Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 4th April 2017 commencing at 1000

Venue: Institute in the Park Large Meeting Room, Alder Hey Children's Foundation Trust

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
		1000	**PATIENT STORY**			
		1015	**BOARD SAFEGUARDING TRAINING, JULIE KNOWLES**			
Board Business						
1.	**17/18/01**	**1030**	**Apologies**	Chair	Hilda Gwilliams, Steve Ryan, Margaret Barnaby and Christian Duncan	--
2.	**17/18/02**	**1031**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**17/18/03**	**1032**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **7th March 2017**	Read Minutes
4.	**17/18/04**	**1035**	**Matters Arising** - Global Digital Exemplar (GDE)	Chair P Young	To discuss any matters arising from previous meetings and provide updates and review where appropriate To provide an update on the "Global Digital Exemplar Programme"	Verbal Verbal
5.	**17/18/05**	**1040**	**Key Issues/Reflections**	All	The Board to reflect on key issues.	Verbal
Strategic Update						
6.	**17/18/06**	**1050**	**Alder Hey 2020 Vision** - **Final Strategic plan** - **Delivery plan: Corporate Objectives 2017/18** - **Communications plan**	All	To finalise delivery and communication of Trust strategy.	Presentation

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
7.	**17/18/07**	**1110**	**Programme Assurance update** - **Deliver Outstanding Care** - **Growing External Partnerships** - **Solid Foundations** - **Park Community Estates and Facilities**	J Gibson	To receive an update on programme assurance including the 2017/18 change programme	Read report
8.	**17/18/08**	**1120**	**External Environment** - **STP progress** **Progress against strategic themes:** - **Neonatal Reconfiguration Options** - **International Business Development** - **Transfer of Community Services**	 L Shepherd D Herring L Dunn D Herring	 To update the Board with regard to ongoing processes with the local health economy To update the Board on progress.	Verbal Verbal Verbal
Delivery of outstanding care						
9.	**17/18/09**	**1140**	**Serious Incidents Report**	P Brown	To inform the Board of the recent serious incidents at the Trust in the last calendar month	Read Report
10.	**17/18/10**	**1150**	**Clinical Quality Assurance Committee: Chair's update**	A Marsland	To receive and review the minutes from the meeting held: February 2017	Read report
11.	**17/18/11**	**1155**	**Alder Hey in the Park update**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
12.	**17/18/12**	**1158**	**PFI Liaison committee minutes**	D Powell	To receive and review the minutes from the meeting held on: 22nd February 2017.	Read minutes
The best people doing their best work						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
13.	**17/18/13**	**1200**	**People Strategy Update**	M Swindell	To provide an update on the strategy and staff survey	Read reports
14.	**17/18/14**	**1205**	**Listening into Action** - **Outpatients** - **Equality and Human Rights**	K Turner Rebecca Jeffrey Hannah Ainsworth/ Abu Sawaneh	Clinical teams from the current cohort to provide an update on progress to the Board	Presentation
15.	**17/18/15**	**1220**	**Well Led Governance Review self-assessment**	E Saunders	To receive the self-assessment and agree any required actions to address gaps	Read report
1230 – 1300 LUNCH						
Strong Foundations						
16.	**17/18/16**	**1300**	**Corporate Report**	C Liddy/ P Brown/ M Swindell	To note delivery against financial , operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of February 2017	Read report
17.	**17/18/17**	**1317**	**Board Assurance Framework** - **Quarterly Corporate risk register** - **Assurance Report Integrated Governance Committee**	E Saunders	To receive the BAF yearend review, IGC assurance report and corporate risk register.	Read report
18.	**17/18/18**	**1320**	**Resources & Business Development Committee: Chair's update**	I Quinlan	To receive and review the minutes from the meeting held on: 1st March 2017.	Read minutes
19.	**17/18/19**	**1325**	**Risk Management Strategy**	P Brown	To ratify the revised Risk Management Strategy	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Any Other Business						
20.	**17/18/20**	**1330**	**Any Other Business**	All	To discuss any further business before the close of the meeting	Verbal
Date And Time Of Next Meeting: Tuesday 2nd May 2017 At **10:00am, Institute In The Park, Large Meeting Room**						

REGISTER OF TRUST SEAL
The Trust Seal was used once during the month of **March 2017 – Modular building**

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the last meeting held on **Tuesday 7th March 2017, at 10am,**
Institute in the Park Large Meeting Room at Alder Hey

Present:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mrs M Barnaby	Interim Chief Operating Officer	(MB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs C Liddy	Acting Director of Finance	(CL)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mr R Turnock	Medical Director	(RT)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Dr U Das	Acting CBU Director	(UD)
	Ms L Dunn	Director of Marketing	(LD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mrs D Herring	Director of Strategic Development & Clinical Service Partnerships	(DH)
	Mrs C McLaughlin	Director of Integrated Community Services CBU	
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mr C Duncan	CBU Director	(CD)
	Mrs J Tsao	Committee Administrator	(JT)
Agenda item:	Mr Stephen Comber	Fire Safety Officer	(SC)
	Ms R Watkinson	Hill Dickinson	(RW)
262	Mrs A Hyson	Complaints Manager	(AH)
266	Mrs J Potier	Clinical Psychologist	(JP)
266	Ms Lauren Cummins	Operational support manager	(LC)
266	Mrs Helen Walker	Specialist Nurse	(HW)
266	Mrs Amanda Haworth	Specialist Nurse	(AH)
266	Mr Phil Raymond	Service Manager	(PR)
266 & 267	Mrs K Turner	Listening into Action Lead	(KT)
	Mr J Gibson	Programme Director	(JG)
Apologies:	Mrs J France-Hayhurst	Non-Executive Director	(JFH)

Board Mandatory Fire Safety Training
Stephen Comber presented the Fire Safety Training to the Board.

Responsibilities from the Mental Health Act
Rachael Watkinson from Hill Dickinson's presented the Board's responsibilities under the Mental Health Act.

Dame Jo Williams and Anita Marsland are due to attend further Mental Health Act training specifically for the role of 'Hospital Manager' on 21st March and agreed to report back at the April Board. Claire Dove will also receive the training in the near future.

16/17/254 Declarations of Interest

None declared.

16/17/256 Minutes of the previous meetings held on 7th February 2017

Resolved:

The Board received and approved the minutes from the meeting held on 7th February 2017.

16/17/257 Matters Arising and Action Log

'Learning from Deaths' Event - London 21st March 2017

Rick Turnock reported on the invitation for both the lead Executive Director and Non-Executive Director to attend a national 'learning from deaths' event linked to the recent CQC report. Julie Grice, Chair of HRMG had agreed to attend. As all Non-Executive Directors present had pre-existing commitments on this date the invitation would be forwarded to Jeannie France-Hayhurst.

Research, Education Build Phase II

The Charity had recently approved the three year financial plan including the Grant for the R&E 2 development. The Board thanked the Charity for their support.

16/17/258 Key Issues/Reflections:

All items for discussion had been listed as an agenda item.

16/17/259 External Environment/STP/Progress against Strategic Themes

STP Governance

Louise Shepherd provided an update on the review of acute services across Cheshire and Merseyside to create a high level blueprint for emergency care and women's and children's services.

As there are 40 organisations included in the review a draft memorandum of understanding had been developed to support quicker decision making. A further update would be presented at the end of Quarter 1.

Transfer of Community Services

Discussions continued to be held with NHS Improvement and Liverpool Community Health NHS Trust on the transfer of the 'lift and shift' element of paediatric community services to Alder Hey on 1st April 2017.

Liverpool Women's NHS Foundation Trust/Neonatal Network

Debbie Herring reported on the Neonatal Network and the progress made on the review of services across Cheshire and Merseyside. Proposals are due to be submitted to the next Neonatal Network Board, following approval it would be presented to NHS England.

International Business Development
Louise Dunn reported on opportunities with three different hospitals in China and agreed to update the Board on further progress.

Board Strategy – 10th February 2017
The Board received the outputs from the strategy session and discussed a number of amendments to Alder Hey's vision statement. Louise Dunn agreed to amend the wording and issue the final version for cascade and communication throughout the organisation. The next step was for the Executive Team to finalise the corporate objectives for 2017/18.

16/17/260 Serious Incidents Report
Hilda Gwilliams presented the report for January 2017. There had been no new SIRIs reported; one was ongoing and two closed.

The Coroner's report in relation to the suboptimal care of a deteriorating patient had been received. The outcome of the report was that the patient had died of natural causes. Hilda Gwilliams and Rick Turnock had recently met with the parents. Clinical Quality Assurance Committee would continue to be updated on the underpinning processes for the management of this category of patient.

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

- No new SIRI, one ongoing and two closed. There had been one new safeguarding incident reported, none ongoing or closed.
- The actions being taken to provide assurance with regard to the deteriorating child, using both new and existing tools.

16/17/261 Clinical Quality Assurance Committee: Chair's Update
The Board received and noted the Minutes from the CQAC meeting held on 18th January 2017.

Margaret Barnaby had circulated the Sepsis implementation plan to CQAC and agreed to circulate to the Board.

Resolved
The Board received the January CQAC minutes and a verbal update from the February meeting.

16/17/262 Complaints Quarter 3 report
Anne Hyson presented the above report highlighting the continued reduction of complaints for the quarter compared to previous years. This was due to more complaints being dealt within the ward/department at an early stage.

The Board reviewed the level of complaints received within each of the Clinical Business Units noting the reduction of complaints received for Neurosciences. Accident and Emergency had received the highest number of complaints for the quarter; this was in line with the high levels of activity within the department.

The Board was asked for a response to the request from the Parliamentary Health Service Ombudsman that complaints are investigated and the

complainant is then signposted straight to the PHSO without the option to come back to the Trust. The Board advised we should give complainants the option to go to the PHSO or to come back to the Trust for further resolution.

Resolved
The Board received the Complaints report for Quarter 3 and noted the year on year reduction in formal complaints.

16/17/263 Infection Prevention and Control Quarter 3 report
Rick Turnock presented the Quarter 3 report on behalf of Richard Cooke. Melissa Swindell provided assurance the training reports had been completed.

Resolved:
The Board received the Infection Prevention and Control report for Quarter 3**.**

16/17/264 Nurse Staffing Levels
Following the last update to Board in September 2016, Hilda Gwilliams presented a report on progress to date. The Board noted the high level of achievement and discussed using the same process in other areas. The report highlighted the strong partnership between corporate services resulting in no further use of external agency staff.

A review of Education and Learning was due to be presented at the March Resource and Business Development Committee.

Last year the Government confirmed their decision to replace NHS bursaries for nursing with student loans and to charge student nurses for tuition fees from August 2017. The Board noted the impact this would have on the number of newly qualified nurses in three years' time. Hilda Gwilliams suggested that given the recruitment challenges nationally the Trust would need to consider incentive schemes. Dame Jo Williams queried if it would be possible for the Trust to fund the third year student nurses with an agreed contract as a nurse with the Trust for a set number of years. Hilda Gwilliams and Melissa Swindell agreed to review and provide an update at a future Board meeting.

Other challenges included re-introducing the Matron structure within the current budget.

Resolved:
The Board thanked Hilda Gwilliams and the teams for the improved Nurse Staffing report.

16/17/265 People Strategy
The Board received the people strategy report for January 2017.

Melissa Swindell presented the results of 2016 staff survey: response rate was 39% this was an improvement of 36% from the previous year. The Board discussed a number of proposals to improve the response rate including CBUs to have more ownership of the response rates.

A number of the improvements noted with the staff survey were part of the Listening into Action process.

Resolved
The Board
a) received the People Strategy report January 2016
b) Workforce and Organisational Key issues report for February 2017.

16/17/266 Listening into Action

Kerry Turner gave an introduction into Listening into Action (LiA). The purpose of LiA was to support and empower teams to resolve the issues they were facing in their own areas. The Board received the two presentations below. The first presentation had been part of the first cohort of LiA Clinical Teams last year and the second presentation was in the current cohort and had been part of LiA for 14 weeks.

CAMHS Self-Referral

Jo Potier Clinical Psychologist reported CAMHS self-referrals had not previously been in place and the reasons for change.

Lauren Cummins Operational support manager discussed the teams' concerns around the increase this could cause to waiting times. Due to this it was agreed the self-referrals would be trialled during the summer as appointments are slightly lower during this time.

To date CAMHS have collected 106 self-referrals across Liverpool and Sefton services between August 2016 and February 2017. This will be presented at the North West CAMHS transformation event as an example to other CAMHS services wishing to implement self-referrals.

The Board thanked Jo Potier, Lauren Cummins and the CAMHS team for sharing their successful journey on self-referrals.

Cardiac Surgical Pathway

Helen Walker, Nurse Specialist reported on the high number of theatre lists rearranged/cancelled, the reasons behind this and the frustration this causes to patients and staff.

The proposed structured process plans a patient journey and includes a pre theatre admission clinic on a Thursday prior to any operations taking place the following week. Ronald McDonald House had agreed to allocate rooms for patients/families who live an hour or more away from the hospital the day prior to the operation.

Phil Raymond Service Manager reported on the introduction of a 'team huddle' and its key importance to ensuring the flow of each patient's journey.

The Board thanked Helen Walker, Phil Raymond, Amanda Haworth and the team for sharing the proposals to improve the cardiac surgical pathway.

Resolved

The Board:

a) Received the two presentations and noting the progress of the projects using the LiA methods.
b) Requested further updates from LiA teams as a regular item.

16/17/267 Freedom to speak up

An update was received with regard to implementation of the framework to support the prescribed *Freedom to Speak Up* Guardian function at the Trust. It was noted that representatives from the Trust had attended various national and local events and that this had reinforced the appropriateness of the proposed approach.

Resolved:

The Board noted the updated position and endorses the planned direction of travel to integrate this initiative with the Trust's existing arrangements for raising concerns.

16/17/268 Corporate Report

Performance

All performance targets had been achieved for month 10. Margaret Barnaby thanked the three recently appointed CBU Directors and their teams for this achievement.

Finance

For the month of January the Trust is reporting a trading surplus of £0.5m, which is in line with plan. Year to date the trading deficit is £2.9m which is an improvement of £0.1m against plan.
Income is ahead of plan by £3.7m to date. Elective and non-elective activity are both on plan with outpatient activity ahead of plan by 2%.

Cash in the Bank is £5.2m. Monitor Use of Resources rating is 3 in line with plan.

Quality

The focus continues on the reduction of pressure ulcers, since the recruitment of the Tissue Viability Nurse Specialist reporting of pressure ulcers has increased.

Due to the support from volunteers the response rate on Friends and Families questionnaires had increased.

Reduction of reported infections continues.

Resolved:

The Board noted the Corporate Report for Month 9.

16/17/269 Programme Assurance Update

Joe Gibson presented the closure of 2016/17 programme highlight the forecast and what was achieved as well as launching the 2017/18 programme.

Resolved:

The Board received an update on Programme Assurance.

16/17270 New NAO/FRC Auditor Regulations Covering Provision of Non - Audit Services

Steve Igoe reported on the new regulation from NAO on non audit services. The implementation date is from the 1st April 2017, the Board noted their concerns with regard to the short timescale for making the decision and the requirement to re-procure one or other element of KPMG's services. Steve Igoe agreed to write to NAO noting the concerns raised.

Resolved:
The Board received notification of new NAO regulations.

16/17/271 Integrated Assurance Report – Board Assurance Framework

The Board received the latest BAF. Erica Saunders noted the closed down reports would be received next month as well as the April Integrated Governance Committee.

Resolved:
Board received the Integrated Governance assurance and BAF report.

16/17/272 Resources and Business Development Committee

Resolved:
Board received RABD minutes from the meeting held on 25th January 2017.

The five key priorities for 2017/18, based on the BAF would be agreed at the March meeting.

16/17/273 Liaison Committee Minutes

Resolved:
The Board received Liaison Committee minutes from the meeting held on 17th January 2016. It was agreed this would be standing item.

16/17/278 Board Work plan

The work-plan was presented. The Board discussed Governors attending future Board meetings and for an item to be included on this at the March Council of Governors meeting.

Resolved:
The Board approved the work-plan.

16/17/279 Alder Hey in the Park

Resolved:
Board received an update on Alder Hey in the park.

16/17/280 Any Other Business

No further business was discussed.

Date and Time of next meeting: Tuesday 4th April 2017, at 10:00am, Large Meeting Room, Institute in the Park.

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)

The Trust financial target for CiP and the programme is £8m in 2017/18, this equates to 4% efficiency. Currently the trust has schemes with project plans amounting to £4.4m, a further £2m of opportunities (red risk), and a gap of £1.1m. The make up of the savings is largely transaction (business as usual) with very little confirmed from the strategic pillars of the programme. The Executive Sponsors are requested to expedite the planning phase and complete PiDs including confirmation of the financial contribution of strategic pillars to allow a more accurate assessment of an residual gap to be completed. Given the challenging environment the Trust should be planning £6m to of financial opportunity from strategic pillars.

C Liddy 28 Mar 17

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

1. This Board reports integrates the assurance reports submitted to CQAC, 22 Mar 17, and R&BD, 29 Mar 17, sub-Committees; Executive Sponsors had been apprised at the February Committee meetings that there was a need for urgency in completing the definition and planning of the 17/18 (and 18/19) change programme.
2. At the time of writing, 1430 28 Mar, there are 11 draft PIDs (of 38 projects) uploaded to SharePoint (**see those in red font, slide 3**) none of which has been signed-off, and many of those require significant further work before the projects are underpinned. I will review the SharePoint site immediately before the Trust Board of 4 Apr 17 and would like to be able to report further progress.
3. As stated in both the February and March Assurance reports to Trust Board: it is evident that the planning process for FY17/18 is underway but needs to accelerated, **see slide 2**, to fully scope all programmes to mitigate the growing risk to timely delivery; given the scale of the efficiency challenge and aspirations to outstanding quality, Executive Sponsors of all programmes **(see slide 3)** need to focus on how they will drive the programme in FY 2017/18.

J Gibson 28 Mar 17

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

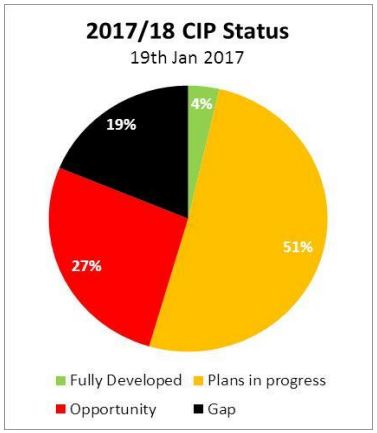
The Month 11 CIP performance across the Trust showed an under achievement of £0.5m in February. The largest variances to date are Surgery (£0.1 behind plan), Medicine (£0.2 behind plan). The main reason for being behind is slippage is the timing of schemes starting and a delay in starting the larger workforce transformation schemes. The full year forecast is £6.5m a gap of £0.7m. Recurrently the gap is now reduced to £179k

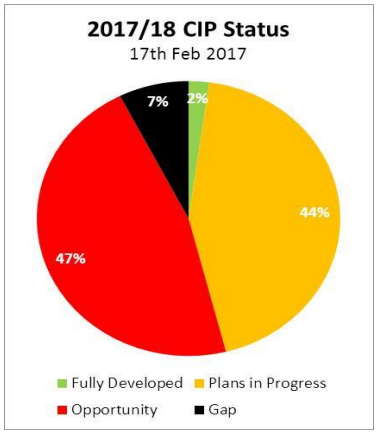
Alder Hey Children's NHS
NHS Foundation Trust

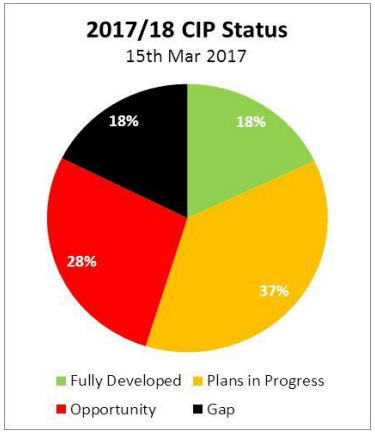
2017/18 CBU CIP Plans as at 29th Mar 2017

Workstream	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	15		307	265	**587**
Sustainability Through External Partnerships		94	215	-150	**159**
The Best People Doing Their Best Work		299	90	13	**402**
Game Changing Research and Innovation	130			100	**230**
Solid Foundations				142	**142**
Business as Usual	1,297	2,551	1,592	1,041	**6,480**
Grand Total	**1,442**	**2,944**	**2,204**	**1,411**	**8,000**

Progress since December 2016 NHSI Submission







Inspired by Children

Change Programme
Outline 23.3.17 v19

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

CQAC | R&BD | WOD | RE&I | R&BD

Internal Delivery Group (CiP) ⟷ **Programme Assurance Framework** ⟷ **Execs**

26/38 = £ indicated projects

Deliver Outstanding Care
Hilda / Rick

1. Deteriorating Patient
2. Reduce Variation by Developing Clinically Effective Pathways £
3. Experience in Outpatients £
4. Best in Operative Care £
5. 7 Day Services
6. Reduce Infections £

Growing Through External Partnerships
Debbie

1. Establish Alder Hey as leader of Children's Health across C & M
   a) High Quality Acute & Emergency Care £
   b) Develop Clinical Support Services Offer £
   c) Strong Specialist Services Offer £
   d) Strong Community Services Offer £
   e) Expand Mental Health Offering £
   f) Establish Rehabilitation Pathway £
2. Strengthen Existing Partnerships £
3. International Health & Non-NHS Patients £

The Best People Doing Their Best Work
Melissa/Hilda

1. Staff Engagement & Development
   a) Apprenticeships £
   b) Leadership & Management Development
   c) Engagement & Communication
2. Workforce Reviews
   a) Specialist Nurse Review £
   b) AHP Review £
   c) Job Planning £
   d) GDE Workforce Change £
   e) Portering £
   f) Domestics £
3. Agile Working
4. Implement Carter £

Steering Group

Game Changing Research and Innovation
David

1. The Academy £
2. The Innovation Co £
3. Implement New Apps for Alder Hey
4. Expand Commercial Research £

Solid Foundations
John/Rick

SG

1. GDE £
2. Strategic Estate Review
3. STP Corporate Services £

Park, Community Estate & Facilities
David

1. Decommission & Demolition
2. R&E 2
3. Alder Centre
4. Park
5. Residential Development
6. International Design & Build Consultancy £

Steering Group

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

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Deliver Outstanding Care

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

Planning for 17/18 is currently underway and teams need to complete their PIDs and project documentation as a matter of urgency – the deadline is 31 March 2017. It should be noted that the documentation must include details of any financial benefits to be delivered.

The latest forecast is savings of £0.3m, which is very low, and not sufficient to meet the financial objectives of the programme. The Executive sponsor is requested to review the saving potential as a matter of urgency.

At present there is limited information on SharePoint; there currently a draft PID for Experience in Outpatients.

Claire Liddy – Acting Director of Finance
15 March 2017

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

At a comparable stage, 17 March 16, in **last years** change programme definition, the status was as shown here to the right. Three projects were fully defined and three were half way to completion. **This year**, the status overleaf indicates that there is a high level of risk that the projects will not deliver in a timely manner with impact on quality and Sustainability gains. **There is an urgent need to accelerate project definition and planning.**

Joe Gibson 15 Mar 17

Project/Scheme Name	Project Definition	Objectives	Approach	Scope	Exclusions	Dependencies	Benefits & Measures	Project Structure	Milestones/ Deliverables	Costs	Comms Plan	Risks	EA & QIA	Financial Info (Appendix 1)	Approved (Yes/No)
Implementing Quality Strategy	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Best Operative Care	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Improving Outpatients	Y	Y	Y	Y	Y	Y	N	Y	Y	N	Y	N	Y	N	
Complex Care Made Simple	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	
Improving Flow	Y	Y	Y	Y	Y	Y	N	Y	N	N	Y	Y	Y	N	
Clinical Support Services	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N	N	N	

Programme Assurance Framework

Deliver Outstanding Care (Completed by Assurance Team)

Alder Hey Children's NHS
NHS Foundation Trust

Sub-Committee	CQAC	Report Date	15 March 2017
Workstream Name	Deliver Outstanding Care	Executive Sponsor	Hilda Gwilliams/Rick Turnock

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 17/18 £931k													
CQAC 1.1	Deteriorating Patient	This project will ensure prompt recognition and management of the deteriorating patient and implementation of the Sepsis Pathway	Hilda Gwilliams										
CQAC 1.2	Reduce Variation by Developing Clinically Effective Pathways	This project will drive the development of clinically effective care pathways across all specialities, using various methodologies including ImERSE, LiA and PFCC	Rick Turnock/ Steve Ryan										
CQAC 1.3	Experience in Outpatients	The project will improve patient & staff experience; understand demand and capacity; improve flow and environment	Hilda Gwilliams										Draft/outline PID on SharePoint. Last updated 13 March 2017
CQAC 1.4	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	Rick Turnock/ Steve Ryan										
CQAC 1.5	7 Day Services	The project aims to deliver 7 day services in line with NHS recommendations	Rick Turnock/ Steve Ryan										
CQAC 1.6	Reduce Infections	This project will ensure we achieve best in class for infection prevention and control	Rick Turnock/ Steve Ryan										
CQAC 1.7	Shared Learning		Hilda Gwilliams										

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Deteriorating Patient	Black	0	0	0	No financial benefits identified to date
Reduce Variations by Developing Clinically Effective Pathways	Black	0	0	0	No financial benefits identified to date
Experience in Outpatients	Red	180	180	0	Financial target based on 3% reduction in DNA rate in Medical specialities. High risk regarding delivery of full target value.
Best in Operative Care	Red	407	143	-264	Financial target based on 2% growth in Elective and Daycase income in Surgical specialties. Risk regarding delivery of full target.
7 Day Services	Black	0	0	0	No financial benefits identified to date
Reduce Infections	Black	0	0	0	No financial benefits identified to date
Shared Learning	Black	0	0	0	No financial benefits identified to date
Total		587	323	-264	

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)

Planning for 17/18 is currently underway and teams need to complete their PIDs and project documentation as a matter of urgency – the deadline is 31 March 2017. It should be noted that the documentation must include details of any financial benefits to be delivered.

The latest forecast is savings of £0.2m, which is very low, and not sufficient to meet the financial objectives of the programme. The Executive sponsor is requested to review the saving potential as a matter of urgency.

At present there is limited information on SharePoint; and some recent amendments to the projects within this Workstream require the teams to review any PIDs that have been drafted to ensure that they meet the full scope of the projects.

Claire Liddy – Acting Director of Finance
16 March 2017

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

At a comparable stage, 24 March 16, in **last years** change programme definition, the status was as shown here to the right. The two projects were all but fully defined. **This year**, the status overleaf indicates that there is a high level of risk that the projects will not deliver in a timely manner with impact on quality and sustainability gains.
There is an urgent need to accelerate project definition and planning.

Project/Scheme Name	Project Definition	Objectives	Approach	Scope	Exclusions	Dependencies	Benefits & Measures	Project Structure	Milestones/ Deliverables	Costs	Comms Plan	Risks	EA & QIA	Financial Info (Appendix 1)	Approved (Yes/No)
Strategic Partnerships	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	
International Clinical Business and Non-NHS Patient Services	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	N	

Joe Gibson - External Programme Assessment – 20 Mar 17

Programme Assurance Framework

Alder Hey Children's NHS
NHS Foundation Trust

Growing Through External Partnerships (Completed by Assurance Team)

Sub-Committee	RABD	Report Date	16 March 2017
Workstream Name	Growing Through External Partnerships	Executive Sponsor	Debbie Herring

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
2.0 Growing Through External Partnerships £211k													
R&BD 2.1a	STP AH @ C&M High Quality Acute & Emergency Care	Lead services to review options to collaborate and maximise joint working across the NM LDS and C&M Footprint; including developing partnerships with Warrington	Debbie Herring										
R&BD 2.1b	STP AH @ C&M Develop Clinical Support Services Offer	Lead services to review options to collaborate and maximise joint working across the NM LDS and C&M Footprint.; including Pathology, Diagnostics and Pharmacy	Debbie Herring										
R&BD 2.1c	STP AH @ C&M Strong Specialist Services Offer	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	Debbie Herring										
R&BD 2.1d	STP AH @ C&M Strong Community Services Offer	Lead services to review options to collaborate and maximise joint working across the NM LDS and C&M Footprint; including delivering Liverpool Community Children's Services	Debbie Herring										
R&BD 2.1e	STP AH @ C&M Expand Mental Health Offering	Lead services to review options to collaborate & maximise joint working across the NM LDS & C&M Footprint; including Community CAMHS, Tier 4 CAMHS & Neuro Developmental Service	Debbie Herring										
R&BD 2.1f	STP AH @ C&M Establish Rehab Pathway	Implement Alder Hey Rehab offer to enhance patient pathway	Debbie Herring										
R&BD 2.2	Strengthen Existing Partnerships	Lead services to review options to collaborate and maximise joint working with partners beyond C&M including Stoke, CMFT & Wales	Debbie Herring										
R&BD 2.3	International Health & Non-NHS Patients	Establish International service offer including: International Health Partnerships and non-NHS patients	Debbie Herring/ Louise Dunn										

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
STP AH @ C&M Children's Services	Black	0	0	0	No financial benefits identified to date
International Health & Private Patients	Red	0	30	30	Medicine CBU forecasting £30k benefit from growth PP Therapies work
Strategic Model Future Tier 4 CAMHS	Black	0	0	0	No financial benefits identified to date
Implement Rehab Pathway	Black	0	0	0	No financial benefits identified to date
Transformation of Developmental Paediatrics	Amber / Red	159	137	-22	
Total		159	167	8	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Solid Foundations

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

Planning for 17/18 is currently underway and teams need to complete their PIDs and project documentation as a matter of urgency – the deadline is 31 March 2017. It should be noted that the documentation must include details of any financial benefits to be delivered.

The latest forecast is savings of £0.1m, which is very low, and not sufficient to meet the financial objectives of the programme. The Executive sponsor is requested to review the saving potential as a matter of urgency.

At present there is limited information on SharePoint; there is currently a draft PID for GDE. This Workstream has also been revised to include Strategic Estate Review and a previously drafted PID relating to Community now forms part of the scope of this project.

Claire Liddy – Acting Director of Finance
17 March 2017

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

There is no directly comparable work stream, from the 16/17 scope, to this new 'Solid Foundations' work stream of the change programme.

However, the status overleaf indicates that there is a high level of risk that the projects will not deliver in a timely manner with impact on quality and sustainability gains. The lack of quantified benefits associated with the Global Digital Excellence (GDE) programme is of particular concern at this stage.

Given the importance of these 3 projects to the change programme as a whole, t**here is an urgent need to accelerate and complete project definition and planning.**

Joe Gibson - External Programme Assessment – 20 Mar 17

Programme Assurance Framework

Solid Foundations (Completed by Assurance Team)

Alder Hey Children's NHS Foundation Trust

Sub-Committee	RABD	Report Date	16 March 2017
Workstream Name	Solid Foundations	Executive Sponsor	John Grinnell/Rick Turnock

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Solid Foundations													
R&BD 5.1	GDE		Rick Turnock/ John Grinnell										Draft PID on SharePoint. Last updated 13 March 2017
R&BD 5.2	Strategic Estate Review	Review Alder Hey estate against future service requirements & specifications. Look at options with partners to rationalise/maximise use	John Grinnell /David Powell										PID previously uploaded to SharePoint relating to Community. Scope now confirmed to cover wider estate - PID to be reviewed/revised to reflect this. Last updated 13 March 2017
R&BD 5.3	STP Corporate Services	The project aims to review options to collaborate and maximise joint working aross the NM LDS and C&M Footprint. The scope will include all corporate areas.	John Grinnell										

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
GDE	Black	0	0	0	No financial benefits identified to date
Strategic Estate Review	Black	0	0	0	No financial benefits identified to date
STP Corporate Services	Amber / Red	142	142	0	HR&OD target of £25k (risk rated Amber) Finance target of £117k (risk rated Red)
Total		142	142	0	

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Park, Community Estate & Facilities

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

Planning for 17/18 is currently underway and teams need to complete their PIDs and project documentation as a matter of urgency – the deadline is 31 March 2017. It should be noted that the documentation must include details of any financial benefits to be delivered.

The projects within this Workstream relating to the 16/17 Programme are currently being reviewed and are due to be presented at this sub-Committee. As part of this review, the Project Team should ensure that existing PIDs are refreshed/updated to take into account any revised scope which has been following definition of the 17/18 Programme.

The information on SharePoint should be updated and any new PIDs produced by the required deadline of 31 March 2017.

Claire Liddy – Acting Director of Finance
16 March 2017

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

At a comparable stage, 24 March 16, in **last years** change programme definition, the status was as shown here to the right. Five projects were more than halfway to being fully defined and four were still to be commenced. **This year**, the status overleaf indicates that five of six projects are part way defined; however a level of risk remains that the projects will not deliver in a timely manner with consequent impact on quality and sustainability gains. **There is an urgent need to conclude the project definition and planning.**

Project/Scheme Name	Project Definition	Objectives	Approach	Scope	Exclusions	Dependencies	Benefits & Measures	Project Structure	Milestones/ Deliverables	Costs	Communications Plan	Risks	EA & QIA	Financial Info (Appendix 1)	Approved (Yes/No)	
Decommission	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	N	Y	N		
Demolition (combined PID with Decommission Above)	Y	Y	Y	Y	Y	Y	N	N	Y	Y	N	N	Y	N		
Park	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	N	N	N	N		
Temporary Moves	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y		
Agile Working	Y	Y	Y	Y	Y	Y	Y	Y	N	N	N	N	N	N		

Joe Gibson – External Programme Assessment – 20 Mar 17

Programme Assurance Framework

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

Alder Hey Children's NHS Foundation Trust

Sub-Committee	RABD	Report Date	16 March 2017
Workstream Name	Park, Community Estate & Facilities	Executive Sponsor	David Powell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
6.0 Park, Community Estate & Facilities													
R&BD 6.1	Decommission & Demolition	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell										Project forms part of 2016 programme. PID/milestones to be reviewed/revised as part of 2017 programme. Last updated 13 March 2017
R&BD 6.2	R&E 2	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell										Project forms part of 2016 programme. PID/milestones to be reviewed/revised as part of 2017 programme. Last updated 13 March 2017
R&BD 6.3	Alder Centre	To plan, develop and construct the new Alder Centre within the park setting	David Powell										Project forms part of 2016 programme. PID/milestones to be reviewed/revised as part of 2017 programme. Last updated 13 March 2017
R&BD 6.4	Park	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell										Project forms part of 2016 programme. PID/milestones to be reviewed/revised as part of 2017 programme. Last updated 13 March 2017
R&BD 6.5	Residential Development	To create a high quality residential scheme that co-ordinates with the themes and activities within the wider park site	David Powell										Project forms part of 2016 programme. PID/milestones to be reviewed/revised as part of 2017 programme. Last updated 13 March 2017
R&BD 6.6	International Design & Build Consultancy		David Powell										

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th April 2017

Report of:	Chief Nurse
Paper Prepared by:	Director of Nursing and Clinical Risk Advisor
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)														
2015/16									2016/17					
Month	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
New	1	3	1	2	1	2	0	1	1	2	2	1	0	1
Open	5	6	7	6	3	2	4	2	3	3	2	2	1	1
Closed	1	0	2	2	5	2	0	2	0	1	3	2	2	0
Safeguarding														
Month	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**
New	1	2	0	0	0	1	0	1	1	2	0	0	1	2
Open	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
Total closed	**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 01/02/2017 to 28/02/2017:							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/3539	06/02/2017	Surgery	The patient (complex) attended the Trust for an elective orthopaedic procedure on the 27/01/17. The patient suffered an extravasation injury from the neck line intraoperatively. Following completion of the surgery, the patient was transferred to the inpatient recovery room where they suffered a cardiac arrest. The patient was transferred from recovery to the High Dependency Unit rather than the ward in case of tracheostomy adjustment. Sadly, the patient died the following day (28/01/17).	Rachael Hanger, Theatre Matron	RCA panel meeting held 20/02/2017, RCA report being written.	Yes	Yes

New Safeguarding investigations reported 01/02/2017 to 28/02/2017: For information							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
StEIS 2017/3800	08/02/2017	Community	SuDiC - Baby asleep in Moses Basket. Mother fed baby 04/02/17 in bed and fell asleep. At approximately 07:00, father woke to find patient unresponsive. Arrived at the Trust A&E at 07:20 in Cardiac Arrest, no respiratory effort, no pulse. Advance Paediatric Life Support (APLS) commenced. Sadly, resuscitation unsuccessful, CPR stopped and time of death 07:39.	Safeguarding Team	For information only	Yes	Yes
2017/5741	23/02/2017	Community	SUDiC - Patient last seen by mum at home at 01.00 23/02/17, went to bed, mum went into his bedroom in the morning and found him unresponsive in his bed, he was pronounced deceased by paramedics.	Safeguarding Team	For information only	Yes	Yes

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**
RCA 208 2016/17 **Internal**	29/10/2016	Surgery	Patient intubated on ward during resuscitation, delay in emergency alarm being raised and in following resuscitation protocol.	Pete Murphy, Consultant Anaesthetist	RCA report in quality check stage.	Internal	N/A (no patient harm).

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**
Nil						

Safeguarding investigations closed since last report
Nil

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 15th February 2017
10:00am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair), Non-Executive Director	AM
	Pauline Brown	Director of Nursing	PB
	Jeannie France-Hayhurst	Non-Executive Director	JFH
	Mags Barnaby	Interim Chief Operating Officer	MB
	Hilda Gwilliams	Chief Nurse	HG
	Steve Igoe	Non-Executive Director	SI
	Laurence Murphy	Head of Contracting	LM
	Phil O'Connor	Deputy Director of Nursing	POC
	Mark Peers	Public Governor	MP
	Tony Rigby	General Manager, Quality Strategy	TR
	Erica Saunders	Director of Corporate Affairs	ES
	Glenna Smith	Interim General Manager, Medicine CBU	GS
	Melissa Swindell	Interim Director of HR	MS
	Rick Turnock	Medical Director	RT
	Will Weston	ACD Medicine	WW
	Julie Williams	Appointed Governor	JW
	Dame Jo Williams	Non-Executive Director	DJW
In Attendance:-	Joe Gibson	External Programme	JG
	Richard Cooke	Director of Infection Prevention Control	RC
	Julie Creevy	EA, Executive Team	JC
Agenda item:-			
16/17/148	Joe Gibson	External Programme	JG
16/17/143	**Apologies:**		
	Urmi Das		UD
	Claire Liddy	Acting Director of Finance	CL

16/17/144 Declarations of Interest
None declared.

16/17/145 Minutes of the previous meeting held on 18th January 2017
Resolved:
CQAC approved the minutes of the last meeting held on 18th January 2017.

16/17/146 Matters Arising and Action list:-

16/17/69 - Outpatient Project, it was agreed that this item could be removed from the action log.

Outpatient Walkabout – 'to review the number of business and walkabout meetings' - HG confirmed that this document would be circulated to CQAC members prior to the next CQAC March 2017 meeting.

17/17/122 – ED Performance & update on pathways – ED performance achieved 93.1 1%, January 97.3%, February 96.9%, March will be difficult, the team are currently planning mitigation to be put in place for March. Further update to March CQAC meeting.
Action: MB/team to provide update at March CQAC meeting.

16/17/22 - Clinical Utilisation – LS to provide verbal update at March CQAC meeting.

16/17/22 – HMRG, following an update at the Board of Directors meeting on 7th February 2017, the Committee agreed that this action could be closed. Accessibility through Image now had been resolved and hard copies of notes would be made available, a range of measures had been put in place, with a further quarterly update to be provided at the Board of Directors meetings. .

Resolved:
This item to be closed from CQAC action log.

16/17/123 – Review of Clinical investigation results and notices, CQAC noted that the Clinical Records meeting in January did not take place, a further Clinical Records meeting is scheduled for 22nd February 2017 for further discussion. Following this meeting NB would be invited to attend the March 2017 CQAC meeting to provide an update/position statement.

Action: NB to attend the next CQAC meeting to provide a position statement.

16/17/128 – 'Board Assurance Framework' – The Committee agreed that this action could be closed and removed from the action log.

16/17/131 – 'SIRI re referral issue' - this item had been discussed at the Clinical Quality Steering Group, the conclusions of the relevant RCA and necessary progress and actions would be monitored through Clinical Quality Steering Group meeting.

16/17/136 – 'Nursing representation to be included at the sub group to review PIDS' – it was agreed that this item is complete and could be removed from the action log.

16/17/137 – 'Assurance Summary with regards to Infection Prevention Control/Water Safety' – Assurance summary report to be deferred to March CQAC meeting.

Action: Assurance summary report to be shared at the March CQAC meeting.

16/17/137 – Infection Prevention Control – Mandatory Training compliance, MS confirmed that a briefing report is due to be circulated within the next couple of weeks, with training records being available to review within the next couple of weeks.

Resolved: This item to be closed from the action log.

16/17/141 – 'Policy Renewal' - this item is complete and to be removed from the action log.

Resolved: This action to be closed from the action log.

16/17/142 – 'Legal Advice Clinic' – ES confirmed that a mtg is planned with colleague from UoL to address this issue, following that meeting, ES will liaise with JFH to obtain any legal advice. ES confirmed that an update will be provided in due course/once appropriate.

16/17/147 Best in Operative Care Closure Report

Benedetta Pettorini, Rob Griffiths & Kate Hollian presented the Best in operative care closure report. The committee recognised the key achievements made to date and noted the next steps. The committee noted the objectives and benefits which were centred upon Safety, Excellence and Wellbeing.

The Committee queried what support CQAC could provide to the CBU. It was agreed that the CBU would require CQAC support with regards to human factors/IM&T support. CQAC agreed that the closure report was an exemplar report. CQAC confirmed that this was a testimony to Rob Griffiths & Rob's theatre team and extended gratitude to CBU team.

The Chair expressed her thanks for the exemplar closure report received.

16/17/148 Progress Assurance/Progress Update - J Gibson provided a programme Assurance update as follows:

JG confirmed that during this time of year the Trust tends to suspend ratings. JG currently working with C Liddy in J Richardson's absence to address this further.

JG highlighted the importance of Execs submitting portfolio for 2017/18. JG emphasised that the Safety/efficiency/quality thresholds needed to have a definition of a project/plan/metrics and need to be urgently put on SharePoint.

By March Exec sponsors should report at CQAC and provide the correct level of assurance and scope.

HG confirmed that she is working with Mags Barnaby and teams to address this issue, ensuring that all of the information links in with Trust pillars.

CQAC agreed that this is a real focus for March 2017 CQAC meeting and sufficient time would be given at March CQAC meeting to review.

Action: Exec sponsors to provide detailed assurance report for the next CQAC meeting.

16/17/149 Sepsis Update

.HG provided the following update:-

- Sepsis Group had been realigned and formalised during the last 3 week period.
- PIDs had been provided with key milestones.
- Tracking to take place through the Clinical Quality Steering Group.
- Ward 3C would be piloting a tool which had been adopted locally in March 2017, Gerri Sefton is in the process of training staff, to ensure that staff fully understand the tool.
- Training package to commence in March 2017
- 3 members of staff have been identified to train and these staff members will cascade training package information to staff.

The Chair expressed her concern with regards to level of assurance provided, and indicated that she did not feel that Non Executive Directors had the level of assurance.

Following the 1st Sepsis meeting on the afternoon of 15th February, the Sepsis Project Plan will be circulated this week by Mags Barnaby. The Sepsis Chair to attend the March CQAC meeting to provide the Committee with assurance.

Action: It was noted that the Sepsis Project Plan would be presented to March CQAC meeting for further discussion and assurance, the Sepsis Chair would be invited to attend March CQAC meeting.

16/17/150 Implementing the Quality Strategy Project Closure Report

TR presented the above closure report, which detailed objectives, benefits/deliverables and outstanding tasks/risks and issues.

The committee received and noted the closure report.

Action: The committee noted that the Quality Account would be presented to CQAC at the March CQAC meeting.

The Chair thanked TR for the closure report.

16/17/151 CQC Action Plans

CAMHS Action Plan – ES confirmed that a recent meeting had taken place with the CAMHS inspector who had reviewed/ signed off the CAMHS Action plan. The CQAC committee commended the work achieved by S Stephenson and CAMHS Team to date with regards to the action plan.

ES confirmed that the Trust will receive a visit within the next 3-4 month period. Sarah Stephenson plan to undertake quality review visits around Sefton/Dewi Jones to use CQC tool to engage with staff and prepare them in advance of CQC visit.

The committee received, noted progress to date, and approved the CAMHS action plan. The Committee recognised that continued challenge is needed which needs maintaining, and that regular updates for CQAC would be beneficial going forward.

The Chair, thanked Sarah Stephenson and CAMHS team for progress to date.

CQC Acute Services Action Plan – February 2017 update
ES presented the above action plan.
Committee noted that most actions were now green, however there were ambers for the following items:-

- No 8 – Compliance rate at 100% across all staff groups – however average results for hand hygiene compliance 83% for January 2017, month on month reduction, highlighting the need for renewed focus.
- No 10 – Improve staff compliance with mandatory training – currently at 76%
- No 14 – All medicines are administered appropriately – latest audit results currently awaited.
- No 21 Continue to develop relationships with adult health and social care providers to ensure the safe and effective transition of care for young people – it was noted that the transition team had made continued efforts to improve this issue.

RT shared with the committee an issue regarding Transition Lead Nurse funding issue and that this was rated as amber as a result. RT expressed that this role is essential to support the transition work, with funding ceasing. This post is to be discussed further at the Investment Review group meeting on 17th February 2017.

Resolved: The committee received and noted the CQC Acute Services Action plan, and noted progress made to date.

16/17/152 Corporate Report – Quality Metrics

Patient Safety – HG reported that Medication errors have decreased from the previous year, indicating a 30% reduction in medication errors, however HG indicated that this still needed to reduce further.

HG reported that Kerry Morgan, IM&T team is currently reviewing and analysing readmissions to PICU after 24 hours, to ensure that patients had not been released from

PICU too prematurely and subsequently having to be readmitted, HG would provide feedback at the next CQAC meeting.

Action: HG to provide further update at the next CQAC meeting in March.

Patient Experience
The Trust received 6 formal complaints during this period which is a reduction against the same period last year. However there had been an increase in complaints regarding attendance at AED. There had been a reduction in the number of responses for both inpatient surveys and FFT, this may have adversely affected the level positive feedback. This is mainly due to the impact that Christmas activities within the Trust had on capacity and volunteers to support this work.

HG indicated that a review is taking place regarding play services, and that she would expect to see in increase on the scoring in due course.

HG indicated that D Powell and his team are reviewing potential alternative feedback scoring mechanisms which are currently in use in other Trusts, which could work well at Alder Hey.

Clinical Effectiveness
The total number of infections continues to be significantly less than 15/16. There were no hospital acquired MRSA or C Difficile in December. The Trust continues to perform well. HG has requested additional information from IM&T team regarding acute admissions within 28 days to review the detail. Theme identified as respiratory, K Morgan is linking with the respiratory team to review cases. HG indicated that it was difficult to obtain comparable benchmarking data, and the Trust pressure ulcer lead for tissue viability – Ellen Buckley is working with other trusts to address issues, and learning and sharing of comparator trust practice. HG indicated that she envisages improvements in due course.

16/17/153 Clinical Quality Steering Group – key issues report

Key issues report

POC presented Clinical Quality Key issues report:-

The Committee received and noted the 10th January 2017 key issues report.

CQSG identified issue regarding first aid training as part of the Rescuscitation report.

Resolved: MS confirmed that financial resource had been allocated to secure first aid training for a 12 month period to ensure that the Trust achieves a 90% compliance rate within 12 months.

The committee recognised the importance of ensuring resilience with regards to a longer term sustainable plan, to ensure that training provided is not facilitated by just one member of staff, to ensure business continuity in the event of staff member being away.

The Chair thanked Phil O'Connor for his report.

16/17/154 Any other business

RT raised issue regarding which had been brought to his attention, with regards to proposed treatment for cystic fibrosis patients. Drug treatment had previously been to NICE, and had subsequently been refused by NICE due to the costs implications (£120,000 per patient). Drug treatment is for 6-11 year old patients. The Trust currently has 1 patient requesting to be treated. The drug company which are based in America have indicated that they are willing to provide the drugs/expenses for free. RT indicated

that there is a short timeframe for this patient to be treated (within 3 weeks time). RT shared with CQAC that he had been approached by Child's consultant (Sarah Mayell) to ascertain permission to sign letter confirming approval to proceed.

The committee expressed concern regarding that the company providing treatment for 3 years – and queried treatement issues following this period. ES confirmed that there is no time limit contained within the letter. This issue had also been discussed in length at Clinical Ethics Group.

Action: CQAC agreed that an offline discussion is required with Erica/Rick and Laurence Murphy.

The committee noted the request, and highlighted the importance of clarifying and explaining to parents at the start of the process would be vital, to ensure that the parents are fully aware that if the drug ceases, that they are fully aware that the Trust would be unable to continue with funding for this treatment.

Action: Offline discussion required with ES/RT & L Murphy.

Resolved : CQAC noted the request, further offline discussion required.

16/17/154 Date and Time of next meeting: - Wednesday 22nd March 2017 at 10am, Large Meeting Room, Institute in the Park.

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development	Date: 29/03/17 Report Number:	Period: March 2017 10	SRO: David Powell Author: Chris McCall
Programme 2016/17	Feb-17 | Mar-17 | Apr-17 | May | June | July		
Week Commencing	6 13 20 27 6 13 20 27 3 10 17 24 1 8 15 22 29 5 12 19 26 3 10 17 24 31		
Temporary Moves			**Project completed**
Decommissioning & Demolition (Phase 1 & 2)			Programme progressing on track. In response to the concerns raised regarding dust levels, a dust management plan is currently being developed, to be completed end April. The management plan will address two sources of dust: 1. demolition of retained estate; 2. R&E II construction.
Residential			Revised bids evaluated and recommendation of Preferred Bidder, including a first reserve, presented to Executive Team and approved. Bidders to be informed of decision week commencing 3rd April. Public consultation to take place mid April to end June, commencing with Local Councillors.
Park			Ongoing engagement with local community/stakeholders - 2 new stakeholder/project partnerships developed including 2 local schools for Forest School initiative. In liaison with LCC to complete contracted park maintenance. Commenced clearance for Woodland Walk. Research into fundraising support continues.
Corporate Offices/Clinical on-site			**Project now wrapped up in the whole estate strategy for the site.**
Research & Education Phase II			Letter of Intent issued to Morgan Sindall - construction to commence first week in April.
Community			CBRE (authorised agents) has identified suitable accommodation and now in the process of producing a report/options appraisal, i.e. size, capacity, rental and a detailed breakdown of costs, expected 17th April in readiness for presenting a report to Trust Board in May. In addition, the project team is currently working up a solution for services that are required to be retained on site.
Agile Working			Following concerns raised at RABD regarding the method of implementation, the PID content and methodology are currently being reviewed. Pilots have been put on hold until this process has been completed (end of April). It is anticipated that the pilots will then commence at the beginning of May.
On-site Residual			**Project now wrapped up in the whole estate strategy for the site.**
Alder Centre			25 Expressions of Interest received (PQQs) and are currently being evaluated. Invitations to Participate in Dialogue to be issued to the shortlisted bidders week commencing 10th April.

