BOARD OF DIRECTORS MEETING

Tuesday 4th July 2017 commencing at 1000

Venue: Innovation Hub, Virtual Engineering Centre (VEC) Room.

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY						
Board Business						
1.		**1015**	**Apologies**	Chair		--
2.	**17/18/75**	**1016**	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**17/18/76**	**1017**	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **25 May 2017**	Read Minutes
4.	**17/18/77**	**1020**	**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.	**17/18/78**	**1040**	**Key Issues/Reflections**	All	The Board to reflect on key issues.	Verbal
Strategic Update						
6.	**17/18/79**	**1050**	**External Environment** - **5 Year Forward View progress** **Progress against strategic themes:** - **Liverpool Community**	 L Shepherd L Shepherd	 To update the Board with progress on delivery of the Cheshire and Merseyside 5YFV To update the Board on progress.	 Verbal Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Services - **Liverpool Women's Reconfiguration Options/Neonatal** - **CAMHS Tier 4 Bid**	D Herring D Herring		
7.	**17/18/80**		**Proposed free school plans**	Mark Hilton, Head Teacher, Sandfield School	To present the proposals to the Board	Paper/ Presentation
Delivery of outstanding care						
8.	**17/18/81**	**1110**	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month	Read Report
9.	**17/18/82**	**1120**	**Clinical Quality Assurance Committee: Chair's update**	A Marsland	To receive and review the approved minutes from the meeting held: 17th May 2017	Read report
10.	**17/18/83**	**1125**	**Alder Hey in the Park update** - **Estates review** - **Alder Centre**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation. To update the Board on the current position To announce the outcome from the bidders process	Read report Presentation Verbal
11.	**17/18/84**	**1145**	**Innovation**	J Taylor	To provide an update to Board on the current projects	Presentation
12.	**17/18/85**	**1200**	**Infection, Prevention and Control Annual report** - **Director of Infection Prevention and Control arrangements**	Valya Weston, Associate DIPC S Ryan	To receive the annual report To update the Board on DIPC arrangements.	Read report Verbal
The best people doing their best work						
13.	**17/18/86**	**1215**	**People Strategy Update** - **Workforce and**	M Swindell C Dove	To provide an update on the strategy and staff survey To receive the approved minutes	Read reports Read minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Organisational Development Committee minutes 19th April 2017			
1230 – 1300 LUNCH						
14.	**17/18/87**	**1300**	**Listening into Action**	K Turner	Two Clinical teams from the current cohort to provide an update on progress to the Board	Presentation
Strong Foundations						
15.	**17/18/88**	**1310**	**Programme Assurance update** - **Deliver Outstanding Care** - **Growing External Partnerships** - **Global Digital Exemplar** - **Park Community Estates and Facilities** - **The best people doing their best work**	J Gibson	To receive an update on programme assurance including the 2017/18 change programme	Read Report
16.	**17/18/89**	**1320**	**Corporate Report**	J Grinnell/ H Gwilliams/ M Swindell	To note delivery against financial , operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of May 2017	Read report
17.	**17/18/90**	**1330**	**Board Assurance Framework**	E Saunders	To receive the BAF report.	Read report
18.	**17/18/91**	**1340**	**Resources & Business Development Committee: Chair's update**	I Quinlan	To receive and review the approved minutes from the meeting held on: 6th June 2017.	Read minutes
19.	**17/18/92**	**1345**	**Audit Committee: Chair's update**	S Igoe	To receive and review the approved minutes from the meeting held on: 28th April 2017	Read minutes

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
20.	**17/18/93**	**1350**	**Integrated Governance Committee Annual report 2016/17**	E Saunders	To receive and review the 2016/17 Committee Annual report	Read report
Any Other Business						
21.	**17/18/94**	**1400**	**Any Other Business**	All	To discuss any further business before the close of the meeting	Verbal
Date And Time Of Next Meeting: Tuesday 5th September 2017 At **10:00am, Institute In The Park, Large Meeting Room**						

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

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Minutes of the last meeting held on **Thursday 25th May 2017 at 1:30pm,**
Large Meeting Room, Institute in the park

Present:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Non-Executive Director	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Dr S Ryan	Medical Director	(SR)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mrs M Barnaby	Interim COO	(MB)
	Mrs D Herring	Director of Strategic Development & Clinical Service Partnerships	(DH)
	Mr S Hooker	Public Governor (Observing)	(SH)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator	(JT)
Agenda item: 67.	Mr J Gibson	Programme Director	
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs C Dove	Non-Executive Director	(CD)
	Mr C Duncan	Director of Surgery	(CD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mrs C McLaughlin	Director of Integrated Community Services	
	Mr D Powell	Development Director	(DP)

17/18/54 Declarations of Interest
None declared.

17/18/55 Minutes of the previous meetings held on 27th April and 2nd May 2017
Resolved:
The Board received and approved the minutes from the meeting held on 27th April and 2nd May 2017.

17/18/56 Matters Arising and Action Log
Global Digital Exemplar (GDE)
Peter Young updated the Board on the GDE programme and reported that a number of projects were in progress including voice recognition.

As previously reported, the GDE Business Case had now been approved by the Treasury securing £9.6m funding over a 3 year period. Receipt of this funding was still awaited.

DRAFT

17/18/57 2016/17 Annual Report and Accounts

The Board received the 2016/17 Annual report and Accounts for approval, as recommended by the Audit Committee following the meeting held yesterday.

Erica Saunders and John Grinnell referred to the clean audit report from KPMG, highlighting that there had been no material issues regarding the accounts and that the national guidance had been fully adhered to. Steve Igoe as Audit Committee chair, reflected on the positive feedback that had been received from both the internal and external auditors and confirmed that it was highly reassuring to have received such a clean audit.

The Chair thanked Erica Saunders, John Grinnell and the finance team for their efforts on the 2016/17 Annual Report and Accounts.

Resolved:
The Board APPROVED;
a) The Annual Report and Accounts 2016/17 and associated Board statements.
b) The Annual Report and Accounts 2016/17 management representation letter
c) The Quality Report management representation letter.

Corporate Governance Statement

The Board received the Corporate Governance Statement 2016/17 including risks and mitigating actions.

Resolved:
The Board APPROVED the Corporate Governance Statement 2016/17.

17/18/58 Board Self – Certification of Compliance with the Provider Licence

NHS Foundation Trusts are required to submit declarations to NHS Improvement signed by the Chair and Chief Executive. The declarations include; Compliance with licence conditions, Corporate Governance Statement and certification on training of Governors.

Resolved:
The Board APPROVED the Board Self – Certification of compliance with the Provider Licence, to be audited by NHS Improvement as required under this year's guidance.

17/18/59 Board Assurance Framework

The majority of risks had been updated, but as the Board was early a number were outstanding and would be completed before the next Board in July.

As agreed previously, the management contract arrangement with Liverpool Community Health NHS Trust had been included as a new strategic risk on the Board Assurance Framework.

Resolved:
The Board received the latest Board Assurance Framework.

17/18/60 Resources & Business Development Committee

DRAFT

Annual report 2016/17
The Board received the Committee annual report.

RABD meeting 25th April 2017
Ian Quinlan gave a verbal update on the last RABD meeting. A number of Innovation projects had been due to be commissioned with private funding. As this funding was no longer available a review to source funding was being looked into.

As the Board had not received an update on Innovation recently it was agreed the next Board meeting would be held in the Innovation Hub with an update on the current projects.
Action: DP

Resolved
The Board:
a) The Board received the annual report for RABD.
b) Agreed for the July Board to be held in the Innovation Hub with a presentation on the latest projects.

17/18/61 Audit Committee

Annual report 2016/17

The Board received the annual report for the Audit Committee.

Audit Minutes 26th January 2016
The Board received the approved minutes of the Audit Committee meeting held on 26th January 2017.

A discussion was held at the meeting yesterday on the number of outstanding recommendations from previous audits. An update on these recommendations being completed or attendance from the Executive lead to report on recommendations outstanding would be received at the next Audit meeting in September.

Resolved:
The Board received:
a) Audit Committee Annual report for 2016/17.
b) Audit Committee approved minutes from the meeting held on 26th January 2017.
c) A verbal update on outstanding Audit recommendations from the meeting held on 24th May 2017.

17/18/62 External Environment/STP/Progress against Strategic Themes
NHS 5 Year Forward View progress
Following the publication of the NHS 5 Year Forward View update, the Cheshire and Merseyside STP is preparing a next steps document and a governance process. One of the proposals for a governance process was to set up a Partnership Board. The purpose of the Partnership Board would be to encourage collaboration to transform the health economy and move to an accountable care system. Attendance from Chair or Chief Executive from each of the organisations would be required.

DRAFT

Liverpool Community Health Services
An update from the LCH Board meeting was received.

Neonatal Network
Meetings were in progress following proposals to consolidate Neonatal Services across Cheshire and Merseyside from two sites. The purpose of the meetings was to identify and minimise any risks identified. Attendees included: Debbie Herring, Steve Ryan as well as clinicians from Alder Hey Children's NHS FT, Liverpool Women's NHS FT and The Royal Liverpool and Broadgreen NHS University Hospital.

Liverpool Women's NHS Foundation Trust
As requested, Liverpool Women's had provided the number of Maternity patients at risk of requiring level three ICU care at the Royal Liverpool and Broadgreen NHS University Hospital.

As reported last month the North West Clinical Senate are holding an independent review on 7th and 8th June. A visit to neither Liverpool Women's nor Alder Hey had been included in their itinerary.

Louise Shepherd, Steve Ryan and Debbie Herring had met with NHS England and they were reviewing the senate pre-consultation business case for change.

Tier 4 CAMHS Cheshire and Merseyside Bid
Debbie Herring updated the Board on the joint bid with Cheshire and Wirral Partnership NHS Foundation Trust and 5 Boroughs Partnership NHS Foundation Trust (now North West Boroughs NHS FT).

17/18/63 Serious Incidents Report
Hilda Gwilliams presented the report for March 2017. There had been two new SIRIs reported, one ongoing and none closed.

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

- Three new SIRIs, two ongoing and two closed. There had been one new safeguarding incident reported, none ongoing or closed.

17/18/67 Clinical Quality Assurance Committee: Chair's Update
Annual Report 2016/17
Resolved:
The Board received the Committee annual report.

CQAC Minutes 19th April 2017
Resolved:
The Board received and noted the Minutes from the CQAC meeting held on 19th April 2017.

17/18/68 Alder Hey in the Park
Resolved:
Board received an update on Alder Hey in the park.

DRAFT

17/18/69 Programme Assurance Update

The Programme Assurance review of programme content had now been completed and presented to the Operational Board earlier today.

Resolved:
The Board received the Programme Assurance update and agreed with the approach.

17/18/70 Any Other Business

No other business was reported.

Date and Time of next meeting: Tuesday 4th July 2017, at 1:30pm, Innovation Hub, Virtual Engineering Centre (VEC) Room.

Trust Board of Directors

4th July 2017

Subject/Title	Global Digital Excellence (GDE) programme update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Associate Director of Informatics
Action/Decision required	The Trust Board is asked to note the updated progress towards participation in NHS England's GDE Programme and subsequent initiation of the Programme.
Background papers	
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	IM&CT Strategy Significant contribution to the strategic objectives for:- - Clinical Excellence - Positive patient experience - Improving financial strength - World class facility

Summary of progress in last month

Funding

The Trust received confirmation of the first tranche of PDC funding on Friday 16th June (approximately £2.5million), it is anticipated that this will be available for draw during w/c 10th July. The remaining milestone one revenue funding (approx. £800k) will also be made available via the CCG imminently.

Fast Follower

A key part of the GDE Programme is to share learning and experiences with other organisations. The Trust has selected the Clatterbridge Cancer Centre to be its fast follower as both Trust's use the same core EPR (Meditech) and face similar challenges as specialist Trusts. Key areas for collaboration include:-

- Interoperability (sharing data with referring/shared care organisations)
- IM&T supporting delivery of care across multiple sites as a "hub and spoke" model
- Patient Portal to provide secure access to patient records with appropriate consent.
- Patient App

Fast Followers receive £5m of funding from NHS England. Clatterbridge are currently undertaking their "due diligence" processes for this. It is currently anticipated that final approval will be given during September 2017.

Programme Delivery

Work is now underway on the programme in earnest building on the preparations that have been undertaken in the last few months:-

- Recruitment to all approved posts. It is anticipated that the full team will be in place by the end of September.
- An induction and training plan is being developed for new starters to the IM&T team.
- Orders for software required to deliver Phase 2 and 3 milestones.
- Internal organisational engagement work ongoing with good progress.
- PID and associated programme documentation finalised and approved.
- A clinically led process for change management and digitisation of Clinical pathways has been developed and £70k funding agreed to support release of clinical time
- System development has commenced on eight "specialty packages".
- Voice recognition project commenced with a target of July for an initial pilot with the Orthopaedic team.
- Testing and planning underway for upgrade to MEDITECH system scheduled for August 2017.
- IMO Clinical Terminology software ordered.

A copy of the GDE Programme Dashboard which summarises the status of all individual workstreams is attached below.

GDE Programme Dashboard 27.06.17.

Next Steps

- Discussion with NHS Digital about the potential revision of milestones to take into account the delays to the funding at national level. However, we are planning to maintain delivery of milestones in accordance with the original plans as far as possible.
- Continue working towards the delivery of milestones one and two (September 2017 and March 2018) respectively.
- One the Benefit Analyst is in place, an exercise will be undertaken to complete a baseline assessment of all anticipated benefits as a priority. Once developed the Benefits dashboard will be shared with the Trust Board on a quarterly basis.

Recommendation

The Trust Board is asked to :-

1. Note the progress with the GDE Programme and ongoing work to progress towards the first milestones due on 30th September 2017.

2. Approve in principle Clatterbridge Cancer Centre's proposal to become a Fast Follower for Alder Hey.

Peter Young

Chief Information Officer 29th June 2017

Proposal for the Alder School – an Alternative Provision Free School for children with significant mental health problems

The Vision and Rationale

Sandfield Park School is currently a single maintained school with special school status under a single Unique Reference Number (URN), which operates as three separate provisions including a special needs Secondary School, the Alder Hey Hospital School and The Alder Centre for Education (ACE). ACE is a Local Authority service who commission 75 part-time equivalent places. The service is a medical needs education support service for pupils who are too ill to attend school. Over the last 5 years the number of referrals due to mental health conditions requiring long-term support has doubled (please see later paragraph). These pupils require a long-term, full-time education with specialist and significant mental health support as they cannot attend mainstream settings nor would they be suitable for SEN schools. Therefore these pupils have been placed at ACE in order to avoid being NEET and/or missing in education. As a result ACE has to operate a waiting list as these pupils do not return to school which leads to others being without education at all. We are proposing to establish an Alternative Provision Free School, The Alder School, near to the present ACE site in Liverpool, for pupils with mental health needs who would not be catered for in special provision as they would not have EHCPs.

ACE is not a school but a part-time support service with a limited education provision as it is only meant to provide temporary places whilst children are recovering from an illness. A team of 5 teachers can deliver lessons in core subjects and some foundation subjects. However it has become evident that the mental health needs require significant support with their high levels of anxiety. Although CAMHS is supportive of ACE it is mutually agreed that these children require wrap-around support in school.

There are aspects of ACE which are beneficial to the above pupils such as: a small setting compared to mainstream schools; small class-sizes and the close monitoring and reviews which take place. Also, staff have developed an expertise in mental health and can apply appropriate strategies in the classroom. However outside of the classroom other forms of support are required, such as: therapies; counselling and calming strategies but with a limited staff this is lacking. It is also clear that Year 11 pupils require additional support in building up their capacity to move onto post-16 provision.

There has also been an overwhelming number of referrals to ACE with children diagnosed with High Functioning ASD but who also suffer from extreme anxiety. These are not SEN children but they just cannot cope in large schools. As a result they have become isolated and withdrawn and many have resorted to self-harm. Again there is nowhere suitable to place these children so they have also had to attend ACE as a last resort. These pupils are attending the maximum timetable ACE can offer but need a full-time provision. Parents, secondary schools, Education Welfare Service and SEN have been asking for this for some time.

Initially the Alder School will admit pupils from Year 9 to Year 11. This will be long term provision especially for Years 10 & 11. KS4 pupils will be referred through the Fair Access Panel (FAP) and will be single registered with the Alder school. For pupils who enter at Year 9 the aim will be where appropriate to re-integrate them back to school at the end of KS3. The school will open 2018 / 2019 with approximately 45 pupils in Years 9, 10 and 11 with plans to grow to 65 by 2021 (including some out of Authority provision – see below). However, the school intends to be able to adapt to 'need' and would be able to be flexible with KS3 pupils and offer places to Y8 pupils if required. There will be no post-16 provision as the school intends to move these pupils on successfully into existing provision within Liverpool after a personalised curriculum of support. The Alder School will serve all

mainstream secondary schools in Liverpool. In addition, provision will be extended to out of city schools in order to meet the regional demand for support with pupils with mental health problems. This is a strategy that is actively supported by Liverpool Authority.

The only other providers of Alternative Provision in Liverpool focus on pupils who have been or are at risk of exclusion. However, within these providers it is recognised that a small number of pupils have been wrongly or inappropriately placed as there is no provision for mental health. The behaviours of pupils suffering with extreme anxiety has led to some exclusions which could otherwise have been avoided.

Once the free school opens ACE will be able to continue as a medical needs education support service as its intended purpose. This will also enable primary pupils who have an illness to receive some lessons at the centre. ACE will continue to be part of Sandfield Park School.

It is intended that as the Free School opens Sandfield Park School will academize therefore forming a Multi Academy Trust (MAT) with the Alder School. The Headteacher of Sandfield Park School (rated good by Ofsted) will become the Executive Headteacher of the MAT which will include the new Free School. The current Head of Alder Centre for Education will become the Head of School (principal designate) for the Alder School. In addition, it is likely that 2 teachers from ACE with extensive experience of working with mental health will move over to the Free School. This will ensure that from opening there is a high level of expertise. It will also enable new staff recruited to the school to receive training and guidance.

Pupil Cohort

Our vision is to establish a specialised and high-quality provision which will support extremely vulnerable children who have become non-attenders at school. These pupils have faced or are currently facing traumatic events in their lives. The pupils are at risk of self-harm and suicide due to the severe levels of anxiety and depression they face. They have a diagnosis of a mental health condition which requires significant input from the health service and a personalised approach to their education which can both keep them safe and improve their emotional well-being. In addition, several young people have been placed in ACE who are transgender and are going through a traumatic phase of their life and have not been able to cope in a mainstream school. The needs of these children will be carefully considered and catered for in the free school. Although there will be significant SEMH characteristics these will be as a result of their mental health condition and therefore would not warrant an EHCP and their needs are best realised with Alternative Provision.

Rationale

In spite of the early intervention of CAMHS within schools there are a significant number of children who have stopped attending and are at risk of long-term mental health problems. During the past 4 years the number of pupils referred to ACE due to mental health problems has increased significantly.

In addition, there is an increasing number of pupils who also have High Functioning ASD with heightened anxiety and have found mainstream school settings impossible to attend. However, they are not suitable for the SEN schools in Liverpool. Liverpool SEN have actually provided, in some cases, EHC Plans identifying long-term support from ACE as there are no suitable places for these children in Liverpool. In the Alder School these pupils will have been identified as appropriate admissions by specialist ASD teachers from their home school and a CAMHS clinician.

Using the difference as defined in the ONS report (October 2015) mental health can be seen as two aspects, psychological well-being and mental ill-health. Mainstream schools are moving towards addressing the former; the latter considers children with a higher likelihood of a clinically diagnosable illness such as anxiety or depression, PTSD, body dysmorphia. It

is the latter population of children for whom an alternative education provision is being considered in this application.

All too frequently children with emotional difficulties that internalise their difficulties, resulting in depression and anxiety disorders find themselves in placements alongside children with emotional disorders for the externalising variety including conduct disorder. This leads to situations where the anxious child with depression cannot tolerate being in a class with children who cause disruption. This is precisely the case that ACE has come across where some children have been placed in a PRU and later referred to ACE as they cannot cope. This is the case with 2 pupils in the last 12 months. In Liverpool, there is currently no Mental-Health full-time education provision.

Vision
The curriculum will be carefully planned with advice from CAMHS and Alder Hey hospital to ensure that strategies can be fully implemented to support children in making progress with their mental health. Successful strategies already used by ACE will be further enhanced in the Alder School. These include: a relaxed and calm environment; less formal approach for example no uniform; small class sizes (between 8 and 10); a sense of family and belonging to a team; a sense of ownership of their school and a strong pupil voice. The Alder School would require sufficient space to provide a suitable environment for these pupils. The Alder AP school will be carefully designed to provide appropriate space for all classes, alternative activities, therapeutic sessions, counselling sessions and outside space which is secure and peaceful.

An integral part of the proposal is to site the school next to Alder Hey hospital on the old site adjacent to the new hospital. The governing body of the hospital are particularly interested in this as a Tier 3 provision especially since there are plans to re-site the Tier 4 Dewi Jones Unit on the same site. This potentially could result in some financial savings regarding the building. However more importantly specialist health support and advice would be on site.

The high degree of personalised support and understanding which will be provided at the AP school will enhance children’s lives, ensure they achieve success and impact on their life opportunities.

BOARD OF DIRECTORS

Tuesday 4th July 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)												
	2016/17											2017/18	
Month	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
New	1	2	0	1	1	2	2	1	0	1	2	3	1
Open	3	2	4	2	3	3	2	2	1	1	2	2	4
Closed	5	2	0	2	0	1	3	2	2	0	0	2	1
	SIRI (Safeguarding)												
Month	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**
New	0	1	0	1	1	2	0	0	1	2	2	0	0
Open	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
Total closed	**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 01/05/2017 to 31/05/2017:								
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**72 hour review completed**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/ 12813	17/05/2017	Surgery	Grade 3 Pressure Ulcer - Acutely unwell patient stepped down from PICU to surgical ward. Patient was found to have a grade 2 pressure ulcer on left ear due to patient acuity and chest drain on right side. Limited options for re-positioning, impacting on deterioration of pressure ulcer to grade 3. Parents fully informed of pressure ulcer and acknowledge seriousness of patient acuity.	Kelly Black, 4A Ward Manager	Yes – initial actions included care plan reviewed and amended by adding pressure ulcer to worklist. Parents informed to nurse child off ear and staff to ensure carers following care plan and all relevant documentation is completed. Safety huddle documentation amended to include children with tissue viability issues.	Pressure ulcer investigation completed. Pressure ulcer deemed avoidable. RCA Level 2 investigation and information gathering commenced.	Yes	Yes

New Safeguarding investigations reported 01/05/2017 to 31/05/2017: For information							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
StEIS 2017/9948	12/04/2017	Surgery	Sudden unexpected death – Patient had PDA stent inserted, deteriorated unexpectedly and cardiac arrest. Patient subsequently died.	Dianne Topping, Senior Nurse & Colin Dryden, Consultant Anaesthetist	First panel meeting held May 2017. Further information requested, 2nd panel meeting held 19/06/2017. Draft investigation report currently in progress.	Yes	Yes
StEIS 2017/9937	12/04/2017	Surgery	Sudden unexpected death – patient had adenotonsillectomy with subsequent deterioration, admitted to HDU, subsequent cardiac arrest and sadly died.	Christine Murray, Sister, HDU	First panel meeting held May 2017. Further information requested, 2nd panel meeting to be scheduled, following additional information gathered.	Yes	Yes
RCA 333 2016/17 **Internal**	28/03/2017	Community	The patient was brought to ED in November 2016 as an emergency with seizures and hypertension. Despite resuscitation and intensive care she died 2 days later. Subsequent post-mortem has revealed previously undiagnosed structural kidney disease which is the likely cause of the malignant	Amanda Turton, ED Manager	Draft report progressing.	Yes	Being open completed, level of harm unknown.

			hypertension. The child had presented to ED in June 2013 and October 2015 with a diagnosis of Bell's Palsy. Blood pressure should have been recorded on each of these occasions but was not recorded.				
RCA 332 2016/17 **Internal**	28/03/2017	Community	During a complaint investigation it became apparent that some elements of the child's inpatient stay had not been managed as robustly as they should have been. During the 4 days of the child's stay there were a number of times where his clinical condition and monitoring of vital signs triggered his PEWS score and required a review by a doctor - all required reviews do not appear to have taken place.	Dianne Topping, Senior Nurse	Draft RCA report completed. First quality check completed 26th June 2017, further work required.	Yes	Being open completed, level of harm unknown.

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

SIRI incidents closed since last report						
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Outcome**	**Duty of Candour/Being open policy Implemented**
StEIS 2017/ 10352	14/04/2017	Surgery	Grade 3 Pressure Ulcer on patient's back. Patient on ECMO, open chest, nursed on repose mattress but unable to position side to side due to open chest.	Sue Tickle, Clinical Nurse Manager PICU	Reported completed and sent to CCG.	Yes

Safeguarding investigations closed since last report
Nil

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 17th May 2017
10:00am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair), Non-Executive Director	AM
	Mags Barnaby	Chief Operating Officer	MB
	Jeannie France-Hayhurst	(Chair), Non-Executive Director	JFH
	Pauline Brown	Director of Nursing	PB
	John Grinnell	Director of Finance	JG
	Tony Rigby	General Manager, Quality Strategy	TR
	Paul Newland	CD, Clinical Support CBU, /Co Biochemistry	PN
	Glenna Smith	Interim General Manager, Medicine CBU	GS
	Melissa Swindell	Interim Director of HR	MS
	Christian Duncan	Director of Surgery CBU	CD
	Hilda Gwilliams	Chief Nurse	HG
	Steve Igoe	Non-Executive Director	SI
	Cath McLaughlin	Director,	CMcL
	Matthew Peak	Director of Research	MP
	Steve Ryan	Medical Director	RT
	Mark Peers	Governor	MP
	Erica Saunders	Director of Corporate Affairs	ES
	Lachlan Stark	Head of Planning & Performance	LS
	Cathy Umbers	Director of Nursing Governance	CU
In Attendance:-	Julie Creevy	EA, Executive Team	JC
Agenda item:	Chery Brindley	Home Care Manager	CB
	Jo Keward	Lead Nurse, Infection Prevention Control	JK
	Sarah Stephenson	Head of Quality	SS
	Anne Hyson	Head of Quality	AH

17/18/01 Apologies:

Richard Cooke	Director of Infection Prevention Control	RC
Julie Williams	Governor	JW
Melissa Swindell	Director of HR & OD	MS
Dame Jo Williams	Non-Executive Director	JG

17/18/02 Declarations of Interest
None declared.

17/18/03 Minutes of the previous meeting held on 19th April 2017
Resolved:
CQAC approved the minutes of the last meeting held on 19th April 2017.

17/18/04 Matters Arising and Action log
The Action log would be reviewed offline by Hilda Gwilliams prior to a detailed update at 21st June 2017 meeting.

17/18/05 CQC Feedback

ES indicated that most committee members will have received an update from LS, which was recently circulated following the well led meetings held on 5th May 2017. Feedback received to date highlighted the engagement and enthusiasm of staff, and how open and honest staff had been during the inspection process. CQC indicated that further information would be requested, however information request had not yet been received.

APPROVED

Feedback included, how the Trust monitors Duty of Candour, how the CQC governance lead, could not easily access the required information when attempting to access a link within the Quality Strategy. CQC did not detail a timescale for response to the Trust.

The Chair and CQAC members fully acknowledged and recognised the commitment and level of engagement from staff within the divisions during the CQC unannounced inspection and the well led interviews.

17/18/06 Sepsis Update

David Porter & Gerri Sefton presented a Sepsis update as follows:-

- Training had been rolled out to 7 wards, with 4 remaining wards being rolled out w/c 22nd May 2017. Team are currently on track to completely roll out to all wards by June.
- 70% of all staff had been trained , with the aim to achieve at least 90% of staff trained.
- CQAC noted that staff educational training is critical, with training package for medical staff. Team are working on capturing HCA's and AHP staff, with ongoing work to develop an e-learning platform and increase clinical skills.
- Challenges were noted to receive appropriate data with regards to definitions, with a great deal of work progressing to obtain the data.
- Time from prescription to dosing equates to 31 minutes.

CQAC noted priorities going forward:-

- Prioritisation of work for meditech to ensure developments and fundamental required changes are made.
- Education & Training, in order to develop a comprehensive training package.
- Building on governance and clinical quality improvement processes.

The Chair questioned that 31 minutes seemed a long time period for patients to receive antibiotics, and required further detail. DP confirmed that within that timescale, clinicians needed to perform the appropriate assessments/investigations, whilst ensuring that these assessments/investigations were carried out in the correct order, ordering any bloods etc,

CQAC noted the plethora of work completed to date in a short space of time.

CQAC would continue to receive regular monthly updates regarding Sepsis, detailing data definitions/training. CQAC noted the blockages with meditech issues, and noted that this issue was included on the Risk Register as a key risk.

AM thanked Sepsis team for update and achievements made to date.

17/18/07 Programme Assurance Update

J Grinnell (JG) provided an update as follows:-

JG indicated that a number of sessions had taken place to date to scrutinise the programme, with focused efforts and prioritisation regarding the programme. JG confirmed that the process is being paused for a 1 month period, with a further update being provided at Trust Board in 1 months time. CQAC noted that there had since been improved clinical engagement with lots of energy and support from staff.

C Brindley provided an update regarding the Outpatient work stream. CQAC noted that outpatients was on track. Outpatient PID had been withdrawn, given that it needed to be presented at Investment Review Group. CQAC noted that a systems review had taken place led by Gail Hewitt, which would be included within the outpatient project.

APPROVED

CB confirmed that a new template would be available at the end of May, which would clearly show any spare capacity of rooms within outpatients, which would be clearly visible for staff to access.

CB indicated that a group would be established to address DNC forms, to progress this further.

AM thanked JG & CB for the update on Programme Assurance.

17/18/08 Q4 DIPC Report

JK provided an update regarding the above.

- 53% (47/89) of the total of objectives had been completed during 2016/17. 34% (30/89) of the total objectives are in progress, but are not yet completed.
- 13% (12/89) of the total objectives had not been initiated; an action plan with realistic timescales for completion had been developed and shared with Clinical Commissioners, following the Clinical Quality & Performance Group meeting held on 31st March 2017.
- CQAC noted the content of the Infection Prevention & Control Strategy and Delivery Plan, together with the Cleanliness Services Action plan.
- JK advised that a cleanliness audit had previously taken place with herself and the domestic services manager which resulted in 95% compliance.
- Audit will commence week commencing 22nd May 2017 with regards to collecting data regarding device days.

Discussion took place regarding cleanliness within the car park, HG confirmed that the car park is cleaned during the evening given the reduced traffic, and that during the day the car park and stairs & floors deteriorate. HG confirmed that the Project Manager will attend June CQAC meeting to provide a further update regarding cleanliness, there will also be a communication plan which will be shared throughout the organisation.

Action: Project Manager to provide update at June 2017 meeting.

CQAC received and noted the DIPC report.

AM thanked JK for Quarter 4 DIPC report.

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17/18/09 Annual Clinical Audit Programme and update/Confidential enquiries/national guidance assurance report

SS provided an update regarding the above.

CQAC received the Proposed Trust Clinical Audit plan, which included the national clinical audits and audit of NICE guidelines. In addition, auditing of Trust policies had been included this year to provide assurance around policy processes and compliance. CQAC noted that a discussion would be required regarding the issue of who will conduct audits, with a potential option to consider clinical staff, that for whatever reason are unable to perform clinical duties, but are available for other work.

CQAC noted that the Neonatal unit are now starting to use BadgerNet, and will now be in a position to start submitting data to the national neonatal audit.

APPROVED

Confidential Enquiries 2016\17

CQAC noted that the data was submitted to all relevant confidential enquiries. There were no submissions to the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness; however, this was due to there being no applicable cases.

SS indicated that a formalisation arrangement would be required in the future with regards to Medical Records supporting any future data requests from confidential enquiries, given that the enquiries can be onerous for clinical teams.

Action: Finalisation agreement required between Trust Lead & Medical Records for future data requests.

CQAC noted the areas of development, and the RCPHCH Clinical Audit training facilitated by Sarah Stephenson.

SR raised the issue of risk/incidents and highlighted that the Trust needed to be extremely visible regarding what improvements had been made, and ensure that the Trust clearly demonstrated evidence, had documented evidence confirming discussions at division level.

AM thanked SS for her update.

17/18/10 Review progress against the NHSI Quality Governance Framework

ES presented the above detailing the position at May 2017. MIAA had undertaken an audit of Trust process for 2016/17, which was presented in April 2017. The Self assessment included care of well led governance.

CQAC received and noted the position to date, and noted the importance of ensuring compliance and ensuring timescales are adhered to.

AM thanked ES for her update.

17/18/11 Update on final sign off – Quality Account

TR indicated that further to the positive comments received at the last CQAC meeting held on 19th April 2017, since that CQAC meeting a number of updates had been included within the Quality Account. The Quality Account is formally being signed off a Trust Board on 25th May, with expected commentary from Health Watch and Clinical Commissioning Team due by 12th May 2017.

Next Steps:-

- Complete Statement of Directors Responsibilities
- Insert Auditors statements from KPMG
- Send to NHS Improvement before 31st May 2017
- Incorporate into Annual Report
- Publish on NHS Choices before 30th June 2017

CQAC received, noted and approved the Quality Account.

AM thanked TR for his update.

APPROVED

17/18/10 Corporate Report – Quality Metrics

Patient Experience – HG provided a verbal update as follows:-

There had been a 20% increase in formal complaints and 18% increase in PALS ` enquiries compared to the same period last year.

There had been an increase in the amount of families who are aware of their planned date of discharge. All other areas of survey responses are within the agreed target. Work is in progress to increase the amount of responses.

AM & HG had previously agreed stretch targets going forward.

Clinical Effectiveness

Total infections shown an increase in March, which correlated to the increased activity across the Trust. However these were down in total compared to 15/16. There were no reports of hospital acquired MRSA or C Difficile in month. The Trust continues to develop the data to produce a baseline in relation to children with long term conditions being readmitted within 28 days. The percentage of patients with an estimated date of discharge later than planned continues to be down in comparison to last year.

Patient Safety

The month saw a rise in medication errors resulting in harm, but comparable to March 16 and overall the trend continues to be lower than in 2016. The data is reviewed closely by the Medication Safety Team for any themes. Increased activity was evident, and errors resulting in moderate, severe harm or death remain consistently lower than the previous year.

Re admissions to PICU related to patient activity, with targets on track.

The Chair thanked Hilda Gwilliams for her update.

17/18/11 Quarter 4 Complaints Report

A Hyson presented the Q4 2016/17 Complaints Report.

The Trust received 19 formal complaints during this period. Two complaints from this quarter were subsequently withdrawn from the process at the complainant's request. 2 complaints had started as informal concerns (PALS), however due to dissatisfaction with informal outcome the complainant requested this progressed to the formal complaint route.

In 2015/16 Quarter 4 the Trust received 16 formal complaints, equating to a 16% increase of formal complaints received in Quarter 4 this year. However the total number of formal complaints received in 2015/16 were 71 and in 2016/17 it was 66 – overall in 2016/17 there had been slight decrease of formal complaints received compared to the year before 7%.

Themes raised were regarding treatment/procedure (44%) – this related to parents questioning whether the care their child had received was appropriate. Second category was regarding consent, communication & confidentiality (26%).

APPROVED

3 complaints were upheld within this quarter, and 2 were not upheld. 12 complaints are still ongoing, 9 complaints received during March, with three of the complaints being complex cases with re-negotiated timeframes.

Referrals to Parliamentary & Health Service Ombudsman – one case had been closed from the PHSO in Quarter 4 – case partially upheld with recommendations (Haematology/Oncology).

The Trust had received notification of intention to proceed to investigate a case - Cardiac surgery and Community Nursing Team

PALS had received 391 enquiries during this period, which indicated a significant increase from Quarter 3 – 218.

Key actions and lessons learnt from PALS during Quarter 3
The most issues identified within Quarter 4 feedback related to Community Paediatrics. Main areas of concern related to waiting times for appointments, appointment cancellations and communication failure (admin/medical).

CQAC received and noted the Quarter 4 complaints report.

Discussion took place regarding the importance of ensuring focus in all divisions regarding ensuring that responses are provided to PALS in a timely manner, to improve timeframes of responses going forward.

Committee agreed that NEDs should review complaints going forward.

Action: ES & HG to discuss further offline to agree process for NEDs reviewing Complaints.

AM thanked Anne Hyson for the detailed update.

17/18/12 Clinical Quality Steering Group Annual Report

P Brown presented the Clinical Quality Steering Group Annual Report. PB presented Clinical Quality Key issues report: on behalf of Phil O'Connor.

CQAC noted that Clinical Quality Steering Group had experienced an extremely busy year, CQSG had been well Chaired by Phil O'Connor, and prior to Phil CQSG had been chaired by Gail Hewitt.

CQAC noted that policy compliance had risen steadily throughout the year, and currently stands at its highest. This had been achieved through a regular focus on policy sign off by CQSG as well as the committed work of the Policy Administrator.

CQAC noted that there had been some slippage of the work plan regarding key issue reports from divisions, with the work plan for 17/18 being reviewed and agreed by relevant CQSG committee members. CQAC recognised that the workplan for CQSG was heavy, with the Terms of Reference for CQSG being reviewed. The June CQSG will reflect new agenda, once the work plan and Terms of Reference had been reviewed.

CQAC received and noted the achievements to date by CQSG, and noted that CQSG had fulfilled its responsibilities in accordance with its Terms of Reference and 2016/17 work plan.

AM thanked PB for the CQSG Annual update report, and expressed thanks to the CQSG committee members.

APPROVED

17/18/13 Clinical Quality key issues report

PB presented the Clinical Quality key issues report. CQAC noted the community key issues regarding the transfer of LCH services and the associated process of each of the individual services undergoing a review with a subsequent report being presented at Trust Board, which would identify any key risks that may require mitigation. CQAC noted that the report will be discussed at Trust Board, and also will be shared at Executive Team meeting held on 18th May 2017.

AM thanked PB for the key CQSG key issues report.

17/18/12 Any other business

None

Date and Time of next meeting: - Wednesday 21st June at 10am, Large Meeting Room, Institute in the Park.

APPROVED

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development	Date: 04/07/17													Period: June 2017													SRO: David Powell
	Report Number:													11													Author: Sue Brown
Programme 2017/18	Apr-17				May-17					Jun-17				Jul-17					Aug-17				Sep-17				
Week Commencing	3	10	17	24	1	8	15	22	29	5	12	19	26	3	10	17	24	31	7	14	21	28	4	11	18	25	
Decommissioning & Demolition (Phase 1 & 2)																											Programme progressing on track. In response to the concerns raised regarding dust levels, a dust management plan has been developed and actioned with DIPC approval. The management plan is in place covering both : 1. demolition of retained estate; 2. R&E II construction, levels have remained safe todate.
Residential																											Revised bids evaluated and recommendation of Preferred Bidder, including a first reserve, presented to Executive Team and approved. Bidders have been informed and subsequent feedback meetings held. Public consultation delayed slightly due to the General Election and extension of PURDA. Public consultation plan agreed between all parties including LCC and ready to commence w/c10 July with completion end of 2017 with long stop date end of March 2018 depending on public response. Bidder working with LCC planners to ensure all consultation material is acceptable within the rules of the planning process to ensure that the final scheme has a high level of acceptance to all parties.
Research & Education Phase II																											Building in progress and on schedule. Piling complete 4 days ahead of schedule. Changes required to accommodate Universities now being considered and drawn by contractor and Trust awaiting response. University space allocations and flows nearing agreement but fiancial agreements still not finalised. Morgan Sindall contract required by Friday 30th June if work is not to be seriously delayed.
Alder Centre																											On Track. ITPD process with 5 bidders for the Design of the Alder Centre via the RIBA in progress. Bidders presented their final designs on 27th June. Notification of the successful Bidder is on plan for the week commencing 17th July. Project will go on hold at that point if LIBOR funding not recieved by the charity This has been delayed due to the General Election and Purda). Charity are writing to Jeremy Hunt to request release of funding at the earliest convenience
Park																											Planning application for woodland path and multi-sensory, technology-assisted, interactive interpretation trail submitted. - First forest school area built with the first school participation during june, this was extremley successful. New partnership with Woodland Trust forged and acquisition of newly commissioned national monument for Springfield secured for Nov 17.- Corporate sponsorship pitch to B&Q successful and ongoing discussion with regards to sponsership at the 2018 Chelsea flower show continue..
International Design & Build Consultancy																											Pricing structure and format for design advice prepared and provided to XI'AN, awaiting response. DH also visited Jersey to offer conultation/advise on their proposed new build, awaiting to hear back from them.
Community/CAMHS (Estates Strategy)																											Currently exploring and conducting a financial analysis of proposed developments and locations for Community services; Onsite Neurodevelopmental new build for Community Paediatrics and an offsite potential lease for CAMHS. Paper planned to be completed in July.
Corporate Offices/Clinical on-site																											**Project now wrapped up in the whole estate strategy for the site.**
On-site Residual																											**Project now wrapped up in the whole estate strategy for the site.**

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Board of Directors

Report of	The Director of Infection, Prevention & Control on behalf of the Trust's Infection Prevention & Control Committee
Paper prepared by	Dr Richard Cooke Infection Control Doctor & DIPC Valya Weston ADIPC & IPC service Lead Josephine Keward Lead Nurse Infection prevention
Subject/Title	2016/17 Annual Report of the Infection Prevention & Control Committee
Background papers	Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and Related Guidance. 2009 (revised 2015)
Purpose of Paper	• To provide assurance in respect of all the elements contained in the assurance framework. • To highlight areas of excellence • To highlight areas of non-compliance and provide actions. • To highlight current pressures
Action/Decision required	• That the Board receives and approves the Annual Report of the Infection Prevention & Control Committee
Link to: **Trust Objectives** **IPC Code**	• Excellence • Openness • Respect • Together • Innovation See page 38
Resource Impact	Healthcare associated infections have a financial resource implication for all Trusts. Implementation of the 2017-18 IPC work plan and associated Trust wide action plans will have resource implications; however the aim of these projects is to have a direct impact on the reduction of Healthcare associated infections.

ANNUAL REPORT TO THE TRUST BOARD

PREPARED BY THE DIRECTOR OF INFECTION PREVENTION AND CONTROL ON BEHALF OF THE INFECTION PREVENTION & CONTROL COMMITTEE

April 1st 2016- March 31st 2017

Director of Infection Prevention and Control
Dr Richard Cooke
Infection Control Doctor & Consultant Microbiologist

Contributors
Valya Weston, Associate *DIPC*
Jo Keward, *Lead Nurse Infection Prevention & Control*
***Lisa Moore**, Surgical Site Surveillance Nurse*
***Claire Oliver**, Infection Prevention & Control Nurse Specialist*
Carly Quirk, *Data Analyst Infection Prevention & Control*
David Sharpe, *Antimicrobial Pharmacist*
***Sue Brown**, Decontamination Lead*

CONTENTS

		Page Number
Executive Summary		Page 4
Section 1	Aims and Performance	Page 7
	Introduction	Page 7
Section 2	Key performance Indicators and Analysis	Page 9
Section 3	Mandatory Reporting	Page 25
Section 4	Infection Prevention and Control Activity	Page 29
Section 5	Delivery against annual Infection Prevention and Control Programme	Page 34
Section 6	Service Development/Innovation	Page 35
Section 7	SWOT Analysis	Page 37

Appendices

Appendix 1	Infection Prevention and Control Delivery Plan	Page 38

EXECUTIVE SUMMARY

Delivery Plan Performance

53% (47/89) of the objectives from the 2016/2017 delivery plan have been fully completed during 2016/2017. 34% (30) of the objectives have been actioned but are yet to be completed (amber). 13% (12/89) of the objectives have not been achieved in Q4 (red) see Table 1.

An action plan with realistic timescales for overall completion has been developed and shared with the Clinical Commissioning Group (CCG). The issues that are under the immediate control of the Infection, Prevention & Control Team (IPCT) have been addressed. The issues that are outside of the IPCT immediate remit remain outstanding.

Table 1: Objectives RAG rating Q4

No. of objectives Q4	Red Q4	Amber Q4	Green Q4
89	13% (12)	34% (30)	53% (47)

Achievements

- There have been NO confirmed viral outbreaks within the Trust in 2016/2017.
- The Trust has established formal contracts with Authorised Engineer(AE) for decontamination
- The IPCT were able to achieve the NHS flu vaccination target of 75% despite losing the flu coordinator role in Health promotion.
- The Trust's compliance with screening guidance to identify patients with multi-drug antibiotic resistant bacteria continues to improve.
- The Trust has achieved its targets for reviewing prescriptions within 72 hours of initiation and the CQUIN target for the reduction in consumption of total antibiotics, (specifically Piperacillin/Tazobactam and Meropenem).
- The Trust is working in close collaboration with Public Health England (PHE) on surgical site infection (SSI) surveillance. Alder Hey is currently the only paediatric Trust in England participating in paediatric cardiac surgical SSI surveillance. Please see SSI section of report.
- There has been Post Infection Review (PIR) investigations conducted following the occurrence of MRSA bacteraemia and *Clostridium difficile* infections, resulting in the development and implementation of improvement plans.

- Establishment of a multidisciplinary hand hygiene improvement group in critical care-which has adopted innovative methods of auditing hand hygiene compliance using mobile phone app iscrub. This has provided larger and greater amounts of hand hygiene opportunities which has assisted in highlighting specific staff or groups with poor hand hygiene compliance

- Hand hygiene awareness week held in October 2016.

- The introduction of online audits for isolation practice (SNAP system) has improved quantity of data collected and feedback to clinical teams

- Establishment of Surgical site Infection surveillance (SSIS) reports in plastic surgery suggesting 0% SSI and agreement on methodology for k wire (SSI) surveillance.

- Introduction of Orthopaedic care bundles and reinstatement of cardiac and neurosurgery care bundle monitoring.

- Establishment of a Theatre Safety Board chaired by Benedetta Pettorini Consultant Paediatric Neurosurgeon and Chief of Operative care where IPC issues are discussed bimonthly

- All central venous catheter associated blood stream infections (CLABSI) and Ventilator associated Pneumonias (VAP) in critical care are now being validated by a MDT on a monthly basis .

- In service evaluation of CUROS (70% alcohol impregnated caps for the end of lines) and the Braun needle free devices in an attempt to reduce the incidence of CLABSI within the organisation.

- Participated in National PHE prevalence survey in Nov 2016 and local HCAI prevalence survey in March 2017. This provides a snap shot of the rate of HCAI for the Trust and identifies areas and prevalence of different type of infection. The Trust overall HCAI in November 2016 was 6.9%

- Post infection Review (PIR) for serious infections i.e. increased incidence of cardiac infections have been introduced.

- The introduction of a level 1 Root cause analysis (RCA) proforma on SNAP has made it easier for clinical teams to carry out reviews of Blood Stream Infections and other reportable HAI. This information determines the requirement for a formal RCA process

- The Introduction of IPC Ward based Key Performance Indicators (KPI).These are reported quarterly to the IPC committee and to the divisions of medicine and surgery. The Associate Chief Nurses feedback on the compliance of their divisional KPI to the IPCC. The ward with the highest score for their KPI's is named Infection Control ward of the year. This year the award went to Ward 3B.

Service changes

- The IPCT have established Central Line Associated Bloodstream Infections (CLABSI) validation meetings within PICU and in Gastroenterology for total parenteral nutrition (TPN) patients.

- The IPCT have established CLABSI rates in PICU and TPN patients which will allow us to benchmark against other Trusts in the UK and also internationally.

- Ventilator associated pneumonia (VAP) surveillance has been established on PICU.

