Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS PUBLIC MEETING
Tuesday 4th September 2018 commencing at 10:00
Venue: Large Lecture Theatre, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY						
Board Business						
1	**18/19/140**	**10:15**	**Apologies.**	Chair	To note apologies.	For noting
2	**18/19/141**	**10:16**	**Declarations of Interest.**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
3	**18/19/142**	**10:17**	**Minutes of the Previous Meeting.**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **3rd July 2018.**	Read Minutes
4	**18/19/143**	**10:20**	**Matters Arising:** - **Action Log.**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Read Attachment
5	**18/19/144**	**10:25**	**Key Issues/Reflections.**	All	Board to reflect on key issues.	Verbal
Delivery of Outstanding Care						
6	**18/19/145**	**10:40**	**Serious Incidents Report.**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report
7	**18/19/146**	**10:50**	**Care Quality Commission:** - **CQC Action Plan.**	H Gwilliams	To provide the Board with progress to date.	Read report
8	**18/19/147**	**11:00**	**Position Statement for Complaints & PALS, Q1.**	A Hyson	To receive the position statement for Q1, 2018/19.	Read report
9	**18/19/148**	**11:10**	**Infection, Prevention and Control Report, Q1.**	V Weston	To receive the position statement for Q1, 2018/19.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
10	**18/19/149**	**11:20**	**Alder Hey in the Park Site Development update.**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
11	**18/19/150**	**11:30**	**Clinical Quality Assurance Committee: Chair's update:** - **Chair's verbal update from the meeting that took place on the 18.7.18.** - **Approved minutes from the meeting took place on the 20.6.18.**	A Marsland	To receive the approved minutes from the 20.6.18.	Read approved minutes
12	**18/19/151**	**11:40**	**Integrated Governance Committee:** - **Chair's verbal update from the 11.7.18.** - **Approved minutes from the meeting that took place on the 24.5.18.**	S Igoe	To receive the approved minutes from the 24.5.18	Read report and approved minutes
13	**18/19/152**	**11:50**	**Global Digital Exemplar (GDE).**	P Young	To update the Board on the programme.	Read report
The best people doing their best work						
14	**18/19/153**	**12:00**	**People Strategy Update; including update on new pay deal:** • **Guardian of Safeguarding report.** • **Chair's update from the Workforce Organisational Development Committee meeting that took place on the 26.6.18**	M Swindell	To provide an update.	Read report
15	**18/19/154**	**12:10**	**A Framework of Quality Assurance for Responsible Officers and Revalidation –**	G Lamont/ H Blackburn	To provide an update.	Read Report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Annual Report for 2018: • **Framework of Quality Assurance – Annual Organisational Audit.**			
16	**18/19/155**	**12:20**	**Listening into Action.** • **Blood Transfusions.** • **Harvey's Tours.**	T Shackleton	For information and discussion.	Verbal
Lunch (12:30pm-1:00pm)						
Sustainability Through External Partnerships						
17	**18/19/156**	**1:00**	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital.**	A Bateman/ S Ryan	To update the Board on progress.	Presentation
Game Changing Research and Innovation						
18	**18/19/157**	**1:10**	**Register of Shareholder Interests.**	J Grinnell	For information and discussion.	Presentation
Strong Foundations						
19	**18/19/158**	**1:30**	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	J Gibson	To receive an update on programme assurance including the 2018/19 change programme.	Read Report
20	**18/19/159**	**1:40**	**Corporate Report.**	J Grinnell/ H Gwilliams/ M Swindell	To note delivery against financial, operational, HR metrics and quality metrics and mandatory targets within the Corporate Report for the month of August 2018.	Read report
21	**18/19/160**	**1:55**	**Board Assurance Framework.**	Executive leads	To receive an update.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
22	**18/19/161**	**2:05**	**Governor Election Results.**	E Saunders	To inform the Board of the outcome of the Summer Governor Elections.	Read report
23	**18/19/162**	**2:10**	**Proposed Constitutional Change.**	E Saunders	For discussion and approval.	Read report
Any Other Business						
24	**18/19/163**	**2:15**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting: Tuesday 2nd October 2018 at 10:00am, Large Meeting Room, Institute in the Park.						

REGISTER OF TRUST SEAL
Funding Agreement (LJMU) – R&E2 – 31.7.18.
Agreement to Lease (LJMU) – R&E2 – 31.7.18.
Licence to make alterations by under tenant relating to premises known as Alder Hey Children's Hospital – 14.8.18.

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Draft Minutes of the meeting held on **Tuesday 3rd July 2018 at 12:30pm,**
Large Lecture Theatre, Institute in the Park

Present:	Sir D Henshaw	Chairman	(SDH)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Mrs C Dove	Non-Executive Director	(CD)
	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	Vice Chair (Chair)	(IQ)
	Dr S Ryan	Medical Director	(SR)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mrs M Barnaby	Interim Director of Strategy	(MB)
	Mr C Duncan	Director of Surgery	(ChrD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mr M Flannagan	Director of Communications	(MF)
	Ms R Greer	Associate Chief Operating Officer	(RG)
	Dr A Hughes	Director of Medicine	(AH)
	Ms C Liddy	Operational Director of Finance	(CL)
	Mrs K McKeown	Committee Administrator (minutes)	(KMc)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
Agenda item: 11	Mr P Young	Chief Information Officer	(PY)
16	Ms H Ainsworth	Equality and Diversity Manger	(HA)
16	Ms M Eccleston	Chair of the Disability Network Group	(ME)
16	Charles Otim	Chair of the BME Network Group	(CO)
17	Mr. G. Lamont	Consultant Paediatric Surgeon	(GL)
18	Ms K Turner	Lead for Listening into Action	(KT)
20	Ms J Haywood	External Consultant for the Children's Transformation Programme	(JH)
Apologies:	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mrs. C. McLaughlin	Director of Community Services	(CMc)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)

Patient Story

Mr. Ward explained that his daughter, Lola, was born with Mowat Wilson syndrome and was admitted to Alder Hey when she was only two days old. Lola has had a number of stays with the hospital and had her first operation when she was five days old. Mr. Ward explained the reason for Lola's latest stay at Alder Hey and informed the Board of the great care that his daughter has received along with the fantastic support provided by staff members. Lily, one of Lola's sisters, bravely spoke about what it's like being a sister to Lola.

The Chairman asked Mr. Ward if there was anything that the Trust could have done to make his family's experience at Alder Hey any better. Mr. Ward informed the Chairman that Alder Hey had

saved his little girl's life, for which, he will be always be grateful for and did not feel that the Trust could have done anything more.

The Chairman thanked Mr. Ward and Lily for sharing Lola's story.

18/19/103 Quality Improvement Update: Inspiring Quality

The Board was provided with an overview of the activities/outcome of the Quality summit that took place on the 14.5.18 and the visit to Sick Kids in Toronto by a team from Alder Hey.

It was reported that the key actions from both events will help underpin the Quality Improvement Strategy. The Board was advised of the Trust's aims, changes to the way the organisation will work and the areas of focus to inspire quality across Alder Hey. Adam Bateman reported on the components of the Sick Kids Lean Management system that will help to sustain improvement.

The Board was made aware of the Quality Delivery Plan for 2018/19 and its timelines. It was confirmed that the draft Inspiring Quality Business Case is in the process of being compiled and will be submitted to the Trust Board on the 2.10.18 for discussion and approval.

18/19/103.1 Action: SF/JM/AB

Anita Marsland queried as to whether a further summit is in the pipeline. Jo Minford confirmed that the organisation is looking into this matter and advised that an additional three workshops have taken place since the summit and enquiries are being received to arrange sessions with other groups.

The chairman felt that there was a very positive response this time round in relation to improving quality across the hospital and asked Sian Falder on behalf of the Trust Board to thank those who participated in the summit.

Resolved:
The Trust Board noted the quality update.

18/19/104 Apologies

The Chair noted the apologies received from Jeanie France-Hayhurst, Cath McLaughlin, Michael Beresford and Erica Saunders.

18/19/105 Declarations of Interest

There were none to declare.

18/19/106 Minutes of the previous meetings held on 22nd of May 2018
Resolved:
The Board received and approved the minutes from the meeting held on the 22nd of May 2018.

18/19/107 Matters Arising and Action Log

It was agreed to update the action log outside of the meeting and circulate it accordingly.

18/19/107.1 Action: KMC

18/19/108 Key Issues/Reflections

Melissa Swindell informed the Board, following the agreement of the new national pay deal, that information is now starting to filter through on the mechanism for applying the pay increases and increments. It was reported that the new deal will affect all employees on Agenda for Change contracts. . It was agreed that a further update will be submitted on the 4.9.18.

18/19/108.1 Action: MS

Claire Liddy reported that the Trust has been asked to participate in a large innovation bid relating to artificial intelligence.

Jo Williams raised concerns around the research guidance that is being compiled for CQC and the point highlighted by Matthew Peak who felt that the Trust wouldn't achieve the standards set for this area of work. Following discussion it was agreed to invite Matthew Peak to September's Board to advise on how the Trust can become outstanding in its research work.

18/19/108.2 Action: LS

Jo Williams informed the Board that the NEDs felt overwhelmed with the amount of documentation that was circulated very last minute prior to July's Trust Board and being unable to read and digest it in time for the meeting. Louise Shepherd advised of the reasons for the delay and confirmed that further attention will be given to ensure Board members are in receipt of information a week prior to meetings.

Steve Ryan reported on the excellent transition conference that recently took place. It was reported that the commissioner from Leigh is coming along to discuss the preparations that are taking place in order to commence the work that is required to move forward.

18/19/109 Strategic Plan 2018/21

The Board approved the Strategic Plan for 2018/21 following a workshop that took place on the morning of the 3.7.18 where the Board of Directors discussed and agreed the contents/direction of the Trust's Strategic Plan.

Resolved:

The Board approved the Strategic Plan for 2018/21

18/19/110 Serious Incident Report

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

StEIS 2018/11892: This patient was admitted to PICU on the 30.3.18. The patient was a pedestrian and was hit by a car at 60 mph following a high speed traffic collision and sustained traumatic injuries. The patient was reviewed by a plastic surgery registrar on the 09.05.18 and it was confirmed that the patient had developed a pressure ulcer on the heel which was identified as a grade 3. Following an investigation it was found that there had been no lapse in care. Christian Duncan highlighted the importance of having awareness of documentation when a patient is brought into hospital with traumatic injuries in order to identify how and when a pressure ulcer develops.

StEIS 2018/2696: The Trust is now in receipt of the post-mortem and it was confirmed that the patient died from natural causes. It was highlighted that the outpatient appointment was not as timely as the consultant wanted but there was no harm to the patient as a result of this.

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

18/19/111 Care Quality Commission

CQC Inspection Report

The Board received and noted the CQC report for the inspection that took place in February 2018. Louise Shepherd informed the Board that following a request by the Trust to re-look at two areas within the report the organisation saw some changes to the End of Life but the community element and safe element remained the same.

It was reported that the Medicine Division and Surgery Division are to be re-inspected. The Divisions are sighted on this and have addressed all actions.

Louise Shepherd advised the Board of the in-depth conversation that took place at the Clinical Quality Assurance Committee following receipt of the report and confirmed that an action plan is in place to deal with the requirement notices.

Following discussion, it was confirmed that work is continuing in preparation for the next CQC visit.

CQC Action Plan
Resolved:
The Board received and noted the exception report as at the end of June 2018.

18/19/112 Mortality Report

The Board received the Medical Director's Mortality report for quarter 4. Steve Ryan advised the Board that there were no major deviations from anticipated variations in death and the lack of trends offers positive assurance.

Since the last Trust Mortality report, there have been 2 in-hospital deaths where there were factors which may have played a role in the child's death. In future the plan is to improve the statistics to distinguish clearly whether the potentially avoidable factor was internal or external. In both of these cases there were issues with the care outside of Alder Hey that the group believed could have been improved.

Steve Ryan highlighted the team's tribute to Julie Grice for her leadership.

Resolved:
The Board received and noted the Medical Director's Mortality report for quarter 4.

18/19/113 GDE

The Board was provided with an update on the progress of the Trust's Global Digital Exemplar (GDE) Programme along with the achievement of Milestone Three and the measures in place to achieve Milestone Four. The Board discussed the achievements to date at programme/project level and the following points were highlighted:

- *Speciality Packages and Clinical Pathways* - There are currently 63 specialities which have been identified of which 13 are live with 12 in development. A total of 40% will be live by July 2018 including a total of 39 pathways.
- *Standard Documents Across All Specialities* – The Board was updated on the project for introducing a generic set of electronic forms that allow staff to document the most common interactions with patients for both inpatient and outpatients. It was confirmed that there will be a refresh following post implementation review in August.
- *Integration Projects* – A summary of achievements was provided on the integration projects that have commenced and the Board was advised of the E-Consent pilot within urology and the availability of medical photography.
- *E-Xchange (The STP Clinical Platform)* – A solution has been agreed across Cheshire and Merseyside STP with 6 Trusts having been connected and Technical UAT complete. Work is underway to incorporate PACs and Lab data and an agreement has been made to connect to Lancashire's platform. Plans are also being developed to expand to other data sets and trusts. It was reported that the Trust's patient platform will work on the back of the STP platform.
- *Patient Portal* – The Board was advised of the progress that has been made to date with the patient portal. It was pointed out that work is taking place to identify who should have access to health records and other valuable health information.

The Chairman queried as to whether the Trust is conducting a tour of the various Boards to promote this area of work. Peter Young reported that a tour of places is happening at the present time. The Chairman agreed to look into the Board aspect of this matter.

18/19/113.1 Action: SDH

Resolved:
The Board noted the GDE Programme update.

18/19/114 Alder Hey in the Park site Development Update

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

- *Sefton Services* – It was confirmed that CAMHS have moved into Burlington House and services are operational.
- *Demolition* – The programme has progressed as planned and has completed on schedule.
- *Research and Education Phase 2* - Building completion is behind schedule by four weeks therefore handover has been delayed until the 6th of August. The Trust is arranging early access agreements for commissioning from July 2018 to ensure that occupancy can still be achieved in September 2018. University lease agreements are still to be signed but university user group meetings have commenced successfully with operational policies, furniture choices and AV and IM&T requirements being confirmed and scheduled into the commissioning plan. Negotiation continues to reduce additional costs to meet available budget via value engineering and contract negotiation, particularly in relation to delays.
- *Alder Centre* – The new budget figures are in the process of being finalised and discussions are taking place with the charity in respect to funding options for the shortfall.

- *Community Cluster Building* – Work has commenced on the design process.
- Two projects at a cost of £7m each are to be located on the site of Alder Hey and will be included in the project list; DEWI Jones Unit and a joint Neonatal unit. Louise Shepherd highlighted the importance of focussing on these two areas.

Resolved
The Board noted the update.

18/19/115 Clinical Quality Assurance Committee

The Board noted the Chair's verbal update from the Clinical Quality Assurance Committee meeting that took place on the 20.6.18. The Board was advised of the positive work that has taken place to address Sepsis but it was also pointed out that this is still a challenging area of which the Committee remains focussed on. It was reported that Committee has delved into some of the issues being experienced in relation to research and Matthew Peak has agreed to spend some time with the NEDs to enable them to gain a better understanding of the problems.

18/19/115.1 Action: MP

Resolved:
The Board received and noted the approved minutes from the Clinical Quality Assurance Committee meeting that took place on the 14.3.18.

18/19/116 Integrated Governance Committee

Resolved:
The Board received and noted the approved minutes from the Integrated Governance Committee meeting that took place on the 14.3.18.

18/19/117 People Strategy Update

The Board received and noted the contents of the People Strategy report for May 2018.

Health and Wellbeing Strategy

Melissa Swindell informed the Board of the focus over the coming year and beyond to improve the wellbeing of the Trust's staff. It was reported that a wellbeing steering group has been established with representatives from Occupational Health, management, staff side, Counselling, Chaplaincy and others to put in place effective initiatives and support to improve staff wellbeing.

Jo Potier presented a number of slides which provided information on the various components of the Wellbeing Strategy and highlighted the actions that are going to be implemented to promote wellbeing at work. Melissa Swindell pointed out that poor mental health is one of the organisation's biggest contributors for sickness and absence and confirmed that the organisation has commenced with its actions on health. Following discussion it was agreed to circulate the Wellbeing and Work presentation.

18/19/117.1 Action: MS

Louise Shepherd thanked Melissa Swindell, Jo Potier and the team for the work that has taken place to move forward with health and wellbeing.

Action Plan for the Diversity Agenda

Melissa Swindell advised the Board of the action plan for the diversity agenda that has been compiled to assist with the retention of staff and to support the Trust's BME staff.

Resolved:

The Trust Board:

- Approved the Wellbeing Strategy.
- Noted the People Strategy update for April May 2018.
- Noted the Action Plan for the Diversity agenda.
- Received and noted the approved minutes from the Workforce Organisation Development Committee meeting that took place on the 15.2.18 and the 21.5.18.

18/19/118 Listening into Action

The Chair of the Disability Network Group, Margaret Eccleston, shared a presentation with the Trust Board, highlighting the figures from the Disability Staff Survey results and the key comparisons between Disability Rights UK and the Trust's NHS Staff Survey.

The Board was made aware of what needs to be done to empower, encourage and promote equitable opportunities for Trust employees and volunteers with a disability or long term health condition, and a discussion took place around the key priorities for the next twelve months.

The Chair of the BME Network Group, Charles Otim shared the outcome of the Ethnicity Staff Survey results bringing attention to the BME figures relating to discrimination, equal opportunities, harassment and bullying/abuse from staff. Christian Duncan highlighted the importance of taking positive action to address these issues. It was pointed out that the action plan for the Diversity agenda will support the work taking place to improve the experience of BME staff at Alder Hey and to increase the diversity of the workforce.

Following discussion it was agreed that a further update from the Chairs of the network Groups would be submitted to the Trust Board in October 2018.

18/19/118.1 Action: ME/CO

18/19/119 Health Education England (HEE) Annual Assessment Visit Feedback

The Board was provided with an update on the progress following the assessment visit carried out by Health Education England North West on the 3.5.18. It was reported that the Trust has received positive feedback from HEE on the Trust's Patient Safety Action Plan.

Graham Lamont advised that Alder Hey provides a very positive experience for the majority of postgraduate medical trainees; some of the feedback in recent months has been exemplary. The Trust is aware that there are a number of systemic issues that can adversely impact on the educational experience but ongoing actions and governance arrangements are designed to address these risks, to ensure all trainees have an extremely positive experience at Alder Hey.

The Board discussed the action plan that was compiled following the postgraduate education monitoring visit, along with the corrective actions. The Chairman queried as to what outstanding would look like. It was felt that an integrated workforce is the

way forward and would give the organisation more access to staff, but it was pointed out that there will always be gaps in medical rotas due to sickness.

Resolved:
The Board noted the update.

18/19/120 Freedom to Speak Up Guidance

Kerry Turner submitted the Freedom to Speak Up self-review tool for NHS Trusts and Foundation Trusts. The Board was advised that completing the self-review tool and developing an improvement action plan will help trusts to evidence their commitment to embedding speaking up and help oversight bodies to evaluate how healthy a trust's speaking up culture is.

It was reported that the Trust has rated itself as green with a number of ambers and will be conducting a full quality process in the near future.

At the present time the organisation has nine advocates who meet on a monthly basis. Two of the advocates are qualified and it was confirmed that additional training courses will be scheduled take place in 2018. The Trust is looking to increase its advocates.

There are fifteen cases on the data base as a result of referrals to the Guardian/advocates, of which, two have been closed and there have been no cases raised anonymously. Jo Williams queried as to whether timelines and metrics could be incorporated against actions, Kerry Turner agreed to look into this.

18/19/120.1 Action: KT

A discussion took place around the embedding of Freedom to Speak Up across the organisation and it was agreed that a further piece of work is required to look at this as a whole to ensure the Trust is robust in its approach and reporting processes are fit for purpose.

18/19/120.2 Action: KT

Resolved:
The Board noted the information provided on the Freedom to Speak Up self-review tool and guidance.

18/19/121 Joint Neonatal Partnership

Adam Bateman informed the Board that the final bid for a Single Neonatal Service for Liverpool and the wider region has been submitted to NHS England. All of the gaps were addressed prior to submission along with the governance and financial elements. It was reported that the bid was well received on the day and the process for approval will take a month as it will have to be submitted to the relevant NHS England committees.

Governance Arrangements - It was reported that Boards of Directors of AHCH and LWH will retain legal sovereignty of their services and will continue to be accountable for its own service provision. The Chairman queried as to whether a Non-Executive Director should sit on the Board. Adam Bateman agreed to look into this matter.

18/19/121.1 Action: AB

The Board discussed the incident governance model and it was confirmed that incidents at both units will be addressed via this process and reporting into commissioners will be done via the Partnership.

Financial Investment - Following detailed work to profile the incremental costs from Phase 2 and Phase 3 of the Implementation Plan, the investment requested from NHS England over the next two years is £0.5m in 2018/19 and £1.7m in 2019/20. All of these costs are direct pay costs for frontline staffing.

Estates development – Adam Bateman informed the Board that significant progress has been made with regards to the Estate Development at AHCH to provide a 24 cot Neonatal Service and confirmed that Option 1 (E) is emerging as the preferred option. A discussion took place around this option and it was pointed out that this will help with the flow at the front door.

Resolved:
The Board:

- Noted the update provided on the Joint Neonatal Partnership.
- Agreed the Memorandum of Understanding between Alder Hey Children's NHS Foundation Trust and Liverpool Women's NHS Foundation Trust for a Single Neonatal Service for Liverpool and the wider region

18/19/122 Provider Alliance Plan

Louise Shepherd introduced Julie Heywood to the Trust Board and thanked her for the recent work that has been undertaken. It was reported that the Children's Transformation Plan is integral to the Provider Alliance plan and is due to be signed off by the Provider Board.

Julie Heywood presented a number of slides to the Board in order to provide an overview of the context and scope for the Children's Transformation Programme, give feedback from stakeholders, discuss the response to feedback and the work that has taken place to date.

The Board discussed the mobilisation of the model for 2018/19 and it was confirmed that the Children's Transformation Plan has been approved by the HWBB, the LSCB, is supported by the Provider Alliance and linked with the work of the CFTB on the Unicef Child Friendly City Bid. It was pointed out that investment for 2019/20 needs to be scoped out and it was agreed that the finance department should have an input into this area of work.

18/19/122.1 Action: JH

From June onwards there will be an on-going socialisation of the signed off plan along with mobilisation of the Programme Delivery Group with the strategic and enabling workstreams. Monthly tracking at the Children's Transformation Board will take place along with quarterly reporting to accountable bodies.

Mags Barnaby felt that it would be beneficial to have a conversation with relevant colleagues outside of the meeting to discuss the governance element of the plan.

18/19/122.2 Action: MB

Resolved:
The Board noted the Children's Transformation Plan and agreed to support the work going forward.

18/19/123 Proposed Change to Trust Constitution: Amalgamation of two public constituencies

Resolved

The Board received and approved the proposed change to the Trust Constitution for the amalgamation of two public constituencies.

18/19/124 Programme Assurance Update

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

18/19/125 Corporate Report

The new version of the Corporate report for month 2, 2018/19 was submitted to the Board for information and assurance purposes. The following points were highlighted and discussed:

- *Effective*: The Trust has achieved all of the NHSI core standards for month 2. It was reported that high non elective numbers have compromised elective capacity in May resulting in a higher than average number of cancellations. Significant improvements have been made in turnaround times for the typing of clinical letters following outsourcing of the activity.

- *Safe*: There have been no never events in month 2 and a stretch target has been set for clinical incidents resulting in minor harm with a plan in place to support this action.

- *Caring: Friends and Family Test* - An action plan has been compiled to address waiting times, seating in sub waiting areas, signage and entertainment for patients.

- *Well Led*: There are a significant number of PDR's to be undertaken before the end of July. The HR &OD team are working closely with divisions to achieve this.

  There has been a slight increase in month 2 sickness absence figures to 4.58%. Sickness absence is being addressed via a large scale project on improving the Health and Wellbeing of the Trust's staff. The Trust is also being supported through the national NHS Improvement project on improving wellbeing and reducing sickness absence. This large project will also deliver positive impacts on temporary spend, some of which is attributed to absence and some through difficult to fill posts.

- **Finance** – John Grinnell advised the Board that month 2 financials were stronger with the Trust achieving a small surplus of £78k which is £154k ahead of plan. Cumulatively the Trust is now showing a deficit of £986k which is £276k behind plan. The cash balance is £10.5m which is ahead of plan with a capital spend of £3.6m. It was reported that the risk relating to specialist commissioners will be addressed as part of the Q1 review.