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

Title	**Liaison Committee Meeting Minutes**	
Date / time	22 February 2017 @ 1600 hrs	
Location	Mezzanine Room 5 , 1st Floor Atrium, Alder Hey Children's NHS Foundation Trust, Eaton Road, Liverpool L12 2AP	
Present	**Trust Senior Management:**	David Powell (Development Director) **DP** Graeme Dixon (Head of Building Services) **GD**
	Project Co Directors:	Tristan Meredith (Interserve Dev Co No 1 Ltd) **TM**
	Other Attendees	Oliver Hannan – Project Co Representative **OH** Laura Joseph-Chamberlain– Interserve FM **LJC** Anthony Rooney - Interserve FM **AR**
Apologies	Louise Shepherd (CEO) Margaret Barnaby (Chief Operating Officer) Alan Travis (Explore Investments Ltd) James Heath (John Laing Investments Ltd)	

Item	**Discussion**	**Action**
1.0	**Quorum** – the meeting was not quorate as defined within clause 12.1 of the PA.	Note
2.0	**Previous Minutes dated 17th Jan 2017** – The previous minutes were accepted as an accurate record of the meeting.	
2.1	Actions from the previous minutes reviewed and actions agreed as complete with the exception of 6.0 (Soft FM) and 8.0 (Fire Drills).	Note
2.2	(6.0) Soft FM – DP still to provide dates for a meeting to discuss issues.	**DP**
3.0	**Key Issues / Hot Topics**	
3.1	Fire Safety Management – Project Co raised concerns regarding the Trust's fire safety management and tabled minutes of a meeting held between IFM and the Trust's Fire Consultant on 21st Feb 2017. Project Co noted what appeared to be significant gaps in the Trust's management of fire safety. GD agreed to review and advise by 29th Feb 2017.	**GD**

3.2	Water / Legionella – OH advised that, in relation to the Trust and Project Co agreed action plan, all parties had been asked to confirm the status of agreed actions by 24th Feb. DP suggested that a further interim AEC survey shouild be commissioned by Project Co to review any areas AEC could not gain access to during their first survey. DP advised that he believed this was agreed with Lenders at the meeting held on 1st Feb. OH advised that he understood the agreement with Lenders was that a further AEC survey would be undertaken during the Summer as per the meeting notes issued on 2nd Feb. OH agreed to laisie with the SPV Board and request approval for an interim AEC review.	**OH**
3.3	RO Water – Trust SOP was agreed as being the key action.	**GD**
3.4	IFM Subcontractor Management – GD advised that the Trust was in agreement with the subcontractor tracker (issued as part of the LC docs 21st Feb) and that resolution of ADT demonstrated the effectiveness of all parties working together.	
3.5	Aseptic – DP noted that the camera validation date needed rescheduling and that the Trust would agree to pay for an alternative knee guard (given that Aseptic unit staff instructed Atlas to put the guard back on) if necessary. OH to liaise with LOR.	**OH**
3.6	Energy – DP confirmed Phil Morgan's info request would be resent to OH with a further request for Project Co to provide this or else advise why it can't be provided.	**DP**
3.7	Scope Washers – Decontamination meeting next step in discussing / agreeing actions to resolve the scope washer TVC issue and thererfore remove the need for acid injections etc.	
3.8	Drains Zone 1 – Under review.	
3.9	Variation turnaround times – IFM process (issued as part of the LC docs 21st Feb) is proposed to improve these.	
3.10	Theatre Heating – It was agreed that the wrong approach had been taken in how this issue was escalated and also addressed. Further that changes had been implemented which would prevent a reoccurrence in the future.	
3.11	Red Button Event – IFM were commended on their response and speedy remediation of the Theatre Panel issue (first red button event).	
3.12	SFPs – DP advised that these thresholds would be reviewed by the Trust during June 2017.	

4.0	**Any Other Business**	
4.1	Standard Reports – AR confirmed that IFM would issue those Trust requested standard reports (subcontractor RAG, Temperature spikes, Drain incidents & Variation turnaround times) within their monthly report moving forward.	**LJC**
4.2	DP noted that NHS Trusts meet quarterly to review PFI projects and suggested that some sort of joint presentation between the Trust and Project Co may be proposed following the results of two further positive customer satisfaction surveys.	
5.0	**Next Meeting –** Tuesday 28th March 14:00 hrs within the Trust Executive Office	Note

ALDER HEY CHILDREN'S HEALTH PARK LIAISON COMMITTEE

AGENDA

1. Quorum
2. Previous Meeting Minutes
   - 2.1 Accuracy
   - 2.2 Actions
3. Key Issues / Hot Topics
4. Any Other Business
5. Next Meeting

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
4th April 2017

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for March 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**	Great Talented Teams
Resource Impact:	None

Section 1 - Engagement

That we build on Alder Hey's strengths to further develop a culture that focuses on quality and the continuous improvement of the service that we provide to patients.

Development of Leaders

Alongside the development of a 'Leading by Values' programme and a 'Workplace Coaching' initiative, the team have developed an intervention aimed at facilitating re-engagement of staff at all levels with the Trust Values; this is following a review of the recent Staff Survey results as well as anecdotal feedback from senior managers regarding staff behaviour. This will include dedicated support to new managers/team leaders transferring in from LCH (see Section 2, below).

The team has also facilitated the initial phase of the General Management Trainee application process (this includes the disciplines of HR, Finance and IT), and in so doing hopes to continue its success in hosting management trainees into 2017/18.

Workplace Coaching

Plans are now in place to support the supervision of the Workplace Coaching cohort, which will enable the further rollout of the skills programme, which aims to support managers at every level. The coaching framework is a key element of the Leadership & Management Development strategy.

Improving communication and hearing the employee voice

The Staff Survey 2016 has been shared with the Trust and individual reports shared with departments and service group teams (where sufficient numbers of team respondents allowed for this). Teams have been asked to conduct Listening into Action '*Big Conversations'* to understand what actions can be taken to improve Alder Hey as a workplace. These outcomes will be collated to inform an organisation-wide action plan.

A refreshed quarterly 'all staff' Temperature Check will be launched in April; this will take place 3 times per year and provide us with data which can be tracked over time, and will map to the Staff Survey questions.

Section 2 - Availability of key skills

That we always have the right people, with the right skills and knowledge, in the right place, at the right time.

TUPE Transfer of services from Liverpool Community Health (LCH)

It has now been confirmed that the following services will transfer from LCH to Alder Hey with effect from 1st April 2017.

- Paediatric Speech and Language Therapy (Liverpool)
- Paediatric Community Matrons (Liverpool)
- Paediatric Occupational Therapy (Sefton)

- Paediatric Physiotherapy (Sefton)
- Paediatric Speech and Language Therapy (Sefton)
- Paediatric Complex Needs (Sefton)
- Children's Dietetics (Sefton)
- Cochlear Implants

These services comprise of a head count of 135 staff due to transfer to the community CBU on 1st April 2017.

HR representatives from Alder Hey are in attendance at weekly workforce mobilisation meetings with LCH to plan for the smooth transition of staff into the Trust, addressing any issues/concerns. Two engagement meetings have taken place between Alder Hey and those staff transferring (23rd January and 8th March 2017). Ongoing daily correspondence is in place with Alder Hey HR and LCH HR in respect of the TUPE process and specific staff information (i.e those currently on long term sick, maternity leave, those who require the transfer of their lease cars etc). There is also ongoing dialogue with IBM in respect of all ESR data transfer and also with each Occupational Health provider in respect of Occupational Health records. Whilst there have been some difficulties in obtaining relevant data from LCH, the Alder Hey HR Team are on track to ensure those staff are accurately paid in April. There is also a bespoke welcome event scheduled for these staff on 3rd April.

Ward 4a

As part of the Trusts review of the Nursing workforce, nursing skill mix right across the organisation, a proposal has been developed to restructure and reconfigure the ward/unit Nursing Workforce on Ward 4A in order to streamline and align clinical nursing structures. There are currently 3 members of staff (2.8 WTE) affected by the proposals. Management are following the Trust's Organisational Change policy and consultation processes have commenced on 20th March 2017.

Trust Nursery

A facilities post is currently at risk in the Trust's childcare facility as a result of an organisational change process. Opportunities for redeployment are being sought, with consultation due to conclude during April 2017.

Hotel Services

Consideration is being given to an independent Cleaning Review report which has assessed the current domestics operation within the Trust and proposed a number of actions to potentially be implemented, of which initial informal discussions commenced in December 2016 with both Trust staffside and union regional officials. Formal consultation on the initial phase of review, that of the domestic supervisors commenced on 4th January 2017 for 30 days and concluded on 3rd February 2017. As a result, a selection process was undertaken to new domestic supervisory roles of which 4 existing staff were successful and the remaining 4 staff who were unsuccessful were placed at risk of redundancy with notice provided up to 12th May 2017. All attempts will be made in the intervening period to redeploy these individuals to suitable roles, if available. In parallel the review of domestics' processes has continue involving trials of technology, which may potentially result in an organisational change process for this group of staff in the first quarter of 2017. A Patient Services Manager (Domestics) has been appointed and commenced duties from beginning of

January 2017. Consideration is now being given to structure reviews of the Catering, domestic and portering staff.

Change to NHSi/HMRC rules - Personal Services Companies

As a result of pending taxation changes from 6th April 2017, which places the liability of making relevant deductions (Tax/NI) on the Trust for those workers engaged directly via PSCs (Limited Company), assessments are currently taking place to identify any relevant liabilities and to take appropriate actions whilst taking account of potential of associated risks including those to service and patient support. There is also a potential liability via those workers on PSC arrangements engaged indirectly via Agencies, and discussions are taking place with Framework providers to understand and consider appropriate actions to mitigate any risks. Individuals who are engaged directly via PSCs have been contacted to discuss their individual positions, with some being given fixed term contracts. Agencies have been notified via communications as to the obligations that we consider they have to abide by the relevant legislation when they provide workers to the trust via PCSs. A full report has been submitted to NHSi in line with their request for information on the governance structure around managing PSCs and details of those engaged directly via this route.

Education, Learning and Development

The Trust was successful in gaining Employer Provider status to deliver apprenticeships; it is only the second trust in the Mersey footprint to acquire this status. Our apprenticeship account is now ready to receive the levy with additional training planned around data, planning and performance. Apprenticeship week was well received by staff at the Trust. This was also supported by TUC Union Learn and the RCN. To date there have been over 40 expressions of interest in our qualifications ranging from basic healthcare support to diploma level management. It is envisaged that our apprenticeship offer will be explicit in PDR discussions as a mechanism for staff development over the coming months and continue to develop via the vacancy management processes across the CBUs. Apprenticeship engagement sessions with CBU Leadership teams will commence in March / April to ensure all senior leaders recognise the benefits to staff and service of adopting an apprenticeship model.

Section 3 - Structure & Systems

That we have a best in class HR processes, policies and collective bargaining arrangements that deliver on the things that are important to the Trust

Employee Relations Activity

There is currently 1 formal disciplinary case ongoing and 1 appeal hearing, continuing the descending movement experienced in formal case management. The HR team are working with staff side colleagues, the LIA team and Team Prevent to review training and coaching opportunities in relation to Mediation, Investigations, Stress and Bullying and Harassment issues.

An Employment Tribunal Claim relating to unfair dismissal and unlawful deductions of wages has been received in respect of a former staff nurse following a rejection of a proposed settlement via ACAS. The claim is being defended and the Trust submission papers have to be issued to the Tribunal offices by 14th April 2017 with a preliminary hearing on 17th July 2017.

Corporate Report

The HR KPIs in the February Corporate Report are:

- Sickness is at 5.3%, slightly reduced from last month
- Corporate Induction has maintained compliance at 77.8%
- PDR rates are steady at 71%
- Mandatory training compliance is up slightly at 78.8%

Actions to address shortfalls are being addressed by members of the HR & L&D team with the CBU management teams.

Section 4 - Health & Wellbeing

That all Trust employees feel valued and respected by the organisation and actively contribute to the organisation's success.

Team Prevent

In light of work that is being driven by the STP and the North West Streamlining project, the Trust has been reviewing the services provided by Team Prevent. This includes reviewing case progress following feedback from referring managers and using this to improve services provided. The Trust has been developing support tools in conjunction with Team Prevent to help staff cope with the demands and challenges of staying healthy and maintaining a positive work and life balance. This is a key component of the People Strategy and ensures our focus on all aspects of workforce wellbeing.

Leading in Equality & Diversity

The Task and Finish Group continues to meet to develop actions to address under-representation of BME staff in the workforce. Alder Hey has set a target of a 1% increase per year over the next 5 years. Initiatives to support this include:

- A 'Big Conversation Event' was arranged on 21st February to develop a Trust black and minority ethnic (BME) network for staff.
- Monthly audits of BME candidates (links with sector-wide Streamlining project and the drive for values-based recruitment and improved job description design).
- Review of related E-learning packages currently under review by senior HR team.
- Wider marketing of the apprenticeship scheme
- Work closely and visit the different local communities through the community leaders to promote Alder Hey as an employer of choice, and with our own BME staff and trade union colleagues to promote opportunities

The monitoring of the above key initiatives are to be presented at future WOD Committee meetings

BOARD OF DIRECTORS

Tuesday 4th April 2017

Report of:	Director of Corporate Affairs
Paper Prepared by:	Director of Corporate Affairs Director of HR & OD
Subject/Title:	Well-led Framework for Governance Review – Self assessment and proposed next steps
Background Papers:	*Well-led Framework for Governance Reviews: Guidance for NHS foundation trusts*
Purpose of Paper:	To provide a baseline self-assessment of the Trust's evidence against the guidance and agree the work required to provide robust assurance of compliance
Action/Decision Required:	The Board is asked to: • Discuss and score the self-assessment • Agree the proposed approach to next steps
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Excellence in Quality** **Great Talented Teams**
Resource Impact:	Not yet identified

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th April 2017

Well-led Framework for Governance Reviews – Self-assessment and proposed next steps

1. Purpose of the Report

The purpose of this paper is to provide a baseline self-assessment of the Trust's evidence against the Well-led Framework guidance and agree the work required to provide robust assurance of compliance.

2. Recommendation

The Board is asked to approve the actions set out in the next steps section below.

3. Background

The *Well-led Framework for Governance Reviews: Guidance for NHS foundation trusts* was updated in April 2015 and set out Monitor's approach to supporting foundation trusts to maintain and develop effective governance arrangements in a climate where governance concerns were on the increase. The framework marries key elements of the Quality Governance Framework with the CQC's well-led domain key lines of enquiry. The guidance suggests that organisations commission an independent review of their compliance every three years. The Trust has not commissioned such a review to date as the Well-led domain was comprehensively assessed by CQC in June 2015 and rated as 'good'; it was subsequently agreed that it would be sensible to delay any follow up external review until the move to the new hospital had been completed and bedded in.

4. Progress to date

It has been made clear that any follow up CQC inspection, even if limited from a service perspective, will include a full assessment against the well-led domain. Work has commenced with the Heads of Quality and members of the wider risk and governance team to ensure the organisation is prepared and the evidence robust; to date this has focused on risk registers and ward to board reporting of risk. A initial self-assessment has been undertaken (attached) again with a focus on evidence.

5. Next Steps

The Board is asked to support the following actions:

- Discuss and rate the various elements of the framework in accordance with the definitions set out in the guidance;
- Request that the Divisions/CBUs undertake their own self-assessment;
- Agree to commission an independent review;
- Receive an updated position at the July meeting.

Erica Saunders
Director of Corporate Affairs
March 2017

Alder Hey Children's NHS
NHS Foundation Trust

Well-led Framework for Governance Review - Self-assessment

No	Question	Priority rating	Explanation of self-assessment rating linked to CQC KLOEs and examples of good practice	How is the Board assured – evidence for assessment or gap identified for action
Strategy and Planning				
1	Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?		• There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant. • The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others. • The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in	• Strategic plan reviewed and approved by Board • Corporate objectives • Operational Plan 2017-19 • Agendas for Board planning sessions inc. governors and CBU leaders • Values conversations outputs (appreciative enquiry process) • Agendas for CBU planning sessions with own teams • CCG/NHSE contracts & service specifications • Outputs from Children's Forum consultations. • Board Assurance Framework • 2020 Delivery Plan • Change Programme

			place. • Strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation. • Staff in all areas know and understand the vision, values and strategic goals.	• Metrics/KPIs in Corporate Report • Performance cascade via Team Brief • Via PDR process - but no audit evidence of effectiveness. • Staff Survey – but need to focus on improvement plan
2	Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?		• There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks. • Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care.	• Board Assurance Framework • Integrated Assurance Report • Corporate Risk Register • Programme Assurance methodology and associated framework • Change Programme and supporting documentation • LiA outputs • Directors of Clinical Effectiveness and Transformation to develop plan
Capability and culture				
3	Does the board have the skills and capability to lead the organisation?		• The board has the experience, capacity and capability to ensure	• Recruitment process for both ED and NED roles • Individual CVs and PDRs

			that the strategy can be delivered. • The appropriate experience and skills to lead are maintained through effective selection, development and succession processes. • The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them.	• Track record of achievement eg national targets, financial stewardship, regulatory ratings • Recruitment strategy • Skills Inventory • Talent Management Strategy • CQAC papers • Board papers
4	Does the board shape an open, transparent and quality-focused culture?		• Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity. • Candour, openness, honesty and transparency and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority. • The leadership actively shapes the culture through effective	• Weekly Meeting of Harm outputs eg save of the week etc. • PDRs/personal objectives • Alder Hey Achievers nominations • E&D Board Papers (WRES etc) • E&D Task and Finish Group papers • Examples of application of DoC (SIRI's and complaints) • Being Open policy • Raise it, Change it feedback • LiA Stories at the Board • Patient stories at the Board • NED engagement in Patients' Forum • Quality Walkarounds

			engagement with staff, people who use the services, their representative and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported.	• Raise it, Change it • CEO surgeries • CQPQ • JNC • Board Visibility Programme
			• Mechanisms are in place to support staff and promote their positive wellbeing.	• Team Prevent early intervention and support • Trade Union recognition • Flu Vaccination Programme • Health Eating approach in restaurant • Alder Centre support • Physical Activity Programmes • WOD Minutes
			• There is a culture of collective responsibility between teams and services.	• Safety huddles • WMH • CBU risk and governance
			• The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued.	• LiA outputs • Raise it, Change it • WMH • Whistleblowing Policy • FTSU Guardian
Process and structures				
5	Does the board support continuous learning and development across the organisation?		• Information and analysis are used proactively to identify opportunities to drive improvement in care.	• Corporate Report • SIRI report • DIPC report • Mortality Report

			• There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning. • Staff are encouraged to use information and regularly take time out to review performance and make improvements.	• LiA outputs • CQAC minutes • Quality Strategy – PFCC • Innovation Strategy • CBU risk and governance • Safety huddles • Team meetings
6	Are there clear roles and accountabilities in relation to board governance (including quality governance)?		• The board and other levels of governance within the organisation function effectively and interact with each other appropriately. • Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective. • Quality receives sufficient coverage in board meetings and in other relevant meetings below board level.	• Board and committee papers • CBU board and risk/governance papers • Risk registers – all levels • Contractual docs re PFI • MoU's with international and innovation partners • New CIC governance docs (tbc) • Board agendas • Committee ToR's

7	Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?		• The organisation has the processes and information to manage current and future performance. • Performance issues are escalated to the relevant committees and the board through clear structures and processes. • Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.	• Internal Recovery meeting • CBU Performance meetings • Weekly Wait Times • Run rate reports • Screen shots MDC • RBD minutes • RBD minutes • Board minutes • Quality Account • Clinical Audit Report
8	Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?		• A full and diverse range of people's views and concerns are encouraged, heard and acted upon. Information on people's experience is reported and reviewed alongside other performance data. • The service proactively engages and involves all staff and assures that the voices of all staff are heard and acted on. • Staff actively raise concerns and those who do (including external whistleblowers) are supported.	• Corporate Report Patient Experience metrics • Patient stories • Temperature Check • Staff Survey • LiA outputs • Staff Side/JNC • Raise it, Change it • Raise it , Change it • WMH

			Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted upon. • The service is transparent, collaborative and open with all relevant stakeholders about performance.	• Local procedures eg theatres • Raising concerns policy • FTSU Guardian • CoG minutes • CQPG minutes • CQC Engagement meetings
Measurement				
9	Is appropriate information on organisational and operational performance being analysed and challenged?		• Integrated reporting supports effective decision-making. • Performance information is used to hold management and staff to account.	• Board and committee papers • CBU performance meetings • Weekly recovery meeting
10	Is the board assured of the robustness of information?		• The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.	• Data Quality audits • Quality Account limited assurance audit • Data validation against source as routine

Erica Saunders - March 2017

Monitor
Making the health sector work for patients

Well-led framework for governance reviews: guidance for NHS foundation trusts

Updated April 2015

www.gov.uk/monitor

About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

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Contents

Introduction

Monitor's 'Risk assessment framework' is guidance for trusts in complying with their continuity of service and governance licence conditions. Under the 'Risk assessment framework' and in line with their Code of Governance we expect NHS foundation trusts to carry out an external review of their governance every three years.

We strongly encourage all NHS foundation trust boards to carry out these reviews for a number of reasons:

1. **Good governance is essential in addressing the challenges the sector faces**

   The boards of NHS foundation trusts face significant financial and operational challenges. They need to ensure that their oversight of care quality, operations and finance is robust in the face of uncertain future income, potential new care models and resource constraints. Good governance is essential if they are to continue providing safe, sustainable and high quality care for patients.

2. **Oversight of governance systems is the responsibility of NHS foundation trust boards**

   In the assessment process, Monitor subjects the governance of applicant NHS trusts to rigorous scrutiny. From spring 2015 we will use the well-led framework as the basis of this assessment. Following authorisation, foundation trust boards are responsible for ensuring that governance arrangements remain fit for purpose. As set out in the 'Risk assessment framework', our oversight of governance relies on information, including national standards and third party concerns, as triggers identifying potential governance issues.

3. **Governance issues are increasing across the sector**

   Since 2008, approximately one in three NHS foundation trusts have been subject to formal regulatory action on at least one occasion, with poor governance a contributing factor in almost all of these cases. In our experience, the majority of issues leading to regulatory action occur at least two years after authorisation. This is why we think it is important to support foundation trust boards in maintaining robust systems of governance in these challenging times.

4. **Regular reviews can provide assurance that governance systems are fit for purpose**

   Monitor's 'Code of Governance', modelled on best practice UK corporate governance principles, recommends that key elements of organisations' governance, including the board and committee structures, be regularly reviewed to ensure they remain fit for purpose. Well-designed and properly executed independent assessment of governance is a valuable tool in establishing whether any of the board's governance practices and capabilities needs improvement. This framework will help trusts with that assessment.

About this document

To support trusts in maintaining and developing the effectiveness of their governance arrangements, we issue guidance setting out how we expect them to comply with the provider licence conditions. The 'Risk assessment framework', for instance, sets out for NHS foundation trusts how we will consider compliance with their governance licence condition and assess risk to continuity of services.

This document supports NHS foundation trusts to gain assurance that they are well led. It will help them continue to meet patients' needs and expectations in a sustainable manner under challenging circumstances. The framework presented here represents a 'core' reference for NHS foundation trusts to structure reviews of their governance. The individual trust can shape the depth and breadth of the areas for investigation through their self-assessment and initial review team findings at the start of the process. Where trusts choose to exclude core elements of the framework, they should tell us, in line with a 'comply or explain' approach.

The framework has four domains, ten high level questions and a body of 'good practice' outcomes and evidence base that organisations and reviewers can use to assess governance.

The evidence base is not intended to be used for 'box-ticking'; rather it should guide trusts' and assessors' views in considering whether their processes and overall organisational culture in these areas are fit for purpose.

This guidance also sets out the suggested review process and what to take into account when choosing an external reviewer.

Flexible approach

NHS foundation trusts are free to tailor their approach to suit their organisational circumstances, provided they incorporate the domains and principal areas of enquiry in the framework set out here. We would, in any event, expect well-run NHS foundation trusts to actively tailor the guidance to reflect their awareness of their trust's governance.

Using this guidance: 'comply or explain'

For the purposes of this guidance:

- **comply** means we strongly encourage all NHS foundation trusts to carry out board governance reviews every three years using this guidance
- **explain** means that a foundation trust should give a considered explanation if it uses alternative means to assure itself regarding its governance, or if it chooses to omit material components of the framework (eg one or more of the ten questions). Departing from the guidance may be justified where a foundation trust can demonstrate that it is meeting the actions expected under the guidance in a similar manner, eg rigorously reviewing specific aspects of governance on an annual basis while ensuring all areas are covered every three years.

Beyond the four domains and ten questions, NHS foundation trusts are free to add other areas they consider require further attention – in these circumstances no explanation is necessary.

Governance reviews are only useful if their findings are acted on, so we strongly encourage trusts to prioritise actions arising from the reviews. We highlight one approach to prioritising actions below but trusts should consider the approach that works for them as appropriate.

1. What is board governance and why review it regularly?

NHS foundation trust boards are responsible for all aspects of performance and governance of the organisation. They should conduct their affairs effectively and, in so doing, build patient, public and stakeholder confidence that the trusts are providing high quality, sustainable care.

The role of the board is to set strategy, lead the organisation and oversee operations, and to be accountable to stakeholders in an open and effective manner. Foundation trusts are complex and multi-faceted organisations and this guidance is intended to lay out how boards can assess their effectiveness in carrying out their role. As the factors underpinning effective governance can change, for example as people leave or organisations restructure, regular reviews can ensure governance remains fit for purpose.

1.1. Governance reviews, 'well-led' and the Care Quality Commission's inspection regime

The Francis report into failings at Mid-Staffordshire NHS Foundation Trust led to major changes in the Care Quality Commission's regulatory regime, and to Monitor's and the NHS Trust Development Authority's (TDA) routine oversight of providers and assessment of aspirant foundation trusts. It has also resulted in the three bodies working even more closely together, particularly around the sharing of information and intelligence.

The characteristics of a well-led organisation, as defined by CQC, Monitor and TDA, are now identical.

By well led, we mean that the leadership, management and governance of the organisation ensure the delivery of sustainable high quality person-centred care, support learning and innovation, and promote an open and fair culture. We have a common understanding of what a good organisation looks like and what it should be able to demonstrate, creating coherence, consistency and transparency across our regulatory activities.

1.2. Aligning approaches

In this version of the well-led framework guidance, updated from 2014, Monitor has aligned the four domains and ten high level questions asked of NHS provider organisations with the CQC's characteristics of 'good' under their well-led domain. The alignment is shown at a headline level in the main body of text from section 2.1. Further detail of the good practice Monitor suggests, which is used in assessing applicant NHS trusts applying to become foundation trusts, is outlined in annex 1.

It should be noted that within this aligned approach, Monitor and CQC will each continue to focus on their respective statutory remits. Monitor and TDA's assessment of well led focuses primarily at board and committee level, covering strategy and planning, capability and culture, process and structures, and measurement, while CQC's inspections are an independent reality check of patient experience at ward and service level to see whether outcomes demonstrate that the board's policies are operating effectively.

As part of its 'ward to board' inspection regime, CQC will ask NHS foundation trusts how they have assured their governance arrangements. This may include asking for information about any independent reviews and how they have been acted on.

2. Reviewing board governance

We suggest organisations should look at four different domains to review how well a board is operating:

1. **Strategy and planning** – how well is the board setting direction for the organisation?
2. **Capability and culture** – is the board taking steps to ensure it has the appropriate experience and ability, now and into the future, and can it positively shape the organisation's culture to deliver care in a safe and sustainable way?
3. **Process and structures** – do reporting lines and accountabilities support the effective oversight of the organisation?
4. **Measurement** – does the board receive appropriate, robust and timely information and does this support the leadership of the trust?

Table 1 below sets out the four domains of this framework and the questions trusts and reviewers should ask themselves. Each question has outcomes that the review 'tests'/investigates. As noted above we have aligned these with CQC's approach to well led.

Table 1: The four domains of the well-led framework for governance reviews

Strategy and planning	Capability and culture	Process and structures	Measurement
Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver? Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?	Does the board have the skills and capability to lead the organisation? Does the board shape an open, transparent and quality-focused culture? Does the board support continuous learning and development across the organisation?	Are there clear roles and accountabilities in relation to board governance (including quality governance?) Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance? Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?	Is appropriate information on organisational and operational performance being analysed and challenged? Is the board assured of the robustness of information?

If delivered effectively, assessment against this framework should provide boards with assurance over the effective oversight of the care provided throughout their trust.

Annex 1 sets out the 10 questions, the associated characteristics and examples of good practice. Sections 2.1 to 2.4 (below) contain a headline mapping of the Monitor questions followed by the relevant CQC characteristics of 'good' well-led organisations.

2.1. Strategy and planning

Q1 Does the board have a credible strategy to provide high quality, sustainable services to patients and is there a robust plan to deliver?

- There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant.
- The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others.
- The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.
- Strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation.
- Staff in all areas know and understand the vision, values and strategic goals.

Q2 Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

- There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
- Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care.

2.2. Capability and culture

Q3 Does the board have the skills and capability to lead the organisation?

- The board has the experience, capacity and capability to ensure that the strategy can be delivered.
- The appropriate experience and skills to lead are maintained through effective selection, development and succession processes.
- The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them.

Q4 Does the board shape an open, transparent and quality-focused culture?

- Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity.
- Candour, openness, honesty and transparency and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority.
- The leadership actively shapes the culture through effective engagement with staff, people who use the services, their representative and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported.
- Mechanisms are in place to support staff and promote their positive wellbeing.
- There is a culture of collective responsibility between teams and services.
- The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued.

Q5 Does the board support continuous learning and development across the organisation?

- Information and analysis are used proactively to identify opportunities to drive improvement in care.
- There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning.
- Staff are encouraged to use information and regularly take time out to review performance and make improvements.

2.3. Process and structures

Q6 Are there clear roles and accountabilities in relation to board governance (including quality governance)?

- The board and other levels of governance within the organisation function effectively and interact with each other appropriately.
- Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.
- Quality receives sufficient coverage in board meetings and in other relevant meetings below board level.

Q7 Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?

- The organisation has the processes and information to manage current and future performance.
- Performance issues are escalated to the relevant committees and the board through clear structures and processes.
- Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

Q8 Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

- A full and diverse range of people's views and concerns are encouraged, heard and acted upon. Information on people's experience is reported and reviewed alongside other performance data.
- The service proactively engages and involves all staff and assures that the voices of all staff are heard and acted on.
- Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted upon.
- The service is transparent, collaborative and open with all relevant stakeholders about performance.

2.4. Measurement

Q9 Is appropriate information on organisational and operational performance being analysed and challenged?

- Integrated reporting supports effective decision-making.
- Performance information is used to hold management and staff to account.

Q10 Is the board assured of the robustness of information?

- The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.

In developing this framework, we consulted experts and reviewed board governance, leadership and quality governance documents alongside our own experience of foundation trust governance.

The domains and question sets are designed to:

- help a board assess their governance practices
- help any independent reviewer to assess whether the processes in place to manage the trust are fit for purpose.

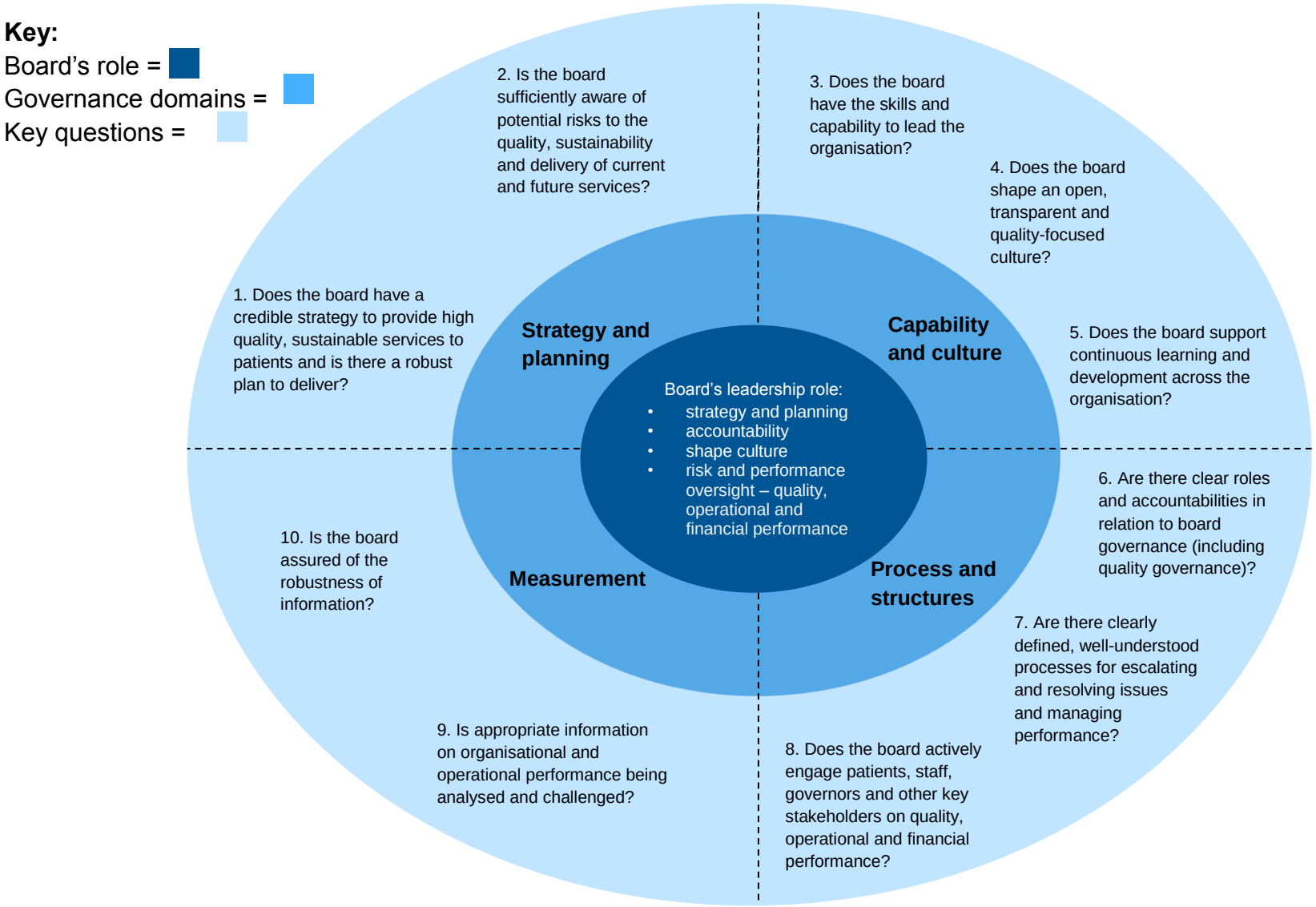
As highlighted above, the outcomes or characteristics for each question have been aligned with the CQC's approach to assessing well-led organisations, so they will vary from earlier versions of this publication.

Annex 1 provides a reference base of evidence and outcomes of good practice against each question with the relevant CQC characteristic mapped alongside the Monitor questions and Monitor good practice as follows:

Monitor question
CQC characteristic of 'good' in the well-led domain, relevant to the Monitor question
Monitor good practice under this question/characteristic *To assist NHS trusts preparing for the foundation trust assessment process, the italicised text refers to the good practice examined as part of the quality governance module.* Standard non-italicised text refers to good practice examined as part of the corporate governance module. .

Figure 1 on the next page sets out how the framework fits together and the main areas for review.

Figure 1. How the well-led framework for governance reviews fits together and the main areas for review



3. Managing the governance review process

The review process supports boards and reviewers in assessing whether an NHS foundation trust's governance is robust and effective, and in identifying areas for improvement.

This section summarises some of the considerations in preparing for a review and the five steps involved in the review process. It is not exhaustive, but should help to start the process.

3.1. Governance reviews – frequency/scope/review teams

Scheduling governance reviews

- Under the 'Risk assessment framework', NHS foundation trust boards should carry out governance reviews **every three years.**
- Trusts are **free to schedule when the reviews take place within the three-year window** –as long as the gap between governance reviews is not longer than three years.
- As these reviews are a new element in our regulatory framework, we would like to understand the uptake of reviews. When a foundation trust has scheduled a governance review they should inform their Monitor relationship manager of this fact and the organisation(s) chosen to carry out the review.

Scope of the review

- The review should be carried out using this guidance, incorporating the questions, outcomes and evidence base in annex 1 as a starting position. We expect trusts to add to the scope, or change emphasis, to reflect their knowledge of their organisation.[1] We expect boards to go on to tailor the scope of the reviews they commission to cover any additional areas that they would specifically like to focus on.
- Additional areas for review may, for instance, result from findings from internal and/or external audit review findings and information from the annual governance statement and the corporate governance statement.

Review teams

- In order to gain maximum benefits and assurance from the reviews, **independent reviewers** should be used to ensure objectivity. Generally,

[1] Although boards, based on their knowledge of their own organisation may want to concentrate on specific areas, they should make sure the reviews cover all the 10 questions to some extent, in case there are unknown governance issues or weaknesses.

Monitor considers reviewers should not have carried out audit or governance-related work for the trust during the previous three years.

- Reviewers must be independent of the NHS foundation trust's board. While the ultimate choice of reviewer is up to boards, review teams should be multi-skilled and bring different disciplines to the work including:
    - experience of evaluating board leadership and governance arrangements
    - knowledge of the healthcare sector
    - specialist expertise, specifically clinical, leadership experience (including culture and board development) and management information systems.
- We note that peer organisations – ie other NHS foundation trusts – may have particular insights on governance, especially clinical governance. In arranging governance reviews, we encourage trusts to ensure that the organisations carrying them out have the relevant expertise to conduct the review and therefore will be able to add value and insight across the whole spectrum of the review framework.
- In some cases, clinical organisations may be able to 'partner' with governance experts to provide a more thorough review than either might be able to offer on their own.

See section 4 for what to consider when choosing an independent reviewer.

3.2. Carrying out a review

This section sets out potential:

- steps in carrying out the review
- methods used to carry out the review
- methodology for rating a review.

Approach to a review

The diagram and table below set out the **suggested approach** to the review and reporting steps. **Trusts commission these reviews**.

With this in mind, they need to shape the review process and approach to support their needs. For example, trusts piloting the review process suggested the following:

- the suggested self-assessment steps to support trust boards to reflect on their own performance could be carried out **before** the review to make sure reviewer skills and experience meet the needs of the specific areas of focus

- board members could focus on the 10 questions and the Care Quality Commission (CQC) characteristics outlined from section 2.1 and take a view on the areas where the organisation performs well and less well. This high level 'top-down' view can then be considered alongside any in-depth 'bottom up' analysis that the trust might carry out, informed by the good practice outlined in the annex, to provide a robust picture of the health of the organisation
- when planning the review work, trusts should think about the phasing of the work, allowing enough time between each step; for example:
    - between planning the review (eg logistics for interviews, focus groups, etc) and the review team undertaking the work
    - providing the board with the findings from the review and giving enough time afterwards for developing the action plan, especially if some actions will need to involve discussions with internal and external stakeholders.

Figure 2: Suggested review steps

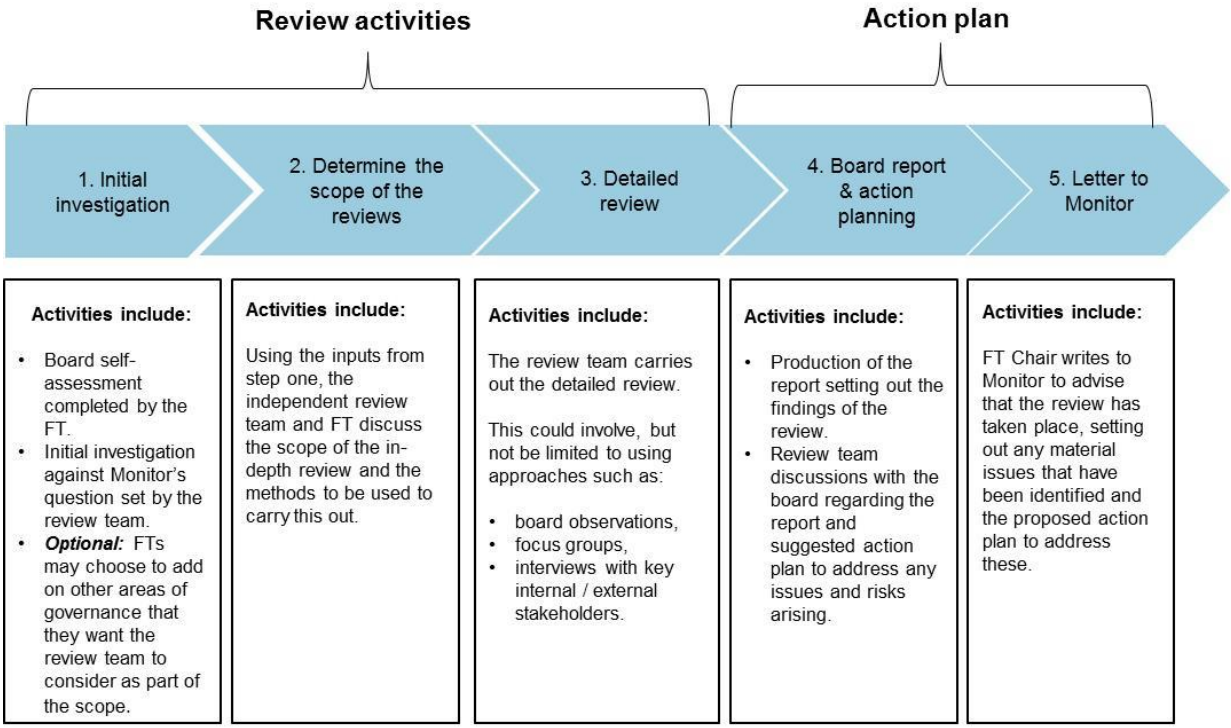


Table 2: Suggested review activities and outputs

Step	Activity	Output
1	**Initial review** **a. Board self-assessment:** Boards should carry out a rigorous self-assessment[2] of how their governance is working, based on evidence, to confirm they are carrying out their role well and/or to help identify gaps in their performance. Evidence could include findings from internal and external audit reviews and work carried out for the annual governance statement and the corporate governance statement. They should rate themselves against the 10 questions in this framework. See annex 2. **b. Initial review against questions:** Independent reviewers should gather evidence from a variety of sources including relevant documentation, stakeholder and board questionnaires, focus groups and interviews to gain insight into how the board is working and how it is perceived throughout the trust. **c. Optional:** Foundation trusts may choose to ask the independent review team to look at specific areas of governance in addition to the areas set out in Monitor's well-led framework. This may involve a deeper investigation of particular lines of governance. The review team can be procured either before or after the board's self-assessment step above.	Self-assessment statement outlining: i. rationale for their rating against each of the review questions ii. documented evidence for the conclusions and ratings iii. opinion about the areas that need further review with the independent reviewer based on the outcomes of the assessment. Overview to identify areas for further scrutiny Agreement to additional areas that should form part the detailed review
2	**Determine the scope (depth and breadth) of the detailed review:** Both parties should agree on the depth and breadth of the review required across the 4 domains and 10 questions and agree any further areas for scrutiny primarily based on risks identified through the initial work (in step 1).	Scope of the detailed review and methods to be used to do this.
3	**Detailed review:** Review to be undertaken by the independent review team against the scope agreed in step 2. The review team should rate each of the 10 questions (refer to the section below on rating the review).	A detailed report of the findings from the review process for the board to consider

[2] This will probably take 2 to 4 weeks, but that is ultimately up to the trust's board

Step	Activity	Output
4	**Board report and action planning:** Independent reviewer to work with the board to consider recommendations and actions required to address the findings of the report.	Action plan
5	**Letter to Monitor:** Trust chair to write to Monitor, within 60 days of the submission of the review to the trust board, either: i. advising Monitor that the review has been completed and that there are no 'material governance concerns' or ii. advising of any material governance concerns that have arisen from the review and the action plan (including timings and priorities) responding to those concerns.[3] This should be in line with the exception reporting requirements in the 'Risk assessment framework'. Monitor will consider the material governance concerns identified and the trust's response and what, if any, steps on our part are appropriate.	Letter to Monitor

Methods used to carry out a review

We suggest a potential approach to review above but it is not compulsory, Experienced reviewers can use their own diagnostic tools and methods. See Table 3 for examples.

Table 3: Diagnostic tools and methods for carrying out a review

Tool	Suggested components	Purpose
Desktop document review	Board minutes, papers, and agendas; board assurance framework; audit reports; strategic documents, eg the trust's strategy and business plan, quality strategy and people strategy; and internal/ external audit reports, annual governance and corporate governance statements, alongside any other relevant reviews	To provide a view of: • how ongoing issues and risks within the NHS foundation trust are communicated and managed • the quality of information being produced to support decision-making and • how the board prioritises issues at the trust and divides its attention.
One-to-one interviews	All board members, the trust secretary, lead governor, clinical directors and leads, local stakeholders, including	To gain individuals' views of the trust's governance and to provide a 'safe' environment in which to explore issues and discuss

[3] This covers any obligations in the 'Risk assessment framework'.

Tool	Suggested components	Purpose
	clinical commissioning groups and patient representatives	sensitive information, as appropriate.
Stakeholder surveys	Staff and patient groups, commissioners and providers	To get internal and external parties' views of the trust's governance to cross-reference with the board's own views – to test the board's awareness.
Focus groups with internal and external stakeholders	Staff, patient groups, commissioners, contracted or outsourced suppliers	
Board and sub-committee observations	Observations of at least one board meeting and relevant sub-committees, including audit and quality.	To identify the dynamics of the board, including agenda management, depth and breadth of the information used to make decisions and progress priorities, and the way they challenge and hold each other to account for the leadership of the trust.
Board skills inventory	Matching skills to the requirements of the board's work and identify any gaps.	To ensure that the board has the skills and experience needed.
Board self-assessment	Board members to rate how effective they believe the board is.	To provide a view of how effective the board believes itself to be.
Peer practices	On areas of governance in the sector, in similar organisations or NHS foundation trusts.	To assess how the NHS foundation trust compares against any known examples of particularly effective and robust governance practices.

The approach and question and evidence sets (see the annexes) have been developed to help NHS foundation trusts gain insight into their leadership and governance practices, and understand if they are well led.

Prioritising findings

Where a review of governance indicates issues or concerns, it is important that these are prioritised and addressed as soon as possible. We strongly encourage trusts to agree, at the start of the review process, the format in which they would like the findings to be presented.

Red-amber-green ratings

One approach is to classify findings via a green/amber-green/amber-red/red approach, as outlined below.

Table 4: Scoring criteria

Risk rating	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and no major omissions
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, some minor omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, has no major omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in governance identified. Significant volume of action plans required with concerns regarding management's capacity to deliver

If the trust decides not to use the above red-amber-green ratings, it should use another appropriate rating system to ensure that any issues and concerns are prioritised and addressed and that any material governance concerns are reported to us, as set out above. Apart from any material issues worthy of exception reporting (see above), we would not expect to see the results of this prioritisation exercise.

3.3. Exceptions to the review process

We recognise that a number of NHS foundation trusts may have already carried out a similar independent governance review within the one to two years before May 2014 when the framework was originally published. If this is the case and the review covered the areas of this framework, the trust may use this to explain why they are not doing an extra review under this guidance within the relevant time period. If your trust falls into this category, please contact us first to confirm the scope of your review, including its findings and any action plan.

4. Selecting a reviewer

The following section sets out the areas an NHS foundation trust should consider when choosing an independent reviewer to carry out reviews against this framework.

While many organisations are capable of carrying out reviews, boards should assure themselves that the reviewer can carry out a robust and reliable judgment of its governance.

We do not currently have any plans to accredit suppliers or set up a preferred reviewer list.

4.1. Potential criteria

Reviewers should demonstrate the following:

- a clear and concise understanding of the purpose and objective of the review, and its significance to NHS foundation trusts; a solid understanding of how to carry out a rigorous governance review, covering the specific areas detailed in the well-led framework; and an appropriate range of tools and approaches
- relevant experience to carry out the work: the quality of the skills and experience of the reviewer is important to the success of a review, including:
    - credibility and experience in carrying out governance and quality reviews at healthcare providers; ideally, a **multidisciplinary team** with a broad range of skills relevant to all aspects of board leadership and governance, such as strategic planning, quality governance, cultural assessment, organisational development and management information and analysis
    - named personnel (and CVs in the response), and clarity about their role and what they'll do during the review
    - knowledge of the healthcare sector, and the internal and external challenges faced by trusts
    - knowledge of Monitor's licence, and the broader regulatory framework the NHS foundation trust operates within
- ability to manage the review process: the reviewer should advise of the following as part of their response:
    - project governance – reviewers should provide a credible and detailed plan of the proposed project governance regime which includes the approach to the quality of the work, risk management, reporting and escalation lines. This should include evidence of clear leadership for the work with a named individual

- implementation/project plan – reviewers should provide a credible and detailed project plan to meet the specification and requirements of the foundation trust, ensuring the review is completed within set timescales
- capacity – reviewers must assure the board that they have the capacity to carry out the review and that named personnel are available to carry out the work
- conflicts of interest/independent perspective – reviewers should declare any factors that may, potentially, reduce the independence of the reviews, eg if the firm has carried out any governance or board development/ review work with the foundation trust within the last three years.

4.2. Peer review teams

We acknowledge that peer organisations – ie other NHS foundation trusts – may have particular insights into governance, particularly clinical governance. We encourage trusts arranging governance reviews to ensure that the organisations carrying these out are able to add value and insight across the whole spectrum of the review framework.

In some cases, clinical organisations may be able to 'partner' with governance experts to provide a more thorough review than either might be able to offer on their own.

Annex 1: Monitor's 10 questions, aligned with CQC characteristics and Monitor good practice

In this annex we provide **examples** of good practice against Monitor's 10 questions. We recognise that how the principles of good practice are applied will vary according to the nature of the services provided.

It is **not** an exhaustive list of practices, nor does it represent a 'tick box' schedule. Trusts and reviewers should consider whether their evidence credibly supports the overall governance outcome on which the review is seeking assurance.

Following the alignment exercise that Monitor has undertaken with CQC, the good practice is now presented in the following format:

Monitor question
The relevant CQC characteristic of 'good' in the well-led domain
Monitor good practice under this question/characteristic *To assist NHS trusts preparing for the foundation trust assessment process, the italicised text refers to the good practice examined as part of the quality governance module.* Standard non-italicised text refers to good practice examined as part of the corporate governance module.

Strategy and planning

Q1 Does the board have a credible strategy to provide quality, sustainable services to patients and is there a robust plan to deliver?
There is a clear statement of vision and values, driven by quality and safety. It has been translated into a credible strategy and well-defined objectives that are regularly reviewed to ensure that they remain achievable and relevant.
The trust has developed a comprehensive and sustainable picture of how its services will look in the future and its strategy is clear and well thought out. The strategy includes: • specific aims that steer the organisation towards its vision • a small number of ambitious trust-wide quality improvement goals or objectives • a set of values and behaviours supporting and underpinning the strategy. There is likely to be a narrative about how the trust is planning to respond to the Five Year Forward View, aligned with its vision and values.

Quality goals:

- *cover safety, clinical outcomes and patient experience*
- *support continuous improvement*
- *comprise local as well as national priorities, reflecting what is relevant to patients and staff.*

The organisation has been informed by an analysis of its performance on key quality indicators when identifying the strategic goals; and overall trust-wide quality goals link directly to goals in divisions/services, suitably tailored to the specific service.

The board can explain how the quality goals have been selected to have the highest possible impact across the overall trust. There is evidence of patient, service user and carer engagement in determining the quality goals. There is a clear action plan for achieving the quality goals, with designated leads and timeframes.