- The Trust has established Public Health England (PHE) surgical site surveillance (SSI) methodology in cardiac and surgical specialities.

- The IPCT has established a weekly Gastroenterology MDT on Ward 3C with the gastroenterologist team.

- The IPCT and cardiac surgical team have established regular surgical site infection (SSI) validation meetings in cardiac surgery prior to submission of data to PHE.

1 Aims and Performance

No child will acquire a preventable infection due to care delivered at Alder Hey.
Sub Aims 1. No child will acquire a viral illness in hospital due to care delivered at Alder Hey 2. No child will acquire a hospital acquired CVC associated bacteraemia due to care delivered at Alder Hey 3. No child will acquire a multi-drug resistant organism due to treatment provided at Alder Hey. 4. No child will acquire an infection from the environment. 5. No child will acquire an infection following surgery due to care given at Alder Hey.
During the year there were 44*cases of reported infection associated with care or the environment at Alder Hey. (*figure excludes surgical site infections and CLABSIs)

During 2016/17 the following hospital acquired alert organism infections occurred

- MRSA bacteraemia **2 cases**
- Clostridium difficile **1 cases**
- MSSA bacteraemia **13 cases**
- RSV (Respiratory Syncytial Virus) **11 cases**
- Rotavirus **0 cases**
- MRSA (not bacteraemia) **4 cases**
- E.coli Bacteraemia **8 cases**
- Influenza A **5 cases**

Periods of Increased Incidence (D&V with no known pathogen):

- 1B HDU October 2016 **5 cases**
- 1B HDU November 2016 **4 cases**

1.2 Introduction

Alder Hey Children's NHS Foundation Trust recognises the obligation placed upon it by the Health Act 2008, (updated 2015) to comply with the Code of Practice for health and social care on the prevention and control of infections and related guidance.

The Trust supports the principle that infections should be prevented wherever possible or, where this is not possible, minimised to an irreducible level and that effective systematic arrangements for the surveillance, prevention and control of infection are provided within the Trust.

1.3 Purpose

The Code of Practice (DH 2008) requires Trust boards to receive an annual report from the Director of Infection Prevention and Control. The purpose of the annual report is to inform

the Trust Board of progress in delivering the Infection Prevention and Control Agenda and to provide assurance that appropriate measures are being taken to prevent and control healthcare associated infections.

1.4 Scope

This report is in relation to the provision of an effective Infection Prevention and Control (IPC) service for Alder Hey Children's NHS Foundation Trust

2 Key Performance Indicators and Analysis

2.1 *Viral Illnesses*

No child should acquire a viral illness in hospital due to care delivered at Alder Hey.		
• RSV	11 cases	Hospital acquired cases
• Influenza A	5 cases	
• Influenza B	0 cases	
• Rotavirus	0 cases	
• Viral Outbreaks	0 cases	

2.1.1 *Respiratory Syncytial Virus (RSV)*

RSV is a highly transmissible seasonal infection predominately seen in the paediatric population. Children require isolation whilst they are symptomatic and high numbers are seen during the winter period. RSV is monitored as part of the Trust local surveillance programme and is a key infection prevention marker for paediatric Trusts.

During 2016/2017 there were **11** cases of hospital acquired RSV compared to **10** in 2015/16.

The table below shows a rate for RSV per 1000 bed days for the Trust, for the winter period 2016/2017. The Trust had a rate of 0.27 per 1000 bed days for hospital acquired RSV for 2016/2017. This has decreased from last year when the Trust rate was 3.0 per 1000 bed days. The rate of 0.27 per 1000 bed days is within limits published in literature but there are no national rates published to be able to benchmark against.

Table 2

******Please note the table below shows 9 cases as 2 of the 11 cases for 2016/2017 fell outside the winter period.***

Hospital Acquired RSV per 1000 bed days for 16/17 season

Ward	Oct-16			Nov-16			Dec-16			Jan-17			Feb-17			Mar-17			Total RSV for season		
	HA RSV infection	Occ Beds	Rate per occupied bed days	HA RSV infection	Occ Beds	Rate per occupied bed days	HA RSV infection	Occ Beds	Rate per occupied bed days	HA RSV infection	Occ Beds	Rate per occupied bed days	HA RSV infection	Occ Beds	Rate per occupied bed days	HA RSV infection	Occ Beds	Rate per occupied bed days	Total RSV for season	Occupied beds for season	Rate per occupied bed days
W3A	0	691	0.00	0	739	0.00	0	654	0.00	0	648	0.00	0	663	0.00	0	766	0.00	0	4,161	0.00
W3B	0	280	0.00	0	302	0.00	0	373	0.00	0	382	0.00	0	294	0.00	0	351	0.00	0	1,982	0.00
W3C	1	803	1.25	1	843	1.19	1	752	1.33	0	792	0.00	1	721	1.39	0	827	0.00	4	4,738	0.84
W4A	0	730	0.00	0	788	0.00	0	620	0.00	0	729	0.00	0	698	0.00	0	781	0.00	0	4,346	0.00
W4B	0	456	0.00	1	459	2.18	0	428	0.00	0	493	0.00	0	488	0.00	0	520	0.00	1	2,844	0.35
W4C	0	805	0.00	1	884	1.13	0	826	0.00	0	844	0.00	0	780	0.00	0	870	0.00	1	5,009	0.20
WBURNS	0	84	0.00	0	76	0.00	0	75	0.00	0	90	0.00	0	92	0.00	0	110	0.00	0	527	0.00
WCARDIAC	0	484	0.00	1	499	2.00	0	450	0.00	0	532	0.00	0	511	0.00	0	549	0.00	1	3,025	0.33
WHDU	0	376	0.00	1	346	2.89	0	387	0.00	1	391	2.56	0	374	0.00	0	409	0.00	2	2,283	0.88
WICU	0	508	0.00	0	496	0.00	0	505	0.00	0	511	0.00	0	476	0.00	0	540	0.00	0	3,036	0.00
WNEO	0	187	0.00	0	174	0.00	0	197	0.00	0	230	0.00	0	176	0.00	0	177	0.00	0	1,141	0.00
Grand Total	1	5404	0.19	5	5606	0.89	1	5267	0.19	1	5642	0.18	1	5273	0.19	0	5900	0.00	9	33,092	0.27

2.1.2 Influenza

During 2016/2017 there have been **5** cases of hospital acquired Influenza (influenza A) compared to **8** (6 influenza A and 2 influenza B) in 2015/2016. The table below shows the Trust rate for hospital acquired influenza per 1000 bed days.

The rate for hospital acquired influenza for 2016/2017 was 0.15 per 100 bed days. This has decreased from last year when the rate was 0.24.

Table 3

Hospital Acquired Influenza per 1000 bed days for 16/17 season

Ward	Oct-16			Nov-16			Dec-16			Jan-17			Feb-17			Mar-17			Total Influenza for season		
	HA influenza	Occ Beds	Rate per occupied bed days	HA influenza	Occ Beds	Rate per occupied bed days	HA influenza	Occ Beds	Rate per occupied bed days	HA influenza	Occ Beds	Rate per occupied bed days	HA influenza	Occ Beds	Rate per occupied bed days	HA influenza	Occ Beds	Rate per occupied bed days	Total influenza for season	Occupied beds for season	Rate per occupied bed days
W3A	0	691	0.00	0	739	0.00	0	654	0.00	2	648	3.09	0	663	0.00	0	766	0.00	2	4,161	0.48
W3B	0	280	0.00	0	302	0.00	0	373	0.00	0	382	0.00	1	294	3.40	0	351	0.00	1	1,982	0.50
W3C	0	803	0.00	0	843	0.00	0	752	0.00	0	792	0.00	0	721	0.00	0	827	0.00	0	4,738	0.00
W4A	0	730	0.00	0	788	0.00	0	620	0.00	0	729	0.00	0	698	0.00	0	781	0.00	0	4,346	0.00
W4B	0	456	0.00	0	459	0.00	0	428	0.00	1	493	2.03	0	488	0.00	0	520	0.00	1	2,844	0.35
W4C	0	805	0.00	0	884	0.00	0	826	0.00	0	844	0.00	0	780	0.00	0	870	0.00	0	5,009	0.00
WBURNS	0	84	0.00	0	76	0.00	0	75	0.00	0	90	0.00	0	92	0.00	0	110	0.00	0	527	0.00
WCARDIAC	0	484	0.00	0	499	0.00	0	450	0.00	0	532	0.00	0	511	0.00	0	549	0.00	0	3,025	0.00
WHDU	0	376	0.00	0	346	0.00	0	387	0.00	0	391	0.00	0	374	0.00	0	409	0.00	0	2,283	0.00
WICU	0	508	0.00	0	496	0.00	0	505	0.00	0	511	0.00	0	476	0.00	0	540	0.00	0	3,036	0.00
WNEO	0	187	0.00	0	174	0.00	0	197	0.00	0	230	0.00	0	176	0.00	1	177	5.65	1	1,141	0.88
Grand Total	0	5404	0.00	0	5606	0.00	0	5267	0.00	3	5,642	0.53	1	5273	0.19	1	5,900	0.17	5	33,092	0.15

Actions

- Compliance with use of personal protective equipment (PPE) needs to be improved across the Trust. This is being addressed through IPC mandatory training, education of ward / department based link personal and audit and feedback of compliance results.
- There needs to be more training on use of FFP3 respiratory face mask for aerosol generating procedures across the Trust. This should be led by the Divisions. Additional Ward / department based key trainers will be trained by the IPCN and will undertake cascade training. The Quality leads will be responsible for keeping and updating training records for their areas.

2.1.3 Rotavirus

Rotavirus is a seasonal infection and cases are usually seen during the spring season.

During 2016/17 there were **0** cases of Hospital Acquired Rotavirus compared to **1** case during 2015/2016 and **9** cases between Dec - April 2014/15. This significant decrease in numbers follows the introduction of the Rotavirus vaccine as part of the National Immunisation Schedule in September 2013.

2.1.4 Viral Outbreaks

There were **0** viral outbreaks during 2016/2017 compared to **1** in 2015/2016.

2.1.5 Staff Influenza Vaccination

The campaign ended with the Trust achieving **75.4%** of all frontline staff vaccinated against influenza. These results show a **2%** decrease on last year but the actual numbers of front line staff vaccinated rose from 1315 in 2015-16 to 1427 in 2016-17.

Table 4 Influenza vaccine uptake by staff group

Group (baseline)	Percentage Uptake
1-Doctors	65%
2- Nurses	80%
3- Support to Tech	62%
4- Support to clinical	71%
Total Uptake	**75.4%**

Compliance (Green) is indicated by a score >75%

What worked well

Although the Trust lost the role of influenza vaccination coordinator the Lead IPC Nurse was still able to achieve the 75% target. Uptake was maximized by the training of ward based vaccinators and the delivery of work place vaccination by the IPCNs.

Actions

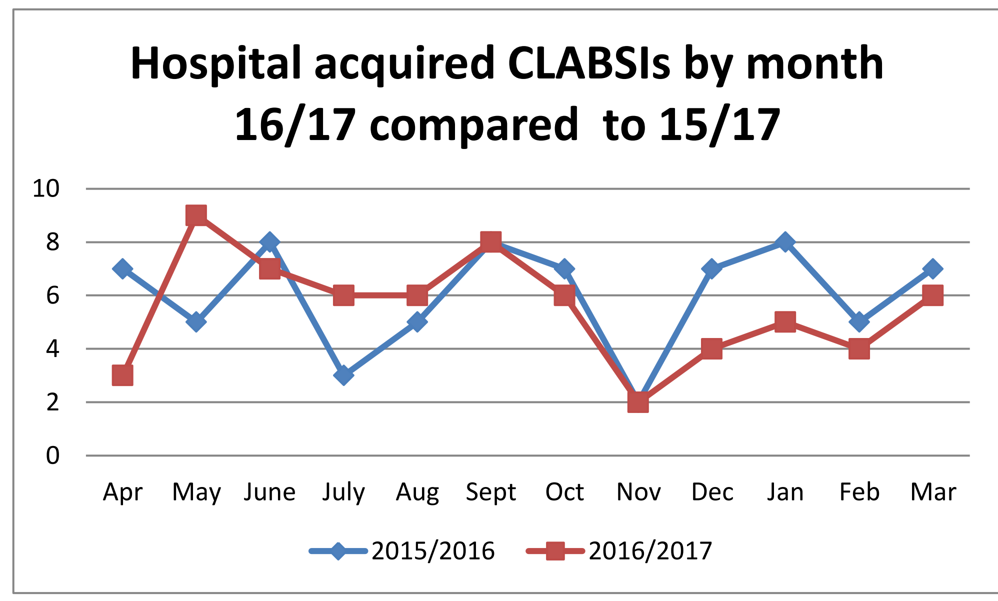
- To develop a question and answer session with staff groups in those areas that had low uptake of the vaccine over the winter period before the beginning of the 2017-18 season. This will help identify underlying reasons for non-vaccine uptake and therefore improve the next flu campaign.
- Additional support for another successful campaign is required from the divisions with clear roles and responsibilities outlined and agreed.
- Clerical support is also required for the inputting of the live database in order for accurate records to be kept of staff vaccination status for PHE ImmForm reporting.

2.2 Central Line Associated Bacteraemia Infections (CLABSIs)

No child should have a hospital acquired CVC associated bacteraemia due to care delivered at Alder Hey.
66 cases of hospital-acquired laboratory confirmed CLABSI occurred during the year.

CLABSIs still remain the most significant hospital-acquired infection with **66 cases** in 2016/2017 compared to **72 cases** in 2015/2016. The table below shows hospital-acquired lab confirmed CLABSIs during 2016/2017 compared to 2015/2016.

Figure 1



Key issues

Currently our CLABSI rate per 1000 catheter days for PICU is approximately 5 per 1000 catheter days. The current CLABSI rate for our TPN patients is 3 per 1000 catheter days.

These rates are high as per paediatric published data. The IPCT team is working with colleagues to reduce the rates to at least 2 per 1000 catheter days for PICU and 1 per 1000 catheter days for TPN patients.

The IPCT are currently unable to report Trust-wide CLABSI rates per 1000 line days which would give us a more comparable rate for benchmarking. The main issue is the current inability to use the Meditech IT system to capture central line catheter days on a daily basis.

Actions

- Collaborative work across the Trust to prevent CLABSIs. This will be included in the project initiation document (PID) led by our Medical Director, Dr Steve Ryan.
- Working with Meditech personnel to capture total catheter days across the Trust (see CQPG action plan document).

2.3 Multi Drug Resistant (MDR) Organisms

Table 5

No child should acquire an infection due to a multi-drug resistant organism due to treatment provided at Alder Hey. Number of hospital acquired multi-drug resistant organsims:	
• MRSA bacteraemia	**2 cases**
• MRSA (not bacteraemia)	**4 cases**
• CRE (Carbapenemase Resistant Enterobacteriaceae)	**1 case**
• CPE (Carbapenemase Producing Enterobacteriaceae)	**0 cases**
• VRE (Vancomycin-resistant Enterococcus)	**0 cases**
• ESBL (Extended Spectrum Beta-Lactamases) outbreaks	**0 cases**

Multi-drug resistant organisms pose a significant clinical risk due to the limited range of therapeutic antibiotics that may be available to treat a patient's infection. There continues to be the emergence of extended spectrum β-lactamases (ESBLs) and Carbapenemase Producing Enterobacteriaceae (CPEs) both regionally, nationally and internationally. The main focus for the reduction of ESBLs and CPEs continues to be effective antibiotic stewardship, patient surveillance by rectal screening and implementation of basic infection prevention and control practices.

NHS Trusts across Cheshire and Merseyside are encountering many more cases of CRE/CPE than Alder Hey, these organisms still remain very rare at Alder Hey. However ongoing surveillance for these organisms is extremely important in view of inter hospital transfers. It is therefore pleasing to note that the Trust's compliance with screening guidance has continued to improve.
Delay in the laboratory confirmation of presumptive CPE results by the reference laboratory is having a significant impact on the period of strict isolation for suspected cases. This could be resolved by the introduction of new technology into our Microbiology Laboratory.

2.3.1 MRSA Hospital Acquired Cases

Definition: Positive screen for MRSA carriage on the same inpatient admission after negative screens have been confirmed.

Table 6

	2013-14	2014-15	2015-16	2016-17
Number of patients Colonised with MRSA	5	11	8	4
Number of patients Infected with MRSA	1	1	3	2

2.3.2 Area in which MRSA was acquired 2016-17

Table 7

Division	Area	Number of cases
Surgical	1B HDU	1
Surgical	1C Cardiac	1
Medical	3C	3* (2 of these were Bloodstream infections)
Medical	4B	1

Key issues

- The cases of MRSA occurred in our most complex patients.
- The wards where some of our most high risk patients are managed (neurosurgery, orthopaedic surgery, and Oncology; wards 4A and 3B) had **0** cases of MRSA acquisition.

Actions

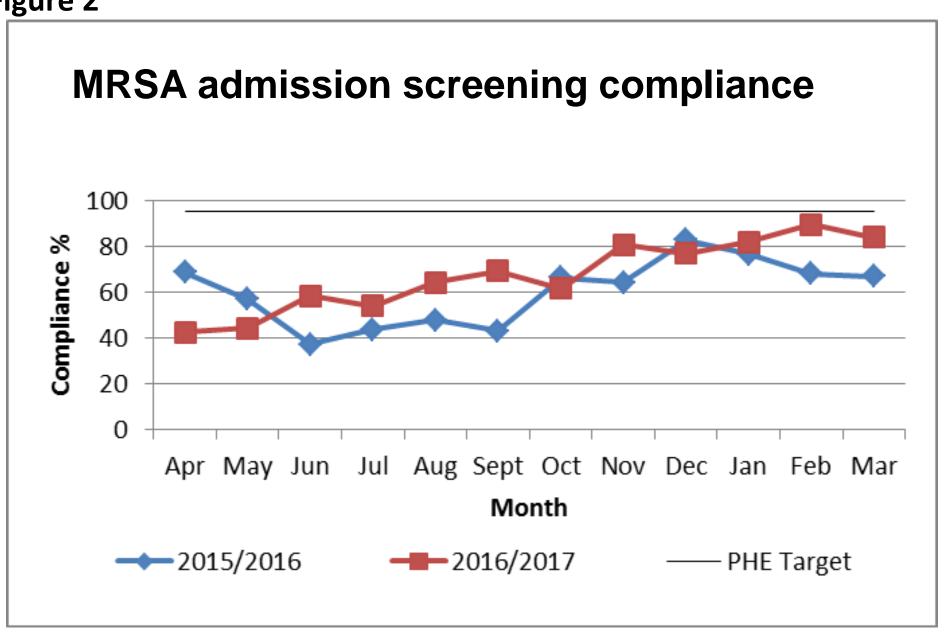
- Collaborative working with the quality leads to develop the area Link personal and Multidisciplinary team
- MRSA management policy revised to include the review of all previous MRSA carriers prior to insertion of indwelling devices by clinical teams and discussion about decolonisation and prophylaxis antibiotics with the IPCT / Medical Microbiologist
- Ward rounds by the IPCT to review the management of MRSA carriers

2.3.3 MRSA Admission Screening

MRSA admission screening is undertaken to detect colonisation (carrying the bacteria without any infection). In certain individuals, colonisation may predispose to infection and colonised patients have the potential to transmit the bacteria to another patient. An internal tolerance for compliance has been set at 95% following the removal of mandatory reporting to the DH.

The graph below shows the compliance by month for MRSA screening for 2016/2017 compared to 2015/2016. Compliance has improved this year compared to last year.

Figure 2



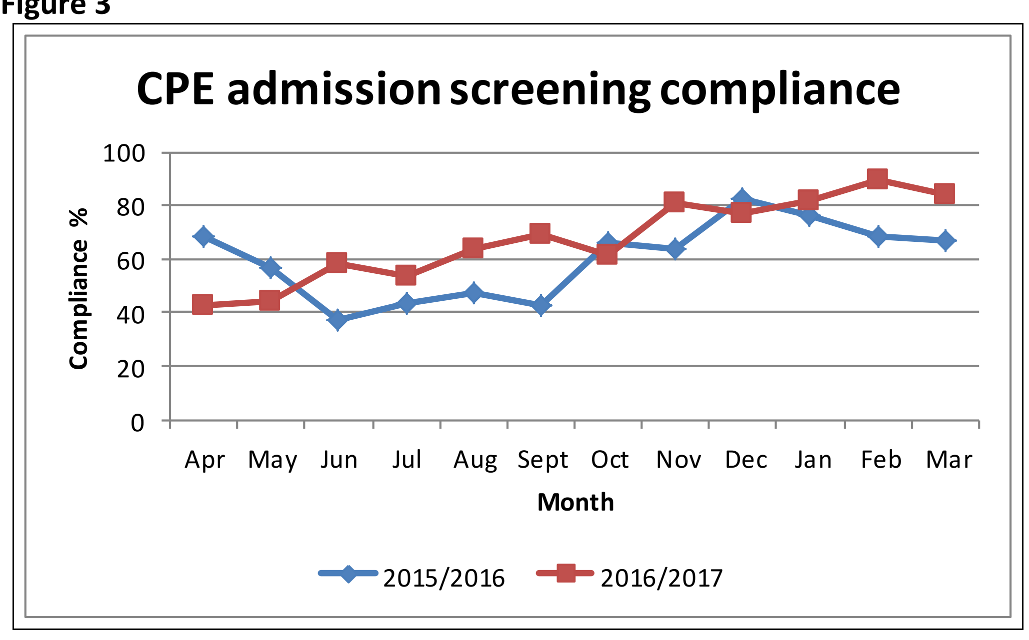
2.3.4 CRE

There has been **1** case of hospital acquired CRE in 2016/2017 which was on PICU in August 2016. This compares to **2** cases in 2015/2016.

2.3.5 CPE Screening

Compliance for CPE admission screening has increased over 2016/2017. The graph below shows compliance by month for 2016/2017 compared to 2015/2016.

Figure 3



Screening has improved across the Trust during 2016-17. Wards have been monitored monthly on their compliance and they have been actively given feedback on their performance.

Actions

The IPCT would like to evaluate the use of groin swab versus the rectal swab for gram negative surveillance. If the groin swab was proved to be as effective as the rectal swab it would mean that the screening procedures could be simplified for nursing staff. No Resources as yet identified.

2.3.6 Antibiotic Stewardship

Although we await processing and publication of our antibiotic consumption data by NHS England, our internal reporting indicates that we have achieved our target.

We have also achieved the target for reviewing prescriptions within 72 hours of initiation (CQUIN targets for reduction in consumption of total antibiotics, piperacillin/tazobactam & meropenem). These improvements are thought to be associated with the introduction of a 3-times-weekly consultant-led Antimicrobial Stewardship (AMS) ward round.

Point prevalence antibiotic prescribing data has been shared as part of the GARPEC project and the PHE national point prevalence survey. We have received feedback from the GARPEC project that has enabled us to benchmark our practice with other centres in the UK, which indicates that our antimicrobial prescribing trends are similar to other centres.

Actions

- Expand the AMS round so that there will be a nurse-led AMS round twice-weekly, this means there will be an AMS round every week day.
- Develop decision-support within the electronic prescribing system so prescribers are guided to the correct antibiotic, dose and duration for certain indications.

2.4 Environment

No child should acquire an infection from the environment

The IPCT have undertaken a number of Infection Prevention Society (IPS) audits. These audits relate to decontamination, waste management, clinical practices and environmental safety. Some audits are very specific and based on national guidelines e.g. Dental / Endoscopy.

100% of inpatient areas were audited during 2016-17 using the Infection Prevention Society audit tools. **All environmental audits have been rag rated green (>=95%) amber (76% - 94%) or red (<=75%).**

Table 8 IPC Environmental audits

Area	Compliance %
AED	85
EDU	88
1B PICU Critical Care	82
1B HDU Critical Care	77
1B Burns	90
1C	90
3A	85
3B	86
3C	93
3C Dialysis	94
4A	80
4B	85
4C	82
Theatres	86
Medical Day case Unit	89
Day case Theatre	97
Surgical Day case Unit	91

Issues

The HDU audit score of 77% overall in their environmental audit was deemed to be concerning. Issues that were identified were as follows:

- Hand hygiene compliance
- Linen Management
- Sharps handling
- General environment and fittings

Actions

- Along with PICU there was an educational drive around the 5 moments of hand hygiene and staff reminding each other about poor practice.

- A hand hygiene app was introduced on the unit to allow for more opportunities to be captured.

- A review of cleaning schedules and staff responsibilities is underway to ensure all areas are cleaned on a regular basis.

- Ongoing critical care mandatory training by the IPCT is undertaken, this training which covers cleanliness and decontamination.

- The unit will be re audited in quarter 2 2017-18 by the IPCT.

2.4.1 Water quality

The Chief Operating Officer (COO) is the chair of the Water safety group and reports into the IPCC on a quarterly basis and as required. There is now a Water safety policy and a water safety plan for Trust which is owned by the water safety group.

During 2016-17 the Microbiology department has conducted 929 pseudomonas water outlet tests throughout the Trust. 126 (14%) of these have been positive for pseudomonas.

Table 9

	No. Tested	No. positive	% positive
3B Oncology	209	12	5.7
1C Neo	73	5	6.8
1B Critical Care	358	67	18.7
3C	260	31	11.9
Bed Wash	10	4	40.0
Theatre	10	6	60.0
3A	2	0	0.0
4A	2	1	50.0
4B	2	0	0.0
4C	2	0	0.0
OPD	1	0	0.0
Total	**929**	**126**	**13.6**

Sampling of water outlets for the presence of pseudomonas is a requirement outlined in HTM-0401. Guidance on what constitutes an 'Augmented care area' in HTM-04-01 is shown below; the guidance is deliberately not prescriptive and is linked to patient groups not clinical areas;

Category A patients –immunocompromised patients
Category B patients –organ support patients
Category C patients- Loss of Skin integrity i.e. Burns patients

<u>Key issues</u>

- There is not enough capacity within the Microbiology Laboratory to carry out sampling in all augmented care areas.

- Changes in the recommendations for the cleaning of water outlets by the AE have led to a requirement for additional education and training for hotel services staff.

- Disinfection of TMV valves is not always satisfactory first time which means they have to be disinfected for a second time.

Actions

- As category A patients can be found throughout the wards and category B patients can be found outside of the critical care floor (especially 4B for respiratory support and 3C for renal support) and we have moved into a new hospital, with a currently unknown pseudomonas-water outlet record for 4A, 4B, 4C and 3A, it seems sensible to survey all these clinical areas before reviewing and possibly narrowing down the Trust's definition of 'augmented care'.

Rinse Water

The Trust has identified significant problems with water quality of rinse water in endoscopy. This is due to a design fault in the RO plant. An action plan has been developed and implemented to rectify the problem. Weekly water sampling has been increased to three times per week and is managed by the DIPC and Decontamination Lead along with the Authorised Engineer until assurance that the above is effective in maintaining compliant rinse water in line with HTM 01-06.

2.4.2 Decontamination

Achievements within 2016-2017:

- Development of a decontamination repository
- Appointment of Authorised Engineer for Decontamination (Under contract)
- Introduced automated processing of ENT endoscopes
- Audits and action plans in place as set out in the table below
- 124 Standard operating procedures developed to support practice

Planned testing during 2016/17 is set out below against the requirements

EQUIPMENT	QTY	MANUFACTURER	EQUIPMENT LOCATION	ANNUAL TESTS or ACCREDITATION required	RAG	QUARTERLY TESTS required	RAG	WEEKLY WATER TEST	RAG
WASHER DISINFECTOR	1	STEELCO	SPECIAL FEEDS UNIT	YES		N/A		N/A	
STORAGE/DRYING CABINETS	2	STEELCO	DAY CASE THEATRES	YES		YES		N/A	

STORAGE/DRYING CABINETS	1	STEELCO	MAIN THEATRES	YES		YES		N/A	
LABORATORY STERILISER AUTOCLAVE	1	STEELCO	PATHOLOGY	YES		YES		N/A	
WASHER DISINFECTOR	3	STEELCO	DAY CASE THEATRES	YES		YES		YES	
REVERSE OSMOSIS (RO) PLANT	2	ELGA	1.DAY CASE THEATRES	No – 6 monthly service only		NO		YES	
CART & BED WASHER	1	MIELE	DECONTAMINATION AREA	YES		NO		N/A	
STERILE SERVICES	1	STERIS was SYNERGY	OFF-SITE Kirkby	YES		N/A		N/A	
COMMERCIAL WASHINGMACHINES	2		1.HYDROTHERAPY 2. MORTUARY	YES		NO		N/A	
LAUNDRY & UNIFORM SERVICE PROVIDER	1	BERENSDEN	OFF-SITE WEDNESBURY	YES		N/A		N/A	
LAUNDRY – MOP CLEANING PROVISION	1	AINTREE HOSPITAL	OFF-SITE AINTREE HOSPITAL	YES		NO		NO	

Operational issues

Following the move to the new Children health park the commissioning of the some of the new decontamination equipment commissioning and/or consistent operation has presented some challenges and this has been for a range of reasons. These are summarised below with actions completed.

Equipment	Operational issue	Solution implemented/agreed	Completed
WASHER DISINFECTORs (EWD's)	Failing rinse water samples (HTM01-06). Resulted in a halt to operation and cancelled planned endoscopy procedures	Weekly peracetic acid injections to the break tanks. Install a loop from the RO plant to the washers to include the EWD's in the RO plant disinfection.	Completed
	(Further information contained later in this report as operational activity had to cease until the water samples were within the complaint levels.)	Monitor water samples more frequently following installation.	Completed
	Compressor supplying air to the EWD's failed and required replacement, this was mistakenly replaced	Immediately sourced and replaced with the correct standard compressor.	Completed

Equipment	Operational issue	Solution implemented/agreed	Completed
	with a non-Clinical standard compressor- the impact was cancelled operations.	Full revalidation of the EWD's, additional water sample testing. Temporary outsourcing of bronchoscopes to Chester and additional SOPs to support emergency use implemented.	Completed Completed
STORAGE/DRYING CABINETS	The mechanism of placing scopes in the drying cabinet holders and moving the holders in and out of the cabinets appeared to be damaging the scopes	Scope holders have been replaced by the cabinet supplier. Additional scope connection tubing installed. Additional training for staff	Completed Completed Completed
WASHER DISINFECTOR (SFU)	No Issues	N/A	N/A
LABORATORY STERILISER AUTOCLAVE	Delayed completion of commissioning validation due to missing component required and additional programming requirement.	Parts acquired. Programming of the unit to process Category 1 waste Commissioning validation process conducted	Completed Completed Completed
REVERSE OSMOSIS (RO) PLANT	No Issues	N/A	N/A
CART & BED WASHER	Delayed commissioning validation documentation (Supplied in German). Unit has to undergo full commissioning validation before operational. Room required some structural alteration before use.	Validation process to be confirmed with AE(D.) Full commissioning Validation testing to be undertaken. Retraining of staff. Structural works to improve flow in line HBN 2030	Completed Remains under discussion and review with Miele due to nature of the cycle and the requirement for EN 15883 Completed Completed
STERILE SERVICES	Outsourced (See Synergy Compliance)		
COMMERCIAL WASHINGMACHINES	No work undertaken against compliance as	Plan to review in 17/18 programme	Target date of March 2018

Equipment	Operational issue	Solution implemented/agreed	Completed
	yet		
LAUNDRY & UNIFORM SERVICE PROVIDER	Outsourced no issues	N/A	N/A
LAUNDRY – MOP CLEANING PROVISION	Outsourced no issues	N/A	N/A

Bed wash

The Miele Bed Washer is still not in use. There are a number of ongoing issues affecting commissioning validation. Additional testing has been requested to meet BS EN 15883, although this standard was not contained within the original specification, the authorised engineer for decontamination (AE (D)) has requested evidence of compliance for the bed washers against the standard before validation for use.

Action

- Additional testing has commenced and further information from the manufacturer on 15883 compliance is being sought.

Endoscopy

The compressor which serves the AER's failed and was replaced in error by the hard FM provider with the incorrect medical grade compressor, this although rectified very quickly resulted in re-validation of the AER's. The impact of this was ceasing of the operational service for approx. 10 days and additional precautions taken in processing bronchoscopes once back in use. Whilst the service was not in operation, Chester processed bronchoscopes for emergency use.

Action

- RCA to be conducted to support learning and avoidance of any similar incident in the future.

2.4.3 Air quality

The Trust has undertaken monthly surveillance for aspergillus in critical care and on the Oncology unit for the past two years, in anticipation of demolition and building work which will start in May 2017. Currently aspergillus air levels remain very low.

Air quality in theatres, particularly in the ultra-clean theatres is compliant with HTM guidance for ventilation. This is monitored by the Trusts Theatre Manager and the AE in Ventilation, Jerry Slann.

2.4.4 *Environmental Cleanliness*

The new Domestic Services Manager has been in post since January 2017. There is now an Organisational change in progress within the department. IPC Lead Nurse meets with the Domestic Services Manager on a weekly basis to discuss relevant issues.

Production of schedules, routine tasks, SOP and policy will be completed once equipment is agreed, staff allocated and additional domestic supervisors appointed.

Environmental cleanliness and the actions required are monitored on a monthly basis via IPC and CPQG meeting.

2.4.5 Surgical Site Infections

No child should acquire an infection following surgery due to care given at Alder Hey.

Current Trust SSI (surgical site infection) rates are:

- Cardiac PHE Rate for quarter 3 is ***4.3%.*** Cardiac surgery overall for quarter 3 is ***4%***.
- Orthopaedic spinal surgery PHE data for quarter 3 is ***0%***
- Orthopaedic implant surgery for quarter 3 is ***0%***
- Neurosurgery PHE rate for quarter 3 is 0% Neurosurgery overall rate is ***2.5%*** for quarter 3.
- Plastic surgery for quarter 3 is ***0%***

Care bundles have been established in neurosurgery, orthopaedic surgery and cardiac surgery. Care bundle Compliance for April 2017 is as follows:

Cardiac surgery

- Screening on admission was ***100%*** however only ***36%*** of patients were screened for MSSA and MRSA.
- Pre-op washing ***50%*** compliance (there was a lack of documentation).
- Intra-op all 5 items were met therefore ***100%*** compliance.
- Post-op dressings ***50%*** compliance (there was a lack of documentation with regards to dressing changes).
- ICU Personal items ***100%*** compliance.

Neurosurgery

- Screening on admission is ***86%*** One patient only had MRSA swabs taken when admitted.
- Decolonisation ***86%*** compliance
- Pre-op washing night before surgery is ***86%*** compliance.
- Pre-op washing day of surgery ***86%*** compliance.
- Intra-op ***100%*** compliance.

- Antibiotics ***86%*** compliance
- Post-op dressings ***86%*** Compliance.

Issues

Ward based surveillance should be carried out 3 times per week but due lack of capacity within the IPCT this is not possible. The IPCT do wish to expand surveillance but the Trust need to expand speciality manpower to enable this to happen. The IPCT do have an ambition to extend surveillance, particularly in orchidoplexy surgery.

Actions

- A review has been carried out and a business case is being produced by the theatre management team to create a Trust wide surveillance team.

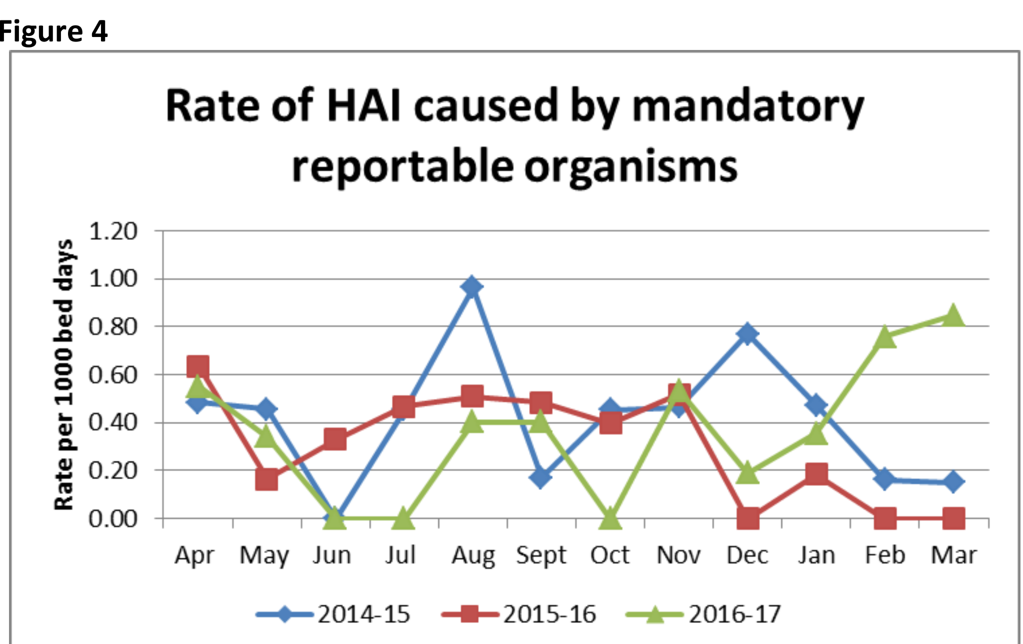
3 Mandatory Reporting

The Trust is obliged to report infections caused by mandatory reportable organism's i.e. Clostridium difficile toxin (CDT) enteritis, E.coli Bloodstream infection (BSI), MRSA BSI and MSSA BSI.

In 2016/2017 the Trust reported 24 hospital acquired infections due to mandatory reportable organisms. This is a rate of 0.37 per 1000 bed days compared to 22 reported in 2015-2016 with a rate of 0.31 per 1000 bed days.

The chart below shows the rate of HAI per 1000 bed days per month for 2014 – 2017.

Figure 4



Comment

The increase in the incidence of mandatory reportable HAI from 2015-16 was due largely to an increase on the incidence of MSSA BSI and the cases of MRSA BSI in patients with previous carriage of MRSA.

3.1 MRSA bacteraemia

There have been **2** hospital acquired cases of MRSA bacteraemia during 2016/17 compared to **3** cases in 2015/2016.

Commissioner trajectory of 0 : Trust performance 2 cases

For both cases a post infection review (PIR) was conducted, action plans were developed and implemented and monitored by the Clinical Quality Steering group (CQSG). The issues considered to play a causative role in the MRSA bacteraemia were as follows:

Case 1

- No MRSA re-assessment prior to Broviac line Insertion. Such cases should be discussed with IPC team on an individual patient basis.
- Octenisan not routinely prescribed on electronic prescribing system. Patients regularly miss doses.
- The clinicians who carry out the Central Line insertions are not fully aware of the protocol to be followed, which includes the use of Biopatch dressing.
- Current Trust policy for MRSA Management was out of date.
- Patient alert system on Meditech 6 not easily seen.
- No current Patient information leaflet available for TPN explaining all issues relating to TPN and central lines.
- Ward staff did not identify the need to change the central line dressing post insertion
- Lack of clarity as to a Clinical Lead Consultant

The patient's mother also attended the Infection Prevention and Control Committee to talk about the family's experience of a hospital acquired infection

Case 2

- Failure to commence decolonisation in previously positive MRSA patient.
- Early identification of patients readmitted to the hospital with special indicators active for IPC.
- Antibiotic app does not have information about prescribing antibiotics to patients with a multi-resistant organism.
- Suboptimal hand hygiene throughout the Trust.
- Lack of awareness amongst clinical staff about policies and information available on the intranet pages.
- IPC unable to obtain information relating to mandatory IPC training compliance.

3.2 *Clostridium difficile toxin positive enteritis*

There has been **1** hospital acquired case of *Clostridium difficile* during 2016/17 compared to **2** cases in 2015/2016.

Commissioner trajectory 0 : Trust performance 1 case

A PIR was conducted for this case to identify any lapses of care and any lessons to be learnt. The Trust were unable to appeal this case with the commissioners as nursing documentation of appropriate isolation was insufficient despite apparent good practices.

Issues

The PIR showed the following findings:

- *IPC patient isolation care plans not commenced for isolated patients*
- *Staff unaware of how to order CDT investigation*
- *Review and update of Clostridium difficile policy required*
- *Lack of staff awareness on Bristol stool score for assessing severity of diarrhoea*

Actions

- Education provided to Link nurses, Ward managers and as part of Mandatory training on the IPC care plans on Meditech. Audit of compliance undertaken and fed back to the Ward managers.
- Education provided to Nursing Staff on HDU on ordering of laboratory specimens by the IPCN
- CDT policy reviewed and updated
- Awareness of Bristol stool chart incorporated in mandatory IPC training and as part of Link nurse education.

3.3 MSSA (Methicillin Sensitive Staphylococcus aureus) bacteraemia

Although reporting of MSSA bacteraemia is mandatory no target has been set by the commissioners. The number of hospital acquired cases for 2016/2017 was **13** compared to **6** cases for 2015/2016. 5 of the cases were identified as being vascular access related. Rates for hospital acquired MSSA per 1000 occupied bed days were 0.08 in 2015-16 rising to 0.19 in 2016-17.

All hospital acquired MSSA bacteraemia are reviewed via the Root Cause Analysis process and specific actions are identified for each case. MSSA bacteraemia relating to invasive devices (CLABSIs) remains a key issue across the Trust.

Actions

- Action plans from RCA's are discussed monthly at divisional risk and governance meetings and reported back to the IPCC.
- A PIR for all HAI MSSA bacteraemia to be led by the clinical teams with IPC, IV team, Tissue viability (as appropriate) support will be commenced in 2017-18.
- Trust wide action plan will be developed 2017-18 to support this process.

3.4 E.coli bacteraemia

There have been **8** cases of hospital-acquired E.coli bacteraemia identified in patients over 48 hours of admission during 2016/17; this is a rate of 012 per 1000 bed days. This compares to **10** cases in 2015/2016 with a rate of 0.14 per 1000 bed days. Therefore we have seen a slight decrease compared to last year's figures.

All cases are reviewed by the IPCT and RCA undertaken if indicated. The PHE have set a reduction target of 10% of absolute cases across the whole health economy for this year, in line with new guidance "Preventing healthcare associated Gram-negative bloodstream infections; an improvement resource May 2017". Therefore the aim is to reduce the number of hospital acquired cases for 2017-18.

Table 10

	HAI E.coli BSI	HCAI E.coli BSI	Total E.coli BSI	Rate per 1000 bed days
2015-16	10	4	14	0.20
2016-17	8	12	20	0.30

Any cases that fit the criteria for a central line associated blood stream infection (CLABSI) will be picked up and reported via the CLABSI surveillance. 4 of the 8 (50%) 26/17 E.coli infections were CLABSIs.

Actions

- Commencement of PIR for all HAI ECOLI bacteraemia to be led by the clinical teams with IPC, or specialist nurse (as appropriate) support.

4 Infection Prevention and Control Activity

4.1 Hand Hygiene Trust Compliance

Ward self-audit Hand hygiene compliance: 86%

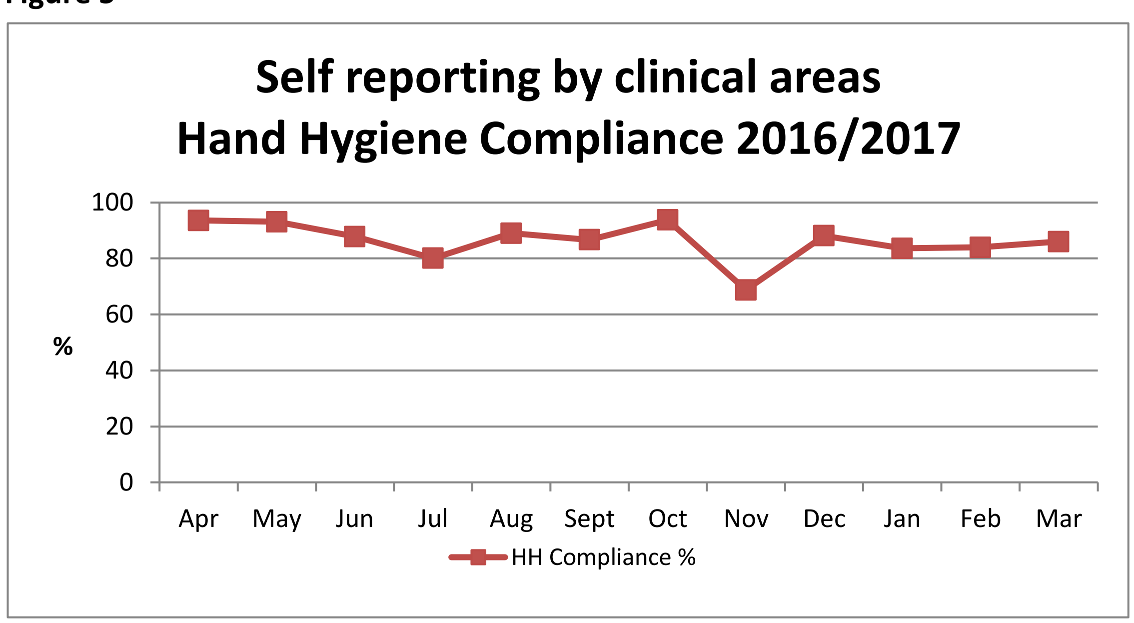
Quality Control Hand hygiene compliance by IPC team: 75%.

Hand Hygiene Compliance-self reporting by clinical areas

Compliance with hand hygiene is demonstrated by scoring above 95%. Overall hand hygiene Compliance was **86%**. Compliance varied by staff group and opportunity. Overall staff nurses scored the highest with **92%** compliance with Medical staff compliance at **82**%. This year the Trust has included porters, domestics and volunteers on the audit sheet. Porters scored **40%** with only 29 opportunities and domestics scored **38%** with 8 opportunities. The total number of opportunities audited were 10577.

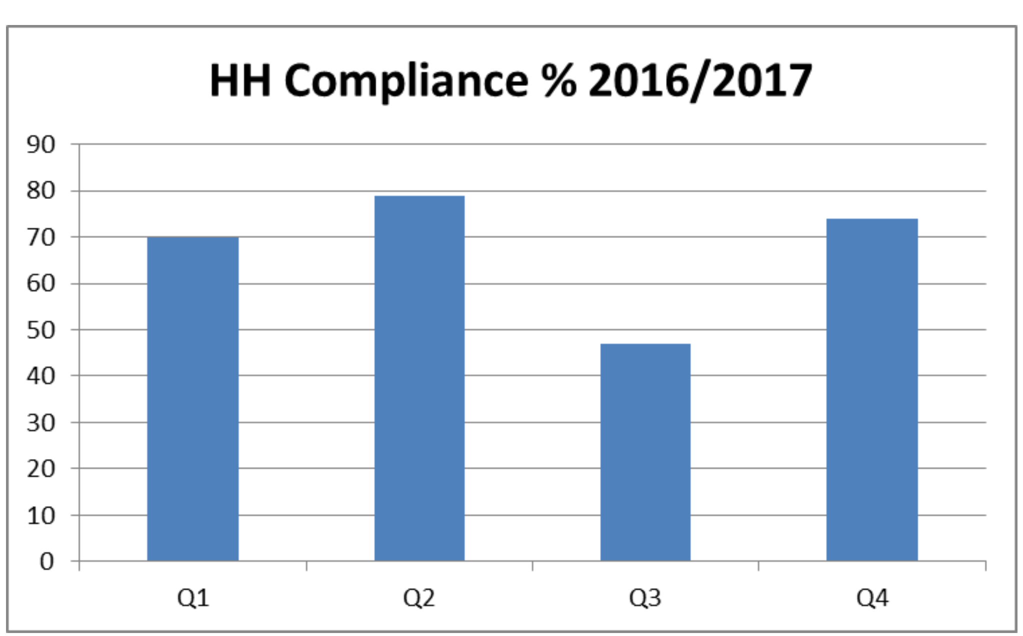
The chart below shows overall hand hygiene (self-reporting by clinical areas) compliance by month for 2016/2017 Trust –wide.