Resolved:
The Board received and noted the Corporate Report for Month 2.

18/19/126 Board Assurance Framework (BAF)

The Board received the BAF update for May 2018
The Board was provided with an overview of the contents of the BAF. It was reported that work has taken place to refresh risk ratings to ensure accuracy.

Resolved:
The Board received and noted the BAF update for May 2018.

18/19/127 Infection, Prevention and Control Annual Report

The Board received and noted the contents of the 2017/18 Infection, Prevention and Control Annual Report.

It was reported that there have been 4 hospital acquired cases of MRSA bacteraemia during 2017/18 compared to 2 cases in 2016/2017, 1 in surgery and 3 on the same patient in medicine. A post infection review (PIR) was conducted for all cases and action plans were developed, implemented and monitored via the Divisional Governance structures and IPCC.

Anita Marsland asked as to whether there was anything in particular that has helped improve the service. Steve Ryan reported that there are multi factorial reasons for this; engagement, new ideas, teamwork, changes in practice and integration. Louise Shepherd pointed out that the team received clarity on expectations/guidelines from the Medical Director plus assistance from the Divisional Directors.

Steve Ryan thanked Valya Weston and her team for the hard work that has taken place in order to compile the report.

Resolved:
The Board approved the 2017/18 Infection, Prevention and Control Annual Report.

18/19/128 Any Other Business

There was none to discuss.

Date and Time of next meeting: Tuesday 4th September 2018, 10:00am, Large Meeting Room, Institute in the park.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 3.7.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for May 2018							
3.7.18	18/19/107.1	Matters Arising	Update the action log outside of the meeting and circulate it to Board members.	Karen McKeown	4.9.18		16.8.18 - **ACTION COMPLETE**
3.7.18	18/19/108.1	Key Issues/ reflections	*New Pay Deal* - Provide an update on the mechanism for applying increments.	Melissa Swindell	4.9.18.		16.8.18 -This action has been included on September's agenda. **ACTION COMPLETE**
3.7.18	18/19/115.1	CQAC	Arrange for Matthew Peak to meet with the Non-Executive Directors to explain the issues being experienced by the Trust from a research perspective.	Karen McKeown	4.9.18.		18.8.18 - A meeting took place on the 24.7.18. **ACTION COMPLETE**
3.7.18	18/19/117.1	People Strategy Update	Circulate the 'Wellbeing at Work' presentation to Board members.	Melissa Swindell	4.9.18.		16.8.18 - **ACTION COMPLETE**
3.7.18	18/19/121.1	Joint Neonatal Parntership	Confirm as to whether a Non-Executive Director from Alder Hey should sit on the Joint Board for the Neonatal Partnership.	Adam Bateman	4.9.18.		16.8.18 - This has been built into the MOU. **ACTION COMPLETE**
3.7.18	18/19/122.1	Provider Alliance Plan	*Children's Transformation Plan* - Include Finance when scoping out investment for 2019/20.	Mags Barnaby/ Julie Heywood.	4.9.18.		18.8.18 - This request has been actioned. **ACTION COMPLETE**
3.7.18	18/19/122.2	Provider Alliance Plan	Discuss the governance element of the Children's Transformation Plan with colleagues outside of the meeting.	Mags Barnaby	4.9.18.		18.8.18 - The governance element of the Children's Transformation Plan was discussed with the Exec Team and the Divine 9. **ACTION COMPLETE**
Actions for October 2018							
10.4.18.	18/19/11.1	Mortality Report	Discuss possible ways to see if the benchmarking of performance indicators can produce more meaningful data/statistics, for example, using alternative peer groups when benchmarking.	CQAC/ Steve Ryan	2.10.18.		16.8.18 - This action is in the process of being addressed. An update will be provided on the 2.10.18.
1.5.18.		Patient Story.	*Oncology Ward* - Look into the funding via the Charity to convert a bathroom into a breakout space for children aged between 7-12.	Jo Williams/ Jeannie France-Hayhurst	2.10.18.		16.8.18 - Awaiting feedback. An update will be provided on the 2.10.18.

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 3.7.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
1.5.18.	18/19/47.1	Arts Programme and Next Steps.	Discussion to take place between Vicky Charnock and Michael Beresford around the possibility of a work experience programme being devised between the University of Liverpool and Alder Hey to support the Active Arts for Health Programme.	Vicky Charnock/ Michael Beresford	2.10.18.		16.8.18 - Awaiting feedback. An update will be provided on the 2.10.18.
22.5.18	18/19/93.1	Research Education and Innovation Committee	Meeting to be scheduled in order to discuss a way forward for the Research, Education and Innovation Committee.	Ian Quinlan/ Sir David Henshaw/ Louise Shepherd	2.10.18.		18.8.18 - This action is in the process of being addressed. An update will be provided on the 2.10.18.
3.7.18	18/19/103.1	Quality Improvement Update	Submit the draft Inspiring Quality business case to the Trust Board in October.	Adam Bateman/ Sian Falder/ Jo Minford	2.10.18		
3.7.18	18/19/108.2	Key Issues/ reflections	*Research Guidance being compiled by CQC* - Invite Matthew Peak to the next meeting to advise on how the Trust can become outstanding in its research work.	Karen McKeown	2.10.18.		18.8.18 - It has been decided to defer this item as it may be included in a larger research that is going to be presented to the Trust Board in October.
3.7.18	18/19/113.1	GDE	Look into the possibility of arranging time on the agenda of other Trust Boards to promote Alder Hey's GDE programme.	Sir David Henshaw	2.10.18.		18.8.18 - An update will be provided on the 2.10.18.
3.7.18	18/19/120.1	Freedom to Speak Up Guidance	Incorporate timelines and metrics against actions in reports.	Kerry Turner	4.9.18.		
3.7.18	18/19/120.2	Freedom to Speak Up Guidance	Conduct a piece of work to look at Freedom to Speak Up as a whole to ensure that the Trust is robust in its approach and reporting processes are fit for purpose.	Kerry Turner	4.9.18.		
Actions for November 2018							

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 3.7.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
3.7.18	18/19/118.1	Listening into Action	*Disability Network Groups* - Provide an update to the Trust Board in November 2018.	Chairs of the Network Groups	6.11.18.		
COMPLETED ACTIONS							
6.3.18.	17/18/242.1	Matters Arising and Action Log	***Booking and Scheduling Review Update*** - Provide a further update to the Trust Board on the 1.5.18.	Adam Bateman	1.5.18.		**10.4.18** - This action has been included on May's Trust Board agenda. **ACTION CLOSED**
6.3.18.	17/18/263.1	Draft Financial Plan 2018/19	Present the final version of the 2018/19 Financial Plan to the Trust Board on the 22.5.18.	John Grinnell	22.5.18.		**10.4.18** - This action will be addressed via the NHSI Operational Plan for 2018-19. **ACTION CLOSED**
6.3.18.	17/18/275.2	Change Programme.	***Delivering Outstanding Care*** - Review the support being received by clinicians in the Outpatients department.	Hilda Gwilliams.	22.5.18.		16.8.18 - Following a three day audit the level of support was increased for clinicians. This action has been moved into the OPD
10.4.18.	18/19/22.1	New Pay Deal.	Feedback to be provided on the new pay deal report following discussion at the Workforce Organisational Development Committee.	Melissa Swindell	22.5.18.		**3.7.18 -** An update was provided during July's Trust Board. **ACTION COMPLETE**
1.5.18.	18/19/46.1	Joint Neonatal Partnership - AH & LWH.	The Board will be provided with a further update on the Joint Neonatal Partnership on the 22.5.18.	Louise Shepherd	22.5.18.		**22.5.18 -** This item has been included on July's agenda. **ACTION COMPLETE**
22.5.18	18/19/75.1	Key Issues	*Quality Summit* - Provide an update to the Board on the agreed process for implementing the Quality Summit learning to support the delivery of quality improvements.	Sian Falder/ Jo Minford	3.7.18.		**3.7.18 -** An update was provided during July's Trust Board. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 3.7.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
22.5.18	18/19/75.2	Key Issues	Discuss the issues with the national NHS structure in more detail, outside of the meeting.	Sir David Henshaw/ Mags Barnaby	3.7.18.		16.8.18 - An initial discussion took place around integrated care going forward. **ACTION COMPLETE**
22.5.18	18/19/82.1	GDE	Provide a more granular report on the details of the patient portal during July's meeting.	Peter Young	4.9.18.		**3.7.18 -** An update was provided during July's Trust Board. **ACTION COMPLETE**
22.5.18	18/19/82.2	GDE	Liaise with Mark Flannagan to discuss the showcasing of the patient portal outside of the organisation.	Peter Young	3.7.18.		18.8.18 - Joe Fitzpatrick is liaising with Peter Young regarding this matter. **ACTION COMPLETE**
22.5.18	18/19/83.1	People Strategy Update	Submit the action plan for the diversity agenda, during July's meeting.	Melissa Swindell	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**
22.5.18	18/19/85.1	Freedom to Speak Up	Submit the completed self-review tool for Freedom to Speak Up, during July's Trust Board.	Erica Saunders	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**
22.5.18	18/19/90.1	Board Assurance Framework	Circulate the outcome of the discussion at May's IGC in respect to the pipe corrosion risk and the water contamination risk.	Adam Bateman/ David Powell	3.7.18		3.7.18 - An update was provided on the 3.7.18 during part 2 of the Trust Board meeting. **ACTION COMPLETE**
22.5.18	18/19/91.1	CQC Action Plan	Submit an exception report during July's meeting.	Erica Saunders	3.7.18.		**22.5.18** - This action has been included on July's agenda. **ACTION COMPLETE**

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 3.7.18

Alder Hey Children's NHS Foundation Trust

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
22.5.18	18/19/94.1	Any Other Business	*Trust Board Documentation* - Include page numbers on the agenda for each item.	Karen McKeown	3.7.18.		**22.5.18** - July's Board pack will include page numbers on the agenda for each item.

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th September 2018

Report of:	Chief Nurse
Paper Prepared by:	Chief Nurse and Clinical Risk Manager
Subject/Title:	Duty of Candour and Incident management, including all incident investigations of moderate harm or above.
Background Papers:	Seven Steps to Patient Safety. National Patient Safety Agency 2004. Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. Incident Investigation reports.
Purpose of Paper:	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.
Action/Decision Required:	Note and approve current assurance position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• **Patient Safety Aim** – Patients will suffer no harm in our care. • **Patient Experience Aim** – Patients will have the best possible experience • **Clinical Effectiveness** – Patients will receive the most effective evidence based care.
Resource Impact	n/a

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1. Background:

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

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, sets specific requirements for registered organisations such as Alder Hey NHS Foundation Trust, about the incidents that must be reported to the CQC. The Trust has a responsibility to report to the CQC serious incidents and Never Events,that relate to patient safety/patient harm. In addition, the Trust has a statutory duty to apply Duty of candour for all moderate and above harm incidents, and Never Events.

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

The introduction of Regulation 20 is a direct response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust, which recommended that a statutory Duty of Candour be introduced for health and care providers. This is further to the contractual requirement for candour for NHS bodies in the standard contract, and professional requirements for candour in the practice of a regulated activity. In April 2015 this became law for all providers and the CQC guidance requires Trusts to achieve a verbal Duty of Candour for moderate harm and above incidents within 10 working days. This should be followed up with a written Duty of Candour in a suitable timeframe.

There are three levels of investigation identified within the NHS, where regulation 20 applies, as follows:

- Level 1 (60 working days to complete) – This is a concise Internal Investigation, suitable for less complex incidents usually at moderate harm level (meaning short term harm), and managed by individuals or a small group.

- Level 2 (60 working days to complete) – This level of investigation is conducted for all severe or catastrophic/death harm incidents. This is a comprehensive Internal Investigation, requiring management by a multidisciplinary team, involving experts and reportable to the Strategic Executive Information System (StEIS), which is accessible to the CCG, CQC and Department of Health.

- Level 3 (6 months to complete) – This is an independent investigation, externally conducted, where the integrity of the organisation has the potential to be challenged.

Current position

Table 1 shows the Trust's 2018/19 performance for serious incidents requiring investigation (SIRI). All SIRI investigations are monitored via the monthly performance assurance meetings with individual Divisions, focusing on the management of investigations, including lessons learned and assurance of progress with actions for improvement. In addition, a monthly report of progress with

actions, from SIRI investigations is presented to the Clinical Quality Steering Group, with exceptions reported to Clinical Quality Assurance Committee.

During this reporting period there was one serious incident and no safeguarding incidents reported.

Table 2 shows there are three ongoing serious incident investigations, which comply with external requirements, including the regulatory requirement for duty of candour.

Table 3 shows the Trust had two moderate harm incidents during this reporting period, and the management of this investigation is compliant with external requirements, including the regulatory requirement for duty of candour.

Table 4 shows the closed SIRIs for this reporting period.

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

	SIRI (General)											
	2017/18											
Month	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**
New	0	2	0	1	2	4	0	0	0	1	1	1
Open	8	5	3	1	1	3	3	3	3	2	3	2
Closed	2	3	4	2	1	0	4	0	0	0	0	2
Safeguarding												
Month	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**
New	0	0	0	0	0	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0
Closed	1	0	0	0	0	0	0	0	0	0	0	0
Never Events												
Month	**Aug**	**Sept**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**
New	0	0	0	0	0	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0

Table 2 Ongoing serious incidents requiring investigation:

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2018/18741	30/07/2018	Medicine	Patient treated at Alder Hey was discharged 26/4/2018 at 1700 and was admitted to Warrington Hospital on 27/04/2018 at 00:13. The	Andrew Riordan, Infectious Diseases Consultant and Jeanette White, Matron for	Information being gathered, RCA panel to be arranged.	Yes	Yes – including Duty of Candour letter.

			patient was admitted with active bleeding from an unknown source. Escalation, treatment and blood products given and patient stabilised and admitted to children's ward. Subsequent deterioration and patient died on 28/04/2018 at 0400.	Cancer Services and Laboratory Medicine			
StEIS 2018/15654	25/06/2018	Surgery	The patient with an antenatal diagnosis of Hypoplastic Left Heart Syndrome (HLHS), Mitral Atresia, Ventricular Septal Defect and Hypoplastic Arch with Coarctation, born at 40 weeks of gestation in Burnley; was transferred to Ward 1C on day one of life. The patient was transferred to theatre on the 15/6/2018 for a Norwood-Sano procedure and had an uneventful post-procedure recovery in the Paediatric Intensive Care Unit (PICU). The patient transferred from PICU to Ward 1C on 20/6/2018 at 19.00, 5 days post op Norwood-Sano procedure. The patient was clerked in by the SHO at 21.30 to do bloods, stop the Milrinone	Ian Street, ENT Consultant Surgeon and Jan Taylor, Sister.	Information gathered; initial RCA panel held 01/08/2018, further statements requested, further panel to be held 29/08/2018.	Yes	Yes - including Duty of Candour letter.

			and take the Central Venous Line (CVL) out (due to the swollen leg). During the evening patient started to deteriorate (Paediatric Early Warning - PEW score 7 at 1.00 am) and the patient was reviewed at 1.30am by the cardiac registrar and an appropriate clinical plan was initiated; the patient made small improvements and the PEW score improved from 7 to 6. At 5.00am, the patient began to deteriorate again (PEW 7) and by 7.00am the PEW was recorded as 9. The SHO was bleeped – the SHO spoke with the registrar; clinical plan outlined. The cardiac registrar reviewed the patient at 8.30am. The patient's temperature spiked and advice was taken from the Infectious Diseases (ID) Consultant by the ST2 doctor on the ward round. The patient then had a full septic screen, including a lumbar puncture (LP). Shortly following the LP, the patient became apnoeic and lost cardiac				

			output. An arrest call was made at 9.58am. The patient was intubated on the ward and transferred to PICU; the patient was in Pulseless Electrical Activity (PEA) on arrival to PICU and put on Extracorporeal Membrane Oxygenation (ECMO).				

StEIS 2018/11892	11/05/2018	Surgery	Grade 3 Pressure Ulcer - The patient was admitted to PICU at Alder Hey from Nobles Isle of Man on 30.03.2018 following high speed road traffic collision (RTC). The patient was a pedestrian and was hit by a car at 60mph. The patient sustained traumatic injuries. Patient reviewed by plastic surgery registrar 09.05.2018, pressure ulcer on heel identified as grade 3.	Paula Clements, Theatre Matron	Final report sent to CCG and family.	Yes	Yes - Final report and Duty of Candour letter sent to family.

Table 3 Moderate harm incidents:

Duty of Candour Incidents (excluding SIRI's)							
Reference Number	**Date investigation started**	**Type of investigation**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance**	**Duty of Candour applied**
29724	05.07.2018	RCA Level 1	Patient with autoimmune hepatitis, discharge January 2018, started on 40mg Prednisolone since 25.1.18, had weekly or 2-weekly blood tests, last seen in consultant clinic in February with advice given to reduce steroids when transaminases returned to normal levels. Child had normal transaminases since 29.3.18 but the nurses and doctors reviewing results did not reduce steroids, which resulted in prolonged higher dose steroids, and cushinoid side-effects.	Peter Laing, Endocrinology Advanced Nurse Practitioner	RCA report in draft; meeting being held to review action plan.	Yes	Duty of Candour completed including letter sent to family.
29966	12.07.2018	RCA Level 1	When out visiting one of the children in her home of the package I manage in the community her mum told me that her broviac line had not been flushed in over 2 weeks, this job is usually done weekly by Children's Community Nursing Team but the child has been an inpatient on HDU for a number of weeks then to ward 4B and was	Hannah Woods, 4B Ward Manager	RCA report in draft; RCA lead awaiting further feedback from IV and Long Term Ventilation Teams to finalise draft report.	Yes	Duty of Candour completed including letter sent to family.

			discharged home on Monday 2/7/18. Mum expressed that HDU staff had told her that it was only to be flushed once a month. I raised the concern with Children's Community Matron over the phone immediately who confirmed that her line should indeed be flushed weekly. I contacted CCNT to see if they could come try flush the line as an emergency, CCNT Nurse came to the home and was unable to flush the line as it was blocked, resulting in the child having to come back into hospital.				

Table 4 Closed SIRIs:

Reference Number	Date investigation started	Division	Incident Description	Lead Investigator	Progress	60 working day compliance	Duty of Candour applied
StEIS 2018/2696	30/01/2018	Medicine	Patient's Consultant informed via Ormskirk Hospital of child's death on 22/01/2018. Patient diagnosed with congenital hyperinsulinism, Beckwith Weidemann Syndrome and Gastroesophageal Reflux Disease. Patient seen in outpatients by Consultant 13/12/2018, mother had issues with feeding and referral to Speech and Language Therapy Team (SALT) was made. No reports of choking episodes or difficulty swallowing. Although the referral stated urgent, the appointment did not occur. Following review of baby's care the Consultant reported the incident and decision taken that this was a serious incident that required further investigation.	Jo Blair, Endocrinology Consultant and Joanne Kendrick, Ward Manager, 3C	Final report sent to CCG and family.	Yes	Yes
StEIS 2018/1590	18/01/2018	Surgery	Child transferred from Whiston Hospital on 23/10/2017 due to secondary scalding episode and trauma to buttock from a smashed ceramic mug. The patient was operated on 24/10/17 to repair laceration	Sarah Wood, Consultant Surgeon and Dianne Topping, Senior Nurse	Final report sent to CCG and family.	Yes	Yes

			to buttock and was discharged on 27/10/17. Patient attended Emergency Department 27/12/2017, reviewed by surgical doctor who noted left sided foot drop. On review of case, it is felt that there was a missed laceration to the nerve in the buttock during initial investigation and surgery. If this was recognised during initial surgery, patient would not have had a secondary nerve graft procedure.				

END

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Tuesday 4th September, 2018

Report of	Director of Corporate Affairs/Chief Nurse
Paper prepared by	Governance Manager/Divisional Leads
Subject/Title	CQC Action Plan
Background papers	CQC Action Plan
Purpose of Paper	To inform the Board of the action plans submitted to CQC in response to the 2018 inspection report.
Action/Decision required	The Board is asked to note the content of the plans which will be monitored via relevant assurance committees on a monthly basis.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	N/A

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Tuesday 3rd July 2018

Report of	Director of Corporate Affairs Chief Nurse
Paper prepared by	Governance Manager Divisional Leads
Subject/Title	CQC Action Plan
Background papers	2018 CQC Inspection Report CQC Action Plan
Purpose of Paper	To inform the Board of the action plans submitted to CQC in response to the 2018 inspection report.
Action/Decision required	The Board is asked to note the content of the plans which will be monitored via relevant assurance committees on a monthly basis.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	N/A

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Alder Hey Children's NHS
NHS Foundation Trust

Key	
B	Completed
G	In progress and on track to be completed by target date
A	Risk of non-completion by target date
R	Overdue

No	Must/ should do	Dept	CQC recommendation/action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
1	Must do	Trust Wide	The trust must ensure that there are effective systems and processes to make sure that the requirements of the duty of candour are met fully on all occasions when a notifiable incident has occurred. (Regulation 20).	Review and revision of Trust Duty of Candour policy	Chief Nurse	Associate Director of Nursing and Governance	completed	B	25th July 2018	Integrated Governance Committee	Duty of Candour policy standards and responsibilities reflect the requirements of regulation 20
				Ulysses Incident Management system will accommodate the requirements of regulation 20	Chief Nurse	Associate Director of Nursing and Governance	completed	B	25th July 2018	Integrated Governance Committee	Ulysses incident management module accommodates the requirements of duty of candour
				Monthly audit of Duty of Candour process via the Ulysses incident management system	Chief Nurse	Associate Director of Nursing and Governance	Completed and ongoing monthly	B	25th July 2018	Clinical Quality Steering group	Monthly audit findings of duty of candour process reflect compliance with regulation 20
				Duty of candour will be included as part of Trust induction and mandatory training	Chief Nurse	Associate Director of Nursing and Governance		G	30th September 2018	Workforce Assurance Committee	Duty of Candour included as part of Trust staff Induction and Mandatory training Compliance reflects Trust policy standards for Induction and Mandatory training
2	Should do	Trust wide	Ensure that all services have up to date strategies or improvement plans in place.	Divisions to ensure service level strategies agreed and shared across the organisation to underpin overall Trust strategy	Director of Strategy	Divisional Directors	Action agreed at Board Well Led workshop July 2018	G	November update to Board	Trust Board	Service level strategies/plans formally incorporated in to overall Trust plans
3	Should do	Trust wide	Ensure that all risks across services are managed in a timely way and any controls and actions identified and recorded as outlined in the risk management strategy	Implement recommendations (3 medium, 1 low) from internal audit of Divisional risk and governance audit, which gives 'substantial assurance'.	Chief Nurse	Associate Director of Nursing and Governance	Audit report in draft, awaiting final version for sign off and agreement of management response.	G	Management response by August – final date will be confirmed once this completed	Audit Committee	Recommendations completed and embedded

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Alder Hey Children's NHS
NHS Foundation Trust

No	Must/ should do	Dept	CQC recommendation/action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
4	Should do	Trust wide	Consider the recording of discussion and challenge of executive led meetings and actions from the meetings are completed in a timely way.	Board Administrator to attend refresh workshop re effective recording of board and committee meetings and cascade to other minute takers; committee chairs to ensure actions followed up within agreed timescales	Director of Corporate Affairs	Executive Directors	Action agreed at Board Well Led workshop July 2018		October 2018	All	Robust action trackers consistently applied
5	Should do	Trust wide	Consider identifying a specific action to improve the ethnic diversity of the executive board	Engage in Board level mentoring programme aimed at BME candidates	Director of HR & OD	Director of HR	Identified partner to facilitate source of suitable candidates		First mentee in place by December 2018	Workforce and OD	Actively provide opportunities for BME candidates
6	Should do	Trust wide	Consider how all groups feed into executive led committees.	Review of all committees, their sub-groups and reporting structures	Director of Corporate Affairs	Executive Directors	Action agreed at Board Well Led workshop July 2018		December 2018	Trust Board	Simplification and clarity of corporate governance structure
7	Should do	Trust wide	Consider how to make best use of information to make improvements	As a GDE site, Trust wide projects already underway to inform quality improvement programme	Director of Finance	Chief Information Officer	GDE Programme Board providing regular milestone updates to Trust Board and NHS England		Three year programme with milestones	Trust Board	GDE benefits
8	Should do	Trust wide	Ensure that all actions from meetings are recorded and implemented in a timely way	See action 4 above							
9	Should do	Trust wide	Ensure that they are fully compliant with the appropriate Lampard recommendations	Business case to undertake appropriate three yearly DBS checks to Operational Board	Director of HR	Director of HR	Business case in development		September for agreement of business case	Workforce and OD	Rolling programme of DBS checks in place for all eligible staff
10	Should do	Trust wide	Ensure that complaint responses are managed in line with the trust policy.	Escalation plans for performance monitoring of KPIs embedded at Divisional level	Chief Nurse	Head of Complaints Management	Monthly monitoring has shown increase in compliance		December 2018	Clinical Quality Assurance	All complaint responses managed in line with policy
11	Should do	Trust wide	Ensure that all serious incidents are reported in line with trust policy and national guidance.	Escalation plans for performance monitoring of KPIs embedded at Divisional level	Chief Nurse	Associate Director of Nursing and Governance	Monthly monitoring meetings with CCG in place		Ongoing/ Maintenance action	Trust Board	All SI's managed in line with policy and national guidance