The vision, values and strategy have been developed through a structured planning process with regular engagement from internal and external stakeholders, including people who use the service, staff, commissioners and others.

The board has self-assessed its approach to strategy development using a suitable framework, such as Monitor's strategy development toolkit, or equivalent. There is clear evidence that the trust:

- understands its external opportunities and challenges and its internal strengths and weaknesses
- has robust solutions to address the opportunities and challenges in light of its strengths and weaknesses
- has the capability and a credible plan to deliver the strategy (see also the section on capability below).

In examining the internal and external challenges facing services, boards should consider whether services are financially, operationally and clinically sustainable in 3 to 5 years time.

In examining the solutions to address the challenges, boards should consider whether transformation is required to achieve long-term sustainability − such as reconfiguration of services, moving to new care models and/or changes to organisational form.

There should be clear evidence of the trust having mechanisms in place to suitably engage with local health economy partners to address critical issues impacting on long term sustainability.

The planning process reflects:

- current and future priorities of local commissioners

- evidence-based forecast changes in the local environment regarding public health, socio-demographic and economic factors
- local and national policy developments and
- an appropriately thorough market assessment for each of the key service lines, including competitive opportunities and threats and how the trust plans to respond.

The strategic planning process takes account of relevant internal factors, for example:

- the organisation's capabilities and weaknesses
- costs and cost reduction priorities
- previous performance and delivery of plans
- operational issues such as people and resources, estates and facilities
- clinical issues of scope and scale of services (are volumes sufficient to support high quality care)
- whether the people strategy fits the needs of the organisation and workforce plans and projections.

The board should be able to demonstrate: who their main stakeholders are; that they have an understanding of those stakeholders' views; and that those stakeholders have been suitably engaged in the development of its vision and strategy.

Stakeholders would normally include:

- patient groups and the council of governors
- staff (who are clear about the organisation's vision and strategy and how their work supports this)
- commissioners and other local health economy stakeholders (such as other providers, local Healthwatch, local politicians and MPs).

The board identifies its main stakeholders based on criteria such as who will have the greatest impact on the delivery of the organisation's particular services.

The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.
The board demonstrates that it has effective, timely horizon scanning and reporting processes in place, so that it is sufficiently aware of changes in the internal and external environment which may impact on the delivery of the strategy/plan and/or impact on clinical and financial sustainability. Processes are in place to monitor and manage the delivery of the plan.

Strategic objectives are supported by quantifiable and measurable outcomes which are cascaded through the organisation.
The organisational objectives in the plan are linked through to the performance targets of business units. The trust has detailed delivery plans for each of its strategic initiatives that lay out milestones, resource requirements, dependencies and risk mitigations. *The development of the quality improvement strategy includes:* • *analysis of the organisation's performance on key quality indicators* • *directly linking the quality accounts with the quality improvement strategy.* *The quality strategy is supported by clear, specific, measurable, achievable and time-bound action plans, with leads and delivery dates to achieve the specific and ambitious goals.* *The board monitors action plans relating to the quality strategy or quality account and takes action where performance is off trajectory.*

Staff in all areas know and understand the vision, values and strategic goals.
The board can demonstrate that the strategic vision, values and goals (including quality goals) are effectively communicated through an implemented plan, across the trust and its sites. *The goals are well understood and the board can demonstrate how staff at all major sites have been informed of the goals.* *The non executive directors and the trust divisional management should be able to articulate the trust's quality goals.* *The quality strategy is supported by a communication plan and there is evidence that this plan is being implemented.*

Q2 Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?

There is an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.
Board members can comprehensively describe the same set of risks facing the organisation. Dynamic risk registers and a board assurance framework are in place and assessed by the board at least quarterly, reflecting risks to the initiatives in the strategic plan. These are considered and reviewed regularly. *The board regularly assesses and understands current and future risks to quality and performance and is taking steps to address them. The board regularly reviews quality risks in an up-to-date risk register.*

The risk register is supported and fed by quality issues captured in directorate/service risk registers. The risk register covers potential future external risks to quality (eg new techniques/technologies, competitive landscape, demographics, policy change, funding, regulatory landscape) as well as internal risks. There is clear evidence of action to mitigate risks to quality.

Management and reporting

The board has clear risk management plans (including quality risks) and there is evidence of action being taken to mitigate risks to quality and performance – for example, key risks and issues being escalated from relevant sub-committees on a consistent basis. As part of these plans:

- *risk-related reporting lines should be in place from ward to board (eg to ensure overall risk is managed)*
- *responsibility for each risk flagged in the board assurance framework is owned by an executive lead*
- *responsibilities for maintaining an oversight of risk mitigation are clearly attributed to board members/sub committees*
- *risk scenarios and contingency plans are in place and are subject to regular updates and reviews.*

Training

Appropriate training is provided to staff and managers on risk and assurance and, as a consequence, the organisation can evidence that risks are owned and managed at all levels of the organisation.

Evaluation and review

The board has reviewed lessons learned from inquiries, internal and external reviews and has considered the impact on the trust. Actions arising from this exercise are captured and progress is followed up.

Service developments and efficiency changes are developed and assessed with input from clinicians to understand their impact on the quality of care. Their impact on quality and financial sustainability is monitored effectively. Financial pressures are managed so that they do not compromise the quality of care.

The board is assured that proposed initiatives are assessed according to their potential impact on quality (eg clinical staff cuts would likely receive a high risk assessment). There is a quality impact assessment approach that is consistently applied.

Initiatives are developed with clinicians; have a clinician as a sponsor or a consultation has been held by clinicians. Schemes have been modified or rejected where concerns have been raised.

Initiatives with significant potential to impact quality are supported by a detailed assessment that could include:

- *'bottom-up' analysis of where waste exists in current processes and how it can be reduced without impacting quality (eg lean)*
- *internal and external benchmarking of relevant operational efficiency metrics (of which nurse−bed ratio, average length of stay, bed occupancy, bed density and doctors−bed ratio are examples that can be markers of quality)*
- *historical evidence illustrating prior experience in making operational changes without negatively impacting quality (eg impact of previous changes to nurse−bed ratio on patient complaints).*

Measures of quality and early warning indicators are identified for each initiative. Quality measures are monitored before and after implementation and there is clear ownership of risk (for example, the relevant clinical director).

Post-implementation, the impact of initiatives on quality is monitored on an ongoing basis. Mitigating action is taken where necessary.

Capability and culture

Q3 Does the board have the skills and capability to lead the organisation?

The board has the experience, capacity and capability to ensure that the strategy can be delivered.

The board has assured itself that the capabilities, experience and capacity are in place within the senior management team and workforce to develop and deliver the strategy.

One or more individuals on the board have strategic planning skills and background and have led the development and implementation of a strategic plan in the last 2 to 3 years in an organisation of similar complexity and challenges.

Board members can clearly explain why the current balance of skills, experience and knowledge on the board is appropriate to effectively govern the trust. The capabilities required in relation to delivering good quality governance are reflected in the make-up of the board.

Board members:

- have insight into the organisation
- are aware of the organisation's impact on its environment
- have clarity on their role
- demonstrate personal values and style that are aligned with the interests of patients and carers
- are effective communicators
- seek personal development and learning.

Trusts are able to give specific examples of when the board has had a significant impact on improving quality performance (for example, providing evidence of the board's role in leading on quality).

Board reviews

The board uses reviews to measure its performance, governance and impact across the organisation. Key findings are openly shared with patients, the public and staff and acted on. The board also reviews the effectiveness of board relationships regularly, with specific focus on board working relationships:

- between the chair and chief executive
- between executive and non executive directors
- between the board and the senior management team/divisional managers
- between the council of governors and the board.

The appropriate experience and skills to lead are maintained through effective selection, development and succession processes.

The board has a development programme and succession plan to ensure that its skills and capabilities are appropriate and maintained (including in relation to quality governance). It conducts regular self-assessments to test its skills and capabilities.

Governors are supported (with training as appropriate) on how to make judgements about the appointment/re-appointment of the non executive directors and the chair.

When vacancies arise, the selection process considers the skills of the existing non executive directors, to ensure that the recruitment process delivers the blend and balance of skills and experience to complement the existing board.

All members of the board, both executive and non-executive, are appropriately inducted into their role as a board member in a timely fashion.

The board takes time out to identify and act upon successes and failures.

The board has put in place a leadership development programme for clinical leadership and non-clinical management that:

- *demonstrates learning and impact on behaviours*
- *encourages and trains clinical leadership and non-clinical management to participate in setting the quality agenda.*

The audit committee (as a group) has the appropriate skills and experience to fulfil its responsibilities:

- the audit committee carries out an annual self-assessment of its effectiveness and
- at least one member of the audit committee has recent and relevant financial experience.

The leadership is knowledgeable about quality issues and priorities, understands what the challenges are and takes action to address them.
Board members are able to: • *describe the trust's top quality-related priorities* • *identify well − and poorly − performing services in relation to quality, and actions the trust is taking to address them* • *explain how it uses external benchmarks to assess quality in the organisation (eg National Institute for Health and Care Excellence guidelines, recognised Royal College or faculty measures)* • *understand the purpose of each metric they review, be able to interpret them and draw conclusions from them* • *be clear about basic processes and structures of quality governance* • *feel they have the information and confidence to challenge data* • *be clear about when it is necessary to seek external assurances on quality, eg, how and when they will access independent advice on clinical matters.* *The board is assured that quality governance is subject to rigorous challenge, including full non executive director engagement and review (either through participation in audit committee or relevant quality-focused committees and sub-committees).* *The board can demonstrate how it has provided challenge to the executive on clinical quality.*

Q4 Does the board shape an open, transparent and quality-focused culture?

Leaders at every level prioritise safe, high quality, compassionate care and promote equality and diversity.
There is evidence of leaders at every level asserting safe, high quality, compassionate care as top priority. Their behaviour demonstrably emulates that of a strong safety culture. *Staff at all levels of the organisation are subject to an appraisal process in which goals are aligned with the vision and values of the organisation.* The organisation has an effective and robust diversity and equality strategy. *A comprehensive induction programme is in place for all staff groups (including junior doctors and agency staff) derived from the organisation's vision, values and strategy.*

Candour, openness, honesty and transparency and challenges to poor practice are the norm. Behaviour and performance inconsistent with the values is identified and dealt with swiftly and effectively, regardless of seniority.
The trust can demonstrate that challenges to poor practice made by board and committee members are delivered, received and acted on positively. The trust has a senior independent director. Board behaviours should be consistent with the identified trust values. *The board is aware of any behaviours contrary to the trust's vision and values and is taking active steps to manage these, wherever they exist in the organisation.* *Examples can be provided of how management has responded to staff that have not behaved consistently with the trust's stated values and behaviours (for example, demonstrably effective HR policies are in place to address the areas where poor behaviours have been identified).* There are comparable processes to manage non executive director and governor behaviours – for example through a standards committee. *The organisation has reflected on the findings of internal and external sources that provide insight into its safety culture (staff survey, patient surveys, NRLS, CQC IMR and any formal cultural assessments).*

The leadership actively shapes the culture through effective engagement with staff, people who use the services, their representatives and stakeholders. Leaders model and encourage co-operative, supportive relationships among staff so that they feel respected, valued and supported.
The board responds to challenges in a positive manner with inquiry about the root causes as opposed to, for example, questioning the data as a first resort. *The board is visible and can be challenged by staff through different channels (eg surveys, focus groups, workshops, patient safety walkabouts and approaches such as the 15 steps challenge)[4] to identify and address blocks to improvement.* *The board demonstrably listens to patients (complaints and other feedback, governors, patient groups and Healthwatch) to identify deficiencies in organisational quality culture and actively takes steps to address these and improve.* Board members spend time developing the relationship with the governors. Governors are trained and supported in holding non executive directors to account and asking them the right questions to check they are in turn holding the executive directors to account for quality and operational delivery. Governors consider that they receive sufficient information in a timely fashion to carry out their role.

[4] The 15 steps challenge is a series of toolkits developed by the NHS Institute based on a parent having said 'I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward'.

The board co-operates with third parties with roles in relation to the trust – for example, there is a constructive relationship with commissioners and other providers which, as a minimum, involves:

- discussing and sharing the overall strategy of the organisation
- sharing information on specific services and care pathways
- contract/performance issues are addressed and resolved quickly without recourse to arbitration and
- regular reviews and discussions to resolve any lessons learnt.

Where appropriate, the board uses external support networks and expertise to support ideas for development and quality improvement, for example: use of benchmarking, working with patient groups, linking with healthcare providers and other improvement interventions and tools.

Mechanisms are in place to support staff and promote their positive wellbeing.
The board can demonstrate how the organisational development strategy addresses staff support and wellbeing. *The board discusses the results of staff feedback on a regular basis to understand if staff feel valued, supported and developed. An action plan is put in place effectively to address any major issues emerging.* *The results of staff surveys and organisational action plans are shared with staff.*

There is a culture of collective responsibility between teams and services.
The board can demonstrate it has mechanisms in place so that teams work collectively to resolve conflict quickly and constructively and share responsibility to deliver good quality care. *Staff are aware of and understand how the organisation is performing overall, their part in that, and how this is being measured.* *The trust can demonstrate it has an approach to recognising staff achievements, such as best practice awards.*

The leadership actively promotes staff empowerment to drive improvement and a culture where the benefit of raising concerns is valued.
There is a demonstrable commitment to improvement and evidence of its achievement. There is appropriate devolution of decision-making, and use of approaches such as service line management. *Staff are supported to deliver the quality improvement initiatives they have identified: for example, staff are provided with quality improvement training to embed quality initiatives; and the board regularly commits resources (time and money) to delivering quality initiatives.* *The reporting of harm and error is encouraged as a means of learning from experience, including how the trust learns from incidents, complaints and feedback from patients.*

Q5 Does the board support continuous learning and development across the organisation?

Information and analysis are used proactively to identify opportunities to drive improvement in care.
The board takes a proactive and self-challenging approach to improving quality and actively looks at how to do this in ways relevant to its context – through adopting or setting sector best practice, setting stretching performance objectives for the trust and using peer/external review. The board challenges itself on whether objectives are sufficiently stretching. *The board seeks to further improve services by looking at best practice across the healthcare sector and, where appropriate, uses benchmarking as a way of evaluating the services being delivered. It seeks to apply lessons learned in other trusts, organisations and industries.* *Information in quality reports is displayed clearly and consistently. The board has sufficient information derived from, for example, ward or service line quality data, service line management/service line reporting to identify areas of underperformance or good practice; and is able to demonstrate how reviewing quality information has resulted in actions which have successfully improved quality performance.* *The organisation has a way of measuring the success or the progress of quality improvement, including innovation, and sees failure not as a negative but as a learning experience. Lessons are learned and embedded in practice from failures to deliver performance improvement.*

There is a strong focus on continuous learning and improvement at all levels of the organisation. Safe innovation is supported and staff have objectives focused on improvement and learning.
The trust's vision sets out a focus on continuous improvement and ambitions towards being a learning organisation or system. The trust's strategy contains a number of trust-wide ambitious quality improvement goals. *The board can articulate the trust's quality and other improvement initiatives and is actively engaged in their delivery (some initiatives could be led personally by board members).* *Governance structures and controls exist in order to support the generation and implementation of new ideas to drive innovation and organisational development. The board has a clear corporate methodology that it uses to drive improvement across the organisation.* *Quality/continuous improvement training and development is offered to staff at all levels.* *Quality is communicated effectively across the organisation (for example, newsletters, intranet, noticeboards regularly feature articles on quality).*

Staff are encouraged to use information and regularly take time out to review performance and make improvement.
Arrangements are in place for leadership to review performance against targets and then update targets for continual improvement on an ongoing basis. *Across the organisation arrangements appropriate to particular roles are in place for frontline staff to identify and report areas for improvement.* *Operational performance improvement processes are in place and the board reviews the outcomes of this work, actively encouraging staff to look at how they can continually improve the way that they work (processes, pathway deployment, etc).*

Process and structures

Q6 Are there clear roles and accountabilities in relation to board governance (including quality governance)?

The board and other levels of governance within the organisation function effectively and interact with each other appropriately.
The board operates as an effective unitary board, demonstrating corporate leadership and a good balance between challenge and support. The board is assured that the size of the board (including voting and non-voting members) is appropriate for the requirements of the organisation. There is clarity on the functions of the board of directors and how it will exercise those functions. A formal statement is in place that specifies the types of strategic decisions, including levels of investment and those representing significant service changes that are expressly reserved for the board, and those that are delegated to committees or the executive. There are defined lines of accountability into directorates and services. Information flows (between the board and its committees and between senior management, non-executive directors and the governors) support decision-making and the rapid resolution of risks and issues. Board sub-committees have a stable, regularly attending membership and operate within their terms of reference. The board's agenda is appropriately balanced and focused between: • strategy and current performance • quality • finance • making decisions and noting/receiving information • matters internal to the organisation and external considerations • business conducted at public board meetings and that done in confidential sessions. The council of governors are actively involved in holding the non executive directors to account for their work at the board.

Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.
The trust's senior leadership is clear about who is responsible for making decisions about the provision, safety and adequacy of services. Every board member understands their ultimate accountability for quality. The board is assured that levels of delegation are in place and is working to support the delivery of the plan and management of risks and issues throughout the organisation and ensure that these delegation processes are monitored and decisions captured and escalated to the appropriate committees, divisions and teams. *There is a clear organisational structure that cascades responsibility for delivering quality performance from 'board to front line to board' (and there are specified owners in post and actively fulfilling their responsibilities).* The board is assured that a sound system of internal control to safeguard investment, the trust's assets, patient safety and service quality is in place and that board sub-committees are set up to focus on these areas. The board is assured that governance and management of any partnerships, joint ventures and shared services are clearly set out and understood, for example: • all parties are clear about their roles • clarity and rules are in place to govern the use of any pooled budgets, and appropriate management structures exist to support and enforce the agreed practice • parties are clear and use the protocols for escalation and resolution of issues between parties • a process for dealing with overspends and underspends exists and is reviewed regularly. If any issues/concerns have been raised by either internal or external audit, recommendations have been implemented in a timely and robust manner. If the trust has encountered any serious fraud in the last two years, procedures and controls are now in place and the trust has received assurance that they are effective.

Quality receives sufficient coverage in board meetings and in other relevant meetings below board level.
Quality is a core part of main board meetings, both as a standing agenda item and as an integrated element of all major discussions and decisions. *Quality performance is discussed in more detail by a quality-focused board sub-committee with a stable, regularly attending membership.* *Discussions suitably interrogate issues to locality/clinical business unit level.*

Q7 Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?

The organisation has the processes and information to manage current and future performance.

The board has agreed and implemented a performance management system which comprises:

- a set of appropriate performance measures covering financial, quality and other areas which are defined, subject to appropriate targets and monitored
- appropriate reporting lines to manage overall performance against these targets in a transparent and timely fashion
- *clinical governance policies for addressing under-performance and recognising and incentivising good performance at individual, team and service line levels*
- means of addressing underperformance across the full range of the trust's operations.

In particular, arrangements are in place to manage/respond to adverse performance in:

- finance
- clinical and other operations
- organisation/HR and
- long-term strategy.

Lessons from performance issues are well documented and shared across the trust on a regular, timely basis, leading to rapid implementation at scale of good practice.

Performance issues are escalated to the relevant committees and the board through clear structures and processes.

The trust is clear about the processes for escalating both quality and financial performance issues to the board:

- *processes are documented*
- *there are agreed rules determining which issues should be escalated (in respect of quality, for example, these cover escalation of serious incidents, complaints and matters related to legal and audit)*
- *there is a defined procedure for bringing significant issues to the board's attention outside monthly meetings.*

The board is assured that the processes are working and that the appropriate person/management level is aware of the issues and are managing these through to resolution.

The board is aware of the most frequent issues being flagged by the workforce to analyse which barriers need to be removed in order to drive improvement.

Robust action plans are put in place to address performance issues (across quality, finance and operations). A*ctions have:*

- *designated owners and timeframes and*
- *regular follow-ups at subsequent board meetings.*

Clinical and internal audit processes function well and have a positive impact in relation to quality governance, with clear evidence of action to resolve concerns.

There is a continuous rolling programme that measures and improves quality. The board actively oversees a co-ordinated programme of clinical audit, peer review and internal audit which is aligned with identified risks and/or gaps in other assurance.

Action plans are completed from audit; and re-audits are undertaken to assess improvement.

Q8 Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?

A full and diverse range of people's views and concerns are encouraged, heard and acted on. Information on people's experience is reported and reviewed alongside other performance data.

The board is assured that patient and public views are heard and acted on, complementing other means of assessing performance. For example:

- *Patient feedback is actively solicited. The process to give feedback is well publicised, feedback is easy to give and based on validated tools.*
- *Patient views are proactively sought during the design of new pathways and processes.*
- *Patient feedback is reviewed on an ongoing basis, with summary reports reviewed regularly and intelligently by the board.*
- *The board regularly reviews and interrogates complaints and serious untoward incident data.*
- *The board uses a range of approaches to engage with individual patients (eg face-to-face discussions, video diaries, ward rounds, patient shadowing, patient stories).*

Feedback from external representatives, eg Healthwatch, is considered alongside the views of current patients and service users, members and governors.

The service proactively engages and involves all staff and assures that the voices of all staff are heard and acted on.
The board can demonstrate a variety of methods to capture the views of staff. Staff are encouraged to provide feedback on an ongoing basis, as well as through specific mechanisms (for example, monthly 'temperature gauge' plus annual staff survey). *All staff feedback is reviewed on an ongoing basis with summary reports reviewed regularly and intelligently by the board.*

Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated in a sensitive and confidential manner, and lessons are shared and acted on.
There is an appropriate mechanism in place for capturing frontline staff concerns. This includes a defined 'whistleblower' policy/error reporting process which is defined and communicated to staff; and staff are prepared if necessary to blow the whistle. *Organisations have considered and implemented the recommendations of the 'Freedom to speak up' review into creating an open and honest reporting culture in the NHS*.

The service is transparent, collaborative and open with all relevant stakeholders about performance.
The board ensures that its decision-making is transparent. There are processes in place that enable stakeholders to find out easily how and why the board has made key decisions without reverting to freedom of information requests. The board works with the council of governors on communicating fully the decisions taken and the reasons that the board reached them, recognising its accountability to the council as the representatives of service users and the public. *The board is clear about governors' involvement in quality governance.* *The board actively engages with the public and stakeholders on significant policy developments. Performance outcomes are made public (and accessible) regularly, and include objective coverage of both good and bad performance.* *The board actively engages all other major stakeholders on quality: for example, quality performance is clearly communicated to commissioners to enable them to make informed decisions* *For care pathways involving GP and community care, discussions are held with all providers to identify potential performance issues and ensure overall quality along the pathway.*

Measurement

Q9 Is appropriate information on organisational and operational performance being analysed and challenged?

Integrated reporting supports effective decision-making.

An integrated reporting approach, appropriate to the size and complexity of the trust, is used by the board to ensure that the impact on all areas of the organisation is understood before decisions are made.

Dashboards

Monthly reporting is supported by a 'dashboard' of the most important metrics. The board is able to justify the selected metrics as being:

- *relevant to the organisation given the context within which it is operating and what it is trying to achieve*
- *linked to the trust's overall strategy and priorities*
- *covering all the trust's major focus areas*
- *the best available ones to use*
- *useful to review.*

The board's information 'dashboard' is frequently reviewed and updated to maximise effectiveness of decisions; and in areas lacking useful metrics, the board commits time and resources to developing new metrics.

The board dashboard is backed up by a 'pyramid' of more granular reports reviewed by sub-committees, divisional leads and individual service lines. Supporting performance detail is broken down by service line so members can understand which services are high and low performing from a financial and quality perspective. *Quality information is analysed and challenged at the individual consultant level.*

Information is compared with target levels of performance (in conjunction with a red-amber-green rating), historic own performance and external benchmarks (where available and helpful).

Information being reviewed must be the most recent available, and recent enough to be relevant. 'On demand' data is available for the highest priority metrics.

Information is 'humanised'/personalised where possible (eg, unexpected deaths shown as an absolute number not embedded in a mortality rate).

Good practice quality dashboards might include:

- *performance against relevant national standards and regulatory requirements*
- *selection of other metrics covering safety, clinical effectiveness and patient experience*
- *selected 'advance warning' indicators*

- *adverse event reports/serious incident reports/ patterns of complaints*
- *measures of instances of harm*
- *Monitor's risk ratings (with risks to future scores highlighted)*
- *where possible/appropriate, percentage compliance to agreed best-practice pathways and*
- *qualitative descriptions and commentary to back up quantitative information.*

A balanced policy exists for data sharing which demonstrates safe and effective sharing of information to facilitate integrated patient care.

The board is willing to use 'soft' information, for example:

- *use of questionnaires and focus groups throughout the organisation and*
- *tools for assessing impact with patients, council of governors and other major stakeholders.*

Board reports reflect the issues and themes that board members are picking up through other channels of information, for example talking to staff, patients and other external stakeholders.

Internal audit of data takes place on a regular basis.

Performance information is used to hold management and staff to account.

Information is clearly aligned to priorities/elements of the trust plan and its delivery.

The board can measure the impact of the organisation's strategy through the use of agreed key performance indicators (eg productivity and efficiency measures), national and local indicator sets, etc. There is robust narrative text/qualitative analysis of outliers/poor performance.

Board reporting provides assurance that patients are receiving person-centred co-ordinated care. Boards also review the performance of patient pathways rather than purely reviewing metrics of the performance of divisions and/or clinical units.

The trust has established financial reporting procedures which provide robust information on organisational performance and enable key risks to be identified and managed, in both operational and strategic terms.

Information includes relevant indicators in relation to the people or HR strategy, eg:

- workforce capacity and capability to deliver the future strategy
- intelligence on values, behaviours and attitudes
- HR health indicators, including information on equality and diversity
- performance appraisal, training and development; and leadership.

Q10 Is the board assured of the robustness of information?

The information used in reporting, performance management and delivering quality care is accurate, valid, reliable, timely and relevant.

The board assures itself that information it receives is from reliable and suitable sources and covers an appropriate mix of intelligence (qualitative and quantitative).

There is assurance covering the data collection, checking and reporting processes in place for producing the information and testing the systems and controls. The following dimensions of data quality could be used to assess the processes and data quality:

- accuracy: data is recorded correctly and is in line with the methodology for calculation
- validity: data has been produced in compliance with relevant requirements
- reliability: data has been collected using a stable process in a consistent manner over a period of time
- timeliness: data is captured as close to the associated event as possible and is available for use within a reasonable time period
- relevance: data is used to generate indicators that meet eligibility requirements as defined by guidance.

The board regularly reviews their arrangements for supporting how they prepare and report performance indicators.

There are clearly documented, robust controls to assure the board on the accuracy, validity and comprehensiveness of information. Local operating procedures are in place to ensure the consistency of data handling and processing, for example :

- *Each directorate/service has a well-documented, well- functioning process for clinical governance that assures the board of the quality of its data.*
- *The clinical audit programme is driven by national audits, with processes for initiating additional audits as a result of identification of local risks (eg, incidents).*
- *Electronic systems are used where possible, generating reliable reports with minimal ongoing effort.*
- *Information can be traced to source and is signed off by owners.*
- *There is clear evidence of action to resolve audit concerns:*
- *Action plans are completed from audit (and subject to regular follow-up reviews).*
- *Re-audits are undertaken to assess performance improvement.*
- *There are no major concerns with coding accuracy performance.*

Annex 2: Governance and capability review self-assessment form

This annex sets out:

- the purpose of the self-assessment step
- how to complete the self-assessment step
- how to rate the self-assessment.

Purpose of the self-assessment questionnaire

The self-assessment process is an important step in setting the starting point for a governance review. Trusts beginning the review process should assess themselves to (i) provide insight to the NHS foundation trust and the independent reviewer about how the trust gauges its own leadership and governance performance; and (ii) to shape the emphasis and scope of the review, identifying areas within the four domains for extra attention or other areas outside the 'core' scope in this document.

Completing the self-assessment

If the self-assessment process is carried out once the external review team have been procured, we suggest that members of the NHS foundation trust board leading the review meet with the independent reviewer to discuss the approach to the self-assessment, ensure consistent expectations about types and levels of evidence to use and make effective use of the tool to inform the review.

While a nominated trust lead or team may co-ordinate the self-assessment and other aspects of the review, the self-assessment should be completed and signed-off by the full board. In practice, this could mean that a nominated board member works with the board secretary and their staff to gather the information and the evidence against each question and present their findings and initial conclusions to the board for discussion and challenge.

Once the board has come to an overall conclusion, the self-assessment questionnaire, ratings and rationale for the rating should be presented to the independent reviewer for comments and further discussion. The reviewer will then agree areas for further scrutiny and approach with the board.

Rating the self-assessment

One way in which NHS foundation trust boards could rate themselves against each of the self-assessment questions might be through using a colour-coded (RAG) system. The good practice examples linked to the questions in annex 1 should be used as a guide to make a judgement about the RAG rating for each question. The self-assessments should be evidence-based. For convenience we repeat the rating table below.

Table 5: Risk ratings explained

Risk rating (or other means of assessment)	Definition	Evidence
Green	Meets or exceeds expectations	Many elements of good practice and there are no major omissions
Amber-green	Partially meets expectations, but confident in management's capacity to deliver green performance within a reasonable timeframe	Some elements of good practice, no major omissions and robust action plans to address perceived gaps with proven track record of delivery
Amber-red	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe	Some elements of good practice, some minor omissions. Action plans to address perceived gaps are in early stage of development with limited evidence of track record of delivery
Red	Does not meet expectations	Major omission in quality governance identified. Significant volume of action plans required and concerns about management's capacity to deliver

Strategy and planning

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
1	Does the board have a credible strategy to provider high quality, sustainable services to patients and is there a robust plan to deliver?				
2	Is the board sufficiently aware of potential risks to the quality, sustainability and delivery of current and future services?				

Capability and culture

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
3	Does the board have the skills and capability to lead the organisation?				
4	Does the board shape an open, transparent and quality-focused culture?				

Process and structures

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
5	Does the board support continuous learning and development across the organisation?				
6	Are there clear roles and accountabilities in relation to board governance (including quality governance)?				
7	Are there clearly defined, well-understood processes for escalating and resolving issues and managing performance?				
8	Does the board actively engage patients, staff, governors and other key stakeholders on quality, operational and financial performance?				

Measurement

No.	Question	Priority rating	Explanation of self-assessment rating	How is the board assured – evidence for assessment	What are the principal actions/areas for discussion with your independent review team
9	Is appropriate information on organisational and operational performance being analysed and challenged?				
10	Is the board assured of the robustness of information?				

Annex 3: References and further reading

Monitor guidance

Monitor (October 2013, revised version expected, April 2015) 'Applying for NHS foundation trust status: Guide for Applicants'

Monitor (December 2013) 'NHS Foundation Trust Code of Governance'

Monitor (July 2010) 'Quality Governance Framework'

Monitor (April 2013) 'Quality governance: How does a board know that its organisation is working effectively to improve patient care?'

Monitor (April 2014, updated March 2015) 'Risk assessment framework'

Monitor (October 2014) Strategy Development: A toolkit for NHS providers

Monitor and PA Consulting (June 2012) 'Director-governor interaction in NHS foundation trusts: A best practice guide for boards of directors'

Interested readers may also find the publications below useful in considering governance (we have provided links where possible)

British Quality Foundation (2013) EFQM Excellence Model

Department of Health (December 2011) 'Board Governance Assurance Framework for Aspirant Foundation Trusts'

NHS Providers and DAC Beachcroft (2013) 'Foundations of Good Governance: A Compendium of Best Practice (2nd edition)'

NHS North West Leadership Academy Board Development Guide 'Knowing what you know and don't know': A practical guide to reviewing effectiveness at Board-level

National Quality Board (March 2011) 'Quality Governance in the NHS – A guide for provider boards'

NHS Leadership Academy (2013) 'The Healthy NHS Board 2013: Principles for Good Governance' (joint introduction from David Bennett and David Flory)

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 Publication code: IRG 12/15

Alder Hey Children's NHS
NHS Foundation Trust

Corporate Report

Feb 2017

Corporate Report

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Table of Contents

Executive Summary

Feb 2017

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17
N	N	N	N	N	N	N	N	N	N	N

Highlights

Activity has significantly improved against the same period last year. 4 hour standard and YTD position achieved despite increased attendances. RTT, cancer & diagnostic standards achieved despite pressures, volume of longest waiting patients has not deteriorated. DQ group established to target key areas of concern that skew data. Productivity has held and improved in some areas despite increased levels of activity and NEL pressures within hospital.

Challenges

Maintaining ED 4 hour standard will require ongoing Winter Plan, surgical support with IP to DC conversion and EDU open to 11 beds . IP long waiting backlog increased slightly as a consequence. ED attendances have increased +246 over plan with a 17% conversion rate which challenges IP bed base. EL activity below plan (winter plan consequence) + OP below plan (Med CBU). Remedial plans being developed where possible. Activity levels have over-achieved against same period last year. Cancellations on the day have increased & 28 day relist breaches. Surgery focusing on reducing. DQ issues continue to skew OP DNA rates but being addressed through DQ group.

Patient Centred Services

Modest deterioration noted with overall achievement of metrics. Main areas to note are increase with NEL LOS which is expected following implementation of the winter plan with increased levels of day case activity, reduced overnight elective and increased NEL admissions. Cancellation on the day have increased but skewed as 1 urol list went down with 8 patients which could not have been prevented no 1 single issue accounted for this increase as it was spread across range of challenges. this will be picked up by the surgical CBU. Some reductions noted within access performance however target achieved i.e. 4 hour standard, RTT and incomplete pathway which was predicted through our winter plan work.

Excellence in Quality

CPE compliance was further improved in February at 89% with 2 areas 100%. This is in comparison to 42% a year ago. Hand Hygiene was at 84% with a 97% submission rate. Ward cleanliness continues to achieve target goal. Total infections are down compared to 15/16 and an upward performance trend continues with readmission of patients with long terms conditions and planned dates of discharge. February saw an increase in medication errors but clinical incidents resulting in severe harm or death are down compared to 15/16. PICU readmissions have also stabilised although are still up on last year. Family and Friends feedback saw a rise in responses from patients in AED and OPD relating to percentages recommending the Trust.

Financial, Growth & Mandatory Framework

For the month of January the Trust is reporting a trading surplus of £0.5m, which is in line with plan. Year to date the trading deficit is £2.9m which is an improvement of £0.1m against plan.

Income is ahead of plan by £3.7m to date. Elective and non-elective activity are both on plan with outpatient activity ahead of plan by 2%.

Pay budgets are £2.1m overspent to date relating to use of agency staffing and CiP slippage. The Trust is behind with the CIP target to date by £0.214m. Cash in the Bank is £5.2m. Monitor Use of Resources rating of 3 in line with plan.

The Trust is forecasting a trading deficit of £0.2m in line with plan at the end of the financial year. This forecast relates to the position as at month 9, as approved by the Board and submitted to NHS Improvement.

Great Talented Teams

In the previous month rates for medical appraisal have increased to xx% whilst PDR compliance for other staff remains steady at 71%. Rates of sickness absence have decreased to 5.3% however this is still over target, and mandatory training compliance has increased to 78.8%. Compliance with corporate induction attendance has maintained its previous level at 77.8%. Work continues to improve all KPIs.

Leading Metrics

Feb 2017

Alder Hey Children's NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Jan 2017	Feb 2017	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	97.3 %	97.0 %	▼	
RTT: 90% Admitted within 18 weeks		87.5 %	88.9 %	▲	
RTT: 95% Non-Admitted within 18 weeks		90.5 %	86.7 %	▼	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.4 %	92.1 %	▼	
Diagnostics: Numbers waiting over 6 weeks		0	1	▲	
Average LoS - Elective (Days)		2.5	3.4	▲	
Average LoS - Non-Elective (Days)		2.0	2.1	▲	
Daycase Rate	0.0 %	70.2 %	72.1 %	▲	
Theatre Utilisation - % of Session Utilised	90.0 %	86.6 %	87.0 %	▲	
28 Day Breaches	0.0	2	4	▲	
Clinic Session Utilisation	90.0 %	84.3 %	84.9 %	▲	
DNA Rate	12.0 %	10.8 %	10.7 %	▼	
Cancelled Operations - Non Clinical - On Same Day		17	27	▲	

Excellence in Quality

Metric Name	Goal	Jan 2017	Feb 2017	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	90.0 %	98.7 %	96.0 %	▼	
IP Survey: % Treated with respect	90.0 %	98.7 %	100.0 %	▲	
IP Survey: % Know their planned date of discharge	60.0 %	78.7 %	72.0 %	▼	
IP Survey: % Know who is in charge of their care	90.0 %	93.0 %	90.9 %	▼	
IP Survey: % Patients involved in play and learning	65.0 %	55.6 %	77.1 %	▲	
Pressure Ulcers (Grade 2 and above)		28	30	–	
Total Infections (YTD)	101.0	84	93	–	
Medication errors resulting in harm (YTD)	70.0	56	63	▼	
Clinical Incidents resulting in harm (YTD)	618.0	575	647	▲	

Great and Talented Teams

Metric Name	Goal	Jan 2017	Feb 2017	Trend	Last 12 Months
Corporate Induction	100.0 %	77.8 %	77.8 %	–	
PDR	90.0 %	71.3 %	71.1 %	▼	
Medical Appraisal	100.0 %	57.2 %	64.8 %	▲	
Sickness	4.5 %	5.4 %	5.3 %	▼	
Mandatory Training	90.0 %	77.2 %	78.8 %	▲	
Staff Survey (Recommend Place to Work)		TBC	TBC		
Actual vs Planned Establishment (%)		89.0 %	92.3 %	▲	
Temporary Spend ('000s)		1442	813	▼	

Financial, Growth and Mandatory Framework

Metric Name	Jan 2017	Feb 2017	Last 12 Months
CIP In Month Variance ('000s)	-373	-464	
Monitor Risk Ratings (YTD)	3	3	
Trading Surplus/(Deficit)	535	470	
Capital Expenditure YTD % Variance	-32.9 %	-33.5 %	
Cash in Bank (£M)	5.2	7.2	

Exceptions

Feb 2017

Alder Hey Children's NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Last 12 Months
Diagnostics: Numbers waiting over 6 weeks	0	1	0	0	0	0	1	0	3	4	2	0	1	
Theatre Utilisation - % of Session Utilised	81.6%	83.6%	85.1%	85.4%	87.5%	84.7%	86.3%	87.8%	85.1%	85.1%	84.3%	86.6%	87.0%	
DNA Rate	12.6%	14.6%	12.9%	12.6%	12.8%	13.1%	14.6%	12.9%	11.5%	11.9%	13.1%	10.8%	10.7%	
IP Survey: % Patients involved in play and learning	73.5%	52.4%	60.4%	54.1%	60.6%	28.2%	30.7%	31.0%	55.9%	55.1%	56.1%	55.6%	77.1%	
Actual vs Planned Establishment (%)	93.1%	90.6%	88.4%	87.1%	90.6%	89.4%	90.7%	91.8%	87.0%	91.8%	87.7%	89.0%	92.3%	

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

Metric Name	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Last 12 Months
RTT: 95% Non-Admitted within 18 weeks	84.9%	85.7%	89.6%	87.8%	87.9%	87.3%	88.8%	87.5%	86.7%	85.8%	87.2%	90.5%	86.7%	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.5%	92.3%	92.2%	92.1%	92.0%	92.1%	92.1%	92.0%	92.1%	92.1%	92.1%	92.4%	92.1%	
IP Survey: % Received information enabling choices about their care	96.1%	93.7%	95.2%	94.2%	97.4%	190.3%	99.1%	93.0%	97.3%	96.4%	96.3%	98.7%	96.0%	
IP Survey: % Know their planned date of discharge	35.3%	44.2%	62.0%	59.3%	54.3%	53.9%	69.0%	71.2%	71.6%	73.5%	73.1%	78.7%	72.0%	
Cash in Bank (£M)	17.8	10.6	6.9	7.9	7.0	4.2	2.9	4.5	6.5	5.4	6.2	5.2	7.2	

Challenge (Top 5 based on % change)

Metric Name	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Last 12 Months
28 Day Breaches	5	7	7	11	3	4	3	5	4	4	3	2	4	
Clinic Session Utilisation	75.5%	76.5%	84.8%	84.8%	85.3%	83.9%	83.4%	83.8%	86.4%	86.9%	83.1%	84.3%	84.9%	
Corporate Induction	72.2%	87.1%	64.3%	94.2%	96.2%	97.1%	65.4%	85.5%	100.0%	74.1%	81.5%	77.8%	77.8%	
PDR	90.1%	90.1%	2.8%	11.5%	32.2%	54.7%	58.5%	69.3%	73.3%	73.0%	70.5%	71.3%	71.1%	
Clinical Incidents resulting in harm (YTD)	607	670	50	91	158	193	239	301	371	451	513	575	647	

Patient Safety

Feb 2017

Alder Hey Children's NHS Foundation Trust

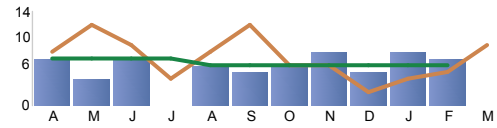
Summary

We saw a significant rise in February relating to medication errors resulting in harm and this is being reviewed by the Medication safety team. Readmissions to PICU have stabilised considerably over the last 2 months with only 1 recorded over our historically busiest period of activity. Clinical incidents resulting in harm are up in comparison to 15/16 although those resulting in moderate, severe harm or death are significantly down. We had one serious incident requiring investigation in February relating to a complex child who died after undergoing a procedure in Theatre.

16/17 15/16 Threshold

Medication Errors

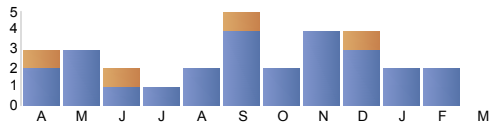
Medication errors resulting in harm (YTD) 63 ▼ (goal: 70.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	7	11	18	18	24	29	35	43	48	56	63	
15/16	8	20	29	33	41	53	59	65	67	71	76	85

Pressure Ulcers

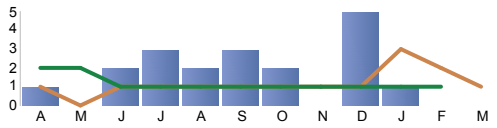
Pressure Ulcers (Grade 2 and above) 30 – (Est. Baseline)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	3	6	8	9	11	16	18	22	26	28	30	
15/16	2	3	5	7	8	8	11	13	13	15	22	24

Readmissions to PICU within 48 hrs

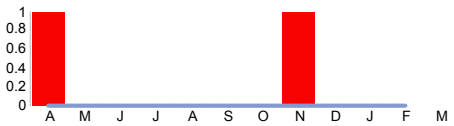
Readmissions to PICU within 48 hrs (YTD) 19 ▼ (goal: 13.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	1	1	3	6	8	11	13	13	18	19	19	
15/16	1	1	2	3	4	5	6	7	8	11	13	14

Never Events

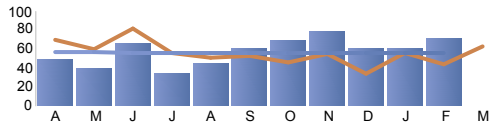
Never Events 0 – (goal: 0.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	1	1	1	1	1	1	1	2	2	2	2	
15/16	0	0	1	1	1	1	1	1	1	2	3	3

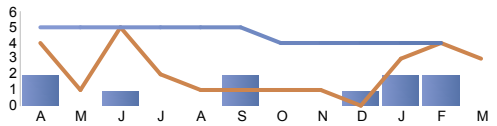
Incidents

Clinical Incidents resulting in harm (YTD) 647 ▲ (goal: 618.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	50	91	158	193	239	301	371	451	513	575	647	
15/16	70	130	212	268	319	372	418	473	507	563	607	670

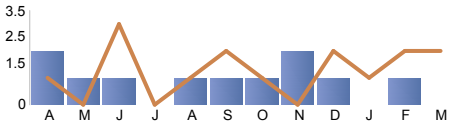
Clinical Incidents resulting in moderate, severe harm or death (YTD) 10 – (goal: 50.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	2	2	3	3	3	5	5	5	6	8	10	
15/16	4	5	10	12	13	14	15	16	16	19	23	26

Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) 1 ▲



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	2	3	4	4	5	6	7	9	10	10	11	
15/16	1	1	4	4	5	7	8	8	10	11	13	15

Patient Experience

Feb 2017

Alder Hey Children's NHS Foundation Trust

Summary

12 Formal complaints were received in February. This is double the number of complaints received for same period, last year. Some additional work will be undertaken to investigate the cause of such a steep increase . PALS concerns are down by 11% from the same time last year.
Significant improvement was made in the Friends and Family data around percentage of attendees who would recommend the Trust across both AED and OPD. The inpatient survey shows some areas of improvement and some areas of challenge specifically around knowing planned discharge date.

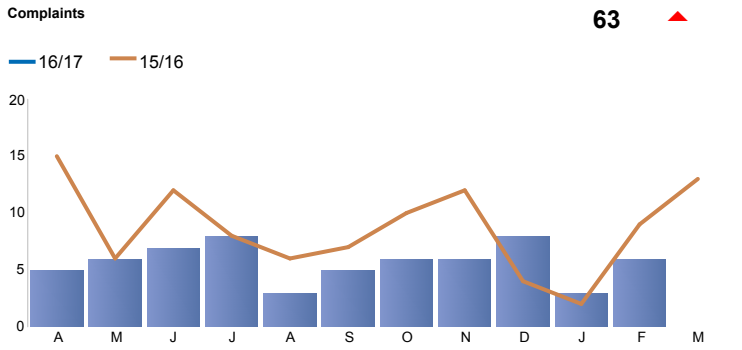
Inpatient Survey

Metric Name	Goal	Jan 2017	Feb 2017	Trend	Last 12 Months
% Know who is in charge of their care	90.0 %	93.0 %	90.9 %	▼	
% Patients involved in play and learning	65.0 %	55.6 %	77.1 %	▲	
% Know their planned date of discharge	60.0 %	78.7 %	72.0 %	▼	
% Received information enabling choices about their care	90.0 %	98.7 %	96.0 %	▼	
% Treated with respect	90.0 %	98.7 %	100.0 %	▲	

Friends and Family

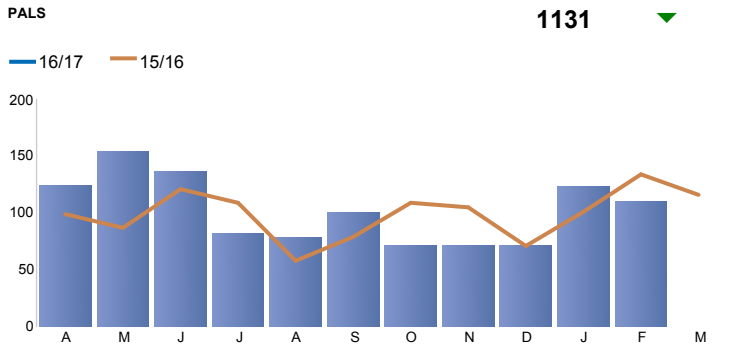
Metric Name	Required Responses	Number of Responses	Jan 2017	Feb 2017	Trend	Last 12 Months
A&E - % Recommend the Trust	250	56	88.1 %	91.1 %	▲	
Community - % Recommend the Trust	29	0	50.0 %	TBC		
Inpatients - % Recommend the Trust	300	554	97.4 %	93.9 %	▼	
Mental Health - % Recommend the Trust	27	0	100.0 %	TBC		
Outpatients - % Recommend the Trust	400	414	89.8 %	94.0 %	▲	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	5	11	18	26	29	34	40	46	54	57	63	
15/16	15	21	33	41	47	54	64	76	80	82	91	104

PALS



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	125	280	417	500	579	680	752	824	896	1,020	1,131	
15/16	99	186	307	416	474	553	662	767	838	939	1,073	1,189

Clinical Effectiveness

Feb 2017

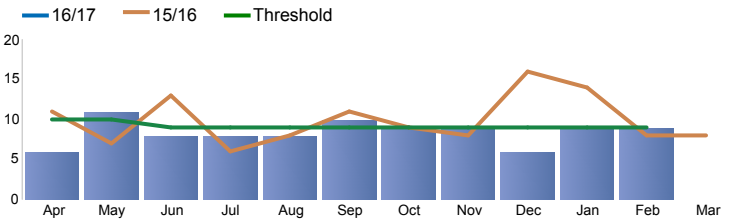
Alder Hey Children's NHS Foundation Trust

Summary

Total infections in comparison to 15/16 continue to be reduced. We have achieved all other targets in the month of February for clinical effectiveness, with continuous improvements in the area of readmissions within 28 days of patients with long term conditions. The EDD data is currently under validation to check compliance with recording and reporting of EDD.

Infections

Total Infections (YTD) — 93 (goal: 101.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	6	17	25	33	41	51	60	69	75	84	93	
15/16	11	18	31	37	45	56	65	73	89	103	111	119

Total Infections (YTD) — 93 (goal: 101.0)

Hospital Acquired Organisms - MRSA (BSI) (YTD) — 2 (goal: 0.0)

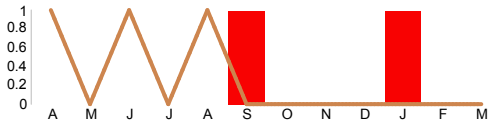
Hospital Acquired Organisms - C.difficile (YTD) — 1 (goal: 0.0)

Outbreak Infections (YTD) — 9

Cluster Infections (YTD) — 0

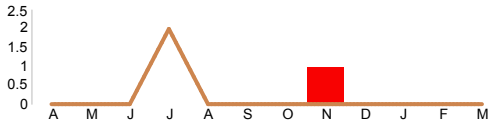
Legend: 16/17; 15/16; Threshold

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



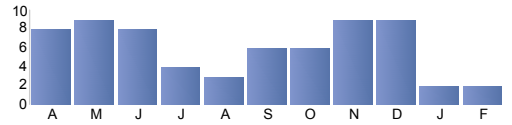
YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0	0	0	0	0	1	1	1	1	2	2	
15/16	1	1	2	2	3	3	3	3	3	3	3	3

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



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	0	0	0	0	0	0	0	1	1	1	1	
15/16	0	0	0	2	2	2	2	2	2	2	2	2

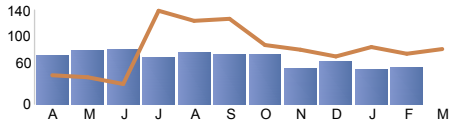
Acute readmissions of patients with long term conditions within 28 days — 66 (Est. Baseline)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb
16/17	8	17	25	29	32	38	44	53	62	64	66

Admissions & Discharges *Data Under Validation*

Patients with an estimated discharge date discharge later than planned (only surgical) — 766 (Est. Baseline)



% of patients with an estimated discharge date discharge later than planned (only surgical) — 4.9 % (Est. Baseline)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	74	155	238	309	387	462	538	592	657	710	766	
15/16	43	83	113	252	376	503	591	672	743	828	903	985

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
16/17	5.4%	5.6%	5.6%	5.4%	5.5%	5.4%	5.4%	5.2%	5.1%	5.0%	4.9%	
15/16	3.2%	3.2%	2.9%	4.7%	5.6%	6.2%	6.5%	6.4%	6.4%	6.4%	6.3%	6.3%

Access

Feb 2017

Alder Hey Children's NHS Foundation Trust

Summary

Incomplete pathway, diagnostic & cancer standards achieved. ED standard passed for February & YTD. Bed occupancy increasing as activity levels; careful management of IP & DC within cap continues. GP referrals increasing and at same level as last year; Choose & Book availability has reduced following medical staff vacancies & sickness. Capacity being monitored via CBU & weekly performance meeting. No patients have been waitng greater than 52 weeks. Admissions & discharges increased from previous month and above position 12 months ago; daycase rates increasing as per winter plan.

