in place. Awaiting response from clinical lead.
1C(b)	IM&T	Prescribing and Medicines Administration Enhancements	Antimicrobial	Thursday, March 1, 2018		35%	Review of resources in place.
1C(c)	IM&T	Prescribing and Medicines Administration Enhancements	Bedside medication verification	Thursday, March 1, 2018			
1C(d)	GDE	Prescribing and Medicines Administration Enhancements	Continuous infusions	Wednesday, February 28, 2018			Pilot Date, no longer a Project
1C(e)	GDE	Prescribing and Medicines Administration Enhancements	Dose range checking	28 Febraury 2018			Pilot Date
1E	GDE	MEDISEC enhancements	Tertiary letter improvements	Wednesday, February 28, 2018			Scoping discussion required with associate COO's, Nik to faciliate
1E(b)	GDE	MEDISEC enhancements	Inclusion of letters into ImageNOW	Saturday, September 30, 2017		100%	Completed
1F	GDE	POCT device integration	Integration of POCT devices into the MEDITECH system	Wednesday, February 28, 2018			1H to be completed first
1G	GDE	GS1 Barcodes	Enable technical solution for use of GS1 barcodes where appropriate	Wednesday, October 31, 2018			Harvey Livingstone as clinical lead. This needs to be put to the GS1 Working Group. Agree scope with organisation. Project Manager required. Next Wednesday. Survey - Send wristbands to see if GS1 complaint. Request ID numbers from GS1 for locations. Meeting required in relation to approach.
1H	GDE	Vital Sign device integration	Integration of Welch Alyn vital signs monitors into MEDITECH	30 December 2017 - Pilot 31 December 2017 - Roll out		45%	ML/MD & NB around workflow change. Interface promoted to live.Amanda Turton to review and sign off.
1J(a)	GDE	Theatre improvements - Emergency List.	Emergency list solution	Saturday, September 30, 2017	Completed	Stage 1 100%	Live
1J(b)	GDE	Theatre improvements - TCI to Theatre	TCI to Theatre improvements	30 September 2017 - Stage 1		Stage 1 100%	Update on Pre-Assessment business case required.
1K(a)	GDE	Internal interfaces Haemonetics	Haemonetics	Procuremnt date: 30 September 2017 Implementation date: 28 February 2017		10%	Meeting to roll in with ~TAR and review implementation.
1K(b)	GDE	Internal interfaces ECM	ECM file import	Saturday, September 30, 2017		70%	Badgernet pdf export.. Split this off on the dashboard.
1L	GDE	IMO implementation	Implementation of Clinical interface terminology software	28 Febraury 2018		25%	Frank working to edit ERD form & Theatres. Changing look up. Roll-out with clinical sign off. Training required. Clinical Lead required with pathology and radiolofy lead.

GDE Programme Dashboard - Assurance

Version 0.1 10/04/17

Project Ref	GDE?	Project Title	Project Description	Delivery Date	PROJECT RAG: OVERALL PROJECT RAG status	% Progress	Comments for attention of the Project Team, Steering Group and sub-Committee
1M	GDE	Day Forward Scanning	Automate the production and scanning of records	Saturday, September 30, 2017		100%	Deployment within Cardiology.
1N	GDE	Historic data migration	Complete migration of historical data from MEDITECH 5	30 September 2017 - Stage 1 procurement and proof of concept		Stage 1 100%	Clinical Group required to review the data.
1Oa	GDE	PACS Other Ologies	EEG - Consolidation of all clinical images into the PACS system	Thursday, May 31, 2018			
10 b	GDE	PACS Other Ologies	ECG - Consolidation of all clinical images into the PACS system	Sunday, December 31, 2017			
1O(c)	GDE	PACS Other Ologies	Gait Lab - Consolidation of all clinical images into the PACS system	Sunday, December 31, 2017			Gait lab procurement to be chased.
1P	GDE	Encoder implementation	Implement integrated encoding software for the Clinical Coding team	Stage 1 - depoly coding solution 30 September 2017		95%	Training organised.
1R	GDE	Mobile Phlebotomy solution	Adaptation of COWs to allow sample labels to be printed at the point of care	Saturday, March 31, 2018			Discussion with Hilda for Operation support. Upgrade of Meditech
1S	GDE	Infrastructure	Provision of additional hardware (subject to approval) to suppport clinical processes including fast user switching	Saturday, September 30, 2017			
1T	IM&T	Booking and Scheduling Enhancements	Develop an enhanced solution to support improvements to booking and scheduling processes	Saturday, September 1, 2018		10%	Scope agreed.
Workstream 2 - Speciality Packages							
2A	GDE	Emergency Department	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, September 1, 2017	Completed	100%	Completed and archived for Gateway 4 Post implemenation Review meeting arranged for 15.11.17 with Bimal Metha and Colin Prayle.
2B	GDE	Gynaecology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, September 1, 2017	Completed	100%	Completed and archived for Gateway 4
2C	GDE	Rheumatology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Saturday, September 30, 2017		60%	Meeting Monday to re-review feedback. 12days copying into go live. 4 weeks Monday.
2D	GDE	Gastroenterology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Thursday, November 30, 2017		10%	Finish process mapping pathways. COP Friday will have all requirements.
2E	GDE	Neurosurgery	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, November 3, 2017			Development to commence. 2 weeks worth of dev.
2F	GDE	Respiratory	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, November 3, 2017		10%	Process mapping of CF Clinic.
2G	GDE	CAMHS	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Thursday, October 19, 2017		40%	Requirements received. 6 weeks to dev.
2H	GDE	Community Paeds	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Page 2 of 4 Tuesday, October 24, 2017		5%	Review of IHA, requirements for ASD pathway received. Review of deadline.