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Alder Hey Children's NHS Foundation Trust

Key	
B	Completed
G	In progress and on track to be completed by target date
A	Risk of non-completion by target date
R	Overdue

No.	Must/ should do	Dept	CQC recommendation/action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
1	Must	Home Care	Ensure that accurate and complete records of the administration of medicines are maintained where relevant and that practice in the management of medicines by unsupervised health care assistant staff is monitored and supported.	Local pharmacies to be requested to produce Medicine Administration Records (MAR) for the medication they are dispensing	Community Divisional Director	Community Nursing Services Manager	In progress.		31st August 2018	Community IGC	All community dispensed Home Care medications listed on a MAR
				Solution to be identified for Alder Hey dispensed medications	Community Divisional Director	Community Nursing Services Manager / Pharmacy Lead	In progress		30th September 2018	Community IGC	MAR in place for AH dispensed medications
2	Must	Home Care	Ensure the trust's policy, standard operating procedures, and relevant guidance for the safe management of medicines are reviewed against current best practice guidelines and covers all necessary areas of medicine administration, including as per required need and over-the-counter medicines administration. Ensure these are available to community staff.	Trust policy, SOPs and any relevant guidance to be updated with the changes regarding medicines administration in Home Care.	Community Divisional Director	Community Nursing Services Manager	In progress.		31st October 2018	Community IGC	Policy, SOPs and any relevant guidance updated.
3	Must	Division wide	Ensure staff knowledge and awareness of the Mental Capacity Act 2005, including the application and implications for ensuring valid informed consent is obtained from patients aged over 16 years of age. The service must also ensure that do not attempt resuscitation orders are appropriately reviewed and documented for all relevant patients who reach, or are past, the age of 16.	Identify a Trust lead for Mental Capacity Act training	Community Divisional Director	Associate Chief Nurse Community			31st July 2018	Community IGC	Lead identified
				Liaise with the Trust's Training Lead to investigate feasibility and options for enhancing the content relating to mental Capacity Act training	Community Divisional Director	Named Nurse for Adult Safeguarding			30th September 2018	Community IGC	Mental Capacity Act training for all relevant staff.
4	Should	Division wide	The service should consider how it can ensure staff are aware of the principles of safeguarding vulnerable adults, and to report safeguarding incidents accordingly, where these apply to potential safeguarding needs of young people (over age 16) or young adults (over age 18) in its care.	Review of Safeguarding Adults training to ensure principles of safeguarding vulnerable adults and reporting of safeguarding incidents is covered.	Community Divisional Director	Associate Chief Nurse Community			31st July 2018	Community IGC	Safeguarding adults training incorporates principles of safeguarding vulnerable adults and reporting of safeguarding incidents

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Alder Hey Children's NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation/action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
				Consider review of Safeguarding training offer across the Trust and if Safeguarding Adults could be incorporated	Community Divisional Director	Trust lead for Safeguarding /Named Nurse for adult safeguarding			31st August 2018	Community IGC	Decision as to future of Safeguarding Adults training and where it sits with safeguarding training
5	Should	Division wide	The service should ensure that all staff within the community children, young people and families service have an appropriate awareness of and ability to recognise, manage and escalate care and treatment for deteriorating children, including those who may be at risk of developing sepsis, and to ensure this is embedded within the relevant policy for deteriorating patients.	Development of Sepsis training specific for community staff	Community Divisional Director	IPCT Sepsis Lead Nurse	Completed		30th June 2018	Community IGC	Specific sepsis training for community staff
				Sepsis training to be rolled out across the Community Division – target of 90% compliance	Community Divisional Director	IPCT Sepsis Lead Nurse	Training is underway		30th September 2018	Community IGC	All relevant community staff trained
				Update of Sepsis Policy as per NICE Guidance for Community services	Community Divisional Director	Consultant Lead Sepsis/ IPCT Sepsis Lead Nurse	To be discussed at the next sepsis steering group meeting is the 15th August		30th September 2018	Community IGC	Policy updated
				Identify named Sepsis Champions for Community Division	Community Divisional Director	Department leads			31st October 2018	Community IGC	Community Sepsis leads identified
				Task and finish group to be set up to investigate options for recognising and managing a deteriorating patient in the community	Community Divisional Director	Community Nursing Services Manager			31st October 2018	Community IGC	Clarity on how community nurses would recognise and manage a deteriorating patient
6	Should	Developmental paediatrics	The service should consider allocating a case co-ordinator to provide oversight of the case for each child accepted onto the autistic spectrum disorder / attention deficit and hyperactivity disorder pathways for assessment and diagnosis.	To review in six month's time if capacity will allow allocation of case co-ordinators	Community Divisional Director	Service Manager Community Paediatrics			January 2019	Community IGC	Assessment of capacity to allocate case co-ordinators
7	Should	Division wide	The service should consider how it can reduce the time taken to issue post-clinic/review consultant letters to patients and families, particularly where a change of medicine or dosage has been made.	Transcription turnaround times to be monitored at the Weekly Performance Meeting meeting to bring timescale down to 3 working days	Community Divisional Director	Therapies Service Manager.	Turnaround time has reduced significantly – currently standing at average of 3 days, but some outliers of 5 working days		31st August 2018	Community IGC	Turnaround time within target of X days
8	Should	Home Care	The provider should consider how it can improve out-of-hours staff knowledge of the Home Care service, the needs of patients receiving care, and the nature of treatment provided within the service.	Develop an action card for use by 1st on-call managers	Community Divisional Director	Community Nursing Services Manager			31st August 2018	Community IGC	Action card developed
				Run through of action card in table top exercise for 1st on call managers at 1st on-call manager's meeting	Community Divisional Director	Community Nursing Services Manager/ Emergency Preparedness			31st October 2018	Community IGC	Action card tested

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Alder Hey Children's NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation/action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
						Manager					
9	Should	Home Care	The service should consider how it can enable Home Care staff to report incidents directly.	Devices with access to Ulysses to be ordered for use by Home care staff	Community Divisional Director	Community Nursing Services Manager	In progress		31at August 2018	Community IGC	Carers able to log incidents from patient's home
10	Should	Home Care	The service should consider the implementation of a clinical review of Home Care records to ensure care and treatment is provided consistently in a safe manner.	Suitable record keeping audit tool to be agreed and implemented	Community Divisional Director	Community Nursing Services Manager	One tool found that would require minor adaptation		September 2018	Community IGC	Audits taking place
11	Should	Division wide	The service should ensure that all staff should be able to access relevant do not attempt cardiopulmonary resuscitation records, if in place.	Requires all community staff to be able to access meditech and medisec. Ensure all community clinical staff have access to view meditech and medisec.	Community Divisional Director	Associate Chief Nurse Community / IM&T			March 2019	Community IGC	All clinical staff can access meditech and medisec.
12	Should	Division wide	The service should continue to review, develop and implement relevant and measurable patient outcome standards across all the service's specialisms.	Scoping exercise to take place to confirm what patient outcome measures are in place in the division and where the outcomes are recorded and monitored	Community Divisional Director	Associate Chief Operating Officer - Community			30th September 2018	Community IGC	Clarification on what patient outcomes are in place
				Where no patient outcome measures currently in use, consider implementing Care Aims or other appropriate outcome tools.	Community Divisional Director	Associate Chief Operating Officer - Community			30th November 2018	Community IGC	Patient outcomes in all teams in Community Division
13	Should	Division wide	The service should consider how it can improve staff's sense of inclusion for the wider geographic locations in Sefton.	Service Manager to work with Sefton teams to identify ways staff feel may improve their sense of inclusion	Community Divisional Director	Therapies Service Manager.			30th September 2018	Community IGC	Sefton teams identify ideas for how they can feel included
				Implement any agreed actions from the Sefton Task and finish group	Community Divisional Director	Therapies Service Manager.			30th November 2018	Community IGC	Improved feeling of inclusion by Sefton based staff
14	Should	Division wide	The service should ensure that transportation of equipment, blood and pathology samples is carried out in line with the trust's policy.	Teams involved in transportation of equipment, blood and pathology samples to audit their current practices against Trust policy to identify any gaps	Community Divisional Director	Head of Quality /Department leads			30th September 2018	Community IGC	Audits completed
				Identify actions to address any gaps in policy	Community Divisional Director	Head of Quality /Department leads			31st October 2018	Community IGC	Action plan agreed
				Action implemented	Community Divisional Director	Head of Quality /Department leads			30th November 2018	Community IGC	Actions implemented

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Alder Hey Children's NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation/action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
15	Should	Division wide	The service should consider how it can ensure patient care plans identify individualised personal goals.	Scoping exercise to take place across all departments to confirm what care plans are in use in the division and which contain individualised personal goals	Community Divisional Director	Associate Chief Nurse Community/ Department leads			30th September 2018	Community IGC	Identification of current care plans that contain individualised personal goals and those that do not
				Where care plans are found to not have individualised personal goals attached, individual teams to review care plans and ensure personal goals are built into the process and are documented	Community Divisional Director	Associate Chief Nurse Community/ Department leads			30th November 2018	Community IGC	Care plans contain individualised personal goals
16	Should	Division wide	The service should consider how it can increase response rates for patient and family surveys such as the NHS Friends and Family test.	The options for methods of conducting Friends and Family test in Community are explored and discussed with community teams	Community Divisional Director	Head of Quality / Head of Volunteers	Potential new provider identified offering a range of methods to capture F&F data.		31st August 2018	Community IGC	Options are presented and discussed
				Plan for the method and process for increasing Friends and Family responses in Community agreed	Community Divisional Director	Head of Quality / Head of Volunteers			31st October 2018	Community IGC	Plan for improving response rate agreed
17	Should	Division wide	The service should consider how it can more readily make available information leaflets in other languages.	Options to be investigated and process to be agreed with Corporate lead for Patient Information leaflets (Corporate Head of Quality)	Community Divisional Director	Head of Quality / Head of complaints			30th September 2018	Community IGC	Process in place for translating patient information leaflets
18	Should	Division wide	The service should consider how it can make information leaflets 'child friendly'.	Options to be investigated and process to be agreed with Corporate lead for Patient Information leaflets (Corporate Head of Quality)	Community Divisional Director	Head of Quality / Head of complaints			30th September 2018	Community IGC	Process in place for ensuring new and updated patient information leaflets are made more child friendly
19	Should	Division wide	The service should consider how it can improve the management of complaints to ensure complaints are responded to in line with the trust's complaints policy.	Recruit a PALS / Complaints Officer dedicated to the Community Division	Community Divisional Director	Head of Quality	- Post advertised - Recruited to post - Start date of 23/07/18 provisionally agreed		31st July 2018	Community IGC	Community PALS/Complaints Officer in post
20	Should	Division wide	The service should consider how it can more effectively record and monitor informal complaints.	To open up 'informal complaint' section of Ulysses on the web end for all users to access	Community Divisional Director	Head of Quality	Agreement of Trust to open this module		30th September 2018	Community IGC	Staff able to access form on Ulysses
				Roll out training for staff	Community Divisional Director	Head of Quality			31st October 2018	Community IGC	Staff familiar with process

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Alder Hey Children's NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation/action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
21	Should	Developmental paediatrics	The service should improve effective operation of referral, triage, assessment and diagnosis processes within the autistic spectrum disorder and attention deficit hyperactive disorder pathways to reduce pathway waiting times, to improve the experience of patients waiting for triage and those accepted to the pathways, and to mitigate any pathway related health and safety risks to patients.	Develop action plans for improvements in: - Liverpool ASD - Liverpool ADHD - Sefton ASD - Sefton ADHD	Community Divisional Director	Service Manager Community Paediatrics			31st August 2018	Community IGC	Action plans developed

Version 1 CQC report June 2018

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

Alder Hey Children's NHS Foundation Trust

Key	
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A	Risk of non-completion by target date
R	Overdue

No.	Must/ should do	Dept	CQC recommendation/action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
1	Should	Critical care	Continue to review its staffing levels.	• Continual external recruitment, in addition to Trust recruitment event. • Regular HR support to review sickness and attendance. • PICU exploring International recruitment. • Proactive forward planning of staffing levels, using workforce data base and age analysis data.	Director HR & Organisational Development	• Alison Fellowes / Alison Scally • Zoe Connor • Denise Boyle • Alison Fellowes / Jayne Peters	• This is an ongoing campaign. • This is an ongoing campaign. • This is an ongoing campaign. • This is an ongoing campaign.		28.9.18 28.9.18 28.9.18 28.9.18	Division of Surgical Care Governance & Assurance & Workforce and Organisational development	• Established, ongoing recruitment process. • Embedded process for review sickness and attendance • Established, ongoing recruitment process. • Adequate staffing levels through effective planning.
2	Should	Critical care	Ensure the services' new cleaning schedules are monitored.	• Regular feedback with domestic services regarding environmental cleanliness audit.	Chief Nurse	• Alison Fellowes / Jayne Peters / Lesley Cooper	• The process of monitoring new cleaning schedules has been introduced.		28.9.18	Division of Surgical Care Governance & Assurance & Integrated Governance Committee	• Cleanliness of the environment to a high standard, consistently.
3	Should	Critical care	Continue to review patients whose stay will be classed as delayed or long term.	• Continue to engage with complex care team and review regularly long term patients. • Patients' progress and care reviewed on a daily basis by nursing and medical staff.	Directors of Operations	• Matron / Alison Fellowes / Jayne Peters • CD / Matron	• Continuous engagement with Complex Care Team + introduction of SAFER. • Daily review of patients' progress and care.		28.9.18	Division of Surgery Board & Clinical Quality Assurance Committee.	• No patients staying longer in hospital than necessary. • No patients staying longer in hospital than necessary.

ALDER HEY CHILDREN'S NHS FOUNDATION TRUST CQC ACTION PLAN

4	Should		Formally monitor the services delayed discharges and reasons for the delays.	• Accurate recording of all delayed transfers/discharges. • Review monthly data from databases ensuring reason for delay and destination of delay recorded. • Feedback data to appropriate teams and service managers.		• Alison Fellowes / Jayne Peters • CD / Matron • CD / Matron	• This is an ongoing campaign. • This is an ongoing campaign • Ongoing – to be discussed at relevant meetings / forums.		28.9.18 28.9.18 28.9.18	Division of Surgery Board & Clinical Quality Assurance	• No delayed discharges / transfers • No delayed discharges / transfers • No delayed discharges / transfers

Name Designation	Designation
Alison Fellows	Ward Manager PICU
Alison Scally	Lead Nurse Clinical Education
Zoe Connor	HR Business Partner
Denise Boyle	Associate Chief Nurse, Division of Surgery
Jayne Peters	Ward Manager HDU
Lesley Cooper	Domestic Operations Manager
Dr Thorburn	Clinical Director
Tracy Wilson	Matron

Alder Hey Children's NHS
NHS Foundation Trust

CQC Action Plan – Diagnostic Imaging

Key	
B	Completed
G	In progress and on track to be completed by target date
A	Risk of non-completion by target date
R	Overdue

No.	Must/ should do	Dept.	CQC action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
1	Should do	Radiology	Ensure that hand gel is available within the corridors and entrance to the department, accessible to both staff and service users	1.Contact IPC and arrange for dispensers to be fitted	Chief Nurse	Radiology Manager	Action now completed	B	31.05.18	Radiology Governance Meeting	Hand Gel has been attached to the walls at the entrance to the department and in both waiting rooms
2	Should do	Radiology	Consider the safety of lone working staff and review the access to staff panic buttons	2a Review Policy RM9 Preventing and managing violence and aggression at work and protecting lone worker policy and update SOPAHCSI12 Radiographers on call in CSI and SOPAHRAD23 lone working out of hours.	Chief Nurse	Radiology Manager	All SOP's have been reviewed and approved Completed	B	01/07/2018	Radiology Governance Meeting	Ensure policy is fit for purpose and that updated SOPs are in place
				2b Risk assessment of the need for additional panic buttons in out of hours areas	Chief Nurse	Security Manager	24.07.18 Risk assessment completed	G	01/09/2018	Radiology Governance Meeting	Risk assessment completed and actions implemented.
				2c RM9 Policy, SOPAHCSI12 Radiographers on call in CSI and SOPAHRAD23 lone working out of hours to be cascaded to all staff once approved	Chief Nurse	Radiology Manager	In progress	G	01/10/2018	Radiology Governance Meeting	Policy and SOP will be disseminated with a sign off sheet and held by the Radiology Manager.
				Audit of process to determine level of assurance around staff safety via incidents review	Chief Nurse	Radiology Manager	In progress	G	01/11/2018	Radiology Governance Meeting Divisional Governance Meeting	To demonstrate policy is effective and efficient Audit reports and local governance minutes reflect compliance.

CQC Action Plan – Diagnostic Imaging

3	Should do	Radiology	Ensure the staff follow the departments own protocol and ensure the staff within the department record the three points of identification on the post procedure screen on the Radiology Information System	3a.Train staff on identification process SOPAHRP5 Policy and procedure used to correctly identify the individual to be exposed to ionising radiation by Radiology staff	Chief Nurse	Radiology Manager	In progress		01/09/2018	Radiology Governance Meeting	Policy and SOP will be disseminated with a sign off sheet and held by the Radiology Manager
				3b.Audit identification process on RIS outlined in SOPAHRP5 Policy and procedure used to identify correctly the individual to be exposed to ionising radiation by Radiology staff	Chief Nurse	Radiology Manager	In progress		01/12/2018	Radiology Governance Meeting Divisional Governance Meeting	To demonstrate SOP and policy are effective Audit reports and local governance minutes reflect compliance.
4	Should do	Radiology/	Consider a chaperone service for patients attending for an ultrasound. To reduce the risk of Radiologist/Sonographer being vulnerable to allegation	4aDepartment to produce an SOP for Chaperoning	Chief Nurse	Radiology Manager	In progress		31.08.2018	Radiology Governance Meeting	Production of a Chaperone SOP
				4b Train staff on Chaperone SOP	Chief Nurse	Radiology Manager	Radiology Department will raise awareness of Trust policy		31.09.2018	Radiology Governance Meeting	SOP will be disseminated with a sign off sheet and held by the Radiology Manager
				4C Audit of process to determine effectiveness of chaperone policy via incident reporting	Chief Nurse	Radiology Manager	Audit scheduled for quarter 3		01.11.2018	Radiology Governance Meeting Divisional Radiology Governance Meeting	To demonstrate SOP is effective and efficient. Audit reports and local governance minutes reflect compliance.
5	Should	Radiology	Re-introduce information leaflets in pictorial format to be included with patient's appointment letters	Produce information leaflets in pictorial form for different examinations	Chief Nurse	Radiology Manager Head of Quality Corporate Services – Patient Information leaflet lead	Need to improve information leaflets and make them child friendly. Department will need to produce about 30 leaflets. Project in development		01/04/2019	Radiology Governance Meeting Divisional Governance Meeting	Pictorial Information leaflets will be included with appointment letters.

6	Should	Radiology	Introduce a performance dashboard for the department, to include "did not attend data", waiting times and risk management, to allow the department to be more responsive to patients and department needs.	Create a dashboard for DNA, waiting times, risk management	Chief Nurse	Radiology Manager with support from the Business Intelligence team	Dashboard in development		01/12/2018	Radiology Governance Meeting Divisional Governance Meeting	Radiology metrics will be visible to the wider Trust.
7	Should	Radiology	Develop a vision and strategy specific to the service	Produce a local strategy; Implement a task and finish group to investigate and bench mark against other Radiology Departments	Chief Nurse	Radiology Manager/ Business Manager	In development		31/10/2018	Radiology Governance Meeting Divisional Governance Meeting	The service will develop Radiology strategy.
8	Should	Radiology	Consider efforts to join the Imaging Services Accreditation Scheme with the Royal College of Radiologists and the College of Radiographers, in order to gain additional support and make continuous improvements.	Carryout a gap analysis to determine if it is feasible for the Trust	Associate COO for Medicine	Radiology Manager	In progress		31.12.2018	Radiology Governance Meeting Divisional Governance Meeting	Review will inform the Division regarding joining ISAS is feasible.
9	Should	Corporate	Include the mental health, learning disability and additional health needs of children on the referral to the department.	9.Communicate need for additional information on all referrals	Chief Nurse	Radiology Manager	In progress		30.09.2018	Radiology Governance Meeting	All referrals to the Department will include additional health needs.
10	Should	Radiology	Review the departments risk register and ensure that arrangements for identifying, recording and managing risks are actioned in a timely manner to reduce risk.	Produce monthly quality reports and report in to Divisional Integrated Governance meeting and Departmental Governance Meeting and attendance at risk validation meetings Ensure all risks are managed in line with Trust policy. To update the Departmental Risk Register. Ensure attendance at regular Medicine Risk/Incident meetings. Communicate risk register contents to departmental staff at monthly meetings.	Chief Nurse	Departmental Lead Radiographer	Monthly quality reports are routinely reported at Divisional integrated Governance Meeting All risks are being managed in line with Trust policy The Departmental Risk Register is updated regularly and discussed at Radiology Governance Meeting A representative will be attending the Medicine risk/incident meetings from August 2018 The risk register is communicated to all staff through the monthly General staff meeting and a risk register bulletin board		31/07/2018	Radiology Governance Meeting Divisional Governance Meeting	All risks will be up to date in line with Trust policy. Minutes will reflect compliance as will the risk register reports submitted to local governance meetings.

Alder Hey Children's NHS
NHS Foundation Trust

CQC ACTION PLAN - END OF LIFE CARE

Key	
B	Completed
G	In progress and on track to be completed by target date
A	Risk of non-completion by target date
R	Overdue

No.	Must/ should do	Dept	CQC action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
1	Should	EOL	The service should ensure that they are fully compliant with relevant national guidance for out of hour's consultant Cover.	Internally Peer Review the service against NICE national guidance. Develop a plan to implement clear out of hours cover for Palliative Care patients.	Clinical Director, Medicine Division	Service Manager Cancer Services	Alder Hey is compliant with NHS England Service Specification E03/S/h for Palliative Care. Alder Hey is currently non-compliant with the NICE guidance 24/7 dedicated Palliative Care out of hours cover. A programme of meetings has been set up with NHS England and Liverpool CCG to agree a plan to resolve out of hours Palliative Care cover regionally. The first meeting was held on 23rd May 2018 final meeting is scheduled for 22nd May 2019. Claire House has appointed a Palliative Care Consultant and cover for Claire House and Alder Hey will be provided in a networked approach and job planning will be done across Alder Hey and Claire House.	G	May 2019	CQAC	Out of Hours provision will be agreed with our commissioner.
2	Should	EOL	The service should ensure that all risks are identified and managed in a timely way and all performance indicators are monitored to improve standards.	Ulysses risk's to be reviewed weekly/monthly depending on risk status. All Ulysses risks and identified new risks to be discussed as part of monthly team meetings. Palliative Care Representation at Division Risk & Governance Meetings	Clinical Director, Medicine Division	Matron Medicine Division Cancer Care Group	Risks reviewed by Service Manager monthly and updated. Palliative Care representative attending Divisional Risk and Governance meetings	G	August 2018	Divisional Governance Group and local governance meetings.	All risks will be up to date in line with Trust policy. Minutes will reflect compliance as will the risk register reports submitted to local governance meetings.