18 Weeks

RTT: 90% Admitted within 18 weeks 88.9 %

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
86.0%	88.1%	87.6%	88.5%	88.1%

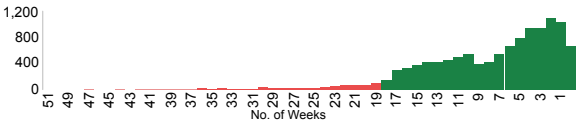
RTT: 95% Non-Admitted within 18 weeks 86.7 %

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
85.7%	88.4%	87.9%	86.6%	88.5%

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

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
92.3%	92.1%	92.1%	92.1%	92.2%

Open Pathways Weekly Profile Feb 2017



0-18 Wks	19-36 Wks	36-51 Wks
11,180	732	136

Cancer

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

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
100.0%	100.0%	100.0%	94.4%	100.0%

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

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
96.3%	100.0%	100.0%	100.0%	100.0%

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

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
100.0%	100.0%	100.0%	100.0%	100.0%

Diagnostics

Diagnostics: % Completed Within 6 Weeks 99.7 % *(goal: 99.0 %)*

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
99.9%	100.0%	99.9%	99.3%	99.9%

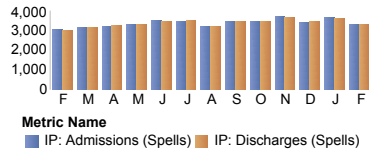
Waiting Times Failed 1

Waiting Times Passed 7

Number of Diagnostics

392

Admissions and Discharges



Bed Occupancy

Bed Occupancy (Funded Beds) 85.1 %

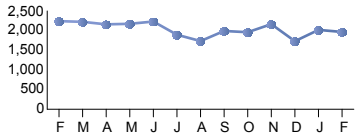
Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
79.8%	81.0%	76.6%	80.2%	83.6%

Provider

Convenience and Choice: Slot Availability 95.5 % *(goal: 96.0 %)*

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
93.7%	96.9%	97.5%	99.2%	97.1%

Referrals Received (GP)



Emergency Department

Feb 2017

Alder Hey Children's NHS Foundation Trust

Summary

Measures put in place achieved forecasted 4 hour performance which was among the best in the country. Time to treat decision was a challenge due to medical staffing constraints. Total time in ED increased by 5 minutes but remains within acceptable parameters.

ED

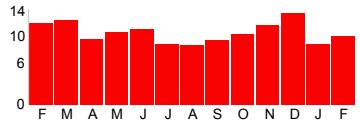
ED: 95% Treated within 4 Hours — 97.0 % (goal: 95.0 %)

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
84.5%	95.0%	96.7%	93.1%	97.1%

ED: Total Time in ED (95th Percentile) — 238.0 mins (goal: 240.0 mins)

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
1,046.0	754.0	705.0	838.8	475.0

ED: Longest Wait Time (Hrs) — 10.2 (goal: 0.0)



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
35.7	31.8	27.6	36.0	19.2

ED: Number Treated Over 4 Hours

137

ED to Inpatient Conversion Rate

16.4 %

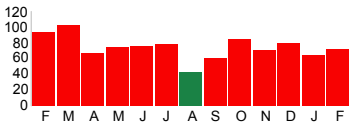
Feb 2017

ED

ED: 15 minute 'Time to Initial Assessment' (95th Percentile) — 0

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
0.0	0.0	0.0	0.0	0.0

ED: 60 minute 'Time to Treat Decision' (Median) — 73.0 mins (goal: 60.0 mins)



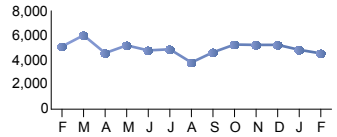
Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
270.0	221.0	184.0	239.0	138.0

ED: Percentage Left without being seen — 2.1 %

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
5.9%	3.1%	2.2%	3.0%	1.9%

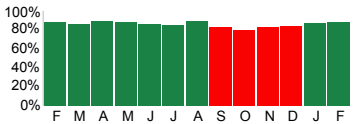
ED: Number of Attendances

4536 Feb 2017



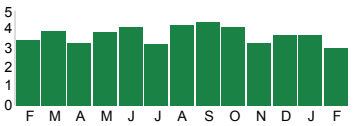
Ambulance Services

Ambulance: Acute Compliance — 88.7 % (goal: 85.0 %)



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
85.9%	88.9%	86.5%	83.3%	88.4%

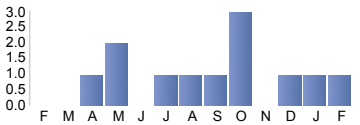
Ambulance: Average Notification to Handover Time (mins) — 3.1 mins (goal: 15.0 mins)



Ambulance: Patients Waiting between 30 and 45 minutes — 5

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
16.0	14.0	16.0	5.0	10.0

Ambulance: Patients Waiting between 45 and 60 minutes — 1



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
0.0	3.0	3.0	4.0	2.0

Productivity & Efficiency

Feb 2017

Alder Hey Children's NHS Foundation Trust

Summary

Winter plan remains in place. IP to DC conversion continues within agreed cap however IP numbers are increasing. Evident as EL LOS increasing however strong DC rates maintained & supported hospital flow. Plan to maintain to the end of March to offset increased NEL activity and achieve EL plan. Theatre & bed utilisation improving as planning regime develops. OP utilisation has increased post festive period and DNA rates have decreased (being validated). Canx ops increased however skewed by urology list going down with 8 patients on. 28 day relists breaches have also increased. No trends.

Length of Stay

Average LoS - Elective (Days) 3.4 ▲

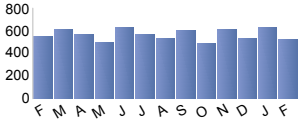
Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
2.9	2.9	2.8	2.9	3.0

Average LoS - Non-Elective (Days) 2.1 ▲

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
2.4	1.9	1.8	1.9	2.0

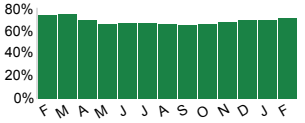
Day Case Rate

Daycases (K1/SDCPREOP) 529 ▼



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
1,738	1,717	1,721	1,652	1,165

Daycase Rate 72.1 % ▲ *(goal: 0.0 %)*



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
74.6%	68.0%	66.5%	68.3%	71.1%

Bed Refusals

Bed Refusals 1 ▲ *(goal: 0.0)*

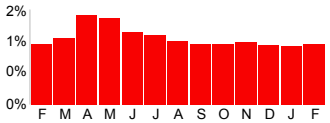
Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
0	1	0	0	1

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 87.0 % ▲ *(goal: 90.0 %)*

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
81.4%	86.1%	86.3%	84.9%	86.8%

Cancelled Operations - Non Clinical - On Same Day (%) (YTD) 1.0 % ▲ *(goal: 0.8 %)*



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
1.3%	1.2%	0.8%	0.9%	1.0%

Cancelled Operations - Non Clinical - On Same Day 27 ▲

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
90	74	50	62	44

28 Day Breaches 4 ▲ *(goal: 0.0)*

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
16	21	12	11	6

Outpatients

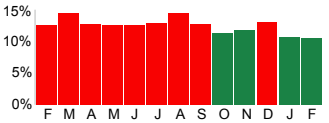
Clinic Session Utilisation * 84.9 % ▲ *(goal: 90.0 %)*

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
76.5%	84.9%	83.7%	85.6%	84.6%

OP Appointments Cancelled by Hospital % 14.2 % ▲ *(goal: 5.0 %)*

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
15.0%	14.0%	13.9%	13.9%	14.0%

DNA Rate 10.7 % ▼ *(goal: 12.0 %)*



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
13.1%	12.8%	13.5%	12.1%	10.7%

OP: New/Follow Up 2.5 ▼

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
2.4	2.3	2.4	2.5	2.6

Facilities

Feb 2017

Alder Hey Children's NHS Foundation Trust

Summary

Due to the commencement of the organisational change in Domestic Services, auditing during February 2017 has been very limited due to a lack of manpower. Theatres have continued to be monitored thanks to the support from that department. During this period of change we will focus on very high risk and spot check other areas when possible

Facilities

Cleanliness Performance VH

98.3 % (goal: 98.0 %) ▲

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
96.5%	96.8%	97.5%	96.7%	97.6%

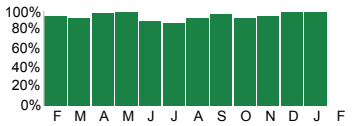
Cleanliness Performance H

94.0 % (goal: 95.0 %) –

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
94.8%	94.4%	94.4%	95.7%	94.0%

Cleanliness Performance S

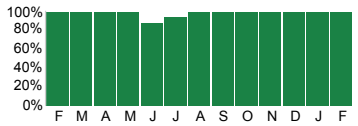
TBC (goal: 85.0 %)



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
94.6%	96.2%	93.0%	96.3%	100.0%

Cleanliness Performance L

100.0 % (goal: 75.0 %) –



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
100.0%	88.2%	98.2%	100.0%	100.0%

Facilities

Audit Compliance

5.0 % (goal: 85.0 %) ▼

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
98.4%	68.0%	100.0%	77.0%	50.0%

Facilities - Other

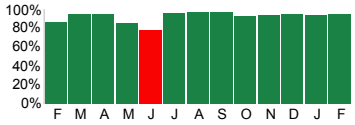
Routine Maintenance Resolution

98.9 % (goal: 85.0 %) ▼

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
67.3%	98.8%	97.4%	99.7%	99.1%

PPM%

96.2 % (goal: 85.0 %) ▲



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
92.6%	89.4%	97.8%	94.4%	95.3%

CAMHS

Feb 2017

Alder Hey Children's NHS Foundation Trust

Summary

Increased levels of sickness and the inability to recruit to a number of fixed term posts have increased waits for CAMHS to a 14 week pathway for Liverpool and 12 week pathway for Sefton. The team continues to monitor capacity through its weekly waiting times meeting.

Waiting Times

CAMHS: Avg Wait to Choice Appt (Weeks) 0.0

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
18.8	0.0	6.0	0.0	0.0

CAMHS: Avg Wait to Partnership Appt (Weeks) 0.0

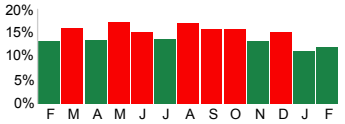
Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
26.9	25.9	6.0	0.0	0.0

DNA Rates

CAMHS: DNA Rate - New 10.9 % ▲ *(goal: 10.0 %)*

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
20.2%	15.2%	14.8%	12.8%	10.8%

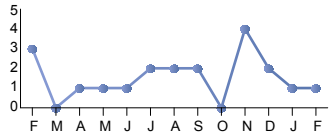
CAMHS: DNA Rate - Follow Up 12.0 % ▲ *(goal: 14.0 %)*



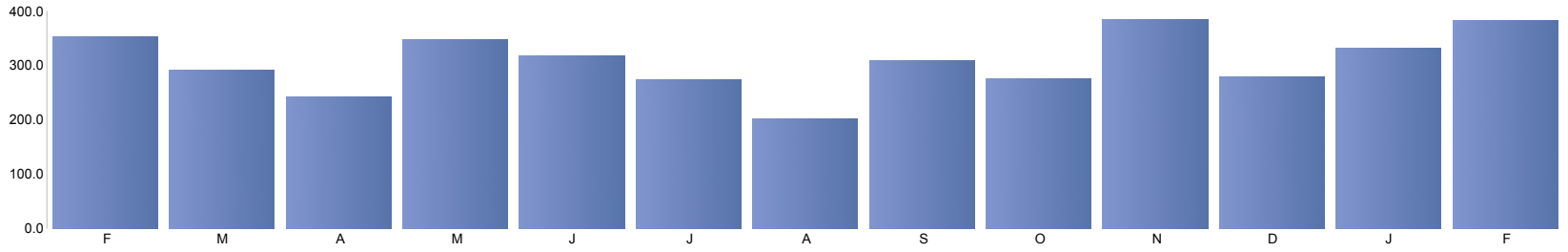
Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
14.4%	15.6%	15.6%	14.8%	11.7%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 1 –



CAMHS: Referrals Received



External Regulation

Feb 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 as at the end of November have been placed in segment 2 under the new NHS Improvement Single Oversight framework.

Monitor - Governance Concern

Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17
N	N	N	N	N	N	N	N	N	N	N

Monitor - Risk Rating

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

Monitor **Feb 2017**

Metric Name	Goal	Jan 17	Feb 17	Trend
ED: 95% Treated within 4 Hours	95.0 %	97.3 %	97.0 %	▼
RTT: 90% Admitted within 18 weeks		87.5 %	88.9 %	▲
RTT: 95% Non-Admitted within 18 weeks		90.5 %	86.7 %	▼
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.4 %	92.1 %	▼
Monitor Risk Ratings (YTD)	3.0	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

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
86.0%	88.1%	87.6%	88.5%	88.1%

RTT: 95% Non-Admitted within 18 weeks

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
85.7%	88.4%	87.9%	86.6%	88.5%

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

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
92.3%	92.1%	92.1%	92.1%	92.2%

Monitor - All Cancers

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

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
100.0%	100.0%	100.0%	94.4%	100.0%

All Cancers: 31 day wait referral to treament

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
96.3%	100.0%	100.0%	100.0%	100.0%

All Cancers: 31 day wait until subsequent treatments

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
100.0%	100.0%	100.0%	100.0%	100.0%

Monitor - A&E 4 Hour Target

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
84.5%	95.0%	96.7%	93.1%	97.1%

Monitor - C difficile

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
0	0	0	1	0

Monitor - Data Completeness

No Data Available

Workforce

Feb 2017

Alder Hey Children's NHS Foundation Trust

Summary

In the previous month rates for medical appraisal have increased to xx% whilst PDR compliance for other staff remains steady at 71%. Rates of sickness absence have decreased to 5.3% however this is still over target, and mandatory training compliance has increased to 78.8%. Compliance with corporate induction attendance has maintained its previous level at 77.8%. Work continues to improve all KPIs.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Last 12 Months
Add Prof Scientific and Technic	2.0%	2.4%	2.9%	2.2%	4.1%	3.9%	5.5%	5.0%	5.9%	5.2%	4.9%	5.7%	
Additional Clinical Services	7.6%	7.0%	6.4%	5.8%	4.8%	5.1%	6.1%	7.0%	6.9%	7.1%	6.9%	5.5%	
Administrative and Clerical	4.0%	4.5%	4.1%	4.3%	4.9%	4.6%	5.0%	5.2%	4.3%	4.5%	4.2%	4.7%	
Allied Health Professionals	2.7%	2.6%	1.8%	3.0%	3.6%	2.2%	3.4%	3.1%	3.3%	4.3%	2.3%	2.6%	
Estates and Ancillary	8.1%	8.2%	10.5%	10.0%	10.8%	9.0%	7.9%	8.4%	8.6%	10.9%	9.1%	7.2%	
Healthcare Scientists	1.6%	2.3%	4.0%	2.2%	1.9%	1.4%	2.8%	2.2%	1.8%	2.0%	1.7%	3.8%	
Medical and Dental	2.0%	1.5%	1.4%	1.9%	2.6%	3.0%	2.7%	2.7%	2.0%	1.6%	2.3%	2.2%	
Nursing and Midwifery Registered	7.1%	6.7%	5.3%	4.7%	4.8%	5.4%	5.1%	5.7%	6.2%	6.1%	6.4%	6.2%	
Trust	5.4%	5.3%	4.8%	4.6%	4.9%	4.8%	5.0%	5.4%	5.4%	5.5%	5.4%	5.2%	

Staff in Post FTE (rolling 12 Months)

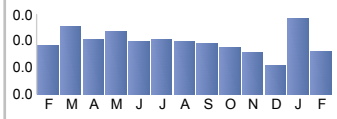
Staff Group	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Last 12 Months
Add Prof Scientific and Technic	180	185	189	190	191	193	196	200	199	197	197	197	
Additional Clinical Services	360	355	354	353	354	361	370	366	369	368	373	375	
Administrative and Clerical	524	535	535	542	547	551	560	568	573	571	584	585	
Allied Health Professionals	127	126	126	126	127	126	125	126	126	129	131	131	
Estates and Ancillary	172	188	190	190	191	191	192	192	190	190	189	190	
Healthcare Scientists	100	101	100	103	104	103	105	105	106	108	107	107	
Medical and Dental	235	235	237	237	234	240	248	245	246	245	245	248	
Nursing and Midwifery Registered	947	937	944	943	938	938	975	974	972	974	975	984	

Staff in Post Headcount (rolling 12 Months)

Staff Group	Mar 16	Apr 16	May 16	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Last 12 Months
Add Prof Scientific and Technic	200	205	209	210	211	214	217	221	220	217	217	217	
Additional Clinical Services	425	420	420	417	416	423	432	431	432	431	437	441	
Administrative and Clerical	614	626	626	635	640	646	658	665	669	668	674	675	
Allied Health Professionals	156	155	156	155	156	155	154	155	155	160	162	162	
Estates and Ancillary	210	237	239	239	240	240	241	241	238	238	236	237	
Healthcare Scientists	111	111	110	113	114	112	114	114	116	118	117	117	
Medical and Dental	275	274	276	274	272	277	287	284	286	285	285	289	
Nursing and Midwifery Registered	1,070	1,060	1,066	1,067	1,063	1,063	1,099	1,100	1,098	1,096	1,098	1,108	

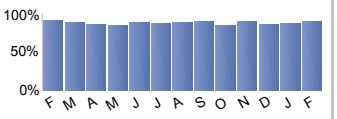
Finance

Temporary Spend ('000s) 813



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
3	3	3	2	2

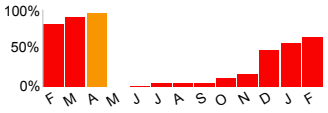
Actual vs Planned Establishment (%) 92.3 %



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
93.4%	88.7%	90.9%	88.8%	90.7%

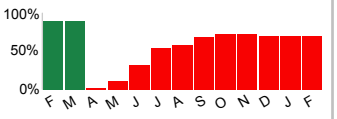
Appraisals

Medical Appraisal 64.8 % (goal: 100.0 %)



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
90.5%	32.7%	5.2%	25.5%	60.9%

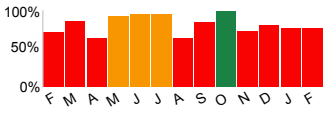
PDR 71.1 % (goal: 90.0 %)



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
90.1%	14.8%	62.7%	72.3%	71.2%

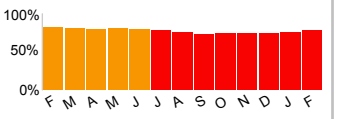
Training

Corporate Induction 77.8 % (goal: 100.0 %)



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
83.5%	86.8%	81.5%	84.0%	77.8%

Mandatory Training 78.8 % (goal: 90.0 %)



Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
82.8%	81.4%	76.1%	75.6%	78.0%

Health and Safety

RIDDOR 0

Q4 15/16	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17
6	2	3	1	2

Performance by CBU

Feb 2017

Alder Hey Children's NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	80.6%	84.9%	85.8%
Convenience and Choice: Slot Availability	100.0%	86.5%	99.8%
DNA Rate (Followup Appts)	10.5%	11.3%	9.3%
DNA Rate (New Appts)	10.7%	12.5%	12.1%
Referrals Received (GP)	333	591	1,042
Temporary Spend ('000s)	72	333	475
Theatre Utilisation - % of Session Utilised		79.1%	88.5%
Trading Surplus/(Deficit)	256	-101	2,181

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		3.8	3.1
Average LoS - Non-Elective (Days)		1.7	2.9
Cancelled Operations - Non Clinical - On Same Day	0	6	21
Daycases (K1/SDCPREOP)	0	62	462
Diagnostics: % Completed Within 6 Weeks		99.7%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	19	37	54
OP Appointments Cancelled by Hospital %	13.3%	14.9%	14.1%
RTT: 90% Admitted within 18 weeks		100.0%	87.0%
RTT: 92% Waiting within 18 weeks (open Pathways)	93.1%	96.0%	90.6%
RTT: 95% Non-Admitted within 18 weeks	73.1%	89.3%	88.1%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores		96.8%	96.3%
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0
Medication Errors (Incidents)	31	271	435

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	87.5%	75.0%	71.4%
Mandatory Training	78.0%	79.2%	78.7%
PDR	76.4%	75.7%	64.2%
Sickness	7.3%	5.2%	4.9%

CBU Performance - Community

Feb 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

New referral process into community paeds has been agreed with CCG and will launch 2017, this will support with managing capacity and directing patients to the right service.
The CBU remains on target to achieve the 18 weeks for Liverpool Community Services by December 2017.

Support Required

none

Operational

Metric Name	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	63.7%	75.3%	76.5%	75.4%	74.8%	76.3%	76.9%	73.9%	79.2%	80.4%	73.8%	75.8%	80.6%	
DNA Rate (New Appts)	17.9%	17.2%	16.4%	14.2%	15.4%	15.7%	15.9%	12.7%	15.7%	12.7%	18.1%	14.0%	10.7%	
DNA Rate (Followup Appts)	14.6%	15.0%	13.6%	17.1%	15.0%	13.7%	16.8%	15.9%	14.1%	12.2%	14.5%	11.9%	10.5%	
Convenience and Choice: Slot Availability	98.8%	87.2%	85.3%	95.7%			92.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Referrals Received (GP)	350	313	282	344	316	261	201	312	306	393	297	269	333	
Temporary Spend ('000s)	196	106	117	116	88	85	149	144	37	60	47	77	72	
Trading Surplus/(Deficit)	625	383	233	200	317	280	371	244	355	341	415	410	256	

Patient

Metric Name	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	83.0%	64.1%	77.0%	61.1%	74.2%	77.1%	80.9%	87.5%	77.4%	78.0%	80.2%	75.3%	73.1%	
RTT: 92% Waiting within 18 weeks (open Pathways)	87.3%	88.0%	87.2%	88.9%	87.1%	91.5%	89.6%	88.5%	82.5%	85.9%	92.3%	92.8%	93.1%	
Average LoS - Elective (Days)										22.00				
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	0	6	1	1	3	12	18	29	23	29	1	9	19	
Daycases (K1/SDCPREOP)	0	1	0	0	2	0	2	0	0	0	3	0	0	
Cancelled Operations - Non Clinical - On Same Day	0	0	0	0	0	0	0	0	0	0	0	0	0	
OP Appointments Cancelled by Hospital %	12.5%	13.5%	15.1%	11.9%	13.8%	11.4%	13.1%	12.7%	14.1%	11.9%	10.1%	11.3%	13.3%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%		100.0%	100.0%	100.0%							

Quality

Metric Name	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
Medication Errors (Incidents)	21	22	5	6	12	13	20	21	25	27	28	30	31	
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	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
Corporate Induction	75.0%	50.0%	60.0%	88.9%	100.0%	100.0%	60.0%	86.7%	100.0%	72.7%	87.5%	87.5%	87.5%	
PDR	92.2%	92.2%	0.9%	7.0%	38.3%	62.8%	68.3%	77.1%	82.1%	81.4%	75.4%	77.2%	76.4%	
Sickness	5.4%	5.0%	5.1%	4.9%	5.7%	5.9%	5.5%	6.2%	7.6%	8.9%	7.1%	7.2%	7.3%	
Mandatory Training	76.8%	75.0%	75.0%	75.8%	77.1%	76.0%	75.4%	73.2%	71.1%	70.9%	72.1%	75.8%	78.0%	

CBU Performance - Medicine (Part 1)

Feb 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Clinic utilisation has been increasing steadily and DNAs reducing this calendar year. Sort availability reduced and will be investigated. OP appointment cancellations remains constant but still a concern. Medication errors on trend. Sickness increased by 0.4% (mainly due to long term).

Support Required

None

Operational

Metric Name	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Last 12 Months
Theatre Utilisation - % of Session Utilised	74.1%	75.6%	80.0%	77.2%	78.5%	78.0%	78.1%	85.0%	80.1%	79.1%	80.1%	82.9%	79.1%	
Clinic Session Utilisation	75.3%	77.4%	81.8%	81.3%	83.8%	82.9%	81.6%	84.2%	86.2%	86.0%	81.9%	83.6%	84.9%	
DNA Rate (New Appts)	13.9%	14.2%	11.7%	12.8%	13.6%	14.6%	17.6%	14.6%	14.8%	12.4%	14.3%	14.0%	12.5%	
DNA Rate (Followup Appts)	15.4%	17.2%	17.0%	15.5%	14.9%	16.0%	18.8%	15.5%	13.6%	16.1%	14.6%	11.0%	11.3%	
Convenience and Choice: Slot Availability	89.2%	86.2%	95.5%	96.3%	99.5%	93.6%	93.7%	99.4%	98.1%	100.0%	99.6%	96.1%	86.5%	
Referrals Received (GP)	761	768	731	739	756	605	566	625	653	731	563	680	591	
Temporary Spend ('000s)	201	307	243	393	231	246	272	272	230	229	164	499	333	
Trading Surplus/(Deficit)	-195	-48	-389	-13	556	-690	-307	525	321	491	212	74	-101	

Patient

Metric Name	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	100.0%	100.0%	100.0%	98.2%	95.2%	96.7%	95.8%	100.0%	89.6%	93.1%	87.6%	92.6%	100.0%	
RTT: 95% Non-Admitted within 18 weeks	89.3%	88.5%	91.3%	88.7%	88.4%	86.8%	86.4%	85.4%	88.6%	83.2%	84.7%	92.4%	89.3%	
RTT: 92% Waiting within 18 weeks (open Pathways)	97.5%	98.0%	97.2%	96.6%	95.6%	94.3%	93.3%	93.2%	95.1%	95.9%	96.6%	96.9%	96.0%	
Average LoS - Elective (Days)	3.04	3.58	2.95	3.22	2.31	2.84	3.32	2.94	3.76	3.75	3.92	4.16	3.79	
Average LoS - Non-Elective (Days)	1.82	2.22	1.39	1.47	1.25	1.28	1.28	1.29	1.27	1.52	1.49	1.40	1.65	
Hospital Initiated Clinic Cancellations < 6 weeks notice	3	6	4	2	0	32	14	27	22	41	29	41	37	
Daycases (K1/SDCPREOP)	76	73	78	52	89	56	68	86	52	46	65	68	62	
Cancelled Operations - Non Clinical - On Same Day	3	3	4	0	1	1	1	4	1	8	4	6	6	
OP Appointments Cancelled by Hospital %	13.6%	13.4%	14.8%	12.8%	12.6%	15.0%	14.7%	13.4%	14.7%	13.6%	14.2%	14.6%	14.9%	
Diagnostics: % Completed Within 6 Weeks	100.0%	99.5%	100.0%	100.0%	100.0%	100.0%	99.5%	100.0%	76.9%	99.1%	99.5%	100.0%	99.7%	

Quality

Metric Name	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Last 12 Months
Medication Errors (Incidents)	300	349	31	55	77	93	115	147	169	199	229	252	271	
Cleanliness Scores	97.0%	96.0%	97.8%	98.3%	95.0%	94.2%	95.0%	96.5%	95.8%	97.5%	97.0%	96.8%	96.8%	
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	1	0	0	0	1	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Feb 2016	Mar 2016	Apr 2016	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Last 12 Months
Corporate Induction	50.0%	83.3%	83.3%	85.7%	100.0%	100.0%	69.2%	80.0%	100.0%	85.0%	83.3%	75.0%	75.0%	
PDR	91.7%	91.7%	1.7%	15.2%	37.3%	75.1%	78.9%	81.6%	79.7%	79.4%	77.6%	76.7%	75.7%	
Sickness	5.7%	5.5%	5.5%	5.0%	4.4%	4.5%	4.5%	4.7%	4.9%	4.6%	4.7%	4.8%	5.2%	
Mandatory Training	86.0%	85.9%	85.5%	86.2%	85.0%	83.1%	80.1%	76.6%	76.9%	76.3%	76.4%	77.3%	79.2%	

CBU Performance - Medicine (Part 2)

Feb 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Imaging turnaround times still a concern in certain areas, but not affecting diagnostic breach risk. Pathology turnaround times for urgent requests remain below 90% and will be investigated.

Support Required

None

Patient

Metric Name	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	98.0%	95.0%	85.0%	93.0%	89.0%	99.0%	91.0%	89.0%	96.0%	95.0%	93.0%	96.0%	97.0%	
Imaging - % Reporting Turnaround Times - ED	92.0%	91.0%	83.0%	65.0%	88.0%	93.0%	89.0%	89.0%	88.0%	87.0%	88.0%	88.0%	93.0%	
Imaging - % Reporting Turnaround Times - Inpatients	89.0%	83.0%	83.0%	75.0%	85.0%	90.0%	84.0%	85.0%	87.0%	76.0%	80.0%	86.0%	89.0%	
Imaging - % Reporting Turnaround Times - Outpatients	96.0%	97.0%	93.0%	89.0%	97.0%	97.0%	97.0%	89.0%	93.0%	93.0%	94.0%	97.0%	98.0%	
Imaging - Waiting Times - MRI % under 6 weeks	91.0%	90.0%	90.0%	92.0%	90.0%	95.0%	94.0%	90.0%	88.0%	90.0%	92.0%	92.0%	86.0%	
Imaging - Waiting Times - CT % under 1 week	88.0%	86.0%	94.0%	88.0%	85.0%	90.0%	92.0%	90.0%	86.0%	84.0%	81.0%	81.0%	77.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	95.0%	95.0%	95.0%	95.0%	94.0%	90.0%	94.0%	95.0%	95.0%	94.0%	94.0%	94.0%	92.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	85.0%	91.0%	92.0%	89.0%	87.0%	90.0%	89.0%	88.0%	86.0%	85.0%	83.0%	83.0%	81.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	95.0%	76.0%	96.0%	100.0%	89.0%	95.0%	81.0%	91.0%	85.0%	100.0%	88.0%	88.0%	84.0%	
BME - High Risk Equipment PPM Compliance	90.0%	88.0%	89.0%	90.0%	90.0%	89.7%	90.0%	90.0%	90.4%	89.7%	93.0%	91.0%	91.1%	
BME - Low Risk Equipment PPM Compliance	78.0%	78.0%	80.0%	80.0%	79.0%	77.0%	80.0%	78.0%	77.0%	79.0%	80.0%	81.0%	80.8%	
BME - Equipment Pool - Equipment Availability	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	99.8%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	85.0%	76.0%	74.0%	64.0%	56.0%	66.0%	64.0%	44.0%	45.0%	50.0%	51.0%	55.0%	50.0%	
Pharmacy - Dispensing for Out Patients - Complex	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	98.0%	100.0%	98.0%	
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%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	82.9%	87.0%	84.3%	86.6%	86.6%	90.5%	90.0%	91.3%	90.2%	89.0%	87.9%	87.5%	88.7%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	98.0%	99.0%	98.7%	99.3%	99.9%	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	81.0%	88.9%	84.6%	90.0%	100.0%	82.0%	83.0%	100.0%	94.7%	100.0%	100.0%	80.0%	100.0%	

CBU Performance - Surgery

Feb 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Theatre utilisation has improved to 88.5%. Attention remains on minimising cancellations due to no bed available and to eradicate admin errors in sending for patients via the new booking & scheduling process.
Clinic utilisation is receiving a lot of operational management attention to ensure all clinic slots are fully booked to offset DNAs.
Appraisals- 6 monthly reviews will be undertaken to improve compliance with this standard and support staff with a development plan.

Support Required

An improvement team as part of the LiA process should be formed to urgently tackle the patient safety risk associated with long transcription turnaround times which is affecting the delivery of timely clinical pathways and the communication of important clinical information.

Operational

Metric Name	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
Theatre Utilisation - % of Session Utilised	83.2%	85.0%	86.3%	86.6%	89.2%	85.7%	87.6%	88.3%	86.0%	86.1%	85.2%	87.2%	88.5%	
Clinic Session Utilisation	77.3%	76.1%	87.5%	88.3%	87.4%	85.7%	85.1%	85.1%	87.6%	88.6%	85.4%	86.6%	85.8%	
DNA Rate (New Appts)	10.4%	12.7%	10.8%	10.4%	10.9%	11.0%	12.1%	11.3%	10.1%	11.8%	13.3%	12.3%	12.1%	
DNA Rate (Followup Appts)	10.1%	13.1%	11.0%	9.7%	11.0%	11.3%	11.8%	10.5%	8.6%	9.0%	10.9%	8.5%	9.3%	
Convenience and Choice: Slot Availability	93.2%	95.3%	97.4%	96.7%	98.3%	95.4%	99.6%	99.1%	97.4%	100.0%	98.7%	100.0%	99.8%	
Referrals Received (GP)	1,130	1,142	1,146	1,090	1,159	1,029	967	1,054	1,000	1,040	871	1,069	1,042	
Temporary Spend ('000s)	419	625	502	520	474	529	436	453	529	426	331	504	475	
Trading Surplus/(Deficit)	1,527	2,951	1,252	1,888	2,106	2,704	1,992	1,921	1,806	2,721	1,539	2,008	2,181	

Patient

Metric Name	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
RTT: 90% Admitted within 18 weeks	82.6%	87.6%	87.5%	85.5%	87.0%	86.2%	85.4%	87.7%	87.9%	88.9%	88.1%	86.8%	87.0%	
RTT: 95% Non-Admitted within 18 weeks	82.6%	85.7%	90.1%	90.3%	89.5%	88.8%	90.8%	88.7%	87.0%	88.6%	89.7%	92.8%	88.1%	
RTT: 92% Waiting within 18 weeks (open Pathways)	91.4%	90.7%	90.7%	90.9%	91.3%	91.2%	91.9%	92.0%	92.1%	91.3%	90.4%	90.6%	90.6%	
Average LoS - Elective (Days)	2.64	2.75	2.72	3.04	2.91	2.88	2.86	2.36	2.71	2.74	2.56	2.10	3.09	
Average LoS - Non-Elective (Days)	3.30	3.10	2.91	2.81	2.85	2.85	2.58	2.37	2.68	2.71	2.64	3.07	2.86	
Hospital Initiated Clinic Cancellations < 6 weeks notice	65	25	30	11	27	24	45	56	34	72	20	30	54	
Daycases (K1/SDCPREOP)	483	532	494	447	540	518	463	515	442	570	470	561	462	
Cancelled Operations - Non Clinical - On Same Day	21	21	26	28	15	19	13	12	16	20	8	11	21	
OP Appointments Cancelled by Hospital %	16.4%	17.2%	16.9%	14.1%	13.0%	14.2%	14.4%	13.8%	14.8%	14.5%	13.7%	14.0%	14.1%	
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	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
Medication Errors (Incidents)	354	396	54	94	151	188	237	269	300	341	372	401	435	
Cleanliness Scores	93.1%	96.3%	96.6%	95.6%	93.7%	95.1%	96.6%	96.6%	95.1%	97.9%	96.0%	96.1%	96.2%	
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	1	0	0	0	

Workforce

Metric Name	Feb-16	Mar-16	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Last 12 Months
Corporate Induction	57.1%	100.0%	60.0%	100.0%	88.9%	100.0%	64.0%	85.7%	100.0%	65.2%	71.4%	71.4%	71.4%	
PDR	87.9%	87.9%	5.6%	16.1%	38.4%	48.4%	51.4%	64.2%	63.4%	63.3%	61.1%	63.4%	64.2%	
Sickness	6.1%	5.9%	5.3%	4.4%	4.0%	4.7%	5.2%	5.7%	5.7%	5.8%	5.6%	5.7%	4.8%	
Mandatory Training	86.5%	86.3%	86.4%	87.5%	87.3%	83.7%	78.5%	75.0%	75.3%	75.7%	77.0%	77.5%	78.7%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended February 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	3,616	3,613	(3)	38,573	38,171	(402)	42,982	41,645	(1,337)
Non Elective	1,985	2,459	474	24,301	24,739	438	26,512	26,635	123
Outpatients	2,383	2,280	(103)	25,270	25,845	575	28,190	28,809	619
A&E	408	405	(3)	4,859	4,617	(243)	5,310	5,129	(181)
Critical Care	1,895	1,970	75	21,654	22,704	1,050	23,739	24,731	992
Non PbR Drugs & Devices	1,544	1,814	270	17,107	18,472	1,366	18,665	19,920	1,255
Excess Bed Days	366	309	(57)	4,359	4,529	170	4,765	4,980	215
CQUIN	245	267	22	2,697	2,810	112	2,942	3,077	134
Contract Sanctions	0	47	47	0	(45)	(45)	0	(203)	(203)
Private Patients	15	55	41	161	259	98	176	234	58
Other Clinical Income	3,253	2,975	(278)	31,000	33,126	2,126	34,058	36,386	2,328
Non Clinical Income									
Other Non Clinical Income	2,298	2,011	(287)	23,132	21,784	(1,348)	25,421	23,955	(1,466)
Total Income	**18,008**	**18,206**	**198**	**193,113**	**197,010**	**3,897**	**212,760**	**215,295**	**2,535**
Expenditure									
Pay Costs	(11,268)	(11,514)	(245)	(124,112)	(126,505)	(2,394)	(135,080)	(137,237)	(2,157)
Drugs	(1,260)	(1,524)	(264)	(15,028)	(17,975)	(2,946)	(16,424)	(19,370)	(2,946)
Clinical Supplies	(1,311)	(1,464)	(154)	(15,163)	(15,934)	(771)	(16,596)	(17,107)	(511)
Other Non Pay	(1,894)	(1,702)	192	(22,869)	(21,868)	1,001	(24,857)	(22,874)	1,983
PFI service costs	(270)	(202)	68	(3,227)	(2,488)	739	(3,526)	(2,780)	746
Total Expenditure	**(16,003)**	**(16,406)**	**(403)**	**(180,398)**	**(184,770)**	**(4,371)**	**(196,483)**	**(199,368)**	**(2,885)**
EBITDA	**2,005**	**1,800**	**(205)**	**12,715**	**12,240**	**(475)**	**16,277**	**15,927**	**(350)**
PDC Dividend	(97)	(91)	6	(1,064)	(996)	68	(1,161)	(1,087)	74
Depreciation	(533)	(462)	71	(5,799)	(5,101)	698	(6,333)	(5,698)	634
Finance Income	2	2	(0)	13	26	13	15	24	9
Interest Expense (non-PFI/LIFT)	(86)	(81)	5	(947)	(991)	(44)	(1,042)	(1,108)	(66)
Interest Expense (PFI/LIFT)	(666)	(687)	(21)	(7,329)	(7,562)	(233)	(7,995)	(8,249)	(254)
MASS/Restructuring	0	(10)	(10)	0	(58)	(58)	0	(48)	(48)
Trading Surplus / (Deficit)	**624**	**470**	**(154)**	**(2,412)**	**(2,442)**	**(31)**	**(240)**	**(240)**	**(0)**
One-off normalising items									
Government Grants/Donated Income	73	330	257	2,141	2,152	11	2,352	2,486	134
Depreciation on Donated Assets	(172)	(159)	13	(1,818)	(1,659)	159	(1,990)	(1,818)	172
Normalised Surplus/(Deficit)	**525**	**641**	**116**	**(2,089)**	**(1,949)**	**139**	**122**	**428**	**306**
Fixed Asset Impairment	0	0	0	0	0	0	(1,920)	(1,847)	73
Gains/(Losses) on asset disposals	0	0	0	0	431	431	0	431	431
Reported Surplus/(Deficit)	**525**	**641**	**116**	**(2,089)**	**(1,518)**	**571**	**(1,798)**	**(988)**	**810**

Key Metrics	In Month			Year to date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income £000	18,008	18,206	198	193,113	197,010	3,897	212,760	215,295	2,535
Expenditure £000	(17,384)	(17,726)	(342)	(195,525)	(199,394)	(3,869)	(196,483)	(199,368)	(2,488)
Trading Surplus/(Deficit) £000**	624	470	(154)	(2,412)	(2,442)	(31)	(240)	(240)	()
Normalised Surplus/(Deficit) £000	525	641	116	(2,089)	(1,949)	139	122	428	306
** Control Total									
WTE	2,964	3,002	(38)	2,964	3,002	(38)			
CIP £000	988	525	(464)	6,096	5,418	(678)	7,200	6,490	(710)
Cash £000	5,404	7,185	1,781	5,404	7,185	1,781			
CAPEX FCT £000	902	554	348	8,789	5,844	2,945	10,689	8,347	2,342
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	2,289	2,083	(206)	24,147	22,957	(1,190)	26,950	24,907	(2,043)
Non Elective	1,232	1,212	(20)	14,710	14,298	(412)	16,071	14,657	(1,414)
Outpatients	16,959	16,128	(831)	178,655	180,848	2,193	199,463	187,056	(12,407)
A&E	4,287	4,533	246	51,142	52,803	1,661	55,899	59,152	3,253

Alder Hey Children's NHS Foundation Trust
CAPITAL PROGRAMME 2016/17

	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	REVISED BUDGET INC SLIPPAGE	FULL YEAR FORECAST	FULL YEAR VARIANCE	ADJUSTED FROM REVENUE	NORMALISED FORECAST VARIANCE
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ESTATES	**190**	**89**	**101**	**2,080**	**1,262**	**287**	**2,270**	**2,792**	**1,847**	**945**	**621**	**1,566**
RESEARCH & EDUCATION	**0**	**27**	**(27)**	**0**	**472**	**(472)**	**0**	**0**	**514**	**(514)**	**24**	**(490)**
ESTATES TOTAL CAPITAL	**190**	**116**	**74**	**2,080**	**1,734**	**(185)**	**2,270**	**2,792**	**2,361**	**431**	**645**	**1,076**
NETWORKING, INFRASTRUCTURE & OTHER IT	0	(25)	25	440	573	(133)	440	440	2,241	(1,801)	193	**(1,608)**
ELECTRONIC PATIENT RECORD	58	232	(174)	642	703	(61)	700	700	744	(44)	410	**366**
IM & T TOTAL CAPITAL	**58**	**207**	**(149)**	**1,082**	**1,276**	**(194)**	**1,140**	**1,140**	**2,985**	**(1,845)**	**603**	**(1,242)**
NON-MEDICAL EQUIPMENT	0	(178)	178	0	15	(15)	0	0	16	(16)	0	**(16)**
ALDER HEY IN THE PARK TOTAL	**613**	**223**	**389**	**5,186**	**2,647**	**3,070**	**6,275**	**6,275**	**2,790**	**3,485**	**57**	**3,542**
OTHER	**40**	**7**	**33**	**442**	**187**	**255**	**482**	**482**	**210**	**272**	**112**	**384**
CAPITAL PROGRAMME 16/17	***902***	***554***	***348***	***8,789***	***5,844***	***2,945***	***10,167***	***10,689***	***8,347***	***2,342***	***1,417***	***3,759***

POTENTIAL

In-Month

CBU	Specialty	POD	Activity Plan	Activity Actual	Activity Variance	Income Plan	Income Actual	Income Variance	Income Variance (case-mix)	Income Variance (volume)	
Surgery CBU	Audiology	Outpatient New	725	570	-155	£68,799	£54,072	-£14,727	-£3	-£14,723	
		Outpatient Follow-up	248	276	28	£23,468	£26,085	£2,617	-£0	£2,617	
		OP Procedure	1	1	0	£147	£113	-£34	-£2	-£32	
	Audiology Total		**975**	**847**	**-128**	**£92,414**	**£80,270**	**-£12,144**	**-£5**	**-£12,139**	
	Burns Care	Daycase	0	5	5	£146	£9,938	£9,792	£1,378	£8,414	
		Elective	7	2	-5	£17,228	£4,944	-£12,284	-£132	-£12,152	
		Non Elective	25	19	-6	£64,611	£57,394	-£7,216	£9,223	-£16,440	
		Outpatient New	32	12	-20	£6,340	£2,378	-£3,962	£5	-£3,967	
		Outpatient Follow-up	89	49	-40	£10,130	£5,601	-£4,529	£9	-£4,537	
		Ward Attender	4	31	27	£482	£3,544	£3,061	£0	£3,061	
		Ward Based Outpatient	12	4	-8	£1,345	£457	-£888	-£0	-£888	
		OP Procedure	0	34	34	£16	£4,305	£4,289	£57	£4,232	
	Burns Care Total		**169**	**156**	**-13**	**£100,298**	**£88,562**	**-£11,736**	**£10,540**	**-£22,277**	
	Cardiac Surgery	Elective	30	28	-2	£379,336	£396,623	£17,287	£37,369	-£20,082	Includes £28k estimated flex/freeze benefit
		Non Elective	7	10	3	£126,325	£198,743	£72,418	£5,108	£67,310	
		Excess Bed Days	66	0	-66	£29,397	£0	-£29,397	£0	-£29,397	
		Outpatient New	9	11	2	£6,599	£7,920	£1,321	-£0	£1,321	
		Outpatient Follow-up	24	40	16	£16,980	£28,800	£11,820	-£0	£11,820	
	Cardiac Surgery Total		**135**	**89**	**-46**	**£558,637**	**£632,085**	**£73,448**	**£42,477**	**£30,971**	
	Cardiology	Daycase	14	23	9	£38,495	£62,246	£23,751	-£562	£24,313	
		Elective	16	20	4	£64,126	£70,515	£6,389	-£8,292	£14,680	
		Non Elective	13	15	2	£59,151	£48,586	-£10,565	-£21,725	£11,160	
		Excess Bed Days	16	49	33	£6,442	£23,565	£17,123	£3,729	£13,394	
		Outpatient New	141	166	25	£33,598	£39,529	£5,932	-£45	£5,977	
		Outpatient Follow-up	399	559	160	£52,694	£72,660	£19,966	-£1,189	£21,155	
		Ward Attender	11	35	24	£1,404	£4,550	£3,146	-£73	£3,219	
		Ward Based Outpatient	29	10	-19	£3,776	£1,300	-£2,477	-£21	-£2,456	
	Cardiology Total		**638**	**877**	**239**	**£259,687**	**£322,952**	**£63,265**	**-£28,178**	**£91,442**	
	Dentistry	Daycase	102	92	-10	£59,203	£52,750	-£6,453	-£554	-£5,898	
		Elective	12	2	-10	£7,185	£1,125	-£6,060	-£119	-£5,941	
		Non Elective	1	0	-1	£1,119	£0	-£1,119	£0	-£1,119	
		Excess Bed Days	1	0	-1	£302	£0	-£302	£0	-£302	
		Outpatient New	119	95	-24	£4,277	£3,379	-£898	-£24	-£874	
		Outpatient Follow-up	153	100	-53	£5,438	£3,557	-£1,881	-£5	-£1,876	
		Ward Attender	0	1	1	£0	£36	£36	£0	£36	
		OP Procedure	32	24	-8	£5,156	£3,893	-£1,263	£23	-£1,286	
	Dentistry Total		**420**	**314**	**-106**	**£82,681**	**£64,740**	**-£17,941**	**-£680**	**-£17,261**	
	ENT	Daycase	115	85	-30	£130,488	£94,139	-£36,349	-£2,392	-£33,957	
		Elective	97	52	-45	£137,067	£79,515	-£57,552	£6,008	-£63,561	
		Non Elective	21	25	4	£33,160	£47,475	£14,314	£8,462	£5,852	
		Excess Bed Days	26	46	20	£10,435	£22,580	£12,144	£4,172	£7,973	
		Outpatient New	362	313	-49	£40,077	£34,826	-£5,251	£172	-£5,423	
		Outpatient Follow-up	522	355	-167	£35,604	£24,364	-£11,240	£128	-£11,367	
		Ward Attender	0	3	3	£17	£206	£188	£1	£187	
		Ward Based Outpatient	5	0	-5	£341	£0	-£341	£0	-£341	
		OP Procedure	179	200	21	£23,464	£23,617	£153	-£2,575	£2,728	
	ENT Total		**1,327**	**1,079**	**-248**	**£410,654**	**£326,722**	**-£83,932**	**£13,977**	**-£97,908**	
	Gynaecology	Daycase	1	0	-1	£1,060	£0	-£1,060	£0	-£1,060	
		Elective	1	0	-1	£665	£0	-£665	£0	-£665	
		Non Elective	0	1	1	£0	£602	£602	£0	£602	
		Outpatient New	24	35	11	£3,503	£5,023	£1,520	-£5	£1,525	
		Outpatient Follow-up	40	57	17	£3,779	£5,275	£1,497	-£83	£1,579	
		Ward Attender	0	0	0	£12	£0	-£12	£0	-£12	
		OP Procedure	0	0	0	£15	£0	-£15	£0	-£15	
	Gynaecology Total		**67**	**93**	**26**	**£9,034**	**£10,900**	**£1,866**	**-£88**	**£1,954**	
	Intensive Care	Elective	0	2	2	£849	£3,607	£2,757	-£449	£3,206	
		Non Elective	15	18	3	£33,570	£99,175	£65,605	£58,530	£7,075	
		Excess Bed Days	31	69	38	£11,641	£29,756	£18,116	£3,573	£14,543	
		Outpatient New	9	13	4	£6,708	£9,584	£2,875	-£11	£2,886	
		Outpatient Follow-up	35	63	28	£24,730	£46,445	£21,715	£2,181	£19,534	
		Ward Based Outpatient	5	0	-5	£3,193	£0	-£3,193	£0	-£3,193	
		OP Procedure	1	3	2	£57	£515	£457	£178	£279	
		PICU	508	559	51	£908,529	£922,975	£14,446	£0	£14,446	
		HDU	416	403	-13	£500,086	£505,516	£5,430	£0	£5,430	
		Cardiac HDU	256	231	-25	£250,398	£179,860	-£70,538	£0	-£70,538	
		Cardiac ECMO	5	0	-5	£16,824	£9,438	-£7,386	£0	-£7,386	
		Respiratory ECMO	8	0	-8	£49,740	£21,944	-£27,796	£0	-£27,796	
	Intensive Care Total		**1,287**	**1,361**	**74**	**£1,806,326**	**£1,828,814**	**£22,489**	**£64,002**	**-£41,514**	
	Maxillo-Facial	Outpatient New	75	43	-32	£10,740	£5,898	-£4,842	-£271	-£4,571	
		Outpatient Follow-up	148	51	-97	£21,436	£7,911	-£13,524	£521	-£14,045	
		Ward Attender	0	0	0	£19	£0	-£19	£0	-£19	
		OP Procedure	0	0	0	£44	£0	-£44	£0	-£44	
	Maxillo-Facial Total		**223**	**94**	**-129**	**£32,239**	**£13,809**	**-£18,429**	**£250**	**-£18,679**	
	Neonatology	Elective	0	1	1	£0	£5,305	£5,305	£0	£5,305	
		Non Elective	0	1	1	£0	£7,699	£7,699	£0	£7,699	
	Neonatology Total		**0**	**2**	**2**	**£0**	**£13,004**	**£13,004**	**£0**	**£13,004**	
	Neurosurgery	Daycase	1	2	1	£741	£1,589	£848	£225	£623	
		Elective	18	42	24	£110,348	£183,779	£73,431	-£74,839	£148,270	
		Non Elective	28	16	-12	£177,433	£141,430	-£36,003	£40,364	-£76,367	
		Excess Bed Days	67	12	-55	£22,292	£4,298	-£17,994	£277	-£18,271	
		Outpatient New	68	61	-7	£6,104	£5,428	-£676	-£55	-£621	
		Outpatient Follow-up	187	167	-20	£16,370	£14,861	-£1,509	£266	-£1,775	
		Ward Attender	41	19	-22	£3,619	£1,691	-£1,928	£0	-£1,928	
		Ward Based Outpatient	0	0	0	£11	£0	-£11	£0	-£11	
		OP Procedure	0	0	0	£29	£0	-£29	£0	-£29	
		Neuro HDU	146	189	43	£142,626	£163,928	£21,302	£0	£21,302	
	Neurosurgery Total		**556**	**508**	**-48**	**£479,574**	**£517,004**	**£37,430**	**-£33,762**	**£71,192**	
	Ophthalmology	Daycase	43	30	-13	£38,084	£23,594	-£14,490	-£3,043	-£11,446	
		Elective	9	0	-9	£13,065	£0	-£13,065	£0	-£13,065	
		Non Elective	1	1	0	£2,129	£2,173	£43	£744	-£700	
		Excess Bed Days	6	0	-6	£2,173	£0	-£2,173	£0	-£2,173	
		Outpatient New	314	266	-48	£47,655	£41,486	-£6,169	£1,079	-£7,248	
		Outpatient Follow-up	1,169	1,142	-27	£116,589	£111,872	-£4,717	-£2,044	-£2,673	
		Ward Based Outpatient	2	0	-2	£229	£0	-£229	£0	-£229	
		OP Procedure	0	73	73	£66	£8,377	£8,311	-£4,242	£12,553	
	Ophthalmology Total		**1,545**	**1,512**	**-33**	**£219,991**	**£187,502**	**-£32,489**	**-£7,507**	**-£24,982**	
	Oral Surgery	Daycase	35	22	-13	£29,935	£20,319	-£9,616	£1,498	-£11,114	
		Elective	16	3	-13	£34,058	£8,512	-£25,546	£1,975	-£27,520	
		Non Elective	12	3	-9	£12,568	£3,548	-£9,020	£292	-£9,312	
		Excess Bed Days	2	0	-2	£1,054	£0	-£1,054	£0	-£1,054	
	Oral Surgery Total		**64**	**28**	**-36**	**£77,615**	**£32,379**	**-£45,235**	**£3,765**	**-£49,000**	
	Orthodontics	Daycase	0	0	0	£92	£0	-£92	£0	-£92	
		Outpatient New	5	8	3	£882	£1,289	£408	-£3	£411	
		Outpatient Follow-up	17	36	19	£1,433	£2,950	£1,517	-£46	£1,563	
		OP Procedure	14	30	16	£1,762	£3,958	£2,196	£131	£2,065	
	Orthodontics Total		**37**	**74**	**37**	**£4,169**	**£8,197**	**£4,028**	**£82**	**£3,947**	
	Paediatric Surgery	Daycase	120	123	3	£141,499	£147,540	£6,041	£3,093	£2,948	
		Elective	49	40	-9	£206,499	£148,492	-£58,007	-£21,371	-£36,635	
		Non Elective	114	135	21	£444,608	£330,240	-£114,369	-£196,249	£81,881	
		Excess Bed Days	231	68	-163	£91,298	£24,279	-£67,019	-£2,579	-£64,440	
		Outpatient New	194	175	-19	£34,387	£30,936	-£3,451	-£41	-£3,409	
		Outpatient Follow-up	306	323	17	£35,363	£36,971	£1,609	-£400	£2,008	
		Ward Attender	75	62	-13	£8,626	£7,092	-£1,534	-£81	-£1,453	
		Ward Based Outpatient	32	13	-19	£3,758	£1,487	-£2,271	-£17	-£2,254	
		OP Procedure	0	0	0	£15	£0	-£15	£0	-£15	
		Neonatal HDU	155	240	85	£110,046	£110,046	-£0	£0	-£0	
	Paediatric Surgery Total		**1,276**	**1,179**	**-97**	**£1,076,099**	**£837,084**	**-£239,015**	**-£217,646**	**-£21,370**	
	Plastic Surgery	Daycase	67	82	15	£68,999	£98,469	£29,470	£14,152	£15,318	
		Elective	25	7	-18	£38,555	£32,445	-£6,110	£21,829	-£27,939	
		Non Elective	95	72	-23	£116,860	£104,876	-£11,984	£16,099	-£28,084	
		Excess Bed Days	3	1	-2	£779	£296	-£482	£70	-£552	
		Outpatient New	241	183	-58	£34,274	£26,307	-£7,966	£262	-£8,229	
		Outpatient Follow-up	454	360	-94	£50,271	£39,307	-£10,965	-£540	-£10,424	
		Ward Attender	3	14	11	£284	£1,529	£1,244	-£29	£1,273	
		Ward Based Outpatient	10	8	-2	£1,152	£874	-£279	-£16	-£262	
		OP Procedure	67	184	117	£8,043	£23,032	£14,989	£1,033	£13,956	
	Plastic Surgery Total		**966**	**911**	**-55**	**£319,218**	**£327,135**	**£7,917**	**£52,860**	**-£44,943**	
	Spinal Surgery	Daycase	0	0	0	£623	£0	-£623	£0	-£623	
		Elective	14	9	-5	£359,196	£198,295	-£160,901	-£39,404	-£121,497	
		Outpatient New	22	48	26	£3,744	£8,086	£4,342	-£20	£4,363	
		Outpatient Follow-up	77	76	-1	£8,144	£7,824	-£320	-£256	-£64	
	Spinal Surgery Total		**113**	**133**	**20**	**£371,707**	**£214,205**	**-£157,502**	**-£39,681**	**-£117,822**	
	Trauma And Orthopaedics	Daycase	44	65	21	£64,823	£84,108	£19,286	-£11,228	£30,514	
		Elective	65	62	-3	£243,239	£291,356	£48,118	£58,915	-£10,797	
		Non Elective	60	27	-33	£149,249	£64,203	-£85,046	-£3,428	-£81,617	
		Excess Bed Days	34	19	-15	£11,478	£6,938	-£4,540	£483	-£5,023	