Figure 5



Quality Control hand hygiene compliance audits by IPC team

Quarterly Quality Control independent hand hygiene audits were carried out by the IPC team to validate the audits undertaken in the clinical areas: overall Trust score of **75%** (470 out of 672 opportunities). The chart below shows the compliance by quarter.



Key issues

We need to see reduction in the gap between self-reporting and quality control audits undertaken by the IPCT.

Actions

- Work has been ongoing across PICU to improve hand hygiene over the last quarter. In collaboration with PICU we are collecting over 250 opportunities per month. We have seen an increase in compliance from 44% to around 80%. Results are displayed and discussed each morning in the Dr handover. Nursing staff received 2 emails per month showing results and the results are also discussed at nursing handover. A non-compliance proforma has been developed which should help manage poor compliance.

- We have introduced a hand hygiene app in PICU and HDU to enable staff to be able to collect more opportunities.

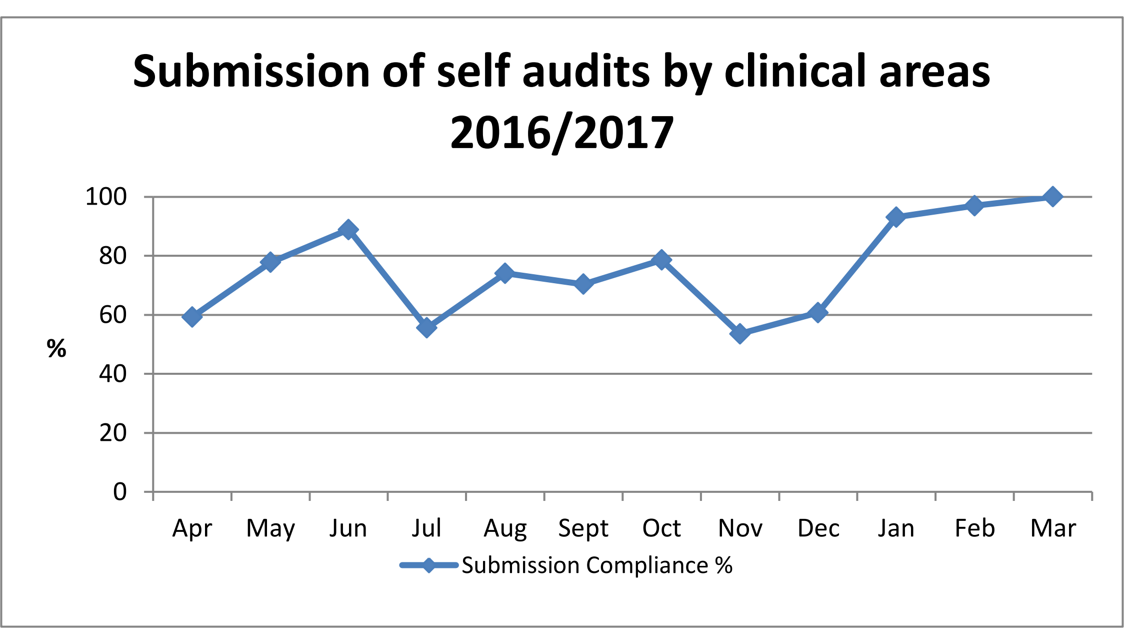
- To follow the model now in place in PICU across the Trust. This includes regular MDTs, local ownership and the use of technology to capture hand hygiene audits to ensure we capture a number of opportunities. This is also reflected in the 2017-18 IPC work plan.

- The development of specific IPC training (to include hand hygiene) for portering and Domestic staff.

Hand hygiene audit submission by inpatient clinical areas

Submission of completed audits from the inpatient clinical areas was **76%** overall, though compliance has risen over the last quarter to **100%** in March 2017.

The chart below shows overall submission by month for 2016/2017. There is clear evidence of improvement since the introduction of CBU quality leads.



4.2 Infection Prevention and Control Mandatory Training

IPC training delivered in stand up sessions at Induction and during mandatory training study days and via online work books.
Additional training is provided for IPC Link personnel at bimonthly education sessions and bespoke sessions are provided for student nurses and medical students.
Ad hoc sessions are provided as required.

Key issues

- There is a lack of up to date and accurate compliance training data for clinical staff from Learning and development (ESR system) to allow the IPC team to target groups or areas with poor compliance.

Actions

- Human Resources to provide data on a monthly basis
- IPC study day for internal and external delegates to share local knowledge and expertise with wider Health care economy

4.3 Policies and Procedures

The following policies/guidelines have been written/reviewed/updated in 2016/2017:

Number	Title
C54	Disinfection
C55	Carbapenem Producing Enterobacteriaceae
M6	Opening and Closing of Wards
C64	Chicken Pox
C44	Management of Patients with Clostridium Difficile
C58	MRSA Management
C14	Hand Hygiene
C19	Major Outbreak
RM17	Water Safety Policy

4.4 Audits

Isolation Audits

Quality control isolation audits were undertaken across the Trust by the IPCT during 2016/2017. The table below shows audit compliance by quarter for each ward.

Table 11

	Q1 (Apr - Jun)	Q2 (Jul -Sept)	Q3 (Oct - Dec)	Q4 (Jan- Mar)	Overall Total
1B PICU		**74%**	49%	90%	71%
1B HDU		**77%**	48%	60%	62%
1B Burns		**85%**			85%
1C cardiac		**64%**	67%	30%	54%
1C Neo		**86%**			86%
3A		**71%**	30%	30%	44%
3B	78%	**57%**	29%		55%
3C	89%	**71%**	60%	90%	78%
4A				50%	
4B		**64%**	56%	70%	63%
4C	78%	**53%**	44%	40%	54%
Overall	**82%**	**71%**	**48%**	**58%**	**65%**

Actions

- Quality control Isolation audits are fed back to the Ward mangers and incorporated into the Infection control KPI

- Ward managers and Link nurses trained to carry out their own audits on the SNAP audit system to raise awareness and drive up practice.

- The isolation practice will be addressed as part of the 2017-18 IPC work plan with regards to training and assurance through audit.

4.5 Infection Prevention & Control Key Performance Indicators (KPIs)

Wards are performance managed in infection prevention and control by key performance indicators. The KPIs for 2016/2017 were:

1) The proportion of hospital acquired infections logged on to the Ulysses system by the clinical area.
2) Staff flu vaccine uptake.
3) Hand hygiene audit compliance
4) Ward flushing logs compliance
5) Surveillance data performance (CPE and MRSA screening)
6) Mandatory compliance with IPC training
7) Isolation audits compliance

This year 3B scored highest overall. This was celebrated at the Infection Prevention and Control Committee (IPCC) in June 2017 with a trophy presented to the ward.

5 Delivery against Annual Infection Prevention and Control Programme

53% (47/89) of the objectives from the 2016/2017 delivery plan have been completed during 2016/2017. 34% (30) of the objectives have been actioned but are yet to be completed. 13% (12/89) of the objectives have not been achieved in Q4.

An action plan with realistic timescales for completion has been developed and shared with the CCG. The issues that are under the immediate control of the Infection, Prevention & Control Team (IPCT) have been addressed and it is those issues that are outside of the IPCT that remain outstanding. The table below shows RAG rating of the 89 objectives in the delivery plan.

Table 12

No. of objectives Q4	Red Q4	Amber Q4	Green Q4
89	13% (12)	34% (30)	53% (47)

6 Service Development/Innovation

6.1 Hand Hygiene

- Development of hand hygiene improvement group in critical care- adopted innovative methods of hand hygiene compliance audit using mobile phone app. This has provided larger and greater amounts of data which has assisted in targeting staff or groups with poor hand hygiene compliance.

- Training of link nurses to carry out the hand hygiene audits.

- Hand hygiene awareness week held in October 2016

6.2 Surgical Site Infection

- Introduction of Surgical site Infection surveillance (SSIS) in plastics and agreement on methodology for k wire (SSI) surveillance.

- Introduction of Orthopaedic care bundles and reinstatement of cardiac and neurosurgery care bundle monitoring.

- Participation in the Cardiac and Neurosurgery SSI modules through Public Health England (PHE) allowing the Trust to benchmark against other organisations.

- Development of Theatre Safety Board chaired by Benedetta Pettorini.

6.3 CLABSIs

- All central venous catheter associated blood stream infections (CLABSI) in critical care are now being validated by a MDT on a monthly basis as are Ventilator associated Pneumonias.

- A new needle free device has been introduced in PICU this will be rolled out across the rest of the Trust by the end of Q2 2017-18.

- The CUROS cap has been evaluated in PICU and a decision was made not to go ahead with this as it was felt that they did not have an impact on CLABSI rates.

- Due to the hand hygiene compliance increasing from 44% to 80% we have seen a reduction in CLABSI rates on PICU this quarter.

- A multi-disciplinary team has been established on PICU to review current practice related to intravenous therapy. The group will look at new recommendations for

practice and implementing them throughout PICU and eventually rolling out across the rest of the Trust.

6.4 IPCT Delivery

- The introduction of an electronic audit for isolation practice has improved data collection as IPCT are able to conduct audits much quicker. The data then automatically goes into an Excel spreadsheet which calculates the compliance score and therefore feedback to clinical teams is in real time.

- The IPCT participated in PHE healthcare associated infection prevalence survey in September 2016 and local prevalence survey in March 2017. The study in September 2016 showed a prevalence of HAI at 6.9% compared 14% in June 2015 and 12% April 2015. This has provided a snap shot of the rate of HAI for the Trust and identifies areas and prevalence of different type of infection.

- PIRs for serious infections have been commenced in addition to those required for mandatory reporting. This facilitates identification of any contributing factors and enhances learning.

- The introduction of an electronic level 1 RCA proforma has made it easier for clinical teams to carry out reviews of Bloodstream Infections and other reportable HAI. This information determines the requirement for a formal RCA process and increases clinical engagement and ownership.

7 SWOT Analysis

S	W
KPIs Assessing performance. 3B are the lead ward for all clinical areas 2016-17	***IT systems*** IPC manually driven, systems not working to our advantage for rapid access to data.
O	**T**
Associate DIPC New appointment will provide opportunity to bring together specialty nurses in IPC, Vascular access, OPAT and tissue viability.	***DIPC retirement*** Loss of DIPC/ Infection Control Doctor role following retirement incumbent with current difficulty in consultant recruitment

Opportunities

- Developing IPC services at Alder Hey to allow the service to take a lead role in paediatric IPC both nationally and internationally. This will assist in staff recruitment
- Develop stronger IT links to allow for Meditech to produce IPC reports and free up IPC nursing time
- Microbiology laboratory to take on a greater role in environmental monitoring which would further secure its position within the Trust

Threats

- Uncertainty around the future roles of the local Microbiology service could have a significant impact on the efficiency of the IPC service

Infection Prevention & Control Annual Work Plan 2017-2018

The table below is the 'Code of Practice' for all providers of healthcare and adult social care on the prevention of infections under The Health and Social Care Act 2008 (revised 2015). This sets out the 10 criteria against which a registered provider will be judged on how it complies with the registration requirements related to infection prevention. This work programme below has been linked to these codes and to the Trust's Objectives 2017-2018.

Compliance criterion	What the registered provider will need to demonstrate
1.	Systems to manage and monitor the prevention and control of infection. These systems use risk assessments and consider how susceptible service users are and any risks that their environment and other users may pose to them.
2.	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections
3.	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance.
4.	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing/medical care in a timely fashion.
5.	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of passing on the infection to other people.
6.	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection.
7.	Provide or secure adequate isolation facilities.
8.	Secure adequate access to laboratory support as appropriate.
9.	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections.
10.	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection.

My Alder Hey. My Values.

Infection Prevention & Control Annual Work Plan 2017/18

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
1. IPC Staffing								
IPC Code: 1,3,4,8,9 **Trust Values:** Excellence Togetherness	DIPC – Consultant Microbiologist	Dr Richard Cooke (RC)	RC to retire July 2017, appoint new DIPC					***Q1*** *Current DIPC to retire in July 17, position advertised but not filled.* **Q2** **Q3** **Q4**
	IPC Doctor – Consultant Microbiologist	Dr Richard Cooke (RC)	RC to retire July 2017, appoint new DIPC					***Q1*** *Current IPC Dr to retire in July 17, position advertised but not filled.* **Q2** **Q3** **Q4**
	Associate DIPC	Val Weston (VW)						
	Lead Nurse IPC	Jo Keward (JK)						
	IPC Specialist Nurse (Band 7)	Claire Oliver (CO)						
	0.4 Surgical site Specialist nurse(Band 7)	Lisa Moore (LM)						
	0.6 IPC Data Analyst (band 5)	Carly Quirk (CQ)						
	Clinical assistant (band 3)	Vickie Lam (VL)						
	PA/Admin assistant (band 4)	Post Vacant						***Q1*** *Associate DIPC in discussion with finance and Chief Nurse with regards to this post.* **Q2** **Q3** **Q4**
	Infection Prevention	DIPC						

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
	& Control Committee (IPCC) The IPC reports to the Board via the IPCC. The IPCC meets 6 times per year and is chaired by the DIPC. The Terms of Reference were reviewed and amended in December 2016.							
2. *Surveillance*								
IPC Code: 1,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together	**Alert organisms** To maintain and alert staff to any potential risks from pathogenic organisms	Microbiology and IPC Team	To provide IPC advice and support in order to minimise the risks to patients, staff and visitors.					
	Mandatory Reporting It is mandatory requirement for the Trust to report a variety of pathogenic organisms/ infections to PHE for monitoring purposes							
	MRSA/ MSSA/VRE/E Coli Bacteraemia	Microbiology, IPC Team and a	To identify, communicate and instigate investigations by the					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
		review panel	clinical teams for all Trust apportioned cases. All cases to be reviewed under the Post Infection Review (PIR) and Root Cause Analysis (RCA) processes, through a Review Panel and to disseminate lessons learned from the process and actions required and monitored.					
	Clostridium difficile/PTP	Microbiology and IPC Team	To identify, communicate and instigate investigations by the clinical teams for all cases. All cases to be reviewed under the Post Infect Review (PIR) and Root Cause Analysis (RCA) processes, through a Review Panel and to disseminate lessons learned for the process and actions required and monitored. To instigate an incident meeting with clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
	CPE	Microbiology	To instigate an incident meeting					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
		and IPC Team	with clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
	Surgical Site Infection (SSI) for Orthopaedics (spinal, elective implants and k wires), Cardiac Surgery, Neurosurgery and plastics.	Microbiology, LM, Theatre safety board & clinical Review Panel	To assist in the collection and submitting of data for SSIs. To disseminate reports to the relevant clinical staff. To include data and reporting in the DIPC IPC report on a quarterly basis.					
			To support the clinical teams to take more ownership of their SSI data – through attendance at the SSI teaching sessions at Colindale London. To support the investigation and presentation of incidences of SSI through the RCA process at the Review Panel meetings and to support the dissemination of lessons learned to the relevant staff and actions required and monitored.					**Q1 –** To encourage greater ownership of surgical site infection data by specific teams. **Q2** **Q3** **Q4**
	Viruses	Microbiology & IPC Team	To provide data on HAI Influenza & RSV rates per 1000 bed days.					
			To support investigations into HAI Influenza and RSV cases and investigations into outbreaks with					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
			other respiratory viruses.					
			To provide predictions and provide commentary during the winter season on Respiratory viruses (in collaboration with the PHE) to assist in planning elective activity and patient flow.					
3. Hand Decontamination								
IPC Code: 1,2,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Development of new hand hygiene posters for all clinical areas to update the hand hygiene process by incorporating the washing of the wrist area.	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Development of new hand hygiene poster incorporating further steps of hand hygiene					**Q1** – *The need has been identified to update hand hygiene posters and work has begun on exploring how this can be done with hand hygiene company.* **Q2** **Q3** **Q4**
	Introduction and dissemination of new hand hygiene posters for all clinical areas.	IPC Team & link nurses	New Hand Hygiene Posters to be distributed and displayed					**Q1** – *The need has been identified to update hand hygiene posters and work has begun on exploring how this can be done with hand hygiene company.* **Q2** **Q3** **Q4**
	Piloting and introduction of new hand hygiene audit technology incorporating PPE	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Pilot commenced on PICU/HDU feedback positive.					**Q1** – *Regular feedback to ward staff and medics with current results and highlighting areas of improvement. Certificates for staff identified.* **Q2** **Q3** **Q4**

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		CO	Capturing PPE usage and education to staff re usage on PICU/HDU.					**Q1** – *Pilot capturing of PPE use to commence July 2017.* **Q2** **Q3** **Q4**
	Introduction of non-compliance proforma	CO/AF/ST	Management of non-compliance with hand hygiene.					**Q1** – *Pilot commenced on PICU* **Q2** **Q3** **Q4**
	Introduction of new hand hygiene audit technology as part of monthly audit indicators	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Dissemination of new hand hygiene audit technology to link personnel through meetings and training					**Q1** – *Dissemination to link personnel.* **Q2** **Q3** **Q4**
	Introduction of hand hygiene technique assessment on an annual basis for all clinical staff.	IPC Team& link nurses IPC Team & IPC link nurses & ward managers	IPC Team to train link nurses, link nurses to assess staff. Ward manager responsible for ensuring that staff are trained and records are kept.					**Q1** – *Training sessions have commenced further sessions planned for Q2.* **Q2** **Q3** **Q4**
	Hand hygiene awareness week	JK	Develop PID					**Q1** – *Development commenced.* **Q2** **Q3** **Q4**
4. Policies								
IPC code 1,2,3,4,5,6,7,8,9 & 10	Review and update IPC policies as required.	IPC Team	Monitored reviewed and updated as part of the IPCT meetings on a bi-weekly basis.					**Q1** – *To review policies for the year and develop policy programme.* **Q2** **Q3** **Q4**
Trust Values Respect Excellence	To provide advice and support on IPC policies.	IPC Team						
	Participation in	EW	Provide an update of policy review					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
Innovation Togetherness Openness	updating where IPC is an integral component of relevant policies.		dates					
5. ANTT								
IPC Code: 1,2,3,4,5,6 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Monitor Trust wide compliance and increase compliance rates.	Sara Melville(SM) (IV team lead)	Provide updated compliance figures to the relevant care groups and for IPCC.					
			Include ANTT compliance scores in IV Newsletter and IPCC Report.					**Q1** – *To develop a system for monthly IV Newsletter for ANTT compliance.* **Q2** **Q3** **Q4**
	Update current ANTT Policy	SM/Associate DIPC/ CO/ ZB	Review new guidelines and update policy and procedures to reflect this.					**Q1** – *All new evidence based standards reviewed.* **Q2** **Q3** **Q4**
	Review role and responsibilities of Link Nurses.	SM/IV team	To review role and responsibilities of Link Nurses.					**Q1** – *To await review and update of current ANTT policy.* **Q2** **Q3** **Q4**
	Provide Key Trainer training.	SM	Key trainer training days are provided are provided 4 times per year.					**Q1** – *To develop key trainer programme. To await review and update of current ANTT policy.* **Q2** **Q3** **Q4**
	ANTT stickers for yearly compliance.	SM	ANTT stickers to be provided for all staff following ANTT training and compliance.					**Q1** – *Discussions have taken place with B Braun to provide ANTT stickers.* **Q2** **Q3** **Q4**
	Liaise with ANTT experts to review and	Associate DIPC/SM	Attend annual ANTT conference and to attend North West IV forum					**Q1** – *To attend ANTT conference and IV forum updates* **Q2**

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	refine existing processes.		meetings.					Q3 Q4
6. Training								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	To ensure that IPC staff and kept updated with IPC evidence based practice.	Lead IPC Nurse	To ensure that a member IPC Team the North West Infection Prevention Society (IPS) meetings at least once per year.					**Q1 –** *To ensure that a member of the IPC team attends IPS meetings at least once per year.* **Q2** **Q3** **Q4**
		Associate DIPC	To regularly attend local HCAI whole health economy meetings.					**Q1 –** *Explore area in whole health economy where Alder Hey can participate.* **Q2** **Q3** **Q4**
		Associate DIPC/Lead IPC Nurse	To attend local and national IPC/relevant conferences as the service will allow					**Q1** **VW** • *3M IV Global Leadership summit* • *EWMA* • *3M North West IV Forum - Speaker* ***JK*** • *HIS Spring Meeting* • *Don't panic conference* ***CO*** • *3M North West IV Forum* **Q2** **Q3** **Q4**
		Lead IPC Nurse	To attend Vaccinator training or undertake on line update					
	To ensure that Trust staff are kept updated with IPC evidence based practice:							

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
	Please see plan below.							
	Induction	Lead Nurse IPC/CO	At least once per month					
	Mandatory	Lead Nurse IPC/CO	For all clinical staff yearly (monthly sessions) & work book Non-clinical 3 yearly – work book					
	ANTT Key Trainers	SM						**Q1 –** *To develop key trainer programme. To await review and update of current ANTT policy.* **Q2** **Q3** **Q4**
	Volunteer IPC Training	CO/VL	Quarterly					
	Hotels Services IPC training	VL	At least once per quarter					**Q1 –** *Meetings have taken place with hotel services and a programme is to be developed for IPC training for all hotel services staff.* **Q2** **Q3** **Q4**
	Link Personnel	IPCT	Bi-monthly					
	Fit Testing Key Trainers	CO	Annually					**Q1 –** *New IPC lead appointed attending training June 17.* **Q2** **Q3** **Q4**
	Flu vaccinator Training	Lead Nurse IPC	Annual (4 sessions per year)					
	Ad hoc training	IPCT	As required					
7. Audit								
IPC Code: 1,2,3,4,5,6,7,8 & 9	To provide assurance to the board and relevant committees of	Lead IPC Nurse/ IPC Specialist Nurse/IPC	All findings are communicated to the relevant clinical staff and reported via the IPC monthly report					**Q1 –** *Due to appointment of Associate DIPC (commenced May 17) audit programme temporarily delayed.* **Q2** **Q3**

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
Trust Values: Excellence Openness Respect Together Innovation	adherence to high quality IPC practices. IPC Audit programme 2017.docx	clinical assistant follow the audit plan The Audit programme is revised on a yearly basis. Further audits are undertaken by the IPC Team as set out in the work plan and as the service requires.	and the IPCC. All lessons learnt are disseminated To the relevant staff and other agencies as Appropriate in a timely manner.					**Q4**
8. Antimicrobial Prescribing								
IPC Code: 1,3,4,5,6,7 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Antimicrobial Stewardship (AMS) ward rounds	Antimicrobial Pharmacist	Appointment of replacement Antimicrobial Pharmacist					**Q1** – *Interviews for the post taking place June 2017.* **Q2** **Q3** **Q4**
			AMS ward rounds (x3/week)					
	AMS Committee meetings		AMS Committee (meet at least quarterly)					
			Introduce mandatory AMS training package					**Q1** – *Need for AMS training package to be developed.* **Q2** **Q3** **Q4**
9. Communication								

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC bi-monthly report	JK	IPC bi-monthly report disseminated to medical and nursing staff.					
	Communication with the Whole Health Economy	VW	To attend HCAI/IPC meetings across the local area.					**Q1** – *Explore area in whole health economy where Alder Hey can participate.* **Q2** **Q3** **Q4**
	Communication with other Trusts and agencies such as Public Health England (PHE)	IPCT	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.					
	Update IPC intranet page	CQ/VL	To attend Trust Intranet training. VK to identify a lead to update intranet. This is a restriction presently due to the admin vacancy.					**Q1** – *Not attended intranet training due to capacity in IPC (admin vacancy).* **Q2** **Q3** **Q4**
10. Information Technology								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Innovation Together	Enhance use of Meditech	JK/IPCT	Exploration of Meditech system with PA. Develop a plan of where we are now with our process uses Meditech and a plan of where we would like to be.					**Q1** – *First meeting has taken place in May 17. IPC Lead nurse and Team to map out requirements.* **Q2** **Q3** **Q4**
11. Interface with Relevant Groups								

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
IPC Code: 1,2,3,4,5,6,7,8,9 & 10	IPC to attend and provide expert opinion for topics related to IPC.	IPCT						**Q1 –** *Due to appointment of Associate DIPC (commenced May 17) audit programme temporarily delayed.* **Q2** **Q3** **Q4**
Trust Values: Excellence Openness Respect Together Innovation	Escalate issues to DIPC as necessary.	Associate DIPC	Regular meetings with DIPC					**Q1 –** *Weekly meetings with current DIPC. Further meetings going forward on a 2 weekly basis with new DIPC.* **Q2** **Q3** **Q4**
	To review new equipment /environmental utilisation	IPCT	Ad hoc meetings as required.					**Q1 –** *Meetings are attended as requested however at times IPC are not informed.* **Q2** **Q3** **Q4**
	Decontamination	Lead Nurse IPC Associate DIPC to attend as required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Water Safety	Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Health & Safety/IPC/Interserve & Building services	Associate DIPC/ Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					**Q1 –** *Request to attend these meetings has been made awaiting date of first meeting.* **Q2** **Q3** **Q4**
	Hotel services	Lead Nurse IPC Associate DIPC to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
	Ward managers/matrons	Lead Nurse IPC Associate DIPC or IPCT to attend when required.	To attend scheduled meetings. To provide expert advice and support as required.					
	Health and safety	Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					**Q1** – *Due to appointment of Associate DIPC (commenced May 17) Lead Nurse has been unable to attend recently.* **Q2** **Q3** **Q4**
	Integrated Governance Committee	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Medical Devices Committee	DIPC/ CO	To attend scheduled meetings. To provide expert advice and support as required.					**Q1** **Q2 –** CO to attend meetings from July onwards in place of DIPC. **Q3** **Q4**
	Trust quality meetings • ***CQAC*** • ***CQSG*** • ***CQPG***	Associate DIPC Lead Nurse IPC to deputise. IPCT to attend ad hoc for training purposes.	To attend scheduled meetings. To provide expert advice and support as required.					
	Theatre Safety Board	LM/CO	To attend scheduled meetings. To provide expert advice and support as required.					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q 1	Q 2	Q 3	Q4	Comments
		Associate DIPC/ LM/CO	To assist in the introduction of the OneTogether programme.					**Q1 –** *To speak to relevant clinicians with regards to introduction of the OneTogether programme for surgery.* **Q2** **Q3** **Q4**
	Trust board	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					

Trust Wide Infection Prevention and Control Action Plans

Drawing from the evidence presented in the IPC Annual Report 2016/17, key themes have been identified to target for 2017/18. Trust wide Action Plans will be developed with other key stakeholders from the Trust to implement and progress these actions.

Key Themes	Infection Prevention and Control Lead	Other Specialist Nurses from the Service
Methicillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia	Claire Oliver	Sara Melville (Lead Nurse –IV)
Surgical Site Infections (SSI)	Lisa Moore	Ellen Buckley (Tissue Viability Nurse)
Environmental Cleanliness	Jo Keward	Vickie Lam (IPC Clinical assistant)
Reduce Infections Change Programme (Executive Sponsor – Steve Ryan)	Val Weston and IPC Team	

These Actions Plans will be reviewed and monitored via the IPCC and the governance structures in each relevant division and progress communicated to the Trust Board

Board of Directors
4th July 2017

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for May 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

Further development of manager's induction processes have commenced with a review of the policy and the Leadership Strategy (operational plan). A programme of delivery of 360 feedback is in progress and all activity is being logged for presentation to the next WOD meeting in September 2017. Work to support the Apprenticeship Strategy will be monitored through the project dashboard and an operational plan is being developed which includes the mapping of current leadership and management provision to apprenticeship programmes, this is to ensure any internal provision of L5 apprenticeships is as cost-effective as possible.

Improving communication and hearing the employee voice

To date 23% of teams have returned their written feedback following the Big Conversation round which took place during April/May in response to last year's Staff Survey. We are working with the divisions to ensure that the remaining conversations take place during June and July. Anecdotal feedback has been received from various quarters and collated into overarching themes as follows:

Staff were generally most pleased about the support they received from colleagues, a positive team working environment, pride in the quality of service they provided, and effective training and development opportunities

When asked what they were surprised about from the survey results, staff said:

- there is little opportunity to show initiative
- feeling under pressure to come into work when unwell
- verbal abuse is not reported more
- work was not always as well valued as it should be
- levels of stress are high
- communication from senior managers is reported as poor
- the levels of bullying taking place (and lack of reporting same)

To deal with things differently, and improve how staff feel about working at Alder Hey, teams have suggested:

- More effective communication
- Address known issues around morale
- Provide targeted support for stress management
- More team building activities
- Facility to provide timely feedback to senior managers about workload and issues
- More visibility from senior managers
- Showcase departmental work and support each other

Work is ongoing to support these suggestions and will be developed using the LiA Big Conversation approach.

A refreshed quarterly 'all staff' Temperature Check was 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. Results will be shared at subsequent Board meetings.

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.

Trust Nursery

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

Hotel Services

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 4 January 2017 for 30 days and concluded on 3 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 12 May 2017 and options of redeployment considered. Three of the unsuccessful staff were made redundant and the fourth member has been engaged in a lower banded role with pay protection.

Domestics and Portering staff (Portering and Portering Supervisors) organisational change programmes were initiated on 9 June 2017 which consist of proposed reductions of staff (portering Supervisors) and review of shift patterns/rotas in the other groups. The three consultations are due to conclude on 24 July 2017

Catering organisational change for restaurant staff and chefs was also due to commence on 9 June 2017 however this has been postponed whilst management reconsider the basis of the proposals.

Pathology (Phlebotomy) contract with Liverpool Women's NHS Foundation Trust

An organisational change process commenced in May 2017 as discussions had concluded in relation to the cessation of arrangements at Liverpool Women's Hospital (LWH) for phlebotomy services provided by Alder Hey. The impact of the potential change affected 4 Alder Hey staff who were to potentially 'TUPE' to LWH. A management proposal paper which set out the changes has been shared with staff side and staff. There is currently sufficient budget and vacancies within the service to enable this move back into Outpatients dept. The impact to staff affected would result in changes to base and reductions in weekend shifts, which would result in short term pay protections. The staff affected have now chosen to transfer back to Alder Hey into the roles available from 1 June 2017 with pay protection (as applicable)

Home Care Service – Community Division

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

Education, Learning and Development

Apprenticeships

The Skills Funding Agency visited the trust on the 6th June 2017 to assess apprenticeship delivery readiness. The feedback from this visit was extremely positive and as a centre we are deemed low risk in terms of governance systems and processes surrounding apprenticeship delivery. We have our first levy funded apprenticeships commencing at the organisation via external training providers in BME and Pharmacy. Edge Hill University has commenced consultation with regional partners on the development of their nurse apprenticeship programme.

CPD

The Trust has now received funding from HEE (Northwest) to support development of Mentors utilising credit based modules within the region.

Vocational Development

The Trust has received £40K investment to support development of specific short programmes with an emphasis on pre-vocational learning (such as traineeships and short outcome based learning programmes). The plan is to develop a pre-employment initiative (similar to those offered through Skills for Health) with recruitment services which will serve to support the Trusts aims as a diverse employer across communities.

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

At the end of April there were two formal disciplinary cases, a formal grievance and one outstanding Bullying & Harassment appeal. 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 was received and the Trust is working towards defending the case to be heard on 30 and 31 August.

An Employment Tribunal Claim relating to unlawful deduction of wages and breaches of the Agency Workers Regulations was received and the hearing was due to heard on 7 and 8 June 2017, but has been postponed to allow for inclusion of an additional respondent.

A preliminary hearing for 27 July 2017 regarding an Employment Tribunal case has recently been received. Previous discussions with ACAS failed to resolve the complaint, which is in relation to a constructive dismissal claim and a disability discrimination case. The Trust is working with legal advisors to complete ET3 responses in time for 27 July and disputes all claims in full.

The Trust has had three ACAS conciliation approaches in relation to three separate cases. The HR team are working with ACAS to look for early resolutions where possible. Further updates will be provided where appropriate.

Corporate Report

The HR KPIs in the May Corporate Report are:

- Sickness remains at 4.7%
- Corporate Induction has increased to 85.7%
- PDR rates are at 12.4% after two months of activity (this denotes activity recorded on ESR as at end May 2018, however compliance is considerably higher than this across the divisions, but recording lags behind activity)
- Mandatory training compliance has decreased slightly to 76%

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

Enhancements to ESR

The HR team have been working with the central team in readiness to introduce the enhanced version of ESR later this month. Communications are being circulated to managers and staff informing them of the benefits these enhancements will bring; these include access via smart phone and tablets, user friendly and easier to navigate screens. In addition to this the roll out of paperless payslips will commence and all payslips are expected to be electronic by September 2017. HR and Finance are trialling paperless payslips in June.

An ESR Strategy Group has met to begin exploring some of the key issues facing managers in the use of ESR and to further inform and involve them in the development of the use of the ESR system.

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

A Health Trainer is now working with the Trust providing stress management and relaxation/mindfulness training. These sessions have proved popular and will be scheduled and promoted accordingly. A session is in the process of being planned for management

training in respect of how to recognise signs of stress with strategies on how to manage it. The OD team is pursuing possible accreditation to the Workplace Health and Wellbeing Charter which will be pursued in support of the revised Trust's People Strategy.

Leading in Equality & Diversity

The second Listening into Action 'Big Conversation' for BME staff was a great success, the group continue with their actions to progress the BME network, and to working closely with HR colleagues to review recruitment processes and access to opportunities. A progress report on actions to date to achieve the increased 1% target for BME staff is being reported to the next WOD Committee.

ANNEX A

WORKFORCE & OD COMMITTEE
MINUTES FROM MEETING
19TH APRIL 2017

Present:	Ms C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mrs M Swindell	Director of HR & OD	(MKS)
In Attendance:	Ms M Salcedo	HR Business Partner	(MS)
	Mrs S Owen	Head of HR	(SO)
	Mrs F Flanagan	Head of OD	(FF)
	Mr M Travis	Chair of Staff Side	(MT)
	Mrs H Ainsworth	Equality & Diversity Manager (Part Attendance)	(HA)
	Ms G Smith	Medicine – GM	(GS)
	Ms M Salcedo	HR Business Partner	(MS)
	Ms L Cooper	Domestic Operations Manager	(LC)
	Ms N Deakin	Facilities Project Manager	(ND)
	Mr M Devereaux	Head of Facilities	(MD)
	Ms J Richardson	Programme Manager	(JR)
	Ms E White	Policies & Guidance Manager (Part Attendance)	(EW)
	Mr G Lamont	Director of Medical Education (Part Attendance)	(GL)
Apologies:	Mr I Quinlan	Non-Executive Director	(IQ)
	Ms D Brannigan	Patient Governor (Parent and Carer)	(DB)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs S Brown	Associate Director of Development – Site	(SB)
	Mr S Ryan	Medical Director	(SR)
	Ms L Dunn	Director of Marketing & Communications	(LD)
	Mrs P Davies	Learning & Professional Development Manager	(PD)
	Mr T Johnson	Development Manager – Unite Rep	(TJ)
	Mr J Gibson	External Programme Assurance	(JG)

Agenda Item	Key Discussion Points	Action	Owner	Timescale
17/10 Minutes of the Previous Meeting & Meeting Protocol	The Committee considered the minutes of the last meeting held on 15th February 2017 and **approved** minutes as an accurate record. **Review of Work Plan for 2017-2018** The Committee received an updated work plan for approval. The Committee **approved** the content.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Draft Annual Report MKS advised that a draft WOD annual report will be brought to the Committee in June for approval.	Draft Annual Report presented to WOD for approval.	MKS/CD	June
17/11 Matters Arising, Actions	The Committee considered the following under matters arising: **16/35 Refreshed People Strategy** MKS advised that an updated refreshed Strategy will be brought to the Committee in June.			
17/12 Programme Assurance 'The Best People Doing Their Best Work'	**The Best People Doing Their Best Work – Programme Assurance Framework – April 2017** The Committee received a regular summary prepared by the Executive Sponsors of the Assurance Framework, External Programme Assessor and Assurance Team. The purpose of this assurance framework is to ensure the monitoring of robust processes for progression. All papers supporting Programme Assurance 'The Best People Doing Their Best Work' are recorded as read prior to the meeting. The Programme Manager, JR gave a summary of the detail of the programme assurance framework for 'The Best People Doing Their Best Work'. JR emphasised that planning for this year's overall programme is now behind schedule. Within this work stream, teams have started to upload project documentation to SharePoint and Executive Sponsors are required to expedite completion of this in order to meet assurance standards in. As outlined in the report JR reflected on latest position of dashboard ratings and financial reporting. MKS noted that Project Ref 3.4 – Implement Carter on the dashboard, should be greyed out as not a current project and suggested that it would be useful to reference expected operational delivery dates on dashboard. MKS outlined the latest status of the following projects: **Communications & Engagement High Level Plan 2017** PID is in the process of development and should be complete in a couple of weeks. **Specialists Nurse Review** Draft PID, shared on SharePoint & Committee, milestone plan to be defined. **AHP into Action (Transformation and Leadership)** Draft PID, shared on SharePoint and with this Committee, project to be fully developed. GS advised that there are lots of opportunities to empower groups/cohorts that don't necessarily have contact with board and to give them a voice. GS referenced that the Director of CAMHS is producing a working model, with the divisions leading, still at the very early stages of completion. It was	.		

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	acknowledged that input from the Director of Development re Hackathon guidance would be beneficial along with importance of external support. **Job Planning** Outstanding PID to be progressed via PID review meeting. Carried forward from last year. **GDE** MKS advised that this project should be greyed on dashboard. **Agile Working** PID available on SharePoint, overall objectives has been signed-off. Development of this project is evolving and progresses via monthly Steering Group that feeds into the dashboard. **Portering & Domestics** MD advised that both PIDS are protected as they will result in organisational change. Once staff have been informed the PIDs may be shared. MKS advised that efficiencies, systems and processes have been reviewed. **Leadership & Management Development** Noted that this project will remain on the 17/18 programme and new PID will be produced. **Apprenticeship Operational Delivery Plan** MKS advised that following receipt by the Committee of the Apprenticeship Strategy in December 2016, this report outlines to the Committee the plans in place to introduce apprenticeships model based on demand for Quarter 1&2 in 2017. MKS noted that overall as a Trust we are not as advanced on the programme as had been planned and acknowledged with reference to Exec sponsors – there is a lack of project management to support projects due to capacity issues. The Committee **noted** the developments made.			
17/13 Progress Against the People Strategy	**Equality Monitoring Process – EDS2, Equality Objectives, BME metrics** The Committee received reports prepared by the Equality & Diversity Manager. The EDS2 Summary Report for May 2017/18 is a requirement on both NHS Commissioners/Providers and is designed to give an overview of the Trusts most recent EDS2 implementation. Once completed and grading approved, the summary report is published on the Trust website. Goals are linked to the evidence drawn upon by 7 Equality Objectives. It was noted that there are 2 goals recorded as			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	'undeveloped' – equal pay audit and recording of non-mandatory training and development opportunities, both have plans in place for improvement. The Equality & Diversity Manager seeks approval of the proposed grading of the workforce aspects ahead of issuing to Health Watch. Equality Objectives Plan for 2017/18 was discussed by the Committee and noted as read. CD requested a quarterly update to the Committee, with objectives reviewed every 6 months. The Committee noted that the EDS2 summary template can only be reviewed electronically, it was agreed that MS will re-issue the report and comments fed back. It was agreed the Equality Metrics Report will be brought back to the next Committee. The Committee **noted** the content	Quarterly update required, along with 6 monthly review of objectives Equality Metrics Report	HA HA/SM	June 2017
17/14	**Trust Board Update – Progress Against the People Strategy April 2017** The Committee received a regular report prepared by the Director of HR&OD. The purpose of the report is to present the Trust Board a monthly update of activity for noting and/or discussion. This paper is noted as previously read. The Committee **noted** the content.			
17/15	**Staff Survey Results (National Summary)** The Committee received a summary of the 2016 National NHS staff Survey for Alder Hey. The report outlines key findings for Alder Hey including comparisons with the Trust 2015 survey and other acute specialists Trusts. Public viewing of this report is available on websites. MKS advised that following outcomes of Staff Survey Results and the requirement to improve responses, local conversations have commenced with departments to agree what actions can be taken to bring about change and help make improvements in working areas. In the spirit of Listening into action all staff are encouraged to get involved to help bring about change which improves both the staff and patient experience. MKS noted that feedback from departments about outcome of local conversation has yet to be received. SO advised that this item has been added to the agenda's CBU Boards to support progression of feedback. The Committee **noted** the content.			
17/16	**Corporate Objectives** MKS agreed to bring the Trust Corporate Objectives to the next			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
17/17 Key Workforce Risks – Review of top Workforce Risks action planning against most significant risks	**Workforce Performance Monitoring** The Committee considered a regular report prepared by the Director of HR & OD concerning the key risks relating to workforce monitoring for February 2017. The purpose of the report is to update on key targets/measures and advise of actions to support improvement. Particular attention was paid to: Sickness absence performance 5.4% - target of 5.3%. Completeness of Mandatory Training 76.05% - target of 90%, completion of Trust Induction 81%. Ended year below all our KPI's – Divisions have their entire workforce KPI's as part of performance. Questions/suggestions raised by the Committee: How has the Trust set targets for Sickness (chest infections)? MKS advised that benchmarking nationally with other Trusts shows that other Trusts have lower sickness rates of 4.5%, this highlights that more robust processes are in place to manage sickness. MKS noted that 0.5% of sickness cost the Trust £0.5M and we need to support more robust processes. The highest % of sickness at the Trust is Estates and Nursing and it was noted infection control/swapping days and nights may influence this outcome. CD suggested staff welfare analyse in this area would be helpful. The Committee **noted** the content of the report.			
17/18 Legislation, terms & conditions, employment policies/EIA's – review & ratification/approval	The Committee considered the following Policies and Equality Impact Assessments for ratification and approval. **Domestic Abuse & Violence Policy** The Committee received the policy for review, presented by the Policies and Guidance Manager in the absence of the Author. The policy was noted as read. EW outlined the content and advised that the policy had previously been presented to CQSG and brought to this Committee due to safeguarding perspective affecting staff. It was noted that employment relations policies have been linked to the Policy. Discussion commenced about the differing pathway/actions needed for patients families and staff. The Committee agreed that clear guidelines/standards of how we treat/support staff is required, with inclusion of support/crises centres/Trade Union information. It was agreed that it was more about an implementation plan for the policy rather than the policy itself. The committee **ratified** the policy, subject to an implementation plan being developed for staff.			

Agenda Item	Key Discussion Points	Action	Owner	Timescale
	Domestic Abuse 7 Violence Policy The committee **approved** the EIA. **Supervision of Medical Staff in Training Policy** The Committee received the policy for review, presented by the Director of Medical Education. The policy was noted as read. GL outlined the content and updates to reflect changes in medical education. GL advised that the policy had previously been approved by the Medical Education Board. The Committee **ratified** the Policy. **Supervision of Medical Staff in Training EIA** The Committee **approved** the EIA.			
AOB	**None.**			
Date of Next Meeting	**Wednesday 21st June 2017, 2pm-4pm, Room 6, Mezzanine**			

Action List

Minute	Action	Who	When	Status

Reference				
Meeting Protocol				
	Terms of Reference			
16/33	• Review of key performance indicators required against the workforce plan to ensure they reflect the workforce strategy.	MKS/CD	April 2017	
17/02	• Work Plan 2017-2018 – updated plan to include Equality Monitoring Processes	MKS	April 2017	Complete
Programme Assurance 'Developing Our Workforce'				
	Programme Assurance/progress update			
16/22	• Summary/matrix of development of actions	MKS	October 2016	This was progressed via Developing our workforce group. – Complete
People Strategy Overview & Progress Against Strategic Aims				
	People Strategy			
16/35, 17/02	• Present updated draft of the Refreshed People Strategy • Refreshed People Strategy to be shared with JCNC.	MKS MKS	June 2017 March 2017	
	LiA			
16/38	• Present Communications Plan	KT/Communications	TBC 2017	
	Engagement			
15/08 16/02	• Develop Values in Procurement, values based recruitment – develop opportunities to incorporate into the Procurement processes/standards for contractors. Liaise with Deputy Director of Finance to progress to review employment opportunities.	MKS/CL	Ongoing	
	Equality & Diversity			
15/03	• Present data on applied/shortlisted recruitment – currently being reviewed.	HA	TBC 2017	
15/03	• Align E&D deliverables with people strategy	HA	Ongoing	Update at future meetings
17/13	• Equality Objectives Plan for 2017/18 – Quarterly Update required & Objectives to be reviewed every 6 months • Equality Metrics Report to be brought back to next Committee	HA HA/SM	1/4ly Update 6 monthly Review June 2017	
	Leadership & Management Development Strategy			
15/31 16/03 & 16/33	• Update on progress of Leadership & Management Development Strategy	FF	Ongoing	
	Staff Survey			
17/04	• Present Staff Survey Results	MKS	April 2017	Complete
	Apprenticeship Update & PID			
17/05	• Conversation re retention strategy for nursing workforce level with	MKS	April 2017	

	Chief Nurse and update on developments			
Key Workforce Risks – Review of Top Workforce Risks				
	Temporary Spend			
16/39	• To support more robust monitoring of temporary spend, more detail to be brought back.	MKS	February 2017	

Workforce and Organisational Development Committee Annual Report 2016-17

The Workforce and Organisational Development Committee

The Workforce and Organisational Development Committee (WOD) was established by the Board of Directors to be responsible for overseeing the implementation of the Trust's People Strategy and Equality Agenda and ensuring the organisational development culture of the organisation is maintained.

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

Oversee the development of the Trust's People Strategy to assure the Trust Board that the Strategy is implemented effectively by receiving progress reports against the Plan and Workforce Key Performance Indicators.

Ratify/approve workforce policies as necessary.

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

Monitor the overall resilience of the organisation and staff through appropriate measurement of engagement and health and wellbeing, and provide reports to the Trust Board as required.

Oversee the development of the workforce elements of the Equality Delivery Scheme (EDS2) action plan and ensure the effective implementation of the EDS2 by receiving regular reports against the action plans. Also, oversee the development and reporting requirements for the Workforce Race Equality Standards (WRES)

Obtain assurance that the organisational values and behaviour framework continue to be embedded and championed across the Trust.

Obtain assurance that partnership arrangements with the Trust's Trade Unions are effective to support organisational change. More specifically, the Committee will oversee the development of the Partnership Agreement.

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

This report outlines how the Committee has complied with the duties delegated by the Board through its terms of reference and identifies key actions to address developments in the Committee's role.

Constitution

In accordance with the terms of reference, the membership comprises:

- 1 Non-Executive Director [Chair]
- 2 x Non-Executive Directors
- Director of Human Resources & Organisational Development [Deputy Chair]
- Chief Operating Officer
- Chief Nurse (or Deputy)
- Medical Director (or Deputy)

- Head of HR
- Head of OD
- Equality and Diversity Manager
- Staff Side Chair
- Divisional Associate Chief Operating Officer

Minutes of the Committee are presented to the Board and are supported by a summary report from the Committee Chair. Terms of Reference are revised annually and were last approved in December 2016.

Achievements

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

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

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

DRAFT

Self Assessment

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

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

Assurance Statement

Through the various mechanisms set out above, the Committee has gained assurance that the delivery of the Trust People Strategy was on track and all key workforce risks were being managed. It has clearly expressed its expectations in relation to areas where controls need to be strengthened and these will be addressed in the coming year.