CQC ACTION PLAN - END OF LIFE CARE

3	Should	EOL	The service should ensure it has oversight of clinical incidents recorded in other speciality areas but related to palliative care, so that any themes and trends are identified and lessons can be learned.	All incidents to be discussed as part of monthly team meetings with clear action plans to resolve any issues 6 monthly audit of all incidents to be undertaken to identified with feedback to the team on any trends and agreed action plans to resolve. Palliative Care Representation at Division Risk & Governance Meetings	Clinical Director, Medicine Division	Matron Medicine Division Cancer Care Group	Palliative Care representative attending Divisional Risk and Governance meetings.		October 2018	Divisional Governance Group and Trust Mortality Audit Group.	All incidents will be managed in line with Trust policy. Minutes will reflect compliance in relation to incident management .
4	Should	EOL	The service should review their systems for recording personal resuscitation plans and advance care plans on the electronic system to ensure staff across the hospital can access them.	Implement robust training programmes for Personal Resuscitation Plans and Advance Care Planning. Develop communication strategies to embed learning. Develop a Task & Finish Group to review how we implement and manage Advance Care Plans across the organisation.	Clinical Director, Medicine Division	Service Manager Cancer Services	Training on resuscitation plans is included as part of mandatory resuscitation training. Training on resuscitation plans and Advance Care Plans is also being implemented through a series of resuscitation simulation sessions across the Trust. The SPCT is teaching on Advance Care Planning and resuscitation plans as part of the 2018 PICU and HDU mandatory training programme. Working with our IM&T department to maximise our software to support recording of key information as part of the Global Digital Exemplar work. Mouse mats have been created and are being distributed across the organisation.		March 2019	CQAC	Staff across the hospital will be able to access advance care plans on the electronic system.
5.	Should	EOL	The service should ensure that information systems to record case management information are managed appropriately.	Implement Palliative Care Global Digital Exemplar Specialty Package Develop a Task & Finish Group to review how we implement and manage Advance Care Plans across the organisation.	Clinical Director, Medicine Division	Service Manager Cancer Services	Specialty package to begin in September 2018.		March 2019	Divisional Governance Group and local governance meetings.	System will be in place to allow the team to appropriately manage cases.

CQC ACTION PLAN - END OF LIFE CARE

6.	Should	EOL	The service should ensure that staff have a good understanding of their roles and responsibilities under the Mental Health Act 1983 and the Mental Capacity Act 2005.	A training session on the Medical Capacity Act.	Clinical Director, Medicine Division	Matron Medicine Division Cancer Care Group	Macmillan Consultant in Paediatric Palliative Care has linked with Safeguarding and developed information on the mental capacity act for transition.		September 2018	Divisional Governance Group and local governance meetings.	Relevant staff will have attended training.
7.	Should	EOL	The service should consider ways to improve engagement with people who use the service.	NB There were no specific patient surveys for the service – general point. The service will commence a working group with patient representatives to improve the level of inclusion from patient groups. The patient group will provide oversight of the operational plan for the service and we will ask a patient representative to be part of the internal peer review process.	Clinical Director, Medicine Division	Service Manager Cancer Services	The service will commence a working group with patient representatives to improve the level of inclusion from patient groups.		December 2018	CQAC	Improved engagement / communication with patients parents staff .
8.	Should	EOL	The service should ensure that the operational plan for 2018 is fully embedded and implemented across the service.	12 month programme of work has been initiated with NHS England and Liverpool CCG. The first meeting was held 23rd May 2018 and the last meeting is scheduled for the 22nd May 2019. Nursing review is in its final stages.	Clinical Director, Medicine Division	Service Manager Cancer Services	Senior management have met with the commissioners and will meet regularly every 8 weeks to ensure progress is made. The Specialist Nursing team is being taken through a process of organisational change currently.		September 2019	CQAC	The service will implement the operational plan.

CQC ACTION PLAN – Out Patient Department

Alder Hey Children's NHS
NHS Foundation Trust

Key	
B	Completed
G	In progress and on track to be completed by target date
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No.	Must/ should do	Dept	CQC recommendation /action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
1a	**MUST**	OPD	Ensure there is a robust and effective process in place for ensuring patient records remain secure in all areas of the outpatients department and ensure staff follow this process.	Department to undertake a review of all patient areas that require a safe and secure store for patient records.	Hilda Gwilliams Chief Nurse	OPD Matron	All areas reviewed and revised processes in place	B	Complete	OPD change programme steering group	Staff comply with the legal requirements relating to security of records CQC regulation 17 – good governance. Audit reports and local governance minutes reflect compliance.
				Department to source additional lockable trollies and purchase for OPD.	Hilda Gwilliams Chief Nurse	OPD Matron	In progress. Lockable trolleys on 2 floors one remaining	G	July 2018	OPD change programme steering group	All areas will comply with national guidance on safe and secure record storage.
				New SOP to be put in place for the management of records within the OPD	Hilda Gwilliams Chief Nurse	OPD Matron	In progress	G	31st August 2018	OPD change programme steering group	SOP available to all outpatient staff.

CQC ACTION PLAN – Out Patient Department

Alder Hey Children's NHS
NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation /action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
				Audit of compliance against new SOP on management of records.	Hilda Gwilliams Chief Nurse	OPD Matron	Audit schedule agreed		From October 2018 and ongoing	OPD Governance Meeting	Audit results demonstrate compliance
1b	**MUST**	OPD	All notes are transcribed in line with trust guidelines to ensure medical records are up to date.	Transcription / Clinical correspondence turnaround times required timescales. Implement and update action plan to bring this back in line.	Adam Bateman Chief Operating Officer	Divisional COO	Correspondence turnaround times are now at 2.5 days		31st July 2018	Transcription Task and Finish Group. Divisional Integrated Governance.	All letters to be available to clinician's within agreed timescales as per trust policy.
2	Should	OPD	Ensure that all medications are stored securely and that staff understand how to monitor those that require refrigeration and how to act on findings in accordance with Trust Policy.	Medicine management policy (C37 version 6) and Medicines Management Code Section 10 (Storage of Medicines) to be circulated to all outpatient staff. Monthly Medicine audits to be undertaken by Senior Nurse on each OPD Floor.	Hilda Gwilliams Chief Nurse	Lesley Taylor OPD Matron	In progress		31st August 2018	OPD Governance Meeting	All staff have read and understood stated policies.

CQC ACTION PLAN – Out Patient Department

Alder Hey Children's NHS
NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation /action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
				Ensure monitoring for drug fridge temperatures is implemented in outpatients and required temperature monitoring form utilised.	Hilda Gwilliams Chief Nurse	Lesley Taylor OPD Matron	In progress		31st August 2018	OPD Governance Meeting	Demonstrate departmental compliance with stated policies.
				To ensure the storage of Tetracaine Hydrochloride gel 4% (Ametop) is compliant with Trust policy.	Hilda Gwilliams Chief Nurse	Lesley Taylor OPD Matron	In progress		31st July 2018	Medicine Management	Demonstrate departmental compliance with stated policies.
3	SHOULD	OPD	Review phlebotomy rooms on the ground floor to better meet the needs of patients and staff using this facility.	Review the phlebotomy service inclusive of appropriateness of rooms to meet patient, carer and staff experience. Report to feed in to Trust Improvement group.	Hilda Gwilliams Chief Nurse	OPD Matron	Commencement date 23rd July 2018 Service Review lead – Outpatient Sister		December 2018	OPD Improvement Group	Phlebotomy service is fit for purpose in meeting the needs of children

CQC ACTION PLAN – Out Patient Department

Alder Hey Children's NHS
NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation /action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
4	SHOULD	OPD	Ensure that all patient leaflets are written in a child friendly way.	Identify all patient leaflets in OPD and ensure each is reviewed by a senior nurse for amendments if required and to ensure compliance with Trust policy.	Hilda Gwilliams Chief Nurse	OPD Matron	Scheduled to commence 1st November 2018		31st March 2019	OPD Governance Meeting Divisional Integrated Governance	Child friendly patient information is available and ratified at Divisional Integrated Governance.
5.	SHOULD	OPD	Consider improving signposting in outpatients.	Review signage in outpatients. Report detailing required improvements to be provided to OPD Improvement Group.	Director of Comms	Matron OPD	In development		31st October 2018	OPD Improvement Group	Clear signage will be in place in OPD. Improved patient/parent/carer experience of OPD.
6.	SHOULD	OPD	Improve staff compliance with mandatory training.	Review all staff training records. Ensure all staff are fully aware of their contractual/ professional duty to ensure compliance with key modules in mandatory training and facilitate staff to ensure compliance. Monitor compliance quarterly.	Hilda Gwilliams Chief Nurse	OPD Matron	Improvement plan developed and in place		31st October 2018	Divisional Governance	All staff will be fully complaint with mandatory training.

CQC ACTION PLAN – Out Patient Department

Alder Hey Children's NHS
NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation /action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
7	SHOULD	OPD	Improve staff compliance with safeguarding training.	Review staff training records and ensure all staff are compliant with safeguarding training.	Hilda Gwilliams Chief Nurse	Asst Director of Safe-guarding	In progress		31st March 2019	Safeguarding committee	All staff trained in Safeguarding Children.
8.	SHOULD	OPD	Assure itself that all frontline staff are briefed on the outcome of complaints and investigations.	To ensure outcome of complaints and investigations are a standing agenda item for monthly department meetings. Minutes to be sent to all dept. staff	Hilda Gwilliams Chief Nurse	OPD Matron	In progress		30th September 2018	OPD Governance Meeting Divisional Governance	Learning identified from complaints and investigations is shared with all staff
9.	SHOULD	OPD	Improve engagement with patients, staff, the public and local organisations.	Trust Quality Improvement plan includes involvement of patients and families in all planned changes	Hilda Gwilliams Chief Nurse	OPD Matron	In progress		December 2018	OPD Improvement Group	Improved engagement / communication with patients parents staff public and local organisations

CQC ACTION PLAN – Out Patient Department

Alder Hey Children's NHS
NHS Foundation Trust

No.	Must/ should do	Dept	CQC recommendation /action	Alder Hey action	Director	Lead	Progress	BRAG	Target completion date dd.mm.yy	Monitoring Committee	Required outcome/output
10	SHOULD	OPD	Ensure that all consultants consistently use the system to track patient flow	To be discussed at the OPD Improvement Programme to agree an action to take forward	Adam Bateman Chief Operating Officer	OPD Operational manager	Observational audit undertaken of compliance with EPR processes		Complete	OPD Improvement Group	All clinics fully supported by administration team to ensure processes completed
11.	SHOULD	OPD	Consider checking staff competencies on a regular basis.	Skills matrix to be in place for all staff.	Pauline Brown Director of Nursing	OPD Matron	In progress		31st October 2018	OPD Governance Meeting	Competent staff delivering safe care
12.	SHOULD	OPD	Ensure that all items on the departmental risk register are regularly reviewed and updated	Matron to ensure all risks are managed in line with Trust policy. To update the Departmental Risk Register. Ensure attendance at regular Medicine Risk/Incident meetings. Communicate risk register contents to departmental staff at monthly meetings.	Hilda Gwilliams Chief Nurse	OPD Matron Clinical Director OPD	In progress		31st October 2018	Divisional Governance OPD Governance Meeting	All risks will be up to date in line with Trust policy. Minutes will reflect compliance as will the risk register reports submitted to local governance meetings.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th September, 2018

Report of:	Corporate Services
Paper Prepared by:	Head of Quality – Corporate Services
Subject/Title:	PALS and Complaints position statement
Background Papers:	n/a
Purpose of Paper:	To provide assurance to the Board regarding PALS /Complaints as real-time as possible
Action/Decision Required:	The Board to note the report
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Deliver Clinical Excellence in all of our services
Resource Impact:	n/a

Alder Hey Children's NHS
NHS Foundation Trust

24 August 2018
Complaints & PALS position statement

In 2017/18 at the same time the Trust had received 26 formal complaints; at the present time in 2018/19 the Trust has received 53 formal complaints.

Between the three Divisions this is Medicine 19, Community 17 and Surgery 17. Notably 7 of the Community complaints have been received from MPs and last year there were none during this timeframe. No MP complaints have been received for Medicine and Surgery Divisions.

Themes of formal complaints:

- Treatment procedure remains the top category of complaint (35 out of 53). Within this category 55% relates to Allegations of failure of Medical Care, 11% relates to Allegations of failure of Nursing Care.
- Consent, Communication and Confidentiality is the second highest category with attitude of Medical staff and Communication failure of Medical staff being the subject areas complained about most.

Responses time so far this year are much improved compared to previous years – the average timeframe taken from the complaints responded to at the time of this position statement is 28 days. There have been a large number of complaints responses that have been responded to very speedily with good engagement from the Divisions.

PALS

Currently the Trust has received 577 PALS concerns this year compared to 478 for the same timeframe last year. There has been an increase in April and May; however the numbers each month since then appear to be reducing.

The highest number of concerns related to the following areas:

Waiting time for appointment – 121
Communication Failure – Medical – 82
Alleged Failure in Medical Care - 51
Communication Failure – Admin - 43
ISHA-Information/support/help/ - 38 (these range from requests for information / explanation of treatment/food availability etc., access to health records)
Cancellation of appointment – 32
Medication Delayed - 18
Car Parking – 17
Operation Cancelled – 14
Premises - Unclean - 3

Complaints training sessions:

3 sessions have now taken place, 33 staff attended from a wide variety of specialities and designations within the Trust. Feedback has been very positive.

Currently the Trust has 21 live first stage complaints and one second stage complaint. There is also one complaint being reviewed by the Parliamentary and Health Service Ombudsman pending a judgement to investigate or not.

Three of the complaints have breached their initial agreed timeframe for responding.

A Hyson
Head of Quality – Corporate Services
Trust Complaints and PALS Lead

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 4th September 2018

Report of:	Infection Control Services
Paper Prepared by:	Val Weston, ADIPC
Subject/Title:	Infection Control Services Q1 Workplan Update
Background Papers:	N/A
Purpose of Paper:	Update the board on ICS workplan progress for Q1 18-19
Action/Decision Required:	For Board to note progress with IPC annual workplan.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	**Trust Objectives** **Health and Social Care Act**
Resource Impact:	

Alder Hey Children's NHS
NHS Foundation Trust

IPC REPORT
2018-19
(1st April 2018 – 30th June 2018)

This report provides the Board with the challenges for delivery of the Infection Prevention & Control Work Plan 2018-19.

The work plan for 2017-18 consists of 14 objectives and a total of 118 deliverables. At the end of Q1 ***59%*** (70/118) of the total of deliverables have been completed. ***25%*** (30/118) of the total deliverables are in progress (amber). ***16%*** (18/118) are classified as red. Please see table 2 below for RAG rating.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green
Q1	14	118	16% (18)	25% (30)	59% (70)

Table 1: Deliverables RAG rating

The table below shows the deliverables that are classified as red.

Activity	Lead	Deliverable	*Comments*
3. Hand Decontamination			
Children's Hand Hygiene Initiative – in conjunction with PDI	IPC Team and PDI	Present finding of the pilot study to the Trust, and at the Infection Prevention Society Conference – October 2018.	***Q1 – Awaiting commencement of pilot study.***
		Write up study for publication.	***Q1 – Awaiting commencement of pilot study.***
		If pilot successful – to introduce scheme across the Trust.	***Q1 – Awaiting commencement of pilot study.***
To explore new hand hygiene audits tools and technology incorporating the use of Protective Personal Equipment (PPE)	Hand Hygiene audit tools – IPC Team	IPC team to source, trial and decide on new hand hygiene tool.	***Q1 – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.***
	New Technology – IPC Team and data analyst (CQ)	IPC team and CQ – to investigate how new tool can be recoded and results disseminated across the Trust.	***Q1 – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.***
To ensure that the non-compliance with hand hygiene proforma is utilised throughout the Trust.	DIPC, Associate DIPC and IPC Team	IPC team to scope how non-compliance can be reported across the Trust.	***Q1 – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.***
		IPC team to communicate the process via the Link Nurse/Representatives and the governance structures	***Q1 – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.***
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 – To be scheduled into Link Nurse Programme.***
		Once hand hygiene assessments are recorded on ESR. To develop a monitoring system across the Trust.	***Q1 – Awaiting meeting with L&D.***
		Include compliance in IPC Dashboards to provide assurance.	***Q1 – Awaiting meeting with L&D.***
6. Vascular Access			
Widen accessibility of teaching and training for MDT	IV Team and Learning and Development	Training drop in sessions in clinical skills room accessible to MDT.	***Q1 – To be reviewed following workshop implementation.***
Review of Sharps safety and vascular access	IV Team ADIPC	Revisit innovative sharps disposal	***Q1 – Delay due to workload of IV Team and IPC Team. Meeting to be scheduled with company.***
7. Training			
Mandatory Training	IPCT	To develop a new E-Learning package to replace monthly sessions and workbook for clinical staff.	***Q1 – IPC Team to be training in setting up e-learning packages.***
		To develop a new E- Learning package to replace the work book. Following the same	***Q1 – To be progressed once clinical staff package is developed.***

		principles developed from the Clinical E-Learning package.	
11. Information Technology			
To develop opportunities to enhance epidemiological surveillance systems and monitoring opportunities within the Trust	Consultant Infectious Diseases/ADIPC/Data Analyst	To instigate a working group to explore possibilities to enhance the surveillance systems and reporting across the Trust.	***Q1 – ADIPC to organise initial meeting.***
		To develop a business case to develop the enhanced surveillance system agreed.	***Q1 – To be progressed through working group.***
14. Community			
To ensure that a high quality Infection Prevention Service (IPC, Tissue Viability and IV services) is delivered to Community Services	Sarah Stephenson (SS) – Quality Lead for Community, Associate DIPC	Impact assessment on the existing Infection Prevention Services in delivering the required service to the Community.	***Q1- To be progressed once scoping exercise is completed.***
		Development of a Business case to deliver the appropriate identified service across Community services.	***Q1- To be progressed once scoping exercise is completed.***

Table 2: Red deliverables 2018-19.

The table below shows the total number of hospital acquired bacteraemia for quarter 1 2018-19 compared to Q1 2017-18.

Bacteraemia	Q1 18-19	Q1 17-18
MRSA	0	0
MSSA	1 (3A)	3 (HDU, PICU, 3A)
E.coli	1 (3B)	1 (1C Cardiac)
Klebsiella	1 (HDU)	1 (1C Cardiac)
Pseudomonas	1 (PICU)	0
Cdiff	0	0
Outbreaks	0	0

Table 3: Hospital acquired bacteraemia 2017-18 and 2018-19

Infection Prevention & Control Annual Work Plan 2018-2019

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.

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.

Alder Hey Children's NHS
NHS Foundation Trust

Infection Prevention & Control Annual Work Plan 2018/19

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
1. IPC Staffing								
IPC Code: 1,3,4,8,9 **Trust Values:** Excellence Togetherness	Director of Infection Prevention and Control – Medical Director	Dr Steve Ryan (SR)						
	IPC Doctor Role: Consultant Microbiologist Consultant Infectious Diseases	Dr Chris Parry (CP) Dr Beatrix Larru (BL)						***Q1*** *- IPC Doctor/Consultant Microbiologist to take up post 3rd September 2018.*
	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)						
	0.2 Seconded IPC Associate Nurse (Band 6) – initially for 1 year	Alan Bridge (AB)						
	0.6 IPC Data Analyst (band 5)	Carly Quirk (CQ)						
	Clinical assistant (band 3)	Vickie Lam (VL)						

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	PA/Admin assistant - shared with the Sepsis Team(band 4)	Romi Eden (RE)						
	Infection Prevention & 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 February 2018.	DIPC and Associate DIPC						
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							