In-Month

	Trauma And Orthopaedics	Outpatient New	756	627	-129	£113,999	£94,539	-£19,460	£23	-£19,483	Activity high due to physio activity recorded under this spec
		Outpatient Follow-up	1,124	1,380	256	£113,502	£137,480	£23,978	-£1,835	£25,813	
		Gait New	22	24	2	£26,062	£28,128	£2,066	-£34	£2,101	
		Gait Follow-Up	18	17	-1	£21,183	£19,924	-£1,259	£48	-£1,306	
		Ward Attender	0	1	1	£26	£98	£72	-£3	£75	
		OP Procedure	43	185	142	£7,632	£41,414	£33,781	£8,941	£24,841	Activity high due to fracture clinic coding
	Trauma And Orthopaedics Total		**2,167**	**2,407**	**240**	**£751,191**	**£768,188**	**£16,997**	**£51,880**	**-£34,883**	
	Urology	Daycase	147	211	64	£137,652	£188,726	£51,074	-£8,765	£59,838	
		Elective	13	15	2	£49,991	£58,493	£8,503	-£112	£8,615	
		Non Elective	3	6	3	£10,076	£10,866	£790	-£10,226	£11,016	
		Excess Bed Days	5	0	-5	£2,171	£0	-£2,171	£0	-£2,171	
		Outpatient New	108	97	-11	£19,370	£17,450	-£1,920	-£20	-£1,901	
		Outpatient Follow-up	224	205	-19	£34,157	£30,697	-£3,460	-£531	-£2,929	
		Ward Attender	3	3	0	£526	£449	-£77	-£8	-£69	
		Ward Based Outpatient	0	1	1	£58	£150	£91	-£3	£94	
		OP Procedure	0	0	0	£22	£0	-£22	£0	-£22	
	Urology Total		**504**	**538**	**34**	**£254,023**	**£306,830**	**£52,807**	**-£19,664**	**£72,471**	
Surgery CBU Total			**12,468**	**12,202**	**-266**	**£6,905,555**	**£6,580,382**	**-£325,173**	**-£107,378**	**-£217,795**	
Medicine CBU	Accident & Emergency	Daycase	0	0	0	£151	£0	-£151	£0	-£151	
		Elective	0	0	0	£166	£0	-£166	£0	-£166	
		Non Elective	446	318	-128	£204,589	£225,367	£20,778	£79,341	-£58,563	
		Excess Bed Days	6	6	0	£2,163	£1,797	-£366	-£380	£14	
		Outpatient New	216	134	-82	£72,885	£44,906	-£27,979	-£255	-£27,724	
		Outpatient Follow-up	23	9	-14	£7,686	£3,039	-£4,647	-£0	-£4,647	
		Ward Attender	1	0	-1	£173	£0	-£173	£0	-£173	
		A&E Attendance	4,287	4,533	246	£407,300	£399,308	-£7,992	-£31,319	£23,327	
	Accident & Emergency Total		**4,979**	**5,000**	**21**	**£695,113**	**£674,416**	**-£20,696**	**£47,387**	**-£68,084**	
	Allergy	Outpatient New	65	74	9	£14,990	£17,124	£2,135	£84	£2,051	
		Outpatient Follow-up	73	98	25	£10,292	£13,933	£3,641	£103	£3,538	
		Ward Attender	0	1	1	£47	£140	£94	-£1	£94	
		Ward Based Outpatient	0	0	0	£31	£0	-£31	£0	-£31	
		OP Procedure	0	1	1	£49	£172	£123	£45	£78	
	Allergy Total		**139**	**174**	**35**	**£25,408**	**£31,369**	**£5,961**	**£231**	**£5,730**	
	Dermatology	Daycase	2	7	5	£1,243	£5,508	£4,265	£1,084	£3,181	
		Outpatient New	174	149	-25	£23,515	£20,142	-£3,372	-£22	-£3,350	
		Outpatient Follow-up	570	467	-103	£56,154	£45,648	-£10,506	-£370	-£10,136	
		Ward Attender	1	0	-1	£63	£0	-£63	£0	-£63	
		Ward Based Outpatient	8	7	-1	£819	£684	-£135	-£6	-£129	
		OP Procedure	93	100	7	£10,644	£11,372	£728	-£124	£852	
	Dermatology Total		**847**	**730**	**-117**	**£92,438**	**£83,354**	**-£9,084**	**£562**	**-£9,646**	
	Diabetes	Outpatient New	31	7	-24	£6,585	£1,478	-£5,107	-£10	-£5,097	
		Outpatient Follow-up	3	18	15	£297	£1,778	£1,481	-£183	£1,664	
		Ward Attender	0	1	1	£0	£99	£99	£0	£99	
		Ward Based Outpatient	0	0	0	£42	£0	-£42	£0	-£42	
	Diabetes Total		**34**	**26**	**-8**	**£6,924**	**£3,355**	**-£3,569**	**-£193**	**-£3,376**	
	Endocrinology	Daycase	96	91	-5	£100,184	£98,880	-£1,304	£3,926	-£5,231	
		Elective	8	5	-3	£11,116	£6,684	-£4,432	-£472	-£3,960	
		Non Elective	2	2	0	£3,622	£11,621	£7,999	£8,462	-£463	
		Excess Bed Days	13	3	-10	£4,667	£1,294	-£3,373	£188	-£3,561	
		Outpatient New	68	63	-5	£27,207	£25,222	-£1,985	-£66	-£1,919	
		Outpatient Follow-up	378	306	-72	£73,152	£59,563	-£13,588	£385	-£13,974	
		Ward Attender	17	21	4	£3,289	£4,062	£772	£1	£772	
		Ward Based Outpatient	34	64	30	£6,628	£12,379	£5,751	£2	£5,749	
	Endocrinology Total		**616**	**555**	**-61**	**£229,866**	**£219,705**	**-£10,161**	**£12,425**	**-£22,586**	
	Epilepsy	Outpatient New	12	6	-6	£2,622	£1,329	-£1,293	-£3	-£1,290	
		Outpatient Follow-up	27	10	-17	£5,012	£1,768	-£3,244	-£61	-£3,184	
	Epilepsy Total		**39**	**16**	**-23**	**£7,634**	**£3,097**	**-£4,537**	**-£64**	**-£4,473**	
	Gastroenterology	Daycase	135	133	-2	£148,157	£162,997	£14,840	£16,985	-£2,145	
		Elective	43	13	-30	£81,626	£28,600	-£53,027	£3,692	-£56,719	
		Non Elective	10	7	-3	£26,734	£21,959	-£4,776	£3,482	-£8,257	
		Excess Bed Days	169	21	-148	£66,847	£8,925	-£57,922	£627	-£58,549	
		Outpatient New	106	57	-49	£28,202	£15,233	-£12,969	£114	-£13,083	
		Outpatient Follow-up	285	162	-123	£45,331	£25,269	-£20,062	-£467	-£19,595	
		Ward Attender	6	21	15	£992	£3,276	£2,283	-£50	£2,333	
		Ward Based Outpatient	217	119	-98	£34,386	£18,563	-£15,823	-£281	-£15,542	
	Gastroenterology Total		**972**	**533**	**-439**	**£432,276**	**£284,821**	**-£147,456**	**£24,102**	**-£171,558**	
	Haematology	Daycase	25	49	24	£29,772	£51,057	£21,285	-£7,963	£29,248	
		Elective	3	5	2	£21,661	£26,656	£4,995	-£8,235	£13,230	
		Non Elective	16	21	5	£46,823	£48,194	£1,372	-£14,867	£16,239	
		Excess Bed Days	4	66	62	£1,625	£23,587	£21,962	-£5,034	£26,996	
		Outpatient New	23	27	4	£10,408	£12,229	£1,821	-£139	£1,960	
		Outpatient Follow-up	158	49	-109	£34,441	£10,600	-£23,841	-£94	-£23,747	
		Ward Attender	82	177	95	£18,004	£37,917	£19,913	-£715	£20,629	
		Ward Based Outpatient	0	0	0	£28	£0	-£28	£0	-£28	
		OP Procedure	0	0	0	£16	£0	-£16	£0	-£16	
	Haematology Total		**310**	**394**	**84**	**£162,777**	**£210,241**	**£47,463**	**-£37,047**	**£84,510**	
	Immunology	Outpatient New	13	23	10	£3,063	£5,323	£2,261	£27	£2,234	
		Outpatient Follow-up	10	35	25	£1,372	£5,023	£3,651	£84	£3,567	
		Ward Attender	4	12	8	£616	£1,685	£1,068	-£9	£1,077	
		Ward Based Outpatient	17	51	34	£2,422	£7,160	£4,738	-£37	£4,775	
	Immunology Total		**45**	**121**	**76**	**£7,473**	**£19,191**	**£11,717**	**£65**	**£11,653**	
	Metabolic Disease	Outpatient New	5	5	0	£1,997	£1,920	-£77	£0	-£77	
		Outpatient Follow-up	31	20	-11	£12,048	£7,680	-£4,368	£0	-£4,368	
		Ward Attender	0	1	1	£0	£384	£384	£0	£384	
		Ward Based Outpatient	0	7	7	£0	£2,688	£2,688	£0	£2,688	
	Metabolic Disease Total		**37**	**33**	**-4**	**£14,045**	**£12,672**	**-£1,373**	**£0**	**-£1,373**	
	Nephrology	Daycase	99	130	31	£63,699	£112,101	£48,402	£28,257	£20,145	
		Elective	33	4	-29	£20,700	£15,405	-£5,295	£12,858	-£18,154	
		Non Elective	4	4	0	£6,892	£16,926	£10,033	£9,411	£623	
		Excess Bed Days	16	0	-16	£6,031	£0	-£6,031	£0	-£6,031	
		Outpatient New	16	20	4	£1,937	£2,361	£424	£0	£423	
		Outpatient Follow-up	131	97	-34	£15,433	£11,450	-£3,983	-£0	-£3,983	
		Ward Attender	83	73	-10	£9,782	£8,617	-£1,165	-£0	-£1,165	
		Ward Based Outpatient	59	55	-4	£6,959	£6,492	-£467	£0	-£467	
	Nephrology Total		**440**	**383**	**-57**	**£131,435**	**£173,352**	**£41,917**	**£50,526**	**-£8,609**	
	Neurology	Daycase	9	7	-2	£10,096	£11,498	£1,402	£3,451	-£2,049	
		Elective	6	9	3	£13,393	£17,213	£3,820	-£1,785	£5,605	
		Non Elective	8	7	-1	£15,469	£12,764	-£2,706	-£1,127	-£1,579	
		Excess Bed Days	51	19	-32	£20,486	£5,690	-£14,796	-£2,010	-£12,785	
		Outpatient New	94	55	-39	£26,056	£15,247	-£10,809	-£54	-£10,755	
		Outpatient Follow-up	272	181	-91	£74,269	£50,175	-£24,094	£696	-£24,790	
		Ward Attender	2	14	12	£638	£3,881	£3,243	-£0	£3,243	
		Ward Based Outpatient	25	0	-25	£6,878	£0	-£6,878	£0	-£6,878	
	Neurology Total		**466**	**292**	**-174**	**£167,285**	**£116,468**	**-£50,817**	**-£830**	**-£49,988**	
	Oncology	Daycase	185	98	-87	£140,862	£74,020	-£66,842	-£656	-£66,186	
		DCHEMO	144	158	14	£48,006	£52,484	£4,478	-£125	£4,603	
		Elective	27	20	-7	£167,274	£142,142	-£25,132	£20,404	-£45,537	
		Non Elective	34	40	6	£85,169	£94,193	£9,024	-£6,878	£15,902	
		Excess Bed Days	28	7	-21	£12,736	£3,019	-£9,717	-£161	-£9,556	
		Outpatient New	11	7	-4	£2,726	£1,813	-£914	-£0	-£914	
		Outpatient Follow-up	261	247	-14	£67,380	£63,958	-£3,421	£166	-£3,587	
		Ward Attender	14	38	24	£3,732	£9,840	£6,107	£26	£6,082	
		Ward Based Outpatient	19	5	-14	£4,888	£1,295	-£3,594	£3	-£3,597	
	Oncology Total		**723**	**620**	**-103**	**£532,775**	**£442,764**	**-£90,011**	**£12,778**	**-£102,790**	
	Paediatrics	Daycase	33	33	0	£27,263	£17,274	-£9,990	-£10,317	£327	
		Elective	14	6	-8	£15,325	£8,848	-£6,478	£2,122	-£8,600	
		Non Elective	255	395	140	£289,297	£490,504	£201,207	£42,619	£158,587	
		Excess Bed Days	68	171	103	£25,131	£64,484	£39,353	£951	£38,402	
		Outpatient New	321	275	-46	£74,010	£63,484	-£10,526	£158	-£10,684	
		Outpatient Follow-up	440	376	-64	£62,151	£52,783	-£9,367	-£276	-£9,091	
		Ward Attender	19	7	-12	£2,617	£983	-£1,634	-£5	-£1,629	
		Ward Based Outpatient	169	9	-160	£23,877	£1,264	-£22,613	-£7	-£22,606	
		OP Procedure	0	1	1	£32	£172	£139	£45	£94	
	Paediatrics Total		**1,319**	**1,273**	**-46**	**£519,703**	**£699,794**	**£180,091**	**£35,291**	**£144,801**	
	Radiology	Daycase	113	120	7	£114,206	£179,710	£65,503	£57,907	£7,597	
		Elective	15	6	-9	£24,386	£9,605	-£14,781	-£379	-£14,402	
		Non Elective	3	1	-2	£17,545	£14,356	-£3,190	£7,702	-£10,892	
		Excess Bed Days	58	0	-58	£23,703	£0	-£23,703	£0	-£23,703	
	Radiology Total		**188**	**127**	**-61**	**£179,841**	**£203,670**	**£23,829**	**£65,229**	**-£41,400**	
	Respiratory Medicine	Daycase	10	12	2	£10,181	£9,386	-£794	-£2,488	£1,693	
		Elective	5	2	-3	£12,226	£8,450	-£3,775	£3,696	-£7,471	
		Non Elective	60	67	7	£56,536	£70,550	£14,014	£7,575	£6,439	
		Excess Bed Days	47	15	-32	£14,774	£4,492	-£10,282	-£265	-£10,017	
		Outpatient New	78	41	-37	£23,331	£12,151	-£11,180	-£51	-£11,129	
		Outpatient Follow-up	264	185	-79	£39,723	£29,216	-£10,507	£1,431	-£11,939	
		Ward Attender	1	0	-1	£134	£0	-£134	£0	-£134	
		Ward Based Outpatient	142	56	-86	£21,324	£8,793	-£12,531	£396	-£12,927	
		OP Procedure	144	88	-56	£20,830	£15,099	-£5,731	£2,364	-£8,095	
	Respiratory Medicine Total		**752**	**466**	**-286**	**£199,059**	**£158,137**	**-£40,922**	**£12,659**	**-£53,580**	
	Rheumatology	Daycase	179	131	-48	£149,615	£108,503	-£41,111	-£1,277	-£39,834	

In-Month

	Rheumatology	Elective	21	3	-18	£21,129	£2,560	-£18,569	-£489	-£18,080	
		Non Elective	1	1	0	£1,382	£1,448	£66	£443	-£378	
		Excess Bed Days	10	58	48	£3,905	£18,292	£14,387	-£3,969	£18,356	
		Outpatient New	58	63	5	£8,665	£9,324	£659	-£161	£820	
		Outpatient Follow-up	174	177	3	£26,245	£26,619	£374	-£29	£403	
		Ward Attender	26	26	0	£3,943	£3,910	-£33	-£0	-£33	
		Ward Based Outpatient	13	11	-2	£1,923	£1,654	-£269	£0	-£269	
		OP Procedure	0	1	1	£15	£172	£156	£52	£104	
	Rheumatology Total		**482**	**471**	**-11**	**£216,822**	**£172,483**	**-£44,339**	**-£5,429**	**-£38,910**	
	Sleep Studies	Elective	26	16	-10	£46,711	£25,284	-£21,426	-£3,921	-£17,505	
	Sleep Studies Total		**26**	**16**	**-10**	**£46,711**	**£25,284**	**-£21,426**	**-£3,921**	**-£17,505**	
Medicine CBU Total			**12,413**	**11,230**	**-1,183**	**£3,667,585**	**£3,534,172**	**-£133,413**	**£213,771**	**-£347,185**	Note that physio income is within T&O (Surgery)
Community CBU	CAMHS	Elective	0	0	0	£249	£0	-£249	£0	-£249	
		Outpatient New	201	214	13	£0	£0	£0	£0	£0	
		Outpatient Follow-up	1,002	1,498	496	£13,991	£6,239	-£7,752	-£14,671	£6,919	
		Ward Based Outpatient	0	1	1	£0	£0	£0	£0	£0	
	CAMHS Total		**1,204**	**1,713**	**509**	**£14,240**	**£6,239**	**-£8,001**	**-£14,671**	**£6,670**	
	Community Medicine	Outpatient New	381	366	-15	£30,802	£28,183	-£2,618	-£1,371	-£1,248	
		Outpatient Follow-up	750	697	-53	£4,581	£2,296	-£2,285	-£1,959	-£326	
		Ward Based Outpatient	1	0	-1	£0	£0	£0	£0	£0	
		OP Procedure	0	0	0	£15	£0	-£15	£0	-£15	
	Community Medicine Total		**1,133**	**1,063**	**-70**	**£35,397**	**£30,479**	**-£4,918**	**-£3,330**	**-£1,588**	
Community CBU Total			**2,337**	**2,776**	**439**	**£49,637**	**£36,718**	**-£12,918**	**-£18,000**	**£5,082**	
Grand Total			**27,218**	**26,208**	**-1,010**	**£10,622,777**	**£10,151,272**	**-£471,505**	**£88,393**	**-£559,898**	

Year-to-date

CBU	Specialty	POD	Activity Plan	Activity Actual	Activity Variance	Income Plan	Income Actual	Income Variance	Income Variance (case-mix)	Income Variance (volume)	
Surgery CBU	Audiology	Outpatient New	7,615	6,059	-1,556	£722,428	£574,726	-£147,702	-£86	-£147,616	
		Outpatient Follow-up	2,607	3,321	714	£246,430	£313,773	£67,344	-£95	£67,438	
		Ward Based Outpatient	0	1	1	£0	£95	£95	£0	£95	
		OP Procedure	13	28	15	£1,546	£3,654	£2,109	£432	£1,677	
	Audiology Total		**10,236**	**9,409**	**-827**	**£970,403**	**£892,248**	**-£78,156**	**£251**	**-£78,407**	
	Burns Care	Daycase	1	68	67	£1,533	£140,956	£139,422	£24,540	£114,883	
		Elective	71	14	-57	£180,905	£39,727	-£141,178	£4,196	-£145,374	
		Non Elective	304	271	-33	£770,698	£735,796	-£34,902	£48,725	-£83,627	
		Outpatient New	337	171	-166	£66,571	£33,464	-£33,107	-£353	-£32,754	
		Outpatient Follow-up	932	755	-177	£106,368	£86,304	-£20,064	£135	-£20,199	
		Ward Attender	44	381	337	£5,066	£43,552	£38,486	£0	£38,486	
		Ward Based Outpatient	124	75	-49	£14,122	£8,573	-£5,549	£0	-£5,549	
		OP Procedure	1	35	34	£168	£4,417	£4,250	£44	£4,205	
	Burns Care Total		**1,814**	**1,770**	**-44**	**£1,145,432**	**£1,092,790**	**-£52,642**	**£77,286**	**-£129,928**	
	Cardiac Surgery	Elective	285	258	-27	£3,657,794	£3,175,294	-£482,500	-£134,976	-£347,524	Includes £28k estimated flex/freeze benefit
		Non Elective	116	133	17	£2,253,564	£2,318,747	£65,182	-£256,594	£321,776	
		Excess Bed Days	724	1,303	579	£323,370	£565,590	£242,221	-£16,724	£258,944	
		Outpatient New	95	122	27	£68,208	£87,839	£19,631	-£0	£19,631	
		Outpatient Follow-up	298	319	21	£214,290	£229,677	£15,387	-£0	£15,387	
		Ward Attender	0	17	17	£0	£12,240	£12,240	£0	£12,240	
		OP Procedure	0	4	4	£0	£686	£686	£0	£686	
	Cardiac Surgery Total		**1,517**	**2,156**	**639**	**£6,517,225**	**£6,390,073**	**-£127,153**	**-£408,293**	**£281,141**	
	Cardiology	Daycase	213	197	-16	£581,318	£623,888	£42,571	£85,922	-£43,351	
		Elective	240	200	-40	£945,649	£749,970	-£195,679	-£38,094	-£157,585	
		Non Elective	124	134	10	£579,610	£492,242	-£87,368	-£135,873	£48,505	
		Excess Bed Days	190	435	245	£76,844	£176,570	£99,726	£473	£99,252	
		Outpatient New	1,799	1,669	-130	£428,832	£397,437	-£31,395	-£451	-£30,944	
		Outpatient Follow-up	4,374	5,547	1,173	£577,889	£721,015	£143,126	-£11,797	£154,923	
		Ward Attender	117	215	98	£15,398	£27,948	£12,550	-£449	£12,999	
		Ward Based Outpatient	314	87	-227	£41,416	£11,309	-£30,107	-£182	-£29,925	
		OP Procedure	0	3	3	£0	£501	£501	£0	£501	
	Cardiology Total		**7,370**	**8,487**	**1,117**	**£3,246,955**	**£3,200,880**	**-£46,075**	**-£100,451**	**£54,376**	
	Dentistry	Daycase	1,073	1,127	54	£621,662	£646,075	£24,413	-£6,903	£31,316	
		Elective	121	18	-103	£75,447	£16,425	-£59,022	£5,226	-£64,248	
		Non Elective	12	3	-9	£13,353	£2,993	-£10,360	-£263	-£10,097	
		Excess Bed Days	12	1	-11	£3,603	£299	-£3,303	£0	-£3,303	
		Outpatient New	1,254	1,162	-92	£44,914	£41,332	-£3,582	-£292	-£3,290	
		Outpatient Follow-up	1,603	1,136	-467	£57,101	£40,408	-£16,693	-£58	-£16,636	
		Ward Attender	0	2	2	£0	£71	£71	£0	£71	
		OP Procedure	336	336	0	£54,145	£54,168	£23	-£23	£45	
	Dentistry Total		**4,411**	**3,785**	**-626**	**£870,225**	**£801,771**	**-£68,454**	**-£2,312**	**-£66,142**	
	ENT	Daycase	1,207	1,126	-81	£1,370,206	£1,247,541	-£122,665	-£31,215	-£91,450	
		Elective	1,018	760	-258	£1,439,287	£1,125,872	-£313,415	£51,543	-£364,958	
		Non Elective	253	284	31	£395,544	£414,152	£18,608	-£29,029	£47,637	
		Excess Bed Days	311	312	1	£124,473	£146,828	£22,355	£21,973	£381	
		Outpatient New	3,801	2,988	-813	£420,830	£332,715	-£88,115	£1,898	-£90,014	
		Outpatient Follow-up	5,476	3,886	-1,590	£373,862	£266,808	-£107,054	£1,504	-£108,558	
		Ward Attender	3	9	6	£183	£618	£434	£3	£431	
		Ward Based Outpatient	52	0	-52	£3,575	£0	-£3,575	£0	-£3,575	
		OP Procedure	1,881	3,133	1,252	£246,385	£397,418	£151,033	-£12,880	£163,913	
	ENT Total		**14,003**	**12,498**	**-1,505**	**£4,374,345**	**£3,931,951**	**-£442,394**	**£3,798**	**-£446,192**	
	Gynaecology	Daycase	13	24	11	£11,127	£17,443	£6,316	-£3,509	£9,825	
		Elective	6	15	9	£6,986	£21,994	£15,008	£4,051	£10,957	
		Non Elective	0	3	3	£0	£3,787	£3,787	£0	£3,787	
		Outpatient New	256	291	35	£36,781	£41,759	£4,978	-£44	£5,021	
		Outpatient Follow-up	422	487	65	£39,678	£45,071	£5,393	-£706	£6,099	
		Ward Attender	1	0	-1	£126	£0	-£126	£0	-£126	
		Ward Based Outpatient	0	1	1	£0	£93	£93	£0	£93	
		OP Procedure	1	0	-1	£160	£0	-£160	£0	-£160	
	Gynaecology Total		**699**	**821**	**122**	**£94,858**	**£130,147**	**£35,289**	**-£207**	**£35,496**	
	Intensive Care	Elective	4	13	9	£8,917	£30,099	£21,182	£3,740	£17,442	
		Non Elective	177	180	3	£400,434	£736,194	£335,760	£329,743	£6,018	
		Excess Bed Days	322	319	-3	£122,235	£125,878	£3,642	£4,827	-£1,184	
		Outpatient New	95	173	78	£70,442	£127,539	£57,097	-£142	£57,238	
		Outpatient Follow-up	370	980	610	£259,683	£721,738	£462,055	£33,187	£428,868	
		Ward Based Outpatient	48	47	-1	£33,524	£34,649	£1,125	£2,057	-£932	
		OP Procedure	5	36	31	£602	£5,606	£5,004	£1,570	£3,433	
		PICU	5,589	6,198	609	£9,993,815	£10,599,589	£605,774	£0	£605,774	
		HDU	4,573	4,223	-350	£5,500,947	£5,667,163	£166,216	£0	£166,216	
		Cardiac HDU	2,816	2,603	-213	£2,754,377	£2,067,922	-£686,455	£0	-£686,455	
		Cardiac ECMO	51	208	157	£185,065	£487,072	£302,007	£0	£302,007	
		Respiratory ECMO	83	74	-9	£547,140	£519,692	-£27,448	£0	-£27,448	
	Intensive Care Total		**14,135**	**15,054**	**919**	**£19,877,183**	**£21,123,142**	**£1,245,959**	**£374,982**	**£870,977**	
	Maxillo-Facial	Outpatient New	786	650	-136	£112,781	£89,312	-£23,469	-£3,948	-£19,521	
		Outpatient Follow-up	1,553	644	-909	£225,086	£98,633	-£126,453	£5,313	-£131,766	
		Ward Attender	1	1	0	£196	£133	-£63	-£13	-£50	
		OP Procedure	3	12	9	£463	£1,541	£1,078	-£529	£1,607	
	Maxillo-Facial Total		**2,343**	**1,307**	**-1,036**	**£338,526**	**£189,619**	**-£148,907**	**£824**	**-£149,731**	
	Neonatology	Elective	0	1	1	£0	£5,305	£5,305	£0	£5,305	
		Non Elective	0	1	1	£0	£7,699	£7,699	£0	£7,699	
	Neonatology Total		**0**	**2**	**2**	**£0**	**£13,004**	**£13,004**	**£0**	**£13,004**	
	Neurosurgery	Daycase	11	16	5	£7,781	£12,790	£5,009	£1,880	£3,129	
		Elective	188	274	86	£1,158,720	£1,383,754	£225,034	-£303,424	£528,459	
		Non Elective	335	252	-83	£2,116,468	£1,636,475	-£479,993	£44,689	-£524,682	
		Excess Bed Days	794	559	-235	£265,904	£187,329	-£78,575	£33	-£78,608	
		Outpatient New	713	696	-17	£64,101	£61,937	-£2,164	-£628	-£1,536	
		Outpatient Follow-up	1,967	1,863	-104	£171,898	£165,788	-£6,109	£2,973	-£9,082	
		Ward Attender	427	334	-93	£38,002	£29,723	-£8,279	£0	-£8,279	
		Ward Based Outpatient	1	35	34	£120	£3,115	£2,995	£0	£2,995	
		OP Procedure	3	0	-3	£306	£0	-£306	£0	-£306	
		Neuro HDU	1,606	2,039	433	£1,568,891	£1,891,698	£322,807	£0	£322,807	
	Neurosurgery Total		**6,045**	**6,068**	**23**	**£5,392,189**	**£5,372,608**	**-£19,581**	**-£254,478**	**£234,897**	
	Ophthalmology	Daycase	450	309	-141	£399,900	£262,967	-£136,934	-£11,397	-£125,537	
		Elective	98	46	-52	£137,192	£69,868	-£67,324	£5,606	-£72,930	
		Non Elective	18	10	-8	£25,398	£14,368	-£11,030	£81	-£11,111	
		Excess Bed Days	72	0	-72	£25,919	£0	-£25,919	£0	-£25,919	
		Outpatient New	3,294	3,037	-257	£500,410	£473,233	-£27,177	£11,891	-£39,068	
		Outpatient Follow-up	12,273	10,674	-1,599	£1,224,248	£1,070,206	-£154,042	£5,462	-£159,504	
		Ward Attender	0	2	2	£0	£171	£171	£0	£171	
		Ward Based Outpatient	24	11	-13	£2,409	£938	-£1,471	-£158	-£1,313	
		OP Procedure	4	309	305	£696	£35,644	£34,948	-£17,772	£52,720	
	Ophthalmology Total		**16,233**	**14,398**	**-1,835**	**£2,316,173**	**£1,927,395**	**-£388,778**	**-£6,288**	**-£382,490**	
	Oral Surgery	Daycase	367	316	-51	£314,331	£292,204	-£22,127	£21,867	-£43,994	
		Elective	164	125	-39	£357,628	£397,699	£40,071	£125,300	-£85,229	
		Non Elective	138	85	-53	£149,919	£102,905	-£47,015	£10,645	-£57,660	
		Excess Bed Days	23	11	-12	£12,571	£5,536	-£7,034	-£507	-£6,528	
	Oral Surgery Total		**693**	**537**	**-156**	**£834,450**	**£798,345**	**-£36,105**	**£157,305**	**-£193,410**	
	Orthodontics	Daycase	1	2	1	£965	£1,085	£120	-£1,069	£1,189	
		Non Elective	0	1	1	£0	£980	£980	£0	£980	
		Outpatient New	57	54	-3	£9,260	£8,866	-£394	£139	-£533	
		Outpatient Follow-up	181	349	168	£15,048	£28,639	£13,591	-£402	£13,993	
		OP Procedure	145	272	127	£18,502	£36,215	£17,714	£1,516	£16,197	
	Orthodontics Total		**384**	**678**	**294**	**£43,775**	**£75,784**	**£32,010**	**£183**	**£31,826**	
	Paediatric Surgery	Daycase	1,265	1,272	7	£1,485,820	£1,532,665	£46,845	£38,874	£7,971	
		Elective	511	469	-42	£2,168,357	£1,876,411	-£291,946	-£115,238	-£176,708	
		Non Elective	1,360	1,559	199	£5,303,420	£4,758,465	-£544,955	-£1,321,510	£776,555	
		Excess Bed Days	2,757	1,102	-1,655	£1,089,032	£424,522	-£664,510	-£10,737	-£653,774	
		Outpatient New	2,040	1,959	-81	£361,080	£346,306	-£14,775	-£464	-£14,311	
		Outpatient Follow-up	3,209	3,247	38	£371,330	£371,760	£431	-£3,915	£4,346	
		Ward Attender	783	839	56	£90,581	£95,973	£5,392	-£1,099	£6,491	
		Ward Based Outpatient	341	102	-239	£39,464	£11,668	-£27,796	-£134	-£27,663	
		OP Procedure	1	11	10	£153	£1,886	£1,733	£634	£1,100	
		Neonatal HDU	1,706	2,641	935	£1,210,511	£1,210,510	-£1	£0	-£1	
	Paediatric Surgery Total		**13,973**	**13,201**	**-772**	**£12,119,748**	**£10,630,166**	**-£1,489,582**	**-£1,413,589**	**-£75,993**	
	Plastic Surgery	Daycase	705	868	163	£724,532	£902,810	£178,278	£10,282	£167,997	
		Elective	267	79	-188	£404,854	£172,003	-£232,851	£52,190	-£285,041	
		Non Elective	1,131	807	-324	£1,393,942	£1,102,660	-£291,281	£107,625	-£398,906	
		Excess Bed Days	41	37	-4	£9,291	£12,450	£3,160	£4,065	-£906	
		Outpatient New	2,529	2,369	-160	£359,894	£340,158	-£19,736	£2,994	-£22,730	
		Outpatient Follow-up	4,769	4,265	-504	£527,880	£465,677	-£62,204	-£6,401	-£55,803	
		Ward Attender	27	155	128	£2,987	£16,924	£13,937	-£316	£14,253	
		Ward Based Outpatient	109	45	-64	£12,099	£4,914	-£7,185	-£92	-£7,093	
		OP Procedure	706	1,370	664	£84,452	£172,011	£87,559	£8,214	£79,346	
	Plastic Surgery Total		**10,283**	**9,995**	**-288**	**£3,519,930**	**£3,189,607**	**-£330,323**	**£178,561**	**-£508,884**	
	Spinal Surgery	Daycase	4	5	1	£6,547	£11,689	£5,142	£3,402	£1,740	
		Elective	143	118	-25	£3,771,768	£3,500,433	-£271,334	£383,934	-£655,268	
		Non Elective	0	5	5	£0	£32,782	£32,782	£0	£32,782	
		Excess Bed Days	0	197	197	£0	£60,795	£60,795	£0	£60,795	
		Outpatient New	233	508	275	£39,311	£85,577	£46,266	-£217	£46,482	
		Outpatient Follow-up	804	878	74	£85,518	£90,387	£4,869	-£2,956	£7,825	

Year-to-date

	Spinal Surgery	OP Procedure	0	8	8	£0	£1,373	£1,373	£0	£1,373	
	Spinal Surgery Total		**1,184**	**1,719**	**535**	**£3,903,143**	**£3,783,035**	**-£120,108**	**£384,162**	**-£504,271**	
	Trauma And Orthopaedics	Daycase	464	491	27	£680,674	£745,657	£64,983	£25,499	£39,484	
		Elective	681	582	-99	£2,554,151	£2,738,013	£183,862	£556,063	-£372,200	
		Non Elective	711	549	-162	£1,780,281	£1,406,695	-£373,586	£31,527	-£405,113	
		Excess Bed Days	403	307	-96	£136,911	£111,791	-£25,120	£7,493	-£32,613	
		Outpatient New	7,941	6,957	-984	£1,197,056	£1,048,977	-£148,078	£253	-£148,332	
		Outpatient Follow-up	11,806	14,904	3,098	£1,191,837	£1,485,336	£293,499	-£19,266	£312,765	Activity high due to physio activity recorded under this spec
		Gait New	233	265	32	£273,661	£310,580	£36,919	-£379	£37,297	
		Gait Follow-Up	190	243	53	£222,432	£284,796	£62,364	£681	£61,684	
		Ward Attender	3	16	13	£271	£1,564	£1,293	-£51	£1,344	
		Ward Based Outpatient	0	10	10	£0	£978	£978	£0	£978	
		OP Procedure	457	2,970	2,513	£80,143	£741,785	£661,642	£220,461	£441,181	Activity high due to fracture clinic coding
	Trauma And Orthopaedics Total		**22,889**	**27,294**	**4,405**	**£8,117,418**	**£8,876,173**	**£758,755**	**£822,281**	**-£63,526**	
	Urology	Daycase	1,544	2,317	773	£1,445,425	£2,218,625	£773,200	£49,977	£723,223	
		Elective	134	188	54	£524,931	£661,671	£136,740	-£72,853	£209,593	
		Non Elective	34	42	8	£120,184	£108,097	-£12,087	-£39,542	£27,454	
		Excess Bed Days	62	16	-46	£25,899	£6,696	-£19,203	£50	-£19,253	
		Outpatient New	1,129	1,085	-44	£203,397	£195,187	-£8,209	-£219	-£7,991	
		Outpatient Follow-up	2,355	2,563	208	£358,670	£383,784	£25,114	-£6,643	£31,757	
		Ward Attender	36	44	8	£5,524	£6,589	£1,065	-£114	£1,179	
		Ward Based Outpatient	4	48	44	£614	£7,188	£6,574	-£124	£6,699	
		OP Procedure	1	1	0	£232	£191	-£40	£19	-£59	
	Urology Total		**5,301**	**6,304**	**1,003**	**£2,684,876**	**£3,588,030**	**£903,154**	**-£69,449**	**£972,602**	
Surgery CBU Total			**133,513**	**135,483**	**1,970**	**£76,366,854**	**£76,006,768**	**-£360,087**	**-£255,433**	**-£104,654**	
Medicine CBU	Accident & Emergency	Daycase	2	1	-1	£1,582	£1,294	-£289	£579	-£867	
		Elective	2	1	-1	£1,741	£23,276	£21,535	£22,304	-£769	
		Non Elective	5,314	4,184	-1,130	£2,440,396	£2,950,347	£509,952	£1,029,057	-£519,106	
		Excess Bed Days	71	45	-26	£25,802	£17,693	-£8,109	£1,366	-£9,475	
		Outpatient New	2,271	1,761	-510	£765,338	£594,246	-£171,091	£753	-£171,845	
		Outpatient Follow-up	239	111	-128	£80,707	£37,478	-£43,229	-£0	-£43,229	
		Ward Attender	5	0	-5	£1,814	£0	-£1,814	£0	-£1,814	
		Ward Based Outpatient	0	1	1	£0	£338	£338	£0	£338	
		OP Procedure	0	1	1	£0	£134	£134	£0	£134	
		A&E Attendance	51,142	52,803	1,661	£4,858,397	£4,630,161	-£228,236	-£386,035	£157,799	
	Accident & Emergency Total		**59,047**	**58,908**	**-139**	**£8,175,777**	**£8,254,967**	**£79,190**	**£668,024**	**-£588,834**	
	Allergy	Outpatient New	684	584	-100	£157,400	£135,187	-£22,212	£706	-£22,918	
		Outpatient Follow-up	766	775	9	£108,073	£109,872	£1,799	£504	£1,295	
		Ward Attender	3	7	4	£490	£983	£492	-£5	£497	
		Ward Based Outpatient	2	4	2	£327	£562	£235	-£3	£238	
		OP Procedure	4	27	23	£510	£3,620	£3,110	£200	£2,909	
	Allergy Total		**1,459**	**1,397**	**-62**	**£266,801**	**£250,223**	**-£16,577**	**£1,402**	**-£17,979**	
	Dermatology	Daycase	21	16	-5	£13,053	£11,157	-£1,897	£1,045	-£2,942	
		Non Elective	0	1	1	£0	£626	£626	£0	£626	
		Outpatient New	1,825	1,702	-123	£246,916	£230,154	-£16,762	-£179	-£16,583	
		Outpatient Follow-up	5,984	6,256	272	£589,651	£612,392	£22,741	-£4,071	£26,812	
		Ward Attender	7	0	-7	£662	£0	-£662	£0	-£662	
		Ward Based Outpatient	87	74	-13	£8,601	£7,234	-£1,368	-£58	-£1,309	
		OP Procedure	972	924	-48	£111,773	£105,967	-£5,805	-£259	-£5,546	
	Dermatology Total		**8,895**	**8,973**	**78**	**£970,656**	**£967,529**	**-£3,127**	**-£3,523**	**£396**	
	Diabetes	Outpatient New	325	91	-234	£69,145	£19,209	-£49,935	-£129	-£49,807	
		Outpatient Follow-up	29	203	174	£3,121	£20,054	£16,932	-£2,064	£18,996	
		Ward Attender	0	1	1	£0	£99	£99	£0	£99	
		Ward Based Outpatient	4	0	-4	£439	£0	-£439	£0	-£439	
	Diabetes Total		**358**	**295**	**-63**	**£72,705**	**£39,362**	**-£33,343**	**-£2,192**	**-£31,151**	
	Endocrinology	Daycase	1,008	992	-16	£1,051,994	£1,069,771	£17,777	£34,672	-£16,894	
		Elective	82	53	-29	£116,724	£71,495	-£45,229	-£4,362	-£40,867	
		Non Elective	27	23	-4	£43,207	£59,516	£16,309	£23,189	-£6,879	
		Excess Bed Days	151	290	139	£55,668	£103,593	£47,925	-£3,297	£51,222	
		Outpatient New	712	654	-58	£285,689	£261,827	-£23,862	-£688	-£23,173	
		Outpatient Follow-up	3,972	3,257	-715	£768,137	£640,098	-£128,039	£10,220	-£138,258	
		Ward Attender	179	189	10	£34,541	£36,556	£2,016	£5	£2,011	
		Ward Based Outpatient	360	886	526	£69,601	£171,370	£101,769	£23	£101,746	
		OP Procedure	0	4	4	£0	£686	£686	£0	£686	
	Endocrinology Total		**6,490**	**6,348**	**-142**	**£2,425,561**	**£2,414,913**	**-£10,648**	**£59,760**	**-£70,408**	
	Epilepsy	Outpatient New	124	95	-29	£27,529	£21,042	-£6,487	-£50	-£6,437	
		Outpatient Follow-up	288	171	-117	£52,632	£30,229	-£22,403	-£1,040	-£21,363	
	Epilepsy Total		**412**	**266**	**-146**	**£80,161**	**£51,270**	**-£28,890**	**-£1,090**	**-£27,800**	
	Gastroenterology	Daycase	1,417	1,307	-110	£1,555,737	£1,506,398	-£49,339	£71,528	-£120,867	
		Elective	447	301	-146	£857,124	£552,886	-£304,237	-£23,821	-£280,416	
		Non Elective	121	86	-35	£318,896	£253,618	-£65,278	£26,613	-£91,891	
		Excess Bed Days	2,018	995	-1,023	£797,367	£370,991	-£426,377	-£22,157	-£404,220	
		Outpatient New	1,116	912	-204	£296,140	£243,727	-£52,413	£1,823	-£54,236	
		Outpatient Follow-up	2,996	2,277	-719	£476,000	£355,165	-£120,835	-£6,565	-£114,270	
		Ward Attender	66	205	139	£10,420	£31,978	£21,558	-£484	£22,042	
		Ward Based Outpatient	2,280	1,011	-1,269	£361,075	£157,706	-£203,370	-£2,388	-£200,982	
	Gastroenterology Total		**10,462**	**7,094**	**-3,368**	**£4,672,759**	**£3,472,469**	**-£1,200,290**	**£44,549**	**-£1,244,839**	
	Haematology	Daycase	260	332	72	£312,623	£351,537	£38,913	-£48,356	£87,269	
		Elective	33	35	2	£227,453	£140,332	-£87,121	-£103,907	£16,786	
		Non Elective	186	204	18	£558,517	£322,108	-£236,409	-£290,492	£54,083	
		Excess Bed Days	45	183	138	£19,385	£62,253	£42,868	-£17,104	£59,973	
		Outpatient New	239	256	17	£109,286	£118,386	£9,100	£1,124	£7,976	
		Outpatient Follow-up	1,657	569	-1,088	£361,655	£125,037	-£236,618	£854	-£237,472	
		Ward Attender	866	1,964	1,098	£189,048	£420,728	£231,680	-£7,935	£239,616	
		Ward Based Outpatient	1	17	16	£293	£3,642	£3,349	-£69	£3,417	
		OP Procedure	1	0	-1	£168	£0	-£168	£0	-£168	
	Haematology Total		**3,287**	**3,560**	**273**	**£1,778,428**	**£1,544,023**	**-£234,405**	**-£465,885**	**£231,480**	
	Immunology	Outpatient New	140	188	48	£32,160	£43,510	£11,350	£218	£11,132	
		Outpatient Follow-up	102	345	243	£14,410	£49,941	£35,531	£1,254	£34,277	
		Ward Attender	46	191	145	£6,474	£26,814	£20,341	-£140	£20,480	
		Ward Based Outpatient	180	536	356	£25,432	£75,249	£49,817	-£392	£50,209	
	Immunology Total		**468**	**1,260**	**792**	**£78,476**	**£195,514**	**£117,039**	**£941**	**£116,098**	
	Metabolic Disease	Outpatient New	55	49	-6	£20,970	£18,816	-£2,154	£0	-£2,155	
		Outpatient Follow-up	329	300	-29	£126,508	£114,816	-£11,692	-£381	-£11,311	
		Ward Attender	0	1	1	£0	£384	£384	£0	£384	
		Ward Based Outpatient	0	46	46	£0	£17,664	£17,664	£0	£17,664	
	Metabolic Disease Total		**384**	**396**	**12**	**£147,478**	**£151,680**	**£4,202**	**-£380**	**£4,582**	
	Nephrology	Daycase	1,037	1,035	-2	£668,879	£894,065	£225,186	£226,538	-£1,351	
		Elective	341	81	-260	£217,366	£139,900	-£77,466	£88,333	-£165,799	
		Non Elective	44	66	22	£82,215	£151,960	£69,744	£27,959	£41,785	
		Excess Bed Days	192	146	-46	£71,943	£60,775	-£11,168	£5,954	-£17,122	
		Outpatient New	172	265	93	£20,343	£31,281	£10,938	£0	£10,938	
		Outpatient Follow-up	1,373	1,484	111	£162,058	£175,171	£13,113	-£2	£13,116	
		Ward Attender	870	809	-61	£102,717	£95,494	-£7,222	-£0	-£7,222	
		Ward Based Outpatient	619	733	114	£73,075	£86,523	£13,449	£0	£13,449	
		OP Procedure	0	1	1	£0	£172	£172	£0	£172	
	Nephrology Total		**4,648**	**4,620**	**-28**	**£1,398,595**	**£1,635,342**	**£236,747**	**£348,782**	**-£112,035**	
	Neurology	Daycase	92	111	19	£106,017	£131,320	£25,303	£3,715	£21,588	
		Elective	67	89	22	£140,636	£165,909	£25,273	-£21,966	£47,239	
		Non Elective	93	94	1	£184,523	£285,916	£101,392	£99,389	£2,003	
		Excess Bed Days	603	1,988	1,385	£244,364	£741,876	£497,512	-£63,852	£561,364	
		Outpatient New	983	1,007	24	£273,600	£278,873	£5,273	-£1,271	£6,544	
		Outpatient Follow-up	2,853	2,491	-362	£779,864	£690,253	-£89,612	£9,303	-£98,915	
		Ward Attender	24	146	122	£6,701	£40,473	£33,772	-£0	£33,772	
		Ward Based Outpatient	261	111	-150	£72,218	£30,770	-£41,448	-£0	-£41,448	
	Neurology Total		**4,976**	**6,037**	**1,061**	**£1,807,925**	**£2,365,390**	**£557,465**	**£25,318**	**£532,147**	
	Oncology	Daycase	1,941	968	-973	£1,479,139	£1,054,896	-£424,242	£317,276	-£741,518	
		Elective	289	311	22	£1,756,479	£1,884,323	£127,844	-£8,699	£136,543	
		Non Elective	402	547	145	£1,015,921	£1,221,376	£205,455	-£160,772	£366,226	
		Excess Bed Days	334	478	144	£151,917	£199,540	£47,623	-£17,611	£65,234	
		Outpatient New	111	75	-36	£28,630	£19,421	-£9,209	-£0	-£9,209	
		Outpatient Follow-up	2,739	3,021	282	£707,525	£781,999	£74,473	£1,771	£72,703	
		Ward Attender	152	554	402	£39,191	£143,453	£104,262	£372	£103,890	
		Ward Based Outpatient	199	118	-81	£51,330	£30,555	-£20,775	£79	-£20,854	
		DCHEMO	1,511	1,891	380	£504,096	£628,152	£124,056	-£2,050	£126,106	
	Oncology Total		**7,678**	**7,963**	**285**	**£5,734,229**	**£5,963,716**	**£229,487**	**£130,367**	**£99,120**	
	Paediatrics	Daycase	342	303	-39	£286,281	£171,127	-£115,154	-£82,206	-£32,948	
		Elective	144	36	-108	£160,926	£83,298	-£77,628	£42,944	-£120,572	
		Non Elective	3,043	3,747	704	£3,450,817	£4,192,740	£741,923	-£55,924	£797,846	
		Excess Bed Days	710	1,042	332	£263,888	£368,072	£104,184	-£19,068	£123,252	
		Outpatient New	3,375	3,362	-13	£777,147	£776,116	-£1,031	£1,929	-£2,960	
		Outpatient Follow-up	4,625	4,450	-175	£652,618	£625,134	-£27,483	-£2,833	-£24,650	
		Ward Attender	195	86	-109	£27,479	£12,074	-£15,405	-£63	-£15,342	
		Ward Based Outpatient	1,777	479	-1,298	£250,718	£67,247	-£183,471	-£350	-£183,121	
		OP Procedure	3	22	19	£340	£3,648	£3,308	£862	£2,446	
	Paediatrics Total		**14,213**	**13,527**	**-686**	**£5,870,215**	**£6,299,457**	**£429,242**	**-£114,708**	**£543,950**	
	Radiology	Daycase	1,181	1,348	167	£1,199,232	£2,177,268	£978,036	£809,014	£169,022	
		Elective	154	58	-96	£256,071	£139,048	-£117,024	£42,531	-£159,555	
		Non Elective	31	18	-13	£209,286	£171,207	-£38,080	£51,440	-£89,520	
		Excess Bed Days	694	318	-376	£282,739	£129,102	-£153,637	-£492	-£153,144	
	Radiology Total		**2,061**	**1,742**	**-319**	**£1,947,329**	**£2,616,625**	**£669,296**	**£902,493**	**-£233,197**	
	Respiratory Medicine	Daycase	108	246	138	£106,904	£210,748	£103,844	-£32,667	£136,511	
		Elective	54	21	-33	£128,376	£46,652	-£81,724	-£3,270	-£78,454	
		Non Elective	717	991	274	£674,380	£1,164,459	£490,079	£232,993	£257,086	