Committee Developments

Whilst the Committee has performed its duties as delegated by the Board it has identified a number of areas to focus on during 2017/18:

- Focus on progressing the development of a refreshed People Strategy.
- In line with the revised governance arrangements of holding Board sub-committees accountable for the assurance and monitoring of the 'Change programme' across the organisation, WOD will continue to have devolved responsibility for all projects relating to workforce issues. The committee meeting time will continue to be split into Strategic and Operational issues to ensure focus on both priorities.
- Agree the key areas which would receive increased focus from the Committee in 2017/18 which would enable the Trust to deliver its people related targets.
- Ensure that particular attention is given to maintenance of engagement of people in the change programme and to ensuring appropriate support is given throughout the change.
- Enhance the monitoring and reporting of follow-up actions taken in respect of its areas of responsibility.

Claire Dove
Committee Chair April 17

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE
2016-17 AGENDA TIMETABLE

Agenda Item	13th April	8th June	5th September	12th October	14th December	15th February
Review and agree WOD TOR					✓	
Discuss and identify key workforce themes	✓				✓	
Review/amend and approve People Strategy				✓		
Monitor progress against People Strategy	✓	✓	✓	✓	✓	✓
Ratify employment policies	✓	✓	✓	✓	✓	✓
Review workforce risks for inclusion in Board Assurance Framework	✓	✓	✓	✓	✓	✓
Sign-off Annual Report to the Trust Board						✓
Change Programme Assurance	✓	✓	✓	✓	✓	✓
Annual Report	✓					

DRAFT

WORKFORCE & ORGANISATIONAL DEVELOPMENT COMMITTEE MEMBERSHIP ATTENDANCE 2016/17

	13th April	8th June	5th September	12th October	14th December	15th February	Attendance
Mrs C Dove - Chair (Non-Executive Director)	✓	✓	✓	✓	✓	X	5/6
Mr I Quinlan (Non-Executive Director)	✓	X	X	✓	X	✓	3/6
Mrs J France-Hayhurst (Non-Executive Director)	X	✓	✓	✓	✓	✓	5/6
Mrs M Swindell (Director of Human Resources & Organisational Development)	✓	✓	✓	✓	✓	✓	6/6
Mrs Mags Barnaby (Chief Operating Officer)	✓	✓	X	X	✓	X	3/6
Mrs H Gwilliams or Deputy (Director of Nursing)	X	X	✓	X	✓	X	2/6
Mr R Turnock or Deputy (Medical Director)	X	✓	X	✓	X	X	2/6

Programme Assurance Summary
Change Programme

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

In response to the delays in fully defining and de-risking the change programme this year a number of actions have been taken/are planned:

1. The review of the programme has led to revised **scope** attached here which the **Board is requested to endorse.**
2. The Change **Programme Boar**d is being re-instituted, 29 Jun 17, on a monthly basis using the front end of the Operation Board meeting. Crucially, this will bring together the Executive Team and Divisional '3 at the top's around the shared mission of making the quality changes happen from which efficiencies will follow. The reporting into Board sub-Committees will remain extant.
3. The External Programme Assessor has been requested to complete assurance checks on the functioning of work stream and (where appropriate) project **Steering Groups**; on the basis that if the steering group function is of a high standard the delivery will be improved.
4. Programme/project management resources will be augmented/trained to ensure that all initiatives have the **capacity and skills** to deliver.
5. The recalibration of the programme scope and depth is generating significant potential for **additional financial efficiencies**, to be fully defined at an extended Delivery Group meeting on 10 Jul 17.

J Grinnell 26 Jun 17

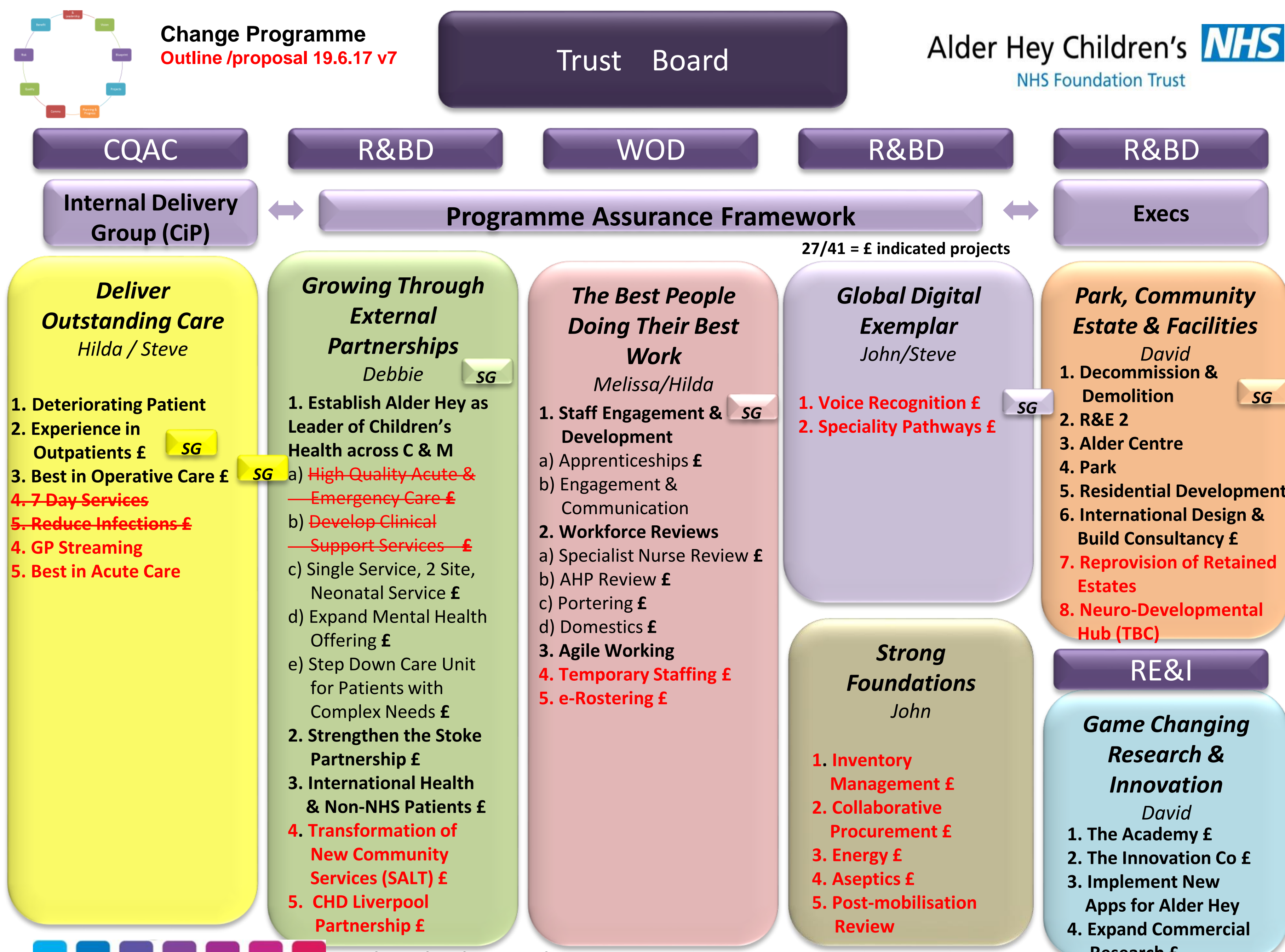
Programme Summary (to be completed by **External Programme Assessment**)

1. This Board report contains assurance reports submitted to the following sub-Cttes: CQAC, 21 Jun 17; WOD, 21 Jun 17 and R&BD, 28 Jun 17.
2. Since the previous Trust Board report was compiled, the review of the change programme scope has been completed. This new level of **clarity** will be advantageous, in particular for addressing prioritisation and capacity issues across the work streams.
3. Notwithstanding the augmented focus on Programme Board and Steering Groups, the assurance framework remains extant as endorsed by the Audit Committee in April 2016. The critical leadership role for assuring delivery is that of the Executive Sponsors who agreed, at the Exec Team meeting of 15 Jun 17, to bring their collective and individual **focus** to bear on the current state of the assurance ratings.

J Gibson 26 Jun 17

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

The Month 2 CIP performance across the Trust showed delivery of £577k for the period Apr-May, which was slightly ahead of the planned profile by £17k. The Clinical Divisions are on track, with Corporate Departments behind plan due to slippage in the timing of schemes starting. **The full year forecast is £5.6m (70%) which leaves a gap of £2.4m.** Red rated schemes of £1.9m represent opportunities which need to be converted into detailed plans in order to close the gap.

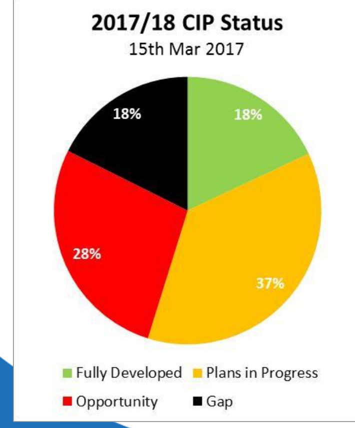

Change Programme
Outline /proposal 19.6.17 v7
Trust Board
Alder Hey Children's NHS
NHS Foundation Trust
CQAC
R&BD
WOD
R&BD
R&BD
Internal Delivery Group (CiP)
Programme Assurance Framework
Execs
27/41 = £ indicated projects
Deliver Outstanding Care
Hilda / Steve
1. Deteriorating Patient
2. Experience in Outpatients £
SG
3. Best in Operative Care £
SG
4. 7 Day Services
5. Reduce Infections £
4. GP Streaming
5. Best in Acute Care
Growing Through External Partnerships
Debbie
SG
1. Establish Alder Hey as Leader of Children's Health across C & M
a) High Quality Acute & Emergency Care £
b) Develop Clinical Support Services £
c) Single Service, 2 Site, Neonatal Service £
d) Expand Mental Health Offering £
e) Step Down Care Unit for Patients with Complex Needs £
2. Strengthen the Stoke Partnership £
3. International Health & Non-NHS Patients £
4. Transformation of New Community Services (SALT) £
5. CHD Liverpool Partnership £
The Best People Doing Their Best Work
Melissa/Hilda
1. Staff Engagement & Development
SG
a) Apprenticeships £
b) Engagement & Communication
2. Workforce Reviews
a) Specialist Nurse Review £
b) AHP Review £
c) Portering £
d) Domestics £
3. Agile Working
4. Temporary Staffing £
5. e-Rostering £
Global Digital Exemplar
John/Steve
1. Voice Recognition £
2. Speciality Pathways £
SG
Strong Foundations
John
1. Inventory Management £
2. Collaborative Procurement £
3. Energy £
4. Aseptics £
5. Post-mobilisation Review
Park, Community Estate & Facilities
David
1. Decommission & Demolition
SG
2. R&E 2
3. Alder Centre
4. Park
5. Residential Development
6. International Design & Build Consultancy £
7. Reprovision of Retained Estates
8. Neuro-Developmental Hub (TBC)
RE&I
Game Changing Research & Innovation
David
1. The Academy £
2. The Innovation Co £
3. Implement New Apps for Alder Hey
4. Expand Commercial Research £
Listening into Action - A staff-led process for the changes we need

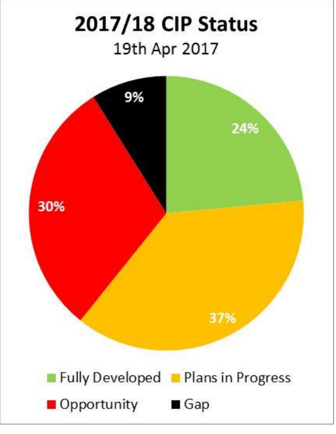
CIP Status at Month 02

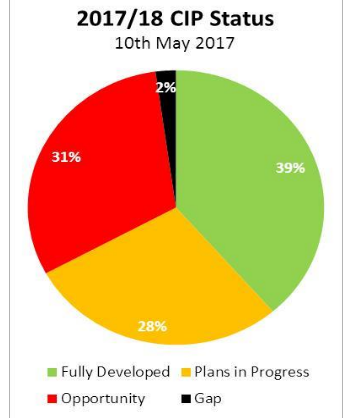
By Strategic Work Stream

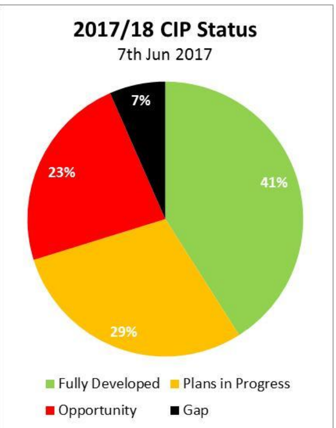
	Risk Rating (In Year)					
Workstream	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	133	0	22	63	369	587
Growing Through External Partnerships	69	0	0	90	0	159
The Best People Doing Their Best Work	0	0	292	115	-5	402
Game Changing Research and Innovation	130	0	0	0	100	230
Solid Foundations	0	0	0	0	142	142
Subtotal: Strategic Workstreams	332	0	314	268	606	1,520
Business as Usual	2,637	311	2,022	1,591	-81	6,480
Unidentified	0	0	0	0	0	0
Grand Total	2,969	311	2,336	1,859	525	8,000

Progress over the last 4 months









Inspired by Children

Programme Assurance Summary
Delivering Outstanding Care

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

This year's Change Programme remains at least a quarter behind schedule. An Executive review of the Programme is underway and arrangements should be made for these recently identified financial and quality improvements (as agreed with the project Executive Sponsor) to be incorporated within the PIDs and project documentation at the earliest opportunity.

It is imperative that the Best in Operative Care, 7 Day Services and Reduce Infections projects within this work stream progress completion of all project documentation to provide assurance to delivery of the required financial and quality benefits.

The latest forecast is savings of £0.2m, which is very low, and not sufficient to meet the financial objectives of the programme. The only project currently forecasting a saving is Best in Operative Care. There is an additional £0.1m of opportunity identified in Experience in Outpatients. The Executive sponsor is requested to review the saving potential as a matter of urgency, converting the opportunities into savings and increasing the value of the overall forecast.

Claire Liddy, Deputy Director of Finance – 14 June 2017

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

Only one of the now five projects has a PID fully completed to the required standard; moreover, we await further details for the '7 Day Services' project which is the subject of a merger with another project, 'High Quality Acute and Emergency Care'. Of the projects that are rated, the 'Outpatients', 'Deteriorating Patient' and 'Best in Operative Care' projects are all making and maintaining good progress with regards to the assurance evidence. However, all milestone plans are currently showing as 'off track' which is a risk to timely delivery of the benefits being pursued.

The focus now should be on accelerating the work to fully define the '7 Day Services' and 'Reduce Infection' projects and reach the assurance standards for both. The additional requirement for further efficiencies, referred to above, should also be the subject of rapid amendment to scope and plans of the projects wherever appropriate.

Joe Gibson, External Programme Assessment 19 Jun 17

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

Sub-Committee	CQAC	Report Date	14 June 2017
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hilda Gwilliams/Steve Ryan

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
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	Green	Green	Green	Green	Amber	Green	Green	Green	Green	Project implementation meeting notes available to April. PID complete. Benefits defined. Milestone Plan has been revised, to be fully updated - some tasks are outstanding. Comms/ Engagement Plan available, evidence required where possible. Risks now available on Ulysses. EA/QIA complete. **Last updated 15 May 2017**
CQAC 1.2	Experience in Outpatients	The project will improve patient & staff experience; understand demand and capacity; improve flow and environment	Hilda Gwilliams	Green	Green	Amber	Green	Amber	Green	Green	Green	Green	Steering Group meeting notes available. PID was complete, however scope is being revised/extended. Benefits fully defined and tracking/dashboard available. Milestone Plans defined - B&S needs updating. Detailed comms/engagement plan available, evidence to be provided where possible. Risk log available. EA/QIA complete. **Last updated 30 May 2017**
CQAC 1.3	Best in Operative Care	The "Best in Operative Care" strategy aims to deliver the best paediatric operative care in the world, as measured by low rates of mortality and harm, and high staff satisfaction rates	Steve Ryan	Amber	Green	Amber	Amber	Amber	Green	Green	Green	Green	Steering Group notes available on SharePoint. Draft PID available - requires completion. Targets/benefits to be fully defined, including start date and completion of financial appendix. Milestone Plan to be fully defined. Comms tracker available. Risk Log complete. EA/QIA complete. **Last updated 22 May 2017**
CQAC 1.4	7 Day Services	The project aims to deliver 7 day services in line with NHS recommendations	Steve Ryan	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Grey	Links to project 2.1a STP AH @ C&M High Quality Acute & Emergency Care - currently under review. **Last updated 5 May 2017**
CQAC 1.5	Reduce Infections	This project will ensure we achieve best in class for infection prevention and control	Steve Ryan	Red	Red	Amber	Red	Red	Red	Amber	Red	Red	Draft/outline PID available on SharePoint - all project documentation to be fully developed. **Last updated 3 May 2017**

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Deteriorating Patient	Black				No financial benefits identified to date
Reduce Variations by Developing Clinically Effective Pathways	Black				No financial benefits identified to date
Experience in Outpatients	Red	180k	0	-180k	Financial target based on 3% reduction in DNA rate in Medical specialities. High risk regarding delivery of full target value.
Best in Operative Care	Green	407k	155k	-252	Financial target based on indicative 2% growth in Elective and Daycase income in all Surgical specialties. Following detailed review and activity forecast, there is high confidence of increased income in Urology, Plastics and Pre-Op Assessment.
7 Day Services	Black				No financial benefits identified to date
Reduce Infections	Black				No financial benefits identified to date
Total		587k	155k	-432k	

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)

An Executive Review of this work stream is underway and this will clarify which projects require focus to enable early initiation.

A Strategy and Business Case is to be finalised for Expand Mental Health Offering and feasibility is being established for Step Down Care Unit.

The International Health & Non-NHS Patients project is fully developed and is currently on track.

The latest forecast is savings of £0.1m, which is very low, and not sufficient to meet the financial objectives of the programme. The only project currently forecasting a saving is the Strong Community Services Offer. There is an additional £0.1m of opportunity identified in International Health and Non NHS Patients. The Executive sponsor is requested to review the saving potential as a matter of urgency, converting the opportunities into savings and increasing the value of the overall forecast.

Claire Liddy, Deputy Director of Finance – 16 June 2017

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

One of the projects in this work stream 'Transition of Community Services' was due to be the subject of a closure report to R&BD which needs to be expedited.

Three projects are still in the process of being defined and clear milestone dates for completing the scope are now an urgent priority. Those projects are: 'Develop Clinical Support Services Offer', ' Expand Mental Health Offering' and 'Step Down Care Unit for Patients with Complex Needs'. **Three projects** – 'Quality Acute and Emergency Care', 'Single Service, 2-Site, Neonatal Service', 'Strengthen the Stoke Partnership' – have fundamental assurance issues in terms of the lack of evidence of systematic progress to the delivery of an agreed design with associated benefits. These gaps need to be remedied.

One project, 'International Health and Non-NHS Patients', gives confidence in delivery and, therefore, the additional benefits alluded to above should be pursued with vigour.
Joe Gibson, External Programme Assessment – 19 June 2017

Programme Assurance Framework
Growing Through External Partnerships (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	16 June 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
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										Draft/outline PID on SharePoint - all project documentation to be fully developed. **Last updated 2 June 2017**
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										PID due to be submitted to RABD in June 2017. Ratings will commence from that date. **Last updated 5 May 2017**
R&BD 2.1c	Single Service, 2 Site, Neonatal Service	Lead services to review options to collaborate and maximise joint working across the NM LDS and C&M Footprint including a single Neonatal Service with LWH	Debbie Herring										Now in implementation planning phase, project documentation to be completed. **Last updated 22 May 2017**
R&BD 2.1di	STP AH @ C&M Strong Community Services Offer - Transition of New Community Services	To ensure safe and efficient transfer of selection of Specialist Paediatric Community Services from LCH	Debbie Herring										Team have requested closure of this project. Closure Report to be presented to July RABD meeting. **Last updated 5 May 2017**
R&BD 2.1d	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										A Strategy and Business Case to be finalised, any future project start date will be notified. **Last updated 5 May 2017**
R&BD 2.1e	Step Down Care Unit for Patients with Complex Needs	Implement Alder Hey Rehab offer to enhance patient pathway	Debbie Herring										Feasibility being established through proof of concept exercise that will lead to an eventual Business Case. Any future project start date will be notified. **Last updated 5 May 2017**
R&BD 2.2	Strengthen the Stoke Partnership	Lead services to review options to collaborate and maximise joint working with Stoke partners	Debbie Herring										Draft/outline PID on SharePoint - all project documentation to be fully developed. **Last updated 11 May 2017**
R&BD 2.3	International Health & Non-NHS Patients	Establish International service offer including: International Health Partnerships and non-NHS patients	Debbie Herring										Steering Group meeting notes available. PID complete. Comms approach defined and plan available. Milestone Plan is defined and on SharePoint, slight slippage. Risks now on Ulysses. EA/QIA complete. **Last updated 1 June 2017**

Programme Assurance Framework
Growing Through External Partnerships (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	16 June 2017
Workstream Name	Growing Through External Partnerships	Executive Sponsor	Debbie Herring

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
High Quality Acute and Emergency Care	Black				No financial benefits identified to date
Develop Clinical Services Support Offer	Black				No financial benefits identified to date
Strong Specialist Services Offer	Black				No financial benefits identified to date
Strong Community Services Offer	Green	159k	69k	-90k	
Expand Mental Health Offering	Black				No financial benefits identified to date
Intermediate Care Unit	Black				No financial benefits identified to date
Strengthen Existing Partnerships	Black				No financial benefits identified to date
International Health & Non NHS Patients	Red				
Total		159k	69k	90k	

Programme Assurance Summary
Global Digital Exemplar

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

An Executive Review of the programme is underway and this will clarify areas where savings/CIP contribution will be generated.

An overarching GDE PID has been completed by the team and individual PIDs or PODs (Project Overview Documents) are in the process of being prepared for the first tranche of projects which are due for delivery by 1 September 2017.

The latest forecast is savings of nil which is 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 and provide a value of the overall forecast.

Claire Liddy, Deputy Director of Finance – 16 June 2017

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

The overarching GDE PID awaits final sign-off but is now being refined to meet the previous key observations. The draft 'Speciality Packages' PID is to a good standard as a draft version and should soon be ready for sign-off.

There remain clear risks to the delivery of GDE to plan, given that the release of resources from NHSE is months behind trajectory. It will be important for the Programme Board to demonstrate that these risks are clearly understood, actively managed, and the consequent impact on benefits taken into account.

The PODs for that first tranche of projects should now be the focus and the pace of production increased wherever possible; given the clinical domains that have been selected, completion of the EA/QIA process should be a 'gate' to further stages of project work.

Joe Gibson, External Programme Assessment – 19 June 2017

Programme Assurance Framework
Global Digital Exemplar (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	16 June 2017
Workstream Name	Solid Foundations	Executive Sponsor	John Grinnell/ Steve Ryan

Current Dashboard Rating:

R&BD 4.1	GDE	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	Steve Ryan/ John Grinnell										SGroup meeting notes available for February. Draft/overarching PID on SharePoint. Full details of projects and benefits to be worked up/defined. Milestone plan/s to be fully defined with tracking to commence, Evidence of Comms/Engagement required. Risks detailed in PID to be updated/reviewed aligned with Trust process. EA/QIA to be completed. **Last updated 15 May 2017**
R&BD 4.2	Speciality Package - ED		Steve Ryan/ John Grinnell										
R&BD 4.3	Speciality Package - Gynaecology		Steve Ryan/ John Grinnell										
R&BD 4.4	Speciality Package - Rheumatology		Steve Ryan/ John Grinnell										
R&BD 4.5	Speciality Package - Gastro		Steve Ryan/ John Grinnell										
R&BD 4.6	Speciality Package - Neurosurgery		Steve Ryan/ John Grinnell										
R&BD 4.7	Speciality Package - Respiratory		Steve Ryan/ John Grinnell										
R&BD 4.8	Speciality Package - CAMHS		Steve Ryan/ John Grinnell										
R&BD 4.9	Speciality Package - Community Paeds		Steve Ryan/ John Grinnell										
R&BD 4.10	Voice Recognition		Steve Ryan/ John Grinnell										Draft PID on SharePoint. All project documentation to be fully developed to meet Programme Assurance Standards.

Programme Assurance Framework
Global Digital Exemplar (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	16 June 2017
Workstream Name	Solid Foundations	Executive Sponsor	John Grinnell/ Steve Ryan

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
GDE	Black	0	0	0	
	Black				
Total					

Programme Assurance Summary

Park, Community Estate and Facilities

The assurance ratings for the majority of projects within this work stream have been suspended since January 2017. Following presentation of an Exception Report to the last RABD meeting, arrangements should be made for all project documentation to be updated in time for the next dashboard assurance update.

A review of the programme has highlighted some projects which have previously been removed (Community Services, Corporate Offices and On-site Residual Services). As these initiatives currently fall outside the programme assurance scope and there are risks arising with these projects, it is recommended that they are incorporated within the programme assurance process once again.

A new addition to this workstream for this year's programme is the International Design and Build Consultancy project and the team should ensure that the PID and project documentation is prepared as a matter of urgency.

The latest forecast is savings of nil which is 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.

Claire Liddy, Deputy Director of Finance – 16 June 2017

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

As per the commentary in May 2017: The continuing absence of ratings (for 5 of the 6 projects), 5 months having elapsed, is an area of significant risk for the organisation as the assurance standard applied to the programme is not in a position to evidence and highlight areas of concern across this work stream.

As per the commentary in May 2017: The new 'consultancy' project and the lack of any projected savings come together to suggest that the potential in this area needs to be defined (in a PID) without delay.

Joe Gibson, External Programme Assessment - 19 Jun 2017

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

Sub-Committee	R&BD	Report Date	16 June 2017
Workstream Name	Park, Community Estate and 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
R&BD 5.1	Decommission & Demolition	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell										Project was part of 2016 programme. Revised Milestones were due to be presented to May RABD for approval.
R&BD 5.2	R&E 2	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell										Project was part of 2016 programme. Revised Milestones to be presented to May RABD for approval.
R&BD 5.3	Alder Centre	To plan, develop and construct the new Alder Centre within the park setting	David Powell										Steering Group meeting notes available. Scope/approach defined in PID (revised recently). Benefits defined in PID. Milestone Plan has been revised recently - shows initial actions on track. Evidence required of Comms/ Engagement activities. Risk status to be confirmed - shows review required EA/QIA complete and signed by Execs. Last updated 26 May 2017
R&BD 5.4	Park	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell										Project was part of 2016 programme. Revised Milestones to be presented to May RABD for approval.
R&BD 5.5	Residential Development	To create a high quality residential scheme that co-ordinates with the themes and activities within the wider park site	David Powell										Project was part of 2016 programme. Revised Milestones to be presented to May RABD for approval.
R&BD 5.6	International Design & Build Consultancy		David Powell										

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
International Design and Build Consultancy	Black	0	0	0	No financial savings identified to date
Total					

Programme Assurance Summary

The best people doing their best work

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

This year's Change Programme remains at least a quarter behind schedule. An Executive review of the Programme is underway and arrangements should be made for any recently identified financial and quality improvements (as agreed with the project Executive Sponsor) to be incorporated within the PIDs and project documentation at the earliest opportunity.

It is imperative that the Apprenticeships, Engagement & Communication, Specialist Nurse Review, AHP Review, Portering and Agile Working projects within this workstream progress completion of all project documentation to provide assurance to delivery of the required financial and quality benefits.

The latest forecast is savings of £0.3m, which is very low, and not sufficient to meet the financial objectives of the programme. There is an additional £0.1m of opportunity identified in the AHP, specialist nurse, job planning reviews and the GDE workforce change. The Executive sponsor is requested to review the saving potential as a matter of urgency, converting the opportunities into savings and increasing the value of the overall forecast.

Claire Liddy, Deputy Director of Finance – 14 June 2017

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

Since the wider review of the programme has taken place the number of projects in this work stream has been reduced from eleven to seven. One of the project still remains to have a project description on the dashboard (see April comments) and four projects that are defined have the same generic statement (see April comments); this lack of clarity and specificity should be addressed to aid comprehension of all stakeholders. All projects need to have the PID completed (all currently amber rated). Turning to the overall ratings, significant progress needs to be made in terms of the project work and documentation if any reasonable level of confidence in delivery is to be attained.

Therefore, the work stream is currently at high risk of not delivering the quality and financial ambitions it aims to deliver. In this respect the 'Agile' project remains a particular concern.

Joe Gibson, External Programme Assurance 14 Jun 17

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

Sub-Committee	WOD	Report Date	14 June 2017
Workstream Name	The Best People Doing Their Best Work	Executive Sponsor	Hilda Gwilliams/Melissa Swindell

Current Dashboard Rating:

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
WOD 3.1a	Staff Engagement & Development - Apprenticeships	To operationalise the Apprenticeship Strategy and realise the benefits of apprentisehip qualitifcations following introduction of the Apprenticeship Levy.	Melissa Swindell	Red	Amber	Amber	Amber	Red	Amber	Red	Red	Red	Reports to Workstream Steering Group. Draft/outline PID on SharePoint, to be finalised with full details of Benefits. Outline Milestone Plan available - to be fully populated and tracking to commence. Risk Log available, to be fully completed and Ulysses updatedand reviewed regularly. EA/QIA to be completed and signed. **Last updated 26 May 2017**
WOD 3.1b	Staff Engagement & Development - Engagement & Communication		Melissa Swindell	Red	Amber	Amber	Red	Red	Red	Red	Red	Red	Reports to Workstream Steering Group. Draft PID on SharePoint, to be finalised. Details of benefits, metrics and tracking to be provided. Milestone Plan to be made available and tracking to commence. Details of Comms/ Engagement to be provided. Risks to be identified and input on Ulysses. EA/QIA to be finalised and signed in accordance with process. **Last updated 5 May 2017**
WOD 3.2a	Workforce Reviews - Specialist Nurse Review	To support the development of a capable, sustainable workforce; sufficiently flexible to meet the changing needs of our services in the hospital & the community	Hilda Gwilliams	Amber	Amber	Amber	Amber	Red	Amber	Green	Green	Green	Reports to Workstream Steering Group. Draft/outline PID on SharePoint to be finalised with full details of benefits and metrics. Milestone Plan to be fully defined/populated. Some evidence of Engagement available. Risks available on Ulysses. EA/QIA complete. **Last updated 30 May 2017**
WOD 3.2b	Workforce Reviews AHP Review	To support the development of a capable, sustainable workforce; sufficiently flexible to meet the changing needs of our services in the hospital & the community	Hilda Gwilliams	Red	Red	Amber	Red	Red	Red	Red	Red	Red	Draft/outline PID on SharePoint - all project documentation to be fully developed. **Last updated 28 March 2017**
WOD 3.2c	Workforce Reviews Portering	To support the development of a capable, sustainable workforce; sufficiently flexible to meet the changing needs of our services in the hospital & the community	Hilda Gwilliams	Red	Amber	Amber	Amber	Red	Amber	Green	Green	Green	Some team meeting actions available. PID to be completed. Full details of benefits, metrics and tracking to be made available. Milestone Plan is available, requires updating and evidence provided where possible - some key milestones outstanding. Evidence required of Comms/Engagement activities. Risk Log is available. EA/QIA complete. **Last updated 28 April 2017**
WOD 3.2d	Workforce Reviews Domestics	To support the development of a capable, sustainable workforce; sufficiently flexible to meet the changing needs of our services in the hospital & the community	Hilda Gwilliams	Amber	Green	Amber	Amber	Amber	Amber	Green	Green	Green	Team meeting actions available. PID to be finalised and to include full details of benefits, metrics and tracking. Milestone Plan is available, requires updating - some slippage with milestones. Evidence required of Comms/Engagement activities. Risk log is available. EA/QIA complete. **Last updated 22 May 2017**
WOD 3.3	Agile Working	The aim of the project is to deliver an agile working solution for the Trust that complements the on site and off-site developments	Melissa Swindell	Red	Red	Amber	Red	Amber	Red	Red	Green	Green	No evidence of project meetings/update at Workstream SG. PID available, however scope/approach to be approved/confirmed by team. Benefits defined in PID, however most start in 2019. Milestone Plan has been revised, however no visibility of project initiation - status of initial milestones is unclear. Risk log requires review. EA/QIA complete. **Last updated 11 April 2017**

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

Sub-Committee	WOD	Report Date	14 June 2017
Workstream Name	The Best People Doing Their Best Work	Executive Sponsor	Hilda Gwilliams/Melissa Swindell

Financial Reporting:

Project Title	RAG Rating	Budget £	Forecast £	Variance £	Comments
Staff Engagement & Development: Apprenticeships	Amber	65k	59k	-6k	
Specialist Nurse Review	Red	30k	0	-30k	Delivery of targets subject to outcome of review
AHP Review	Red	30k	0	-30k	Delivery of targets subject to outcome of review
Job Planning	Red	30k	0	-30k	Delivery of targets subject to outcome of review
GDE Workforce Change	Red	0	0	0	
Portering	Amber	147k	123k	-25k	
Domestics	Amber	100k	111k	11k	
Implement Carter	Black				No financial benefits identified to date
TOTAL		402k	292k	-110k	

Corporate Report

May 2017

Corporate Report

Table of Contents

Executive Summary 3
Leading Metrics 4
Exceptions 5
Patient Safety - Section 1 6
Patient Experience 7
Clinical Effectiveness 8
Access 9
Accident and Emergency 10
Productivity and Efficiency 11
Facilities 12
CAHMS 13
External Regulation 14
Workforce 15
Performance by CBU 16
CBU Performance - Community 17
CBU Performance - Medicine (Part 1) 18
CBU Performance - Surgery 20
Financial Strength 21

Executive Summary

May 2017

Is there a Governance Issue?

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

Highlights

NHSI core standards achieved: 4 hour access, RTT, diagnostic and cancer standards as planned activity levels start to increase and 2 bank holidays in-month. Productivity has generally improved across all metrics despite the high number of cancellations.

Challenges

Highest recorded number of on the day cancellations due to a combination of issues which will require careful maintenance to prevent subsequent 28 day relist breaches and contractual fines for activity. 12hr ED CAMHS breach noted due to a complex presentation; safe haven requirements; sections and treatment compliance. Awaiting confirmation if reportable. Follow up and lessons learned will be required from this event. Activity levels improving but still behind plan; plans continually being refined. IP long waiting backlog has increased as a consequence of the high number of cancellations which will need to be dated as priority for June.

Patient Centred Services

Metrics have been improved; are reflective of the general trend and of the change within the Trust as activity levels start to increase post winter plan. Main areas to note are increases with LOS which is expected following 2 bank holidays in-month and increased levels of In-Patient and Daycase activity with increased NEL admissions and acuity. Overall performance has held with achievement of 4 hour standard, incomplete pathway and diagnostics. Theatre utilisation has increased slightly despite a significant number of on the day cancellations which was due to a high number of medical outliers; out of area transfers in; higher than planned TCI's and the impact of the Manchester terrorist event. 28 day breaches increased to 4 due to critical care & general bed capacity; OP utilisation has increased with reduced DNA levels.

Excellence in Quality

Improvements have been seen during May in respect of patient experience measures, with an increase in the percentage of patients receiving information to enable choices about their care, and knowing who is in charge of their care, plus 100% reported being treated with respect. There was a deterioration in the percentage of patients that know their planned date of discharge and more work is required to ensure patients have an opportunity to be involved in play and learning.
There were 3 reported hospital acquired infections in May. Year to date there have been 7 Medication errors recorded against a target of 10. The high reporting levels of clinical incidents continues, and whilst this is significantly higher than target there were only 4 clinical incidents that resulted in moderate harm or worse. This continues to reflect a strong reporting culture for incidents of minor or no harm.

Financial, Growth & Mandatory Framework

For the month of May the Trust's year to date deficit of £2.35M which is still £0.3M behind plan.

Income is ahead of plan by £1.0m for the month. The main over performing areas were non-electives by £0.4m, drugs that are rechargeable to commissioners by £0.2m, and excess bed days by £0.3m (due to the discharge of a very long stay patient). This was offset by elective under performance of £0.3m.

Pay budgets are overspent for the month due to high temporary staffing costs. Drug costs remain high and purchase of clinical supplies is over due to external lab charges. The Trust has improved on CIP this month, over performing by £0.1M to bring CIP back on target for the year. Cash in bank is £5.2M, ahead of plan. Monitor Use of Resources Risk Rating of 3 remains in line with plan.

Great Talented Teams

Rates for medical appraisal have remained at 77% with the next round due to be completed in July 2017, the general PDR compliance rate is now 12.4% with all appraisals to be completed by the end of July 2017. The Trust rate of sickness absence has increased very slightly to 4.7%; with the biggest staff group increase among Healthcare Scientists (2.3%), sickness in Estates & Ancillary has fallen nearly 1% and is now below 10%. Mandatory training compliance remains static at 76% and compliance with Corporate Welcome attendance has increased to 85%. Work continues to improve all KPIs.

Leading Metrics

May 2017

Alder Hey Children's NHS
NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Apr 2017	May 2017	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	96.4 %	95.6 %	▼	
RTT: 90% Admitted within 18 weeks		89.6 %	90.3 %	▲	
RTT: 95% Non-Admitted within 18 weeks		90.2 %	88.3 %	▼	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.1 %	92.1 %	▲	
Diagnostics: Numbers waiting over 6 weeks		0	0	▬	
Average LoS - Elective (Days)		3.0	3.5	▲	
Average LoS - Non-Elective (Days)		2.0	2.2	▲	
Daycase Rate	0.0 %	70.8 %	71.8 %	▲	
Theatre Utilisation - % of Session Utilised	90.0 %	87.2 %	87.3 %	▲	
28 Day Breaches	0.0	4	2	▼	
Clinic Session Utilisation	90.0 %	89.3 %	87.6 %	▼	
DNA Rate	12.0 %	11.2 %	10.8 %	▼	
Cancelled Operations - Non Clinical - On Same Day		7	57	▲	

Excellence in Quality

Metric Name	Goal	Apr 2017	May 2017	Trend	Last 12 Months
Never Events	0.0	0	0	▬	
IP Survey: % Received information enabling choices about their care	90.0 %	94.1 %	94.9 %	▲	
IP Survey: % Treated with respect	100.0 %	98.5 %	100.0 %	▲	
IP Survey: % Know their planned date of discharge	80.0 %	79.4 %	69.1 %	▼	
IP Survey: % Know who is in charge of their care	95.0 %	91.2 %	96.1 %	▲	
IP Survey: % Patients involved in play and learning	80.0 %	81.4 %	75.8 %	▼	
Pressure Ulcers (Grade 2 and above) YTD		2	7	▲	
Total Infections (YTD)	14.0	6	9	▼	
Medication errors resulting in harm (YTD)	10.0	2	7	▲	
Clinical Incidents resulting in harm (YTD)	98.0	73	158	▲	

Great and Talented Teams

Metric Name	Goal	Apr 2017	May 2017	Trend	Last 12 Months
Corporate Induction	100.0 %	82.9 %	85.7 %	▲	
PDR	90.0 %	2.1 %	12.4 %	▲	
Medical Appraisal	100.0 %	77.7 %	77.7 %	▬	
Sickness	4.5 %	4.6 %	4.7 %	▲	
Mandatory Training	90.0 %	76.1 %	76.0 %	▼	
Staff Survey (Recommend Place to Work)		TBC	TBC		
Actual vs Planned Establishment (%)		94.8 %	94.9 %	▲	
Temporary Spend ('000s)		948	917	▼	

Financial, Growth and Mandatory Framework

Metric Name	Apr 2017	May 2017	Last 12 Months
CIP In Month Variance ('000s)	-52	69	
Monitor Risk Ratings (YTD)	3	3	
Trading Surplus/(Deficit)	-1905	-449	
Capital Expenditure YTD % Variance	-75.4 %	-67.2 %	
Cash in Bank (£M)	6.2	5.2	

Exceptions

May 2017

Alder Hey Children's NHS
NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Last 12 Months
CIP In Month Variance ('000s)	-107	-97	191	96	42	157	-18	78	-373	-464	-183	-52	69	
Monitor Risk Ratings (YTD)	2	2	2	2	2	3	3	3	3	3	2	3	3	
Temporary Spend ('000s)	1,189	1,008	1,052	1,002	969	894	800	550	1,442	813	1,037	948	917	
Total Infections (YTD)	17	25	33	41	51	60	69	75	84	93	104	6	9	
Medication errors resulting in harm (YTD)	10	14	14	20	25	31	39	44	52	57	67	2	7	

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

Metric Name	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Last 12 Months
RTT: 95% Non-Admitted within 18 weeks	87.8%	87.9%	87.3%	88.8%	87.5%	86.7%	85.8%	87.2%	90.5%	86.7%	89.5%	90.2%	88.3%	
DNA Rate	12.7%	12.8%	13.1%	14.6%	12.9%	11.5%	11.9%	14.5%	12.9%	12.7%	9.7%	11.2%	10.8%	
IP Survey: % Received information enabling choices about their care	94.2%	97.4%	190.3%	99.1%	93.0%	97.3%	96.4%	96.3%	98.7%	96.0%	96.0%	94.1%	94.9%	
Actual vs Planned Establishment (%)	87.1%	90.6%	89.4%	90.7%	91.8%	87.0%	91.8%	87.7%	89.0%	92.3%	95.1%	94.8%	94.9%	
Trading Surplus/(Deficit)	-1,334	-1,289	-970	-695	2,293	500	1,104	-776	535	470	5,972	-1,905	-449	

Challenge (Top 5 based on % change)

Metric Name	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Last 12 Months
Clinic Session Utilisation	82.1%	82.9%	90.1%	89.0%	88.9%	90.2%	91.9%	87.6%	87.7%	88.8%	91.5%	89.3%	87.6%	
PDR	11.5%	32.2%	54.7%	58.5%	69.3%	73.3%	73.0%	70.5%	71.3%	71.1%	59.2%	2.1%	12.4%	
Medical Appraisal	0.0%	1.2%	5.2%	5.3%	5.1%	11.0%	16.7%	48.4%	57.2%	64.8%	87.0%	77.7%	77.7%	
Sickness	4.8%	4.6%	4.9%	4.8%	5.1%	5.4%	5.4%	5.5%	5.4%	5.2%	4.7%	4.6%	4.7%	
IP Survey: % Know their planned date of discharge	59.3%	54.3%	53.9%	69.0%	71.2%	71.6%	73.5%	73.1%	78.7%	72.0%	75.7%	79.4%	69.1%	

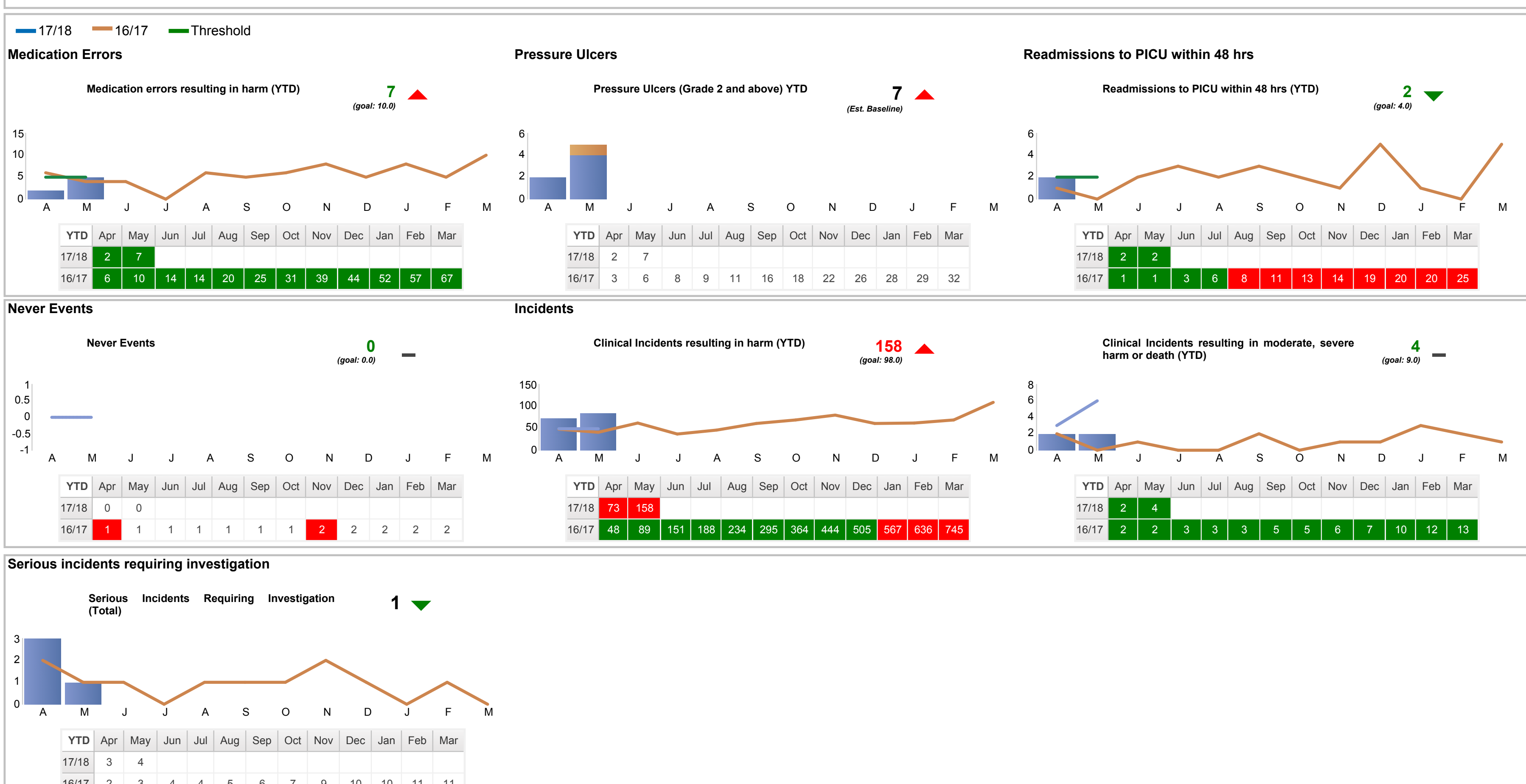
Patient Safety

May 2017

Alder Hey Children's NHS
NHS Foundation Trust

Summary

Year to date, there have been 158 clinical incidents associated with harm reported. This is significantly higher than last year, however only 4 of these resulted in moderate harm or above, which is below the target of 9. This reflects the continued open culture of reporting incidents whilst evidencing a reduction in serious harm. There have been 7 medication errors year to date against a target of 10, plus 7 pressure ulcers year to date, which is 1 more than this time in 2016/17.
There were zero Never Events and zero readmissions to PICU within 48hours during May.



Medication Errors

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	7										
16/17	6	10	14	14	20	25	31	39	44	52	57	67

Pressure Ulcers

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	7										
16/17	3	6	8	9	11	16	18	22	26	28	29	32

Readmissions to PICU within 48 hrs

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	2										
16/17	1	1	3	6	8	11	13	14	19	20	20	25

Never Events

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

Incidents

Clinical Incidents resulting in harm (YTD)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	73	158										
16/17	48	89	151	188	234	295	364	444	505	567	636	745

Clinical Incidents resulting in moderate, severe harm or death (YTD)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	4										
16/17	2	2	3	3	3	5	5	6	7	10	12	13

Serious incidents requiring investigation

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3	4										
16/17	2	3	4	4	5	6	7	9	10	10	11	11

Patient Experience

May 2017

Summary

There has been a decrease in the number of inpatients that would recommend the Trust. Other areas that require improvement are availability of play resource and knowing planned date of discharge. This will be shared with ward managers.