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	PHE for monitoring purposes							
	MRSA/ MSSA/VRE/E.coli Bacteraemia	DIPC/ Associate DIPC/ IPC Doctor(BL), IPC Team and a review panel	To identify, communicate and instigate investigations by the 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/ IPC Team and Antimicrobial Pharmacist (AT)	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.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	CPE	Microbiology and IPC Team	To instigate an incident meeting with clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
			To develop and submit a business plan for rapid PCR testing to ensure timely screening and isolation of identified at risk and previous positive patients.					***Q1*** *- Business case submitted. Further data required for review July meeting.* ***Q2*** *– Business case successful August 2018.*
	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****-Review panels to be progressed once IPC Doctor is in post. New SSI reporting template (Shared by Royal Wolverhampton Hospital) – work to be progressed so that reporting can be available across the surgical division.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	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 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.					
	Expert Virology provision and expertise	Medicine General Manager Glenna Smith (GS) and Microbiology.	To secure expert Virology provision and expertise.					***Q1-*** *Talks ongoing with Virology department at The Royal Liverpool Hospital.*
3. Hand Decontamination								
IPC Code: 1,2,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Children's Hand Hygiene Initiative – in conjunction with PDI	IPC Team and PDI	Complete an initial evaluation of hand hygiene behaviour of children across the areas identified for the pilot.					
			Introduce the pilot scheme into the identified areas. Pilot study to run over 2 months.					***Q1*** *– Meetings continue with industry partner. Delay due to long term sickness (industry partner). Progress meeting scheduled for 2nd August 2018.* *Q2 – Industry partner to present work so far to IPC link nurses on 24th September 2018. Plans to then trial process on identified wards and roll out across the*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								Trust IN Infection Control Week (15th October 2018).
			Present finding of the pilot study to the Trust, and at the Infection Prevention Society Conference – October 2018.					***Q1** – Awaiting commencement of pilot study.*
			Write up study for publication.					***Q1** – Awaiting commencement of pilot study.*
			If pilot successful – to introduce scheme across the Trust.					***Q1** – Awaiting commencement of pilot study.*
	To scope and implement new and innovative hand hygiene signage across the Trust to ensure	IPC Team	To explore the feasibility of introducing new and innovative hand hygiene signage across the Trust.					***Q1** – ADIPC to approach hand hygiene industry partner to scope feasibility of developing new signage.* *Q2 – Roll out of new hand hygiene products across the Trust now completed, including increased signage in public areas.*
	To explore new hand hygiene audits tools and technology incorporating the use of Protective Personal Equipment (PPE)	Hand Hygiene audit tools – IPC Team	IPC team to source, trial and decide on new hand hygiene tool.					***Q1** – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* ***Q2** – Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.*
		New Technology – IPC Team and data analyst (CQ)	IPC team and CQ – to investigate how new tool can be recoded and results disseminated across the Trust.					***Q1** – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.* *Q2 – Summit has taken place. Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.*
	To ensure that the non-compliance with hand hygiene proforma is utilised throughout the	DIPC, Associate DIPC and IPC Team	IPC team to scope how non-compliance can be reported across the Trust.					***Q1** – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to be organised.*
			IPC team to communicate the process					***Q1** – IPC to discuss new hand hygiene alternatives. IPC hand hygiene summit to*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Trust.		via the Link Nurse/Representatives and the governance structures					*be organised.*
	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** – To be scheduled into Link Nurse Programme.* ***Q2** – Summit has taken place. Industry partner in process of setting up system to fit Trust requirements. Training sessions organised for users in Sept and Oct 2018 with launch to follow.*
	To ensure that hand hygiene technique assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC and Learning and Development.	To explore the feasibility of putting hand hygiene compliance on the ESR system for all clinical staff on an annual basis.					***Q1** – Meeting arranged with Head of Learning and Development 5th July 2018.*
			Once hand hygiene assessments are recorded on ESR. To develop a monitoring system across the Trust.					***Q1** – Awaiting meeting with L&D.*
			Include compliance in IPC Dashboards to provide assurance.					***Q1** – Awaiting meeting with L&D.*
4. Policies								
IPC code 1,2,3,4,5,6,7,8,9 & 10 **Trust Values** Respect Excellence Innovation Togetherness Openness	Review and update IPC policies as required.	IPC Team	Monitored reviewed and updated as part of the IPCT meetings on a bi-weekly basis.					
	To provide advice and support on IPC policies.	IPC Team						
	Participation in updating where IPC is an integral component of relevant policies.	EW	Provide an update of policy review dates					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
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.	ANTT Specialist Nurse	Provide updated compliance figures to the relevant care groups and for IPCC.					
			ANTT compliance scores to be communicated in IV Newsletter and IPCC Report.					
			ANTT compliance scores communicated in ward and department dashboards.					
	To ensure that ANTT assessments are recorded as a mandatory field on an annual basis for all clinical staff and reflected in ESR.	Associate DIPC, ANTT Specialist and Learning and Development	To explore the feasibility of putting ANTT annual assessments on the ESR system as a mandatory field for all clinical staff.					***Q1*** *– ADIPC to meet with L&D Lead. Meeting scheduled for 5th July 2018.*
	Ensure guidelines and ANTT policy remain up to date with latest evidence based practice.	IV Lead Nurse (SM) and ANTT Specialist Nurse	Review all latest evidence based practice and review guidelines and update policy where necessary and appropriate.					
	Provide and update Key Trainer training on an annual basis.	ANTT Specialist Nurse assisted by BBraun.	Key trainer training days are provided 6 times per year.					
	Liaise with St Helens and Knowsley Trust regarding standardising ANTT rotational staff	Associate DIPC/SM	To develop a SOP to standardise ANTT assessments for rotational staff recognising from other Trusts within the last 12 months.					***Q1*** *– SOP discussions have taken place to be progressed.* ***Q2*** *– Meetings have taken place across the North West with regard to standardising ANTT training. Permission has been granted by National ANTT*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	assessments							*authors to progress standardisation across the whole of the North West.*
	Plan to expand this process to cover other Trusts in the North West	Associate DIPC/SM	To progress the work started with Whiston to other Trusts in the region through the North West IV Forum.					***Q1** – ADIPC progressing this work through NW IV Forum group.* ***Q2** – Meetings have taken place across the North West with regard to standardising ANTT training. Permission has been granted by National ANTT authors to progress standardisation across the whole of the North West.*
	Liaise with ANTT experts to review and refine existing processes.	Associate DIPC/SM	Attend annual ANTT conference and to attend North West IV Forum meetings.					***Q1** – ANTT Lead to attend conference in November 2018.*
6. Vascular Access								
IPC Code: **Trust Values:**	Improving patient flow for vascular access.	Lead Nurse IV	Initiation of GDE project – the use of digital technology to implement evidence based practice to improve patient care delivery.					***Q1** – GDE work complete and will be launched at the beginning of September 2018.*
			Implementation of IV access team assessment from receipt of Meditech referral					***Q1** – GDE work complete and will be launched at the beginning of September 2018.*
	Implementation of vessel health and preservation.	Lead Nurse IV	Initiation of GDE project incorporating VHP decision tool.					***Q1** – GDE work complete and will be launched at the beginning of September 2018.*
	Improve workload awareness in vascular access team.	Lead Nurse IV ANS IV	Introduction of daily workload planner.					
	Widen accessibility of teaching and training for MDT	IV Team and Learning and Development	Introduction of ward based workshop/training updates to keep staff educated in the best evidence based vascular access practice.					***Q1** – Dates to be scheduled workshop content completed.* ***Q2**- Completed*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			Training drop in sessions in clinical skills room accessible to MDT.					***Q1** – To be reviewed following workshop implementation.*
			Records to kept by IV team and sent to L&D for recording on ESR.					***Q1** – Attendance records kept by IV Team for all training. Meeting to be scheduled with ESR Lead to discuss process.*
	Review of Sharps safety and vascular access	IV Team ADIPC	Review of butterfly needles and clinical trials.					***Q1** – This will be reviewed following the cannula review. IV Team have started to obtain butterfly needles for review.*
			Review of cannula and clinical trials.					***Q1** – Review underway. Workshop taking place July 2018 to discuss. Plan to take to table top exercise open to the Trust for evaluation.*
			Revisit innovative sharps disposal					***Q1** – Delay due to workload of IV Team and IPC Team. Meeting to be scheduled with company.*
			Exploration of possible introduction of pre filled saline syringes.					***Q1** – These are being trialled July 2018 in A&E, Radiology and Community.*
	Review of vascular access dressings.	IV Team	Explore dressing options					***Q1** – New 3M peripheral vascular access dressings being implemented across the Trust July 2018 with exception of Theatres.*
			Undertake clinical trial					
			Implementation of new dressing for peripheral vascular access.					***Q1** – New 3M peripheral vascular access dressings being implemented across the Trust July 2018 with exception of Theatres.*
7. Training								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness	To ensure that IPC staff are kept updated with IPC evidence based practice.	Lead IPC Nurse	To ensure that a member IPC Team attends the North West Infection Prevention Society (IPS) meetings at least once per year.					***Q1** – Dates to be arranged.*
		Associate DIPC	To regularly attend local HCAI whole health economy meetings.					
		Associate	To attend local and national					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Respect Together Innovation		DIPC/Lead IPC Nurse	IPC/relevant conferences as the service will allow					
		Lead IPC Nurse	To attend Vaccinator training or undertake on line update					***Q1** – Lead IPC booked onto training.*
	To ensure that Trust staff are kept updated with IPC evidence based practice: Please see plan below.							
	Induction	Lead Nurse IPC/CO	At least once per month					
	Mandatory	IPC Team	For all clinical staff yearly (monthly sessions) & work book.					
			To develop a new E-Learning package to replace monthly sessions and workbook for clinical staff.					***Q1** – IPC Team to be training in setting up e-learning packages.* ***Q2** – Team meetings have commenced to progress.*
			Non-clinical 3 yearly – work book					
			To develop a new E- Learning package to replace the work book. Following the same principles developed from the Clinical E-Learning package.					***Q1** – To be progressed once clinical staff package is developed.*
	ANTT Key Trainers	SM	Bimonthly					
	Volunteer IPC Training	CO/VL	Quarterly					
	Hotels Services IPC training	VL	At least once per quarter					
	Link Personnel	IPCT	Monthly					
	Fit Testing Key Trainers	CO	Updated Annually – records of staff					***Q1** – Training sessions continue. However update from wards and departments*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			training reported through IPC Dashboards					*remains sporadic.* ***Q2*** *– Fit testing compliance now forms part of the monthly dashboard.*
	Flu vaccinator Training	Lead Nurse IPC	Annual (4 sessions per year)					***Q1*** *– Training sessions arranged prior to flu season.*
	Ad hoc training	IPCT	As required					
8. Audit								
IPC Code: 1,2,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	To provide assurance to the board and relevant committees of adherence to high quality IPC practices.	Lead IPC Nurse/ IPC Specialist Nurse/IPC 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.	All findings are communicated to the relevant clinical staff and reported via the IPC dashboards and discussed at divisional governance meetings and the IPCC. All lessons learnt are disseminated to the relevant staff and other agencies as Appropriate in a timely manner.					
9. Antimicrobial Prescribing								
	Antimicrobial Stewardship (AMS) ward rounds	Antimicrobial Pharmacist	AMS ward rounds (x3/week)					
	AMS Committee		AMS Committee (meet at least					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	meetings		quarterly)					
	Introduction of AMS training to all clinical staff in the Trust.	Antimicrobial Pharmacist (AT) Sepsis Nurse Specialist – James Ashton (JA) OPAT Nurse Specialist – Ruth Cantwell (RC).	AMS training to be introduced across the Trust – currently delivered to junior doctors on induction but not to nurses. To introduce AMS training into induction training.					***Q1** – Initial discussions have taken place with Learning and Development.*
			To introduce AMS training into mandatory training					***Q1** – Initial discussions have taken place with Learning and Development.*
10.Communication								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC bi-monthly report	Lead Nurse IPC	IPC bi-monthly report reported through the IPCC.					
	IPC Dashboard	IPC Data Analyst	Monthly dashboard distributed Trust wide reported through Divisional Governance meetings and IPCC.					
	Communication with the Whole Health Economy	ADIPC	To attend HCAI/IPC meetings across the local area.					
	Communication with other Trusts and agencies such as Public Health England (PHE) and NHS England	IPCT	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.					
	To keep Infection Prevention and Control Intranet page up to date with relevant	IPC Administrator	Ensure that the IPC intranet pages are kept up to date on a monthly basis or as necessary.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	information							
	To ensure that Paediatric Infection Prevention and Control remains high on the agenda at a national level.	Associate DIPC	Associate DIPC to communicate specific paediatric needs to Infection Prevention Society (IPS) through representation on the IPS Board.					
	Communication with other Paediatric Trusts and other hospitals/healthcare facilities caring for paediatric patients. Scoping Paper for the Paediatric Special	Associate DIPC/CO	Commencement of the national IPS Paediatric Forum to share best evidence based practice, benchmarking and innovative projects. To include meetings face to face and virtual and a national annual conference.					
11. Information Technology								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Innovation Together	To continue to enhance the use of Meditech to assist the IPC team in monitoring HCAI	IPC Team, IT team and Pathology IT Manager.	Set up regular meetings to explore how the Meditech system can assist IPC.					***Q1*** *– Ad hoc meetings have taken place. Diary of regular meetings to be developed.*
	To develop opportunities to enhance epidemiological surveillance systems and	Consultant Infectious Diseases/ADIPC/ Data Analyst	To instigate a working group to explore possibilities to enhance the surveillance systems and reporting across the Trust.					***Q1*** *– ADIPC to organise initial meeting.* ***Q2*** *– Awaiting arrival of IPC Doctor.*
			To develop a business case to develop					***Q1*** *– To be progressed through working*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	monitoring opportunities within the Trust		the enhanced surveillance system agreed.					*group.*
12. Interface with relevant groups								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC to attend and provide expert opinion for topics related to IPC.							
	Escalate issues to DIPC as necessary.	Associate DIPC	Regular meetings with DIPC					***Q1 –*** *IPC review equipment as requested. However IPC not always involved in the process.*
	To review new equipment /environmental utilisation	IPCT	Ad hoc meetings as required.					
	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.					
	Hotel services	Lead Nurse IPC Associate DIPC to attend when	To attend scheduled meetings. To provide expert advice and support as required.					

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		required.						
	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.					
	Integrated Governance Committee	DIPC/Associate DIPC/ Lead Nurse IPC	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.					
	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.					
		Associate DIPC/ LM/CO	To assist in the introduction of the OneTogether programme.					***Q1*** *– OneTogether programme instigated and progressing.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Trust Board	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
13. Gram Negative Bacteraemia								
IPC Code: 1,3,4,5,6,7,8 & 9 **Trust Values:** Excellence Innovation Respect Together Openness	Adherence with regards to Gram Negative Blood Stream Infections (GNBSIs) targets	DIPC/ Associate DIPC	To attend whole health economy meetings to develop robust action plans to tackle gram negative bacteraemia reduction targets.					
		IPC Data Analyst	Ecoli, Klebsella spp, Pseudomonas aeruginosa bacteraemia data to be recorded on the MESS system.					
		DIPC/ Associate DIPC	PIR reviews to be commenced for all named gram negative bacteraemia.					
		Associate DIPC/IPC Data Analyst	Trust wide situation reports to be developed to share lessons learnt.					***Q1**-Situation reports for 2017-18 completed and to be disseminated. Monthly sit reps to be shared going forward.*
		Associate DIPC	PIR reviews to be shared across the whole health economy and NHSI.					***Q1**-Situation reports for 2017-18 completed and to be disseminated. Monthly sit reps to be shared going forward.*
14. Community								
IPC Code 1, 2, 3, 4, 5, 6, 8, 9. 10 **Trust Values** Respect	To ensure that a high quality Infection Prevention Service (IPC, Tissue Viability and IV services) is delivered to Community Services	Sarah Stephenson (SS) – Quality Lead for Community, Associate DIPC	To scope out the provision and requirements for Infection Prevention Services for Community Services. To include an audit programme, specific training – mandatory and ad hoc, advisory services and Link personnel updates and requirements. To include					***Q1**-Work has begun to scope out requirements for community.*

IPC Code & Trust Values	Plan & Priority Activities 2018-19	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Excellence Innovation Together Openness			what is achievable able with the existing team resources.					
			Impact assessment on the existing Infection Prevention Services in delivering the required service to the Community.					***Q1*** *- To be progressed once scoping exercise is completed.*
			Development of a Business case to deliver the appropriate identified service across Community services.					***Q1*** *- To be progressed once scoping exercise is completed.*

Alder Hey Children's NHS
NHS Foundation Trust

Trust Wide Infection Prevention and Control Action Plans

Drawing from the evidence presented in the IPC Annual Report 2016/17, key themes were identified to target for 2017/18. Trust wide Action Plans have been developed with other key stakeholders from the Trust to implement and progress these actions and will continue throughout 2018/19.

Key Themes	Infection Prevention and Control or identified Lead	Other Specialist Nurses from the Service
Methicillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia	Val Weston	Sara Melville (Lead Nurse –IV)
Surgical Site Infections (SSI)	Rachael Hanger	Lisa Moore (SSI Nurse Specialist)
Environmental Cleanliness	Jo Keward	Vickie Lam (IPC Clinical assistant)
Prevention of pressure ulcers	Val Weston	Jansy Williams TV Specialist Nurse (to commence in post July 2018) Hannah Dunderdale TV Support Nurse (to commence in post June 2018)
Isolation (New for 2018/19)	Claire Oliver	Jo Keward

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.

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT **Site & Park Development**																									**SRO: David Powell** **Author: David Houghton**
Programme 2018/19	**Apr-18**				**May-18**					**Jun-18**					**Jul-18**					**Aug-18**				**Sep-18**				
Week Commencing	**3**	**10**	**17**	**24**	**1**	**8**	**15**	**22**	**29**	**5**	**12**	**19**	**26**	**3**	**10**	**17**	**24**	**31**	**7**	**14**	**21**	**28**	**4**	**11**	**18**	**25**	
The Park																											Plans submitted for planning permission for the early reinstatement of the first phase of park near Oncology. Meetings continue with universities to consider the development of an outside research lab in Springfield park utilising the space and park users for environmental and health and well being research within university semester subjects. New benches chosen by the local parks group will be installed soon. work on developing the interactive interpretation boards in the forest area continues. This work to be funded by the Veolia trust.
Future Site Development																											The residential scheme has been put on hold and the development team is exploring the full range of uses for the site and revisiting the DCP. Discussions are under way with the preferred partner secured through the OJEU process last year to explore uses other than residential including science, research and health and wellbeing.
New Schemes: Institute Phase II																											Building completion & handover on August 24th. University lease agreements to be signed by October3rd prior to any occupation. Furniture delivery commencing 24th Sept, AV installation from 17th Sept. Occupancy from 3rd October.
New Schemes:The Alder Centre																											Following the high cost within building tender returns; discussions and regular meetings have continued with architects AHMM and possible building partners to reduce building costs to match available funding. Design ready, site ready, but start of scheme on site delayed until final costs are fully covered.
New Schemes: Community Cluster																											The Community Building and Dewi Jones Unit designs are held at stage 2 level whilst affordability is market tested following creeping building costs. The designs have all been well received by users, the parents and children's forum and the friends of Springfield park. Stage three will see the development of 1:50 room layouts and data sheets. Ground levels are being adjusted by demolition contractor in readiness for undercroft parking and commencement on site in spring of 2019
Site Clearance-Demolition Phase 1 & 2			**Completed**																								Programme progressed as plan and has completed on schedule. Additional work has been agreed within the budget to prepare land levels in preparation for the Alder centre, Community Cluster and temporary car park schemes. Next demolition phase not due to commence until 2019/20.
Site Clearance-relocation of on-site services/corporate teams																											The layout and occupancy of the Institute Phase 2 is agreed and all furniture and IT equipment ordered to allow successful agile working and accommodate staff numbers required. Following the Medical Records Review plans and lease arrangements are being developed for medical records to move to Faraday Building. The delay in the Alder centre Build has compressed space within Oncology for the clinical teams moving from Neurology. this is being re planned and will increase the cost of refurbishment. a review of costs is presently taking place to identify build cost, engineering cost, energy use, rates and leases across all building to identify best fit of time, convenience and money.
Site Clearance: Temporary car park and new park phase 1																											Plans drawn up and planning submission submitted for temporary car park and new park phase 1. Land levels being reduced and prepared for car park under Community Cluster and temporary car park commencing 28th August
Community Sefton Services and CAMHS (Relocations)														**Completed**													Sefton Physio Services & CAHMS both moved into new lease premises on time and fully operational.

Alder Hey Children's NHS
NHS Foundation Trust

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 20th June 2018
10.00 am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Hilda Gwilliams	Chief Nurse
	Dame Jo Williams	Non-Executive Director
	Steve Ryan	Interim Medical Director
	Cathy Umbers	Associate Director of Nursing & Governance
	Tony Rigby	Deputy Director of Risk & Governance
	Louise Shepherd	Chief Executive
	Steve Igoe	Non-Executive Director
	Erica Saunders	Director of Corporate Affairs
	Melissa Swindell	Director of HR
	Christian Duncan	Director, Surgical Division
	Rachel Greer	Associate Coo- Community Division
	Denise Boyle	Associate Chief Nurse, Surgery
	Anne Hyson	Head of Quality - Medicine
	Will Weston	Associate Chief of Operations
	Sarah Stephenson	Head of Quality – Community Division
	Lachlan Stark	Head of Planning and Performance
	Mark Flannagan	Director of Communications
	Stefan Verstraelen	Head of Quality, Surgery Division
	Matthew Peak	Director of Research
	Cathy Wardell	Associate Chief Nurse, Medicine

In Attendance:

	David Porter	Consultant
	Glenna Smith	General Manager – Medicine
	Phil O'Connor	Deputy Director of Nursing
	Julie Creevy	Executive Assistant (Minutes)

18/19/040 Apologies:

	Pauline Brown	Director of Nursing
	Louise Shepherd	Chief Executive
	Jeannie France-Hayhurst	Non-Executive Director
	Adrian Hughes	Director, Medicine Division
	Mark Peers	Public Governor
	Mags Barnaby	Interim Director of Strategy
	John Grinnell	Director of Finance
	Steve Ryan	Interim Medical Director
	Jacqui Ruddick	Head of Quality, Medicine Division
	Cath McLaughlin	Director, Community Services Division
	Adam Bateman	Acting Chief Operating Officer
	Mark Flannagan	Director of Communications
	Julie Williams	Governor

Jo McPartland Consultant Paediatric Pathologist

18/19/41 Declaration of Interest
None declared

18/19/42 Minutes of the previous meeting held on 16th May 2018
Resolved:
CQAC approved the minutes of the previous meeting held on 16th May 2018, with the exception of the typo graphical error within complaints./PALS update – PALS complaints should read 421 not 41.

18/19/43 Matters Arising and Action Log:-
18/19/23 DIPC Quarter 4 Report – Training programme for nursing staff
Action: HG agreed to circulate report on PBs return from leave w/c 26th June 2018, for discussion at the next CQAC meeting.
18/19/36 – CQSG Medical Representation at CQSG – HG confirmed that she had discussed this issue with Dr. Ryan who is awaiting confirmation regarding divisional representation at CQSG.
18/19/37 – Customer care provided by front line staff – HG confirmed that she had recently met with the Heads of Service who were currently addressing this issue.
HG confirmed that there is a now dedicated staff resource addressing issue regarding car parking**.**
HG confirmed that the cleaning/signage and bin issues have been addressed. HG stated that an improvement should be evident by the next CQAC meeting.

Action: Committee stated that communication updates should be provided to staff to advise on position statement. HG confirmed that she is currently working with David Powell with regards to pressures on car parking, with regards to contractors parking within the staff and visitor bays.

ART Business Case update - HG confirmed that the Business Case is currently in the process of quality control process; HG confirmed that this would be presented to the July CQAC meeting.
Action: Business Case to be presented at July CQAC meeting.

PALS verbal update following presentation at Trust Board on 22nd May 2018 – AH confirmed that a detailed briefing paper was discussed at Trust Board on 22nd May 2018. AH confirmed that staff are good at managing appointments, with concern relating to appointments (33%).

Community Paeds had appointed a PALS complaint officer who is due to start soon.

Issues regarding ENT/Gastro. Committee noted that ongoing work is progressing regarding booking and scheduling, to ensure a coherent Improved message for parents when parents are ringing to book appointments. AH reminded all that the PALS team need prior notification

regarding upcoming/ongoing challenges/issues in order to respond in a timely manner.

RG stated that there is a lack of shared care regarding the process for repeat prescriptions, and that a meeting is due shortly with pharmacy to ascertain if any further improvements could be made to improve the current position. LShepherd stated that this issue needed to be escalated to the Transformation agenda if a systematic process was required.

Action: RG would raise at the Clinical Quality Performance meeting with the CCG and following that meeting, if a separate meeting is required thereafter then this needed to be followed up.

Discussion took place regarding ongoing work regarding continuous improvement within divisions. HG stated that the 4 divisions would be requested to provide updates/position statements at future CQAC meetings.

L Shepherd requested an overview regarding booking and scheduling – this would be provided for next CQAC meeting.

Action: Booking & Scheduling update for next meeting

18/19/44 Sepsis Update

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

Time from diagnosis to dosing (high risk sepsis)

- ED – mean time 58.6 mins (median 56 mins, n=35)
- Inpatients – mean time 57.4 mins (median 47.5 mins, n=22)

Progress:-

- Algorithm errors corrected
- 'Sepsis status' development to continue for ED
- Standard documents update due soon

E-learning

- Packages on ESR, initial feedback positive
- No junior doctor recording – Committee expressed concern that this issue had not yet been resolved. MS confirmed that the HR team is working with Whiston Hospital to resolve current issues. Discussion took place regarding training of junior doctors and the robustness of ESR information. HG stated that training is taking place for juniors through ongoing annual reviews. MS stated that she was confident that the Trust had robust mechanisms in place and that the team could work together, in order to compile reports to monitor compliance, which would include Sepsis numbers for Trust staff if required. Committee agreed it would be beneficial to see position statement/briefing report.

Action: MS to provide detailed update for next meeting.

- 90% compliance target of September

CQUINs

- Proposals drafted
- Replacement of NEWS2 with nursing concern (PEWS & NICE sepsis risk) or doctor concern
- More accurate ED recording
- 'Senior clinical decision maker' – not defined but should include ANPs- team currently trying to reach agreement within the next month.
  - Agree with Commissioners, as new wording does not fit with Paediatrics, Trust to feedback to commissions - (next submission due September 2018.)

Detect/VitalPAC

- Staged implementation – independent monitoring group
- Stage 1 (potentially 3-4 months)
- VitalPAC: PEWS, Sepsis Q and risk factors
- Meditech: Sepsis assessment & risk calculations

Stage 2 (potentially 10 months)

- VitalPAC: PEWS, sepsis Q, risk factors, sepsis assessment and risk calculations
- Meditech: Prescribing, investigations and medical notes

Community

- Training sessions had been scheduled for the next few months, first training session scheduled 19th June, which was well attended by 40 members of staff.
  - Community PAEDS
  - Sefton CAMHS

AM thanked DP for his update.

18/19/45 Research Annual Report

M Peak presented the Research Annual Report, key issues to note as follows:-

Effectiveness – 9184 patients were recruited into NIHR clinical research studies at Alder Hey during 2017/18. This is a significantly high number and places the Trust as the 15th highest recruiting hospital in England. Despite compelling drivers, many challenges exist in adopting research at pace and scale:-

- Equity of access – not all services and consultants are research active
- Affordability – excess treatment costs and other elements of research that the Trust should fund and essentially has not budget within the financial construct of the organisation
- Facilities – space, workforce – to increase the volume of research expansion in all of these areas is required which is challenging given the current financial climate that the NHS operates in. Reinvestment into research infrastructure is lacking at the Trust.
- Business mechanisms – some of these are currently not fit for purpose e.g. HR processes for recruitment of new and temporary staff required for a research study

- Leadership – which has changed in recent months and the individual now leading research in the NW Coast CRN Children Specialty is new to the role. This will take time to embed and elicit added value. An external senior nurse is undertaking a review of the research nurse leadership and structures within the Trust.

These challenges require a whole organisation approach, and this will be the focus of the CQC regulation. Ongoing discussions are taking place with Execs/Divisional Director level to improve divisional research integration and a supportive research business model.

Safety - All safety events within research are required to be reported to the study sponsor within a specified timeframe. Adverse events (AE) and Serious Adverse Events (SAE) defined by individual protocol. There is a regulatory requirement to report SAEs to sponsor within 24 hours. In addition, research staff also reports event to the Research Governance & Quality Assurance lead, this information is stored centrally as per local SOP. In the period January 2017-January 2018, across the entire portfolio 82% of events were reported to sponsor within this time period. Alder Hey sponsored studies, any adverse events are reviewed monthly as part of the Sponsor Oversight Committee.

- Research training – A new training refresher programme had been developed and created by the team to bring everyone in the CRD delivery team up to the basic required standard for MHRA. Training had commenced and a rolling programme of induction and refresher training scheduled going forward. This should drive up both the quality of work undertaken and the safety inherent on doing the basics brilliantly.
- Discussion took place regard DETECT study and the challenges which had created a significant delay in the study being rolled out across the Trust, colleagues are currently working hard to resolve issues. MP highlighted the importance of addressing ongoing challenges to ensure this issue was promptly resolved, - MP agreed to keep the committee updated.
  Discussion took place regarding ensuring that costing and pricing is correct.

  Quality Assurance – MHRA had signed off the CAPA plan and work is well under way to fulfilling the action plan.

- A new Research facilitator had been appointed within the Clinical Research Department to support Trust sponsorship process. A Quality Assurance Officer had also been appointed. Both roles will increase Trust capacity to sponsor studies and provide a quality assurance function that would support the division in its plan to meet all regulatory requirements.
- A Senior Analyst post within the Business Intelligence Team (funded through the CRF) had been agreed but not yet appointed.

AM thanked MP for his update and stated that it would be helpful for a separate further update meeting with M Peak, and extended the invitation to other NED's, should they be available to attend.

Action: Meeting to be diarised:

18/19/46 Programme Assurance/progress update

J Gibson stated that progress had been made during the month regarding improvement projects.