Year-to-date

	Respiratory Medicine	Excess Bed Days	556	1,085	529	£176,228	£408,270	£232,042	£64,164	£167,878
		Outpatient New	823	624	-199	£244,989	£185,144	-£59,844	-£560	-£59,284
		Outpatient Follow-up	2,777	2,386	-391	£417,119	£378,523	-£38,596	£20,175	-£58,771
		Ward Attender	9	38	29	£1,410	£5,967	£4,557	£269	£4,289
		Ward Based Outpatient	1,493	1,216	-277	£223,919	£190,936	-£32,983	£8,596	-£41,579
		OP Procedure	1,511	1,030	-481	£218,723	£176,776	-£41,947	£27,726	-£69,673
	Respiratory Medicine Total		**8,050**	**7,637**	**-413**	**£2,192,046**	**£2,767,475**	**£575,428**	**£317,426**	**£258,002**
	Rheumatology	Daycase	1,875	1,874	-1	£1,571,040	£1,476,862	-£94,178	-£93,584	-£594
		Elective	218	44	-174	£221,868	£93,519	-£128,349	£48,799	-£177,149
		Non Elective	16	13	-3	£16,487	£23,777	£7,290	£10,719	-£3,429
		Excess Bed Days	121	254	133	£46,580	£94,646	£48,065	-£2,843	£50,909
		Outpatient New	604	629	25	£90,985	£94,295	£3,310	-£404	£3,714
		Outpatient Follow-up	1,830	1,833	3	£275,590	£275,514	-£75	-£453	£378
		Ward Attender	275	205	-70	£41,401	£30,830	-£10,571	-£0	-£10,571
		Ward Based Outpatient	134	169	35	£20,196	£25,416	£5,220	£0	£5,220
		OP Procedure	1	16	15	£160	£2,681	£2,520	£770	£1,750
	Rheumatology Total		**5,077**	**5,037**	**-40**	**£2,284,307**	**£2,117,539**	**-£166,768**	**-£36,996**	**-£129,772**
	Sleep Studies	Daycase	0	2	2	£0	£2,779	£2,779	£0	£2,779
		Elective	269	203	-66	£490,491	£324,808	-£165,682	-£45,738	-£119,944
		Non Elective	0	5	5	£0	£16,280	£16,280	£0	£16,280
		Excess Bed Days	0	184	184	£0	£57,463	£57,463	£0	£57,463
	Sleep Studies Total		**269**	**394**	**125**	**£490,491**	**£401,330**	**-£89,160**	**-£45,738**	**-£43,422**
Medicine CBU Total			**138,234**	**135,454**	**-2,780**	**£40,393,936**	**£41,508,824**	**£1,114,887**	**£1,828,548**	**-£713,661**
Community CBU	CAMHS	Elective	2	0	-2	£2,612	£0	-£2,612	£0	-£2,612
		Outpatient New	2,112	2,553	441	£0	£427	£427	£427	£0
		Outpatient Follow-up	10,525	16,816	6,291	£146,912	£125,147	-£21,765	-£109,576	£87,811
		Ward Attender	0	3	3	£0	£0	£0	£0	£0
		Ward Based Outpatient	0	1	1	£0	£0	£0	£0	£0
	CAMHS Total		**12,640**	**19,373**	**6,733**	**£149,524**	**£125,574**	**-£23,950**	**-£109,149**	**£85,200**
	Community Medicine	Outpatient New	4,005	3,371	-634	£323,435	£194,721	-£128,713	-£77,483	-£51,230
		Outpatient Follow-up	7,880	6,802	-1,078	£48,104	£41,902	-£6,202	£379	-£6,581
		Ward Attender	0	16	16	£0	£0	£0	£0	£0
		Ward Based Outpatient	9	0	-9	£0	£0	£0	£0	£0
		OP Procedure	1	0	-1	£153	£0	-£153	£0	-£153
	Community Medicine Total		**11,896**	**10,189**	**-1,707**	**£371,691**	**£236,623**	**-£135,068**	**-£77,104**	**-£57,964**
Community CBU Total			**24,536**	**29,562**	**5,026**	**£521,215**	**£362,197**	**-£159,018**	**-£186,253**	**£27,235**
Grand Total			**296,283**	**300,499**	**4,216**	**£117,282,006**	**£117,877,789**	**£595,783**	**£1,386,862**	**-£791,079**

Note that physio income is within T&O (Surgery)

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors
Tuesday 4 April 2017

Report of	Director of Corporate Affairs
Paper prepared by	Quality Assurance Officer
Subject/Title	Integrated Governance Committee Assurance Report (Mar 2017), Quarterly Corporate Report Update and Year-end Board Assurance Framework Review
Background papers	Bi-monthly IGC Assurance Reports Quarterly Corporate Risk Register Reports Monthly BAF Reports
Purpose of Paper	To provide the Board with the assurance report from the Mar IGC meeting, BAF update report and Corporate Risk Register.
Action/Decision required	The Board is asked to discuss and note the IGC Assurance Report (March 2017), changes to the Board Assurance Framework and Quarterly Corporate Risk Register Report.
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.

Board of Directors – 4 April 2017

Assurance Report from the Integrated Governance Committee

(15 March 2017)

1. Purpose

This report is a summary of the key points of assurance that were discussed at the Integrated Governance Committee (IGC) held on the 15 March 2017. It also provides a summary of the current corporate risk register and year-end BAF review

2. Recommendation

The Committee is asked to review the report and provide any feedback to the Chair of IGC.

3. Key Points of Assurance and any associated gaps

3.1. Fire Safety Training

The Committee received an update on the risk relating to fire safety arrangements in the CHP and retained estate (Ulysses Risk ID: 1118). Progress was highlighted as follows:

- Evacuation drills: A fire drill schedule has been formulated for non-clinical areas which will commence 22 March to include both retained estate & CHP. The exercise will involve a full evacuation of departments to designated assembly points. Evacuation Plans have been requested from Clinical Ward and Theatre Managers and will be subject to a walk through type fire drill in order to ensure plans are suitable and sufficient.
- The Committee was alerted to an issue regarding the 'break-glass' fail safe mechanisms which can only be located on the outside of fire escapes. The Committee agreed for works to begin immediately to rectify this alongside an assessment to determine if this was a construction defect.

4. Risk Registers

4.1. CBU Risk Register Drill Down Report: Community CBU

The first deep dive report from the Community CBU was received.

Demonstrable improvements were seen in terms of proactive management of risks at CBU level. A thorough review has been undertaken to sanitise, remove old, mitigated and duplicate risks. During this exercise a number of departmental risks were recognised as having an impact across the whole CBU and have now been reflected as such. The report identified that further training and support is required for risk owners in order that they can independently manage their risks, this is being set up for April.

The main focus for the CBU in the next few months will be the transfer of services from Liverpool Community Health NHS Trust (LCH) to Alder Hey; the risks relating to the transition of these services have been identified as part of the transition project, however the number of risks is likely to increase.

A risk highlighted to the Committee was the increasing number of incidents relating to violence and aggression recorded from the Dewi Jones. Management teams are

meeting to look at how this can be managed more effectively to protect patients and staff; guidelines are currently under revision with input from security and health & safety. Quarterly meetings with commissioners are held to discuss issues and progress. The associated issue of damage to the estate and ongoing cost of repairs is also being managed as part of this matter.

Risk and governance structures have been refined and a structure is in place for monthly CAMHS governance meetings along with monthly Business Meetings for Statutory Services and Developmental Paediatrics. At these meetings the Risk Register is a standing item of discussion where new, escalating risks and risks to close are debated. A process now needs to be put in place to ensure a similar robust governance structure for the therapies arm of the Community CBU as well as the community nursing teams. It is anticipated that following the transition of services for Liverpool Community Health NHS Trust, we will be able to put these structures in place.

The CBU did not have any risks for escalation to the corporate risk register.

4.2. Corporate Risk Register (CRR)

An overview of which risks were considered for escalation / de-escalation / closure at the meeting.

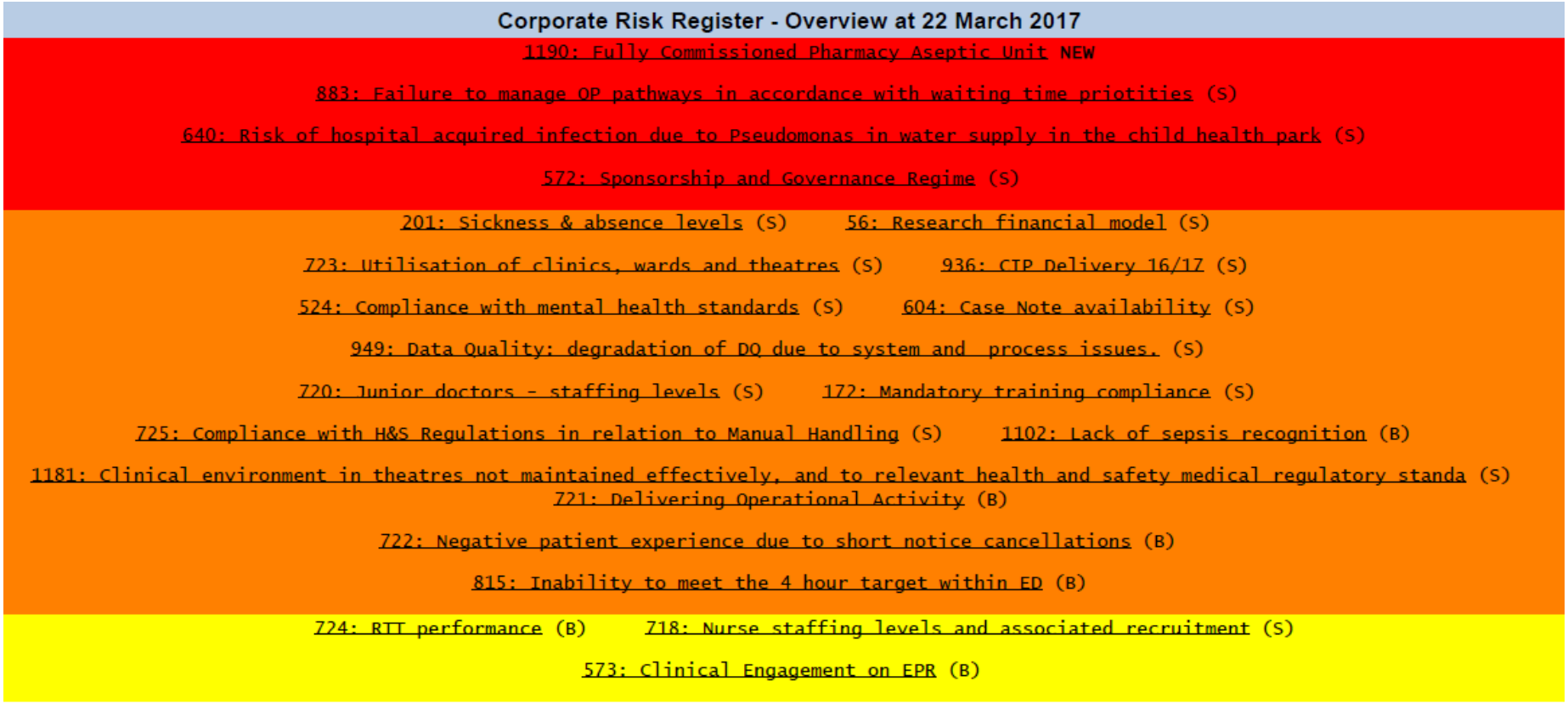
Risks presented for escalation this meeting	Decision
PFI Contract Risk; Chillers for all MRI units (Risk 962)	Not escalated
Risks presented for closure / de-escalation	**Decision**
Lack of Autoclaving facility in Microbiology (Risk 867) Workforce Engagement & Support (Risk 500)	Autoclave is now fully operational; **de-escalate** to local level until residual issues completely resolved **De-escalate**

Risk movements since the last IGC meeting (not reflected on the heliview)

3	Shortfall of Junior Doctor Medical Staff	Risk merged with 720 (Junior Doctors – Staffing Levels) and **closed**.
399	Employee relations / staff partnership working	**Closed** risk. Dates back prior to having an agreed Partnership Agreement.
725	Compliance with H&S Regulations in relation to manual handling	Initially suggested to de-escalate from CRR and merge with departmental risk 1196; however, decision to leave at CRR level pending demonstrable improvements in training numbers
1091	Reduction in Tariff from 2017-19	Risk **closed** as potential financial risk deferred to 2019/20
571	Defining benefits for the Programme	Risk **closed** as superseded by Change Programme. 2017/18 PIDs and milestone trackers in development – risks to delivery to be reflected as such in a new risk (April 2017)

Analysis of corporate risk register current set of open risks by Trend
Risk getting worse = 0
Risks closed = 4
Risks remaining static = the rest

The following diagram gives a high level view of the corporate risk register following the March IGC meeting: the full register can be found at appendix B.



4.3. CHP - Post Occupation Risk Register

Following the appointment of an external reviewer, the health and safety review has been conducted and the Trust is now in receipt of the report. The Executive Team will now review the report for factual accuracy.

One risk on the CHP Post Occupation Risk Register had worsened in–month due to a near-miss incident regarding the internal balconies for which a full root cause analysis is underway in order to identify immediate mitigations and future recommendations.

A full report on the findings of the health & safety review will be presented to the May IGC meeting.

5. Assurance reports from Sub Committees and Groups:

5.1. Emergency Preparedness

- The issue relating to staff being unable to receive **emergency bleeps or mobile phone calls in** certain areas of **Radiology** is now **resolved**. On 13th February 2017, IM&T and Radiology conducted a thorough emergency paging signal survey in the Radiology department which confirmed that the signal is consistently good throughout and the emergency pagers work successfully without any problems. It is thought that the problems previously reported may have been as a result of low battery, a pager fault, or user error.
- **Clinical Emergency Planning Lead for the Emergency Department.** The job description for the clinical emergency planning lead has been finalised at the Agenda for Change Working Group. Expressions of interest will now be sought.
- **Building Management (BMS) Alarms:** As previously advised, the BMS system is still not linked to the Interserve Shift Engineer paging system. The IM&T Head of Technical services will be reviewing the matter further and feeding into the next emergency preparedness group to confirm if there is a resolution available.
- **UPS testing** – phase I commenced. Phase II will involve switching off one of the mains to allow the other mains to take the load and then phase III which will see both mains being switched off to allow generator supply.
- Four **incidents** had occurred since the January IGC, three of which related to fire alarms and one was a lighting failure. Lessons learned are being taken forward.

5.2. Health & Safety

- A **manual handling trainer** has now been appointed for 22.5hrs per week
- **Mitigation** has been identified for the issue regarding **falling ceiling tiles** in OPD which will now be clipped into place.
- A meeting has been scheduled to discuss and agree a **resolution** for **contractors** breaching **health & safety regulations**
- **Near-miss** incidents were highlighted in the **delivery area** due to lack of segregation of vehicles and pedestrians.
- The **asbestos breach** incident continues to be thoroughly investigated and the HSE will meet with affected staff.

5.3. Infection Control

- A number of **positive assurances** were noted by the Committee including: work around the diagnosis and management of **Sepsis**; achievement of the **75% influenza** vaccination **target** for frontline clinical staff; **successful** implementation of the **Winter Pressure Plan**; increased **MRSA & CPE** screening **compliance** and secondment of a **breastfeeding champion**.
- **Gaps** in assurance were highlighted with a particular focus on the **need to establish** a **Policy for Highly Communicable Infectious Diseases**; PPM within **theatres** and **dust control** resulting from **demolition** of the old hospital.

5.4. Information Governance (IG)

- Two **risks closed.**
- **Training compliance** numbers have **decreased.** The Trust is expected to receive a limited assurance rating on the IG Toolkit as a result.
- A paper was received highlighting the benefit of **Fast User Switching** (FUS) in clinical areas speeding up time taken to access relevant applications and in turn reducing sharing of login details. The committee agreed to the benefits of rolling out this functionality whilst continually addressing the risks associated.

5.5. Clinical Records

- This group is continuing to gain **momentum** and **clinical engagement**.
- **Training** of the 2 WTE staff to **scan** the **Day Forward Loose Documentation** is well underway and a robust QA process has been put in place.
- Band 4 **Senior Auditor** has been **agreed**.
- Preparation work is underway for the upgrade to **ImageNow V7.**

5.6. Data Quality

- External DQ **performance** for national data dashboard **above national score** for all data submissions.
- **Action plans** are in place to resolve ongoing issues from **Meditech v6** data migration.

5.7. Building Services Team

- **Access** for completion of **PPMs** was highlighted as an issue resulting in non-compliance. It is recognised that unforeseeable circumstances undoubtedly arise given the nature of business at Alder Hey therefore, agreement has been reached to feed the PPM schedule into Trust planning meetings and map to activity and try to avoid this wherever possible.
- The Committee agreed to issue a meeting **invitation** to **Interserve, Laing O'Rourke and HCP** in order to have questions answered in real time and **gain assurance** where necessary.

Board Assurance Framework 2016-17

Year End Review

1. Introduction

The BAF is a tool for the Board to corporately assure itself about successful achievement of the organisation's strategic objectives and how the risks to delivery are managed and mitigated.

The BAF directly underpins the Annual Governance Statement (AGS) and is the subject of annual review by Internal and External Audit, with the former providing a formal opinion on the fitness for purpose of the process and approach. This assessment comprises a view on the BAF's structure, the Board's engagement with it and the quality of the content.

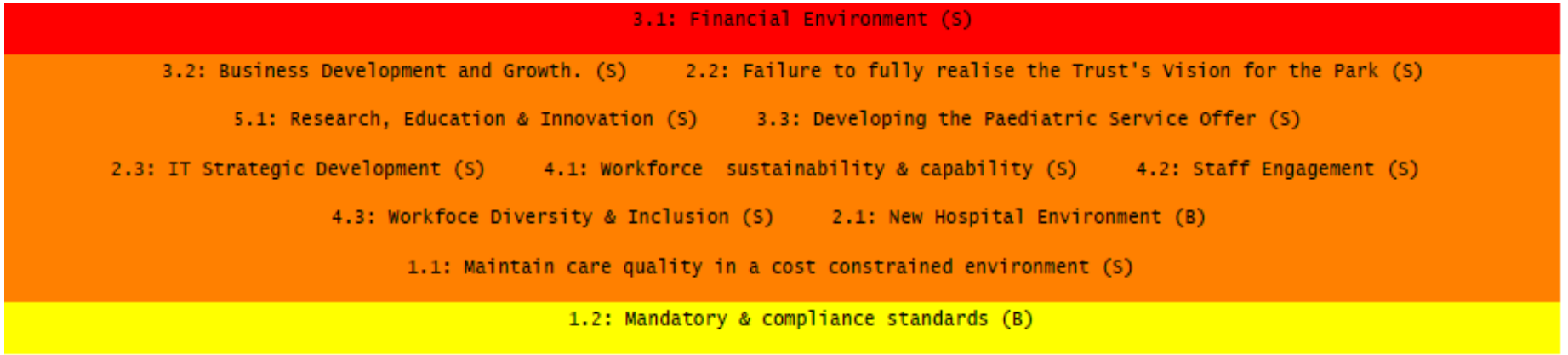
2. Key issues

The Board must satisfy itself that appropriate and timely action is being taken to sufficiently mitigate the risks to the achievement of the Trust's objectives.

Following the implementation of the risk module on Ulysses in Sept 2015, the BAF continues to be used more interactively and is used by the Trust Executive Team, the Board and its sub-committees to better drive the management and mitigation of our key risks.

This report provides a comparison of the BAF at the start and end of 2016/17; an analysis of progress thorough the year, potential changes for next year and finally a table that shows links between the BAF and associated corporate risks.

3. BAF at start of financial year 2016-17 (April 2016)



4. BAF at end of financial year 2016-17 (March 2017)

5. Comparison of ratings: start and end of financial year (April 2016 and March 2017)

Ref	Risk Title	Risk Rating: I x L	
		Current: Apr 16 : **Mar 17**	Target: Apr 16: **Mar 17**
STRATEGIC PILLAR: Excellence in Quality			
1.1 (HG)	**Maintain care quality in a cost constrained environment**	4-2 = **4-2**	4-2 = **4-2**
1.2 (MB)	**Mandatory & compliance standards**	**4-5** > 5-1	**4-2** > 3-2
STRATEGIC PILLAR: Patient Centred Services			
2.1 (DP)	**New Hospital Environment**	**3-4** > 4-2	4-1 = 4-1
2.2 (DP)	**Failure to fully realise the Trusts Vision for the Park**	**4-3** > 4-3	4-1 < **4-2**
2.3 (CL)	**I.T. Strategic Development**	3-4 = **3-4**	3-2 < **3-3**
STRATEGIC PILLAR: Growing our Services and Safeguarding our Business			
3.1 (CL)	**Financial Environment**	4-4 < **5-4**	4-2 < **3-4**
3.2 (CL)	**Business Development & Growth**	4-3 = **4-3**	4-2 = **4-2**
3.3 (RT)	**Developing the Paediatric Service Offer**	4-3 = **4-3**	4-2 = **4-2**
STRATEGIC PILLAR: Great Talented Teams			
4.1 (MS)	**Sustain Workforce Capability**	4-3 = **4-3**	4-1 < **4-2**
4.2 (MS)	**Staff Engagement**	3-3 = **3-3**	3-2 = 3-2
4.3 (MS)	**Workforce Diversity & Inclusion**	3-3 = **3-3**	3-1 = **3-1**
STRATEGIC PILLAR: International Innovation, Research & Education			
5.1 (DP)	**Research, Education & Innovation**	**4-3** > 4-1	4-1 = 4-1

6. Analysis of the risk ratings

It can be difficult to effectively score and update the ratings of BAF risks, because of their very nature they are often a composite of a number of lower level risks: the risk rating score is therefore largely indicative at any point in time and any consideration of progress at the end of a year represents a direction of travel rather than an absolute score. However, the following observations can be made:

- Of the 12 risks on the BAF:
  - 7 didn't change their current rating during the course of the year;
  - 1 had a worse current rating at the end of the year; and
  - 4 had improved current ratings at the end of the year.
- Financial Environment presents the biggest risk to the Trust and has increased from 16 (*major x likely)* to 20 (*catastrophic x likely*)
- Mandatory & compliance standards has reduced from a score of 20 (*major x almost certain*) to 5 (*catastrophic x rare*)
- Both 'New Hospital Environment' and 'Failure to realise the Trusts vision for the Park' risks both saw a decrease in score during 2016/17
- Research, Education & Innovation reduced from 12 (*major x possible*) to 4 (*major x rare)*

The full Board Assurance Framework for the month of March can be found at Appendix A.

7. Summary of BAF - at 28 March 2017

The diagram below shows that all risks on the BAF remained static.

Ref, Owner	Risk Title	Risk Rating: I x L		Monthly Trend	
(15-16 references given in brackets where different)		Current	Target	Last	Now
STRATEGIC PILLAR: Excellence in Quality					
1.1 HG	**Maintain care quality in a cost constrained environment**	4-2	4-2	STATIC	STATIC
1.2 MB	**Mandatory & Compliance Standards**	5-1	3-2	STATIC	STATIC
STRATEGIC PILLAR: Patient Centred Services					
2.1 (1.3) DP	**New Hospital Environment**	4-2	4-1	STATIC	STATIC
2.2 (2.1) DP	**Failure to fully realise the Trust's Vision for the Park**	4-3	4-2	STATIC	STATIC
2.3 (6.2) CL	**IT Strategic Development**	3-4	3-3	STATIC	STATIC
STRATEGIC PILLAR: Growing our Services & Safeguarding Core Business					
3.1 (5.1) CL	**Financial Environment**	5-4	3-4	STATIC	STATIC
3.2 (6.1) CL	**Business Development & Growth**	4-3	4-2	STATIC	STATIC
3.3 (6.3) RT	**Developing the Paediatric Service Offer**	4-3	4-2	STATIC	STATIC
STRATEGIC PILLAR: Great Talented Teams					
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: International Innovation, Research & Education					
5.1 DP	**Research, Education & Innovation**	4-1	4-1	**BETTER**	STATIC

8. Changes since March 2017 Board meeting

External risks

- ***Business development and growth (CL)***
  No change in-month

- ***Mandatory and compliance standards (MB)***
  Performance year to date has recovered a significant amount of activity/income - non elective, elective and in particular day case activity. Year-end we are predicting all RTT targets are met, ED Performance, income against revised plan, with material improvement in activity levels. This is a reflection of the commitment and good work of the CBU Directors and teams, together with financial support and advice.

- ***Developing the Paediatric Service Offer (RT)***
  The ODN recommendation single service, single workforce, two site model has been accepted by NHS England and AH and LWH will now be working on an implementation plan together.
  Focus for 2017/18: There will be a need for some Capital funding to support the reconfiguration of the ICU and the number of cots required.

Internal risks:

- ***Maintain care quality in a cost constrained environment (HG)***
  Target risk score met at year-end & sustaining mitigation in place.
  Continuous monitoring for 2017/18 to ensure risks are managed accordingly.

- ***New Hospital Environment (DP)***
  System has settled down. Residual snagging issues almost entirely complete. List of probation items remaining include: energy, water, theatres and aseptic suite.
  Red button mechanism in place to escalate major problems and has worked efficiently do far.
  Actions for 2017/18 include: review of probation items (June 2017) and conduct senses of surveys (1 per quarter) to assess progress.

- ***Financial Environment (CL)***
  Month 11 (Feb): on track to deliver 2016/17 control total £0.2m deficit.
  Risks emerging around 2017/18 control total relating to CIP, ward budgets and activity run rate.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Procurement of residential scheme to be completed by 31 March. Main residual risks in ability to move the preferred scheme through planning and maintain:
  - Dowry for Park
  - Receipt for Disposal
  - Quality of Development

  Main actions for 2017/18 are:
  - To take preferred scheme to the public for consultation.
  - Develop a Communication Strategy to support the planning process.
  - Confirm arrangements for the CIC to run the Park.

- ***IT Strategic Development (CL)***
  No change in-month

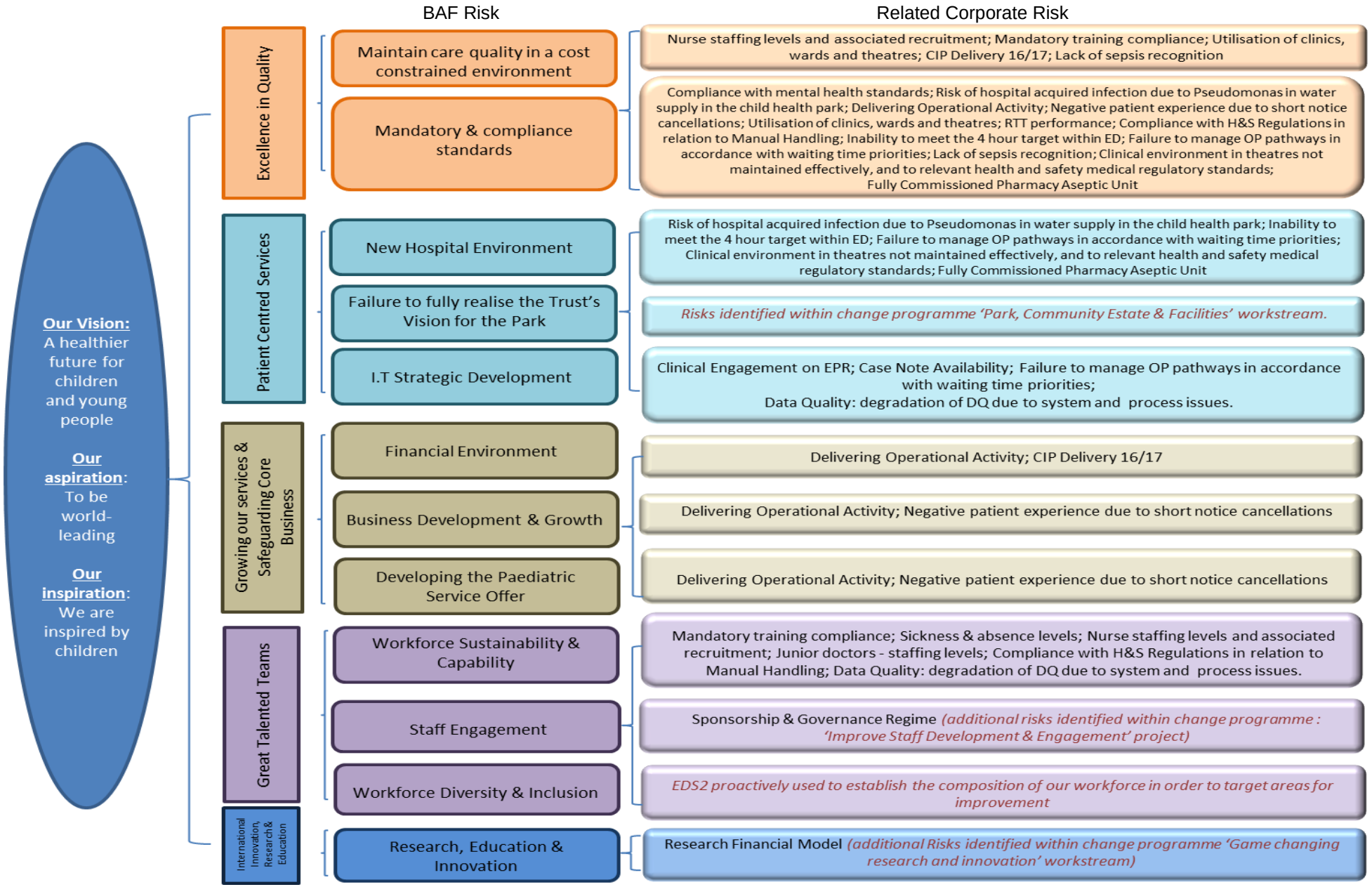
- ***Workforce Sustainability & Capability (MS)***
  Approval received for Alder Hey to be a registered Apprenticeship Delivery organisation. 40 expressions of interest received during Apprenticeship week.

- ***Staff Engagement (MS)***
  Year 2 LiA plan progresses. Local Staff Survey Results shared with local teams to conduct conversations in teams. development of PID for Communications and Engagement, which will be a key strand of the 2017/18 Change Programme.

- ***Workforce Diversity & Inclusion (MS)***
  Approval received for Alder Hey to be a registered Apprenticeship Delivery organisation. 40 expressions of interest received during Apprenticeship week.

- ***Research, Education & Innovation (DP)***
  Academy Business Case to be presented to Execs by 31 March. Institute Phase II initial works contract let.
  Innovation - Shadow Innovation Co. Board to meet by 31 March.
  Research - Distribution model discussed and agreed at REI Committee.
  Actions going into 2017/18 include:
  - Appoint Academy Leadership Team
  - Launch Innovation Co. and secure funding
  - Execute Plan to increase research portfolio
  - Execute contact for RIE with back-to-back arrangements with the Charity and the HEIs

9. Links between BAF and corporate risks – as at March 2017



Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 1.1	**Strategic Objective:** Excellence In Quality	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 issues to eradicate reportable HAIs
• "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 45 new nurses recruited, commenced in September 2016 Further national open recruitment exercise in September 2016 PEWS audit scores on improvement trajectory	Reduced investment opportunity to respond to clinical development as a result of financial situation. Full electronic access to specialty performance results Sign up to Safety 'resource' ended in July 2016 (new CQC style ward accreditation (Journey to the Stars) has remained static. Roll out of support structure for Sepsis 6 yet to be fully implemented

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
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	Co-director of transformation and patient experience now appointed - will embed PFCC in all projects.
Continue to maintain nurse staffing pool	Ongoing
Support structure for Sepsis to be fully implemented	Sepsis is now a national CQUIN for 17/18 and built into the Change Programme (17/18). Business Case Developed & submitted for discussion/approval (Fri 31/3)

Executive Lead's Assessment

JAN 2017: Sepsis roll out plan in place to be monitored by Sepsis Steering Group; new PEWS policy out for consultation; comms to staff re sepsis recognition reinforced.
FEB 2017: PEWS Policy approved and training programme commenced (ward 3C) for nursing and medical teams. Monthly monitoring in place.
MAR 2017: Target risk score met at year-end & sustaining mitigation in place. Continuous monitoring for 2017/18 to ensure risks are managed accordingly.

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 1.2	**Strategic Objective:** Excellence In Quality	Risk Title: Mandatory & compliance standards		
Related CQC Themes: Safe, Caring, Responsive, Well Led, Effective				
Exec Lead: Margaret Barnaby	**Type:** Internal, Known	Current IxL: 5-1	Target IxL: 3-2	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	• Performance Review Group meeting monthly with CBU Dashboards - now in place
• CBU Performance Meetings - now strengthened as of May 2016 and meeting regularly each month	• Regulatory status with: Monitor, 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
• Activity to year end re-forecast from Q3 and is on track into Q4. Winter Plan is supporting continued good performance. Weekly Delivery Group in place to track progress.	• Early Warning indicators now in place
• Due to sickness absence of a consultant in Gastroenterology and the recent resignation of another consultant in the same specialty, maintenance of the RTT waiting times standard is at increased risk. Continued positive efforts of the Gastroenterology team has resulted in RTT being met. We have also received four applications for current consultant vacancy.	

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 CQC Action plan reviewed at Execs and Operational Delivery Group Compliance assessment against Monitor Provider Licence to go to Board A&E Target Recovery Plan	Failure of CCG and local health economy to successfully deliver on agreed plans to meet reduction in ED attendances - discussions on-going with commissioners. Quarter 1 Performance delivered, Quarter 2 Performance on track. Q3 Performance off track. Q4 Performance on track for Jan and Feb. High levels of elective and non-elective activity in March 2017 which will be challenging. Theatre and bed capacity Some areas remain fragile e.g. IG toolkit, 4 hour waits, 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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
March end of year financial position, delivery of higher levels of elective and non elective activity and delivery of performance targets for Q4 is challenging and is under weekly monitoring and tracking.	
Review bed capacity and staffing model for seasonal variation	As at January 2017, the Winter Plan is effective.
Implement devolved governance structure (quality governance teams within CBUs)	All CBU's have appointed Directors, with Medicine Director not yet commenced in post. All CBUs have Assoc COO and Assoc Chief Nurses and Head of Quality post holders in place. Business partners in Finance and Human Resources are in place. Clinical Directors have been appointed. Outstanding is the implementation of the Matron roles in each CBU.

Executive Lead's Assessment

JAN 2017: ED performance for the month was 97.12%. For many days in the month Alder Hey was in the top 3 reporting Trust's in the country.
FEB 2017: ED Performance at 97.3%. All other national reporting waiting times targets met. Activity delivered above forecast. Winter Plan enabling elective activity to be completed.
MAR 2017:
Performance year to date has recovered a significant amount of activity/income - non elective, elective and in particular day case activity. Year end we are predicting all RTT targets are met, ED Performance, income against revised plan, with material improvement in activity levels. This is a reflection of the commitment and good work of the CBU Directors and teams, together with financial support and advice.

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 2.1	**Strategic Objective:** Patient Centred Services		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
Increase profile of hospital Fix-It Team and correct procedure for resolution of issues	Action being taken forward following BIG conversations
Finalisation of external (wider) review	On-site review conducted 24 Jan 2017
Closure of legacy commissioning issues	Case study review session with Project Co. and service users scheduled 8 Feb 2017
Reviewing Health & Safety interface with Estates and Building Services Team	
review of probation items	
conduct senses of surveys (1 per quarter) to assess progress.	

Executive Lead's Assessment

JAN 2017: Teams main focus is clearing legacy defect issues with LOR.
FEB 2017: External H&S Review concluded - awaiting report. Case study and lessons learned senses with Proj. Co. Partnership Charter between Alder Hey and Proj. Co. Survey of users completed.
MAR 2017: System has settled down. Residual snagging issues almost entirely complete. List of probation items remaining include: energy, water, theatres and aseptic suite.
Red button mechanism in place to escalate major problems and has worked efficiently do far.
Actions for 2017/18 include: review of probation items (June 2017) and conduct senses of surveys (1 per quarter) to assess progress.

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 2.2	**Strategic Objective:** Patient Centred Services		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
Broaden stakeholder engagement	Produced & circulated newsletter. Held 3 meetings of Shadow Board
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	Meeting held with LCC Team. Heads of Terms under review
Income generation opportunities to be thoroughly explored (grant applications) and reconcile requirement for funding versus available	Review of income opportunities under way
Agree a way forward on planning with LCC	
Develop a Planning Process Communication Strategy	
Confirm arrangements for the CIC to run the Park.	

Executive Lead's Assessment

JAN 2017: Risk increased due to poor reception of planning application. Now need to reassess process and approach.
FEB 2017: Planning application withdrawn. Bidders asked to re-present schemes with additional 0.6 hectares of parkland.
MAR 2017: Procurement of residential scheme to be completed by 31 March. Main residual risks in ability to move the preferred scheme through planning and maintain:
- Dowry for Park
- Receipt for Disposal
- Quality of Development

Main actions are:
- To take preferred scheme to the public for consultation.
- Develop a Communication Strategy to support the planning process.
- Confirm arrangements for the CIC to run the Park.

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 2.3	**Strategic Objective:** Patient Centred Services		Risk Title: IT Strategic Development		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: Claire Liddy	**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**
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	
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
Executive Lead's Assessment	
JAN 17: Funding Agreement received and approved by Trust Board. PiD and milestones to be formalised as part of programme assurance. FEB 2017:Funding agreement yet to achieve final stage of DH approval there is a risk the funding may not flow in 2016/17 financial year, which could result in sunk costs. This has been escalated to NHS I. MAR 2017: no change	

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 3.1	**Strategic Objective:** Growing Our Services & Safeguarding Core Business		Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: Claire Liddy	**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
Executive Lead's Assessment	
JAN 17: month 9 (December): results ahead of plan by £80k, residual risk to control total for full year of £1m best -£1.8m worst case. RR of a 3. CBU working towards control totals and additional measures including technical review to close gap under review. FEB 2017:month 10 (January): results ahead of plan by £44k, residual risk to control total for full year of £1m best -£1.5m worst case. Emerging risk of activity run rate than requires close management. RR of a 3. Additional measures including technical review to close gap likely. MAR 2017:month 11 (Feb): on track to deliver 2016/17 control total £0.2m deficit. Risks emerging around 2017/18 control total relating to CiP, ward budgets and act5ivty run rate.	

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 3.2	**Strategic Objective:** Growing Our Services & Safeguarding Core Business		Risk Title: Business Development and Growth.		
Related CQC Themes: Caring, Effective, Responsive, Safe, Well Led					
Exec Lead: Claire Liddy		**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

JAN 17: Director of strategy commenced. Work underway to agree priorities for 2017 as part of programme development.
FEB 2017:no change
MAR 2017:no change

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 3.3	**Strategic Objective:** Growing Our Services & Safeguarding Core Business		Risk Title: Developing the Paediatric Service Offer		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led					
Exec Lead: Richard Turnock		**Type:** External, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

Failure to maximise opportunities with regard to service reconfiguration

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.	• Derogations secured in relation to specialist service specs.

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
Clear plan for delivery of strategic services (cardiac, neonatal, rehab, community care, primary care, Vanguard, CAMHS)	
Pursue the community tender incorporating the public health offer	
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
Monitoring of action plans.	Now working with NHS England to secure a resolution for the North
progress neonatal T&F group under Spec Comm leadership	T & F group scheduled to report recommendations by end March 2017

Executive Lead's Assessment

JAN 2017: No change in-month
FEB 2017: Liverpool Community Health - Bridgewater acquisition of services has been 'paused' due to unsatisfactory CQC report. AH offered their support to Bridgewater but also to NHSI and CCG re leading on an alternative delivery model for the children's community services.
Neonatal Surgical Review - ODN Preferred Option - Single Service Two Site model (AH and LWH) recommendation going to ODN Board on 9/3/17 then to NHS England
North West Neonatal Intensive Care Reconfiguration - ODN Preferred Option - Single service two site model (fixed sites for tertiary maternity : LWH & neonatal surgery/ tertiary paediatric services : AHCH) recommendation going to ODN Board on 9/3/17 then to NHS England
MAR 2017: The ODN recommendation single service, single workforce, two site model has been accepted by NHS England and AH and LWH will now be working on an implementation plan together. There will be a need for some Capital funding to support the reconfiguration of the ICU and the number of cots required.

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 4.1	**Strategic Objective:** Great Talented Teams		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	• Workforce Group
• Performance Review Group	• CBU Performance Meetings.
• Mandatory training reviewed and updated in summer 2014	• All training records available online and mapped to competency framework
• Permanent nurse staffing pool	• 'Developing our Workforce' workstream 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	Low compliance in critical training e.g. safeguarding, transfusion, manual handling. Inability to train staff due to clinical workforce and acuity preventing them leaving the clinical areas No proactive assessment of impact on clinical practice Education Strategy Small number of issues remain re. the interface with ESR which has slowed the progress of the action plan and reducing assurance

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
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	Education Governance group to support implementation, setting up in September, reporting through WOD
Build and sustain leadership capacity and capability	Leadership and management project has commenced, but has experienced slippage due to competing priorities
Sickness Policy refreshed	Implemented 1 July 2016
Develop our Education Strategy	
Task & Finish Group to review prior action failures and identify solution	Action Plan signed off at WOD
Review mandatory training programme - July 2016	Review still underway, to conclude by end Sept 2016
Recruitment & Retention Strategy to focus on specific groups	Currently being refreshed with action plan to support

Executive Lead's Assessment

Jan 2017: Apprenticeship Strategy now ratified, and we are now working on implementation. Resource secured for additional Manual Handling Training to support improved compliance. first Workplace Coaching programme delivered in January 17 with a positive response.
FEB 2017: Apprenticeship PID approved at WOD. Draft Education Strategy presented to Education Governance Committee.
MAR 2017:approval received for Alder Hey to be a registered Apprenticeship Delivery organisation. 40 expressions of interest received during Apprenticeship week

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** Great Talented Teams		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 (monthly)
• Values based PDR process	• People Starategy 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 Monthly Engagement Temperature Check reported to the Board. Monthly Engagement Temperature Check local data now sent to CBUs on a monthly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board	Overarching Engagement Strategy Reward & Recognition

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Analysis of Staff Survey	Survey outcomes are being actioned as evidenced via a plan to support CQUINS requirements
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
Listening into Action methodology to provide the framework for organisational engagement	Remains in progress
Communications Strategy published	

Executive Lead's Assessment
JAN 2017: Initial Staff Survey Results shared with Senior Management Team. Plan agreed to ensure a staff survey conversation will take place with every department in February and March. Listening into Action continues with the teams progressing well with their improvements. communications team engagement exercise with staff around the development of the new internet and intranet going well. FEB 2017: Official Staff Survey results received to be presented at Board in March 17. Year 2 LiA commitment agreed with senior management. MAR 2017: Year 2 LiA plan progresses. Local Staff Survey Results shared with local teams to conduct conversations in teams. development of PID for Communications and Engagement, which will be a key strand of the 2017/18 Change Programme.

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 4.3	**Strategic Objective:** Great Talented Teams		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	Proactive working with partners to promote our commitment to diversity and inclusion Recruitment Strategy to focus on specific groups
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Increase declaration rates with Equality Act 2010	Actioned, with all organisation reports reporting on protected characteristics where required
Work with partner organisations to develop effective BME recruitment strategy	Underway, and plan to be produced
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	
JAN 2017: a Listening into Action improvement team has been launched to support the development of a BME network for staff. BME T&F group continues their work on progressing the agenda. FEB 2017: Access to work programme launched, supporting members of the community to access work experience. volunteers supported to actively apply for posts within the Trust. MAR 2017:LiA Big Conversation took place in March to explore the creation of a BME network. T&F actions continue	

Board Assurance Framework 2016-17

Alder Hey Children's NHS Foundation Trust

BAF 5.1	**Strategic Objective:** International Innovation, Research & Education	Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led				
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 4-1	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

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
Work with our charity colleagues to raise the profile of our research and innovation capability.	Presentation to Board of Charity Trustees
Educational Partnerships to be cemented	Academy proposals to be discussed Feb 2017
Develop a robust commercial Education Business Model	First cut academy model completed
Finalise digital exemplar budget and reconcile with charity contribution	Budget completed & reconciled
Refine Innovation Co proposal and produce draft budget	Draft budget in place
Turn Outline Business Case for Academy into definitive action plan	drafted for discussion 9 March
Establish pipeline structure for sensors including finances	Proposal submitted to UoL and LJMU

Executive Lead's Assessment

JAN 2017: General Manager appointed for HUB
FEB 2017: Academy proposals firmed up for presentation at Execs. Commercial Research / Research expansion paper presented at REIC.
Mar 2017: Academy Business Case to be presented to Execs by 31 March. Institute Phase II initial works contract let.
Innovation - Shadow Innovation Co. Board to meet by 31 March.
Research - Distribution model discussed and agreed at REI Committee.
Actions going into 2017/18 include:
- Appoint Academy Leadership Team
- Launch Innovation Co. and secure funding
- Execute Plan to increase research portfolio
- Execute contact for RIE with back-to-back arrangements with the Charity and the HEIs

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17	Risk Title: Fully Commissioned Pharmacy Aseptic Unit
Ref: 1190	Risk Owner: Clare Langdon	Originating BU / Programme: Medicine
Reporting Committee: IGC	Where Risk Managed: Corporate	
External	Link to Quality AimsIGC	
Strategic Objective: Patient Centred Services		

Current IxL	Target Residual - Appetite for Risk	Trend: New Risk
4-5	4-1	

Description	Causes	Consequences
Delays in fully commissioning the Pharmacy Aseptic Unit (see also risks 1132, 1061 & 1166)	Un-validated unit, not yet fully commissioned being used to prepare sterile products	* £400k p.a. unrecoverable costs * Unit could become contaminated, increasing likelihood of patient harm due to preparation error or contamination * Associated environmental risks

Existing Set of Controls

• Workstreams set up and staff released to work on validation/commissioning	• Accountable pharmacist appraised QCNW that she is satisfied that current work is within safe limits
• External expert advice provided by QCNW and John Rhodes	

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Inspection of Unlicensed Aseptic Preparation against the Quality Assurance of Aseptic Preparation Services Standards	Debra Walker	17/01/2017	A revisit was undertaken in December 2016 and the risk has been increased to high due to the lack of progress on a number of issues
Formal notice issued to Atlas for improvements to be made	Glenna Smith	17/01/2017	Improvement still not made.