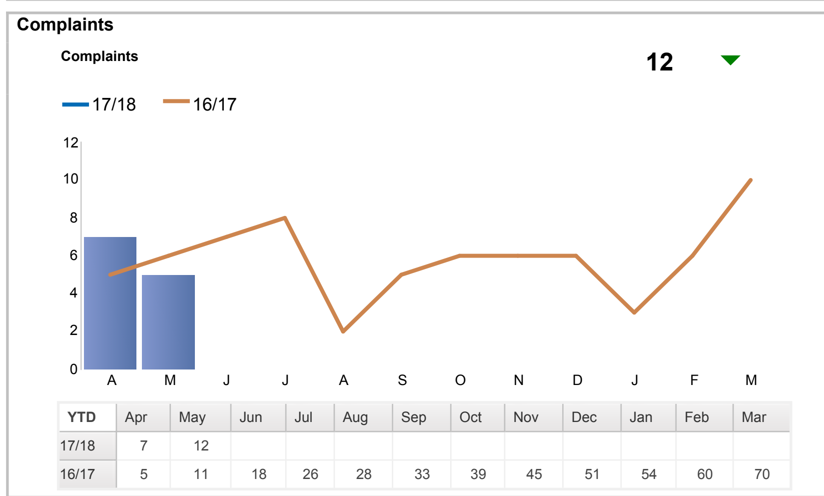
Inpatient Survey

Metric Name	Goal	Apr 2017	May 2017	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	91.2 %	96.1 %	▲	
% Patients involved in play and learning	80.0 %	81.4 %	75.8 %	▼	
% Know their planned date of discharge	80.0 %	79.4 %	69.1 %	▼	
% Received information enabling choices about their care	90.0 %	94.1 %	94.9 %	▲	
% Treated with respect	100.0 %	98.5 %	100.0 %	▲	

Friends and Family

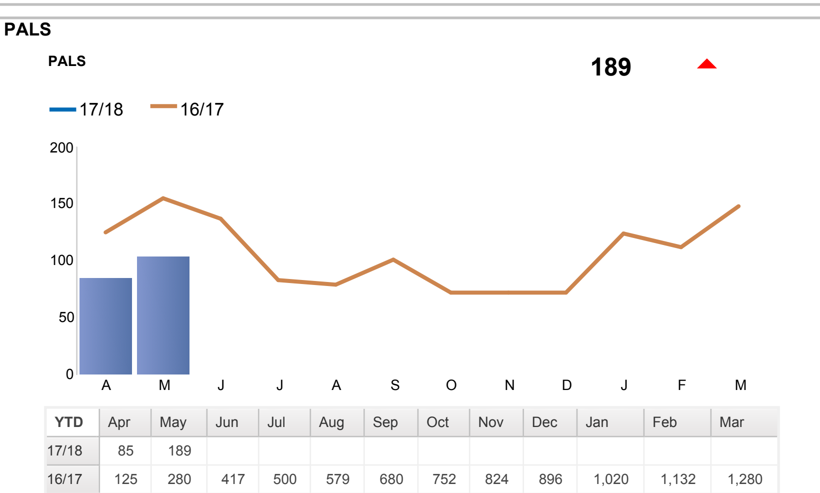
Metric Name	Required Responses	Number of Responses	Apr 2017	May 2017	Trend	Last 12 Months
A&E - % Recommend the Trust	250	52	97.2 %	88.5 %	▼	
Community - % Recommend the Trust	29	1	100.0 %	100.0 %	▬	
Inpatients - % Recommend the Trust	300	526	94.8 %	82.1 %	▼	
Mental Health - % Recommend the Trust	27	27	100.0 %	100.0 %	▬	
Outpatients - % Recommend the Trust	400	387	94.3 %	94.3 %	▲	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	12										
16/17	5	11	18	26	28	33	39	45	51	54	60	70

PALS

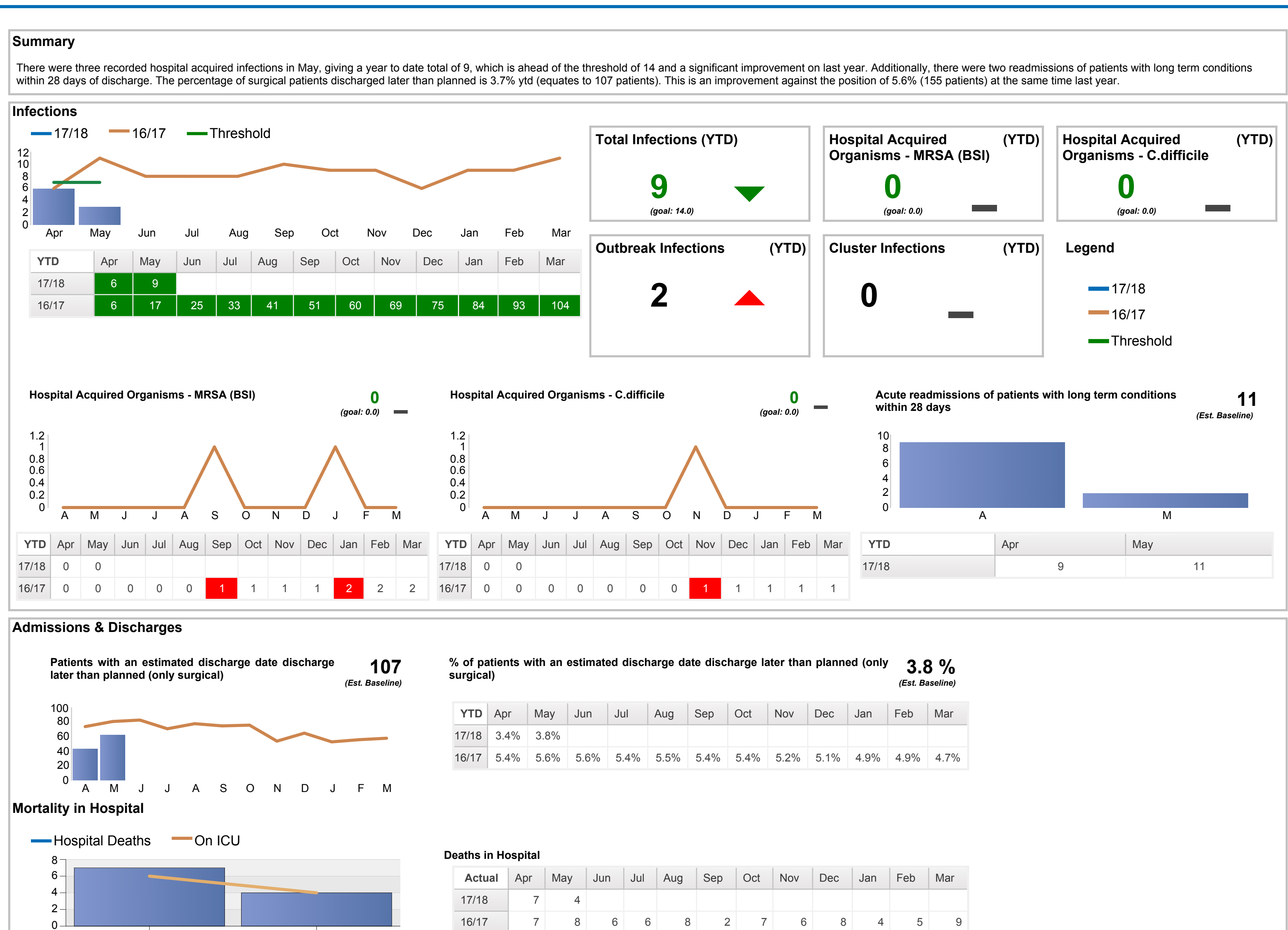


YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	85	189										
16/17	125	280	417	500	579	680	752	824	896	1,020	1,132	1,280

Clinical Effectiveness

May 2017

Alder Hey Children's NHS
NHS Foundation Trust



Summary

There were three recorded hospital acquired infections in May, giving a year to date total of 9, which is ahead of the threshold of 14 and a significant improvement on last year. Additionally, there were two readmissions of patients with long term conditions within 28 days of discharge. The percentage of surgical patients discharged later than planned is 3.7% ytd (equates to 107 patients). This is an improvement against the position of 5.6% (155 patients) at the same time last year.

Infections

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6	9										
16/17	6	17	25	33	41	51	60	69	75	84	93	104

Total Infections (YTD)
9
(goal: 14.0)

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

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

Outbreak Infections (YTD)
2

Cluster Infections (YTD)
0

Legend
17/18
16/17
Threshold

Hospital Acquired Organisms - MRSA (BSI)

0
(goal: 0.0)

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

Hospital Acquired Organisms - C.difficile

0
(goal: 0.0)

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

Acute readmissions of patients with long term conditions within 28 days

11
(Est. Baseline)

YTD	Apr	May
17/18	9	11

Admissions & Discharges

Patients with an estimated discharge date discharge later than planned (only surgical)

107
(Est. Baseline)

% of patients with an estimated discharge date discharge later than planned (only surgical)

3.8 %
(Est. Baseline)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3.4%	3.8%										
16/17	5.4%	5.6%	5.6%	5.4%	5.5%	5.4%	5.4%	5.2%	5.1%	4.9%	4.9%	4.7%

Mortality in Hospital

Deaths in Hospital

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

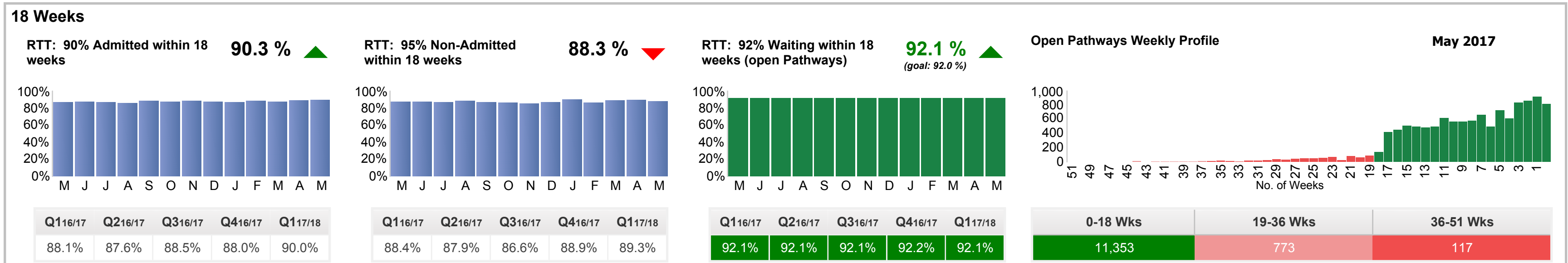
Access

May 2017

Alder Hey Children's NHS
NHS Foundation Trust

Summary

4 hour access standard, incomplete pathway, diagnostic & cancer standards achieved. Bed occupancy has increased following increased levels of elective and non-elective IP activity. GP referrals have increased in M2 to a level higher than 2016 and in line with seasonal trends with C&B available to meet current demand. Capacity being monitored via Divisions & daily bed meetings. No patients waiting greater than 52 weeks.

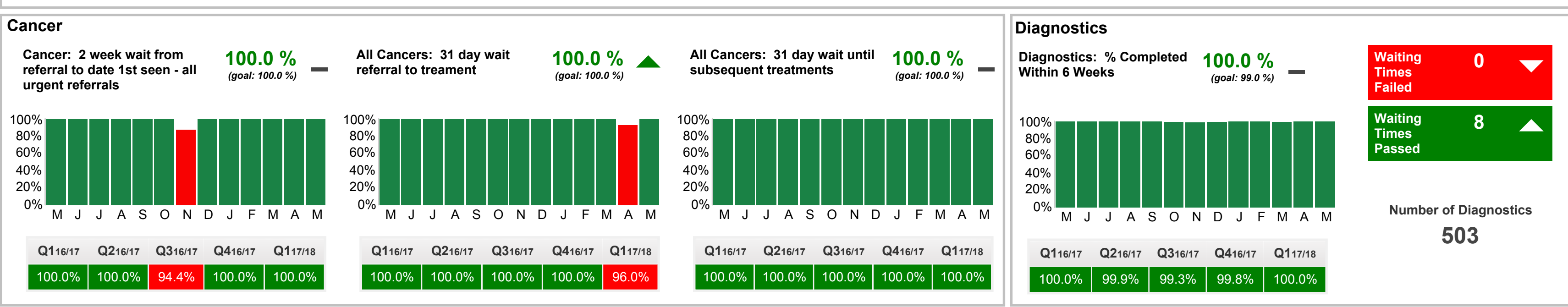


Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
88.1%	87.6%	88.5%	88.0%	90.0%

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
88.4%	87.9%	86.6%	88.9%	89.3%

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

0-18 Wks	19-36 Wks	36-51 Wks
11,353	773	117

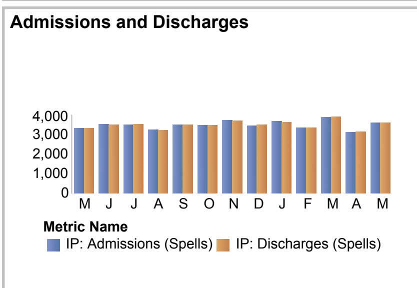


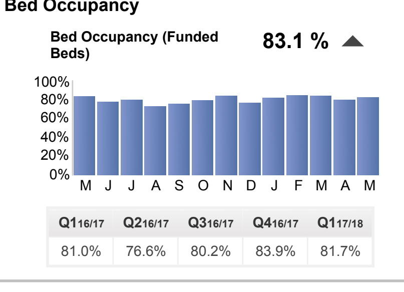
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
100.0%	100.0%	94.4%	100.0%	100.0%

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
100.0%	100.0%	100.0%	100.0%	96.0%

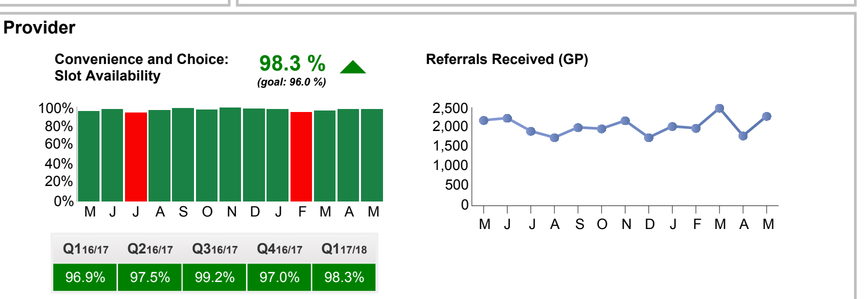
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
100.0%	100.0%	100.0%	100.0%	100.0%

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
100.0%	99.9%	99.3%	99.8%	100.0%





Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
81.0%	76.6%	80.2%	83.9%	81.7%



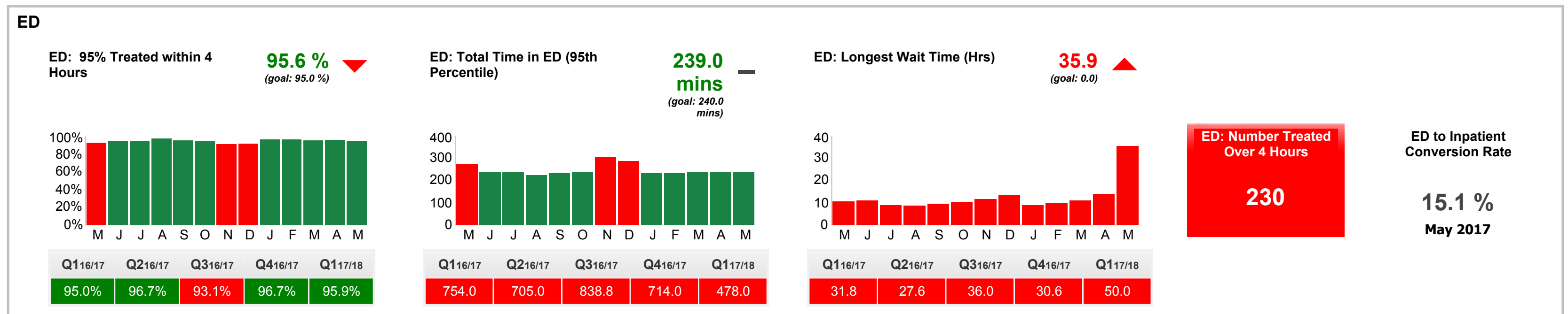
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
96.9%	97.5%	99.2%	97.0%	98.3%

Emergency Department

May 2017

Summary

The Department had an extremely challenging start to May with breaches caused by lack of flow out into the hospital as the trust escalation status increased. In addition to this a rare 12 hour breach occurred. This related to a patient requiring a specialist CAMHS inpatient facility with limited capacity nationally this resulted in the patient remaining within the department and Trust whilst provision was sort by the regional CAMHS team/commissioner.



ED: 95% Treated within 4 Hours

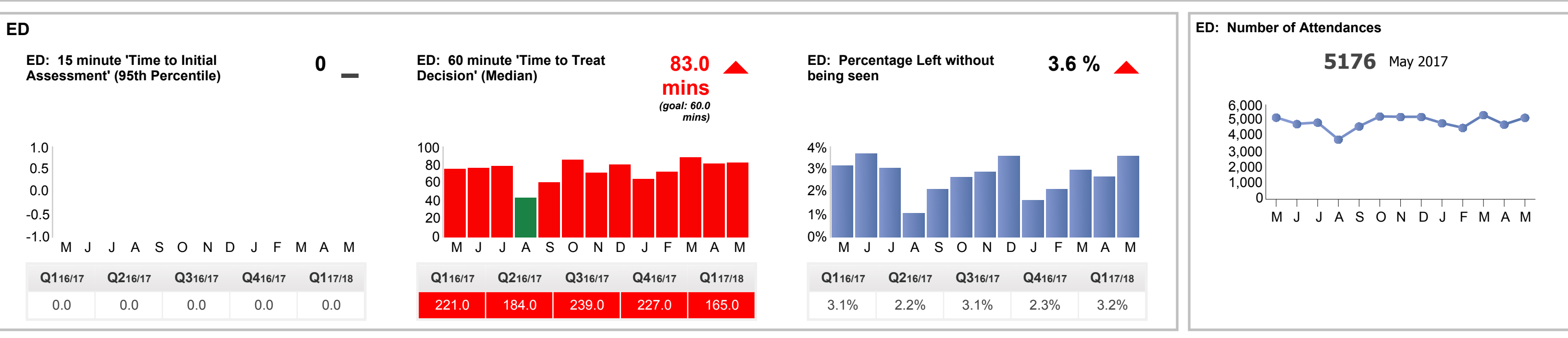
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
95.0%	96.7%	93.1%	96.7%	95.9%

ED: Total Time in ED (95th Percentile)

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
754.0	705.0	838.8	714.0	478.0

ED: Longest Wait Time (Hrs)

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
31.8	27.6	36.0	30.6	50.0



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

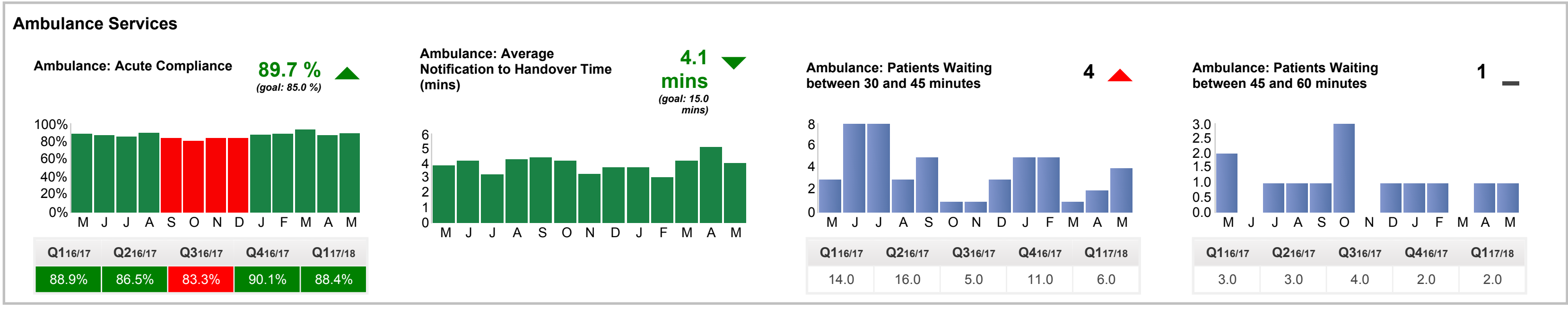
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
0.0	0.0	0.0	0.0	0.0

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

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
221.0	184.0	239.0	227.0	165.0

ED: Percentage Left without being seen

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
3.1%	2.2%	3.1%	2.3%	3.2%



Ambulance: Acute Compliance

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
88.9%	86.5%	83.3%	90.1%	88.4%

Ambulance: Patients Waiting between 30 and 45 minutes

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
14.0	16.0	5.0	11.0	6.0

Ambulance: Patients Waiting between 45 and 60 minutes

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
3.0	3.0	4.0	2.0	2.0

Productivity & Efficiency

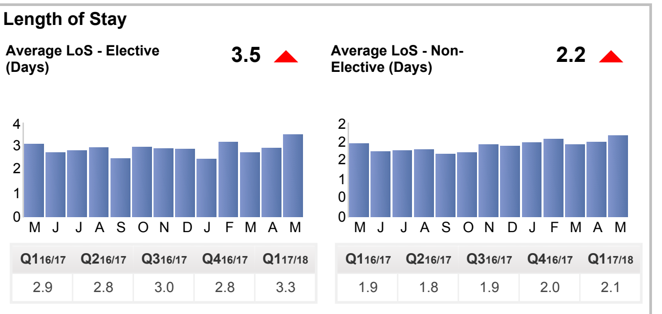
May 2017

Alder Hey Children's NHS
NHS Foundation Trust

Summary

As planned activity levels have started to increase length of stay and daycase numbers have also started to increase. However we have seen a higher than expected number of cancellations on the day due high numbers of outliers; external transfers in and the terrorist incident as we sought to support colleagues in Manchester. This will challenge 28 day relist figures also for June as we try to rebook these patients back in. Theatre and Out Patient utilisation has increased as routine operating has recommenced.

Length of Stay



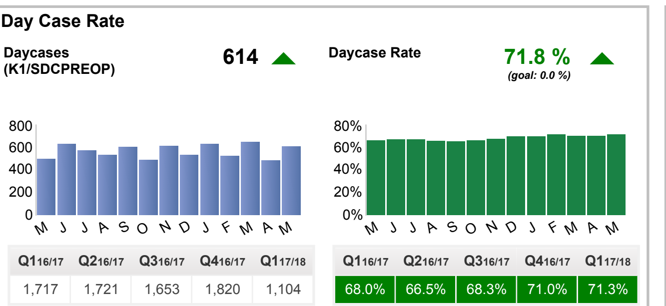
Average LoS - Elective (Days): 3.5

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
2.9	2.8	3.0	2.8	3.3

Average LoS - Non-Elective (Days): 2.2

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
1.9	1.8	1.9	2.0	2.1

Day Case Rate



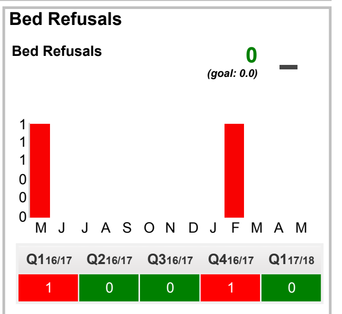
Daycases (K1/SDCPREOP): 614

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
1,717	1,721	1,653	1,820	1,104

Daycase Rate: 71.8 % (goal: 0.0 %)

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
68.0%	66.5%	68.3%	71.0%	71.3%

Bed Refusals

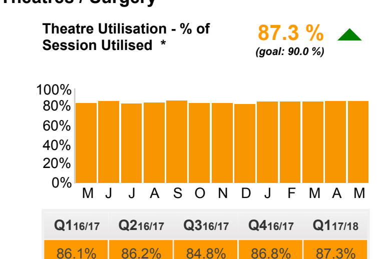


Bed Refusals: 0 (goal: 0.0)

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

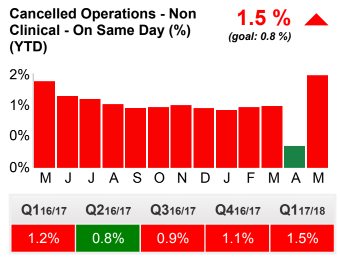
Theatres / Surgery

Theatre Utilisation - % of Session Utilised *: 87.3 % (goal: 90.0 %)



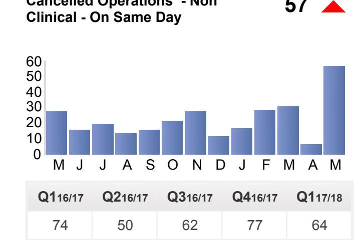
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
86.1%	86.2%	84.8%	86.8%	87.3%

Cancelled Operations - Non Clinical - On Same Day (%) (YTD): 1.5 % (goal: 0.8 %)



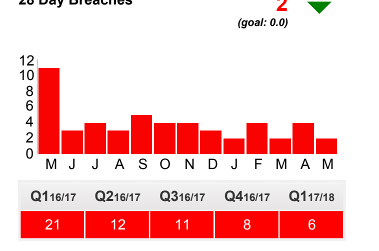
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
1.2%	0.8%	0.9%	1.1%	1.5%

Cancelled Operations - Non Clinical - On Same Day: 57



Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
74	50	62	77	64

28 Day Breaches: 2 (goal: 0.0)



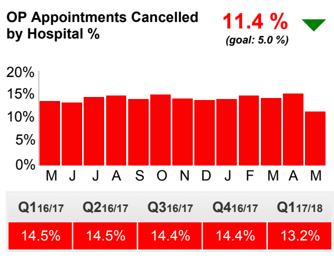
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
21	12	11	8	6

Outpatients

Clinic Session Utilisation *: 87.6 % (goal: 90.0 %)

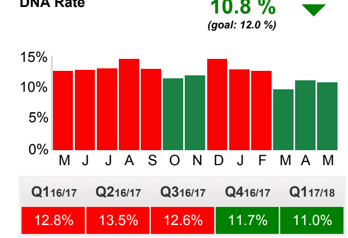
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
82.9%	89.3%	90.0%	89.4%	88.3%

OP Appointments Cancelled by Hospital %: 11.4 % (goal: 5.0 %)



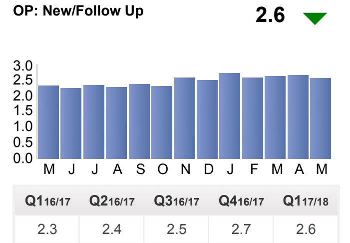
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
14.5%	14.5%	14.4%	14.4%	13.2%

DNA Rate: 10.8 % (goal: 12.0 %)



Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
12.8%	13.5%	12.6%	11.7%	11.0%

OP: New/Follow Up: 2.6



Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
2.3	2.4	2.5	2.7	2.6

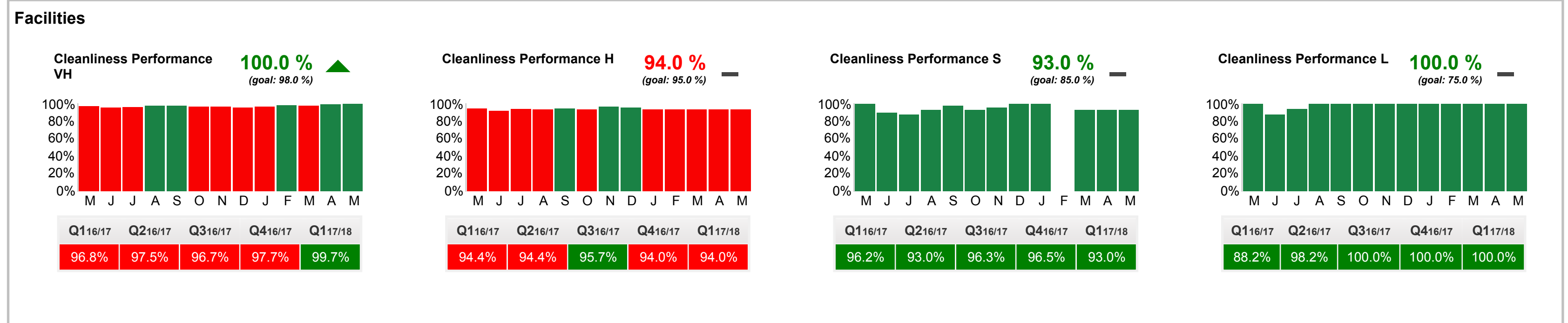
Facilities

May 2017

Summary

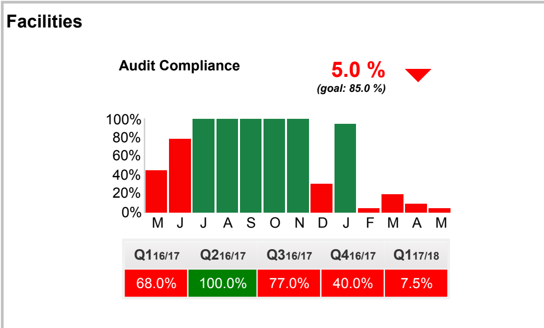
Again due to the Oganisational Change in Domestic Services, auditing during May 2017 has been very limited due to the reduced number of Domestic Supervisors. Theatres have continued to be audited thanks to the support from the Theatre department. During this period of change we will continue to focus on very high risk areas and spot check other areas when possible. Two additional supervisors have started at the beginning of June so we are hopeful to improve our audit compliance next month.

Facilities



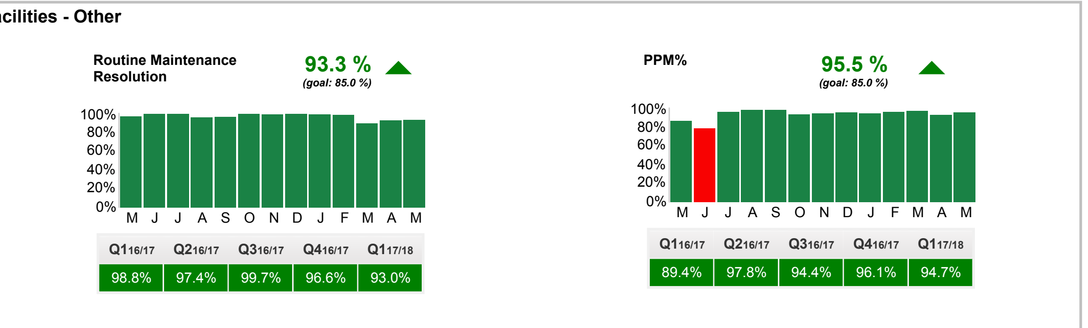
	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Cleanliness Performance VH	96.8%	97.5%	96.7%	97.7%	99.7%
Cleanliness Performance H	94.4%	94.4%	95.7%	94.0%	94.0%
Cleanliness Performance S	96.2%	93.0%	96.3%	96.5%	93.0%
Cleanliness Performance L	88.2%	98.2%	100.0%	100.0%	100.0%

Facilities



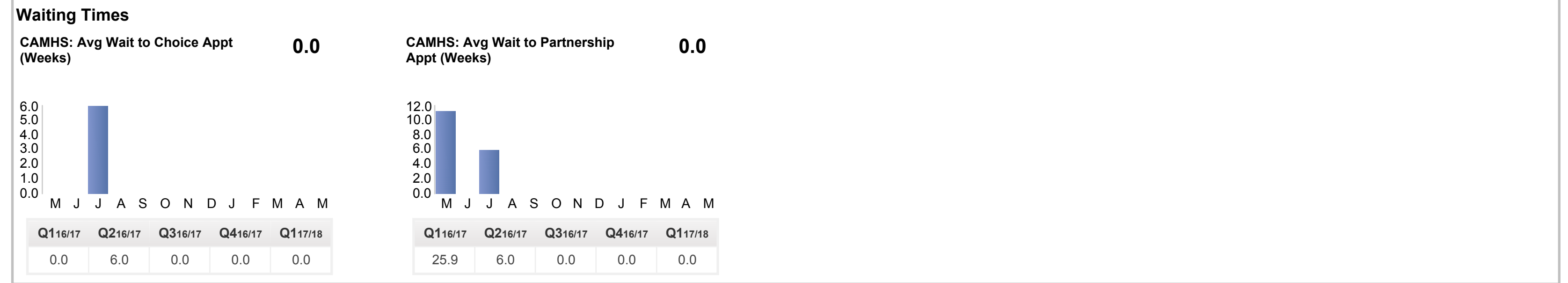
	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Audit Compliance	68.0%	100.0%	77.0%	40.0%	7.5%

Facilities - Other



	Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
Routine Maintenance Resolution	98.8%	97.4%	99.7%	96.6%	93.0%
PPM%	89.4%	97.8%	94.4%	96.1%	94.7%

May 2017

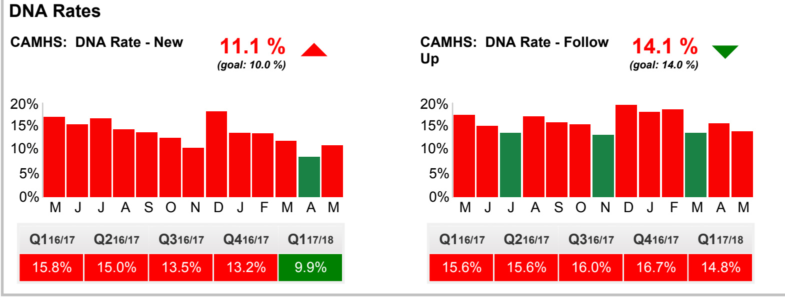


CAMHS: Avg Wait to Choice Appt (Weeks)

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
0.0	6.0	0.0	0.0	0.0

CAMHS: Avg Wait to Partnership Appt (Weeks)

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
25.9	6.0	0.0	0.0	0.0

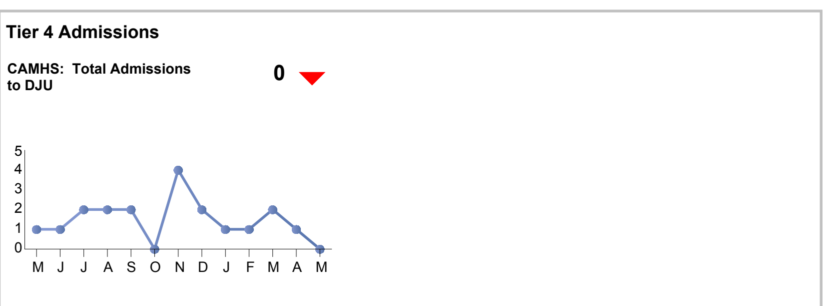


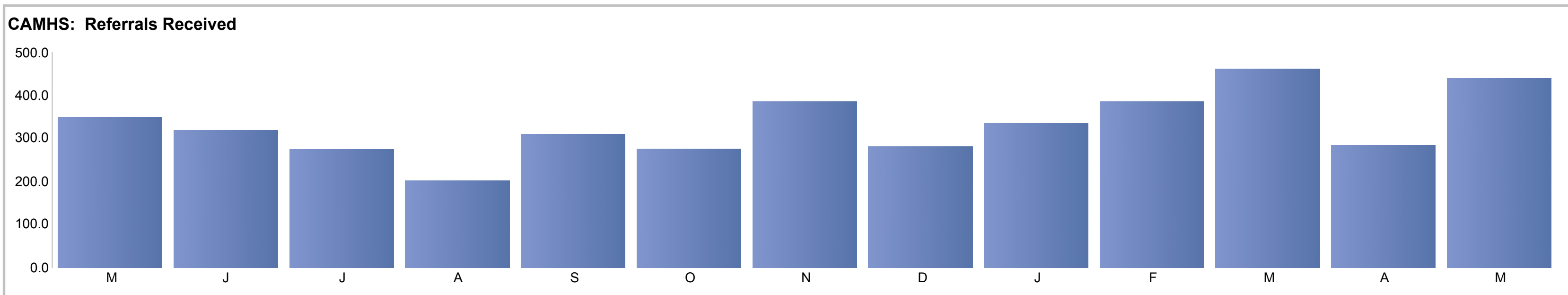
CAMHS: DNA Rate - New

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
15.8%	15.0%	13.5%	13.2%	9.9%

CAMHS: DNA Rate - Follow Up

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
15.6%	15.6%	16.0%	16.7%	14.8%





External Regulation

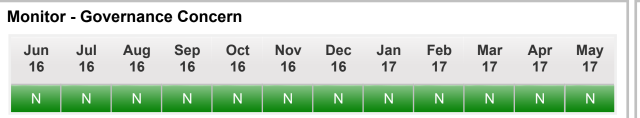
May 2017

Alder Hey Children's NHS
NHS Foundation Trust

Summary

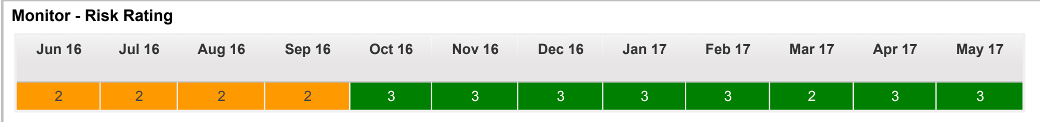
The Trust is currently rated as Good by CQC and remains registered without conditions. We are compliant with our Provider Licence and at the end of March continue to be placed in segment 2 under the new NHS Improvement Single Oversight Framework.

Monitor - Governance Concern



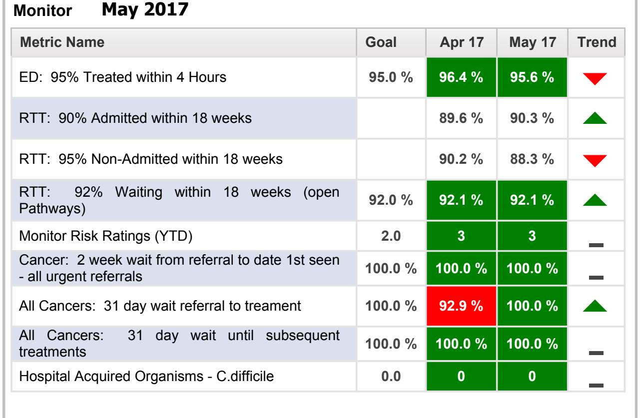
Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
N	N	N	N	N	N	N	N	N	N	N	N

Monitor - Risk Rating



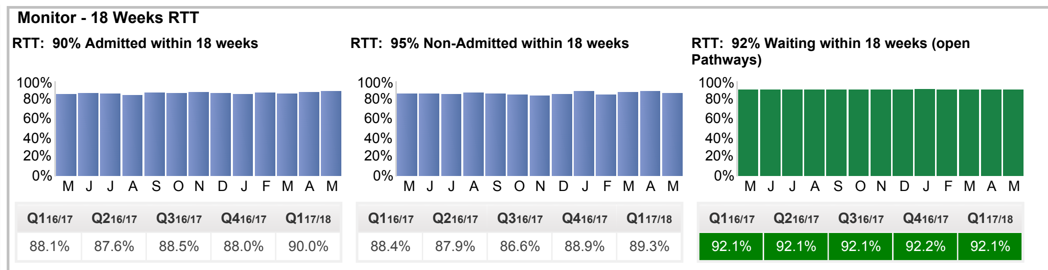
Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17
2	2	2	2	3	3	3	3	3	2	3	3

Monitor May 2017



Metric Name	Goal	Apr 17	May 17	Trend
ED: 95% Treated within 4 Hours	95.0 %	96.4 %	95.6 %	▼
RTT: 90% Admitted within 18 weeks		89.6 %	90.3 %	▲
RTT: 95% Non-Admitted within 18 weeks		90.2 %	88.3 %	▼
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.1 %	92.1 %	▲
Monitor Risk Ratings (YTD)	2.0	3	3	–
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	92.9 %	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

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
88.1%	87.6%	88.5%	88.0%	90.0%

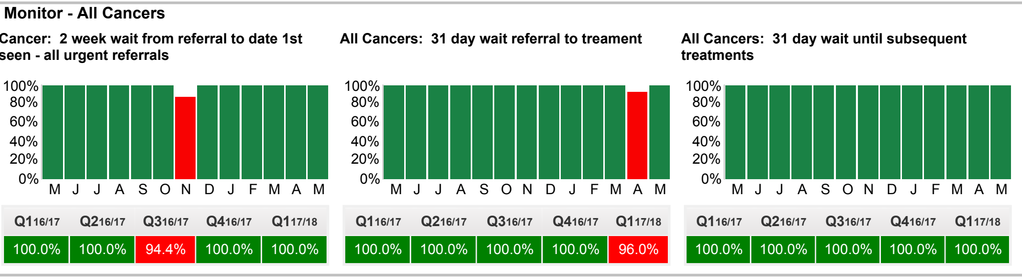
RTT: 95% Non-Admitted within 18 weeks

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
88.4%	87.9%	86.6%	88.9%	89.3%

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

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

Monitor - All Cancers



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

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
100.0%	100.0%	94.4%	100.0%	100.0%

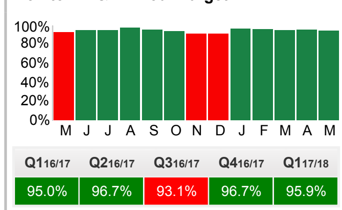
All Cancers: 31 day wait referral to treament

Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
100.0%	100.0%	100.0%	100.0%	96.0%

All Cancers: 31 day wait until subsequent treatments

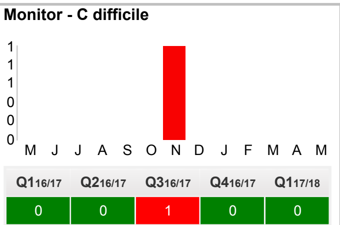
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
100.0%	100.0%	100.0%	100.0%	100.0%

Monitor - A&E 4 Hour Target



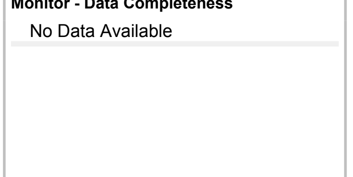
Q1 16/17	Q2 16/17	Q3 16/17	Q4 16/17	Q1 17/18
95.0%	96.7%	93.1%	96.7%	95.9%

Monitor - C difficile



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

Monitor - Data Completeness



No Data Available

Workforce

May 2017

Alder Hey Children's NHS
NHS Foundation Trust

Summary

Rates for medical appraisal have remained at 77% with the next round due to be completed in July 2017, the general PDR compliance rate is now 12.4% with all appraisals to be completed by the end of July 2017. The Trust rate of sickness absence has increased very slightly to 4.7%; with the biggest staff group increase among Healthcare Scientists (2.3%), sickness in Estates & Ancillary has fallen nearly 1% and is now below 10%. Mandatory training compliance remains static at 76% and compliance with Corporate Welcome attendance has increased to 85%. Work continues to improve all KPIs.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

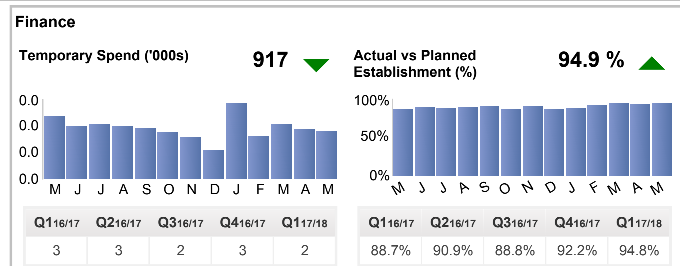
Staff Group	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Last 12 Months
Add Prof Scientific and Technic	2.2%	4.1%	3.9%	5.5%	5.0%	5.8%	5.2%	5.0%	5.9%	4.9%	3.6%	3.6%	
Additional Clinical Services	5.8%	4.8%	5.2%	6.1%	7.0%	6.9%	6.9%	6.6%	5.2%	5.5%	6.9%	7.1%	
Administrative and Clerical	4.3%	4.9%	4.6%	5.0%	5.2%	4.5%	4.7%	4.6%	5.0%	3.3%	3.0%	2.7%	
Allied Health Professionals	3.0%	3.6%	2.2%	3.4%	3.1%	3.3%	4.3%	2.3%	2.2%	3.5%	3.2%	3.8%	
Estates and Ancillary	10.0%	10.8%	9.0%	7.9%	8.4%	8.6%	10.9%	9.1%	7.3%	8.9%	10.7%	9.5%	
Healthcare Scientists	2.2%	1.9%	1.4%	2.8%	2.2%	1.9%	2.0%	1.7%	3.7%	2.3%	0.8%	3.1%	
Medical and Dental	1.9%	2.6%	3.0%	2.7%	2.7%	2.0%	1.6%	2.3%	2.4%	1.4%	1.0%	1.3%	
Nursing and Midwifery Registered	4.7%	4.8%	5.4%	5.1%	5.7%	6.2%	6.1%	6.4%	6.1%	5.5%	5.2%	5.5%	
Trust	4.6%	4.9%	4.8%	5.0%	5.4%	5.4%	5.5%	5.4%	5.2%	4.7%	4.6%	4.7%	

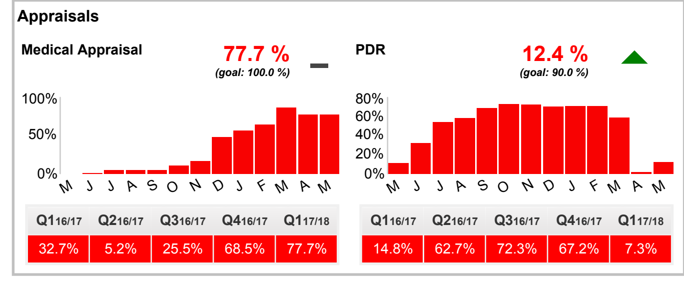
Staff in Post FTE (rolling 12 Months)

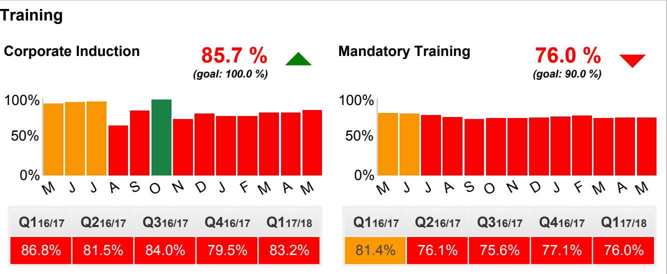
Staff Group	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Last 12 Months
Add Prof Scientific and Technic	190	191	193	196	200	199	198	198	197	201	197	201	
Additional Clinical Services	353	353	360	369	365	368	367	370	373	376	391	394	
Administrative and Clerical	542	547	551	560	568	574	573	586	588	585	612	621	
Allied Health Professionals	126	127	126	125	126	126	130	132	132	131	208	209	
Estates and Ancillary	190	191	191	192	192	190	190	189	190	190	187	186	
Healthcare Scientists	103	104	103	105	105	106	108	107	107	107	107	107	
Medical and Dental	237	234	240	248	245	246	245	245	247	243	242	245	
Nursing and Midwifery Registered	943	938	938	975	973	971	970	972	981	970	968	971	

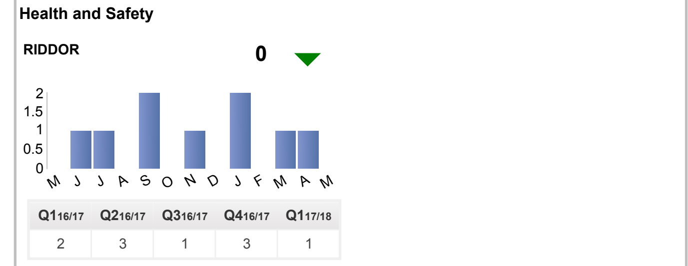
Staff in Post Headcount (rolling 12 Months)

Staff Group	Jun 16	Jul 16	Aug 16	Sep 16	Oct 16	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Last 12 Months
Add Prof Scientific and Technic	210	211	214	217	221	220	218	218	217	221	218	222	
Additional Clinical Services	417	415	422	431	430	431	430	434	439	442	469	472	
Administrative and Clerical	635	640	646	658	666	671	670	677	678	672	700	709	
Allied Health Professionals	155	156	155	154	155	155	161	163	163	161	257	258	
Estates and Ancillary	239	240	240	241	241	238	238	236	237	237	234	232	
Healthcare Scientists	113	114	112	114	114	116	118	117	117	117	117	117	
Medical and Dental	274	272	277	286	283	285	284	284	288	284	284	287	
Nursing and Midwifery Registered	1,067	1,063	1,063	1,099	1,099	1,097	1,093	1,095	1,105	1,094	1,093	1,094	









Performance by CBU

May 2017

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	81.9%	86.8%	89.1%
Convenience and Choice: Slot Availability	100.0%	96.3%	99.5%
DNA Rate (Followup Appts)	11.9%	10.9%	9.7%
DNA Rate (New Appts)	13.1%	12.0%	11.1%
Referrals Received (GP)	385	756	1,139
Temporary Spend ('000s)	103	321	402
Theatre Utilisation - % of Session Utilised		83.6%	87.9%
Trading Surplus/(Deficit)	414	110	2,930

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		3.7	3.4
Average LoS - Non-Elective (Days)		1.5	3.2
Cancelled Operations - Non Clinical - On Same Day	0	3	54
Daycases (K1/SDCPREOP)	2	70	540
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	3	18	23
OP Appointments Cancelled by Hospital %	14.8%	11.2%	11.1%
RTT: 90% Admitted within 18 weeks			90.3%
RTT: 92% Waiting within 18 weeks (open Pathways)	97.4%	94.5%	90.8%
RTT: 95% Non-Admitted within 18 weeks	85.4%	86.2%	89.8%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores			
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0
Medication Errors (Incidents)	5	56	97

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction		81.8%	90.0%
Mandatory Training	56.1%	80.0%	80.7%
PDR	5.7%	15.4%	11.2%
Sickness	5.5%	4.6%	4.7%

CBU Performance - Community

May 2017

Key Issues

Support Required

Operational

Metric Name	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	73.7%	72.5%	78.7%	78.4%	73.8%	79.5%	82.2%	76.1%	75.9%	81.0%	83.6%	80.2%	81.9%	
DNA Rate (New Appts)	14.4%	16.1%	15.9%	15.8%	12.6%	15.6%	12.8%	19.0%	15.2%	11.9%	11.5%	12.3%	13.1%	
DNA Rate (Followup Appts)	17.1%	14.9%	13.7%	16.7%	15.9%	13.9%	12.3%	17.7%	16.5%	15.6%	11.8%	13.4%	11.9%	
Convenience and Choice: Slot Availability	95.7%			92.1%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Referrals Received (GP)	345	316	264	200	313	307	393	298	269	335	384	229	385	
Temporary Spend ('000s)	116	88	85	149	144	37	60	47	77	72	150	67	103	
Trading Surplus/(Deficit)	200	317	280	371	244	355	341	415	410	256	442	343	414	

Patient

Metric Name	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	61.1%	74.2%	77.1%	80.9%	87.5%	77.4%	78.0%	80.2%	75.3%	73.1%	88.4%	87.9%	85.4%	
RTT: 92% Waiting within 18 weeks (open Pathways)	88.9%	87.1%	91.5%	89.6%	88.5%	82.5%	85.9%	92.3%	92.8%	93.1%	94.4%	94.0%	97.4%	
Average LoS - Elective (Days)							22.00							
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	1	3	12	18	29	23	29	1	9	19	8	15	3	
Daycases (K1/SDCPREOP)	0	2	0	2	0	0	0	3	0	0	0	0	2	
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 %	16.8%	21.8%	15.4%	21.7%	20.8%	19.5%	15.7%	14.2%	13.5%	19.2%	20.7%	23.3%	14.8%	
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%	100.0%										

Quality

Metric Name	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
Medication Errors (Incidents)	5	11	12	19	20	24	26	27	29	30	31	3	5	
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	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
Corporate Induction	88.9%	100.0%	100.0%	60.0%	86.7%	100.0%	72.7%	87.5%	87.5%	87.5%	100.0%	82.9%		
PDR	7.0%	38.3%	62.8%	68.3%	77.1%	82.1%	81.4%	75.4%	77.2%	76.4%	67.0%	0.0%	5.7%	
Sickness	4.9%	5.7%	5.9%	5.5%	6.2%	7.6%	8.8%	7.1%	7.1%	6.9%	5.9%	5.2%	5.5%	
Mandatory Training	75.8%	77.1%	76.0%	75.4%	73.2%	71.1%	70.9%	72.1%	75.8%	78.0%	57.1%	57.1%	56.1%	

CBU Performance - Medicine (Part 1)

May 2017

Key Issues

We are continuing to see an improved DNA rate for the division and we have had improved clinic utilisation, with significant improvements in our planned utilisation. RTT remains good and the number of hospital cancellations is reducing to get nearer to our internal target of 10%.