Sepsis information had been uploaded onto SharePoint. With revised programme plan and evidence of risk.
The overall ratings from the 'Delivering Outstanding Care' work stream had seen a marked improvement this month, with the May ratings of 4 red rated and 2 amber rated projects now superseded by 2 green rated, 3 amber and just the single red rated. It is clear from the evidence (the working project documents) on SharePoint that a lot of hard work had been put into improving the pace and governance of projects by both the leaders, programme team members and the new DMO. However, teams should not be satisfied with remaining amber/red ratings and focus should now be turned to improving all the sub-ratings.

L Shepherd stated that she would envisage that CQAC would receive reports to ensure granular assurance, 'Deep dive'. HG confirmed that from July that CQAC would start to review reports at CQAC meetings, with the intention to receive 2 divisional reports at July's CQAC meeting, HG would review and timetable as appropriate onto CQAC agenda and ascertain if achievable to receive all reports in one meeting.

Action: Workplan to be agreed to enable divisional reports to be shared at future CQAC meetings.

L Shepherd stated that Andrew Gibson, STP lead is keen to share progress with the Trust.

AM thanked J Gibson for this update.

18/19/47 'Stranded Children update'

K Kay presented the Standard Children Update regarding children with medical complexities that occupied bed days at the Trust.

- 16/17 – over 14,331 children occupying beds
- 17/18 – 9,357 children occupying beds
- 35% improvement in the number of bed days above trim as a result of the additional scrutiny applied.
- Team had freed up 13.6 more beds this year that had been available in previous year, with the team aiming at further improvements.
- Children are now being discharged in a more timely manner
- Medically fit delayed discharged – work is progressing to improve issue further

- Care package delays/panel /agreement at panel/ recruitment of carers – minimum of 6 month process
- Delays are due to care packages, repatriation, equipment, housing, discharge planning/MDT, parental engagement.
- 1 child had been discharged with a care package with a length of stay greater than 600 days, with 1 other child discharged with a length of stay of greater than 400 days.
- Ongoing work is continuing regarding repatriation

Next steps

Team are reviewing what is working well:-

- Weekly 30 day scrutiny/multi-disciplinary process – which challenges custom and practice.
- Medical leadership is being provided by Dr. Jane Ratcliffe, who is working with clinical teams to support teams, with a complex Needs Matron (Angela McDonald)
- Discharge Co-ordinator who is based on Ward 4B, with the team liaising with appropriate colleagues to ensure timely actions.
- Further improvements to review diagnostics - to improve multi-speciality clinical plans.
- Parent/carer workshop took place on 15th June 2018.
- Business Case is currently in preparation to support 7/10 day MDT and 21 day MDT for super stranded patients.
- Social worker in place from Liverpool City Council to improve engagement and help streamline engagement issues.
- SAFER - aiming to start implementation towards end of June 2018, requirement for correct resources in place.

C Wardell commented on the significant improvement she had witnessed to date. HG echoed those comments and confirmed that this was as a result of a tremendous team effort, and that the Trust is starting to see different trends with parents and families refusing to be discharged which posed a challenge, with S Ryan, H Gwilliams and E Saunders, together with the legal team reviewing this approach.

AM thanked KK for her update, and applauded the progress made, CQAC looked forward to the continued acceleration regarding stranded patients.

Action: CQAC to receive a further update at September meeting, followed by updates on a 2 monthly basis.

18/19/48 CQC Action plan

ES presented the CQC action plan, and expressed thanks to J Preece for ongoing efforts. Key issues to note as follows:-

1. – Serious incidents – ES reported that this item is to be removed from the action log.

5 – APLS - ES stated that a plan had been developed and is currently on target. Committee agreed that APLS should be monitored through CQSG as an action. All agreed that the APLS plan should be internally monitored

through CQSG and CQSG would provide update to CQAC via CQSG exception report.
10 – Resus roles – CQAC noted that training is progressing and that there is an audit process in place, together with equipment purchased, with an ongoing action plan – CQAC agreed that Resus should also be moved to CQSG for monitoring purposes, with any escalation required to CQAC to be made via CQSG exception report.
15 – GDE - CQAC agreed it would be beneficial for Steve Ryan & A Hughes to provide an update at the next CQAC meeting.

Action: CQAC also agreed it would be beneficial to receive an update on training at the July meeting.

Action: SR & AH to provide an update on GDE at July CQAC meeting.

L Shepherd queried how the Trust is monitoring drugs practice for discarding of controlled drugs – CQAC agreed that this should be monitored through CQSG and CSGQ to provide exception report via reporting process to CQAC. HG confirmed that the Trust works with police liaison to ensure a bespoke process, for discarding of controlled drugs which is an annual event and should not be placed on the CQC action log.

17 – MHA Training – Catherine McLaughlin leading on this issue. CM had met with Merseycare regarding training for CAMHS and where to target next co-hort – suggestion of community teams. CQAC agreed that MHA training needed to be finalised and agreed sign off that the evidence is robust.

E Saunders commended colleagues in relation to progress made to date. L Shepherd stated that appropriate feedback was required at divisional level. L Shepherd advised that a report would be beneficial for CQC.

CQAC agreed that the Trust needed to advise CQC that the CQAC Action Plan was complete.

Mandatory training should be monitored and reported at CQAC as a regular update.

CQAC received the CQC action plan and noted progress made to date.

L Shepherd stated that the Trust had received a response from CQC confirming that Trust comments had been considered, and that the ratings had been changed in a number of areas, - the ratings base had changed, with the Community rating for safe and responsive now rated as good. End of life well led – had now moved to good – with the Trust required to submit further evidence.

With the overall rating for acute rated as good.

Ratings for Safe – had not been changed and still required improvement – given that the CQC had witnessed purple files in a public area.

Public statement had been revisited.

L Shepherd had spoken with CQC on 19th June 2018 with regards to disportionate information – CQC confirmed that they have refused to review this further.

L Shepherd confirmed that CQC will reinspect Surgery within 6/12 months. L Shepherd had spoken with S D Henshaw and both had agreed that the Trust would write to CQC regarding concern in terms of the overall process and approach. CQAC also noted that there was a change in Senior Leadership team at CQC with changes regarding inspector, maternity leave cover for replacement inspector is currently being sought at present. L Shepherd thanked all involved and confirmed that the CQC report would be shared at CQAC in due course.

Dame J Williams congratulated all for tremendous efforts to date, and stated that the Trust should agree on the most appropriate way in which to celebrate.

18/19/49 Corporate Report – Quality Metrics

HG confirmed that the corporate report content had changed to include 34 pages of narrative.

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

- **Patient Experience** –There were 9 formal complaints in April and 151 PALS attendances, which is a marked increase in month. Family and Friends tests results are behind target exception in CAMHS, who achieved 100% positive responses, although number of respondents was small. Three of the inpatient survey questions showed worsening in month, and whilst 'knowing the planned date of discharge' showed a slight improvement, this remains the poorest performing measure. The Trust had recently invested in play and learning. HG stated that the the team are currently trialling new innovative ways of capturing information and reviewing information provided in Friends and Family responses.

- **Clinical Effectiveness** – There were 4 Central line Associated Blood Stream Infections in April: 2 on PICU and 2 on HDU, with all 4 cases reviewed. There were zero MRSA bacteraemia, and zero C difficile infections in month. The percentage of ED patients receiving antibiotics

within 1 hour increased to 66.7%, whilst for in-patients this was 76%. There were 6 hospital deaths in April.

HG requested any comments/questions regarding the new style of the Corporate report. Dame Jo W liked the new format and stated that the comment was helpful. CQAC agreed that a 1 page summary on the front of the Corporate Report would be beneficial. Further work is continuing regarding smart objectives.

S Igoe stated that the report is excellent, but highlighted caution regarding risk, and how CQAC would use the report, to ensure that CQAC are not too involved in the level of risk detail – and that the summary would assist with CQAC focussing on appropriate level of detail.
AM sought advice in terms of what elements CQAC needed to focus on within the new corporate report and mechanism in process re process/trajectory/deep dive in terms of assurance role for CQAC.

Action: HG to follow this up with team in order to provide update to AM

- AM thanked all involved for significant amount of work regarding new style of Corporate Report.

18/19/50 M13 Patient Information Leaflet Policy

In the absence of Elvina White, Policy Administrator POC agreed to establish whether M13 Patient Information Leaflet Policy had been discussed at CQSG meeting. CQAC agreed that providing that due process had been followed by CQSG, that CQAC were content to ratify the policy.

AM thanked PoC.

18/19/51 Findings regarding KIRKUP report

ES presented response to findings by theme report of LCH Independent Review by Dr. Bill Kirkup.
Key issues as follows:-

- Leadership capability – Trust to ensure a succession plan for directors and ensuring plan articulates the right level experience and individuals have skills to complement those of existing members. Ensuring NED challenge is adequately minuted in meetings.
- Financial management – Trust to maintain existing checks and balances and senior scrutiny of all change programmes via Programme Board.
- Risk and incident management – Trust to continue to develop Divisional risk and governance arrangements. MIAA are undertaking a follow up review of local Risk Management arrangements in Quarter 1 – Terms of Reference agreed.
- Raising concerns – Trust to keep support processes under review and respond to new initiatives as appropriate.

- Expansion/diversification of business – Board to ensure robust analysis undertaken before decisions made to expand or diversify service portfolio.

SI queried whether there is a plan to resolve issues contained in the themed report – confirmation received that this is reported/discussed at CQSG with appropriate documented evidence. A plan is required to resolve commissioning issues. Dame Jo Williams stated that further clarity was required within the report in terms of identifying ownership of actions.

CQAC noted the contents on the response to Review by Dr. Bill Kirkup - findings theme report.

AM thanked ES for her update.

18/19/52 Board Assurance Framework

ES presented Board Assurance Report and sought any questions by exception. BAF is due to be discussed at Executive Team meeting on 21st June 2018 for scoring to ensure a thorough review, whilst ensuring evidence is appropriately captured and scored correctly.

CQAG received and noted BAF report.
AM thanked ES for her update.

18/19/53 Clinical Quality Steering Group key issues report

PoC presented the Clinical Quality Steering Group key issues report, key issues as follows:-

- IPC Quarterly Report: Quarter 4 report showed 4 MRSA bactaraemias, of which 3 were related to the same patient. MRSA infection rates per bed days are higher than comparable neighbouring Trusts. The Trust is an outlier for MSSA bacteraemia. By the end of Quarter 4 there were no red standards and the Trust achieved 84% of the targets. The Trust was amber for 1 standard, but an agreement is in place for the Medical Director to continue being Director of IPC with a new IPC Director appointed at the end of March. A Business Plan is being developed for rapid PCR testing and this is awaiting review by IRG. Work is ongoing regarding SSI and auditing. Initiative to improve children hand hygiene in partnership with PDI. IPC training is now almost completed for Hotel Services staff.
- Safeguarding Report – Training was red in Quarter 3 in terms of compliance. A training action plan, with a clear trajectory in place of achieving full compliance by Quarter 4 was in place. The safeguding team have challenged the amber multi agency work rating as the criteria focus on early intervention. GDE may help capture this. Prevent strategy training is incorporated into level 3 training. Mandatory training is green. Although Friends and Family responses were quite low, the feedback was very positive. Key risks include the lack of FMEs and trying to move to a single doctor exam for historic abuse and nurse training. Another risk if the overuse of CCI function. 21 SUDIs in 2017, more than 50%

presented at ALTE, though there were 2 serious case reviews from the 21.

- Divisional Quality Dashboards were noted for Community, Surgery and Medicine.

- Deteriorating Patient Report was presented of 12 RCA's from the last 2 years relating to unexpected death of deterioration of patients resulting in PICU. This was due to concerns regarding the same themes were recurring. There were 15 finding, the report also highlighted some potential changes to the PEW scoring system and high lactate recognition issues. An action plan had been devised following the review which included, Development of an early response team; further specific training in areas such as Human Factors and SBAR; development of a deteriorating patient committee. Action plan would be monitored via CQAC. TECH project highlighted which records vital signs which can convert to PEWS.

- Transition – Update on pathway work (10 steps) implemented in 9 specialities with 35 still remaining. Links to complex neuro disability CQUIN. Developed transition planning tool in MV6. Training programme in place and 3rd Annual conference scheduled in June.

- Ward accreditation report shared at CQSG, 2nd accreditation round completed. Significant improvements to processes and scoring evident.

- AM thanked PoC for his update.

18/19/54 Any other business

MS stated that a meeting to discuss ESR is due to take place on the afternoon of 20th June, and that a further update would be provided at July's CQAC meeting.

18/19/60 Date and Time of Next meeting -

10.00 am – Wednesday 18th July 2018, Large meeting room, Institute in the Park.

Alder Hey Children's NHS
NHS Foundation Trust

INTEGRATED GOVERNANCE COMMITTEE
24th May 2018
Time: 14:00-16:00
Venue: Institute in the Park, Large Meeting Room

Present:

Mr S Igoe	Non-Executive Director **(Chair)**	(SI)
Mr J Grinnell	Director of Finance	(JG)
Ms E Saunders	Director of Corporate Affairs	(ES)
Mr S Ryan	Medical Director	(SR)
Mr D Powell	Development Director	(DP)
Mr A Bateman	Chief of Operations	(AB)
Mrs P Brown	Director of Nursing	(PB)

In Attendance:

Mr A Hughes	Director of Medicine Division	(AH)
Mrs A Kinsella	Health & Safety Manager	(AK)
Mrs E Menarry	EP and Business Continuity Manager	(EM)
Miss L Calder	Quality Assurance Facilitator (Minutes)	(LC)
Mr T Rigby	Deputy Dir. of Risk & Governance	(TR)
Mrs L Robinson	Quality Assur & Compliance Manager	(LR)
Mr A McColl	Assoc. Chief of Operations (Surgery)	(AM)
Ms K Morgan	Deputy Head of Information	(KM)
Mr G Dixon	Operational Lead (Building Services)	(GD)
S Stephenson	Head of Quality (Community)	(SS)
Mrs C Barker	Chief Pharmacist	(CB)
Mrs M Swindell	Director of HR & OD	(MS)
Mr M Devereaux	Head of Facilities and Soft Services	(MD)
Mr W Weston	Assoc. Chief of Operations (Medicine)	(WW)
Ms J Gwilliams	Clinical Risk Manager	(JG)
Mrs R Greer	Assoc. Chief of Operations (Community)	(RG)
Ms J Preece	Governance Manager	(JP)
Mrs J Keward	Lead Nurse, Infection Prevention	(JK)
Mrs J Hutfield	Compliance, Risk & Contracts Manager	(JH)
Mrs L Fearnehough	Head of Technical Services (IM&T)	(LF)
Mr A Whittaker	Information Governance Officer	(AW)
Mrs S Owen	Head of Human Resources	(SO)
Mr S Verstraelen	Head of Quality (Surgery)	(SV)

Apologies:

Mrs C Orton	Assoc. Chief Operating Officer (Research)	(CO)
Prof M Peak	Director of Research	(MP)
Mrs H Gwilliams	Chief Nurse	(HG)
Mrs V Weston	Infection Control & Prevention	(VW)
Mrs D Walker	Head of Pharmacy	(DW)
Mrs C Wardell	Assoc. Chief Nurse (Medicine)	(CW)
Mrs C Umbers	Assoc. Dir. Nursing & Governance	(CU)
Mrs S Brown	Assoc. Dir. (Development)	(SB)
Mrs R Douglas	Assoc. Chief Nurse Community	(RD)
Mrs D Boyle	Assoc. Chief Nurse (Surgery)	(DB)
Mrs A Hyson	Head of Quality Corporate Services	(AH)

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
Housekeeping						
	1.	**Apologies for absence**	Noted			
18/19/01	**2.**	**Minutes of previous Meeting**	The Committee considered the minutes of the previous meeting of the Integrated Governance Committee held on 14th March 2018. The Committee **APPROVED** the minutes as a correct record. The committee welcomed Stefan Verstraelen, Head of Quality for Surgery. SV joined the Trust in April 2018.			
	2.2	**Action list**	**Resolved** that: the Committee agreed all actions from 14th March 2018.		SI/CU	
	3.	**Risk Register Management Reviews**				
18/19/02	**3.1**	**Surgery Division**	Andy McColl (AM) presented the risk management report for Surgery. AM focused on the high risks from the Surgical Division for this reporting period. Risks from the Surgical Divisions report were highlighted as follows: • Total number of risks = 72 • Number of new risks identified since the last reporting period = 1 • Number of risks closed and removed from the risk register =6 • Number of risks with an overdue review date = 37 • Number of risks with no agreed action plan = 1 • Number of high/extreme risks escalated to the Executive Team = 3		AM	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			AM advised the surgical division has in excess of 30 moderate risks, 15 of these are in critical care (low to moderate). However the surgical division is in a much better position. There are 3 high risks with a score of 15: Risk 964 – Elective Lists - The main reason this is sitting at a risk of 15 is due to the delays in patients going to theatre. We are working with ideas from the GDE Framework to mitigate this risk. Risk 424 – risk of transmission of vCJD – Implementation date has been pushed back to 2nd week in July 2018 to ensure all correct instruments have arrived before this goes live. We are still waiting for 5% of the instruments. We will monitor this risk throughout June 2018 and hopefully will be able to reduce the risk rating down to 15. Risk 1276 – Medical Equipment Replacement strategy – this risk is no longer showing as 15 it has come down to 10. There is a demand for this equipment that we have no budget for. We are reviewing quantities of equipment being purchased where possible, taking up the option to lease some of the equipment to spread the cost over a longer period and have agreed payment terms with selected suppliers to ensure the equipment is delivered at the earliest opportunity. Best in Operative Care – there are 4 risks however none significantly high. 3 out of 4 risks (75%) have been reviewed as required within the agreed time frame. CU advised the Surgical division that even though none are high they still need to remain on the risk register. JG informed the committee that it is good news about the medical equipment. AB advised risk 1305/1308/964 patient access & cancellations - should this be a collective risk throughout the trust? Can we see confirmation and assurance that these are all being managed?	AM to provide confirmation /assurance Best in Operative Care risks are being managed	AM	Immediate

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			AM advised the committee that although there is ongoing work required, the division are comfortable with the progress to date. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/03	**3.2**	**Medical Division**	Adrian Hughes (AH) presented the risk management report for Medicine. Risks from the report were highlighted as follows: • Total number of risks = 127 • Number of new risks identified since the last reporting period = 5 • Number of risks closed and removed from the risk register = 16 • Number of risks with an overdue review date = 26 (20%) • Number of risks with no agreed action plan = 20 • Number of high/extreme risks escalated to the Executive Team = 2 AH focused on the high risks from the Medical Division for this reporting period. Risk no 1144 – Delay in turnaround time of all patient related clinical correspondence of just over 2 weeks as of 25th April 2018, resulting in incomplete patient records. The Medicine division have asked for support from the consultants in signing letters off to reduce delays in them being sent out. Risk no 1169 – Fragile medical workforce within the Haematology Service – Inability to run complex and acute care trust wide within the trust due to insufficient clinical cover caused by sickness or gaps in service. 2 consultants off sick and running a single handed service. Single handed consultant is on annual leave for 4 weeks and we have no consultant cover for June 2018. A retired consultant		WW/CW	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			from Royal Manchester Children's Hospital has agreed to provide some support. Advert to go out for a consultant Haematologist with special interest in Leukaemia. This has proven to be a significant risk to the service and in that context is a systemic issue for the trust. On a positive note we have a haematology trainee that finishes training next year and is happy to join the team. Risk no 1344 – Pharmacy and ASU cold stores failure. Funding has been agreed at the Capital Projects Group Meeting on 5th April 2018. Manufacturer (Green Cooling) have been out to assess requirements and we are awaiting their response to Building Services/Interserve on next steps which is clear progress. AH advised there are challenges within the division and we have to find ways to agree an outcome. AH advised that CU is working with the division holding monthly risk revalidation meetings. There are also weekly internal meetings. The medicine division will be on track within the next 2 months. SI advised it's important that all divisions/functions put in the effort with managing the risks and maintain up to date risk registers that reflect their risk profile. AH advised the committee that the Medical Division are satisfied with progress, while recognising that ongoing work is required to enable assurance of effective management of risk across the division. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/04	**3.3**	**Community Division**	RG presented the risk management report for Community. Risks from the report were highlighted as follows: • Total number of risks = 49 • Number of new risks identified since the last reporting period = 1		RG/SS	

Item No	Item	Key Point Discussions	Action	Owner	Time Scale
		• Number of risks closed and removed from the risk register = 3 • Number of risks with an overdue review date = 4 • Number of risks with no agreed action plan = 4 • Number of high/extreme risks escalated to the Executive Team = 1 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrate Governance Committee = 0 RG presented the risk management report and focused on the high risks identified for community. RG presented the corporate risks reduced on the risk register. There is currently one high risk. Risk 1524 – Lack of appropriate services to transition patients with ADHD. Risk of harm due to inappropriate care or advice provided to patients by paediatricians with lack of clinical knowledge about this age group. Letter has been sent to the CCG and a meeting is being arranged. RG advised that South Sefton transition services may become a risk and we are seeing a trend with the growing numbers of children over the age of 16 with no transition to adult services. The division is working with the CCG to address this problem. ES advised the committee that in the draft CQC report waiting times came up at Trust Board on Tuesday 22nd May 18 and the level of risk for the Dewi Jones unit is moving forward and the expectation is that this risk will be minimised. The relocation of the unit and having conversations with NHSE have helped to decrease the risks with this			Immediate