Date Last Reviewed	Review Details
02/03/2017	staff continue on work streams when released. Accountable pharmacist to complete an updated audit action plan and risk assessment for continued use of the unit for preparation. products continue to be outsourced wherever possible.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register			2016--17	Risk Title: Failure to manage OP pathways in accordance with waiting time priotities
Ref: 883	Risk Owner: Rachel Greer	Originating BU / Programme: Community		
Reporting Committee: IGC		Where Risk Managed: Corporate		
Internal	Link to Quality AimsIGC			
Strategic Objective: Patient Centred Services				

Current IxL	Target Residual - Appetite for Risk	Trend: STATIC
4-4	4-2	

Description	Causes	Consequences
Data quality issues affecting information on PtL used to manage patient wait times	Failure to manage patient pathways in accordance with SOPs and lack of capacity to ensure timely follow up/review.	Patients not receiving timely OPD appointments, lost to follow up, missing outcome information to support management plan

Existing Set of Controls	
• flag corporately and work with team to address issues local service teams to constantly review ptl	• Improving outpatient project - booking and scheduling workstream in place to review SOPs/Training for staff
• Regular validation of patients waiting by CBU teams to identify patients at risk	• Trust wide data quality committee established to monitor and deliver improvements in data quality

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Review of all individual SOPs to ensure fit for purpose	Mandy Burns	31/12/2016	A number of SOPS have been reviewed and a SOP sign off day planned wk commencing 21/11/16
Proposal to review booking process including recommendation to change current partial booking system to be presented to Improving OP Steering Group	Mandy Burns	31/07/2016	
Data quality monitoring report developed to enable regular monitoring of compliance with processes	Mandy Burns	30/09/2016	
Booking and scheduling work stream in Improving Outpatients programme developed clear project objectives and milestone plan	Mandy Burns	31/12/2016	Monitored at IOP Steering Group and assurance through CQAC
Booking and scheduling (10 week) task and finish group established under COO	Margaret Barnaby	15/01/2017	

Date Last Reviewed	Review Details
06/09/2016	Review as part of IOP risk register

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Risk of hospital acquired infection due to Pseudomonas in water supply in the child health park
Ref: 640	Risk Owner: Richard Cooke	Originating BU / Programme: Business Support	
Reporting Committee:		Where Risk Managed: Corporate	
Internal	Link to Quality Aims		
Strategic Objective: Excellence In Quality			Current IxL 5-3 / Target Residual - Appetite for Risk 5-1 / Trend: STATIC

Description	Causes	Consequences
Pseudomonas from the water supply can colonise water outlets if taps aren't maintained , cleaned properly and patient wash water is appropriately discarded into hand wash basins. High risk patients using this water can then become colonised and develop infection	Inadequate flushing of outlets Incorrect cleaning of water outlets Incorrect disposal of waste water in hand washing sinks. Inadequate sampling to ensure water of known satisfactory quality	Risk of Health care associated infection and subsequent morbidity or mortality in high risk vulnerable patients

Existing Set of Controls

• For direct contact with patients water of known quality is used.	• Ice isn't provided for patients
• In critical care patients washed with disinfectant wipes (octenisan)	• Bedside equipment cleaned with disinfectant wipes.
• SOP for sink cleaning	• No water features present
• servicing of TMV and associated components undertaken by Interserve.	• Accurate records of water systems available
• staff installing, removing and replacing outlets and pipework are suitably trained to prevent contamination of outlet and water system.	• Flushing of outlets daily

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
sterile water or saline used for medical devices	Josephine Keward	29/04/2016	Complete
Drug preparation and aseptic procedures occur away from water outlets	Josephine Keward	29/04/2016	Accessed in ward areas and compliant
All outlets to be properly labelled so can be easily identified for sampling	Bill Foster	29/04/2016	No action by Interserve
Standard operating procedure for cleaning sinks revised since move into CHP and training undertaken by Domestic supervisors.	Carol Zanin	31/05/2016	SOP produced. Training in SOP under way
Water sampling undertaken in all patient areas	Richard Cooke	04/11/2015	Sampling has only been undertaken on 1C neo, 3B, 3C and critical care and theatre 8
Disinfection of colonised outlets using the SOP from the water safety plan to be undertaken by Interserve	Bill Foster	29/04/2016	Disinfection undertaken for outlets found to be colonised. This hasn't all been successful . plan to fit PALL water filters on clinical outlets
Risk assessment for all patient areas to be undertaken by IPCT	Josephine Keward	29/04/2016	risk assessment completed for 3B
Patient wash water to disposed off down sluice hopper/ toilet not HWB	Josephine Keward	29/04/2016	Wards disposing of wash water down sluice hopper or toilets

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Date Last Reviewed	Review Details
08/03/2017	2 areas need to be addressed; Flushing compliance below 95% (January 2017 75%) An audit of compliance with SOP for cleaning of sinks demonstrating cleaning of outlets

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register			2016--17	Risk Title: Sponsorship and Governance Regime		
Ref: 572	Risk Owner: Erica Saunders	Originating BU / Programme: Business Support				
Reporting Committee: CQAC		Where Risk Managed: Corporate				
Internal	Link to Quality AimsCQAC					
Strategic Objective: Excellence In Quality				Current IxL 5-3	Target Residual - Appetite for Risk 5-1	Trend: STATIC

Description	Causes	Consequences
Lack of application of the sponsorship and governance regime of the Programme - in its entirety - resulting in insufficient tempo, sub-optimal performance and consequent impact on hospital and community services	Adoption of the programme assurance protocols and programme board/Steering Group	Insufficient tempo, sub-optimal performance and consequent impact on hospital and community services.

Existing Set of Controls
• Clear accountabilities established from SRO and Executive Sponsors for workstreams through to Corporate Leads. A highly effective "Programme Board" has been established to direct events, make timely decisions and support the workstreams (expediting actions and unblocking issues).

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Ongoing monitoring by Project Teams/Steering Group/Programme Board. See comments re controls.	Louise Shepherd	30/09/2016	Continuing tight governance, assurance and grip on the extensive, and ongoing, programme of change at Alder Hey. Programme Board performance is good.
Refocus of programme is currently underway by Executive Team	Louise Shepherd	23/11/2015	Change Programme now established with progress tracked at Trust Board sub-committees and by exception at the weekly Executive Team Meeting.

Date Last Reviewed	Review Details
07/11/2016	Risk remains static. Outcome of MIAA review of Change Programme Assurance Framework to be reviewed by Audit Committee (NOV).

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Sickness & absence levels		
Ref: 201	Risk Owner: Melissa Swindell	Originating BU / Programme: Business Support			
Reporting Committee: RABD		Where Risk Managed: Corporate			
Internal Monitoring	Link to Quality AimsRABD				
Strategic Objective: Great Talented Teams			Current IxL 4-3	Target Residual - Appetite for Risk 3-3	Trend: STATIC

Description	Causes	Consequences
Required reduction in sickness absence not achieved	Trust policy to effectively manage sickness absence rates not properly implemented.	High levels of sickness absence has a detrimental impact on service; team effectiveness, increased cost of absence to the organisation.

Existing Set of Controls	
• All managers accountable for adherance to the process set out in policy for managing sickness. Regular monitoring by CBU Boards. Monitored through Corporate Report and CBU Performance meetings. Reports to WOD.	• Report in corporate report, monthly CBU reviews with HR. Targeted OH interventions. Local BI reporting via MSS
• Reports to WOD.	• Resources to be identified for the management of workforce health and wellbeing. Occupational Health identifying options to support the Trust's health and wellbeing agenda for staff.
• Occupational Health Provider, Team Prevent established with focused work on H&WB and sickness absence	• Team Prevent Contract renegotiated. KPIs being reviewed and enhanced.
• Increased focus on the effective management of sickness absence at CBU level.	• Sickness Absence Policy HR Business Partners and HR Advisors to provide additional coaching, workshops, training sessions.

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Early Intervention Service delivered by Team prevent to support early OH referral for staff with stress, msk and surgery	Melissa Swindell	02/02/2015	Delivered and on-going - subject to quarterly monitoring
Supportive interventions to be identified between HR and CBUs/Heads of Department	Melissa Swindell	03/05/2016	
Increase attention on wellbeing through change in Team Prevent's focus, establish Trust Health and Wellbeing Steering group	Fleur Flanagan	01/12/2016	Plan in place to establish an enabler team with LiA
Monitoring effectiveness of Sickness Absence Policy	Fleur Flanagan	31/01/2017	
Additional support to be provided to aid managers with implementation of Policy	Fleur Flanagan	03/04/2017	

Date Last Reviewed	Review Details

This risk has not been reviewed.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Research financial model
Ref: 56	Risk Owner: Charlotte Orton	Originating BU / Programme: Business Support	
Reporting Committee: CQAC		Where Risk Managed: Corporate	
Internal	Link to Quality AimsCQAC		
Strategic Objective: International Innovation, Research & Education			Current IxL 3-4 / Target Residual - Appetite for Risk 3-1 / Trend: STATIC

Description	Causes	Consequences
Unsustainable internal financial model for research	Finance department overheads on expenditure.	Overheads exceed available income preventing expansion of research and creating a financial defecit

Existing Set of Controls	
• Levying of overhead charge on research monies is detrimental to future research growth. Recurrent cost pressure on provision of basic Reseach Management & Governance function.	• Ongoing discussions with new Director of Finance to address issue of overhead charge against RBU.
• Agreed that a fixed overhead target will be set at the beginning of the financial year based on the Trust calculated figure of what the RBU costs as an overhead. Once the overhead target is reached any surplus monies will be retained by the RBU and reinvested in research	

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Meet with Finance to discuss options and agree implementation plan	Mathew Peak	20/06/2014	Draft finance model prepared for initial discussion Aim to complete by June 2015
A finance model has been completed and agreed with Director of Finance	Lucy Cooper	20/12/2016 20/12/2016	
We are in the process of undertaking a commercial research scoping exercise that aims to establish options for drawing in additional commercial income to the trust and the department.	Lucy Cooper	31/01/2017	
We also have a KPMG plan which outlines costs per patient. Our next steps is to seek and secure assurances from the trust that we will be able to mobilise the clinical workforce to allow us to grow our commercial portfolio .	Lucy Cooper	20/12/2016	

Date Last Reviewed	Review Details
02/11/2016	Risk remains static. CRBU team met with Finance Director and the Business Case was finalised (26/9/2016). He is pleased with the work we have carried out so far. Jonathan Stephens has requested an additional piece of work around scoping and horizon scanning commercial research opportunities globally for Alder Hey. The CRBU team hope to have completed this by the end of 2016. No further updates.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register		2016--17	Risk Title: Utilisation of clinics, wards and theatres
Ref: 723	Risk Owner: Margaret Barnaby	Originating BU / Programme: Business Support	
Reporting Committee: RABD		Where Risk Managed: Corporate	
Internal	Link to Quality AimsRABD		
Strategic Objective: Excellence In Quality			Current IxL 4-3 / Target Residual - Appetite for Risk 3-2 / Trend: STATIC

Description	Causes	Consequences
There is a risk that the utilisation of clinics, wards and Theatres isn't as effective as it should be	-Clinics cancelled with less than 6 weeks' notice -Patients do not attend (DNA) -Patient and Hospital short notice cancellations -Long stay patients stay longer than expected -Delayed discharges/ transfers -Staffing levels/ scheduled activity -Excess bed days -Theatre late starts, overruns -Sessions cancelled -No clear policy for transfer of care to/from a local authority -Booking system unable to support complex pathway patients or capacity constrained specialties	-Quality of patient experience suffers leading to increased number of complaints -Increased time spent on managing utilisation issues - "crisis management" -Fall in income from Commissioners -Possible additional scrutiny by Commissioners, NHSE and regulators -Wasted capacity -Management of queues of patients

Existing Set of Controls	
• Utilisation reports	• Text reminders service and partial booking
• Performance management meetings at CBU and Trust level	• Discharge planning including EDD
• Theatre utilisation group and list planning	• Policy and controls for cancellations of clinical activity with less than 6 weeks' notice
• Trust access policy	• Weekly TUG meeting refreshed and refocused by new Theatre Manager
• Implementation of real time ADT	• Appointment of Head of Performance & Planning to manage performance related issues
• OPD clinic template review for all consultants	• MT6 OP data quality review process
• OPDQ group in place to identify & resolve system issues	• Visibility of clinic utilisation through business information system (InfoFox) regularly reviewed as part of CBU performance and reported weekly at WWT Group and CBU Performance Review Meetings

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Development of real time business intelligence system	Jonathan Stephens	/ /	Ongoing
Scheduling work commenced looking at maximising available capacity	Margaret Barnaby	/ /	Ongoing
OPDQ group in place to identify system issues	Margaret Barnaby	17/08/2015	To continue with the group post go-live
Develop in-session utilisation of clinics	Richard Turnock	31/12/2015	Needs to be scoped in context of Meditech v6 functionality. Theatre user Group to be relaunched which will identify operational efficiencies

Phase 2 HWWITF projects to be developed to maximise benefits of CHP	Hilda Gwilliams	31/12/2015	Project Plans for Improving Outpatients & Improving Flow workstreams developed and performance managed at CQAC
Deliver actions agreed with medical staff re Theatre efficiencies including start times, session lengths and capacity.	Rachel Greer	31/12/2015	Work ongoing to align theatre and medical staff.

Date Last Reviewed	Review Details
22/12/2016	November performance improved, still not reaching target sustainably however.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: CIP Delivery 16/17		
Ref: 936	Risk Owner: Claire Liddy	Originating BU / Programme: Business Support			
Reporting Committee: RABD		Where Risk Managed: Corporate			
Internal	Link to Quality AimsRABD				
Strategic Objective: Growing Our Services & Safeguarding Core Business			Current IxL 4-3	Target Residual - Appetite for Risk 2-3	Trend: STATIC

Description	Causes	Consequences
Non delivery of CIP target of £7.2m, £5m gap.	Lack of deliverable schemes	Trust will not balance its budget

Existing Set of Controls

• 1. Weekly Reviews at Execs
2. PMO Assurance Methodology
3. External Programme assurance extended for 12 months

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
focus on workforce schemes to bridge recurrent gap of £2.5m	Melissa Swindell	30/12/2016	improved CIP forecast in year to £6.2m (improvement on in year £5.2m planning assumption). Focus on in year gap to £7.2m target of £1m and recurrent gap of £1.8m against recurrent target of £9.5m
CIP gap reduced to £0.7m through performance mgt at 'Internal Recoery Group'. Recurrent gap reduced to £0.5m,	Claire Liddy	06/03/2017 06/03/2017	Risk value has reduced considerably.

Date Last Reviewed	Review Details
06/03/2017	Risk value has reduced considerably.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register		2016--17	Risk Title: Compliance with mental health standards
Ref: 524	Risk Owner: Andrew Williams	Originating BU / Programme: Community	
Reporting Committee: CQAC	Where Risk Managed: Corporate		Changed from Business Unit level on 01/03/2017
Internal	Link to Quality AimsCQAC		
Strategic Objective: Excellence In Quality			Current IxL 4-3 / Target Residual - Appetite for Risk 4-1 / Trend: STATIC

Description	Causes	Consequences
The Trust was granted mental health staus in 2013 and yet the Trust has failed to integrate the CAMHS statutorty and mandatory trining requirements into its own programme. This means we have staff caring for acute mental health patients without formal training and could be in breach of our policies which we submitted to the CQC around compliance.. failure to implement CAMHS training including roll out of Approach training across the Trust following CQC compliance and mental health registration Part of CQC accreditation to be a mental health Trust includes having an RMN/LD nurse on site on duty 24hrs a day. We are not compliant with this standard and if reviewed we may lose accreditation and staus as mental health Trust failure to achieve compliance with CQC standards as a mental health Trust.	Staff are caring for CAMHS patients without any formal training, training in part delivered by DJU team compromising their own operational delivery. Trust has not integrated the training into its own mandatory and statutory training programme No RMN/LD cover on site all day and night.	Possibility of losing accreditation as a MH Trust

Existing Set of Controls	
• meeting arranged to discuss way forward with L and D Director	• Discussed at CQAC and follow-up meeting agreed with Gill Core (Exec) to discuss options with Edge Hill Uni
• some training in isolation	• Contingency plans rely on additional resource or organisational change

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Meeting arranged with Melissa Swindell after previous meeting with Pat Tyrer failed to move anything forward	Stephen Earnshaw	28/03/2014	
Looking to develop e learning module and reader with POC and learning and development.	Stephen Earnshaw	30/09/2014	
Updated training needs in RM40 Suicide prevention policy	Stephen Earnshaw	14/09/2014	
employed an LD nurse and RMN on 4C extended hours of work of SPA team by April 16 weekend in call from SPA team to attend 4C to review weekend CAMHS patients	Andrew Williams	04/04/2016	
Three staff now trained to deliver Mental Heath first aid training . All new nursing recruits in April (37 staff) trained. Annual training programme to be planned .	Brigid Doyle	25/10/2016	
CBU business plan 2017/18 includes plan to bring Dewi Jones Unit back onto main site, providing 24/7 mental health presence on site	Jacqueline Flynn	18/12/2017	
Three LD Nurses due to start employment in May 2017	Andrew Williams	30/01/2017	

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Date Last Reviewed	Review Details
30/01/2017	Owner changed from Jacqui Flynn to Andrew Williams. Risk rating changed to bring along consequance line. New action added re: new LD nurses starting in May.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Case Note availability
Ref: 604	Risk Owner: Margaret Barnaby	Originating BU / Programme: Business Support	
Reporting Committee: RABD		Where Risk Managed: Corporate	
Internal	Link to Quality AimsRABD		
Strategic Objective: Patient Centred Services			

Current IxL	Target Residual - Appetite for Risk	Trend: STATIC
4-3	3-2	

Description	Causes	Consequences
There is a risk that case notes are not available or in a suitable format for clinicians in clinic	- The notes are not available within the ImageNow system. - The notes are not in the location that they are tracked to within the case note tracking system. - Lack of process for scanning external & loose correspondence sent to medical records.	This can cause delays to patient care and could potentially mean that key clinical information is not available at the point of care

Existing Set of Controls

• Set of KPIs agreed and currently being measured	• High level project plan and milestones in place. Project team in place
• Scanning Quality Control process established QA process for all scanning (internal and external) in place and occurring.	

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Proposal for real-time scanning of purple notes together with proposal for scanning outstanding notes to go to Execs 20 Oct 2016	Margaret Barnaby	12/10/2016	A room on site to be identified to facilitate this. All OPD records presented to Medical Records are now scanned within a maximum of 7.5 working hours. To help reduce this further a member of staff has been identified to become a dedicated transporter for the collection of OPD records. This has allowed an additional 4 collections a day giving a total of 6 collections a day to help ensure that OPD records are scanned as quickly as possible. Work needs to be done to ensure that notes are released form the clinical rooms as soon after the patient departs and left in the dedicated collection points for the transporter to collect.
Ensure clear Policies and audit process for returning of paper-lite notes and outstanding Buff notes to HRL	Mandy Burns	12/10/2016	Paperlight - as part of the ImageNow upgrade both Lexmark and IT are exploring possible opportunities. Paper case notes - a process is in place to ensure all case notes sent to community clinics are return. Exploring the possibility to extend this to other clinics that paper case notes are released to.
Process for retrospective bookmarking of scanned noted to be agreed and resourced	Margaret Barnaby	12/10/2016	
Review of staffing resource to deliver all elements of digitisation project and sustainability of electronic health records	Margaret Barnaby	12/10/2016	Band 4 Senior Auditor post has been agreed at Vacancy Panel; awaiting AfC banding. The 2 WTE x Band 2 staff for the scanning of Day Forward for a trial period of 3 months are now in post and are currently in the process of being trained. Once this has been completed the 4.2 WTE Band 2 staff for the scanning of the back log and also the 1.1WTE Band 3 staff the complete the QA process will be appointed.

Date Last Reviewed	Review Details
11/01/2016	risk updated

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Data Quality: degradation of DQ due to system and process issues.
Ref: 949	Risk Owner: Margaret Barnaby	Originating BU / Programme: Business Support	
Reporting Committee: IGC	Where Risk Managed: Corporate		
Internal	Link to Quality AimsIGC		
Strategic Objective: Patient Centred Services			Current IxL 3-4 / Target Residual - Appetite for Risk 2-2 / Trend: STATIC

Description	Causes	Consequences
Data Quality: degradation of DQ due to system and process issues. Increasing evidence that poor data quality is impacting on our ability to deliver a quality clinical and business service.	multiple to include poor processes, lack of compliance, system issues, lack of understanding of impact, failure to follow SOPs	clinical, business, financial, operational impact in delivery of services

Existing Set of Controls

• Ad-hoc review underway of DQ governance structure	• Data Quality Steering Group established (reporting to Board via IGC)
• Base line assessment against data quality standards now complete	• Data Quality Dashboard in place to track progress
• Data Quality Strategy approved	• Managerial & Clinical DQ Lead (or champion) for each business area in place (all are members of the DQ Steering Group and expected to liaise with relevant CBU Board, or equivalent Group)

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Take forward key DQ controls and maintain strategic focus for 2016/17	Margaret Barnaby	12/10/2016	Key SOPS have been updated and signed off by the OPD Senior team. Work has begun on next set of SOPS. Good Practice approach and Standards to be adopted by other OPD functions who are not part of the core OPD team (Community, CAMHS) - Timeline for this is by End of March 2017. ePPF implemented mid January - this process was to ensure timely cash up of clinic/every patient with a plan for follow up/discharge. Process has been successful in reducing the risk of admin burden on clinicians, and ensuring cash up is complete and monitored. Current position - some backlog still outstanding however the risk associated with incomplete/inaccurate/delayed cash up has been reduced
Team now looking to mitigate and reduce gaps in data quality standards	Elaine Morgan	12/10/2016	Booking and scheduling standards Task & Finish Group to include improvement of standardised SOPs and formal electronic EPPF process which will directly improve DQ compliance during Q4

Date Last Reviewed	Review Details

This risk has not been reviewed.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Junior doctors - staffing levels
Ref: 720	Risk Owner: Richard Turnock	Originating BU / Programme: Business Support	
Reporting Committee: CQAC		Where Risk Managed: Corporate	
Internal	Link to Quality AimsCQAC		
Strategic Objective: Great Talented Teams			Current IxL 4-3 / Target Residual - Appetite for Risk 4-3 / Trend: STATIC

Description	Causes	Consequences
There is a risk of insufficient junior doctors being available to cover duties required in clinics, wards theatres and to staff the acute rotas	_National difficulties in recruitment to paediatric specialties _Short term - maternity leave and program short of doctors- now resolved _Medium term - probably improving with STP? _Long term difficulty in attracting junior doctors to work with children	_Short term - junior doctors not available when required - increasing workloads and pressures on other staff _Medium term - junior doctors leave to find alternative opportunities _Long term - difficult to sustain a realistic working model

Existing Set of Controls

• Constant monitoring of national/local situation through liaison with HEE/CBU reporting	• Visibility of junior staffing levels as part of overall Trust workforce planning

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Need to scope likely short falls through CBU monitoring		17/08/2015	2x SCPs in development
Implement PACE Team		17/08/2015	SAAT plans approved Modified SAAT plans approved
Develop in house training programmes for alternative practitioners - e.g. ANP etc development, Surgical Care Practitioners with partner HEIs	Philip O'Connor	17/08/2018	ANPs now started training

Date Last Reviewed	Review Details
15/03/2017	Progress made through OOH working group. Universal middle grade rota to be developed across acute paediatrics and specialties. Patient pathways to be developed, in order that patients seen by the right doctor at the right time. May require job planning reviews around 7 day services

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Mandatory training compliance
Ref: 172	Risk Owner: Melissa Swindell	Originating BU / Programme: Business Support	
Reporting Committee: WOD	Where Risk Managed: Corporate		
Internal Monitoring	Link to Quality AimsWOD		
Strategic Objective: Great Talented Teams			Current IxL 3-4 / Target Residual - Appetite for Risk 3-1 / Trend: STATIC

Description	Causes	Consequences
Mandatory training target not achieved in all subject areas	Staff not attending mandatory training or completing training requirements as per Workbooks/elearning relevant to their role. Lack of universal access to e-learning modules due to IE compatibility problems Difficulties in releasing staff to undertake training in work time Essential for HR to clarify for Trust managers how compliance data can be accessed and monitored, and where accountability for compliance lies Essential for HR to gain internal assurance of OLM data quality	Non compliant with Trust targets and causing potential safety issues with staff not having received the basic minimum training requirements.

Existing Set of Controls

• monthly corporate reporting	• Policy in place but needs review
• Mandatory training workbooks provide an alternative method for completing training, rather than in the classroom	• Develop alternatives to e-learning modules due to IE compatibility issues

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Specific intervention in practical Manual Handling	Fleur Flanagan	31/01/2017	Gap analysis underway
Mandatory Training Database under review	Melissa Swindell	30/04/2015	Data cleansed and period between programmes adjusted on a risk basis
Improve compliance to agreed rates through various methods across all relevant subjects	Fleur Flanagan	31/01/2017	E-learning package being explored; currently working with IT re suitable software package
Local reports to be provided to CBUs	Fleur Flanagan	31/10/2016	

Date Last Reviewed	Review Details

This risk has not been reviewed.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register			2016--17	Risk Title: Compliance with H&S Regulations in relation to Manual Handling		
Ref: 725	Risk Owner: Melissa Swindell	Originating BU / Programme: Business Support				
Reporting Committee: H&S		Where Risk Managed: Corporate				
External	Link to Quality AimsH&S					
Strategic Objective: Great Talented Teams				Current IxL 4-3	Target Residual - Appetite for Risk 4-1	Trend: STATIC

Description	Causes	Consequences
Breach of Manual Handling Operations Regulations	- levels of training compliance not meeting Trust target of 90% - Non release of the 79 Manual Handling Key Trainers resulting in non-compliance of their training , therefore leading to training not being carried out in local areas	- Enforcement Action/Prosecution by HSE - Increased risk of injuries to staff - Increased risk of Employer Liability Claims

Existing Set of Controls	
• Manual Handling Policy	• Mandatory Training in Manual Handling

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Health & Safety Team delivering practical manual handling training across the organisation.	Amanda Kinsella	30/09/2015	From February 2015, 130 staff trained = 22% of staff trained. Progress with training ongoing. At end of May 2015, approximately 500 staff trained, difficulty obtaining data from OLM so unclear as to how many staff remain outstanding, approx. 400. H&S Team compiling lists of staff for completeness to produce final training schedule in order to achieve compliance for September 15.
H&S Adviser will be allocated to focus their time (3 days per week) on MH which will include training, risk assessment, supporting staff, reviewing incidents and claims.	Amanda Kinsella	07/09/2016	

Date Last Reviewed	Review Details
06/03/2017	Residual mitigating actions merged with 1196

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register		2016--17	Risk Title: Lack of sepsis recognition
Ref: 1102	Risk Owner: Richard Turnock	Originating BU / Programme: Business Support	
Reporting Committee: CQAC	Where Risk Managed: Corporate		
Internal	Link to Quality AimsCQAC		
Strategic Objective: Excellence In Quality			Current IxL 5-2 / Target Residual - Appetite for Risk 5-2 / Trend: BETTER

Description	Causes	Consequences
Lack of recognition of a child with sepsis	Awaiting implementation of new sepsis strategy	Possible death of a child

Existing Set of Controls	
• Trust's Antimicrobial guidelines	• Actions of the Antimicrobial Stewardship Group
• Pharmacy guidelines regarding the administration of iv antibiotics within 1 hour of prescription	• PEWS trigger scores - now ensures consultant to be contacted if over 4

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
establishment of multidisciplinary group to implement paediatric sepsis 6	Stephane Paulus	01/09/2016	Full Project Implementation Team established that meet every 2 weeks
awareness of paediatric sepsis 6 included in IPC mandatory training for clinical staff	Geraldine Sefton	/ /	ongoing
Development of standardised process for the management of sepsis using the paediatric sepsis 6.	Stephane Paulus	/ /	Pilot of 4 Sepsis Toolkits scheduled following training of Sepsis Pathway
paediatric sepsis 6 awareness and training for medics	Graham Lamont	07/03/2017	being rolled out at Grand Round
Chair of Sepsis Steering Group (Consultant Lead for implementation of Sepsis Strategy) to attend March CQAC (assurance committee) to provide assurance on progress	David Porter	22/03/2017	

Date Last Reviewed	Review Details
16/12/2016	New documentation developed by Dr Paulus being trialled on ward 4C

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Clinical environment in theatres not maintained effectively, and to relevant health and safety medical regulatory standards		
Ref: 1181	Risk Owner: David Powell	Originating BU / Programme: Surgery			
Reporting Committee: IGC		Where Risk Managed: Corporate			
Internal	Link to Quality AimsIGC				
Strategic Objective: Excellence In Quality			Current IxL 3-3	Target Residual - Appetite for Risk 3-2	Trend: STATIC

Description	Causes	Consequences
Concern that theatres are not maintained in line with guidelines. Concern that issues of importance are not responded to in an appropriate timely way.	Lack of clarity over practices and procedures in place	Concern over level of risk. Potential to impact on surgical cases i.e. surgical site infection.

Existing Set of Controls	
• PPM Register & Records	• Trigger of payment realisation
• Escalation process confirmed and clarified	• Monitoring of response times and audit of PPM Red Button mechanism built into Partnership Charter
•	

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review

Date Last Reviewed	Review Details

This risk has not been reviewed.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register		2016--17	Risk Title: Delivering Operational Activity
Ref: 721	Risk Owner: Margaret Barnaby	Originating BU / Programme: Business Support	
Reporting Committee: RABD	Where Risk Managed: Corporate		
Internal	Link to Quality AimsRABD		
Strategic Objective: Excellence In Quality			Current IxL 3-3 / Target Residual - Appetite for Risk 3-2 / Trend: BETTER

Description	Causes	Consequences
There is a risk that the Trust fails to deliver the levels of activity expected under the various contracts with commissioners	- CBUs encounter operational problems - singularly and collectively in terms of capacity (beds, theatre slots, clinic sessions) and the most appropriate resources required to provide that capacity - Lack of available, trained workforce to ensure all physical capacity utilised - Impact of industrial strike action - Sustained above average sickness and absence levels affect all parts of the Trust - System & Operational consequences of post go live being realised and subsequently managed	- Clinical and financial targets not achieved - Increased scrutiny from commissioners and regulators - Spiralling effect of increased pressure through dealing with backlogs to deliver the activity - Pressure to achieve 18 week incomplete pathway target - Booking and scheduling processes are not supporting timely addition to waiting lists - INTouch is not supporting check in activity onto Meditech 6. This means that patient activity is not tracked losing income and potentially recording patients as DNA - EPPF process is not being followed meaning patient outcomes are not being recorded. This means that 18 week pathways remain open skewing waiting list size, incomplete pathway waits and generating cost as teams are required to validate later in the process -

Existing Set of Controls

• On-going daily, weekly, monthly monitoring of activity across CBUs.	• Performance management systems and processes established.
• Additional resources for Transformation team	• Monitor activity through COGNOS activity reports
• Weekly Exec performance reviews	• Recovery plans where activity off target
• Comprehensive Winter Plan implemented for delivery of activity & achievement of RTT	

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Ensure operationalisation of EPR delivers in a manner that allows successful 18 week management	Margaret Barnaby	/ / 31/10/2016	Completed
Ensure execution of all agreed collective actions for improvement in operational productivity	Lachlan Stark	/ / 31/03/2017	Task and Finish resulted in a re-forecast year end activity level. All CBUs are on track as at end Jan 2017.
Exec Activity review & remedial plan discussion	Margaret Barnaby	/ / 31/10/2016	weekly meeting to review activity against plan
Daily activity published through COGNOS	Margaret Barnaby	/ /	Ongoing. System operational publishing activity against original plan

Weekly Winter Planning Meeting to look at forecast	Dan Grimes	12/10/2016 31/03/2017	Completed. Winter Plan in situ for Winter 2016-17 and is effective.

Date Last Reviewed	Review Details
22/12/2016	Contract activity & performance remained stable during November. Daily & weekly tracking of activity in place to optimise RTT and contract activity each month of final quarter.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Negative patient experience due to short notice cancellations
Ref: 722	Risk Owner: Margaret Barnaby	Originating BU / Programme: Business Support	
Reporting Committee: RABD	Where Risk Managed: Corporate		
Internal	Link to Quality AimsRABD		
Strategic Objective: Excellence In Quality			Current IxL 4-2 / Target Residual - Appetite for Risk 4-1 / Trend: BETTER

Description	Causes	Consequences
There is a risk that last minute cancellations impacts negatively on patient experience, clinical care and disrupts the flow of patients through the hospital.	-Theatre and ward staffing -Bed closures -Emergency Theatre usage and utilisation	Increased number of complaints and general lower levels of good patient experience

Existing Set of Controls	
• Weekly scheduling meeting - service managers and theatre staff	• Performance meetings at CBU and Trust level
• Implementation of real time ADT	• PRAID team in place utilising SRG monies
• Workforce Strategy and associated plans approved by Ops Board	• 2016/17 Winter Plan agreed to minimise risk of elective cancellations
• Winter Planning Meeting in place led by Dan Grimes	

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Implementation of plans to facilitate improved discharge of patients with complex needs	Dan Grimes	30/11/2015	CCG and Specialised Commissioners failed to identify funding to establish a complex care pathway in 2017-2019
Recruitment plans for ward staff and theatres including an International Strategy	Melissa Swindell	/ /	As at Jan 2017 nursing establishment is full, with very low levels of agency nursing in use, and fewer cancelled operations due to staff shortages.

Date Last Reviewed	Review Details
22/12/2016	Only 4 elective cancellations during Nov 2016 due to no bed

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Inability to meet the 4 hour target within ED		
Ref: 815	Risk Owner: Margaret Barnaby	Originating BU / Programme: Medicine			
Reporting Committee: Board		Where Risk Managed: Corporate			
Internal	Link to Quality AimsBoard				
Strategic Objective: Excellence In Quality			Current IxL 4-2	Target Residual - Appetite for Risk 4-2	Trend: BETTER

Description	Causes	Consequences
There is a risk that the 4 hour target will not be met within the CHP	Loss of ability to book into an observation area within ED Process changed required with layout of a new department Limited bed availability at times.	National target not met

Existing Set of Controls	
• EDU has 11 beds for ED to admit into over the winter. EDM tracker available in patient flow Hub to enable visibility of status of ED	• Alder Hey now part of the Liverpool ED Group to ensure ED improvements are implemented
• Breach activity report distributed to GM's and service managers on a weekly basis	

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Breach activity report to be distributed to GM's and service managers on a weekly basis	Amanda Turton	17/11/2015	ongoing
work ongoing with CCG re GP on site and use of primatry care facilities outsude Trust	Kate Brizell	08/05/2016	Was not agreed and did not proceed.

Date Last Reviewed	Review Details
22/12/2016	ED performance will fail quarter 3 (predicted 92.5%). Year to date 94.5%. Recovery Trajectory being finalised for quarter 4, in order to deliver year to date 95%. High level of confidence.

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: RTT performance
Ref: 724	Risk Owner: Margaret Barnaby	Originating BU / Programme: Business Support	
Reporting Committee: RABD	Where Risk Managed: Corporate		
Internal	Link to Quality AimsRABD		
Strategic Objective: Excellence In Quality			Current IxL 3-2 / Target Residual - Appetite for Risk 3-2 / Trend: BETTER

Description	Causes	Consequences
There is a risk of not meeting key performance targets in relation to Referral to Treatment (RTT), 18 weeks waiting times.	_Ineffective managing of stages of treatment across: Admitted pathways; Non admitted pathways; Open pathways _Capacity issues _Available workforce: Theatre sessions; Clinic sessions; Bed usage _Increase in demand beyond current rates and those agree within annual contract _Ineffective management of 18 week pathways _PCO's listing patients in a non-chronological wrong order	-Quality of patient experience and care suffers -Increased time spent on managing performance issues -Possible additional scrutiny and fines by Commissioners, NHSE and regulators

Existing Set of Controls

• Performance management meetings at CBU and Trust level	• Trust wide action plan to address data validation, data quality and administration of 18 week pathways
• Completion of IST action plan	• Implementation of real time ADT
• Revised Patient Access Policy now published and operational to provide platform for discharging DNA's	• New SOP's developed for MT6

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Capacity and demand assessment at each service line level to deal with 'steady state' and reduce backlog in agreed timescales	Margaret Barnaby	/ /	Ongoing
Recruitment to agree workforce complement	Hilda Gwilliams	/ /	Ongoing
Reduce sickness absence	Melissa Swindell	/ /	Ongoing
Completion of booking and scheduling action plan	Margaret Barnaby	30/11/2015	Reports monthly to PMG, weekly task and finish group. Revised action plan submitted to PMG in Dec for monitoring and assurance. Review of all SOP and processes underway by new manager following failure to process internal referrals Initial under 6 weeks actions completed. Ongoing work required on full action plan for booking and scheduling due to delayed deployment of MTV6 and move to CHP.
Improve hospital flow and discharge planning	Margaret Barnaby	/ /	Ongoing. Bid to spec com for support with hospital discharge co-ordinator
Implement revised DNA process within updated Patient Access Policy	Margaret Barnaby	30/09/2015	Currently an active item being tracked through PMG CBU's to present PA policy at Boards

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Date Last Reviewed	Review Details
22/12/2016	RTT met during November overall. 1 cancer breach was made resulting in no harm

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register	2016--17		Risk Title: Nurse staffing levels and associated recruitment
Ref: 718	Risk Owner: Hilda Gwilliams	Originating BU / Programme: Business Support	
Reporting Committee: CQAC		Where Risk Managed: Corporate	
Internal	Link to Quality AimsCQAC		
Strategic Objective: Great Talented Teams			Current IxL 3-2 / Target Residual - Appetite for Risk 3-1 / Trend: STATIC

Description	Causes	Consequences
There is a risk of insufficient qualified nurses being available to cover duties required in clinics, wards and Theatres.	_Maternity leave (main contributing factor; comparative analysis shows equivalent to -40WTEs at any one time) _Short term sickness and absence _Medium term inefficiencies to develop nursing staff capability and capacity _Long term difficulty in attracting, developing and keeping suitably experienced and qualified nurses to work with children and at AH	Short term - experienced nurses not available when required - increasing workloads and pressures on other staff _Medium term - experienced nurses leave to find alternative opportunities _Long term - difficult to sustain a realistic working mode

Existing Set of Controls	
• Agreed levels of staffing to meet national guidance.	• Finances agreed by Board
• Recruitment process in place.	• SoP in place for escalation of skill mix / staffing / bed closure
• Introduced temporary staffing procedure requiring senior authorisation for any emergency support from NHSP	• Robust sickness and absence policy overseen by HR
• Monitoring of incidents/ complaints where staffing levels are a factor: observing for trends and themes	• Themes and trends reviewed weekly by RMT and when evident discussed at weekly meeting of harm: these include incidents/ near misses relating to reduced nurse staffing levels.

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
Continue to work closely with HEI's and have undertaken successful national and international recruitment during March 16 enabling the Trust to fill all vacancies and build resilience within the nursing pool.	Hilda Gwilliams	03/10/2016	Quarterly meetings on-going. Continue to perform well in relation to recruitment from HEI's
Review impact of temporary workforce arrangements	Hilda Gwilliams	30/12/2016	Demonstrable improvements continuing to be seen
monitor bed closures resulting from nurse staffing issues	Hilda Gwilliams	12/12/2016	Demonstrable improvements being seen
monitor lost theatre sessions due to nurse staffing issues	Hilda Gwilliams	05/12/2016	Demonstrable improvements being seen
Recruitment programme on-going	Hilda Gwilliams	01/03/2017	Recruitment Plan in place for 17/18 inclusive of additional student nurse practice placements leading to increase in appointments

Date Last Reviewed	Review Details
02/03/2017	risk reviewed and progress against actions updated

Corporate Risk Register

Alder Hey Children's NHS Foundation Trust

Corporate Risk Register			2016--17	Risk Title: Clinical Engagement on EPR		
Ref: 573	Risk Owner: Richard Turnock	Originating BU / Programme: Business Support				
Reporting Committee: RABD		Where Risk Managed: Corporate				
Internal	Link to Quality AimsRABD					
Strategic Objective: Patient Centred Services				Current IxL 3-2	Target Residual - Appetite for Risk 4-2	Trend: BETTER

Description	Causes	Consequences
Organisation unable to deploy and/or realise the full benefits of the new Meditech EPR due to lack of engagement across the organisation; this would reduce the benefits to clinicians and patients in terms of patient experience and clinical effectiveness	Due to lack of engagement across the organisation	Reduce the benefits to clinicians and patients in terms of patient experience and clinical effectiveness

Existing Set of Controls	
• Sufficient clinical capacity to be created to allow credible engagement with the complexity of EPR. A comprehensive EPR communications and engagement plan to be delivered. Phase 1 issues to be worked through systematically; in particular training and capability gaps to be addressed.	

Actions to Reduce Risk to Target Residual Rating

Actions to Reduce Risk to Target Residual Rating	Resp.	Imp. Date	Progress Since Last Review
There has been strengthening of the in-house teams to support change but the risk of limited clinical engagement is high	Richard Turnock	04/04/2017	Though we are supporting a role to provide clinical support there is a concern about the resilience beyond this role as it does not seem that there any other clinicians with dedicated time to support this.

Date Last Reviewed	Review Details
08/03/2017	Clinician engagement much improved following recent Mv6 upgrades

Resource and Business Development Committee
Minutes of the meeting held on: **Wednesday 1st March 2017**, **at 1300**
Room 6, Level 1 Mezzanine

Present:	Ian Quinlan (Chair)	Non-Executive Director	IQ
	Mags Barnaby	Interim Chief Operating Officer	MB
	Claire Dove	Non-Executive Director	CD
	Claire Liddy	Acting Director of Finance	CL
	Melissa Swindell	Director of HR	MS
In Attendance:	Louise Dunn	Director of Marketing	LD
	Joe Gibson	External Programme	JG
	Debbie Herring	Director of Strategy	DH
	Laurence Murphy	Head of contracting	LM
	Erica Saunders	Director of Corporate Affairs	ES
	Julie Tsao	Committee Administrator	EJ
Agenda item:	Tony Johnson	Project Manager, Agile Working PID	TJ
	Chris Gildea	Operational Lead	CG
Apologies:	Sue Brown	Project Manager and Decontamination Lead	SB
	Janette Richardson	Programme Manager	JR
	Phil O'Connor	Deputy Director of Nursing	POC
	Peter Young	External IM&T Consultant	PY
	Lachlan Stark	Head of Planning and Performance	LS
	Rick Turnock	Medical Director	RT
	Graham Dixon	Head of Building	GD

16/17/193 Minutes of the previous meeting held on 27th January 2017
Resolved:
RABD received and approved the minutes of the previous meeting.

16/17/194 Matters Arising and Action log
It was agreed the update on Research Education Building II and the update on the programmes within the park work-stream would be received at the March meeting.

16/17/195 Performance
Mags Barnaby presented the activity plan, actual activity and re-forecast plan for each of the CBUs for Month 10. A&E targets had been met for month 10 and are set to achieve month 11. For Theatres to meet their targets 124 sessions would need to be carried out each week, this had been met for month 10. As Theatres are currently down by 2 Anaesthetist Consultants, this may affect Theatres targets for month 11.

RABD discussed the continuing high rate of DNAs in Outpatients despite efforts being made by the team. Mags Barnaby provided assurance to RABD that the reduction of DNAs is a main priority for the Executive team.

Resolved RABD:
Noted the contents of the report.

16/17/196 Finance report
For the month of January the Trust is reporting a trading surplus of £0.6m which is ahead of budget. The CBU forecast for month 10 provided at month 9, was £0.2m surplus in the month, therefore the Trust exceeded this forecast by £0.4m.

Income is ahead of plan by £0.9m but is offset by expenditure. The year to date deficit is £2.9m which is £0.1m ahead of plan, control total (CT).

The Use of Resources risk rating is 3 in line with plan and cash in the bank of £5.2m.

1.7m drugs overspend was reported, a review was to take place to resolve the overspend.

A discussion was held on the PFI service charges. The outstanding pieces of work are to be completed by PFI before the end of February, if the work remains outstanding the Trust will commence a claim.

The Trust has 2 leases for buildings on site. The leases had been extended for a further 2 years with a £1.7m saving agreed in the new contract.

CBUs are to present their forecast for quarter 1 by the end March 2017.

Workforce CIP
300K of Workforce CIP failures was reported. This would be presented at the Executive Committee on Thursday with a proposal to ensure no further slippage.

Resolved RABD:
Received and noted the content of the Finance report for month 10.

Internal Financial Recovery

The Trust continued to work towards the CT, however an indication for overachievement would not be submitted to NHSI as this was unlikely.

The likely gap is £1.6m (last month £2.2) and if all identified actions are converted into validated plans the remaining gap reduces to a best case of £1.1m (last month £1.5m).

Resolved RABD:
Noted the financial risk and how tight the position currently is which allows for a shortfall tolerance of £400k and continues to work towards control total and does not signal a plan to overachieve.

Medical equipment replacement programme briefing
RABD received a briefing on the Trust's position with replacement of medical equipment for the total value of £37m over the next 5-10 years.

Historically the Trust has purchased medical equipment using available internally generated cash balances. Given the Trusts current and medium term cash projections, it is now becoming more challenging to continue to fund the replacement programme through cash balances, therefore alternative options need to be considered.

Option 1: Operational Plan requires further loans.

Funding source	£000
Carry forward charity cash	289
New charity applications	300
ITFF loan (not approved)	800

Option 2: Plan B

Funding source	£000
Carry forward charity cash	289
Top slice large capex	600
STP incentive cash (50% of £1m)	500

Resolved RABD:

a) Noted the contents of the report:
b) Support the amendment of business case requirements to include an assessment of leasing and managed service options.
c) Consider a review of replacement assets against available resources (depreciation) to ascertain viability of alternative procurement methods outlined; and
d) Consider the proposal for alternative funding ("plan B") of 2017/18 capital programme.
e) It was agreed the risk would be added to the Board Assurance Framework if it was not already included.

Corporate report

RABD received the CR for month 10. MB highlighted the significant points;
1) ER targets had been met.
2) The winter plan had now been implemented.
3) Productivity had improved across the trust

Resolved RABD:

a) Received and noted the contents of the CR report for January month 10.

16/17/198 Programme Assurance 'developing our business'

The definition of the programme for 2017/18 was currently being finalised with the first update being presented next month.

Programme Assurance Agile Working PID

Tony Johnson presented the Agile working PID. The aim of the PID is based on the complete flexibility of work to drive long-term organisational success. Whilst it can unlock value for both the Trust and the staff, it will be driven by the Trust's business, financial and performance requirements.

The first pilot was due to commence in September 2017. RABD requested to see details of the pilot action plan. Melissa Swindell and Tony Johnson agreed to discuss this further outside of the meeting.

Resolved RABD:

Received the draft Agile Working PID and requested further details and an action plan on the pilot due to take place in September 2017.

Existing Community Services

Resolved:

As a number of areas were ongoing it was agreed to defer the report until all areas had been closed.

16/17/199 2017/18 CIP

In 2017/18 the Trust has a CIP target of £8m, which is a larger target than recent years and represents a significant challenge to ensure achievement of our financial objectives.

Business Units developed initial plans as part of the 2-year planning process, which were collated as part of the submission to NHS Improvement (NHSI) in December 2016. The paper provided a summary of progress to date. The current gap is £0.6m.

Resolved:

RABD noted the focus remains on planning and preparation for delivery of schemes.

16/17/200 Monthly Debt Write Off

The monthly debt write offs for February included an over payment of £6,550.68. RABD noted concern of the high payment. A discussion was held on the number of debts the Trust does receive and it was agreed this would be included in future reports.

Resolved RABD:

a) RABD APPROVED the monthly debt write offs for February for the total of £6,550.68.
b) To include debts paid back to the Trust in future reports.

16/17/201 Overseas Patient

Resolved:

RABD noted the report indicating new guidance for identifying and charging overseas patients, SOP for Emergency Department (ED) patients & current process for non-ED patients.

16/17/202 Business Development

The 2016/17 "Developing our Business" encompassed three discrete work streams:

- International & Non-NHS Clinical Business
- Strategic Partnerships
- CBU Business Development Plans

The work streams were allocated a £1.5m CIP target for the year with an in year contribution identified as £813k contribution in year, leaving a gap of £687k to meet the full target.

Resolved:

a) RABD noted the progress made to develop strategic partnerships during 2016/17
b) The new Strategic Partnership programme, together with associated benefits for 2017/18 is due to be presented at the April RABD.

16/17/203 Contract Income Monitoring

Laurence Murphy presented the Contract report for December 2016.

Total income cumulative to the 31st December was £159,947 which represents an over performance of £2,798k (1.8 %) compared to the profiled plan for the period of £157,149k . There was a material in-month over performance of £1,046k (6.3%) largely relating to electives & out-patient activity which had been expected to reduce over the Christmas & New Year period.

It is noted that January income continued to over performance plan by £901k however £348k of the over performance is offset by higher than planned expenditure on high-cost drugs.

The Trust has not achieved the Sepsis CQUIN target for all 3 quarters & has therefore incurred contract sanctions of £92k year to date . In addition a query notice has been received from Liverpool CQUIN requested more information regarding the quarter 3 CQUIN performance for Learning Disabilities & CAMHS, this has now been submitted.

Resolved:

RABD noted the report , indicating an income over performance of £2,798k (1.8%) for the 1st 9 months of the year. Year-end discussions underway & an update on any significant current contract issues & the latest position regarding the finances for the services transferring from LCH .

16/17/1204 PFI Contract Monitoring report

Chris Gildea presented the above report on behalf of Graeme Dixon, highlighting the following key points:

- Energy is still over target, the main area of overspend is within Theatres. Chris Gildea agreed to circulate the energy report to RABD.
- Settlement Deal 3'- The outcome of the settlement deal is due to be received on 31st March 2017.
- Four incidents had been reported in January with no claims. RABD requested future reports to include whether a claim has been submitted or not.

Resolved RABD:
Received an update on the PFI monitoring report and the Building Service Customer survey.

16/17/205 Liverpool Community Health Service Transfer

An update was given on the financial position and project plan for the transfer of services from Liverpool Community Health to the trust in the Non-Core bundle (known as the `lift and shift` services).

The Trust has been completing due diligence and negotiating financial envelopes since Jan 17 given there was a material financial gap between the CCG offer and the trust requirement. The formal TUPE process has been on hold. The due diligence report will be presented at the March Trust Board.

The Trust was aiming towards an overhead contribution of 20% across all 3 services (Liverpool, Sefton, Cochlear). The latest contractual position as at 16th is an overall income value of £5.373m with a contribution of 8% which equates to £421k.

To enable the TUPE process to be reinstated and the transfer deadline of the 1st April achievable, the trust has a mitigated plan which closes the financial gap in offers which is required to maintain the £421k contribution.

Resolved RABD:
Received and noted the contents of the progress update.

16/17/206 Weekly waiting times update

All access standards have been achieved for January. Winter Plan remains in place and is also being managed under the requirement from NHSI to run down the elective programme and subsequent capacity to 85% bed occupancy until the 16th January. This was required to ensure there is sufficient non-elective capacity within the system to manage demand. Our planning assumptions and actions taken supported this which ensured that we managed to maintain elective activity levels and achieved access targets.

Incomplete pathway performance for January is 92.4%. Monthly validation is still required to manage the data quality challenges however the Data Quality steering group and Out Patient Improvement group continue to tackle the current number of issues.

Resolved:
RABD received the content of the weekly waiting times report.

16/17/207 Board Assurance Framework

The risks for 2017/18 would be presented at the next meeting.
Resolved:

a) RABD received and noted the content of the BAF update.
b) RABD agreed to have an item at the next meeting to discuss priority issues for 2017/18.

16/17/208 Marketing and Communication Activity report

Louise Dunn updated the committee on recent press around the planning applications for the reinstatement of Springfield Park and the proposed residential application.

The 2 initial outline planning applications caused some concern in the local community, the Trust has decided jointly with the council to re-submit a combined planning application for both the park and residential development. In addition the Trust will engage more with the local community with respect to the plans, and potential benefits to the local area.

The residential development will enable the reinstatement of a better park of equal area, and will contribute towards it's running expenses. There will be a full community engagement plan for the process, led by Hil Berg. Planning application is anticipated to be submitted in April. The process to appoint the preferred developer is underway so more detailed plans can be developed and shared with stakeholders.

Resolved:
RABD received and noted the contents of the January 2017 report.

16/17/209 Any Other Business

No other business was discussed.

Date and Time of the next meeting: Wednesday 29th March 2017 at 9:30am, room 5, level 1.