We are seeing improvements in corporate induction and we are working hard to increase the number of PDR's in line with the trust target of completing all by the end of July.

Support Required

None

Operational

Metric Name	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Last 12 Months
Theatre Utilisation - % of Session Utilised	77.2%	78.5%	78.0%	75.8%	85.0%	80.1%	79.1%	80.1%	82.9%	79.1%	85.4%	81.1%	83.6%	
Clinic Session Utilisation	79.4%	81.5%	85.3%	83.5%	87.2%	87.8%	89.7%	87.2%	87.5%	88.1%	91.8%	90.6%	86.8%	
DNA Rate (New Appts)	12.9%	13.6%	14.7%	17.6%	14.6%	14.8%	12.5%	14.6%	14.1%	12.6%	10.0%	14.9%	12.0%	
DNA Rate (Followup Appts)	15.5%	14.9%	16.1%	18.7%	15.4%	13.6%	16.1%	18.5%	16.3%	16.9%	10.3%	11.3%	10.9%	
Convenience and Choice: Slot Availability	96.3%	99.5%	93.6%	93.7%	99.4%	98.1%	100.0%	99.6%	96.1%	86.5%	99.4%	98.0%	96.3%	
Referrals Received (GP)	739	756	605	566	626	653	732	563	679	592	820	575	756	
Temporary Spend ('000s)	393	231	246	272	272	230	229	164	499	333	310	290	321	
Trading Surplus/(Deficit)	-13	556	-690	-307	525	321	491	212	74	-101	1,001	-299	110	

Patient

Metric Name	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	98.2%	95.2%	96.7%	95.8%	100.0%	89.6%	93.1%	87.6%	92.6%	100.0%	91.5%	96.4%		
RTT: 95% Non-Admitted within 18 weeks	88.7%	88.4%	86.8%	86.4%	85.4%	88.6%	83.2%	84.7%	92.4%	89.3%	90.9%	90.9%	86.2%	
RTT: 92% Waiting within 18 weeks (open Pathways)	96.6%	95.6%	94.3%	93.3%	93.2%	95.1%	95.9%	96.6%	96.9%	96.0%	94.8%	94.9%	94.5%	
Average LoS - Elective (Days)	3.22	2.31	2.84	3.32	2.94	3.76	3.75	3.94	4.18	3.79	3.62	4.06	3.71	
Average LoS - Non-Elective (Days)	1.47	1.25	1.28	1.28	1.29	1.27	1.52	1.49	1.41	1.64	1.56	1.58	1.55	
Hospital Initiated Clinic Cancellations < 6 weeks notice	2	0	32	14	27	22	41	29	41	37	27	20	18	
Daycases (K1/SDCPREOP)	52	89	56	68	86	52	46	65	68	62	70	58	70	
Cancelled Operations - Non Clinical - On Same Day	0	1	1	1	4	1	8	4	6	6	3	1	3	
OP Appointments Cancelled by Hospital %	12.6%	12.5%	15.0%	14.6%	13.4%	14.7%	13.6%	14.2%	14.6%	15.0%	14.0%	17.2%	11.2%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	99.5%	100.0%	76.9%	99.1%	99.5%	100.0%	99.7%	99.6%	100.0%	100.0%	

Quality

Metric Name	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Last 12 Months
Medication Errors (Incidents)	54	76	92	114	146	168	198	228	251	270	303	24	56	
Cleanliness Scores	98.3%	95.0%	94.2%	95.0%	96.5%	95.8%	97.5%	97.0%	96.8%	96.8%	99.0%			
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	1	0	0	0	1	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	May 2016	Jun 2016	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Last 12 Months
Corporate Induction	85.7%	100.0%	100.0%	69.2%	80.0%	100.0%	85.0%	83.3%	75.0%	75.0%	68.8%		81.8%	
PDR	15.2%	37.3%	75.1%	78.9%	81.6%	79.7%	79.4%	77.6%	76.7%	75.7%	69.7%	2.9%	15.4%	
Sickness	5.0%	4.4%	4.5%	4.5%	4.7%	4.9%	4.6%	4.8%	4.9%	5.2%	4.5%	4.0%	4.6%	
Mandatory Training	86.2%	85.0%	83.1%	80.1%	76.6%	76.9%	76.3%	76.4%	77.3%	79.2%	79.7%	80.1%	80.0%	

CBU Performance - Medicine (Part 2)

May 2017

Key Issues

Imaging - we have seen some deterioration in our reporting times that we are reviewing, but our waiting times are improving.
OPD Pharmacy dispensing continues to be a challenge for the organisation but the team are look at how they can improve this.
The Clinical Support Teams are also looking at the measures they feel are the most appropriate and are working with Informatics to develop specific dashboards.

Support Required

None

Patient

Metric Name	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	93.0%	89.0%	99.0%	91.0%	89.0%	96.0%	95.0%	93.0%	96.0%	97.0%	87.0%	96.0%	91.0%	
Imaging - % Reporting Turnaround Times - ED	65.0%	88.0%	93.0%	89.0%	89.0%	88.0%	87.0%	88.0%	88.0%	93.0%	90.0%	80.0%	64.0%	
Imaging - % Reporting Turnaround Times - Inpatients	75.0%	85.0%	90.0%	84.0%	85.0%	87.0%	76.0%	80.0%	86.0%	89.0%	90.0%	78.0%	74.0%	
Imaging - % Reporting Turnaround Times - Outpatients	89.0%	97.0%	97.0%	97.0%	89.0%	93.0%	93.0%	94.0%	97.0%	98.0%	94.0%	92.0%	90.0%	
Imaging - Waiting Times - MRI % under 6 weeks	92.0%	90.0%	95.0%	94.0%	90.0%	88.0%	90.0%	92.0%	92.0%	86.0%	85.0%	71.0%	81.0%	
Imaging - Waiting Times - CT % under 1 week	88.0%	85.0%	90.0%	92.0%	90.0%	86.0%	84.0%	81.0%	81.0%	77.0%	87.0%	95.0%	89.0%	
Imaging - Waiting Times - Plain Film % under 24 hours	95.0%	94.0%	90.0%	94.0%	95.0%	95.0%	94.0%	94.0%	94.0%	92.0%	93.0%	93.0%	94.0%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	89.0%	87.0%	90.0%	89.0%	88.0%	86.0%	85.0%	83.0%	83.0%	81.0%	87.0%	84.0%	88.0%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	100.0%	89.0%	95.0%	81.0%	91.0%	85.0%	100.0%	88.0%	88.0%	84.0%	93.0%	88.0%	95.0%	
BME - High Risk Equipment PPM Compliance	90.0%	90.0%	89.7%	90.0%	90.0%	90.4%	89.7%	93.0%	91.0%	91.1%	88.0%	80.2%	91.7%	
BME - Low Risk Equipment PPM Compliance	80.0%	79.0%	77.0%	80.0%	78.0%	77.0%	79.0%	80.0%	81.0%	80.8%	79.0%	100.0%	82.0%	
BME - Equipment Pool - Equipment Availability	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	100.0%	99.8%	100.0%	100.0%	91.4%	99.8%	
Pharmacy - Dispensing for Out Patients - Routine	64.0%	56.0%	66.0%	64.0%	44.0%	45.0%	50.0%	51.0%	55.0%	50.0%	45.0%	57.0%	37.0%	
Pharmacy - Dispensing for Out Patients - Complex	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	97.7%	98.0%	100.0%	98.0%	98.0%	98.0%	100.0%	
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%	63.0%	63.0%	63.0%	

Quality

Metric Name	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	86.6%	86.6%	90.5%	90.0%	91.3%	90.2%	89.0%	87.9%	87.5%	88.7%	87.9%	89.7%	89.9%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	99.3%	99.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Reporting times for perinatal autopsies in 56 Calendar Days	90.0%	100.0%	82.0%	83.0%	100.0%	94.7%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	
Blood Traceability Compliance	99.8%	99.9%	98.4%	100.0%	99.5%	100.0%	99.6%	99.8%	99.7%	98.8%	99.6%	99.4%	100.0%	

CBU Performance - Surgery

May 2017

Alder Hey Children's
NHS Foundation Trust

Key Issues

We are focused on the delivery of PDRs and are publishing weekly performance information by department. We will be providing a need-based support session to teams who have not delivered 50% of PDRs to staff by the 19 June 2017. As at 12 June 2017 the rate of PDRs had increased to >30%.
Clinic utilisation is low and we are prioritising the roll-out of a new booking system which is easier for patients to obtain an appointment to clinic. The pilot of the new system commenced in May for cardiology and we will complete an initial evaluation of the change in June.

Support Required

Implement a corporate solution for electronic PDRs which are integrated with our staff record to ensure data reporting and accuracy is not an inhibitor to recording completion of PDRs.
Expedite the switch from partial booking to new booking system.

Operational

Metric Name	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
Theatre Utilisation - % of Session Utilised	86.6%	89.2%	85.7%	87.6%	88.3%	86.0%	86.1%	84.8%	87.2%	88.5%	87.1%	88.3%	87.9%	
Clinic Session Utilisation	85.0%	85.0%	94.8%	93.5%	92.6%	93.4%	95.2%	89.8%	90.3%	90.8%	93.1%	90.2%	89.1%	
DNA Rate (New Appts)	10.4%	10.9%	10.9%	12.1%	11.3%	10.1%	11.7%	13.2%	12.5%	11.9%	9.7%	10.2%	11.1%	
DNA Rate (Followup Appts)	9.7%	11.0%	11.2%	11.9%	10.6%	8.7%	9.0%	11.0%	8.8%	9.4%	8.2%	9.9%	9.7%	
Convenience and Choice: Slot Availability	96.7%	98.3%	95.4%	99.6%	99.1%	97.4%	100.0%	98.7%	100.0%	99.8%	95.3%	98.2%	99.5%	
Referrals Received (GP)	1,091	1,159	1,030	970	1,055	1,001	1,042	875	1,073	1,047	1,280	977	1,139	
Temporary Spend ('000s)	520	474	529	436	453	529	426	331	504	475	443	516	402	
Trading Surplus/(Deficit)	1,888	2,106	2,704	1,992	1,921	1,806	2,721	1,539	2,008	2,181	2,821	1,826	2,930	

Patient

Metric Name	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
RTT: 90% Admitted within 18 weeks	85.5%	87.0%	86.2%	85.4%	87.7%	87.9%	88.9%	88.1%	86.8%	87.0%	87.2%	86.9%	90.3%	
RTT: 95% Non-Admitted within 18 weeks	90.3%	89.5%	88.8%	90.8%	88.7%	87.0%	88.6%	89.7%	92.8%	88.1%	89.1%	90.1%	89.8%	
RTT: 92% Waiting within 18 weeks (open Pathways)	90.9%	91.3%	91.2%	91.9%	92.0%	92.1%	91.3%	90.4%	90.6%	90.6%	90.9%	90.9%	90.8%	
Average LoS - Elective (Days)	3.04	2.91	2.88	2.86	2.36	2.71	2.74	2.58	2.08	2.88	2.54	2.50	3.44	
Average LoS - Non-Elective (Days)	2.81	2.85	2.85	2.58	2.37	2.68	2.70	2.64	3.07	2.89	2.64	2.84	3.17	
Hospital Initiated Clinic Cancellations < 6 weeks notice	11	27	24	45	56	34	72	20	30	54	22	19	23	
Daycases (K1/SDCPREOP)	447	540	518	463	515	442	570	471	562	462	582	425	540	
Cancelled Operations - Non Clinical - On Same Day	28	15	19	13	12	21	20	8	11	23	28	6	54	
OP Appointments Cancelled by Hospital %	14.1%	13.0%	14.1%	14.3%	13.8%	14.8%	14.4%	13.7%	14.0%	14.1%	13.5%	13.1%	11.1%	
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	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
Medication Errors (Incidents)	93	147	184	233	264	295	336	367	396	430	477	40	97	
Cleanliness Scores	95.6%	93.7%	95.1%	96.6%	96.6%	95.1%	97.9%	96.0%	96.1%	96.2%	97.7%			
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	1	0	0	0	0	0	0	

Workforce

Metric Name	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Last 12 Months
Corporate Induction	100.0%	88.9%	100.0%	64.0%	85.7%	100.0%	65.2%	71.4%	71.4%	71.4%	94.1%		90.0%	
PDR	16.1%	38.4%	48.4%	51.4%	64.2%	63.4%	63.3%	61.1%	63.4%	64.2%	45.1%	1.9%	11.2%	
Sickness	4.4%	4.0%	4.7%	5.2%	5.7%	5.7%	5.9%	5.5%	5.6%	4.9%	4.4%	4.6%	4.7%	
Mandatory Training	87.5%	87.3%	83.7%	78.5%	75.0%	75.3%	75.7%	77.0%	77.5%	78.7%	79.3%	80.6%	80.7%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended May 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	4,079	3,779	(299)	7,539	6,854	(685)	47,582	47,582	0
Non Elective	2,438	2,804	366	4,822	5,290	467	29,184	29,184	0
Outpatients	2,420	2,495	75	4,497	4,496	(1)	28,757	28,757	0
A&E	551	520	(31)	1,068	974	(94)	6,036	6,036	0
Critical Care	2,182	2,250	69	4,226	4,462	236	25,222	25,222	0
Non PbR Drugs & Devices	1,847	2,090	243	3,548	4,233	685	21,243	21,243	0
Excess Bed Days	388	698	310	776	1,088	311	4,658	4,658	0
CQUIN	261	271	10	522	532	10	3,134	3,134	0
Contract Sanctions	(10)	(10)	0	(21)	(21)	0	(125)	(125)	0
Private Patients	15	18	4	29	18	(11)	176	176	0
Other Clinical Income	2,983	3,035	52	6,032	6,280	247	38,474	38,474	0
Non Clinical Income									
Other Non Clinical Income	1,847	2,031	185	3,746	4,131	384	24,636	24,636	0
Total Income	18,999	19,982	983	36,786	38,337	1,551	228,977	228,977	0
Expenditure									
Pay Costs	(12,173)	(12,354)	(181)	(24,332)	(24,672)	(340)	(144,181)	(144,181)	0
Drugs	(1,638)	(2,100)	(462)	(3,221)	(4,127)	(906)	(19,292)	(19,292)	0
Clinical Supplies	(1,577)	(1,638)	(61)	(3,090)	(3,084)	6	(18,568)	(18,568)	0
Other Non Pay	(2,376)	(2,504)	(128)	(4,746)	(5,259)	(513)	(25,895)	(25,895)	0
PFI service costs	(329)	(310)	19	(658)	(617)	41	(3,948)	(3,948)	0
Total Expenditure	(18,093)	(18,907)	(813)	(36,046)	(37,758)	(1,712)	(211,884)	(211,884)	0
EBITDA	905	1,075	170	740	579	(161)	17,092	17,092	0
PDC Dividend	(114)	(114)	0	(228)	(228)	0	(1,365)	(1,365)	0
Depreciation	(527)	(495)	32	(1,054)	(991)	64	(6,409)	(6,409)	0
Finance Income	0	2	1	1	3	2	5	5	0
Interest Expense (non-PFI/LIFT)	(90)	(89)	0	(176)	(176)	0	(1,087)	(1,087)	0
Interest Expense (PFI/LIFT)	(675)	(675)	0	(1,350)	(1,350)	0	(8,098)	(8,098)	0
MASS/Restructuring	0	(153)	(153)	0	(195)	(195)	0	0	0
Gains/(Losses) on asset disposals	0	3	3	0	3	3	0	0	0
Control Total Surplus / (Deficit)	(500)	(447)	53	(2,067)	(2,353)	(287)	138	138	0
One-off normalising items									
Government Grants/Donated Income	701	427	(274)	2,449	665	(1,784)	12,750	12,750	0
Depreciation on Donated Assets	(173)	(170)	3	(346)	(339)	7	(2,089)	(2,089)	0
Normalised Surplus/(Deficit)	28	(190)	(218)	36	(2,028)	(2,064)	10,799	10,799	0
Fixed Asset Impairment	0	0	0	0	0	0	(1,536)	(1,536)	0
Reported Surplus/(Deficit)	28	(190)	(218)	36	(2,028)	(2,064)	9,263	9,263	0

Key Metrics	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income £000	18,999	19,982	983	36,786	38,337	1,551	228,977	228,977	0
Expenditure £000	(19,498)	(20,429)	(930)	(38,853)	(40,691)	(1,837)	(228,839)	(228,839)	0
Control Total Surplus/(Deficit) £000	(500)	(447)	53	(2,067)	(2,353)	(287)	138	138	0
WTE	3,142	3,053	(89)	3,142	3,053	(89)			
CIP £000	281	350	69	560	577	17	8,000	5,616	(2,384)
Cash £000	3,301	5,243	1,942	3,301	5,243	1,942			
CAPEX FCT £000	1,543	710	833	4,013	1,317	2,696	29,092	29,092	0
Use of Resources Risk Rating	3	3	0	3	3	0	3	3	0

Activity Volumes	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Elective	2,490	2,265	(225)	4,635	4,230	(405)	29,307	29,307	0
Non Elective	1,137	1,315	178	2,279	2,479	200	13,769	13,769	0
Outpatients	17,567	18,558	991	32,694	34,134	1,440	206,735	206,735	0
A&E	5,153	5,167	14	9,995	9,899	(96)	56,463	56,463	0

Alder Hey Children's NHS Foundation Trust

CAPITAL PROGRAMME 2017/18

	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	FULL YEAR ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	REVISED BUDGET INC SLIPPAGE	FULL YEAR FORECAST	FULL YEAR VAR TO REV BUDGET
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ESTATES	**128**	**200**	**(72)**	**256**	**489**	**(233)**	**1,536**	**1,536**	**1,536**	**0**
RESEARCH & EDUCATION	**568**	**221**	**347**	**2,247**	**428**	**1,819**	**13,120**	**13,120**	**13,120**	**0**
ESTATES TOTAL CAPITAL	**696**	**422**	**274**	**2,503**	**917**	**1,586**	**14,656**	**14,656**	**14,656**	**0**
GDE, NETWORKING, INFRASTRUCTURE & OTHER IT	250	4	246	500	9	**491**	3,431	3,431	3,431	0
ELECTRONIC PATIENT RECORD	0	43	(43)	0	73	**(73)**	604	604	604	0
IM & T TOTAL CAPITAL	**250**	**47**	**203**	**500**	**82**	**418**	**4,035**	**4,035**	**4,035**	**0**
MEDICAL EQUIPMENT	204	205	(1)	409	237	**172**	1,529	1,529	1,529	0
NON-MEDICAL EQUIPMENT	210	0	210	300	0	**300**	340	340	340	0
CHILDRENS HEALTH PARK	183	29	154	301	74	**227**	5,347	5,347	5,347	0
ALDER HEY IN THE PARK TOTAL	**597**	**235**	**362**	**1,010**	**311**	**699**	**7,216**	**7,216**	**7,216**	**0**
OTHER	0	7	(7)	0	7	**(7)**	3,185	3,185	3,185	0
OTHER	**0**	**7**	**(7)**	**0**	**7**	**(7)**	**3,185**	**3,185**	**3,185**	**0**
CAPITAL PROGRAMME 17/18	***1,543***	***710***	***833***	***4,013***	***1,317***	***2,696***	***29,092***	***29,092***	***29,092***	***0***

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	Anaesthetics	Outpatient New	3	5	2	£2,431	£3,690	£1,259	£3	£1,256
		Outpatient Follow-up	102	53	-49	£12,487	£39,112	£26,625	£32,648	-£6,023
	Anaesthetics Total		**106**	**58**	**-48**	**£14,917**	**£42,802**	**£27,884**	**£32,652**	**-£4,767**
	Audiology	Daycase	3	4	1	£2,930	£3,515	£585	-£1	£586
		Non Elective	0	2	2	£0	£1,758	£1,758	£0	£1,758
		Outpatient New	506	792	286	£48,027	£75,155	£27,128	£50	£27,078
		Outpatient Follow-up	373	320	-53	£35,285	£30,273	-£5,012	£28	-£5,040
		OP Procedure	1	0	-1	£127	£0	-£127	£0	-£127
	Audiology Total		**884**	**1,118**	**234**	**£86,369**	**£110,702**	**£24,333**	**£77**	**£24,255**
	Burns Care	Daycase	5	2	-3	£5,608	£1,609	-£3,999	-£590	-£3,409
		Elective	2	0	-2	£5,807	£0	-£5,807	£0	-£5,807
		Non Elective	25	15	-10	£165,590	£86,499	-£79,091	-£12,153	-£66,938
		Outpatient New	15	11	-4	£2,962	£1,983	-£978	-£196	-£782
		Outpatient Follow-up	69	40	-29	£13,770	£7,934	-£5,837	£7	-£5,844
		Ward Attender	31	38	7	£6,240	£7,537	£1,296	£6	£1,290
		Ward Based Outpatient	3	16	13	£689	£3,173	£2,484	£3	£2,481
		OP Procedure	0	6	6	£5	£727	£722	-£22	£743
	Burns Care Total		**151**	**128**	**-23**	**£200,673**	**£109,462**	**-£91,210**	**-£12,946**	**-£78,265**
	Cardiac Surgery	Elective	26	29	3	£424,947	£542,166	£117,219	£76,175	£41,044
		Non Elective	12	10	-2	£321,070	£320,122	-£949	£46,633	-£47,581
		Excess Bed Days	75	6	-69	£38,217	£4,717	-£33,500	£1,673	-£35,173
		Outpatient New	9	14	5	£6,546	£10,090	£3,544	£9	£3,535
		Outpatient Follow-up	46	50	4	£33,010	£36,036	£3,026	£32	£2,993
		Ward Attender	0	4	4	£0	£2,883	£2,883	£0	£2,883
	Cardiac Surgery Total		**168**	**113**	**-55**	**£823,790**	**£916,013**	**£92,223**	**£124,522**	**-£32,300**
	Cardiology	Daycase	21	21	-0	£56,709	£54,668	-£2,041	-£1,619	-£422
		Elective	22	11	-11	£70,278	£27,741	-£42,537	-£7,796	-£34,740
		Non Elective	11	13	2	£43,627	£70,599	£26,971	£19,038	£7,934
		Excess Bed Days	20	3	-17	£9,256	£1,608	-£7,648	£208	-£7,856
		Outpatient New	186	148	-38	£37,743	£30,010	-£7,732	-£34	-£7,699
		Outpatient Follow-up	535	560	25	£66,933	£69,879	£2,946	-£230	£3,176
		Ward Attender	51	45	-6	£6,592	£5,615	-£977	-£187	-£789
		Ward Based Outpatient	9	10	1	£1,091	£1,248	£157	-£0	£157
		OP Imaging	610	622	12	£54,409	£55,498	£1,089	£18	£1,070
	Cardiology Total		**1,464**	**1,433**	**-31**	**£346,638**	**£316,867**	**-£29,771**	**£9,398**	**-£39,168**
	Dentistry	Daycase	127	113	-14	£76,562	£69,232	-£7,330	£917	-£8,247
		Elective	3	1	-2	£3,192	£1,491	-£1,701	£429	-£2,131
		Non Elective	1	1	-0	£993	£7,001	£6,008	£6,131	-£123
		Outpatient New	127	97	-30	£4,541	£3,454	-£1,087	-£1	-£1,086
		Outpatient Follow-up	118	120	2	£4,209	£4,273	£64	-£3	£67
		OP Procedure	32	37	5	£4,240	£4,556	£316	-£369	£684
	Dentistry Total		**408**	**369**	**-39**	**£93,737**	**£90,006**	**-£3,731**	**£7,104**	**-£10,835**
	ENT	Daycase	129	106	-23	£133,666	£121,300	-£12,366	£11,421	-£23,786
		Elective	97	61	-36	£129,715	£84,530	-£45,185	£2,638	-£47,823
		Non Elective	24	21	-3	£32,745	£39,981	£7,236	£10,746	-£3,510
		Excess Bed Days	28	3	-25	£11,330	£1,160	-£10,170	-£64	-£10,105
		Outpatient New	418	392	-26	£51,158	£48,915	-£2,243	£920	-£3,162
		Outpatient Follow-up	389	385	-4	£24,469	£24,454	-£14	£249	-£264
		OP Procedure	267	296	29	£32,894	£37,181	£4,287	£729	£3,558
	ENT Total		**1,351**	**1,264**	**-87**	**£415,977**	**£357,522**	**-£58,455**	**£26,638**	**-£85,094**
	Gynaecology	Daycase	2	1	-1	£1,172	£735	-£437	£142	-£579
		Elective	1	4	3	£1,405	£5,099	£3,694	£839	£2,856
		Outpatient New	37	38	1	£6,126	£6,283	£157	-£0	£157
		Outpatient Follow-up	51	48	-3	£3,632	£3,394	-£238	£0	-£238
	Gynaecology Total		**92**	**91**	**-1**	**£12,335**	**£15,512**	**£3,177**	**£980**	**£2,197**
	Intensive Care	Non Elective	17	21	4	£92,871	£201,029	£108,159	£85,496	£22,663
		Excess Bed Days	21	0	-21	£13,115	£0	-£13,115	£0	-£13,115
		Outpatient Follow-up	0	1	1	£0	£0	£0	£0	£0
		PICU	554	630	76	£977,430	£1,051,023	£73,593	£0	£73,593
		HDU	382	456	74	£454,931	£493,613	£38,682	£0	£38,682
		Cardiac HDU	247	251	4	£238,388	£243,618	£5,231	£0	£5,231
		Cardiac ECMO	13	0	-13	£45,104	£34,218	-£10,886	£0	-£10,886
		Respiratory ECMO	8	11	4	£49,790	£63,377	£13,587	£0	£13,587
	Intensive Care Total		**1,240**	**1,370**	**130**	**£1,871,627**	**£2,086,878**	**£215,251**	**£85,496**	**£129,755**
	Maxillo-Facial	Outpatient New	58	93	35	£8,816	£15,408	£6,591	£1,151	£5,441
		Outpatient Follow-up	62	74	12	£11,167	£15,868	£4,702	£2,518	£2,184
		Ward Attender	0	1	1	£6	£146	£139	-£0	£139
		OP Procedure	1	0	-1	£128	£0	-£128	£0	-£128
	Maxillo-Facial Total		**121**	**168**	**47**	**£20,117**	**£31,422**	**£11,305**	**£3,669**	**£7,636**
	Neurosurgery	Daycase	1	4	3	£1,916	£3,219	£1,302	-£3,859	£5,162
		Elective	24	23	-1	£218,455	£243,879	£25,424	£32,835	-£7,411
		Non Elective	25	38	13	£212,292	£256,151	£43,859	-£61,393	£105,252
		Excess Bed Days	25	53	28	£14,978	£17,146	£2,168	-£14,087	£16,255
		Outpatient New	68	66	-2	£6,023	£5,879	-£144	£5	-£149
		Outpatient Follow-up	175	207	32	£15,591	£17,725	£2,134	-£698	£2,832
		Ward Attender	51	29	-22	£4,507	£2,583	-£1,924	£2	-£1,926
		Ward Based Outpatient	2	0	-2	£155	£0	-£155	£0	-£155
		Neuro HDU	217	196	-21	£195,356	£185,946	-£9,410	£0	-£9,410
	Neurosurgery Total		**588**	**616**	**28**	**£669,272**	**£732,527**	**£63,255**	**-£47,195**	**£110,450**
	Ophthalmology	Daycase	36	43	7	£43,536	£49,716	£6,181	-£2,868	£9,049
		Elective	5	1	-4	£9,786	£2,584	-£7,202	£437	-£7,640
		Non Elective	2	2	0	£3,291	£1,577	-£1,714	-£2,413	£699
		Outpatient New	313	239	-74	£52,544	£34,591	-£17,953	-£5,580	-£12,373
		Outpatient Follow-up	1,140	1,221	81	£90,715	£81,570	-£9,145	-£15,609	£6,464
		OP Procedure	20	49	29	£5,913	£6,162	£249	-£8,011	£8,260
	Ophthalmology Total		**1,515**	**1,555**	**40**	**£205,784**	**£176,201**	**-£29,584**	**-£34,044**	**£4,461**
	Oral Surgery	Daycase	26	24	-2	£22,864	£17,777	-£5,087	-£3,034	-£2,053
		Elective	16	14	-2	£55,983	£38,559	-£17,423	-£11,766	-£5,657
		Non Elective	10	7	-3	£10,351	£15,054	£4,702	£7,630	-£2,928
	Oral Surgery Total		**52**	**45**	**-7**	**£89,198**	**£71,390**	**-£17,808**	**-£7,170**	**-£10,638**
	Orthodontics	Outpatient New	6	8	2	£951	£1,298	£347	-£0	£347
		Outpatient Follow-up	30	66	36	£2,154	£4,762	£2,608	£9	£2,599
		OP Procedure	22	0	-22	£2,493	£0	-£2,493	£0	-£2,493

In-Month

	Orthodontics Total		**58**	**74**	**16**	**£5,597**	**£6,059**	**£462**	**£9**	**£453**
	Paediatric Surgery	Daycase	145	120	-25	£157,059	£141,060	-£15,999	£10,672	-£26,671
		Elective	42	44	2	£143,623	£134,198	-£9,425	-£15,070	£5,645
		Non Elective	126	155	29	£351,650	£357,274	£5,623	-£74,652	£80,275
		Excess Bed Days	126	127	1	£57,431	£54,046	-£3,385	-£4,060	£675
		Outpatient New	190	175	-15	£32,435	£29,844	-£2,591	-£2	-£2,588
		Outpatient Follow-up	298	239	-59	£34,363	£27,463	-£6,900	-£63	-£6,837
		Ward Attender	83	64	-19	£9,535	£7,321	-£2,214	-£5	-£2,210
		Ward Based Outpatient	11	8	-3	£1,252	£915	-£337	-£0	-£337
		OP Procedure	0	0	-0	£0	£0	-£0	£0	£0
		Neonatal HDU	11	41	30	£132,920	£238,733	£105,813	£0	£105,813
	Paediatric Surgery Total		**1,032**	**973**	**-59**	**£920,268**	**£990,854**	**£70,585**	**-£83,179**	**£153,764**
	Plastic Surgery	Daycase	85	99	14	£94,135	£129,396	£35,260	£19,938	£15,322
		Elective	11	6	-5	£16,468	£7,467	-£9,001	-£1,271	-£7,730
		Non Elective	86	106	20	£141,159	£185,851	£44,691	£12,671	£32,020
		Excess Bed Days	11	19	9	£6,344	£11,546	£5,203	£67	£5,136
		Outpatient New	250	388	138	£34,041	£52,047	£18,006	-£802	£18,809
		Outpatient Follow-up	427	410	-17	£45,319	£43,487	-£1,832	-£2	-£1,830
		Ward Attender	10	31	21	£1,073	£3,288	£2,215	-£0	£2,215
		Ward Based Outpatient	2	10	8	£220	£955	£734	-£106	£840
		OP Procedure	124	205	81	£15,489	£26,049	£10,559	£508	£10,052
	Plastic Surgery Total		**1,007**	**1,274**	**267**	**£354,248**	**£460,085**	**£105,837**	**£31,003**	**£74,834**
	Spinal Surgery	Daycase	1	0	-1	£684	£0	-£684	£0	-£684
		Elective	13	13	-0	£387,274	£254,693	-£132,580	-£126,355	-£6,226
		Non Elective	0	1	1	£0	£22,325	£22,325	£0	£22,325
		Outpatient New	38	47	9	£7,891	£9,677	£1,786	-£0	£1,787
		Outpatient Follow-up	83	90	7	£6,326	£6,919	£593	£74	£519
	Spinal Surgery Total		**135**	**151**	**16**	**£402,174**	**£293,614**	**-£108,560**	**-£126,281**	**£17,721**
	Trauma And Orthopaedics	Daycase	44	35	-9	£84,511	£67,667	-£16,844	£504	-£17,348
		Elective	63	58	-5	£263,234	£250,575	-£12,659	£6,399	-£19,058
		Non Elective	51	55	4	£139,051	£145,199	£6,148	-£5,213	£11,361
		Excess Bed Days	31	67	36	£14,423	£32,070	£17,647	£814	£16,833
		Outpatient New	735	891	156	£117,219	£140,017	£22,797	-£1,990	£24,787
		Outpatient Follow-up	1,568	1,465	-103	£146,745	£135,205	-£11,540	-£1,919	-£9,621
		Ward Attender	2	0	-2	£167	£0	-£167	£0	-£167
		OP Procedure	224	263	39	£27,635	£32,536	£4,901	£58	£4,843
		Gait New	31	23	-8	£36,203	£26,959	-£9,244	£0	-£9,244
		Gait Follow-Up	27	28	1	£31,323	£32,819	£1,496	£0	£1,496
	Trauma And Orthopaedics Total		**2,775**	**2,885**	**110**	**£860,512**	**£863,047**	**£2,535**	**-£1,347**	**£3,882**
	Urology	Daycase	200	247	47	£179,913	£237,887	£57,974	£15,239	£42,735
		Elective	13	10	-3	£40,008	£53,733	£13,725	£22,354	-£8,629
		Non Elective	3	4	1	£7,808	£8,541	£733	-£1,303	£2,036
		Excess Bed Days	13	2	-11	£6,748	£1,196	-£5,552	£124	-£5,676
		Outpatient New	101	98	-3	£14,935	£14,471	-£465	-£1	-£464
		Outpatient Follow-up	205	211	6	£20,055	£20,625	£570	-£1	£570
		Ward Attender	4	19	15	£386	£1,857	£1,471	£0	£1,471
		Ward Based Outpatient	7	0	-7	£702	£0	-£702	£0	-£702
		OP Procedure	17	41	24	£3,936	£9,380	£5,443	-£43	£5,486
	Urology Total		**563**	**632**	**69**	**£274,493**	**£347,690**	**£73,198**	**£36,369**	**£36,828**
Surgery CBU Total			**13,711**	**14,317**	**606**	**£7,667,727**	**£8,018,652**	**£350,925**	**£45,755**	**£305,170**
Medicine CBU	Accident & Emergency	Daycase	0	0	-0	£192	£0	-£192	£0	-£192
		Elective	0	0	-0	£115	£0	-£115	£0	-£115
		Non Elective	303	328	25	£210,606	£233,081	£22,476	£5,472	£17,003
		Excess Bed Days	3	0	-3	£1,161	£0	-£1,161	£0	-£1,161
		Outpatient New	216	153	-63	£72,769	£51,711	-£21,058	£47	-£21,105
		Outpatient Follow-up	23	9	-14	£7,631	£3,042	-£4,589	£3	-£4,592
		Ward Based Outpatient	1	0	-1	£197	£0	-£197	£0	-£197
		A&E Attendance	5,153	5,167	14	£550,875	£510,781	-£40,094	-£41,596	£1,502
	Accident & Emergency Total		**5,699**	**5,657**	**-42**	**£843,545**	**£798,615**	**-£44,931**	**-£36,074**	**-£8,857**
	Allergy	Daycase	34	19	-15	£18,689	£8,272	-£10,417	-£2,172	-£8,245
		Outpatient New	77	96	19	£16,470	£20,719	£4,249	£54	£4,195
		Outpatient Follow-up	102	117	15	£13,930	£16,070	£2,140	£131	£2,009
		Ward Based Outpatient	0	0	-0	£42	£0	-£42	£0	-£42
		OP Procedure	0	0	-0	£48	£0	-£48	£0	-£48
	Allergy Total		**213**	**232**	**19**	**£49,178**	**£45,061**	**-£4,117**	**-£1,986**	**-£2,130**
	Dermatology	Daycase	2	9	7	£1,567	£6,037	£4,469	-£1,160	£5,630
		Outpatient New	168	189	21	£23,183	£26,139	£2,956	-£2	£2,957
		Outpatient Follow-up	371	335	-36	£33,231	£29,958	-£3,272	-£34	-£3,238
		Ward Attender	0	0	-0	£4	£0	-£4	£0	-£4
		Ward Based Outpatient	5	13	8	£414	£1,163	£749	£0	£749
		OP Procedure	299	402	103	£34,865	£44,938	£10,073	-£1,980	£12,053
	Dermatology Total		**844**	**948**	**104**	**£93,264**	**£108,235**	**£14,971**	**-£3,176**	**£18,146**
	Diabetes	Outpatient New	31	0	-31	£6,229	£0	-£6,229	£0	-£6,229
		Outpatient Follow-up	3	2	-1	£541	£354	-£187	-£0	-£187
		Ward Attender	0	2	2	£0	£354	£354	£0	£354
		Ward Based Outpatient	0	0	-0	£7	£0	-£7	£0	-£7
	Diabetes Total		**34**	**4**	**-30**	**£6,777**	**£707**	**-£6,070**	**-£0**	**-£6,070**
	Endocrinology	Daycase	96	91	-5	£73,585	£69,795	-£3,790	-£194	-£3,596
		Elective	8	3	-5	£9,198	£4,324	-£4,874	£759	-£5,633
		Non Elective	2	2	0	£5,816	£5,220	-£596	-£1,665	£1,069
		Excess Bed Days	27	69	42	£11,830	£32,600	£20,770	£2,274	£18,496
		Outpatient New	68	71	3	£20,579	£21,632	£1,053	-£1	£1,054
		Outpatient Follow-up	299	348	49	£45,645	£52,855	£7,210	-£274	£7,484
		Ward Attender	19	4	-15	£2,940	£603	-£2,337	-£0	-£2,337
		Ward Based Outpatient	110	92	-18	£16,519	£13,872	-£2,646	-£0	-£2,646
	Endocrinology Total		**628**	**680**	**52**	**£186,113**	**£200,903**	**£14,789**	**£899**	**£13,891**
	Epilepsy	Outpatient New	12	12	0	£2,986	£3,045	£59	-£0	£59
		Outpatient Follow-up	27	16	-11	£5,425	£3,178	-£2,247	-£0	-£2,247
	Epilepsy Total		**39**	**28**	**-11**	**£8,411**	**£6,223**	**-£2,188**	**-£0**	**-£2,188**
	Gastroenterology	Daycase	149	135	-14	£106,406	£109,441	£3,035	£12,877	-£9,842
		Elective	42	21	-21	£58,373	£28,124	-£30,249	-£751	-£29,498
		Non Elective	9	9	-0	£28,119	£26,929	-£1,191	-£158	-£1,033
		Excess Bed Days	104	161	57	£48,527	£70,675	£22,149	-£4,388	£26,536
		Outpatient New	106	95	-11	£24,641	£22,189	-£2,452	£94	-£2,547
		Outpatient Follow-up	331	295	-36	£48,229	£42,946	-£5,282	-£3	-£5,279
		Ward Attender	26	4	-22	£3,817	£582	-£3,235	-£0	-£3,235
		Ward Based Outpatient	91	99	8	£13,263	£14,413	£1,150	-£0	£1,151