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			service. SS advised that the QAR (Quality Assurance Round) has been effective at identifying risks within the division. RG advised that Community Division are maintaining the risk register and continue to add and remove risks on a regular basis. RG advised the committee that the division are confident they are keeping on top of all risks in terms of effective management. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/05	**3.4**	**Infection Control Service**	JK presented the risk management report for Infection Prevention Control. Risks from the report were highlighted as follows: • Total number of risks = 16 • Number of new risks identified since the last reporting period = 0 • Number of risks closed and removed from the risk register = 0 • Number of risks with an overdue review date = 2 (showing a decrease of 2 overdue risks) • Number of risks with no agreed action plan = 0 • Number of high/extreme risks escalated to the Executive Team = 3 • Changes in the risk profile or categories of risk being reported that need to be brought to the attention of the Integrate Governance Committee = 0 JK presented the risk management report and focused on the high risks identified for Infection Control.		VW/JK	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			. Risk 1439 – Risk of long stay patients acquiring vaccine preventable diseases. General Manager for medicine to scope IT systems between Liverpool and Sefton CHIS and Alder Hey ERP. VW and team to carry on working on this to resolve, however there is nothing additional to add until next month June 18. Risk 640 – Risk of Hospital acquired Pseudomonas due to Pseudomonas in the water supply. This is being managed through the Water Safety Group (WSG). All actions were discussed at the WSG on 21st May18 and agreed to outsource for help/advice for ADIPC on water safety. Risk no 795 – Water Safety on CHP/Retained Estate (Legionella etc.). Trust should encourage further water usage across the Trust and increase flushing. The Water Safety Group has agreed to outsource help/advice for ADIPC on water safety. GD advised there is a high level of concern with the water temperatures. We have put immediate mitigation in place. Filters have been fitted in critical care & PICU. The Health & Safety Manager AK has been given advice on this area. AK advised the water is not circulating and needs a full review of the circulation system. JK advised the committee that although there is ongoing work required, the Infection Control team are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	AK to provide an update at next IGC July 18		Immediate
18/19/06	**3.5**	**Facilities**	There was no representative from the Facilities to present the risk management report. Risks from the report are highlighted as follows:		MD	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Total no of risks 7, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). The Facilities department has in place effective systems and processes to identify manage and escalate risks to the delivery of patient care.			
18/19/07	**3.6**	**IM&T**	LF presented the risk management report for IM&T. Risks from the report were highlighted as follows: Total no of risks 25, new risks since last report 0, risk closed and removed 1, risks overdue 16, no of risks with no agreed action plan 2, high risks need escalating to execs for their support 1 (high risks). Risk no 865 - Limitation of EPMA functionality within Meditech V6. It was decided at IGC Meeting on 16th Feb 18 that this should be transferred over to IM&T. This was actioned on 3rd March, however this risk has yet to be reviewed by the Head of Clinical Systems to bring mitigation down. Risk no 1210 – Failure of data migration of legacy patient Pathology results and reports from meditech 5 to meditech 6 resulting in loss of patient data prior to June 2015. This is historical data not the current system and the functionality is not good however mitigations are in place to minimise the risk. LF advised that the trend report shows a steady increase of risks on the register, which demonstrates the risk profile for the service, enabling effective management. IT have good systems in place and are now able to show the efficient management of risks. SI advised he didn't see any plans for mitigation and what is the		PY/LF	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			benefit of mitigation if risks are not brought down. LF advised the committee that although there is ongoing work required, the IM&T are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/08	**3.7**	**HR**	SO presented the risk management report for HR. Risks from the report were highlighted as follows: Total no of risks 4, new risks since last report 0, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Trend report is showing a reduction in the number of risks and also the risk scores associated with them and since the last reporting period this reduction has been maintained. Mandatory training compliance has been an issue, however the trust have now surpassed the trust target of 90% which has significantly reduced the risk and the HR housekeeping is showing assurance. ES asked have HR got Diversity & Workforce on the risk register as this was commented on in the CQC report? SO advised the committee that HR are on top of their risks and their housekeeping is showing assurance and this reflects their current position. **Resolved** that: the Committee NOTED the contents of the paper	SO to put E&D risk on the risk register	MS	Immediate
18/19/09	**3.8**	**Finance**	JG presented the risk management report for Finance. Risks from the report were highlighted as follows: There are 5 risks identified on the finance risk register. 0 new risks since last report 0, risk closed and removed 1, risks overdue 0, no of		JG	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). JG advised the committee that Finance have no new risks identified and there are no risks out of review date or overdue. JG advised the committee that the Finance department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/10	**3.9**	**Estates**	JH present the risk management report for **Estates**. Risks from the report are highlighted as follows: Total no of risks 26, new risks since last report 0, risk closed and removed 2, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). JH advised the committee that there are no changes since the last reporting period and Estates are still showing 4 high risks. Risk 1529 – Alarm panel showing disablement - Risk 1530 – Maintenance Records inaccurate and lacking in detail. Risk 1549 – Flammable store in very close proximity to the medical gas storage (Helium, Nitrogen and CO2) and the liquid o2 storage units. Risk 1409 – Fire break glass - New Hospital. This is currently sitting at 16 on the risk register as we are non-compliant and cannot take off the register until Interserve confirm remedial work has been completed. The fire safety officer is awaiting confirmation from Interserve that the identified risk has had remedial works carried out to eradicate the risk and once confirmed can be closed.		DP/JW/SB	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/11		**Building Services**	JH advised there have been changes and these will be shown on the register forthwith and confirmed in the next IGC reporting period. JH advised the committee that the Estates department are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper GD presented the risk management report for **Building Services**. Risks from the report were highlighted as follows: Risks on register for Building services. There are 13 risks identified - new risks since last report 1, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 3 (high risks). Risk 825 – Internal Balconies. On the horizontal handrail there is facilitates for climbing, resulting in the risk of potential fall from the balcony. There was a near miss with patient escaping from the ward. GD advised this is a major piece of work to complete as is the corroded pipework risk. Risk 640 – Risk of hospital acquired infection due to Pseudomonas in water supply in the children' health park. Risk currently under discussion with IPC and Medical Director as to where the risk should sit. Risk no 1388 – (Score 20) – Pipe Corrosion. To date there are now confirmed 41 pin holes since occupation of CHP. Increased frequency of burst and subsequent issues has led to the risk being			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			increased. Testing is now underway to confirm the problem and potential solutions. Report due by July 2018. GD advised all risks have been reviewed and within timescale. There is a moderate risk of a number of power surges affecting the innovation hub and theatres. GD has spoken with the trust fire officer for help/advice. The power surge is internal not external in order to determine where it's coming from Theatre electricity supply to be moved to an alternative circuit. Agreed mitigation in place. Surge protection leads supplied, also kit now turned off during the evening. Conversations with Interserve and waiting on a full action plan. The highest risks are around the building risks, pipework corrosion, water temperature & sale of PFI Project co. The discussion around this raised question as to whether the risk score of 12 for was too low. The owner and manager is to review the controls, gaps in controls and actions to determine if the risk score is accurate. CU questioned whether the owner and managers were confident all the risks associated with pipework were on the risk register? AK advised that all the risks were identified on the register. GD to look at the issues and determine if there are any additional risks that need adding to the register. SI added there are a few high risks identified and this needs to be addressed as a matter of priority. GD advised the committee that although there is ongoing work required, Building Services are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper	GD to feedback report outcome at IGC July 18		July 18

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/12		**Directorate Projects**	JH presented the risk management report for **Development Directorate Projects**. Risks from the report were highlighted as follows: Risks on register for Development Directorate. There are 24 risks identified - new risks since last report 3, risk closed and removed 2, risks overdue 1, no of risks with no agreed action plan 3 (team to address), high risks need escalating to execs for their support 0 (high risks). JH advised the committee that of the 24 risks 96% have been reviewed in accordance with the agreed review date and 1 risk requires review. Of all 24 risks 21 (88%) have agreed actions with an agreed action plan, 75% of agreed actions have timescales for delivery. Some of the timescales are challenging to be predicted due to on-going discussions with Liverpool City Council; however this score had improved from the 25% in the last reporting period. JH advised there have been no changes since the last reporting period and still waiting on finances to be finalised from the Universities for the second phase of the institute in the park. DP advised there are a series of actions in place, however infrastructure issues need to be resolved. A number of risks been circulating for some time , and mitigations are in place however we now need to be doing something different to change the dynamics. One of the root cause of risk is the pipework issue. GD has a number of actions in place and as of yesterday 23rd May 2018 there is assurance and key action plans. AK advised from a Health & Safety point of view an audit needs completing on IFM processes to give us visibility of what we don't know.			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			JH advised the committee that even though there is ongoing work to complete the Development Directorate are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/13	**3.10**	**Health & Safety**	AK presented the risk management report for Health & Safety. Risks from the report were highlighted as follows: Total no of risks = 7, new risks since last report = 0 Risk closed and removed = 0. Risks with an overdue date = 0, No of risks with no agreed action plan = 0, No of high risks need escalating to execs for their support = 0 (high risks) Changes in the risk profile or categories in risk being reported that need to be brought to the attention of the Integrated Governance Committee = 0 AK advised Health & Safety has gained momentum recently following a review of the current H&S risks and control measures are in place. AK advised the committee that Health & Safety are satisfied with the progress at this point. **Resolved** that: the Committee NOTED the contents of the paper		MS	
18/19/14 **18/19/15**	**3.11**	**Business Preparedness & Associated reports**	Preparedness & Associated reports. Risks from the risk management report were highlighted as follows: Total no of risks 14, new risks since last report 1, risk closed and		MS	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk no 1630 – Trust Wide Business Continuity Action Cards are required. **Cyber Attack** action card to be produced – IM&T leading on completion. Draft to be submitted to Emergency Preparedness Group in June 2018. **Pipework Leak** action card to be produced due to recent incidents occurring. EP & BC Manager, Interserve Estate Manager and small group working on leading on completion. Deadline 29.06.18. **Ameritech V6** action card requires update for contingency arrangements for patient notes when Meditech is not available due to planned or unplanned downtime. IT Consultant Lead for Meditech, Matron EP&BC Manager to lead on completion. Deadline 29.06.18. **Medical Gases** action card requires updating to provide additional information on manifold and portable resources during medical gases outage. Chief Pharmacist leading and in liaison with the Medical Gases Committee. Deadline 29.06.18. Risk no 1376 – It was agreed that the CBRNE/HAZMAT training compliance report would be submitted to each IGC meeting until there is assurance that the Emergency Dept. staff are up to date with their training. Compliance report Appendix A – current position of staff training is 31%. Nursing 39%, Registered nurses 36%. EM advised that Steve Ryan and Hilda Gwilliams are to send a letter to staff to say it is compulsory to attend the CBRNE/HAZMAT training. EM is satisfied with management of risks on the register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/16	**3.12**	**Information Governance**	ES presented the risk management report for Information Governance. Risks from the report were highlighted as follows:		ES	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Total no of risks 9, new risks since last report 1, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 0, high risks need escalating to execs for their support 0 (high risks). Risk 1613 – Breach of legislation due to lack of identified process and appropriate records management of adopted children. Information Governance and Safeguarding are working on a policy and having a decent set of mitigations in place is one of the main focuses. In process of getting the right team to work on this. ES is confident that all risks have controls in place and is happy where they sit. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/17		**Medicines Management & Pharmacy**	CB presented the risk management report for Medicines Management & Pharmacy. Risks from the report were highlighted as follows: Total no of risks 33, new risks since last report 0, risk closed and removed 0, risks overdue 6, no of risks with no agreed action plan = Unable to report due to current limitations of reporting system, high risks need escalating to execs for their support 0 (high risks). CB advised there are 6 risks with an overdue review date to end of April 18 however these will be reflected on the next reporting period. There are a large number of residual risks however bodies that look at us expect to see them there i.e. it is expected for Pharmacy to have risks around eye drops. Risk 1344 – Pharmacy cold store. Progress has been made led by the building services team and there are actions in place. If reaches targets this should be reduced to a 12 on the register. If reach		CB	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			targets and not closed down the MIAA will criticise us for this one. CB advised the committee she is satisfied with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/18		**Global Digital Excellence Programme**	KM presented the risk management report for Global Digital Excellence Programme reports. Risks from the report were highlighted as follows: Total no of risks 21, new risks since last report 9, risk closed and removed 0, risks overdue 0, no of risks with no agreed action plan 1 (mitigations in place), high risks need escalating to execs for their support 0 (high risks). Changes in the risk profile of categories of risk being reported that need to be brought to the attention of the Integrated Governance Committee = 2 have decreased risk scores, 1 has increased. KM advised the committee that GDE have reviewed all risks and there are mitigations in place. There is a residual risk in place but this is being managed. KM advised the committee GDE have no risks above moderate risk and is happy with management of risks on register in this area. **Resolved** that: the Committee NOTED the contents of the paper		KM	
18/19/19		**Clinical Research Division**	There was no representative from the Clinical Research Division to present the risk management report. Risks from the report were highlighted as follows: Total no of risks 6, new risks since last report 0, risk closed and			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			removed 0, risks overdue 0, no of risks with no agreed action plan 0 (mitigations in place), high risks need escalating to execs for their support 0 (high risks). Changes in risk profile or categories of risk being reported t need to be brought to attention of IGC = 3 (risks reduced). SI advised that due to there being no representative from the Clinical Research division could CU speak to the Research division in relation to their risks. **Resolved** that: the Committee NOTED the contents of the paper	CU to meet with LC/MP about outstanding risks		Immediate
18/19/20	**4.**	**Corporate Risk Register Review**	CU presented the Corporate Risk Register Review. CU informed the committee that there are 532 risks on the Trust risk register, and the detail is reflected in the Division and corporate functions risk registers. The total number of risks on the risk register is 532 compared to 542 for the previous reporting period. 22 (4.1%) of the Trusts risks are rated as' High/Extreme' risks compared to 24 (4.42%) for the previous reporting period. 356 (66.9%) of the Trusts risks are rated as 'Moderate', compared to 365 (67.3%) for the previous reporting period, of which 150 (28%) risk rated 12 (high moderate) compared to 155 (29%) risk rated 12 for the previous reporting period. 126 (23.7%) of the Trust risks rated are as 'low risk' compared to for the 123 (22.69%) previous reporting period. 24 (4.5%) of the Trust risks rated as 'very low risk' compared to 17 (3.1%) for the previous reporting period. There are currently 22 high risks on the CRR; 2 (9%) in the Medical Division,		CU	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			3 (13.6%) in the Surgical Division. 1 (4.5%) in Community services. 0 (0%) in Research Division. 16 (72.7%) in Corporate Services. CU advised the committee there are assurance concerns both on the Trust and corporate risk registers and has discussed and advised on these concerns with the risk owners at the monthly risk validation meetings **Assurance concerns Trust risk register** • 175 (32.89%) risk assessments have an **overdue** review date, compared to115 (21%) for the last reporting period. • 64 (12%) risks do **not** have controls compared to 71 (13%) for the last reporting period. • 83 (15.60%) risks do **not** have actions compared to 83 (14.4%) for the last reporting period. • 360 (48.32%) **overdue** actions same as previous reporting period. **Assurance concerns corporate risk register (High risks)** 2 (9%) – no actions 6 (27.2%) – no controls 20 (39.22%) – overdue actions 5 (22.7%) - overdue review CU advised that the discussions at the meeting today demonstrated that many of the risk actions are progressing, to minimise the effects should the risk be realised however if this is not reflected on the			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			registers then there is no assurance of progress to mitigate the risks. Moreover If the gaps associated actions and controls are not reflected on the registers then the understanding of anyone internally (e.g. Board) or externally (CQC, MIAA etc.) is that they have not been done and this presents a risk for the Trust. CU advised that there needs to be a focused effort on high moderate and moderate risks as the evidence shows this group of risk are showing minimum movement when trends are reviewed. On the other hand there is strong evidence to support good management of high risks, although ongoing work is required in terms of evidence on the registers. There are 360 risks with overdue actions and this is not a satisfactory position for the Trust and needs to be addressed as a matter of priority. CU advised on paper this is a risky position to be in and this is what the trust will be judged on in terms of its effectiveness around management of risk, therefore there needs to be an accelerated effort to demonstrate that all risks on registers are being managed in line with best risk management practice. SI advised the committee that it was vital that they keep on top of updating/closing risks to provide the necessary assurance evidence of good risk management. **Resolved** that: the Committee NOTED the contents of the paper			
18/19/21	**5.**	**Board Assurance Framework (BAF)**	ES presented the Board Assurance Framework. ES advised the committee that continued progress is being made with the on-going work around BAF controls, to ensure they reflect the current position, and support effective management of the risks identified. ES stressed the importance of consideration around Equality & Diversity in terms of the BAF and advised the committee that a BME Network has been established and is sponsored by the Director of HR & LD. ER also highlighted the importance of all staff adherence to the Mandatory training standards which are available on-line and mapped to Core skills Framework.		ES	

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
			Resolved that: the Committee NOTED the contents of the paper			
18/19/22		**CQC Plan**	ES presented the CQC Plan. ES presented the CQC Action Plan and highlighted progress made since the last meeting on the specific actions for the Committee to be sighted on. ES advised that a real focus on closing all open actions be undertaken given the imminent arrival of the new report from the February 2018 inspection and associated actions. All actions should be completed within the indicated timescale or indeed an exception report explaining any overdue timeframes. **Resolved** that: the Committee NOTED the contents of the paper		ES	
18/19/23		**Integrated Governance Committee – Annual Report 2017/18**	CU presented the Integrated Governance Committee – Annual Report 2017/18. CU advised that the IGC – Annual Report 2017/18 includes all reported over the last 12 months **Resolve** that: the Committee APPROVED the contents of the paper			
	7.	**Policies**				
18/19/24 **18/19/24a**		Prevent Policy Equality Analysis (EA) for policies	CU advised the committee that the prevent policy was last reviewed 3 years ago in 2017 to comply with CCG/KPI submission standards to review all safeguarding related policies annually. This arrangement has now been revisited and agreed that as a department as long as we can provide CCG assurance that policies are current they will agree to trusts arrangements of 3 yearly review with more frequent if new publication/ significant national change etc. Recent Amendments : Reference to the Counter Terrorism and Security Act (section 26) 2015 included within the relevant legislation section of the policy Information Sheet: PREVENT. The role of health staff in preventing terrorism added to the policy to provide additional information for			

Item No	Item	Key Point Discussions		Action	Owner	Time Scale
18/19/25		Emergency Preparedness, Resilience and Response (EPRR) Annual Report 2017/18	staff to clarify expectations Reference list and associated documents section updated. Resolved that: the committee APPROVED the content of the paper EM advised the committee that the Emergency Preparedness, Resilience and Response Annual Report has already been approved by the Emergency Preparedness Group and it has now come to IGC to be ratified. The report includes all what has happened over the last 12 months. **Resolved** that: the committee RATIFIED the content of the paper			
	8.	**Ad Hoc Reports**				
	9.					
	10.	**Any other business**				
Date and Time of Next Meeting		The next meeting of the IGC will be held on Wednesday 11th July 2018, 10:00am. Institute, Large Meeting Room				

ACTION LIST – May 2018

No	Item	Owner	When	Status
18/19/02	1305/1308/964 - confirmation and assurance that these are all being managed.	A McColl	Immediate	AM to provide confirmation /assurance Best in Operative Care risks are being managed.
18/19/08	Diversity & Workforce risk on risk register	S Owen	Immediate	SO to put E&D risk on the risk register.
18/19/19	Clinical Research Division risks	C Umbers	Immediate	CU to meet with LC/MP about outstanding risks.
18/19/05	Full review of the water system	A Kinsella	11th July	AK to provide an update at next IGC July 18
18/19/11	Building Services risks need reviewing Report outcome	G Dixon	Immediate 11th July	GD to look at risk scores and if all risks are on the register. GD to feedback the report outcome at IGC July 18.
18/19/12	Directorate Projects risks need reviewing - building risks, pipework corrosion, water temperature & sale of PFI Project co.	G Dixon	Immediate	GD to look at the issues and determine if there are any additional risks that need adding to the register.
18/19/11/12	Directorate Projects review controls, gaps in controls & actions	D Powell/G Dixon	Immediate	The owner and manager are to review the controls, gaps in controls and actions to determine if the risk score is accurate.

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
4 September 2018

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Associate Director IM&T Sabrina Brown, GDE Programme Manager
Action/Decision required	The Board is asked to note the updated progress of the Trusts GDE Programme the achievement of Milestone Four and the commencement of Milestone 5
Background papers	N/A
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	IM&CT Strategy Significant contribution to the strategic objectives for:- - Clinical Excellence - Positive patient experience - Improving financial strength - World class facility

1.0 Executive Summary

The purpose of this paper is to provide the Board with an update on the progress of the Trusts Global Digital Exemplar (GDE) Programme; the achievement of Milestone Four and the commencement of Milestone 5.

2.0 Update of Progress

Since the previous update to Board on 3 July 2018 The Trust continues to show demonstrable progress against its GDE commitments. This progress brings with it the associated benefits of quality and patient care and taking both staff and patients on the digital journey experience. Recent GDE programme level achievements include:

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

Primary work has also included:

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

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

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

3.0 Summary of Key Benefits

Category	Project	Aim	Measurement	Improvement	Current/Future
Safety	Community Matrons Specialty Package	Improve accessibility to Community Matrons clinical information. Move from EMIS to	Information stored in Meditech system.	Information now stored in Meditech; available to	Current

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

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

5.0 Milestone Assurance

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

4.0 Next deliverables

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

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

5.0 Recommendations

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

Peter Young
Chief Information Officer 28 August 2018

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

4th September 2018

Report of:	Director of Human Resources & Organisational Development
Paper Prepared by:	Director of Human Resources & Organisational Development
Subject/Title:	People Strategy Update for July 2018
Background Papers:	None
Purpose of Paper:	To present to the Board monthly update of activity for noting and/or discussion.
Action/Decision Required:	none
Link to: **Trust's Strategic Direction Strategic Objectives**	The Best People Doing their Best Work
Resource Impact:	None

1. Staff Engagement

Reward & Recognition

The Star Award for April was awarded to Emma Patterson, Specialist Clinical Pharmacist; May joint winners were Marie Horan and the PICU team and June's winner was Leanne Fearnehough, IT. July's nominations are currently being reviewed. As the awards have now been running for 12 months, the Reward and Recognition (R&R) group will be undertaking a review of the current system during August to ensure they are fit for purpose. The R&R group are also reviewing both Retirement and Long Service processes to scope out additional areas of improvements.

Plans are being put in place to continue to celebrate 70 years of the NHS during 'Fab Week' from 17th October to 19th October 2018. Based on how well the events worked last year, it is anticipated that the format will be similar to last year with food stalls, fruit and cakes, treatments, community focused contributions. There will also be a review following last year's staff pledges.

Staff Survey

The 2018 Staff Survey is due to commence in September and we are working hard to ensure that we continue the theme of recent years in increasing completion rates.

Last year we reached a completion rate of 54% (up 15% from the previous year) and are aiming to reach at least 60% this year.

We are aiming to launch the survey week commencing the 10th September 2018 to give staff as long as possible to return their responses and will again be asking for all staff to complete the survey and providing a blended offering of completions via email or paper, based on departmental preferences.

Over the coming weeks and months we will be working very closely with Communications and the newly formed working group to promote the Staff Survey and its importance in improving the working environment at Alder Hey for all staff.

Improving Staff Wellbeing

The Trust will ensure particular focus over the coming year and beyond is given to improving the wellbeing of our staff. A wellbeing steering group has been established with representatives from Occupational Health, management, staff side, Counselling, Chaplaincy and others to put in place effective initiatives and support to improve staff wellbeing. The inaugural meeting took place on 2nd July 2018 which set the terms of reference for this group and monthly steering groups have been established. The first priority of this group is to identify key actions to support staff across the organisation and the group will report to the Workforce and Organisational Development Committee (WOD).

Alder Hey has also been invited to be part of a national staff health and wellbeing improvement programme being led by NHS Improvement in order to improve the health and wellbeing of our workforce and to reduce sickness absence rates. The first workshop took place on 31st May 2018 in Birmingham and the Trust is in the process of undertaking a full action plan for NHSI which complements the actions of the Wellbeing steering group. NHSI

undertook a visit to the Trust in August; feedback from the visit was that our plan and initial actions went above and beyond what was expected.

Clinical Excellence Awards (CEA)

The 2018 local CEAs were finalised in July, with 35 awards awarded to consultants who had demonstrated excellence in their fields. The standard of awards continues to be excellent, and the Committee are undertaking a review of the awards to ensure that we have good representation from all clinicians in the 2019 round, in particular from women, part-time consultants and BME staff.

2. Workforce Sustainability and Capability

Agenda for Change New Pay Deal

Payment of the new Agenda for Change pay increases for staff were successfully made in July's salary, and back pay will be made in the August payment. Work has now commenced on the removal of the Band 1 salary scale, and we are working in partnership with Trade Union colleagues to deliver this project. Work is commencing on a review of the appraisal system in light of the changes to increment progression which will come into force on the 1st April 2019.

Education, Learning and Development

Apprenticeships

The Apprenticeship programme is going from strength to strength, and we have seen a significant rise in staff showing an interest in taking up an Apprenticeship. The expectation is that 49 learners will be signed up to an Apprenticeship before the end of the year and at least 22 of these will start their learning in September 2018. The training is worth approx. £337k, all drawn from the Apprenticeship Levy, and is made up of the following:

- **Liverpool John Moores University** - Nurse Associate Level 5 x 3, Leadership and Management Level 7 (Masters) x 6
- **Southport College -** Leadership and Management Level 5 x 11, Health Care Support Worker Level 3 x 4
- **Wirral Metropolitan** College - Business Administration Level 2 and 3 x 6, IT Level 2 x 2
- **iCount Ltd** - Accountancy Level 7 x 2
- **Internal delivery** - Business Admin L2/L3 x 4, Team Leader L2 x 4, Customer Service L2 x 5 and Management L3 x 5

We are working towards increasing our capacity to deliver a wider range of apprenticeships internally, allowing us to recieve monies directly from Levy into the organisation.

Mandatory Training

Core mandatory training as of end of July was 92% and has been above the 90% Trust target for the last 6 months, overall mandatory training remains just below target at 89%.

The team have spent some time reviewing and updating the current reporting structure for mandatory training to ensure maximum visibility and will be working closely with specific departments and subject matter experts with low compliance to ensure that there is a plan for improving compliance rates going forward.

Workforce Diversity

The BME and Disability Networks continue to actively develop, and we remain sighted on our goals to increase the diversity of our workforce, and improve the experience of our staff. The Diversity Action Plan was approved in the June Board, and we are exploring the use of some external expertise and advice to support this agenda.

Employee Consultations

Hotel Services

The Porter service Organisational Change consultation has been extended to explore any further options with full trade union engagement to bring about a satisfactory conclusion. An offer, which the trade unions agreed to make to the portering group was rejected, and a further review meeting with management and the trade unions is to took place on 20th June 2018 to seek a resolution. It was provisionally agreed at that meeting that management would trial the proposed changes to working practises for a three month period with full staff engagement. Final preparations are taking place for the trial, anticipated to be middle to end of September 2018.

Catering management is considering a Catering Review proposal which was commissioned externally; this identified the requirement for the appointment of a Catering Manager to focus on development of staff capability. Recruitment is to take place week commencing 20th August 2018. Further recommendations in line with the Catering Review will also be considered.

Crisis Care – Community Division

Following the organisational change in Single Point of Access, a counter proposal was approved and accepted and the new service has been in operation since early July. Teams are now set up, with all vacancies now completed with positive feedback from staff on process and working arrangements.

Employee Relations Activity

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

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

Employment Tribunal Cases

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

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

Corporate Report

The HR KPIs in the July Corporate Report are:

- Sickness rates have increased slightly this month compared to last month to 5.23%.
- Mandatory training compliance remains at 92%, above the compliance target of 90%.
- The PDR window opened in April. Compliance at the end of July was 64.88% and a decision was made to extend the window until the end of September. The latest report (as of 28/8/18) now shows compliance at 82.38%, just short of the 90% target.