Alder Hey Children's NHS
NHS Foundation Trust

Risk Management Strategy

Document Number	
Version Number	14
Scope	The purpose of this strategy is to provide a framework that ensures the Trust critically examines, and effectively manages all risks to people, systems and processes, which could impact upon or compromise the ability of the Trust to carry out its normal activities
Prepared By	Deputy Director of Risk & Governance
Target Audience	Trust wide
Other Relevant approved Documents	See section 17
Evidence Based/ Legislation	Health and Social Care Act 2012
CQC Essential Standards for Quality and Safety	This is an underpinning corporate strategy and in particular provides assurance of governance arrangements in compliance with the Well Led Domain
Consultation on Document	Complete
Equality Issues	Equality Impact Assessment complete
Training Implications	To be considered with CBU's, and corporate functions
Resource Implications	The devolved governance model provides resource in the CBUs to ensure clear focus on implementation of the strategy and focussed local leadership
Risk/H&S/Quality Implications	The strategy is designed to improve the management of risk and health & safety and therefore support quality improvement
Monitoring and Audit	Integrated Governance Committee, Audit Committee
Key Words	Risk, Assurance
Dissemination	See section 14
Approved by	Integrated Governance Committee, 11/01/2017
Ratified by	Trust Board
Review Date and by whom	11/01/2020 at Integrated Governance Committee
Date Valid From	Xx/xx/xxxx

Alder Hey Children's NHS
NHS Foundation Trust

Risk Management Strategy

2017/18

Version 14 – January 2017

Contents

1. Introduction

The purpose of this document is to provide a risk management framework that ensures the Trust proactively and continuously manages all risks to people, systems and processes to ensure the efficient and effective delivery of its service aims and objectives, and to protect patients, carers, visitors and staff from harm.

Risk is inherent in all aspects of the Trust's activities, including the treatment and care we provide to our patients, the determining of our service priorities, the projects and programmes that we manage, the equipment we purchase, the decisions we take on our future strategies, or deciding when no action is to be taken.

To effectively manage these risks requires a culture that engages **ALL** staff, and the recognition that risk management is a routine part of daily practice throughout the organisation with all staff making decisions based on formal and informal assessment of risk and potential consequences.

This document sets out the key risk management structures and processes, and identifies the intentions of the Trust Board and the responsibilities of all staff in the management of risk, including clinical, organisational and financial risk.

Risk Management
A framework for the systematic identification, assessment, treatment, and monitoring of risks, whether the risks are clinical, organisational, project, programme, financial or environmental

An effective Risk Management Strategy will provide a framework that will identify a **hazard**, and assess and mitigate the associated **risk** before it becomes an **issue**

Hazard
*A source of **potential harm** or a situation with a **potential to cause damage or loss***

Risk
*The probability or likelihood that harm, damage or loss **may occur**, coupled with the consequences of that harm, **if a hazardous event were to happen***

Issue
*Something that **has happened** and resulted in harm, damage or loss, and **requires management action***

2. Statement of Purpose

The Trust Board is committed to ensuring risk management is an integral part of Trust, Clinical Business Unit (CBU), Ward and Departmental objectives and management systems, so that all corporate, clinical, operational and financial risks are eliminated or reduced to an acceptable level with appropriate control measures in place.

The Trust Vision is to *build a healthier future for children and young people as one of the recognised world leaders in healthcare and research.* Implementation of the Risk Management Strategy is critical to delivery of the vision, and commitment and engagement from all members of staff is required to ensure children receive high quality, safe, effective care within a culture that values honesty and openness at all levels of the organisation.

Risks that are properly assessed and managed can help set priorities for the organisation, specific teams and individuals, and improve decision-making to reach a balance of risk, benefit and cost. This can only be achieved by having effective systems in place to ensure risks are identified and controlled.

The strategic approach reflected in this document strongly supports the requirements of the 'Well Led' CQC domain in developing an internal devolved risk and governance structure that reflects the necessary leadership at all levels of the organisation, ensuring clear accountabilities and effective processes to measure performance and address concerns.

This strategy is endorsed by the Chief Executive and ratified by the Board of Directors.

3. Scope of Strategy

This Strategy applies to the management of risk throughout Alder Hey Children's NHS Foundation Trust, and includes all staff whether full or part time, temporary, flexible workers or contracted staff.

4. Aims and objectives of the Strategy

The overall aim of the Risk Management Strategy is:
To ensure a comprehensive and cohesive risk management system is in place, underpinned by clear accountability arrangements with the proactive management of risk being an integral part of everyday activity across the Trust.

To assist in the delivery of the Risk Management Strategy the Trust has embraced the principles of a widely adopted Risk Management Maturity Model, recognised by Mersey Internal Audit Agency (MIAA). The need to review Risk Management processes will be considered by MIAA and discussed with management as part of the annual planning process, with a view to moving the Trust towards being recognised as a 'Risk Enabled' organisation. Further details of this approach are provided below.

- ***Risk Management Maturity Model***
  The Trust will continue to monitor its position against the Risk Management Maturity Model, with a view to becoming recognised as a '*Risk Enabled'* organisation, and will demonstrate that:
  - the Trust's '*risk appetite'* is a clearly defined and is used to drive the Board agenda,
  - Risk Management systems and processes are fully embedded into day to day workings of the Trust,
  - learning lessons and providing feedback are a key part of the approach.

In considering the major risks presented through the corporate risk register, the Board will be cognisant of the differentiation of 'risk appetite' and 'risk tolerance', and will use this differential to inform risk driven strategic decisions, whilst ensuring appropriate control is maintained to avoid unacceptable consequences.

'Risk appetite' is the risk that the Board will actively seek to engage in pursuit of its organisational objectives. This is recorded as 'target risk' when undertaking a risk assessment. 'Risk tolerance' is the limit of risks that the Board is able to cope with.

Risk Appetite
The amount and type of risk that an organisation is willing to take in order to meet its strategic objectives.

The Risk Management Maturity Model identifies key characteristics that an organisation should strive to improve, moving from a reactive to proactive approach to Risk Management. A summary of the high level characteristics is provided below, with full details of the model at Appendix 1.

Risk Tolerance
The limit of risk that an organisation is able to cope with.

Risk Management Maturity Model – High Level Characteristics

1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
The Trust has little or no awareness of the importance of risk management/ No formal approach developed for risk management as part of an integrated governance model.	*The Trust is aware of risk management responsibilities, and needs to embed systems/ Scattered silo based approach to risk management..*	*The Trust has considered risk management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles risk management / Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite is clearly defined and used to drive Board agenda./ Risk management fully embedded into day to day workings of the Trust./ Learning lessons and providing feedback key part of approach.*
Reactive >>> **Proactive**				

The main objectives of the Risk Management Strategy are:

- *To protect children & young people, carers, visitors and staff from harm*
- *To protect the Trust from litigation and reputational damage from untoward events.*
- *To ensure the confidentiality and security of data processed by the Trust, whether service user or staff*
- *To provide assurance to the Trust Board that all risks are being appropriately identified, reported, mitigated and escalated.*
- *To ensure an effective integrated Board Assurance Framework is in place*
- *To ensure feedback systems are in place that enable lessons learned to be shared widely across the Trust.*
- *To ensure all staff are appropriately trained to identify, report and proactively manage risks.*
- *To ensure risk management is integrated into the planning and policy making mechanisms of the Trust in order to improve the quality of care*
- *To ensure compliance with all appropriate legislative, statutory and regulatory requirements, including NHS Improvement (NHSI), Care Quality Commission (CQC), Health & Safety Executive (HSE)*
- *To create a culture of proactive risk management with a positive approach to reporting of risks, incidents and near misses and establish an environment in which staff feel supported when things go wrong*
- *To ensure a process is in place that will enable*
    - *residual risk to be highlighted and assurance provided that appropriate control mechanisms are in place to maintain residual risk at an acceptable level.*
    - *the escalation of risks to an appropriate level, when necessary.*
    - *the documentation and timely review / update of all risks on the electronic risk management system.*

5. Roles and Responsibilities

Every member of staff has an individual responsibility for the management of risk within the Trust. Managers at all levels must understand the Trust's Risk Management Strategy and be aware that they have the authority and duty to manage risk within their area of responsibility.

There are specific roles and responsibilities for certain functions as well as a number of key committees and groups that provide the governance for managing risk across the organisation, the detail of which can be found in Appendix 2.
The overall Trust Governance Structure can be found at Appendix 5.

6. Board Assurance Framework (BAF) Process

Board Assurance Framework
A key mechanism which the Trust Board uses to reinforce strategic focus and maintain an understanding of risks that have the potential to impact on corporate objectives.

The Director of Corporate Affairs has responsibility for the development and implementation of the Trust's Board Assurance Framework.

This includes:

- Liaison with Mersey Internal Audit Agency with regard to the 'Director of Audit Opinion' which subsequently contributes to the Board's completion of the annual governance statement (*refer to Section 7*)
- Co-ordinating work across the Trust in respect of the Assurance Framework process
- Ensuring that the Trust meets the necessary reporting requirements.

The Board of Directors has delegated responsibility to Executive Directors for the development and dissemination of the Assurance Framework process across the organisation. The BAF is used by the Board of Directors and the Integrated Governance Committee as a planned and systematic approach to the identification, assessment and mitigation of the risks that could hinder the Trust achieving its strategic goals.

The BAF is linked to the corporate risk register to ensure that there is appropriate alignment of risks coming up the organisation to the BAF as well as risks emanating from discussions at Board.

7. Annual Governance Statement (requirement from National Health Service Improvement (NHSI) as part of annual reporting)

The Trust is required to prepare an annual governance statement which covers the wider aspects of risk management.

NHSI's quality governance framework may be used for information on good practice in quality governance. The Annual Governance Statement covers the following key points:

- Scope of responsibility
- The purpose of the system of internal control
- Capacity to handle risk
- The Risk and Control Framework
- Review of economy, efficiency and effectiveness of the use of resources
- Annual Quality Report
- Review of effectiveness of the system on internal control
- Conclusion.

8. Implementation of the Risk Management framework

The Trust is required to have effective systems in place to ensure that the organisation can identify and control all threats to the following:

- The safety of staff, patients, and others who may be affected by activities of the Trust.
- The maintenance of services and the quality of services provided by the organisation.
- The financial and operational viability of the Trust.
- The privacy of individuals, including but not limited to, the confidentiality and security of data processed by the Trust, whether service user or staff

The Trust will adopt the principles and apply the system below as identified in the International Organisation for Standardisation (ISO) risk management standard, ISO 31000:2009 Risk Management Principles and Guidelines, as recommended by the Chartered Institute of Internal Auditors (CIIA).
An outline of the stages of the risk management process that the Trust applies is given below.

8.1 Embedding Risk Management through a structure of devolved governance

The Trust has implemented a system of devolved governance which will enable the establishment of Quality Improvement Teams in each Clinical Business Unit (CBU) led by a CBU Head of Quality, and will provide local responsibility and accountability for ensuring ward and departmental risks are owned and managed locally. Each CBU / corporate function will monitor local compliance with the risk management framework, ensuring risk registers are populated and kept up to date, with appropriate controls and action plans delivered in a timely manner. Trust Board assurance will be gained by CBUs and departments providing regular updates to Clinical Quality Steering Group, Clinical Quality Assurance Committee and Integrated Governance Committee, with feedback being provided to local wards and departments to establish a true 'Ward to Board' system of governance with local accountability for delivery.

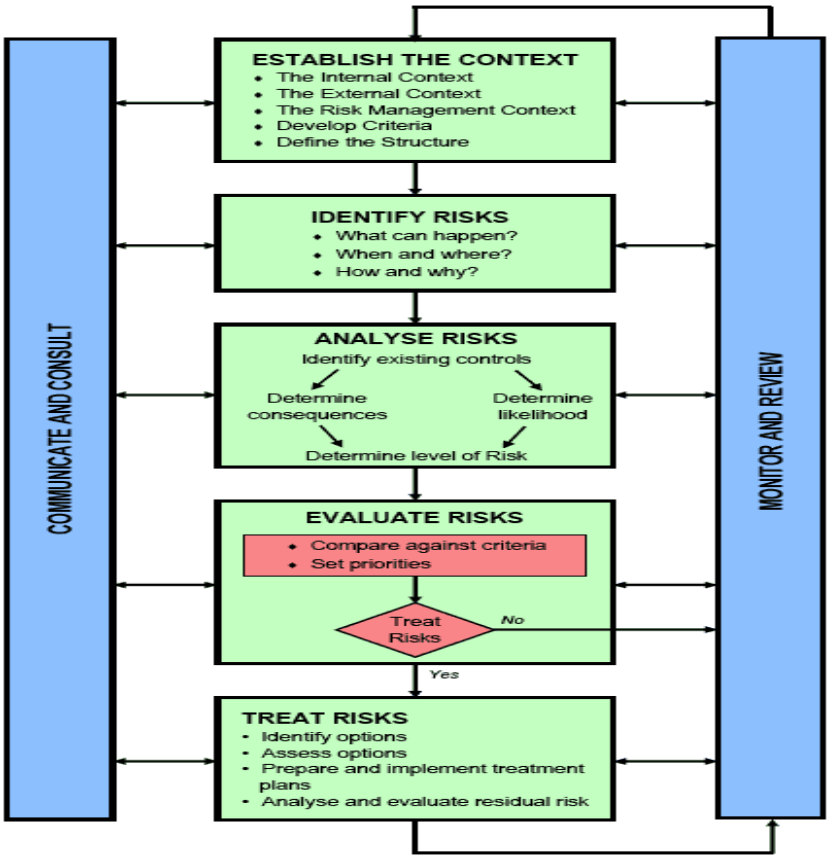
8.2 Trust Risk Assessment Process:

As part of routine daily practice, all staff will make decisions based on informal assessment of risk and potential consequences. Having determined that a situation or event has the potential to cause harm or disruption to the delivery of the Trust's

strategic aims and objectives, a formal risk assessment should be undertaken and documented, with appropriate control measures put in place to mitigate the risk. This involves several key steps including:

- **Establish the context** – including (but not limited to) strategic and operational planning, business objectives, financial and environmental context
- **Identify the risks** – e.g. from incidents, accidents, external or internal assessments, claims, complaints, safety alerts, audits, and others.
- **Analyse risks** – based on likelihood of the event happening vs the potential consequences if it did happen. Also requires an assessment of control measures that may already be in place.
- **Evaluate risks** – the National Patient Safety Agency (NPSA) 'risk grading matrix' is used to ensure consistency of grading of risks
- **Treat risks** - potential options should be identified and assessed as to their anticipated effectiveness. Suitable options should then be implemented and a further assessment made to determine the residual risk. This process should also include setting an acceptable risk level or 'target risk'. Target risk defines the '*risk appetite'*, which as a minimum, the control measures should set out to achieve.

The illustration below depicts a process that supports the assessment of risks.



Every risk should initially be managed at the point of risk identification. All risks should be monitored to ensure any control measures implemented are effective in removing or mitigating the risk.

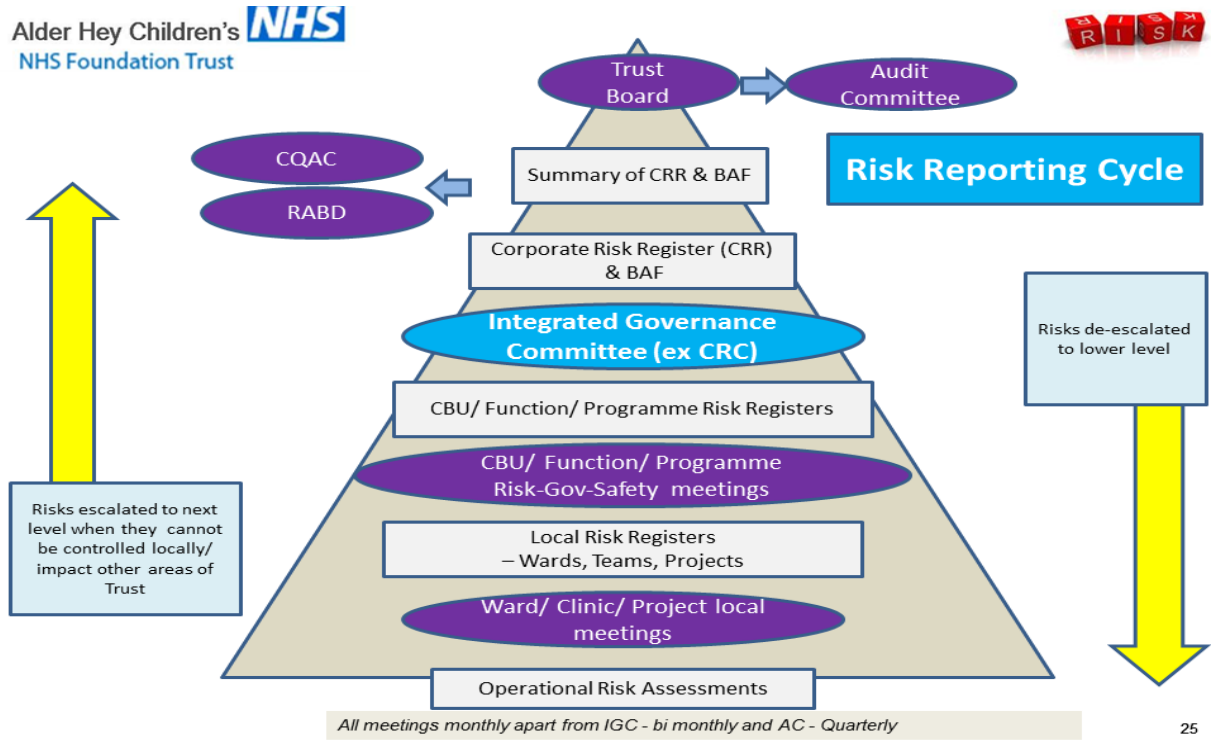
Risks should be reviewed at a frequency suitable for the type and level of risk, the potential impact of the risk, and the timescales built in to the control measure actions. The frequency of review is recorded on the electronic risk register which must be updated at each review.

If local control measures have been exhausted and are not effective in mitigating a risk or reducing the risk to an acceptable level, the risk should be escalated to the next level of management.

Further details of the risk assessment process can be found in the Trust's Risk Assessment Policy (RM4)

8.3 Risk Reporting Cycle & Escalation

The graphic below represents the Risk Reporting Cycle which reflects how risks should be managed at the appropriate level and demonstrates how the escalation of risks will ensure that the Trust Board is fully sighted on risks that have potential for significant impact on Trust strategic objectives.



8.3.1 Wards / clinics / corporate teams / local project groups will review local risk registers monthly to ensure newly identified risks are documented, and existing risks are discussed in respect of progress on outstanding actions / control measures or changes to level of risk. This discussion will consider the option of escalation to CBU / Corporate Department / Project Sponsor level.

8.3.2 CBU / Research Business Unit / Corporate Departments / Project Sponsors will review risks via regular Risk / Governance / Quality / Project team meetings. This level will consider existing and new risks on their registers, ensure controls and actions are implemented, and identify if any risks require escalation to the Corporate Risk Register (CRR). This information along with any proposals for escalation is then taken forward to the Integrated Governance Committee (IGC).
Additionally, CBU's / RBU are required to provide an annual 'deep dive' report to IGC to provide robust assurance around the management of risk locally, demonstrating that systems and controls are in place to ensure wards and departments are proactively reviewing risks and implementing appropriate mitigating actions.

8.3.3 Integrated Governance Committee (IGC) considers the exception reports from CBUs, Research BU, Corporate Departments, Project Sponsors and makes a judgement as to whether the risk is accepted onto the CRR or is devolved back to the Business Unit / Department with suitable recommendations and support for resolution. IGC will also agree to any necessary changes to the Board Assurance Framework (BAF), taking account of any gaps in assurance, progress against any outstanding actions and any potential new BAF risks emerging from discussions of the CRR.
IGC will produce an Assurance Report for the Board of Directors on the current position of the CRR and BAF. The Assurance Report will form the basis of reporting to the Audit Committee on a quarterly basis.

8.3.4 Audit Committee has delegated responsibility from the Board of Directors, to oversee this process, ensuring that there is adequate external review and assurance and that this is used to inform the Annual Governance Statement which is presented to Audit Committee by the Chief Executive Officer.

8.3.5 All areas holding a risk register from wards / departments to IGC should carry out a full risk register review on a six monthly basis and reassess all risks against annual objectives / strategic plan. In addition each CBU and Corporate function need to carry out various annual statutory risk assessments (health & safety, environmental etc), as per the Trust's Risk Assessment Policy and feed those assessments, as appropriate into their local risk register.

9. Communication, Training and Awareness

The revised Risk Management Strategy has been developed following the recent revision of CBU structures and roll out of a devolved model of risk and governance.

The Strategy will be widely shared across the organisation utilising electronic means, governance structures, and training sessions. It will form part of the Trust mandatory training sessions, and the Trust Induction package. Additional bespoke Risk Management training sessions will be provided, which all staff are invited to attend.

The Trust will work collaboratively with other local organisations and stakeholders in relation to risk management. This will include participating in local and regional forums related to risk management, working closely with the relevant NPSA, Health &

Safety Executive and Care Quality Commission representatives and working with other local Trusts to identify risks, learn lessons and share good practice.

The Risk Management intranet pages will be regularly updated to ensure staff have instant access to the latest information and support. Heads of department and CBU managers are also required to ensure they are aware of their own responsibilities in respect of the strategy, and ensure their staff also fulfil their responsibilities.

10. Responding to external recommendations

The Trust will maintain a process that provides good coordination and evaluation of the work of external agency visits, inspections and accreditations. This will bring increased benefits to both the organisation and the review bodies and is in line with the Trust's Policy on the Management of External Agency Visits, Inspections and Accreditations (Policy No M43).

11. Consultation, Approval and Ratification

This document has been shared with Senior Nursing and Governance leads, Clinical Business Units' Associate Chief of Operations, Associate Chief Nurses, Heads of Quality, Research Business Unit leads, Trust leads for Health & Safety and risk related functions, and Staff side representatives

It was formally approved by the Integrated Governance Committee on 11/1/17 and ratified by the Board of Directors on xx/xx/xx

12. Equality and Diversity

The Trust is committed to treating all patients, families, and staff whether full time, part time, permanent or temporary, equally with respect and dignity and in a non-discriminatory manner, whilst promoting equality and embracing diversity at all times.

In implementing this strategy all staff are reminded of their duty to consider the potential impact of risks and control measures on all people including groups and individuals with protected characteristics under the Equality Act 2010, and the requirement to avoid direct and indirect discrimination. An Equality Assessment is provided at Appendix 3

13. Review

This strategy will be reviewed on or before 31st December 2019 by the Integrated Governance Committee.

14. Dissemination and Implementation

Dissemination and implementation will take place through the Executive Team and the CBU Associate Chief of Operations, CBU Associate Chief Nurses, CBU Heads of Quality, Research Business Unit General Manager, and Heads of Corporate Functions.

15. Compliance and monitoring

Compliance with this strategy will be monitored by the Integrated Governance Committee, receiving annual reports from the clinical and non-clinical Business Units on a rolling basis in the form of 'deep dive' assurance reports.

Implementation of this Risk Management Strategy is also formally monitored by the Trust's Internal Auditors (Merseyside Internal Audit Agency), as well as external regulators such as CQC, NHSI and HSE.

16. References

- The Management of Health and Safety at Work Regulations 1999
- Five steps to risk assessment HSE. INDG 163
- The Health and Safety at Work etc. Act 1974
- ISO 31000: 2009 – Risk Management – Principles and Guidelines

17 Associated Documentation

- The Manual Handling Operations Regulations 1992
- Provision and use of Work Equipment Regulations 1992
- The Lifting Operations and Lifting Equipment Regulations (LOLER) 1998
- Workplace (Health, Safety and Welfare) Regulations 1992
- Reporting of Injuries, Diseases and Dangerous Occurrence Regulations (RIDDOR) 1995
- Reducing Error & Influencing behaviour HSG48
- Health and Safety Policy RM1
- Slips, Trips and Falls Policy RM30
- COSHH Policy RM13
- Fire Policy RM11
- Manual Handling of Loads and People Policy RM10
- Security Policy RM48
- Safeguarding Children M3
- Business Continuity Policy
- Business Continuity Plan
- Sickness Absence and Management of Attendance Policy E4
- Mandatory Training Policy E21
- Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy RM9
- Risk Assessment Policy RM4
- Policy on the Management of External Agency Visits, Inspections and Accreditations. (Policy No. M43)

Appendix 1 - Risk Management Maturity Model: Assessment Criteria

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for risk management as part of an integrated governance model.	*The Trust is aware of risk management responsibilities, and needs to embed systems/ Scattered silo based approach to risk management..*	*The Trust has considered risk management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles risk management / Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda./ Risk management fully embedded into day to day workings of the Trust./ Learning lessons and providing feedback key part of approach.*
	Reactive >> Proactive				
Specific Key Characteristics : Leadership & Management					
Appropriate risk management culture for an NHS Trust.	Focus is primarily on responding to crises at an operational level with little strategic oversight.	People tend to be risk averse. Risks are identified primarily at the operational and project level with no effective escalation to senior levels.	Risk management is done proactively to anticipate risks and develop mitigation plans. Risk implications are considered in all major decisions.	Risks are managed effectively at all times and at the most appropriate level. People are encouraged to be innovative. The organisation fosters a culture of continuous learning.	Risk management is effective at every level in the Trust and is integrated with related governance issues and other disciplines across the organisation.
A risk management strategy and associated policies have been put in place across the Trust.	Central risk team establishes a minimum of mandated policies, but these are not communicated to staff.	Risk Management Strategy has been put in place, but there are no risk management guidelines at Business Unit (BU)/ programme level and below	Each BU/ programme appoints a Risk Lead who facilitates the awareness of and compliance to the risk management strategy at a local level	Local Risk Leads liaise with the central risk team to ensure that staff at all levels are aware of their roles and responsibilities. Compliance to the strategy monitored by an Integrated Governance Committee (IGC).	Risk Management Strategy has been approved and owned by the Board and is underpinned by detailed systems & process, guidelines, training and awareness initiatives.
Risk management is clearly linked to business planning and performance management	Risk management is not linked with, or forms part of the business planning and or performance management process.	Risks relating to the planning activity of the Board are identified as part of the annual development of the BAF. No linking of risk to business planning and performance at BU level.	Risk management is an integral part of strategic and business planning at Board, corporate, BU and local level with risks identified as the planning process unfolds. No link to performance management.	Risks associated with the management of performance are reviewed and monitored by appropriate Board Committees, eg RABD, CQAC, WAD).	Risks on the Corporate Risk register are reviewed in total by IGC and disseminated to the appropriate Board Assurance Committee (RABD, CQAC, WAD).

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for risk management as part of an integrated governance model.	*The Trust is aware of risk management responsibilities, and needs to embed systems/ Scattered silo based approach to risk management..*	*The Trust has considered risk management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles risk management / Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda./ Risk management fully embedded into day to day workings of the Trust./ Learning lessons and providing feedback key part of approach.*
	Reactive	**>>**			**Proactive**
Arrangements have been established for overseeing all aspects of risk management.	There is no evident overseeing by the Board or Executives of the management of risk within the Trust.	There is a central risk team and an operational risk management committee, chaired by an Executive. There are local risk meetings at BU / programme level that feed into the risk committee.	Integrated Governance Committee (IGC) chaired by a non-Exec with supporting committees which provides assurance to the Board on the BAF, corporate risk register and embedding risk management.	The Audit Committee receives reports from IGC and challenges the overall systems and processes relating to risk management and the effectiveness thereof.	Clear reporting lines and responsibility for performance related risks across the various Board Committees.
An effective Board Assurance Framework (BAF) has been established.	There is a basic BAF but there are no structured systems in place to collate the Trusts corporate risks and link those to the risks on the BAF or to those at BU/programme level.	There is a corporate risk register (CRR) derived from escalated risks from BU/ programme level, but it is not linked to the risks on the BAF.	The BAF is updated quarterly by the Board but does not drive its agenda or those of its Committees. Each risk on the BAF is linked to a number of risks on the CRR.	The BAF is reviewed at each Board meeting following review at IGC. It is utilised by the Board to aid its decision making.	The BAF is utilised by the Board in order to provide structure to Board and Committee meetings and provide clear challenge of issues and decisions.
Appropriate risk management training is provided at all levels of the Trust.	No formal risk management training takes place.	Central risk team attend relevant external training events. Risk features as part of mandatory training cycle	Risk management awareness is included as part of the induction process. Awareness session are backed up material available on Trust Intranet.	Risk management training sessions are held and promoted via Risk leads in the BUs/ programme.	On-going risk management training is provided as appropriate for all staff (including the Board).
Specific Key Characteristics : Roles & Responsibilities					
Responsibility for risk management has been clearly defined at all levels of the Trust.	Risk management is seen as being the sole responsibility of the central risk team/ risk manager.	Risk Leads established in each BU/programme but with little support in terms of resource and commitment.	Responsibility for risk has been clearly defined within each BU/ programme and has appropriate commitment and resources to back that up.	Responsibility for risk management is defined within job descriptions and forms part of both BU/ programme and individual performance assessment criteria.	Board level responsibility/ sponsorship for risk has been clearly defined. There are clear lines of accountability for risk throughout the Trust.

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for risk management as part of an integrated governance model.	*The Trust is aware of risk management responsibilities, and needs to embed systems/ Scattered silo based approach to risk management..*	*The Trust has considered risk management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles risk management / Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda./ Risk management fully embedded into day to day workings of the Trust./ Learning lessons and providing feedback key part of approach.*
	Reactive	>>			**Proactive**
Employees are clear regarding their role in managing risk.	Employees do not see themselves as being accountable for managing risk. Roles and responsibilities are not documented, and are unclear	Roles and responsibilities established in Risk Management Strategy but no guidelines at what that means to staff. Senior members of staff receive some basic briefing,	Responsibilities and accountabilities for managing risk are clear, well communicated, understood and followed.	Management of risk is embedded in managers/ senior clinical/ technical staff' behaviour and their accountabilities are an integral part of their job descriptions.	Management of risk is embedded in behaviour at all levels of the organisation. Every employee sees himself / herself as a risk manager.
Specific Key Characteristics : Systems & Processes					
Processes have been defined to systematically identify, record, assess and analyses risks on a continuous basis.	There are no formal risk management processes in place	A system of risk registers has been established and is managed by the central risk team and progress reported to an operational risk committee but not the Board.	Each BU/ programme has its own risk register which feeds into a corporate register maintained by the central risk team with exception reports provided to an Integrated Governance Committee (IGC).	Effective escalation and de-escalation of risks to /from wards/ departments up to BU/ programme and IGC and Board	The whole system of risk management is continuously monitored and reviewed by Executives, Audit Committee and the Board in order to learn and improve.
Risks are regularly reviewed by the Trust.	There is no effective review process in place	Risks are reviewed on an ad hoc basis in specific areas by the central risk team. No challenge to/ from the Executives or the Board.	Risk system set up to enable managers have access to or request updates on risks relating to their areas of responsibility.	Each BU/ programme has its own Risk/ Quality/ Governance meeting where risks are reported to and reviewed on a regular basis with exception reports going to an Integrated Governance Committee (IGC). Meetings should challenge progress and lessons learned as appropriate.	There is a thorough process of review embedded in the organisation. Trust Board and its assurance committees receive reports on specific risks and associated actions from IGC. Lessons learned features on every Board agenda.

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for risk management as part of an integrated governance model.	*The Trust is aware of risk management responsibilities, and needs to embed systems/ Scattered silo based approach to risk management..*	*The Trust has considered risk management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles risk management / Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda./ Risk management fully embedded into day to day workings of the Trust./ Learning lessons and providing feedback key part of approach.*
	Reactive	**>>**			**Proactive**
Effective aggregated analysis of risks	Risks, incidents, claims, complaints and PALS; reported separately without any triangulation across and between them.	Risks and incidents linked via RM system. Some annual aggregated analysis at corporate level but not within the BUs.	Complaints and PALS link into risks and incidents via RM system/ inter team liaison.	Quarterly aggregate analysis at BU of risks, incidents, claims, complaint, PALS and associated lessons learned, presented at BU Risk/ Quality/ Governance meetings with six monthly reports to Board.	Aggregate analysis of risks, incidents, claims, complaints, PALS and associated lessons learned reported quarterly to Board.
Management report risks to Executives where responses have not managed the risks to a level acceptable to the Board.	No apparent/ regular reporting or review of high level risks	High level risks reported to operational risk committee on basis of highest scores, but the Board not generally aware of those risks.	Unclear and informal escalation process from Ward to Board means that confusing/ incomplete information may reach the Board.	Streamlined process for reporting and escalation of risks from Ward/ department/ project to BU/ programme and then to Integrated Governance Committee and Board.	Board members are continually updated on current state of corporate risks, BAF including any urgent ones being escalated, any requiring urgent action and any emerging risks which may cause significant problems.
All significant new projects are routinely assessed for risk.	Project teams do not consider risks to the project or the wider implications to the Trust.	Risks are assessed from project point of view but not for the wider impact on the Trust. No appreciation of project risks by Executives or Board.	Project teams assess risks from project and operational perspectives, reporting on progress to appropriate Project/ Programme Board but not into mainstream risk reporting cycle.	Effective escalation of risks from projects and work streams with Programme Board escalating their top programme risks to Integrated Governance Committee with most strategic ones being considered for the BAF.	Project risk assessments consider opportunities as well as conventional risks. Board Committees receive update on progress on the major programmes and challenge on their risks as appropriate.

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for risk management as part of an integrated governance model.	*The Trust is aware of risk management responsibilities, and needs to embed systems/ Scattered silo based approach to risk management..*	*The Trust has considered risk management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles risk management / Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda./ Risk management fully embedded into day to day workings of the Trust./ Learning lessons and providing feedback key part of approach.*
	Reactive	**>>**			**Proactive**
Specific Key Characteristics : Monitoring and Feedback					
Measurement and monitoring	No measurement framework is in place to assess risk management practices.	Number of internal and external reviews provide a range of opinions but no one overall framework to evaluate progress	Risk Management Improvement Plan (RMIP) developed, updated and progress reported via Integrated Governance Committee with assurance report to Audit Committee.	RM Maturity Model developed to provide cross Trust measurement and monitoring of the effectiveness of the embedding of risk management in Bus/programme. Key Performance Indicators established for each BU/ programme on risk and governance matters.	Performance against indicators is measured and results are tracked over time. Action plans are developed to improve performance and action is taken as required. Performance indicators and benchmarks are refined and updated.
Managers provide assurance on the effectiveness of their risk management.	No but typically not asked for either.	Risk Manager reports to operational risk management committee on activity within the year.	Central risk team and Risk Leads take forward actions from the RMIP and provide feedback to Integrated Governance Committee with assurance reports to Board and Audit Committee.	Risk Leads report to their BU/programme Risk/Quality/Governance meeting on the effectiveness of the risk management processes within their BU/ programme.	For all risks there is a clear reporting structure for responsible officers to assure Board via governance structures that risks are being managed as agreed.

High Level Characteristics >	1 - Risk naïve	2 - Risk aware	3 - Risk defined	4 - Risk managed	5 - Risk enabled
	The Trust has little or no awareness of the importance of risk management/ No formal approach developed for risk management as part of an integrated governance model.	*The Trust is aware of risk management responsibilities, and needs to embed systems/ Scattered silo based approach to risk management..*	*The Trust has considered risk management and put in place strategies which are communicated.*	*Board and all staff are aware of the importance of and how the Trust handles risk management / Board and staff at all levels actively consider and manage risk in all areas of activity.*	*Risk appetite defined and used to drive Board agenda./ Risk management fully embedded into day to day workings of the Trust./ Learning lessons and providing feedback key part of approach.*
	Reactive	**>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>**	**>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>**	**>>>>>>>>>>>>>>>>>>>>>>>>>>>>>>**	**Proactive**
Assurances are received regarding the effectiveness of the Trusts risk management system.	No effective assurance processes in place, nor are any sought from Executives or the Board.	Internal assurances on risk management process are received via the central risk team and operational risk management committee.	The Trust receives regular assurance both internally and externally regarding the effectiveness of its risk management system.	Action plans and feedback from internal and external reviews are formally documented and progress monitored.	The Trust has clear mechanisms in place to proactively seek assurance in respect of risk management. Assurances are identified, monitor and reviewed with feedback used to further enhance the arrangements in place. The Board would typically be challenging Executives as appropriate on all matters risk.

Appendix 2 - Roles and Responsibilities

The Trust manages risk proactively through a number of specific committees, groups and individuals working together to integrate risk management activity across the organisation. The principal committees are described below followed by the roles and responsibilities of specific functions and individuals.

Committees and Groups

Integrated Governance Committee (IGC)

The IGC will:

- ensure the Trust has an up-to-date risk management strategy, BAF policy and associated policies that comply with relevant regulatory, legal and code of conduct requirements
- oversee the design and effective operation of the risk management processes across the Trust including the management of the production of the Corporate Risk Register (CRR) and Board Assurance Framework (BAF).
- provide the Trust Board with a bi-monthly assurance report on the outcome of the meeting including an updated BAF and summary of the CRR. Extracts from the BAF and CRR will also be produced to inform Board Committees including RABD and CQAC of the latest position on their related risks.
- oversee the continuing evolution of risk management processes across the CBUs and other business areas
- oversee the integration of all aspects of managing risk across the Trust, including clinical, organisational, project and financial risk and associated links to corporate business planning.
- take remedial action to resolve weaknesses and incorporate best practice.

Clinical and non-clinical Business Units are required to provide appropriate representation to IGC to highlight significant risks that require escalation to the Corporate Risk Register or provide appropriate assurance such that risks can be de-escalated.

IGC also provides an opportunity to share information and learning regarding the management of risks across CBUs, and will receive annual reports from CBUs providing assurance of implementation of the risk management strategy at ward and department level.

Business Units are also required to provide an annual ‘deep dive’ report to IGC to provide robust assurance around the management of risk locally, demonstrating that systems and controls are in place to ensure wards and departments are proactively reviewing risks and implementing appropriate mitigating actions. This supports the delivery of ward to board reporting and a truly integrated risk management system.

Audit Committee (AC)

The principal purpose of the Audit Committee is to review the establishment and maintenance of an effective system of integrated governance, risk management and

internal control, across the whole of the organisation's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy of:

- all risk and control related disclosure statements together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;
- the underlying assurance processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements;
- the policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by the Counter Fraud and Security Management Service.

Clinical Quality Assurance Committee (CQAC)

The Committee will provide assurance to the Board of Directors, of the effectiveness of the systems and processes for ensuring the highest standards of clinical quality, embracing clinical effectiveness, patient safety and patient/carer experience.

The Committee has delegated powers from the Board of Directors to oversee, coordinate, improve, review and assess the effectiveness of clinical quality, clinical practice and clinical governance arrangements and activities within the Trust. The principal devolution of responsibilities relates to:

- Agreeing and coordinating an assurance framework for clinical quality that focuses on continuous improvement of the patient experience, safe practice and clinical effectiveness. The establishment and embedding of Trust strategies, systems and processes with sufficient capacity and capability to deliver clinical quality across the Trust.
- The monitoring and evaluation of clinical quality and governance performance within the Trust utilising agreed performance indicators. The relevant sections of the Corporate Report will be reviewed by exception, and any concerns reported to the Board.
- Ensuring the quality dashboard indicators support the production of the Quality Account, CQUIN indicators and Quality report.
- Ratification of policies and procedures required for effective clinical governance and clinical practice across the Trust.
- Reporting areas of concern/ risks arising from clinical practice to the Board of Directors for its scrutiny and review.
- Providing recommendations to the Board of Directors on the assurances received on all clinical, public health and patient experience related to Care Quality Commission standards.

Clinical Quality Steering Group
CQSG will ensure the effective management and implementation of the quality strategy including monitoring performance against clinical effectiveness, patient safety and patient experience.

In fulfilling its duties the CQSG will:

- hold CBUs to account for performance in quality and clinical risk
- receive key issues reports from CBU risk and governance groups and several other Trust wide groups dealing with matters of clinical safety / risk including
    - Infection Prevention & Control Group
    - Quality, Safety, Patient Experience Improvement Projects
    - Drugs and Therapeutics Committee
    - Safeguarding Children
    - CBU Clinical Governance and Risk Groups
    - Transfusion Committee
    - Resuscitation Committee
    - Medical Device Committee
    - Weekly Meeting of Harm
- assist the Clinical Quality Assurance Committee with high level horizon scanning to ensure that new risks are identified and managed appropriately
- ensure the Clinical Quality Assurance Committee is regularly updated on areas of performance/risk

Resources and Business Development Committee (RaBD)

The Committee will operate under the three broad aims of reviewing financial strategy, performance, workforce and organisational and business development.

The Committee has responsibility on behalf of the Board of Directors to:

- Review and recommend business, operational and financial plans to the Board of Directors.
- Monitor performance assuring the Board of Directors, that performance is in line with plans.
- Ensure value for money is obtained by the Trust
- Identify related areas of strategic and business risk and report these to the Board of Directors
- Oversee the development of the Trust's long term financial strategy, its Business Development Strategy and its Investment Strategy
- Oversee the development and implementation of the Trust's overarching workforce strategy.

Clinical and non-Clinical Business units - Risk / Governance / Quality meetings

These meetings will serve as the forum that will oversee local implementation of the Risk Management Strategy and provide formal feedback on progress to the Integrated Governance Committee (IGC), including a monthly update on progress against relevant corporate level risks, and including an annual 'deep dive' report providing assurance on the management of risk locally, demonstrating that systems

and controls are in place to ensure wards and departments are proactively reviewing risks and implementing appropriate mitigating actions.

The meeting will normally be held monthly and the agenda will include discussion around:

- Progress against current risks and actions/control measures relevant to the business unit and it's wards / departments / services
- Suggested risks for escalation to / de-escalation from Business Unit Risk Register
- Suggested risks for escalation to / de-escalation from the Corporate Risk Register
- Update on corporate risks relevant to the Business Unit
- Feedback from Integrated Governance Committee (IGC), Clinical Quality Assurance Committee (CQAC), Clinical Quality Steering Group (CQSG), Weekly Meeting of Harm (WMoH) and any other meetings as appropriate
- Recognition and triangulation of themes/trends from incidents, claims, complaints and PALS
- Sharing of lessons learned from investigations, root cause analyses, inspections and compliance reports
- Compliance with CQUINs, NICE guidance, CAS Alerts, and other relevant quality related mandates
- Clinical Audit and Health & Safety related issues

CBU Heads of Quality will establish a cross CBU Quality & Risk Forum that will provide an opportunity for detailed discussion of local risk related matters and challenges experienced in the implementation of the Risk Management Strategy, including responses to specific quality and risk related issues. This will ensure learning and good practice is shared widely and can be implemented Trustwide.

Information Governance Steering Group

The IG Steering Group provides assurance that effective arrangements are in place to manage the processing of and control risks to information and data through an Information Governance framework based around legal requirements and Department of Health guidelines.
The principles contained within this Risk Management Strategy apply equally to risks to information and the IG Steering Group will ensure appropriate assessments and controls are in place in relation to

- Openness and Freedom of Information
- Legal compliance, including data protection legislation
- Information security
- Information Quality Assurance

The Steering Group will also ensure that the Trust undertakes or commissions annual assessments and audits of its Information Governance policies and management arrangements.

Specific functions and individuals

All Trust Employees, part time and contract staff

Every member of staff has an individual responsibility for the management of risk within the organisation.

Individuals are responsible for reporting any identified risks in order that they can be addressed and are accountable for ensuring their own competency and that their training needs are met in discussion with their line managers.

They must attend induction and statutory and mandatory training as required, including Risk Management training. They must ensure that they practice within the standards of their professional bodies, national standards and trust policies, procedures and guidelines.

All Managers

Managers at all levels must understand the Trust's Risk Management Strategy and be aware that they have the authority and duty to manage risk within their area of responsibility. Duties are monitored and reviewed as the strategy/policy is updated or as job roles change.

Union Accredited Safety Representatives:

Act as an integral part of the risk management process within the Trust and should be consulted on safety related issues.

Occupational Health:

Will provide advice regarding the specific issue of risks to staff health in the workplace.

CBU Associate Chief of Operations / Heads of Corporate functions

These senior managers are responsible for the effective embedding of Risk Management within their area; the ongoing managing of risks; the effective running of appropriate risk/governance/ quality meetings and attending the bi-monthly IGC meetings.

CBU - Associate Chief Nurse

In leading the CBU Governance function, the ACN will work closely with the Head of Quality to ensure all aspects of Risk and Governance are appropriately integrated into all aspects of the CBU performance, and will support the drive for embedding of risk management at all levels of the CBU.

CBU Heads of Quality

Ensures CBUs have robust and sustainable governance systems in place that are operating effectively, providing appropriate assurance reports to IGC, CQAC, CQSG as required. Ensures learning is shared widely between CBUs and across the organisation.

Service Group/ Ward/ Departmental Managers

Service Group, Ward and Department Line Managers ensure that relevant staff training is provided and incidents are reported and actions taken when required. They provide feedback to staff, ensuring that Trust policies, procedures and guidelines are followed to minimise risk.

- Will ensure that risk assessments are carried out and reviewed at least annually and manage any local risks, ensuring any high risks are reported to CBU heads to be added to the CBU risk register
- Will be aware of the results of risk assessments and take action to eliminate or mitigate the risks identified. This may involve the line managers, CBU management team and may require corporate support / advice.
- Will ensure compliance with relevant legislation, in particular with the requirements of the Management of Health and Safety at Work Regulations (1999), and to operate in line with HSE Guidance.
- Are responsible for ensuring that all slip, trip or fall hazards are removed or minimised ensuring compliance is recorded on the electronic risk reporting system.
- Copies of all risk assessments undertaken must be retained for ad hoc review / audit as required. Managers must also ensure that risk assessment documentation is retained for 10 years.
- It is the responsibility of the Human Resources Line Managers/Estates Managers to ensure that agency and contract workers receive relevant risk management information. (See Control of Contractors Policy, RM3.)

Corporate Support for Risk

The Associate Director of Nursing & Governance will lead a corporate team to support the Executive Team, CBU Management teams and corporate functions in ensuring that strategies are implemented across the Trust; providing specialist support in matters of risk including risk management and root cause analysis training, the use of the electronic reporting system for tracking and updating risks and incidents, and handling legal aspects of claims and complaints.

The Deputy Director of Risk & Governance will work closely with the Associate Director of Nursing and Governance to monitor implementation of the Risk Management Strategy and provide regular reports to Integrated Governance Committee and Audit Committee on effectiveness of the strategy.

Local Security Management Specialist (LSMS):

- The Trust has a nominated local security management specialist who is responsible for ensuring that systems and processes are in place, and subject to continuous review, in order to eliminate, minimise and control security risks to patients, parents, staff, visitors and the organisation based on the new national and legal frameworks established by NHS Protect.
- Responsible for the provision of Conflict Resolution training as required by the above.
- Will carry out all security related risk assessments for the Trust. (Please see: RM48 Security Policy and RM9 Preventing and Managing Violence and Aggression at Work and Protecting Lone Worker Policy.)

Emergency Preparedness & Business Continuity Manager:

- The EPBCM will ensure all CBUs and corporate functions have business continuity plans in place to handle major incidents and threats to business continuity.
- Regular reports will be provided to IGC describing the current position in terms of business continuity and lessons learned from business continuity incidents will be shared through this forum
- This role also includes maintaining up to date risk register to ensure business continuity risks are highlighted and mitigated appropriately

Executive Directors

Director of Corporate Affairs:

The Director of Corporate Affairs reports to the Chief Executive and is responsible for maintaining the Trust's Board Assurance Framework through the operation of an effective Board Committee structure. They are also responsible for liaison with the various external regulators and ensuring compliance with Health & Safety Executive (HSE) guidance and UK legislation.

The Director of Corporate Affairs is also responsible for the Policy for the Management of External Agency Visits, Inspections and Accreditations, ensuring that the Board Assurance Framework is populated with risks identified from external agency visits, inspections and accreditations.

The Director of Corporate Affairs is also responsible for compliance with Information Governance requirements and acts as the Senior Information Risk Owner (SIRO)

Chief Nurse

The Chief Nurse is the Executive lead for risk management. The Chief Nurse is accountable to the Board of Directors and the Chief Executive for the Trust's risk management activities.

The Chief Nurse is the executive lead for Business Continuity Management and for the provision of an effective patient experience throughout the Trust. They are also responsible for the overall embedding and compliance of CQC standards across the Trust.

Director of Human Resources

The Director for Human Resources is responsible for the overview of statutory training and for all aspects of Health & Safety Management. This post holder will report to the Chief Executive and the Board of Directors as appropriate.

Director of Finance

The Director of Finance is accountable to the Board of Directors and the Chief Executive for ensuring the Trust carries out its business with sound financial governance arrangements that are controlled and monitored through effective audit and accounting systems. They are also responsible for IM&T, information systems and information quality.

Medical Director

The Medical Director is accountable to the Board of Directors and the Chief Executive for clinical risk management and clinical governance and will report to them as appropriate.

Chief Operating Officer

The Chief Operating Officer is the executive lead for Estates and Facilities and is responsible for the effective management of risk in those areas. The post holder also has line management responsibility for the CBU Associate Chief of Operations.

Chief Executive

The Chief Executive, as Accountable Officer, has overall responsibility and accountability for risk management. As a member of both the Board of Directors and the Integrated Governance Committee, the Chief Executive is informed of significant risk issues and therefore is assured that their role for risk management is fulfilled.

Appendix 3 - Equality Impact Assessment

Equality Analysis and Quality Impact Assessment		
Please refer to guidance when completing this form		
Project / Scheme Name:	Risk Management Strategy	
Project / Scheme Overview:	Integrated Governance Committee	
Project / Scheme Lead:	Name: Tony Rigby	
CBU / Department:	Corporate	
Form completed on:	Date: 01/01/2017	
Form completed by:	Name: Tony Rigby	Job Title: Dep Dir of Risk & Governance

Part A – Equality Analysis

Equality Indicators Identify the equality indicators which will or could potentially be impacted by the project/scheme. (use hyperlink to assess the impact on each protected characteristic)	Age ☐ Details: Disability ☐ Details: Click here to enter text. Gender reassignment ☐ Details: Click here to enter text. Marriage & Civil Partnership ☐ Details: Click here to enter text. Pregnancy or Maternity ☐ Details: Click here to enter text. Race ☐ Details: Click here to enter text. Religion or Belief ☐ Details: Click here to enter text. Sex ☐ Details: Click here to enter text. Sexual Orientation ☐ Details: Click here to enter text. Human Rights (FREDA principles) ☐ Details: Click here to enter text.
Equality Relevance Select LOW, MEDIUM or HIGH	LOW
If the project / scheme is LOW relevance, you **MUST** state the reasons here.	The RM Strategy represents a positive approach to ensuring all patients and staff are protected from harm and discrimination in describing the Trust approach to the assessment and management of risk. The strategy provides a real opportunity to ensure groups and individuals with protected characteristics are considered as part of any identified risk and any mitigating control measures

Appendix 4 - Version Control Sheet

Version	Date	Author	Status	Comment
13.1	**January 2017**	**Deputy Director of Risk & Governance**	**Draft**	**For discussion at Audit Committee**
13	January 2017	Deputy Director of Risk & Governance	Draft	For discussion at IGC / AC
12	December 2014	Interim Governance & Risk Manager	Current	Amended following comments at IGC, 13/11/14
11	November 2014	Interim Governance & Risk Manager	Archived	To Integrated Governance Committee (IGC), 13/11/14
10	April 2014	Clinical Risk Advisor	Archived	To Corporate Risk Committee, 12/4/14
9	March 2013	Clinical Risk Advisor	Archived	
8	February 2012	Clinical Risk Advisor	Archived	To Corporate Risk Committee, 28/02/12
7	August 2011	Risk Manager	Archived	To Board of Directors, 6/9/11
6	December 2010	Risk Manager	Archived	
5	December 2009	Head of integrated risk management and clinical governance	Archived	
4	March 2008	Risk Manager	Archived	
3	January 2007	Risk Manager	Archived	
2	September 2006	Risk Manager	Archived	
1	November 2003	Risk Manager	Archived	
0	July 2003	Risk Manager	Archived	

Alder Hey Children's NHS
NHS Foundation Trust

Appendix 5 - Overall Trust Governance Structure