GDE Programme Dashboard - Assurance

Version 0.1 10/04/17

Project Ref	GDE?	Project Title	Project Description	Delivery Date	PROJECT RAG – OVERALL PROJECT RAG status	% Progress	Comments for attention of the Project Team, Steering Group and sub-Committee
2I	GDE	Dietetics	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Tuesday, October 31, 2017		50%	John developing. Friday to review.
2J	GDE	Junior Doctors	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	TBC		10%	Generic docs - underway. Review of project plan required by ML/LF and JW
2K	GDE	LTV	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018		1%	Chased up
2L	GDE	Pre-Op	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018		1%	Requirements end of week
2M	GDE	Chronic Pain	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018		1%	Requirements end of week.
2N	GDE	Immunology & Infectious Diseases	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018		1%	Scope received. GS to be chased re requirements.
2O	GDE	Transitional Care	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Friday, February 2, 2018		1%	Requirmeents being pulled together. Meeting to clinicall review and review by IM&T
Workstream 3: Paediatric Clinical Portal							
3A	GDE	Paediatric Clinical Portal	Provide secure access to multiple aspects of a pateint record in one place	Stage 1 Scope and commence procurement 28 February 2017		30%	Test data populated by Friday.
Workstream 4 - Patient Portal							
4A	GDE	Patient Portal	To allow patients/families/carers secure access to patient records	Wednesday, February 28, 2018			
Workstream 5: Interoperability & APIs							
5A	GDE	MESH	Implementation of MESH standard for message exchange	31 Ocotober 2017		85%	Feedback from CCG.
5B	GDE	EMIS to MEDITECH interface	Electronic access to primary care records	Tuesday, October 31, 2017		10%	Interface ordered but commercial debate.
5C	GDE	GP Ordering for Diagnostics	To provide the ability for GPs to order Pathology investigations direct	Saturday, March 31, 2018		50%	Testing on-going. Patient match issue to work through.
5D	GDE	GP Ordering for Diagnostics	To provide the ability for GPs to order Radiology investigations direct	Saturday, March 31, 2018		50%	Testing on-going. Patient match issue to work through.
Workstream 6: Improving Patient Experience							
6A	GDE	PET App	Development of an App to improve patient experience	30 September 2017 - Stage 1, complete engagement phase for PET App 28th February 2018 - Stage 2 , build pilot for PET App		Stage 1 100%	Implementation underway for delivery Nov.
Workstream 7: National Requirements							

GDE Programme Dashboard - Assurance

Version 0.1 10/04/17

					PROJECT RAG		
Project Ref	GDE?	Project Title	Project Description	Delivery Date	OVERALL PROJECT RAG status	% Progress	Comments for attention of the Project Team, Steering Group and sub-Committee
7A	IM&T	e-Referrals	e-Referral paper switch off programme	Monday, October 1, 2018		50%	e-Referrals on track for delivery.
7B	IM&T	Emergency Care Data Set	Emergency Care data set to be added as part of IMO	Sunday, October 1, 2017		80%	Live on Friday
Workstream 8: Other							
8A	IM&T	Chemocare HL7 Interface	HL7 ADT Interface for Chemocare	Thursday, March 1, 2018			Pending go live. Live next week.
8B	IM&T	R&E 2	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	Friday, June 1, 2018			Uni's to finalise requirements. Additional meetings scheduled. Costings. Occupancy June 18, staff / students Sept 18. Costing received.
8C	IM&T	Outpatient Coding	Outpatient Coding	Friday, September 1, 2017			Raised with reporting sub-group. Indication septe milestones delivery, october. To be chased. Build in test - 3 specialities to be reviewed.
8D	IM&T	Sepsis Management	Review of Sepsis Pathway	Friday, September 1, 2017			MD to describe change to clinician process. End October all development to be completed. Urgent and ciriticals.
8D	IM&T	Data Centre back on site	Move of the Data Centre back onto site	Monday, January 1, 2018			Lack of confirmation of additional power.
8E	IM&T	A&E Capacity and Demand App	Deployment of an A&E waiting time app across the STP footprint	01 January 2018?			STP initiative.

Project RAG

Black - Failed/ Gap
Red - Project team/workbook requiring significant assistance/management
Amber - Project team and workbook have issues and these are resolvable at the project level
Green - Project team in place with workbook overall in good order and proceeding to plan