In-Month

	Gastroenterology Total		**859**	**819**	**-40**	**£331,375**	**£315,299**	**-£16,075**	**£7,672**	**-£23,748**
	Haematology	Daycase	25	58	33	£19,394	£43,108	£23,713	-£2,562	£26,276
		Elective	3	9	6	£14,138	£48,731	£34,593	£7,595	£26,999
		Non Elective	11	16	5	£14,147	£41,228	£27,080	£21,074	£6,007
		Excess Bed Days	3	2	-1	£879	£955	£76	£353	-£276
		Outpatient New	23	30	7	£10,195	£13,508	£3,313	-£1	£3,313
		Outpatient Follow-up	62	74	12	£13,135	£15,621	£2,485	-£1	£2,486
		Ward Attender	177	217	40	£37,359	£45,809	£8,450	-£0	£8,450
		Ward Based Outpatient	0	0	-0	£63	£0	-£63	£0	-£63
		OP Procedure	0	0	-0	£27	£0	-£27	£0	-£27
	Haematology Total		**304**	**406**	**102**	**£109,337**	**£208,959**	**£99,622**	**£26,457**	**£73,165**
	Immunology	Daycase	4	3	-1	£1,924	£1,151	-£773	-£498	-£275
		Outpatient New	13	21	8	£2,853	£4,575	£1,722	£54	£1,668
		Outpatient Follow-up	10	50	40	£1,366	£7,055	£5,688	£243	£5,445
		Ward Attender	5	16	11	£686	£2,180	£1,494	-£0	£1,494
		Ward Based Outpatient	16	24	8	£2,191	£3,270	£1,079	-£0	£1,079
	Immunology Total		**48**	**114**	**66**	**£9,020**	**£18,230**	**£9,210**	**-£200**	**£9,410**
	LTV	Outpatient New	10	11	2	£6,736	£7,380	£644	-£420	£1,064
		Outpatient Follow-up	42	78	36	£29,119	£54,609	£25,490	£98	£25,392
	LTV Total		**51**	**89**	**38**	**£35,855**	**£61,989**	**£26,134**	**-£322**	**£26,455**
	Metabolic Disease	Outpatient New	5	1	-4	£1,990	£384	-£1,606	£0	-£1,606
		Outpatient Follow-up	28	19	-9	£10,930	£7,303	-£3,626	£6	-£3,633
		Ward Based Outpatient	3	0	-3	£1,056	£0	-£1,056	£0	-£1,056
	Metabolic Disease Total		**36**	**20**	**-16**	**£13,976**	**£7,688**	**-£6,288**	**£7**	**-£6,295**
	Nephrology	Daycase	140	146	6	£250,771	£234,158	-£16,613	-£26,499	£9,886
		Elective	32	40	8	£34,356	£23,131	-£11,225	-£19,283	£8,057
		Non Elective	4	8	4	£12,484	£16,411	£3,927	-£8,184	£12,110
		Excess Bed Days	17	1	-16	£8,513	£387	-£8,127	-£121	-£8,005
		Outpatient New	16	34	18	£1,931	£4,017	£2,087	£4	£2,083
		Outpatient Follow-up	147	161	14	£17,347	£19,024	£1,677	£18	£1,659
		Ward Attender	70	4	-66	£8,233	£473	-£7,761	£0	-£7,761
		Ward Based Outpatient	55	34	-21	£6,484	£4,017	-£2,466	£4	-£2,470
	Nephrology Total		**482**	**428**	**-54**	**£340,119**	**£301,617**	**-£38,502**	**-£54,061**	**£15,560**
	Neurology	Daycase	27	14	-13	£29,797	£16,455	-£13,343	£1,068	-£14,410
		Elective	6	10	4	£11,542	£18,594	£7,052	£339	£6,714
		Non Elective	9	10	1	£46,877	£34,898	-£11,979	-£19,425	£7,446
		Excess Bed Days	81	76	-5	£49,084	£46,186	-£2,898	£179	-£3,077
		Outpatient New	93	104	11	£25,875	£27,751	£1,876	-£1,082	£2,958
		Outpatient Follow-up	247	265	18	£68,345	£65,770	-£2,575	-£7,703	£5,128
		Ward Attender	14	28	14	£3,982	£7,770	£3,788	£8	£3,780
		Ward Based Outpatient	19	1	-18	£5,134	£278	-£4,856	£0	-£4,857
	Neurology Total		**496**	**508**	**12**	**£240,636**	**£217,701**	**-£22,934**	**-£26,617**	**£3,683**
	Oncology	Daycase	187	94	-93	£178,201	£64,798	-£113,403	-£24,582	-£88,821
		DCHEMO	143	173	30	£47,679	£57,524	£9,846	£0	£9,846
		Elective	30	19	-11	£115,343	£77,723	-£37,620	£5,787	-£43,407
		Non Elective	51	54	3	£103,012	£114,960	£11,948	£5,046	£6,901
		Excess Bed Days	58	2	-56	£26,779	£774	-£26,006	-£155	-£25,850
		Outpatient New	10	10	-0	£2,717	£2,592	-£125	£2	-£128
		Outpatient Follow-up	232	268	36	£60,049	£69,466	£9,416	£24	£9,392
		Ward Attender	52	109	57	£13,437	£28,253	£14,816	£25	£14,791
		Ward Based Outpatient	10	21	11	£2,485	£5,443	£2,958	£5	£2,953
	Oncology Total		**773**	**750**	**-23**	**£549,703**	**£421,533**	**-£128,170**	**-£13,847**	**-£114,323**
	Paediatrics	Daycase	16	2	-14	£8,590	£2,010	-£6,580	£911	-£7,490
		Elective	1	5	4	£726	£12,277	£11,551	£8,113	£3,438
		Non Elective	301	421	120	£349,439	£477,041	£127,603	-£11,453	£139,056
		Excess Bed Days	86	173	87	£35,027	£103,038	£68,011	£32,172	£35,839
		Outpatient New	320	324	4	£68,941	£69,742	£801	-£3	£804
		Outpatient Follow-up	527	478	-49	£71,738	£65,114	-£6,624	-£4	-£6,620
		Ward Attender	10	1	-9	£1,313	£136	-£1,177	-£0	-£1,177
		Ward Based Outpatient	43	15	-28	£5,842	£2,043	-£3,799	-£0	-£3,799
		OP Procedure	0	0	-0	£32	£0	-£32	£0	-£32
	Paediatrics Total		**1,303**	**1,419**	**116**	**£541,647**	**£731,402**	**£189,755**	**£29,736**	**£160,019**
	Radiology	Daycase	117	105	-12	£152,413	£120,346	-£32,067	-£16,178	-£15,889
		Elective	20	8	-12	£36,746	£11,689	-£25,057	-£3,231	-£21,826
		Non Elective	2	3	1	£25,525	£20,288	-£5,237	-£10,411	£5,174
		Excess Bed Days	24	0	-24	£11,551	£0	-£11,551	£0	-£11,551
		OP Imaging	942	960	19	£124,966	£127,465	£2,499	£43	£2,456
	Radiology Total		**1,105**	**1,076**	**-29**	**£351,201**	**£279,789**	**-£71,413**	**-£29,776**	**-£41,636**
	Respiratory Medicine	Daycase	10	19	9	£13,406	£22,752	£9,345	-£2,093	£11,438
		Elective	11	9	-2	£18,802	£18,956	£154	£3,907	-£3,753
		Non Elective	50	9	-41	£105,634	£25,318	-£80,316	£6,370	-£86,686
		Excess Bed Days	23	32	9	£13,351	£22,566	£9,215	£4,321	£4,894
		Outpatient New	78	83	5	£20,187	£21,529	£1,343	-£83	£1,426
		Outpatient Follow-up	257	311	54	£36,897	£44,629	£7,732	-£3	£7,735
		Ward Attender	4	1	-3	£543	£144	-£399	-£0	-£399
		Ward Based Outpatient	142	42	-100	£20,446	£6,027	-£14,419	-£0	-£14,419
		OP Procedure	61	0	-61	£13,045	£0	-£13,045	£0	-£13,045
	Respiratory Medicine Total		**637**	**506**	**-131**	**£242,312**	**£161,921**	**-£80,390**	**£12,420**	**-£92,810**
	Rheumatology	Daycase	178	159	-19	£112,990	£103,462	-£9,527	£2,480	-£12,007
		Elective	21	6	-15	£27,105	£8,149	-£18,956	£298	-£19,255
		Non Elective	2	4	2	£2,642	£4,767	£2,125	-£2,171	£4,296
		Excess Bed Days	26	7	-19	£10,695	£2,708	-£7,987	-£228	-£7,759
		Outpatient New	57	76	19	£8,626	£9,032	£406	-£2,399	£2,805
		Outpatient Follow-up	203	245	42	£30,480	£15,506	-£14,975	-£21,275	£6,300
		Ward Attender	16	7	-9	£2,408	£1,054	-£1,354	£1	-£1,355
		Ward Based Outpatient	11	5	-6	£1,636	£753	-£883	£1	-£883
		OP Procedure	0	0	-0	£17	£0	-£17	£0	-£17
	Rheumatology Total		**513**	**509**	**-4**	**£196,598**	**£145,430**	**-£51,168**	**-£23,293**	**-£27,875**
	Sleep Studies	Elective	26	14	-12	£31,243	£17,473	-£13,770	£320	-£14,090
	Sleep Studies Total		**26**	**14**	**-12**	**£31,243**	**£17,473**	**-£13,770**	**£320**	**-£14,090**
Medicine CBU Total			**14,090**	**14,207**	**117**	**£4,180,309**	**£4,048,774**	**-£131,535**	**-£111,841**	**-£19,693**
Community CBU	CAMHS	Elective	0	0	-0	£306	£0	-£306	£0	-£306
		Outpatient New	200	170	-30	£0	£0	£0	£0	£0
		Outpatient Follow-up	999	1,579	580	£13,409	£8,449	-£4,959	-£12,748	£7,789
	CAMHS Total		**1,199**	**1,749**	**550**	**£13,715**	**£8,449**	**-£5,265**	**-£12,748**	**£7,483**
	Community Medicine	Outpatient New	380	318	-62	£30,789	£12,354	-£18,434	-£13,404	-£5,031
		Outpatient Follow-up	746	684	-62	£3,768	£3,447	-£320	-£5	-£315

In-Month

Community CBU	Community Medicine	Ward Attender	2	0	-2	£0	£0	£0	£0	£0
		OP Procedure	0	0	-0	£15	£0	-£15	£0	-£15
	Community Medicine Total		**1,129**	**1,002**	**-127**	**£34,571**	**£15,802**	**-£18,769**	**-£13,409**	**-£5,360**
Community CBU Total			**2,328**	**2,751**	**423**	**£48,285**	**£24,251**	**-£24,034**	**-£26,157**	**£2,123**
Grand Total			**30,129**	**31,275**	**1,146**	**£11,896,321**	**£12,091,677**	**£195,356**	**-£92,244**	**£287,600**

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	Anaesthetics	Outpatient New	7	9	2	£4,861	£6,642	£1,781	£6	£1,774
		Outpatient Follow-up	205	83	-122	£24,973	£60,513	£35,539	£50,390	-£14,851
	Anaesthetics Total		**211**	**92**	**-119**	**£29,834**	**£67,154**	**£37,320**	**£50,396**	**-£13,077**
	Audiology	Daycase	7	4	-3	£5,860	£3,515	-£2,345	-£1	-£2,344
		Non Elective	0	2	2	£0	£1,758	£1,758	£0	£1,758
		Outpatient New	941	1,476	535	£89,274	£140,070	£50,796	£101	£50,696
		Outpatient Follow-up	694	592	-102	£65,589	£56,006	-£9,583	£53	-£9,636
		OP Procedure	2	1	-1	£236	£88	-£148	-£11	-£136
	Audiology Total		**1,644**	**2,075**	**431**	**£160,959**	**£201,437**	**£40,479**	**£141**	**£40,337**
	Burns Care	Daycase	9	3	-6	£10,424	£2,737	-£7,687	-£562	-£7,125
		Elective	3	1	-2	£10,795	£4,148	-£6,647	£828	-£7,475
		Non Elective	50	32	-18	£326,293	£198,344	-£127,949	-£12,114	-£115,835
		Outpatient New	28	20	-8	£5,505	£3,768	-£1,737	-£195	-£1,542
		Outpatient Follow-up	129	79	-50	£25,597	£15,471	-£10,126	-£185	-£9,941
		Ward Attender	59	83	24	£11,600	£16,462	£4,862	£14	£4,848
		Ward Based Outpatient	6	36	30	£1,282	£7,140	£5,859	£6	£5,853
		OP Procedure	0	26	26	£10	£3,192	£3,183	-£52	£3,235
	Burns Care Total		**284**	**280**	**-4**	**£391,505**	**£251,263**	**-£140,242**	**-£12,259**	**-£127,983**
	Cardiac Surgery	Elective	49	49	-0	£789,902	£942,920	£153,019	£155,557	-£2,538
		Non Elective	23	21	-2	£631,930	£585,770	-£46,160	£11,443	-£57,603
		Excess Bed Days	151	43	-108	£76,433	£28,273	-£48,160	£6,459	-£54,619
		Outpatient New	17	22	5	£12,167	£15,856	£3,688	£14	£3,674
		Outpatient Follow-up	85	93	8	£61,360	£67,026	£5,666	£60	£5,606
		Ward Attender	0	4	4	£0	£2,883	£2,883	£0	£2,883
	Cardiac Surgery Total		**325**	**232**	**-93**	**£1,571,792**	**£1,642,728**	**£70,936**	**£173,534**	**-£102,598**
	Cardiology	Daycase	39	33	-6	£105,413	£85,383	-£20,029	-£3,069	-£16,961
		Elective	40	35	-5	£130,634	£98,606	-£32,028	-£14,468	-£17,560
		Non Elective	22	27	5	£85,867	£130,914	£45,046	£23,825	£21,222
		Excess Bed Days	40	24	-16	£18,512	£10,820	-£7,692	-£380	-£7,311
		Outpatient New	346	278	-68	£70,157	£56,371	-£13,786	-£63	-£13,723
		Outpatient Follow-up	994	1,080	86	£124,416	£134,766	£10,350	-£444	£10,794
		Ward Attender	95	71	-24	£12,254	£8,860	-£3,394	-£295	-£3,098
		Ward Based Outpatient	16	19	3	£2,027	£2,371	£344	-£0	£344
		OP Procedure	0	1	1	£0	£185	£185	£0	£185
		OP Imaging	1,220	1,156	-64	£108,819	£103,161	-£5,658	£51	-£5,709
	Cardiology Total		**2,812**	**2,724**	**-88**	**£658,099**	**£631,437**	**-£26,662**	**£5,156**	**-£31,818**
	Dentistry	Daycase	235	214	-21	£142,315	£132,865	-£9,451	£3,489	-£12,939
		Elective	6	1	-5	£5,933	£1,491	-£4,443	£429	-£4,872
		Non Elective	2	2	-0	£1,954	£7,624	£5,670	£5,885	-£215
		Outpatient New	237	204	-33	£8,441	£7,264	-£1,178	-£3	-£1,175
		Outpatient Follow-up	220	227	7	£7,823	£8,047	£224	-£41	£265
		OP Procedure	59	73	14	£7,882	£9,040	£1,158	-£676	£1,834
	Dentistry Total		**759**	**721**	**-38**	**£174,349**	**£166,329**	**-£8,020**	**£9,083**	**-£17,102**
	ENT	Daycase	240	185	-55	£248,461	£201,521	-£46,939	£9,751	-£56,691
		Elective	180	124	-56	£241,118	£166,265	-£74,853	-£204	-£74,649
		Non Elective	46	50	4	£64,448	£89,960	£25,511	£20,354	£5,158
		Excess Bed Days	56	20	-36	£22,661	£5,693	-£16,967	-£2,473	-£14,495
		Outpatient New	777	639	-138	£95,094	£79,737	-£15,357	£1,499	-£16,856
		Outpatient Follow-up	723	707	-16	£45,483	£44,879	-£604	£430	-£1,034
		OP Procedure	497	576	79	£61,145	£71,344	£10,199	£410	£9,790
	ENT Total		**2,518**	**2,301**	**-217**	**£778,409**	**£659,399**	**-£119,010**	**£29,766**	**-£148,777**
	Gynaecology	Daycase	4	4	0	£2,179	£2,542	£364	£168	£196
		Elective	2	4	2	£2,612	£5,099	£2,487	£839	£1,649
		Outpatient New	69	50	-19	£11,386	£8,267	-£3,119	-£0	-£3,119
		Outpatient Follow-up	95	86	-9	£6,751	£6,081	-£670	£0	-£670
	Gynaecology Total		**170**	**144**	**-26**	**£22,928**	**£21,990**	**-£938**	**£1,007**	**-£1,945**
	Intensive Care	Non Elective	33	36	3	£182,788	£342,618	£159,831	£144,561	£15,270
		Excess Bed Days	39	235	196	£24,378	£98,717	£74,339	-£47,488	£121,827
		Outpatient Follow-up	0	4	4	£0	£738	£738	£0	£738
		PICU	1,108	1,218	111	£1,954,861	£2,032,306	£77,446	£0	£77,446
		HDU	764	851	87	£909,861	£962,190	£52,329	£0	£52,329
		Cardiac HDU	493	480	-13	£476,775	£471,412	-£5,363	£0	-£5,363
		Cardiac ECMO	25	7	-18	£90,207	£80,889	-£9,318	£0	-£9,318
		Respiratory ECMO	15	43	28	£99,580	£205,815	£106,236	£0	£106,236
	Intensive Care Total		**2,477**	**2,874**	**397**	**£3,738,449**	**£4,194,685**	**£456,236**	**£97,073**	**£359,163**
	Maxillo-Facial	Outpatient New	107	145	38	£16,388	£23,623	£7,235	£1,394	£5,840
		Outpatient Follow-up	115	112	-3	£20,757	£24,021	£3,264	£3,815	-£551
		Ward Attender	0	1	1	£11	£146	£134	-£0	£134
		OP Procedure	2	0	-2	£237	£0	-£237	£0	-£237
	Maxillo-Facial Total		**224**	**258**	**34**	**£37,394**	**£47,789**	**£10,395**	**£5,209**	**£5,186**
	Neurosurgery	Daycase	2	8	6	£3,562	£8,359	£4,798	-£5,796	£10,594
		Elective	44	45	1	£406,069	£399,167	-£6,902	-£13,746	£6,843
		Non Elective	50	53	3	£417,832	£344,445	-£73,387	-£98,445	£25,058
		Excess Bed Days	51	75	24	£29,956	£26,405	-£3,551	-£17,792	£14,241
		Outpatient New	126	123	-3	£11,195	£10,956	-£239	£9	-£248
		Outpatient Follow-up	326	360	34	£28,981	£31,085	£2,104	-£955	£3,059
		Ward Attender	94	65	-29	£8,378	£5,790	-£2,588	£5	-£2,593
		Ward Based Outpatient	3	0	-3	£288	£0	-£288	£0	-£288
		Neuro HDU	434	381	-53	£390,711	£366,855	-£23,856	£0	-£23,856
	Neurosurgery Total		**1,130**	**1,110**	**-20**	**£1,296,972**	**£1,193,062**	**-£103,910**	**-£136,720**	**£32,810**
	Ophthalmology	Daycase	66	81	15	£80,925	£100,639	£19,714	£1,584	£18,129
		Elective	8	4	-4	£18,190	£10,531	-£7,659	£1,946	-£9,605
		Non Elective	3	3	-0	£6,478	£2,055	-£4,423	-£3,931	-£492
		Excess Bed Days	0	1	1	£0	£574	£574	£0	£574
		Outpatient New	581	462	-119	£97,669	£66,824	-£30,846	-£10,829	-£20,016
		Outpatient Follow-up	2,119	2,406	287	£168,623	£160,347	-£8,276	-£31,147	£22,871
		OP Procedure	38	107	69	£10,991	£17,158	£6,167	-£13,792	£19,959
	Ophthalmology Total		**2,816**	**3,064**	**248**	**£382,877**	**£358,127**	**-£24,750**	**-£56,169**	**£31,419**
	Oral Surgery	Daycase	49	46	-3	£42,500	£34,194	-£8,306	-£5,693	-£2,613
		Elective	29	22	-7	£104,062	£70,058	-£34,004	-£9,025	-£24,979
		Non Elective	19	20	1	£20,374	£27,980	£7,606	£6,770	£836
	Oral Surgery Total		**97**	**88**	**-9**	**£166,936**	**£132,233**	**-£34,703**	**-£7,948**	**-£26,755**
	Orthodontics	Outpatient New	11	16	5	£1,768	£2,595	£828	-£0	£828
		Outpatient Follow-up	56	117	61	£4,004	£8,421	£4,417	-£4	£4,421
		OP Procedure	41	13	-28	£4,633	£1,413	-£3,220	-£42	-£3,178
	Orthodontics Total		**108**	**146**	**38**	**£10,405**	**£12,429**	**£2,025**	**-£47**	**£2,071**

Year to Date

	Paediatric Surgery	Daycase	269	223	-46	£291,945	£252,494	-£39,451	£10,189	-£49,640
		Elective	79	95	16	£266,969	£323,388	£56,419	£1,105	£55,314
		Non Elective	248	269	21	£692,118	£720,684	£28,566	-£28,915	£57,481
		Excess Bed Days	251	266	15	£114,862	£106,213	-£8,649	-£15,490	£6,841
		Outpatient New	354	347	-7	£60,290	£59,177	-£1,114	-£4	-£1,110
		Outpatient Follow-up	555	488	-67	£63,874	£56,132	-£7,742	-£71	-£7,671
		Ward Attender	155	109	-46	£17,724	£12,468	-£5,256	-£8	-£5,248
		Ward Based Outpatient	20	22	2	£2,328	£2,517	£189	-£0	£189
		OP Procedure	0	0	-0	£0	-£0	£0	£0	£0
		Neonatal HDU	22	107	85	£265,841	£402,829	£136,988	£0	£136,988
	Paediatric Surgery Total		**1,952**	**1,926**	**-26**	**£1,775,951**	**£1,935,901**	**£159,950**	**-£33,194**	**£193,144**
	Plastic Surgery	Daycase	158	170	12	£174,981	£212,407	£37,426	£24,450	£12,976
		Elective	21	11	-10	£30,611	£21,977	-£8,634	£5,957	-£14,591
		Non Elective	170	195	25	£277,829	£363,679	£85,850	£45,095	£40,755
		Excess Bed Days	21	30	9	£12,688	£15,272	£2,584	-£2,853	£5,438
		Outpatient New	465	709	244	£63,276	£95,210	£31,934	-£1,363	£33,297
		Outpatient Follow-up	794	735	-59	£84,239	£77,959	-£6,281	-£3	-£6,278
		Ward Attender	19	58	39	£1,994	£6,152	£4,158	-£0	£4,158
		Ward Based Outpatient	4	18	14	£410	£1,803	£1,394	-£106	£1,500
		OP Procedure	231	425	194	£28,792	£54,297	£25,506	£1,347	£24,159
	Plastic Surgery Total		**1,883**	**2,351**	**468**	**£674,820**	**£848,757**	**£173,937**	**£72,524**	**£101,414**
	Spinal Surgery	Daycase	1	2	1	£1,271	£1,832	£561	-£82	£642
		Elective	25	27	2	£719,873	£540,854	-£179,020	-£250,553	£71,534
		Non Elective	0	1	1	£0	£22,325	£22,325	£0	£22,325
		Excess Bed Days	0	10	10	£0	£5,014	£5,014	£0	£5,014
		Outpatient New	77	105	28	£15,781	£21,619	£5,837	-£1	£5,838
		Outpatient Follow-up	166	192	26	£12,652	£14,771	£2,119	£168	£1,951
	Spinal Surgery Total		**269**	**337**	**68**	**£749,578**	**£606,415**	**-£143,163**	**-£250,468**	**£107,305**
	Trauma And Orthopaedics	Daycase	82	67	-15	£157,091	£123,520	-£33,571	-£5,050	-£28,521
		Elective	116	116	-0	£489,306	£446,850	-£42,456	-£41,503	-£953
		Non Elective	107	105	-2	£292,766	£302,280	£9,514	£15,130	-£5,616
		Excess Bed Days	62	85	23	£28,846	£41,469	£12,623	£1,816	£10,807
		Outpatient New	1,367	1,599	232	£217,890	£251,327	£33,436	-£3,520	£36,956
		Outpatient Follow-up	2,914	2,733	-181	£272,774	£251,395	-£21,379	-£4,414	-£16,965
		Ward Attender	3	0	-3	£311	£0	-£311	£0	-£311
		OP Procedure	416	521	105	£51,369	£64,220	£12,851	-£118	£12,970
		Gait New	57	55	-2	£67,294	£64,467	-£2,828	£0	-£2,828
		Gait Follow-Up	50	47	-3	£58,224	£55,090	-£3,135	£0	-£3,135
	Trauma And Orthopaedics Total		**5,175**	**5,328**	**153**	**£1,635,871**	**£1,600,616**	**-£35,254**	**-£37,658**	**£2,404**
	Urology	Daycase	371	406	35	£334,427	£359,820	£25,392	-£6,153	£31,545
		Elective	24	21	-3	£74,368	£109,074	£34,706	£43,178	-£8,472
		Non Elective	6	10	4	£15,369	£20,926	£5,558	-£3,685	£9,243
		Excess Bed Days	25	2	-23	£13,496	£1,196	-£12,300	£124	-£12,424
		Outpatient New	188	192	4	£27,762	£28,351	£589	-£2	£591
		Outpatient Follow-up	381	371	-10	£37,278	£36,264	-£1,014	-£1	-£1,013
		Ward Attender	7	40	33	£718	£3,910	£3,192	£0	£3,192
		Ward Based Outpatient	13	1	-12	£1,305	£98	-£1,207	£0	-£1,207
		OP Procedure	32	76	44	£7,317	£17,387	£10,070	-£80	£10,150
	Urology Total		**1,048**	**1,119**	**71**	**£512,041**	**£577,026**	**£64,985**	**£33,382**	**£31,604**
Surgery CBU Total			**25,903**	**27,170**	**1,267**	**£14,769,167**	**£15,148,779**	**£379,612**	**-£57,192**	**£436,804**
Medicine CBU	Accident & Emergency	Daycase	0	0	-0	£357	£0	-£357	£0	-£357
		Elective	0	1	1	£214	£947	£732	£269	£464
		Non Elective	597	613	16	£414,514	£482,039	£67,525	£56,660	£10,865
		Excess Bed Days	6	0	-6	£2,321	£0	-£2,321	£0	-£2,321
		Outpatient New	401	275	-126	£135,264	£92,944	-£42,321	£85	-£42,405
		Outpatient Follow-up	42	16	-26	£14,185	£5,070	-£9,115	-£333	-£8,782
		Ward Based Outpatient	1	0	-1	£394	£0	-£394	£0	-£394
		A&E Attendance	9,995	9,899	-96	£1,068,565	£973,887	-£94,677	-£84,363	-£10,315
	Accident & Emergency Total		**11,043**	**10,804**	**-239**	**£1,635,814**	**£1,554,886**	**-£80,927**	**-£27,683**	**-£53,245**
	Allergy	Daycase	68	33	-35	£37,378	£13,834	-£23,543	-£4,305	-£19,238
		Outpatient New	142	158	16	£30,614	£34,173	£3,559	£162	£3,397
		Outpatient Follow-up	190	194	4	£25,894	£26,560	£666	£131	£535
		Ward Based Outpatient	1	0	-1	£77	£0	-£77	£0	-£77
		OP Procedure	1	2	1	£89	£265	£176	£16	£161
	Allergy Total		**402**	**387**	**-15**	**£94,051**	**£74,832**	**-£19,219**	**-£3,996**	**-£15,223**
	Dermatology	Daycase	4	19	15	£2,914	£12,641	£9,727	-£2,553	£12,280
		Outpatient New	312	294	-18	£43,094	£40,661	-£2,433	-£2	-£2,431
		Outpatient Follow-up	690	569	-121	£61,770	£50,885	-£10,886	-£58	-£10,828
		Ward Attender	0	0	-0	£7	£0	-£7	£0	-£7
		Ward Based Outpatient	9	20	11	£769	£1,789	£1,019	£0	£1,019
		OP Procedure	555	659	104	£64,807	£73,376	£8,569	-£3,536	£12,105
	Dermatology Total		**1,569**	**1,561**	**-8**	**£173,361**	**£179,351**	**£5,989**	**-£6,149**	**£12,139**
	Diabetes	Outpatient New	57	3	-54	£11,579	£605	-£10,974	-£0	-£10,974
		Outpatient Follow-up	6	5	-1	£1,005	£884	-£121	-£0	-£121
		Ward Attender	0	2	2	£0	£354	£354	£0	£354
		Ward Based Outpatient	0	0	-0	£13	£0	-£13	£0	-£13
	Diabetes Total		**63**	**10**	**-53**	**£12,598**	**£1,843**	**-£10,755**	**-£0**	**-£10,755**
	Endocrinology	Daycase	178	188	10	£136,781	£142,853	£6,072	-£1,740	£7,812
		Elective	14	7	-7	£17,098	£8,884	-£8,214	£565	-£8,779
		Non Elective	3	5	2	£11,448	£12,113	£666	-£5,099	£5,765
		Excess Bed Days	54	193	139	£23,660	£86,165	£62,505	£1,340	£61,165
		Outpatient New	126	103	-23	£38,253	£31,382	-£6,871	-£1	-£6,870
		Outpatient Follow-up	556	644	88	£84,847	£97,655	£12,808	-£665	£13,473
		Ward Attender	36	11	-25	£5,465	£1,659	-£3,807	-£0	-£3,807
		Ward Based Outpatient	204	141	-63	£30,705	£21,261	-£9,445	-£1	-£9,444
	Endocrinology Total		**1,171**	**1,292**	**121**	**£348,258**	**£401,972**	**£53,714**	**-£5,602**	**£59,315**
	Epilepsy	Outpatient New	22	22	0	£5,550	£5,582	£32	-£0	£32
		Outpatient Follow-up	51	28	-23	£10,084	£5,561	-£4,523	-£0	-£4,523
	Epilepsy Total		**73**	**50**	**-23**	**£15,634**	**£11,143**	**-£4,491**	**-£0**	**-£4,491**
	Gastroenterology	Daycase	277	268	-9	£197,790	£210,476	£12,686	£18,779	-£6,092
		Elective	79	40	-39	£108,506	£60,890	-£47,615	£5,890	-£53,506
		Non Elective	18	14	-4	£55,344	£59,515	£4,171	£17,381	-£13,210
		Excess Bed Days	208	257	49	£97,054	£117,249	£20,196	-£2,572	£22,768
		Outpatient New	197	148	-49	£45,803	£34,549	-£11,254	£129	-£11,383
		Outpatient Follow-up	616	436	-180	£89,648	£63,473	-£26,175	-£4	-£26,171
		Ward Attender	49	8	-41	£7,096	£1,165	-£5,931	-£0	-£5,931
		Ward Based Outpatient	169	188	19	£24,653	£27,370	£2,717	-£1	£2,718
	Gastroenterology Total		**1,613**	**1,359**	**-254**	**£625,893**	**£574,688**	**-£51,205**	**£39,602**	**-£90,808**
	Haematology	Daycase	46	107	61	£36,051	£77,017	£40,966	-£7,236	£48,202
		Elective	6	11	5	£26,280	£64,643	£38,363	£14,365	£23,998

Year to Date

	Haematology	Non Elective	22	32	10	£27,845	£73,659	£45,815	£33,352	£12,463
		Excess Bed Days	6	2	-4	£1,759	£955	-£803	£353	-£1,156
		Outpatient New	42	46	4	£18,951	£20,712	£1,761	-£1	£1,762
		Outpatient Follow-up	116	132	16	£24,416	£27,864	£3,448	-£1	£3,449
		Ward Attender	329	412	83	£69,443	£86,973	£17,530	-£0	£17,530
		Ward Based Outpatient	1	0	-1	£117	£0	-£117	£0	-£117
		OP Procedure	0	0	-0	£49	£0	-£49	£0	-£49
	Haematology Total		**567**	**742**	**175**	**£204,910**	**£351,824**	**£146,914**	**£40,831**	**£106,083**
	Immunology	Daycase	7	4	-3	£3,848	£1,535	-£2,313	-£664	-£1,649
		Outpatient New	25	42	17	£5,303	£9,149	£3,846	£108	£3,738
		Outpatient Follow-up	19	76	57	£2,540	£10,616	£8,076	£262	£7,814
		Ward Attender	9	20	11	£1,275	£2,725	£1,450	-£0	£1,450
		Ward Based Outpatient	30	68	38	£4,072	£9,264	£5,191	-£0	£5,191
	Immunology Total		**90**	**210**	**120**	**£17,038**	**£33,288**	**£16,250**	**-£294**	**£16,544**
	LTV	Outpatient New	19	22	3	£13,472	£15,497	£2,026	-£101	£2,127
		Outpatient Follow-up	83	130	47	£58,238	£92,983	£34,745	£2,131	£32,613
	LTV Total		**102**	**152**	**50**	**£71,710**	**£108,480**	**£36,770**	**£2,030**	**£34,741**
	Metabolic Disease	Outpatient New	10	3	-7	£3,700	£1,153	-£2,546	£1	-£2,547
		Outpatient Follow-up	53	48	-5	£20,316	£18,450	-£1,866	£16	-£1,882
		Ward Based Outpatient	6	2	-4	£2,112	£769	-£1,343	£1	-£1,344
	Metabolic Disease Total		**68**	**53**	**-15**	**£26,128**	**£20,372**	**-£5,756**	**£18**	**-£5,774**
	Nephrology	Daycase	261	280	19	£466,139	£450,389	-£15,750	-£49,501	£33,751
		Elective	60	77	17	£63,862	£44,013	-£19,850	-£37,634	£17,784
		Non Elective	8	10	2	£24,571	£21,341	-£3,230	-£9,402	£6,172
		Excess Bed Days	34	5	-29	£17,027	£1,934	-£15,093	-£607	-£14,485
		Outpatient New	30	62	32	£3,589	£7,326	£3,737	£7	£3,730
		Outpatient Follow-up	273	336	63	£32,245	£39,702	£7,457	£37	£7,420
		Ward Attender	130	9	-121	£15,304	£1,063	-£14,241	£1	-£14,242
		Ward Based Outpatient	102	107	5	£12,052	£12,643	£591	£12	£579
	Nephrology Total		**898**	**886**	**-12**	**£634,788**	**£578,410**	**-£56,378**	**-£97,087**	**£40,710**
	Neurology	Daycase	50	28	-22	£55,388	£35,521	-£19,867	£4,747	-£24,614
		Elective	12	22	10	£21,454	£45,889	£24,435	£5,727	£18,708
		Non Elective	17	14	-3	£92,263	£52,515	-£39,748	-£23,538	-£16,210
		Excess Bed Days	162	159	-3	£98,168	£91,112	-£7,055	-£5,138	-£1,917
		Outpatient New	173	180	7	£48,097	£48,564	£468	-£1,339	£1,807
		Outpatient Follow-up	458	460	2	£127,041	£113,224	-£13,817	-£14,315	£497
		Ward Attender	27	37	10	£7,402	£10,268	£2,866	£10	£2,856
		Ward Based Outpatient	34	32	-2	£9,543	£8,880	-£663	£9	-£671
	Neurology Total		**934**	**932**	**-2**	**£459,356**	**£405,973**	**-£53,383**	**-£33,837**	**-£19,545**
	Oncology	Daycase	348	150	-198	£331,245	£110,631	-£220,613	-£31,996	-£188,617
		DCHEMO	267	328	61	£88,626	£109,063	£20,437	£0	£20,437
		Elective	57	40	-17	£214,402	£171,769	-£42,634	£20,325	-£62,959
		Non Elective	100	100	0	£202,749	£248,163	£45,414	£44,619	£795
		Excess Bed Days	115	14	-101	£53,558	£6,143	-£47,416	-£358	-£47,057
		Outpatient New	20	14	-6	£5,051	£3,629	-£1,422	£3	-£1,425
		Outpatient Follow-up	431	518	87	£111,621	£134,266	£22,644	£47	£22,598
		Ward Attender	96	186	90	£24,977	£48,211	£23,235	£43	£23,192
		Ward Based Outpatient	18	33	15	£4,619	£8,554	£3,934	£8	£3,927
	Oncology Total		**1,451**	**1,383**	**-68**	**£1,036,848**	**£840,428**	**-£196,420**	**£32,689**	**-£229,110**
	Paediatrics	Daycase	29	5	-24	£15,974	£3,805	-£12,169	£1,057	-£13,226
		Elective	2	8	6	£1,350	£15,920	£14,569	£9,257	£5,313
		Non Elective	634	840	206	£735,729	£1,037,845	£302,116	£63,176	£238,940
		Excess Bed Days	159	215	56	£65,110	£122,676	£57,566	£34,606	£22,961
		Outpatient New	595	548	-47	£128,148	£117,958	-£10,190	-£5	-£10,186
		Outpatient Follow-up	979	801	-178	£133,348	£109,114	-£24,234	-£6	-£24,227
		Ward Attender	18	3	-15	£2,441	£409	-£2,032	-£0	-£2,032
		Ward Based Outpatient	80	28	-52	£10,859	£3,814	-£7,045	-£0	-£7,045
		OP Procedure	0	0	-0	£59	£0	-£59	£0	-£59
	Paediatrics Total		**2,496**	**2,448**	**-48**	**£1,093,018**	**£1,411,540**	**£318,523**	**£108,084**	**£210,439**
	Radiology	Daycase	218	226	8	£283,309	£257,838	-£25,471	-£36,014	£10,543
		Elective	37	12	-25	£68,305	£23,468	-£44,837	£1,087	-£45,925
		Non Elective	5	4	-1	£50,238	£24,371	-£25,867	-£16,561	-£9,306
		Excess Bed Days	49	16	-33	£23,102	£7,644	-£15,458	£49	-£15,507
		OP Imaging	1,883	1,785	-98	£249,932	£236,935	-£12,997	£10	-£13,008
	Radiology Total		**2,191**	**2,043**	**-148**	**£674,886**	**£550,255**	**-£124,631**	**-£51,429**	**-£73,202**
	Respiratory Medicine	Daycase	19	30	11	£24,920	£36,664	£11,744	-£2,564	£14,308
		Elective	21	10	-11	£34,950	£20,592	-£14,358	£3,871	-£18,229
		Non Elective	91	15	-76	£190,642	£73,224	-£117,419	£41,643	-£159,062
		Excess Bed Days	47	36	-11	£26,702	£25,387	-£1,315	£4,861	-£6,177
		Outpatient New	144	134	-10	£37,524	£34,735	-£2,789	-£158	-£2,631
		Outpatient Follow-up	478	531	53	£68,584	£76,199	£7,615	-£5	£7,619
		Ward Attender	7	1	-6	£1,009	£144	-£865	-£0	-£865
		Ward Based Outpatient	265	81	-184	£38,006	£11,624	-£26,382	-£0	-£26,382
		OP Procedure	114	0	-114	£24,248	£0	-£24,248	£0	-£24,248
	Respiratory Medicine Total		**1,185**	**838**	**-347**	**£446,586**	**£278,568**	**-£168,018**	**£47,649**	**-£215,667**
	Rheumatology	Daycase	331	293	-38	£210,028	£190,643	-£19,385	£4,556	-£23,941
		Elective	39	9	-30	£50,383	£10,818	-£39,565	-£958	-£38,608
		Non Elective	3	6	3	£5,199	£21,685	£16,486	£11,279	£5,207
		Excess Bed Days	51	46	-5	£21,390	£19,557	-£1,834	£263	-£2,097
		Outpatient New	107	137	30	£16,034	£15,355	-£679	-£5,251	£4,572
		Outpatient Follow-up	377	447	70	£56,657	£26,796	-£29,861	-£40,309	£10,448
		Ward Attender	30	14	-16	£4,476	£2,108	-£2,368	£2	-£2,370
		Ward Based Outpatient	20	14	-6	£3,040	£1,957	-£1,083	-£149	-£934
		OP Procedure	0	0	-0	£31	£0	-£31	£0	-£31
	Rheumatology Total		**957**	**966**	**9**	**£367,240**	**£288,918**	**-£78,321**	**-£30,567**	**-£47,755**
	Sleep Studies	Elective	47	33	-14	£58,075	£37,216	-£20,859	-£3,216	-£17,643
	Sleep Studies Total		**47**	**33**	**-14**	**£58,075**	**£37,216**	**-£20,859**	**-£3,216**	**-£17,643**
Medicine CBU Total			**26,920**	**26,149**	**-771**	**£7,996,191**	**£7,703,988**	**-£292,202**	**£11,044**	**-£303,246**
Community CBU	CAMHS	Elective	0	0	-0	£568	£0	-£568	£0	-£568
		Outpatient New	373	337	-36	£0	£0	£0	£0	£0
		Outpatient Follow-up	1,857	2,944	1,087	£24,924	£17,634	-£7,291	-£21,889	£14,598
	CAMHS Total		**2,230**	**3,281**	**1,051**	**£25,493**	**£17,634**	**-£7,859**	**-£21,889**	**£14,030**
	Community Medicine	Outpatient New	707	576	-131	£57,231	£21,963	-£35,268	-£24,693	-£10,575
		Outpatient Follow-up	1,387	1,328	-59	£7,003	£6,608	-£396	-£96	-£300
		Ward Attender	5	0	-5	£0	£0	£0	£0	£0
		OP Procedure	0	0	-0	£27	£0	-£27	£0	-£27
	Community Medicine Total		**2,099**	**1,904**	**-195**	**£64,261**	**£28,570**	**-£35,690**	**-£24,789**	**-£10,901**
Community CBU Total			**4,328**	**5,185**	**857**	**£89,754**	**£46,204**	**-£43,550**	**-£46,678**	**£3,128**
Grand Total			**57,152**	**58,504**	**1,352**	**£22,855,111**	**£22,898,972**	**£43,860**	**-£92,826**	**£136,686**

Board of Directors
Thursday, 4 July 2017

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, and Quality Assurance Officer
Subject/Title	2017/18 BAF Report
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF June report
Action/Decision required	The Board is asked to note the June position relating to the Board Assurance Framework
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	By 2020, we will: ➢ be internationally recognised for the quality of our care ***(Excellence in Quality)*** ➢ be recognised for the exceptional care we provide to our children, that is technologically enabled and matched by exceptional facilities ***(Patient Centred Services)*** ➢ have a fully engaged workforce that is actively driving quality improvement ***(Great Talented Teams)*** ➢ be a world class, child focussed centre of research & innovation expertise to improve the health and wellbeing outcomes for babies, children & young people ***(International Research, Innovation & Education)*** ➢ have secured sustainable long term financial and service growth supported by a strong international business ***(Growing our Services and Safeguarding Core Business)***
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2017/18

1. Purpose

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

2. Review of the BAF

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

BAF Risk Register - Overview at 29 June 2017
2.4: Financial Environment (S)
3.3: Developing the Paediatric Service Offer (S)   3.2: Business Development and Growth. (S)
2.2: Failure to fully realise the Trust's Vision for the Park (S)   2.3: IT Strategic Development (S)
4.1: Workforce Sustainability & Capability (S)   1.3: Management Contract arrangement with Liverpool Community Health Trust (S)
4.2: Staff Engagement (S)   4.3: Workforce Diversity & Inclusion (S)   2.1: New Hospital Environment (S)
5.1: Research, Education & Innovation (S)   1.1: Maintain care quality in a cost constrained environment (S)
1.2: Mandatory & compliance standards (S)

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

Changes since 30 May 2017 Board meeting

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

External risks

- ***Business development and growth (DH)***
  1) AH were awarded the Management Contract for Liverpool Community Health, (Liverpool Bundle) for May 2017. Future organisational structure being developed with NHSi, the 3 Acute Trusts, local authority, LCCG and local GP's. Opportunities for all to rationalise patient pathways.
  2) Partnership with Al Jalia now entering Phase 2. Specific deliverables identified and agreed. Work due to commence in Q2. Non NHS patient stretch target agreed and Q1 activity delivered.
  3) MOUs signed with two hospitals in China and work in progress to identifying workstreams and benefits.
  4) AH awarded contract for Design and Build Consultancy for Children's Hospital in Xian.

- ***Mandatory and compliance standards (ES)***
  Complaint with all national targets in month. Registration of community services with CQC is resolved.

- ***Developing the Paediatric Service Offer (DH)***
  Work commencing on the Implementation of the single service, two site model;
  1) Neonatal service model with NHS England and LWH on 6/7/17
  2) CHD Public Consultation closes in July. Results not expected to be released until January 2018. In the meantime AHCH and LCH are providing support to deliver services for patients due to the collapse of the Manchester service following the departure of their last remaining surgeon in June.
  3) Out of Hours group has been merged with the other workstreams to design a sustainable 24/7 paediatric service in light of further reductions and gaps in rotation. This workstream is named best in Acute Care and is led by the MD and Chief Nurse.

Internal risks:

- ***Maintain care quality in a cost constrained environment (HG)***
  All nursing staff now trained in Sepsis triggers; medical staff training to take place in August & September. Re-introduction of matron role across the Trust over next three months.

- ***Management Contract arrangement with Liverpool Community Health Trust (LS)***

Stock take report compiled for NHS I. Plans in place to ensure services at both AH & LCH are managed safely and effectively. Senior Roles and associated back fill confirmed and communicated to all AH staff.

- ***New Hospital Environment (DP)***
  Probation period ended. Main outstanding issue – energy.

- ***Financial Environment (JG)***
  £0.3m behind control total at month 2. Residual Forecast financial risk of circa £5m identified by Divisions. Action Plan Produced and delivery tracked via Internal Recovery and RABD.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Consultation strategy presented at July board.

- ***IT Strategic Development (JG)***
  GDE funding confirmed and agreements signed / returned by DoF. Cash not received 27.06.17. Overall GDE programme milestones have slipped but on track to deliver objectives.

- ***Workforce Sustainability & Capability (MS)***
  Temporary Staffing Project initiated

- ***Staff Engagement (MS)***
  Launch of the Big Conversations with staff from across the Trust. Executive Visibility Programme commenced

- ***Workforce Diversity & Inclusion (MS)***
  First BME Network meeting. HRD as Exec sponsor.

- ***Research, Education & Innovation (DP)***
  Academy model agreed.

Erica Saunders
Director of Corporate Affairs
July 2017

Board Assurance Framework 2017-18

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

Risk Description

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

Existing Control Measures

• Quality impact assessment of all planned changes	• Risk assessment and utilisation of risk registers in responding to incidents and other drivers.
• Quality section of Corporate Report scrutinised at CQAC and Board.	• CBU and Corporate Dashboards in place and are part of updated Performance Framework.
• Weekly Meeting of Harm	• Programme of quality reviews (deep dives) planned across all departments. Implemented and being reported via the WMoH quarterly report.
• Refresh of CQAC to provide a more performance focussed approach	• Changes to ESR to underpin workforce information -
• New Change Programme established - associated workstreams subject to sub-committee assurance reporting	• Robust risk & governance processes from Ward to Board, linked to NHSI Single Oversight Framework
• Quality Strategy 2016-2020 implemented to deliver safe and effective services demonstrated via measurable Quality Aims and Sign up to Safety campaign	• External review on IPCC resulted in action plan to address issues identified and track improvements.
• "Our Patients at the Centre" projects subject to assurance committee monitoring (CQAC)	• Quarterly 'themes' report from Weekly Meeting of Harm shared within meeting & CQSG as multidisciplinary engagement and cross-organisational learning.

Assurance Evidence	Gaps in Controls/Assurance
Monthly reporting to CQSG. CQAC focus on performance. Analysis of incident reports. Monthly reporting of the Corporate Report to Board. Improved reporting - in the top 20% of NRLS nationally Ongoing national open recruitment exercise in Spring 2017 PEWS audit scores on improvement trajectory Sepsis implementation plan underway, overseen by project team; audit data showing improvement in recognition and escalation.	Reduced investment opportunity to respond to clinical development as a result of financial situation. Full electronic access to specialty performance results Meditech issues identified as key challenge to obtaining accurate Sepsis audit data without extensive manual analysis by clinical lead. Nursing maternity leave continues to rise - currently at 50 WTE per month.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Develop and build audit programme within Meditech to ensure continuous monitoring in place and deliver CQUIN	Key stakeholders working with IM&T to build audit programme
Heads of Quality to take forward Quality Ward Accreditation Programme in 17/18 (as part of devolved governance)	Revised framework agreed. On-going work in progress. Electronic sharing of information with the public - completed programme July.
Successfully implement all Change Programme workstreams to improve efficiency and flow	16/17 year-end reports to CQAC. Actions to carry forwards into 17/18 change programme in association with PIDs and milestone trackers.
Roll out PFCC model for all appropriate services	PFCC model now forms part of transformation toolkit
Continue to maintain nurse staffing pool	Recruitment on-going. Further analysis of maternity leave factors to be undertaken (July 2017)
Clinical lead for Sepsis in dialogue with Meditech team to develop solution to systems issues re data.	

Executive Lead's Assessment

APR 2017: no change in-month
MAY 2017: the Trust continues to maintain appropriate workforce levels ensuring care quality in a cost constrained environment. Achieving Monitor capped nursing agency targets
JUNE 2017: All nursing staff now trained in Sepsis triggers; medical staff training to take place in August & September. Re-introduction of matron role across the Trust over next three months.

Board Assurance Framework 2017-18

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

Risk Description
Failure to deliver on all mandatory and compliance standards due to lack of engagement with internal throughput plans and targets

Existing Control Measures	
• New Operational Delivery Group (July 2016) to take action to resolve non-compliance relating to performance. Reporting to RBD	• Emergency Planning & Resilience meetings in pace
• CBU Executive Review Meetings - now strengthened as of May 2016 and meeting regularly each month	• Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and CBU Dashboards.	• Risks to delivery addressed through RBD, CQAC, WOD & CQSG and then through to Board
• Early Warning indicators now in place	• Weekly performance meetings in place to track progress
• 6 weekly meetings with commissioners (CQPG)	• Revised CBU leadership structure to implement clinically led leadership team for CBU
• Weekly Performance meetings	

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through CQSG, CQAC & Board. Monthly reporting to the Board via the Corporate Report. Monitor / NHSI governance risk rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against Monitor Provider Licence to go to Board CBU / Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly Report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. IG toolkit, MSE, evidence of compliance relating to learning disabilities declaration Assurance required to underpin CBU reporting on CQC standards 'Horizon scanning' to anticipate risks & issues now implemented through performance review meeting Work with CCG to manage demand & develop / fully utilise existing capacity across PC Junior Doctor Rotas

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Ensure divisional governance embedded and working effectively to reflect ward to board reporting	Awaiting the implementation of the Matron roles in each CBU
Plans to ensure performance sustained across the year need to be embedded and maintained	
Review bed capacity and staffing model for seasonal variation	The Winter Plan was effective. Planning for next winter to commence early

Executive Lead's Assessment
APR 2017: All access targets achieved at 31/3. Letter of congrats received from SoS for most improved ED 4 hour performance. MAY 2017: Need to maintain grip on activity plan and ensure community waiting times are a focus in the short term especially CAMHS and SALT JUNE 2017 Complaint with all national targets in month. Registration of community services with CQC is resolved.

Board Assurance Framework 2017-18

BAF 1.3	**Strategic Objective:** Sustainability Through External Partnerships		Risk Title: Management Contract arrangement with Liverpool Community Health Trust		
Related CQC Themes: Well Led, Responsive, Safe					
Exec Lead: Louise Shepherd		**Type:** External, New	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description

- Risk to senior leadership team visibility & capacity
- Risk to operational delivery at Alder Hey (quality & performance standards)
- Financial risk to achieving the AH control total
- Risk to delivery of AH strategic plan and associated brand and reputation
- Impact on staff morale at AH

Existing Control Measures

• Backfill arrangements for some key members of Exec Team in place & gaps actively being backfilled	• MIAA due diligence process undertaken at LCH
• Cross agency Transition Board place at LCH to oversee safe transfer of remaining services	• Interim Provider Group in place to retain oversight of the Management Contract

Assurance Evidence	Gaps in Controls/Assurance
Interim governance arrangements in place including Exec Team meetings	Financial package not yet agreed with NHSI & Liverpool CCG Some senior and support posts not yet filled Potential for further quality risks to emerge Staff engagement & motivation across the two sites

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Develop plans to ensure services at both AH & LCH are managed safely and effectively	

Executive Lead's Assessment

MAY 2017: Plans continue to be developed to ensure services at both AH & LCH are managed safely and effectively
JUNE 2017: Stock take report compiled for NHS I. Plans in place to ensure services at both AH & LCH are managed safely and effectively. Senior Roles and associated back fill confirmed and communicated to all AH staff.

Board Assurance Framework 2017-18

BAF 2.1	Strategic Objective: Strong Foundations		Risk Title: New Hospital Environment		
Related CQC Themes: Safe, Effective, Well Led					
Exec Lead: David Powell		Type: Internal, Known	Current IxL: 4-2	Target IxL: 4-1	Trend: STATIC

Risk Description

Failure to deliver world class healthcare due to constraints of new environment

Existing Control Measures

• Regular Fix-It Team reports to Execs, CQAC & IGC	• Interserve Reports & representation at Health & Safety Committee
• Monitoring & Fix-It Team in place responsible for day to day management of PFI Contractor ensuring services are delivering the required standards	• Fix-It Team governed by a Steering Group (meets monthly)
• Joint Energy Committee to monitor performance & compliance	• Joint Water Committee to monitor performance & compliance
• Survey of all departmental users to assess quality of service	• Review of Charter compliance or liaison committee

Assurance Evidence	Gaps in Controls/Assurance
Tracker in place. Reporting compliance of PFI Services against contract to Trust Board. Confirmation that invoices and sums are charged correct (Finance Lead to approve all invoices and expenditure). Number of reported faults is falling. The items on the 'red list' i.e. main snags have reduced significantly. Further meeting arranged to review energy performance Partnership Charter Liaison Committee - meeting minutes	Delay in commissioning external Health & Safety Review. Gap in reporting from Project Co. and inconsistencies in description of faults

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Reviewing Health & Safety interface with Estates and Building Services Team	Recommendation issued to Dir. of HR fro consideration
review of probation items	Review postponed due to issues with energy
conduct series of surveys (1 per quarter) to assess progress.	Second survey results received
Implement recommendations in external H&S Review	

Executive Lead's Assessment

APR 2017: Review of progress at Liaison Committee
MAY 2017: Review and agree actions from H&S Report
JUNE 2017: Probation period ended. Main outstanding issue - energy

Board Assurance Framework 2017-18

BAF 2.2	Strategic Objective: Strong Foundations		Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led					
Exec Lead: David Powell		Type: Internal, Known	Current IxL: 4-3	Target IxL: 4-2	Trend: STATIC

Risk Description	
Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations	
Existing Control Measures	
• Business Cases developed for various elements of the Park & Campus	• Alignment with the 'Alder Hey in the Park' vision and the 'Alder Hey Campus' visions
• Heads of Terms agreed with LCC for joint venture approved	• Redeveloped Steering Group
• Monthly reports to Board & RABD	
Assurance Evidence	**Gaps in Controls/Assurance**
Establishment of a Community Interest Charity to operate the park for AHCH and the local community Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Representation at Springfield Park Shadow Board Stakeholder events held Representation at Friends of Springfield Park Group	Fully reconciled budget with Plan. Risk quantification around the development projects. Joint business case approval with LCC
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	dependent upon residential scheme (target date no Sept 2017)
Income generation opportunities to be thoroughly explored (grant applications) and reconcile requirement for funding versus available	Draft Business Case prepared. Final requirement will depend upon contribution from residential scheme
Develop a Planning Process Communication Strategy	Strategy to be presented at July board
Confirm arrangements for the CIC to run the Park.	
Executive Lead's Assessment	
APR 2017: Shortlisted - first step as preferred bidder MAY 2017: Compile draft Consultation Strategy. Consultation process held for purdah. JUNE 2017: Consultation strategy presented at July board	

Board Assurance Framework 2017-18

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

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

Existing Control Measures	
• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Investment in IM&T Team (2016/17 budget)

Assurance Evidence	**Gaps in Controls/Assurance**
Regular progress reports presented to RABD and Operational Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews	IM&T Strategy out of date - update work in progress Internal Programme Assurance Reports Resources required to deliver Strategy proposed and aspirations of Trust - review Oct 2016 - Strategy update deferred pending consultation with new restructure CBU leadership teams and outcome of Global Digital Excellence bid.

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Link to innovation partnerships in paediatric healthcare	
Conclude the review of IM&T Infrastructure	currently being reviewed in relation to GDE bid and business case
IM&T Strategy development & approval	Trust GDE bid submitted and approved by Board and NHSE Nov / Dec 2016. NHSE undertaking due diligence review pre sign off and approval of funding agreement. Full I&MT strategy to be updated Q4 2016/17
Continual improvement of MEDITECH and other clinical systems as prioritised by the Clinical Systems Informatics Steering Group	changes to software tracked by and reported to the Clinical Informatics Steering Group
Engage with iLinks programme to progress interoperability	

Executive Lead's Assessment
APR 2017: email confirmation from NHSE highlighting treasury approval - awaiting final confirmation MAY 2017: escalated NHSE funding for GDE by FD as impacting on programme delivery JUNE 2017: GDE funding confirmed and agreements signed / returned by DoF. Cash not received 27.06.17. Overall GDE programme milestones have slipped but on track to deliver objectives.

Board Assurance Framework 2017-18

BAF 2.4	Strategic Objective: Strong Foundations		Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led					
Exec Lead: John Grinnell		Type: Internal, Known	Current IxL: 5-4	Target IxL: 3-4	Trend: STATIC

Risk Description
Failure to deliver Trust control total and Risk rating Rating

Existing Control Measures	
• Organisation-wide financial plan.	• Monitor financial regime and financial risk ratings.
• Financial systems, budgetary control and financial reporting processes.	• Capital Planning Review Group
• Monthly performance review meetings with CBU Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• Weekly meeting with CBUs to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	• COO Task & Finish Group targeted at increasing activity in line with planned levels
• CIP subject to programme assessment and sub-committee performance management	

Assurance Evidence	Gaps in Controls/Assurance
Monthly Corporate Performance Report presented to both Board and the RBDC. Specific Reports (i.e. Monitor Plan Review by RBDC) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support CBU performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results	Improved financial control and effective recovery required in identified CBU's where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff CBU recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP Based on month 7 run rate performance (£0.3m adrift in month overall from recovery profile) and update projections and risks reported by Clinical Business Units, heightened risk of failure to deliver target control. In order to address emerging risk CBU control targets issued to address risk profile gap of circa £2.7m. (£3.7m gross but £1m mitigation identified).

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Focus on activity delivery	Recovery plans under development and review
Improve delivery of clinical business developments to meet local CCG outsome needs, e.g. as part of Healthy Liverpool, to achieve and exceed financial targets	COO task & finish group established; targeted at increasing activity in line with planned levels
Plans to address CIP shortfall - scheme PIDs to be complete by end of May - progressing against milestones agreed	Trust in discussions with NHSI re. formal approval of required £8m interim cash support

Executive Lead's Assessment
APR 2017: 16/17 control overachieved. 17/18 risks remain as CIP £4m, Activity run rate £3m, pay cost pressures (ward related) £3m MAY 2017: key risks highlighted: pay, activity & CIP. Individual Exec Leads in place. Tracking of internal improvements through Internal Recovery Team JUNE 2017: £0.3m behind control total at month 2. Residual Forecast financial risk of circa £5m identified by Divisions. Action Plan Produced and delivery tracked via Internal Recovery and RABD.

Board Assurance Framework 2017-18

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

Risk Description

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

Existing Control Measures

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

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Workshop held in June to identofy options for bridging business development gap	Alternative schemes being developed. Report to RABD
Identify models and services to provide to non NHS patients / commercial offers	Trust currently progressing tender application for LCH paediatric community services. Timeframe: June - end Aug 2016. Financial assessment will be part of due diligence. Report to RABD and through to Board. Duscussions with surgical teams and Stoke to accelerate increase in cardiac cases

Executive Lead's Assessment

APR 2017: No change in-month.
MAY 2017: No change
JUNE 2017: 1) AH were awarded the Management Contract for Liverpool Community Health, (Liverpool Bundle) for May 2017. Future organisational structure being developed with NHSi, the 3 Acute Trusts, local authority, LCCG and local GP's. Opportunities for all to rationalise patient pathways.
2) Partnership with Al Jalia now entering Phase 2. Specific deliverables identified and agreed. Work due to commence in Q2. Non NHS patient stretch target agreed and Q1 activity delivered.
3) MOUs signed with two hospitals in China and work in progress to identifying workstreams and benefits.
4) AH awarded contract for Design and Build Consultancy for Children's Hospital in Xian.

Board Assurance Framework 2017-18

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Key developments monitored through CBU Boards. Risks highlighted to CRC. Monitored at Performance Management Group. Monthly to Board via RABD & Board Compliance with final national specifications	Inability to recruit to highly specialist roles due to skill shortages nationally. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date. Potential elective underperformance due to cancelled sessions. Awaiting final results re. CHD service at national level. Working with partners including CMFT to progress transfer of adult CHD services and to support partners during transition

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitoring of action plans.	Now working with NHS England to secure a resolution for the North
Clear plan for delivery of strategic services (cardiac, neonatal, rehab, community care, primary care, Vanguard, CAMHS)	
Pro-active recruitment in identified areas.	Trust in discussion with Liverpool Women's re future service models for neonates and in discussion with Liverpool Heart and Chest re future model for cardiac service
Develop a strong Community Service offering for Children in Liverpool.	Alder Hey has been awarded a Management Contract for 6 months to deliver the LCH Community Services
Strengthening the paediatric workforce	Now part of Change Programme and 7 day service as Best in Acute Care led by Steve Ryan.

Executive Lead's Assessment

APR 2017: The ODN recommendation single service, single workforce, two site model has been accepted by NHS England and AH and LWH are now working on an implementation plan together with Alder Hey leading. There will be a need for some Capital funding to support the reconfiguration of the ICU and the number of cots required. This is a key work stream of the Trusts Change Programme for 2017/18.
Alder Hey has been awarded a Management Contract for 6 months to deliver the LCH Community Services.
MAY 2017:

Board Assurance Framework 2017-18

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

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

Existing Control Measures	
• Compliance tracked through the corporate report and CBU dashboards	• Performance Review Group
• CBU Performance Meetings.	• Mandatory Training reviewed in February 2017.
• Mandatory training records available online and mapped to Core Skills Framework	• Permanent nurse staffing pool
• 'Best People Doing our Best Work' Steering Group implemented	• Attendance management process to reduce short & long term absence
• Positive Attendance Policy	

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

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Sickness Policy refreshed	Training for managers on Sickness Absence Policy ongoing
Recruitment & Retention Strategy to focus on specific groups	Currently being refreshed with action plan to support
Develop and support talent identified within the organisation and via local supply routes e.g. apprenticeships by leveraging networks via HEE and HENW to address future workforce supply challenges	Apprenticeship Strategy ratified and under implementation. Corporate objective agreed to support a succession planning process for business critical roles by end Dec 17

Executive Lead's Assessment
APRIL 2017: planning underway to support apprenticeship roll out. successful Recruitment Day for nursing, resulting in over 40 nurses being appointed. MAY 2017: Task & Finish Group with staff side reviewing approach and sickness absence June 2017: Temporary Staffing Project initiated

Board Assurance Framework 2017-18

BAF 4.2	**Strategic Objective:** The Best People Doing Thier Best Work	Risk Title: Staff Engagement	
Related CQC Themes: Safe, Effective, Responsive, Well Led			
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description	
Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims	
Existing Control Measures	
• Internal Communications Strategy.	• Refine Trust Values.
• Roll out of Leadership Development and Leadership Framework	• Action Plans for Engagement, Values and Communications.
• Medical Leadership development programme	• Staff Temperature Check Reports to Board (quarterly)
• Values based PDR process	• People Strategy Reports to Board (monthly)
• Listening into Action methodology	• Staff surveys analysed and followed up (shows improvement)
Assurance Evidence	**Gaps in Controls/Assurance**
Outcomes from Annual Staff Survey reported to the Board. PDR completion rates Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data now sent to CBUs on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board	Reward & Recognition schemes embedded
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Revised governance arrangements that underpin effective assurance mechanisms utilising the discipline and systems provided by Programme Management methodology	Change programme monitors Listening into Action deliverables

Executive Lead's Assessment
APR 2017: Progress continues with LiA and development of C&E Project. Quarterly Temperature Check launched. MAY 2017: Local staff survey conversations continue JUNE 2017: Launch of the Big Conversations with staff from across the Trust. Executive Visibility Programme commenced

Board Assurance Framework 2017-18

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

Risk Description

Failure to proactively develop a future workforce that reflects the diversity of the local population

Existing Control Measures

• Equality, Diversity & Human Rights Group	• Workforce Committee re-enforced and includes recruitment and education
• Workforce Plan established	• Staff Survey results
• Workforce Planning Poilcy signed off at WOD June 2015	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	

Assurance Evidence	Gaps in Controls/Assurance
Monthly recruitment reports provided by HR/Payroll provider Quarterly reports to the Board via WOD on the Workforce Strategy and Workforce Plan Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication	Recruitment Strategy to focus on specific groups

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Workforce Planning Policy	Draft policy produced, however future work is to focus on identifying priority workforce needs in light of current financial position
Deliver on our new Recruitment and Retention Strategy to ensure an optimum workforce is in place and that the workforce reflects the diversity of the local community	Currently being drafted with action plan to support
Proactively utilise the EDS2 results to establish the composition of our workforce in order to target areas for improvement	Currently being refreshed with action plan to support

Executive Lead's Assessment

APR 2017: scoping apprenticeship opportunities for local communities as part of our strategy development.
MAY 2017: Recruitment Policy reviewed. EDS2 scoring agreed and equality objectives approved
JUNE 2017: First BME Network meeting. HRD as Exec sponsor.

Board Assurance Framework 2017-18

BAF 5.1	Strategic Objective: Game-Changing Research And Innovation		Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led					
Exec Lead: David Powell		Type: Internal, Known	Current IxL: 4-2	Target IxL: 4-1	Trend: STATIC

Risk Description

Failure to develop a cohesive approach to research, innovation & education.

Existing Control Measures

• Establishment of RIEC Steering Board	• Steering Board reporting through to Trust Board
• RABD review of contractual arrangements	• Programme assurance via regular Programme Board scrutiny
• Digital Exemplar budget completed and reconciled	• Innovation Co budget in place

Assurance Evidence	Gaps in Controls/Assurance
Research Strategy Committee set up as a new Board Assurance Committee Research, Education and Innovation Committee established Secured ERDF funding for Innovation Team	Lack of integration with other academic partners Commercial research offer not quantified Education Strategy needs to be refreshed

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Educational Partnerships to be cemented	Academy proposals agreed at execs
Develop a robust Academy Business Model	Agreed
Establish pipeline structure for sensors including finances	Proposal agreed in principle
Appoint Academy Leadership Team	JDs agreed at Execs
Launch Innovation Co. and secure funding	Shell Co. formed
Execute plan to increase research portfolio	
Execute contract for RIE with back to back arrangements with the Charity and HEIs	

Executive Lead's Assessment

APR 2017: Issue around charitable commitment now resolved - letter of intent to be re-issued.
MAY 2017: Institute Phase 2 building commenced
JUNE 2017: Academy model agreed

Alder Hey Children's NHS
NHS Foundation Trust

Resource and Business Development Committee
Minutes of the meeting held on: **Monday 5th June 2017**, **at 1400**
Large Meeting Room, Institute in the park

Present:	Ian Quinlan (Chair)	Non-Executive Director	IQ
	Claire Dove	Non-Executive Director	CD
	John Grinnell	Director of Finance	JGr
In Attendance:	Alison Chew	Head of Operational Finance	AC
	Joe Gibson	External Programme	JGi
	Debbie Herring	Director of Strategy	DH
	Laurence Murphy	Head of contracting	LM
	Becky Murphy	Head of External Communications	BM
	Erica Saunders	Director of Corporate Affairs	ES
	Lachlan Stark	Head of Planning and Performance	LS
	Steve Ryan	Medical Director	SR
	Julie Tsao	Executive PA	JT
Agenda item: 33/34	Cathy Fox	Associate Director of Informatics	CF
35	Christopher Gildea	Building Services Operational Lead	CG
Apologies:	Sue Brown	Project Manager and Decontamination Lead	SB
	Claire Liddy	Deputy Director of Finance	CLi
	Graham Dixon	He ad of Building	GD
	David Powell	Development Director	DP
	Melissa Swindell	Director of HR	MS

17/18/21 Minutes of the previous meeting held on 25th April 2017
Resolved:
RABD received and approved the minutes of the previous meeting.

17/18/22 Matters Arising and Action log
Review Run Rate for March 2017
Following an action from the previous meeting Lachlan Stark had reviewed March's run rate to see if this could be replicated.

Lachlan Stark reported on why the run rate had increased in March and advised this could be replicated by increasing activity in Surgery and Medicine. Whilst this wouldn't be an issue for Surgery, Medicine currently had a shortage of staff, particularly middle grades within the rota. A meeting was being held on Monday morning to review.

17/18/23 Performance
As an action from the last meeting Surgery was now in line to meet targets set for quarter 1. This was to be achieved by increasing activity from 124 sessions per week to 130.

The gap within Medicine had been reduced although there was still some way to go. The team was in the process of reducing the remaining gap. Margaret Barnaby requested further accountant support for Medicine to ensure the figures are correct.
Action: AC/JG

17/18/24 Finance report
For the month of April the Trust is reporting a trading deficit of £1.9m which is behind plan by £0.3m. Income is ahead of plan however expenditure is higher than budgeted this is largely in relation to temporary spend although this is within the NHSI cap of £3.7m. The Use of Resources risk rating is 3 which is in line with plan and cash in the bank of £6.2m.

APPROVED

The Divisions produced a series of 2017/18 Control total risks as part of business planning in March 17. The top corporate risks identified were:

1. Pay Control £2.7m
2. Activity Run Rate £3m
3. CiP £3m

In a doing nothing scenario without mitigation this could result in a deficit of £10.8m against the control total of £0.1m surplus. However the likely case is divisions will make recovery actions improve forecasts and the underlying risk is more around the £5m deficit. RABD went through the action plan to reduce overspend.

The Month 1 CIP performance across the Trust showed an underachievement of £0.05m. For the year the Trust is forecasting savings of £5.3m against a target of £8m. The main gaps are in Medicine (£1.2m), Surgery (£0.8m) and Community (£0.4m) divisions.

Trade receivables at the end of April were £4.7m, £0.5m of which was over 90 days old (12%). Laurence Murphy went through the table with the top ten organisations highlighting the 275k from Liverpool CCG. This related to an old dispute over an invoice, this had now been resolved by Alder Hey and Liverpool CCG equally splitting the invoice.

As requested at the last meeting the Return on Investment for Commercial Activities had been included in the report. A discussion was held on how the international private work is taken forward. Alison Chew agreed to request original plans, timescales and performance against the commercial workstreams. Alison advised that as this was a large piece of work it was hoped this would be presented at the July RABD.
Action: AC/Racheal Lea

A discussion was held on the catering trading account. Alison Chew agreed to provide details on costs of catering at the old hospital compared to the new.
Action: AC/Christina Puccini

The Chair requested an update on the costs of postage to be reported at RABD as this continues to be a pressure.
Action: AC

Mags requested for the Control Total presentation to be presented at the Delivery Group meeting on Monday morning.
Action: AC

Resolved RABD:
Received and noted the content of the Finance report for month 1.

Corporate report

Resolved RABD:
Received and noted the contents of the CR report for March month 1.

17/18/25 Agree Key Priority Areas for 2017/18
Resolved:
RABD agreed the following key areas:

- Activity/Run Rate including operational productivity in Theatre
- CIP
- Pay run rate
- GDE percentage of improvement and Efficiency

It was agreed that these items would be first on the agenda.
Action: JT

APPROVED

17/18/26 Programme Assurance

Joe Gibson presented a summary sheet with the 6 overarching workstreams, the projects that report to them and the subcommittees of the Board each workstream reports to. RABD went through the three workstreams reporting to the committee:

Growing through External Partnerships

This project is a long way off were we want to be and the description needs more detail. Equality Impacts are outstanding on four of the live projects.

International and Non NHS patients – Needs a plan on the income to be received.
Strengthen the Stoke Partnership – Work in progress.
Single Service, 2 site, Neonatal Service – This workstream would not necessarily generate a contribution however, it was a priority from a strategic priority.
STP Workstreams – it was noted these workstreams would not be delivered this year due to the progress being made at an STP level.

Debbie Herring update RABD on work in progress in refreshing the benefit of the whole programme this included:

- Outpatients
- Temporary Skills
- Reducing levels of sickness
- Agile Working
- Procurement

Action: DH

Solid Foundations

Equality Impacts are outstanding. The voice recognition PID was currently in draft.

Park, Community Estate and Facilities

David Houghton presented a paper on the workstreams noting each of them has been reviewed with an extended completion date of a maximum of 6 months. Trackers have been reset. Changes have only been made to the timescales not finances. The only project where the finances may change is to the housing resident project as this is ongoing regarding the planning aspect.

Resolved:

RABD noted the report and the work being undertaken to increase pace and benefit

opportunities

17/18/27 Weekly waiting times update

Lachlan Stark noted the terms of reference would be presented at the June meeting for ratification.

Action: LS

All access standards have been achieved for April with the exception of the 31 day cancer standard due to 1 unavoidable breach relating to a complex orthopaedic patient that required a 2nd opinion and onward referral to Birmingham Children's Hospital (BCH). Winter Plan completed at the end of March which meant that the elective activity cap ceased from month 1. Incomplete pathway performance for April is 92%.

Diagnostic testing was complaint for the month of April.

Resolved:

RABD received the weekly waiting time report.

APPROVED

17/18/28 Marketing and Communication Activity report

For the month of April Becky Murphy reported:
Increase in external exposure on Innovation.
Reviewing social media, contacting bloggers to write pieces on the hospital mainly around research and innovation.
Internal plan on a page would be updated in more detail at the June meeting.
Looking into starting a TV series focusing on Alder Hey.
CBBC have contacted the communications team to advise they would like to have their Christmas programme at the hospital again, this was being looked into.
Interviews for the Director of Communications post was due to take place in June.

Resolved:
RABD received and noted the contents of the April report.

17/18/29 Board Assurance Framework

Erica Saunders agreed to:
- ensure 6 key risk areas here reflected in the BAF.
- Ratings of risks were being reviewed.

Action: ES/Jill Preece
Resolved:
RABD received and noted the content of the BAF update.

17/18/30 2017/18 CIP

Resolved:
RABD received the current slides on CIP and the work being undertaken to bridge the current gap of £2.5m.

17/18/31 Monthly Debt Write Off

The write off for £ 7,318.50 was a credit note and should not have been included.

Resolved:
RABD approved May's write offs for £68.50.

17/18/32 2017 – 19 Contract

Laurence Murphy presented the Contract report for March 2017.

2 Year Contract NHSE – 2017/2019 agreed at **£116.3m** (2016/2017 initial baseline £102.3m).

QIPP reduction of - £550k included. This represents a significant reduction compared to -£2.7m in the original proposal & discussions with NHSE continue to ensure that any agreed QIPP reduction is aligned to identified workstreams. Target areas are high cost drugs and excess bed days.

Additional funding has been recognised for oncology MDT's and renal dialysis.

The baseline has increased by £5.7m relating to the transfer of commissioner responsibility for specialist activity.

Funding for new NICE approved drugs (Ataluren & Ivacaftor), approximately £1.3m, excluded at this stage whilst NHSE receive a financial allocation.

It is noted that no further progress has been made to secure the investment needed to establish a dedicated Rehabilitation service.

2 year CCG contract for 2017/2019 agreed at £53.9m (2016/2017 initial baseline £55.4m).

APPROVED

£800k investment in the Community Paediatric service made recurrent (plus £112k non-recurrent funding to address residual 18 week backlog for ASD patients).

£476k investment in the Eating Disorder service made recurrent.

The North Mersey providers have agreed block contracts with Liverpool, South Sefton, Southport, Formby and Knowsley CCG's as part of the 'Acting as One' principle.

Laurence highlighted risks and challenges within the contract including the transfer of services to Liverpool Community Health, Tendering of Tier 4 CAMHS (Dewi Jones Unit) and Non-achievement of CQUIN targets

Lachlan Stark presented the NHS Standard contract that required to be complied with.

Operational Standards will report into RABD.
National Quality Requirements are reported within the corporate report.
Local Quality Requirements – The team are working on this.

Resolved:
RABD noted the contacts presentation for 2017/18.

17/18/33 Global Digital Excellence Programme
Resolved:
Cathy Fox reported that funding for this project was still awaited. Once the funding had been received the 6 posts would be appointed to.

17/18/34 Cyber Incident
Resolved:
Cathy Fox reported on the national cyber incident that took place on 12th May. Due to the attacks the Trust's external IT facilities were closed down as agreed with NHSE.

Cathy Fox went through the action plan. Mags Barnaby thanked IT for their prompt response to the incident.

17/18/35 PFI Contract Monitoring report
Christopher Gildea presented the monthly report noting the settlement deal 3 is due to be completed by the end of July.

Energy continued to be over target, provided that the initial assumptions and design are accurate it was hoped this would be back in line by September 2017. Phil Morgan, Trust Engineer Provider is leading the working group on this.

Resolved:
RABD received an update on the PFI monitoring report and an update from Phil Morgan on the Trusts energy consumption.

Any Other Business
Laurence Murphy
The Chair thanked Laurence Murphy for his support with contracts and wished him a happy retirement.

Date and Time of the next meeting: Wednesday 28th June 2017 at 09:30, Room 5, Level 1 Mezzanine.

APPROVED

Audit Committee

Minutes of the meeting held on **Friday 28 April 2017**
Room 7, Mezzanine, Level 1

Present:	Mr S Igoe (Chair)	Non-Executive Director	(SI)
	Mrs A Marsland	Non-Executive Director	(AM)
In Attendance:	Mrs L Cobain	Assistant Director, MIAA	(LC)
	Mr D Davies	Assistant Director (Anti-Fraud), MIAA	(DD)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs J Lewis	Audit Manager, KPMG	(JL)
	Mrs C Liddy	Deputy Director of Finance	(CL)
	Mrs M McMahon-Joseph	Senior Audit Manager, MIAA	(MMc)
	Miss J Preece	Quality Assurance Officer *(minutes)*	(JP)
	Mrs E Saunders	Director of Corporate Affairs	(ES)
Item 17/18-05	Mrs C Fox	Associate Director of Informatics	(CF)
Item 17/18-18	Mr P OConnor	Deputy Director of Nursing	(POC)
Apologies:	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs V Martin	Counter Fraud Specialist, MIAA	(VM)

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17/18-01 Minutes of the previous meeting held on 26 January 2017

Resolved:

The Committee approved the minutes of the previous meeting.

17/18-02 Matters Arising and Action list

There were no matters arising; the action list was updated accordingly.

17/18/-03 Internal Audit Progress Report

MMcM reported that the following five audits had been completed since the January Audit Committee:

- **Server Infrastructure** – Limited Assurance
- **Quality Governance Framework** – Significant Assurance
- **Information Governance Toolkit** – Limited Assurance
- **Assurance Framework Opinion** – Fully Met
- **Composite Follow Up** – N/A

ES commented on the disappointing position with regards to the assurance opinion on the IG Toolkit and stated this was due to two issues;

1. Provision of training of staff, both mandatory for all staff and additional training for specialist staff.
2. Information Asset Owners to complete reviews of the assets they are responsible for, and then prepare a report for the Trust Senior Information Risk Owner identifying any relevant risks.

ES reported that focussed pieces of work would be taken forward to address these issues and commented that recognition and support for the Trust being a Global Digital Exemplar would act as a mechanism for improving such standards.

SI requested that the Information Governance Manager attend the May meeting to discuss actions.

Work that remained in progress was reported as follows:-

- **PFI Contract Management** – Significant Assurance. Work was in progress to provide management responses and finalise the draft report with Trust Officers. CF stated that this piece of work had been extremely useful and suggested building this into the audit plan going forward. It was agreed this would be done every 2 years.
- **ESR (HR / Payroll Interface) Review** – this report was in draft stage and being discussed with management.
- **Cyber Security** – being concluded.
- **CBU Performance Management** - being concluded.
- **CBU Sickness Metrics** - review commenced in April 2017 as requested by the Trust.

A full update on the items in progress would be presented at the May meeting.

Resolved

Audit Committee: received the Internal Progress Report and noted progress to date.

17/18-04 Composite Follow up Report

The Committee received the position statement with regard to follow up reviews of previous audits.

MMcM commented that positive engagement and Exec support had been very helpful in terms of concluding outstanding recommendations, however 56 recommendations remained outstanding, 51 of which had been followed up with management and 5 in progress.

JG commented on the large number of high risk recommendations and stressed the need to understand the context following his recent commencement in post. SI agreed and requested a report to the May meeting on progress, following which, Exec Leads would be invited to the subsequent meeting (Sept) to explain any outstanding recommendations. ES provided the Chair with reassurance that the report had been taken to the Exec Meeting for immediate action.

Resolved

Audit Committee:

a) Received the Internal Audit Follow Up Report.

DRAFT

b) Agreed to receive a further update on outstanding recommendations to the May meeting.

17/18-05 Electronic Patient Record System Report 2016/17

The Committee received the advisory report with regard to the review of the Electronic Patient Record System.

CF commented on the usefulness of this piece of work which had highlighted a number of issues to resolve. MMcM advised that a task & finish group had been established in repose to, and to take forward the 11 recommendations within the report.

SI welcomed sight of the report and requested that an invitation to the May meeting be extended to the Chair / Lead of the task & finish group to provide an update on resolution of issues. AM commented that issues relating to EPR had also been raised at CQAC.

Resolved:

a) The Committee NOTED the report
b) EPR task & finish group Lead to attend May meeting.

17/18-06 Director of Internal Audit Opinion & Annual Report 2016/17

LC introduced the Director of Internal Audit Opinion & Annual Report 2016/17 and was pleased to report that the Trust had been awarded an overall assurance opinion of 'significant'.

Attention was drawn to specific areas of assurance forming the basis of the opinion. LC was very complimentary in terms of Alder Hey proactively engaging the services of MIAA.

The Committee was advised that, the opinion for 2017/18 would reflect the challenging issues organisations across the NHS are facing in respect of financial performance. Full consultation and engagement with Trusts would be applied on this approach.

A correction to page 10 of the report was requested to reflect the review of the Corporate Governance Manual.

SI took the opportunity to thank colleagues at MIAA for their professionalism, excellent work and challenging and constructive dialogue during the year.

Resolved:

The Committee NOTED the report and overall assurance opinion of 'significant' for 2016/17.

17/18-07 Internal Audit Charter

Resolved:

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Audit Committee received the Internal Audit Charter confirming MIAAs ongoing compliance with the Public Sector Internal Audit Standards.

17/18-08 Draft Internal Audit Plan 2017/18

The Committee received the Internal Audit Plan 2017/18.

MMcM presented the Plan and drew attention to the coverage across different elements. It was noted that the Executive Team had agreed their respective areas. JG agreed with the proposed timings of 2017/18 audits and commented that this was a well-rounded plan.

The fee cost for delivery of the 2017/18 internal audit plan was to remain the same as the previous year.

Resolved:

The Committee received and APPROVED the proposed Internal Audit fees and Plan 2017/18; subject to the need to re-prioritise any pieces of work should this be necessary.

17/18-09 Counter Fraud Plan 2017/18

The MIAA Counter-Fraud Services Plan 2017/18 was received for consideration.

DD advised that the Plan accounted for both national strategy and Trust requirements in respect of NHS Protect.

Attention was drawn to the specific pieces of work proposed for 2017/18.

JG commented that Counter Fraud needed to feature on Trust Induction and undertook to pick this up with VM.

The fee cost for delivery of the 2017/18 counter fraud audit plan was to remain the same as the previous year (£15,275)

Resolved:

The Committee APPROVED the Counter Fraud Plan 2017/18 and associated fees.

17/18-10 Counter Fraud Annual Report 2016/17

DD presented the Counter Fraud Annual Report 2016/17.

He drew the Committees attention to the summary of work completed along with ongoing investigations. DD was pleased to report that the Trusts level of compliance with NHS Protect Standards were all green rated.

AM questioned Alder Heys performance against other NHS organisations and was advised that the Trust was in line with other organisations.

Response to questions within the MIAA Fraud Investigations Benchmarking InSight

The Committee received the follow up report in response to the questions within the MIAA Fraud Investigations Benchmarking InSight (presented at the February meeting).

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The report concluded that, the questions posed in the InSight indicated a good level of compliance with recommended actions and highlighted areas for further development for the 2017/18 Counter Fraud Plan.

Resolved:

Audit Committee received the Counter Fraud Annual Report.

17/18-11 KPMG Technical update

JL presented the Technical Update Report for Committee information.

Preliminary Findings of 2016/17 Quality Account

JL took the opportunity to provide a verbal update on the outcome of the three indicators tested within the 2016/17 Quality Account.

She reminded the Committee that three indicators had been tested (two mandated and one local) and provided the following updates:

1. Mandated indicator: Referral to treatment within 18 weeks for patients on incomplete pathway. KPMG had not come across any indications that data for this indicator was not produced in line with national guidance.
2. Mandated indicator: Accident and Emergency waiting times - a number of issues in relation to data accuracy were evident when undertaking this audit suggesting that data may not be presented in line with national guidance (a similar control issue for 2015/16).
3. Local indicator: Emergency readmissions within 28 days of discharge from hospital - one small recommendation from this audit.

JL was very complimentary in relation to the high standard of the draft Quality Account 2016/17.

SI commented on the recent request by NAO to “split” audit and consulting advice from audit clients and expressed his disappointment to be in this position. He wished to formally record on behalf of the Audit Committee, thanks to KPMG for their professionalism and efficient work to date.

Resolved:

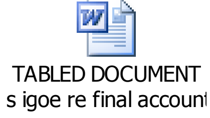
Audit Committee NOTED the content of the KPMG Technical report.

17/18-12 Draft Annual Governance Statement 2016/17

The Committee considered the draft Annual Governance Statement 2015/16 for the Trust.

Chief Executive, Louise Shepherd had been unable to attend the meeting.

Deputy CEO, John Grinnell presented the following note to the Committee outlining some key themes and reflections:-



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The paper highlighted that progress had been made in the context of risk and governance arrangements, and that the Trust had embarked on a journey to embed robust ward to board reporting.

JG supported these observations and further highlighted the need for improvements in productivity following the move which saw an expected 'dip'.

SI welcomed the report from LS and took the opportunity to thank CL for her support as Interim Director of Finance during the final quarter of the year.

Resolved:

a) Audit Committee NOTED the contents of the statement received from Chief Executive; and
b) APPROVED the draft Annual Governance Statement 2015/16.

17/18-13 Assurance Committee Annual Reports 2016/17

The Committee considered and discussed the Annual Report for the Assurance Committees as follows:-

- Audit Committee;
- Resources and Business Development Committee; and
- Clinical Quality Assurance Committee.

The Committee was advised that owing to the cycle of meetings the IGC & WOD Annual Reports had not yet been approved and submission to the Audit Committee would follow (May meeting).

Resolved:

a) Audit Committee APPROVED the 2016/17 Audit Committee Annual Report;
b) NOTED the contents of the 2016/17 Resources and Business Development Committee Annual Report; and
c) NOTED the contents of the 2016/17 Clinical Quality Assurance Committee Annual Report.

17/18-14 Waiver Activity

CL presented the activity in relation to waiver requests which had been approved during the period 1 April 2016 to 31 March 2017.

95 waivers had been approved for the whole year with a total value of £4.1m; an increase on the previous year. A message would be cascaded back to teams regarding this increase.

Resolved:

Audit Committee NOTED the contents of the report.

17/18-15 Gifts & Hospitality Register

The Committee received the Gifts & Hospitality Register 2016/17.

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ES presented the report and stated that this remained a challenging area. New guidance had now been released which would be used as an opportunity to raise awareness and encourage staff to log.

It was hoped that the commencement of the Interim Medical Director would also help in delivering an educational piece.

Resolved:

Audit Committee NOTED the contents of the report.

17/18-16 Losses & Special Payments

CL presented a report detailing the Losses and Special payments made in the period January 2017 to March 2017.

The Trust had 19 cases of losses and special payments with associated costs of £48k relating to the reporting period.

SI queried if a decrease had been seen in personal injury claims. CL undertook to look at trends within particular areas.

Resolved:

Audit Committee NOTED the contents of the report.

17/18-17 Integrated Board Assurance Report

The Committee considered the End-of-Year BAF Report and summary of key points of assurance discussed at the Integrated Governance Committee (March).

ES presented the report and highlighted that both internal and audit reports were consistent with key risks. An area which had progressed in-year was the escalation / de-escalation process for risks requiring Executive oversight on the Corporate Risk Register. The devolved governance model was now in the process of embedding throughout the organisation and continuing to mature.

SI agreed with the progress made in-year and commended the accountability being taken locally regarding risk management. Ward to Board assurance was now being seen through the CBU deep dive reports, but this was an evolving process.

Discussion ensued regarding the announcement from NHSI for Alder Hey to lead on the short term management of Liverpool Community Health and its impact on the overall risk profile of the Trust. ES reported that conversations were ongoing to establish the new structure.

It was agreed that the impact of this new arrangement would need to be referenced in the annual report risk profile section.

Resolved:

Audit Committee received and NOTED the content of the Integrated Board Assurance report.

DRAFT

17/18-18 Policy Register report

The policy review report highlighting progress and policies outstanding was received.

Phil O'Connor reported that, since the last report to Audit Committee in January 2017, the number of policies within review date had increased from 69% to 73%. The main areas of concern that remained were Employment policies, Infection Control policies and Health & Safety policies.

Target dates and Executive Leads had been identified for escalation purposes.

ES commented on the large number of policies in existence and stated that an exercise was needed to amalgamate where possible.

SI welcomed the progress made since January.

Resolved:

a) Audit Committee NOTED progress highlighted in the policy review report; and

b) AGREED to remain sighted on this item until further notice.

17/18-19 Any other business

No further business was discussed.

17/18-20 Meeting Review

Audit Committee agreed the meeting had gone well.

Date and Time of next meeting: -

Thursday 25th May 2017 2016 at 1400, Room 7, Mezzanine.

NB: Rearranged to Wednesday 24th May at 1530, Room 7, Mezzanine.

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Integrated Governance Committee - Annual Report 2016/17 - DRAFT

DRAFT

The Integrated Governance Committee

The purpose of the Integrated Governance Committee is to:

- Performance manage the design and effective operation of the risk management systems and processes across the Trust including the management of the Corporate Risk Register 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, a summary of the corporate risk register and any key issues arising from the meeting. Extracts from the BAF and corporate risk register will also be produced to inform Board Committees including Resources and Business Development and Clinical Quality Assurance Committee of the latest position on their related risks.
- Oversee the continuing evolution of risk management systems and processes across the CBUs, corporate business areas and programmes.
- Oversee the integration of all aspects of managing risk across the Trust, including clinical, organisational, programme, project and financial risk and associated links to corporate business planning.
- Advise on remedial action to resolve specific weaknesses, promoting best practice., and monitor progress

Constitution

The Membership comprises one Non-Executive Director, who currently chairs the committee, all the Executive Directors, plus senior Heads of Department including CBU General Managers (now Associate Chiefs of Operations), CBU Heads of Quality, Director of Estates and Deputy Director of Risk & Governance.

To ensure that there is a link to the detail risk work done across the Trust, the Committee is supported by a number of sub groups, including Emergency Preparedness, Health & Safety, Information Governance, Data Quality and the Building Services Team.

IGC meets bi-monthly and the schedule of attendance for 2016-17 is shown in Appendix a, showing the May meeting as not quorate; attendance from some General Managers has been disappointing during the year, though deputies have attended in most cases.

An assurance report from each IGC meeting is provided to the proceeding Board on the key issues and outcomes from the Committee meeting.

Achievements in 2016/17

- The Committee has received al ‘deep dive’ risk report from each CBU which is used as a mechanism to provide more robust assurance around management activities and that systems and controls are in place to proactively review and identify mitigating actions for risks that could impact upon the Trust.
- During the year, a follow up audit was undertaken by MIAA on their initial work looking at Incident Management and Reporting - all recommendations have been completed.
- A number of new reports were developed in the Ulysses System and rolled out to CBU R&G meetings including:-

  - Risk at A Glance Report – a six monthly overview of risks highlighting ongoing trends on the risk register which can be printed for the BAF, Corporate Risk Register and CBU Risk Registers.
  - Risk Movement Report – a report that summarises risk level (ward/department; business unit or corporate), risks worsening, getting better, changes from a selected date, risks overdue a review and risks with old unclosed actions.
- Risk Management training sessions were delivered throughout the year which not only teach staff the general principles of risk management but now puts a great emphasis on teaching staff how to use the risk module effectively.
- A devolved model of governance within CBUs was implemented in December 2016 and CBU Heads of Quality have been appointed to support this, including the management of risk
- An exercise to reflect the change from 5 CBUs down to 3 was undertaken on the Ulysses system in January 2017; mapping each department to its relevant CBU and ensuring scheduled reports from the system were updated.
- In March 2016, a follow up review of the MIAA Audit of CBU Risk Management was undertaken. Of the 16 recommendations, 14 were confirmed as implemented with 2 partially implemented:-
  - Development and embedding of Local Risk Registers – now complete
  - Linking CBU Risk Registers to organisational objectives and CBU Annual Plans – now complete
- The sub groups of the Committee provide concise Assurance reports from their activities, highlighting positive assurances, gaps and any resultant key issues that they need action from the committee on. This is providing a clearer focus not just for the reporting to the committee but also for the sub groups themselves:
  - Emergency Preparedness
  - Health & Safety
  - Infection Control
  - Building Services
  - Data Quality
  - Clinical Records
- A thorough refresh of the Risk Management Strategy was undertaken in-year and ratified at the January IGC Meeting. The Strategy, which is readily available on the Trust intranet now adopts the principles of the Risk Management Maturity Model intended to move the Trust towards being recognised as a '*risk enabled' organisation. (**definition: 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).*
- Improving the information available on the corporate risk register and BAF is helping the Committee instigate a more rigorous challenge on what is being considered for escalation, de-escalation and the progress on the set of open risks. An exercise was undertaken in-year to map the corporate risk register and BAF to ensure the risks were linked through to the revised strategic vision to 2020.
- Regular updates on Fire Safety have been provided to the Committee since the move to the CHP.
- The Committee approved and monitored its annual work programme and the effectiveness of each meeting is assessed by the Chair and Director of Corporate Affairs. The meeting is subject to scrutiny by Internal Audit as part of their annual audit plan and ongoing review of the risk management systems and processes.

Assurance Statement

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

Committee Priorities for 2017/18

- The Committee will continue to hold Directors and managers accountable on progress in dealing with their corporate risks and associated risks on the BAF,Divisional risks and support services.
- The Committee will strive to ensure that key issues from the Sub Groups are dealt with effectively and progress on the priorities for each Sub Group are being managed appropriately.
- Continue to monitor the effectiveness of the devolved governance model and receive assurance that risk management is owned and managed locally and that this is providing an effective ward to board system of governance.
- Support the ongoing enhancement and functionality of the Ulysses risk management module as well as further development of reports.
- The Committee will ensure a coherent and integrated approach to risk management & governance through the Governance and Assurance Strategy and associated policy currently in development.

Steve Igoe
Committee Chair
April 2017

APPENDIX A

IGC - RECORD OF ATTENDANCE 2016/17

Quorum: Chair or nominated deputy, two Executive Directors (one of whom is a clinical lead)
(if the Medical Director cannot attend then, one of the Clinical Directors should deputise for them)*

Members

	11 May 2016	29 Jul 2016	14 Sept 2016	15 Nov 2016	11 Jan 2017	15 Mar 2017
Mr S Igoe **(Non-Executive Director)**	✓ (Chair)	✓ (Chair)	Ian Quinlan	✓ (Chair)	✓ (Chair)	✓ (Chair)
Mags Barnaby **(Interim Chief Operating Officer)**	X	X	X	✓	X	✓
Mrs M Swindell **(Interim Director of HR)**	X	✓	✓	✓	✓	✓
Mrs H Gwilliams **(Chief Nurse)**	X	Deputy attended	Deputy attended	Deputy attended	Deputy attended	Deputy attended
Miss E Saunders **(Director of Corporate Affairs)**	X	✓	✓	✓	✓	✓
Mrs L Shepherd **(Chief Executive)**	X	X	X	n/a	n/a	n/a
Mr J Stephens **(Director of Finance)**	✓	✓	X	✓	n/a	n/a
Mrs C Liddy **(Acting Director of Finance)**	n/a	n/a	n/a	n/a	✓	✓
Mr D Powell **(Development Director)**	✓	X	✓	X	X	✓
Mr R Turnock **(Medical Director)**	X	Deputy attended	✓	X	✓	✓

Attendees

	11 May 2016	29 Jul 2016	14 Sept 2016	15 Nov 2016	11 Jan 2017	15 Mar 2017
Adam Bateman - CBU GM/ Associate Chief of Operations (SCACC)		**Deputy**	✓		✓	
Brigid Doyle – Associate Chief of Operations (Community)	**n/a**	**n/a**	**n/a**	**n/a**	✓	✓
Dan Grimes - CBU GM/ Associate Chief of Operations (Med Specs.)		✓	**Deputy**	✓	**G Smith**	**n/a**
Will Weston – Associate Chief of Operations (Medicine)	**n/a**	**n/a**	**n/a**	**n/a**	**n/a**	✓
Rachel Greer - CBU GM/ Associate Chief of Operations (NMSS)	✓	**Deputy**	**Deputy**		✓	
Jackie Flynn - CBU GM (ICS)		**Deputy**	**Deputy**	✓		
Charlie Orton - Research Manager						
Richard Cooke - Director of Infection Prevention and Control	✓	**Deputy**				✓
Louise Dunn - Marketing & Communications Director						
John Williams - Assistant Director of Estates			✓			
Sue Brown – Strategic Project Manager & Decontamination Lead		✓		✓	✓	✓
Mark Deveraux - Head of Soft Services						
Tony Rigby – GM/ Deputy Director of Risk & Governance	✓	✓	✓	✓		
Karen Kay – Head of Risk	✓	✓			✓	
Sarah Stephenson - CBU Head of Quality (Community)	**n/a**	**n/a**	**n/a**	**n/a**	✓	✓
Liz Edwards - CBU Head of Quality (Surgery)	**n/a**	**n/a**	**n/a**	**n/a**	✓	✓
Anne Hyson - CBU Head of Quality (Medicine)	**n/a**	**n/a**	**n/a**	**n/a**		✓
Lesley Robinson – Quality Assurance & Compliance (Medicine)						
Elaine Menarry – EP & Business Continuity Manager	✓	✓	✓		✓	✓
Amanda Kinsella – Health & Safety Manager	✓	✓	✓	✓		✓