Alder Hey Children's NHS
NHS Foundation Trust

GUARDIAN OF SAFEWORKING REPORT ON SAFE WORKING HOURS: DOCTORS AND DENTISTS IN TRAINING

This report covers the period 1st April 2018 to 30th June 2018 (Q1 2018/2019). This report will be produced on a quarterly basis in the future.

Introduction

Within the doctors in training terms and conditions of service there is a requirement for the Trust Board to receive a Guardian of Safe Working Report no less than once per quarter. This report shall also be provided to the Joint Local Negotiating Committee (JLNC).

The Terms and Conditions of service also requires that a consolidated annual report on rota gaps and the plan for improvement to reduce these gaps shall be included in a statement in the Trust's Quality Account.This report shall also be provided to the JLNC.

Where the Guardian has escalated a serious issue to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level and the issue remains unresolved, the Guardian must submit an exceptional report to the next meeting of the Board. Future reports will include data on all rota gaps on all shifts.

There are no issues currently.

Staffing information

Number of doctors / dentists in training (total):	133
Number of doctors / dentists in training on 2016 TCS (total):	71
Amount of time available in job plan for guardian to do the role:	1.0 PAs per week
Admin support provided to the guardian (if any):	N/A
Amount of job-planned time for educational supervisors:	0.25 PAs per trainee

a) Exception reports (with regard to working hours)

Exception reporting is the mechanism used by doctors in training to inform the Trust when their day-to-day work varies significantly and/or regularly from the agreed work schedule. Primarily these variations will be:

- differences in the total hours of work (including opportunities for rest breaks)
- differences in the pattern of hours worked
- differences in the educational opportunities and support available to the doctor, and/or
- differences in the support available to the doctor during service commitments.

Exception reports by department				
Specialty	No. exceptions	No. exceptions	No. exceptions	No. exceptions

	carried over from last report	raised	closed	outstanding
N/A	0	0	0	0
Total	**0**	**0**	**0**	**0**

Exception reports by grade				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
N/A	0	0	0	0
Total	**0**	**0**	**0**	**0**

Exception reports by rota				
Specialty	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
N/A	0	0	0	0
Total	**0**	**0**	**0**	**0**

Exception reports by reason				
Reason	No. exceptions carried over from last report	No. exceptions raised	No. exceptions closed	No. exceptions outstanding
N/A	0	0	0	0
Total	**0**	**0**	**0**	**0**

Exception reports (response time)				
	Addressed within 48 hours	Addressed within 7 days	Addressed in longer than 7 days	Still open
N/A	0	0	0	0
Total	**0**	**0**	**0**	**0**

Note: As the Trust still has Lead Employer trainees on the old 2002 contract, this report includes information on hours monitoring exercises to ensure that assurance can be given

for all doctors in training, not only those on the new terms & conditions of service. A minimum 75% return is required for the monitoring to be a valid episode.

Hours monitoring exercises (for doctors on 2002 TCS only)					
Specialty	**Grade**	**Rostered hours**	**Monitored hours**	**Banding**	**WTR compliant (Y/N)**
Emergency Medicine	ST3+		N/A as only 12% return	1A	Unable to confirm due to low response
PICU	ST3+		N/A as only 21% return	1A	Unable to confirm due to low response
Anaesthesia	ST3+		N/A as only 32% return	1A	Unable to confirm due to low response
Cardiology	ST3+		N/A as nil return	1A	Unable to confirm due to low response
Cardiac Surgery	ST3+		N/A as only 62% return	1A	Unable to confirm due to low response
CAMHS	ST3+		N/A as nil return	1A	Unable to confirm due to low response
Radiology	ST3+		N/A as nil return	1A	Unable to confirm due to low response
Haematology	ST3+		N/A as nil return	1A	Unable to confirm due to low response
Neurosurgery	ST3+		N/A as only nil return	1A	Unable to confirm due to low response
OMFS	ST3+		N/A as nil return	1A	Unable to confirm due to low response
ENT Surgery	ST3+		N/A as nil return	1A	Unable to confirm due to low response
Paediatric Surgery	ST3+		N/A as only 67% return	1A	Unable to confirm due to low response
Paediatrics	ST4+		N/A as only 32% return	1A	Unable to confirm due to low response
Community Paediatrics	ST3+		N/A as only 30% return	1A	Unable to confirm due to low response
Paediatrics	CT1/CT2/F2		N/A as nil return	1A	Unable to confirm due to low response
Trauma & Orthopaedics	ST3+		N/A as only 21% return	1A	Unable to confirm due to low response

Historically, and not limited to Alder Hey, monitoring episodes do not usually achieve high rates of return. Efforts are made to encourage trainees to participate in monitoring, but trainees often view the monitoring as of little value to them. Monitoring will be slowly phased out as trainees currently employed on the 'old' 2002 contract complete the training programme, and are replaced by trainees on the 'new' 2016 contract.

b) Work schedule reviews

No work schedule reviews were requested / necessary during the period April - June 2018.

c) Locum bookings

i) Bank

As the Trust does not have a formal medical staff bank, it has not been possible to retrospectively collate locum bookings to provide meaningful data for the period April - June 2018. The aim for future reports is to provide the following data.

ii) Agency

Locum bookings (agency) by department				
Specialty	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked*
Trauma & Orthopaedics	1	1		40
Total	1	1		40

Locum bookings (agency) by grade				
Grade	Number of shifts requested	Number of shifts worked	Number of hours requested	Number of hours worked
ST1/ST2	1	1		40
Total	1	1		40

Locum work carried out by trainees
It has not been possible to retrospectively collate locum information to provide meaningful data for the period April - June 2018. The aim for future reports is to provide the following data.

d) Vacancies

It has not been possible to retrospectively collate vacancy information to provide meaningful data for the period April - June 2018. The aim for future reports is to provide the following data.

e) **Fines**

The Guardian of Safe Working Hours will review all exception reports to identify whether a breach has occurred which incurs a financial penalty, as set out below.

Where such concerns are validated and shown to be correct in relation to:

- a breach of the 48-hour average working week (across the reference period agreed for that placement in the work schedule); or
- a breach of the maximum 72-hour limit in any seven days; or
- that the minimum 11 hours' rest requirement between shifts has been reduced to fewer than eight hours

The doctor will be paid for the additional hours at the penalty rates set out in the terms and conditions of service, and the Guardian of Safe Working Hours will levy a fine on the department employing the doctor for those additional hours worked, at the rates set out in the terms and conditions of service.

There have been no fines levied by the Guardian for the period April - June 2018.

Qualitative information

The Junior Doctors' Forum in Q1 was held on 16th May 2018 and one of the main issues raised by trainees again related to the feeling amongst trainees that there is a culture of reluctance amongst the trainees to raise exception reports. Graham Lamont, Director of Medical Education challenged this, and the BMA Industrial Relations Officer advised the trainees that an issue being raised at a trainee's ARCP which had not been raised by the exception reporting process had been problematic for that trainee, and he encouraged trainees to submit exception reports.

Issues arising:

To date all Exception reports have been resolved without the need for fines.

Some trainees have stated that there is a culture of not reporting on the DRS system, even when hours are being breached, due to concern about how this will be perceived by the Educational Supervisor. Informally, trainees have mentioned that they feel nothing will change, as that is their impression of reporting in previous posts.

At every opportunity, trainees have been assured, by the Guardian of Safeworking & Director of Medical Education, that Alder Hey takes Exception Reporting seriously and that changes will be made as needed when there are genuine problems. This has been reiterated by Steve Ryan who has attended all the Junior Doctors' Forums so far.

Actions taken to resolve issues:

It was agreed that posters encouraging exception reporting would be put in handover rooms. The senior trainees agreed that they will continue to encourage exception reporting. Medical Education agreed to add a reminder to teaching correspondence. Poonam Dharmaraj, Guardian of Safe Working Hours will add this issue to the Medical Board agenda.

Poonam Dharmaraj
Guardian of Safe Working Hours
July 2018

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

26th June 2018

Workforce & Organisational Development Committee (WOD) – Chairs Note

1. Purpose of the Report

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

2. Key Issues

The following issues were raised and discussed at the Workforce & Organisational Development Committee on the 26th June 2018; the minutes of the meeting will be submitted to the October 2018 Board for noting.

- The Committee **noted** the improved ratings (Apprenticeship & Portering Service) for The Best People Doing Their Best Work – Programme Assurance.
- The Committee noted the content of the presentation outlining the LiA progress to date.
- The Committee received the annual EDS2 report, agreed the approach to support completion and **noted** the progress made.
- The Committee received a report outlining the latest development in Apprenticeship scheme and **noted** the progress made.
- As part of the focus to see improvement of the Health & Wellbeing of our staff, the Committee received a presentation outlining the action plan in place to support the reduction of Sickness Absence rates at the Trust and **noted** the advances made.
- The Committee received a report outlining the latest developments for Mandatory Training and **noted** the significant progress made.
- The Committee received a report outlining the challenges facing Medical Education and **noted** the content.
- The Committee received a presentation outlining Marketing & Communications objectives to support the Trust's plans to build a healthier future for children and young people and **noted** the content.
- As part of the focus to see improvement of the Health & Wellbeing of our staff, the Committee received a Staff Support Action Plan and noted the content.
- The Committee received the Board Assurance Framework May 18 and **noted** the content.
- The Committee received the workforce elements of the CQC Action Plan reflecting May 2018 position and **noted** the progress made.
- The Committee received an update of the Workforce Leading Indicators and **noted** the content.
- The Committee **ratified** the following policies and **approved** the accompanying EIA's:
  Flexible Working Policy & EIA
  Organisational Change Policy & EIA
  First Aid Policy & EIA
- The Committee noted the content of the following Committee notes:
  Joint Consultation Negotiation Committee 5th April 2018
  Joint Consultation Negotiation Committee 27th April 2018

3. Recommendations

It is recommended that the Board note the contents of the Chairs Update relating to the key issues from the Workforce and Organisational Development Committee held on 26th June 2018.

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BOARD OF DIRECTORS

Tuesday 4th September 2018

Report of:	Corporate Report
Paper Prepared by:	Mr Graham Lamont Mrs Helen Blackburn
Subject/Title:	A Framework of Quality Assurance for Responsible Officers and Revalidation **-** Annual Board Report September 2018
Background Papers:	N/A
Purpose of Paper:	To inform the Board of compliance for medical appraisal
Action/Decision Required:	The Board is asked to: • Approve the contents of this report. • Approve the 'statement of compliance' confirming that the organisation, as a designated body, is in compliance with the regulations. • This is also submitted annually to the higher level responsible officer.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	
Resource Impact:	

NHS England

A Framework of Quality Assurance for Responsible Officers and Revalidation

- Annual Board Report

September 2018

Table of Contents

1. Executive summary

For the period of the report there were 295 Drs with a prescribed connection to the Trust. The number of completed appraisals is 214, 76 appraisals were either not due or deferred for valid reasons. There are still five Drs who have not completed their appraisal for 2017-18.

2. Purpose of the Paper

. To update Trust Board on medical revalidation and appraisal for the year 2017/18

To set out the key priorities that the Trust needs to take forward into 2018-19.

3. Background

Medical revalidation was launched in 2012 to strengthen the way that doctors are regulated, with the aim of improving the quality of care provided to patients, improving patient safety and increasing public trust and confidence in the medical system.

Provider organisations have a statutory duty to support their Responsible Officers in discharging their duties under the Responsible Officer Regulations[1] and it is expected that provider boards / executive teams monitoring the frequency and quality of medical appraisals in their organisations;

- checking there are effective systems in place for monitoring the conduct and performance of their doctors;
- confirming that feedback from patients and colleagues is sought periodically so that their views can inform the appraisal and revalidation process for their doctors; and
- Ensuring that appropriate pre-employment background checks (including pre-engagement for locums) are carried out to ensure that medical practitioners have qualifications and experience appropriate to the work performed.

4. Governance Arrangements

Responsible Officer – Dr Steve Ryan

Lead for Revalidation– Mr Graham Lamont

Revalidation Manager – Mrs Helen Blackburn

Revalidation Administrator – Mrs Sharon Goumas

The list of Doctors with a prescribed connection is maintained by the administration team, updated when new connections are established. The information is sent via a number of routes: the GMC, CBU managers, Recruitment, or directly from individuals

[1] The Medical Profession (Responsible Officers) Regulations, 2010 as amended in 2013' and 'The General Medical Council (Licence to Practise and Revalidation) Regulations Order of Council 2012'

after they have commenced employment at the Trust. It is difficult to manage new recruits as the various sources are not always accurate. This results in the need for secondary validation of information by the administration team, thus increasing the volume of work.

The RO, Revalidation Lead and Manager attend the regular NHS North meetings and any relevant updates are incorporated into the Trust policy and cascaded to all Drs with a prescribed connection.
http://intranet/DocumentsPolicies/Documents/Medical%20Revalidation%20and%20Appraisal%20Guidelines.pdf

5. Medical Appraisal

a. Appraisal and Revalidation Performance Data

GMC Rating	1(a)	1(b)	2	3	Not done yet	Total
Consultants						
Community Services CBU	3	15	4			**22**
Medicine CBU	14	64	17		3	**98**
Surgery CBU	27*	66*	7		1	**101**
Total consultant numbers	**44**	**145**	**28**		**4**	**221**
Other (hon contracts or reciprocal RO)		2	2		1	**5**
Staff grade, Associate Specialists, Specialty Drs	1	11	8			**20**
Clinical Fellows	7	4	38			**49**
Total Others	**8**	**17**	**48**		**1**	**74**
Total All	**52**	**162**	**76**		**5**	**295**
Revalidation	**Positive Revalidation 2017/18**	**Number of revalidation deferrals**	**Total**			
Community Services CBU	1	2	3			
Medicine CBU	10	3	13			
Surgery CBU	5	3	8			

*Included Dental Consultants- not included in GMC figures

- *There are four cases open with the GMC*

b. Appraisers

Appraisers	Number of trained appraisers	Average per appraiser	Range of Appraisals
Community Services CBU	11	3	2-4
Medicine CBU	19	6.1	2-11
Surgery CBU	27	4.5	2-11

c. Quality Assurance

In assessing the quality of the Appraisal Process for the year 2017 -18 it had been the intention of the team to provide a Survey Monkey Tool previously used within the Trust to both appraisers and appraisees to help the team understand how the process was being perceived by both groups of participants. A further potential benefit was the opportunity it could provide of collating specific anonymised feedback for appraisers if sufficient numbers of responses were received for any individual. The survey is analysed by the Audit department independently from the Revalidation team but the tool proved difficult, both to administer and then derive results from, with a result that only 8 responses were received from the group of appraisees and only 4 from the appraiser group. Though the information given back suggested that both groups had few problems with either the process of the appraisal or the overall quality, the numbers were too small to make any meaningful analysis. Of interest however was a comment that came from most of the respondents around the availability of Trust provided information. This ranged from activity data, to current status of completion of mandatory training, and more easily collated information on complaints data. Although as noted in sections below this information can be found in InfoFox, it is not clear that all staff are aware of how to interrogate this system.

Consequently a further analysis of the portfolios was undertaken by the Revalidation team. A purposeful sample of 25 records was selected from the completed appraisal records. The group were selected from the completed records by the Revalidation Lead using a number of criteria: a range of specialties from each division was chosen, the doctors were not used in last years' analysis, there was a range of experience from new to senior consultants, non-consultant and clinical academic colleagues were included, and no concerns had been raised about any of the individuals to the team during the appraisal cycle.

The records reviewed broken down as follows:

- Medical division : 10 records
- Surgical division: 10 records
- Community division: 5 records.

The portfolio was assessed in two aspects overall – the six domains related to Good Medical Practice that the appraisal should cover (numbers 2 – 6 in the following list), and an assessment of the quality of the outcome of the meeting (numbers 9 and 10).

#1 Scope of work

#2 Evidence of CPD requirement

#3 Evidence of quality improvement activity

#4 Feedback from colleagues

#5 Feedback from patients

#6 Review of complaints

#7 SUI review

#8 Evidence of teaching

#9 Evidence of appraisal outcomes

#10 Relevant PDP created

Overall, the quality of information presented has been high, and for those consultants who are undertaking their second or subsequent appraisal, it has been possible to follow the narrative, linking previous PDP to the evidence presented.

The 'scope of work' category has in the main been well populated, though there is a variation in the amount of detail presented. Some respondents categorise their role as a series of tasks and then link subsequent CPD attendance and future plans to the relevant part of the 'scope of work' , whereas others may give less detail at that part of the portfolio, but in the subsequent sections will again link their PDP to aspects of their role in a more specific rather than generic fashion.

In the review of the 25 records, each of the 6 categories of evidence that the GMC requires has evidence of completion, (numbers 2 - 7) showing that these have been considered as part of the appraisal process. In that respect the process is achieving the primary aim of ensuring a review of the doctor's practice. Of specific interest is the response to Significant Incidents. A total of 4 doctors within this sample have reported as being involved in such incidents and these have formed a part of the appraisal discussion, with evidence of the doctor's reflection on their part in the incident. This aspect of the appraisal has invariably been commented upon in the outcomes section.

There is good evidence from this sample of a widespread active role being taken by medical staff in the delivery of a 'quality service'. This ranges from the performance of local audits, through to the involvement in both submitting data to national audits and in some cases being involved in the national agenda setting for this type of work. In the main the outcome section makes reference to this for each individual and there is clear linkage to the GMP domains.

The collection of colleague and patient feedback is clearly linked in the system to a revalidation date and at present there is a tendency for appraisees to collect the relevant evidence in the year prior to their revalidation date. In those records reviewed where feedback was undertaken there is evidence of review of this feedback in the discussion, and a reflection on the information from the appraisee.

There continue to be areas however that requires further work. While all of the reviewed records have shown good evidence of their teaching commitments, and while there is evidence in the discussion sections that they have both received and acted upon feedback, in only a few records is their specific linkage made to the evidence being suitable to maintain recognition as an Educational Supervisor.

Review of the input of the appraiser to the discussion comes largely in the form of the outcome section (no.9) and agreed PDP (no.10). In 24 of the 27 records reviewed there is a good depth of discussion recorded by the appraiser and clear linkage of the evidence to the GMP domains. This is an indication of the commitment by both parties to this system of appraisal and is indicative of both the quality of information collected by the appraisee and also the desire of the appraiser to help the appraisee explore issues regarding their practice. In this sample there are only 3 outcome discussions that have recorded what might be seen as the bare minimum of comment to judge that an appropriate decision has been made. Review of the records of these individual doctors and the evidence presented has identified that they presented sufficient evidence, and therefore the judgement about successful appraisal is justified. However it does tend to suggest that for some appraisers there is a need to re-visit how they record the discussions to ensure a good evidence trail of how decisions are reached. In the training of appraisers, this is an area that will require additional focus on the required standard.

Overall from the sample selected there is good evidence that the appraisal process is functioning as expected and the quality remains at an acceptable level.

d. Access, Security and Confidentiality

There have been no issues with Allocate; all users are given a personal username and password. The information is held by Allocate in a ‘cloud’ which meets the IT security requirements. All information is backed up by Allocate and can be accessed by the user or the administrators.
During training all Drs are informed that patient identifiable information should not be included in their appraisal documents. Previous audits have not identified this as an issue.

No information governance breaches have been identified.

e. Clinical governance

There are a variety of sources to access information, such as Info Fox, and department M& M records. The system of complaints and response to complaints is discussed in appraisal, but from the responses to the questionnaire to appraisees, there is definitely

concern that not all issues may be known to the individual. Thus, it is not clear if every complaint is reviewed at appraisal.

The sample used in the assessment in the quality section identifies that the relevant sections for clinical governance (nos. 3- 7) are completed appropriately, and the respondents do show evidence that they are participating in activities relevant for clinical governance

6. Revalidation Recommendations

- *The following recommendations were made; Recommendations between April – March* ***17***
- *Recommendations completed on time* ***17***
- *Positive recommendations,****17***
- *Deferral requests,****4***
- *Non-engagement notifications,* ***0***

The four deferrals were due to insufficient evidence as all of the appraisees were newly appointed to the Trust

7. Monitoring Performance

Performance is monitored through a number of mechanisms based at divisional and directorate level. Specific performance data is available via Info Fox, and although it may form part of the appraisal discussion, this is not primarily seen as a mechanism of performance monitoring.

Concerns over the performance of an individual are dealt with through trust managerial process and follow trust policies. These may form part of an appraisal discussion, but if any new issues related to patient safety are raised then a judgement is made by the appraiser as to whether the appraisal should cease and any concerns dealt with via a different mechanism. The expectation for an individual is that if any complaints have arisen in the preceding time period, they are recorded in the portfolio, and discussed at appraisal. From the sample that was analysed, if the respondents noted that they had a complaint raised, the substance of the response to the complaint was discussed in appraisal, and outcomes of that discussion recorded in the outcome section.

In the general running of the system some issues come to light that do need discussion with the GMC directly. The RO will escalate specific cases directly to the GMC as required.

8. Risks and Issues

In general there is widespread acceptance of the Trusts system of appraisal and the fact that we have now used the same system for more than 3 years has drawn positive comment, as people become familiar with the system. There are however a couple of potential risks that need to be monitored.
There is risk of people not making the link between quality of service and participation in appraisal. It can be seen as more a tool of performance management and regulation

rather than the opportunity for a time for an individual to reflect on how they would like to focus both their personal and service development.
Linked in part to this first issue is the risk that we will not maintain adequate numbers of appraisers due to pressure of clinical work and without dedicated time within a job plan. This is an area that warrants specific focus within team job plan discussions.

9. Board / Executive Team Reflections

More licences required to include all Drs with a prescribed connection to the Trust.

10. Corrective Actions, Improvement Plan and Next Steps

Following feedback from the appraisees we have changed the following:

- Appraisal folders open 1st April to allow the appraisal form to be populated throughout the year.
- Appraisers will not be confined to specialty or department. Appraisers are only allowed to appraise each individual three times in a five year revalidation period. For this reason it was necessary to pair appraisers/appraisees from different medical and surgical groups.
- The feedback was very positive and it will continue in the next cycle of appraisals.
- This may in part be a solution to the issues of mismatched numbers of appraisers and appraisees between divisions.
- Further consideration of how to improve the analysis of the quality of the appraisal process needs to be enacted.

11. Recommendations

The Board is asked to approve the contents of this report.

The board is requested to approve the ‘statement of compliance’ c confirming that the organisation, as a designated body, is in compliance with the regulations.

This is also submitted annually to the higher level responsible officer.

12. Appendix A – Audit of all missed or incomplete appraisals

Doctor factors (total)	**Number**
Maternity leave during the majority of the 'appraisal due window'	*7*
Sickness absence during the majority of the 'appraisal due window'	*4*
Prolonged leave during the majority of the 'appraisal due window'	*3*
Suspension during the majority of the 'appraisal due window'	*2*
New starter within 3 month of appraisal due date	*1*
New starter more than 3 months from appraisal due date	*2*
Postponed due to incomplete portfolio/insufficient supporting information	*N/A*
Appraisal outputs not signed off by doctor within 28 days	
Lack of time of doctor	*N/A*
Lack of engagement of doctor	*N/A*
Other doctor factors	*N/A*
(describe)	
Appraiser factors	**Number**
Unplanned absence of appraiser	*1*
Appraisal outputs not signed off by appraiser within 28 days	*0*
Lack of time of appraiser	*0*
Other appraiser factors (describe)	*0*
(describe)	
Organisational factors	**Number**
Administration or management factors	*0*
Failure of electronic information systems	*0*
Insufficient numbers of trained appraisers	*0*
Other organisational factors (describe)	*0*

To: All Responsible Officers / Designated Bodies

NHS England
Waterfront 4
Goldcrest Way
Newcastle upon Tyne
NE15 8NY

0113 825 3052
mike.prentice@nhs.net

3rd April 2018

Dear Responsible Officer

Framework of Quality Assurance – Annual Organisational Audit (Annex C)

In May 2017, all responsible officers completed the **Annual Organisational Audit** on behalf of their designated bodies. I would like to thank you for your efforts in making the audit a great success, both in terms of the number of returns received (100%) and in ensuring the increase in the overall appraisal rate, year on year. The annual audit provides assurance to patients, the public, the service and the profession that the systems and processes underpinning revalidation are in place and are working effectively.

The Framework of Quality Assurance for Responsible Officers and Revalidation (FQA) has been designed to assist responsible officers in providing assurance to their organisation's board (or equivalent governance/executive group) that doctors working in the designated body remain up to date and fit to practise. The process supports responsible officers in the preparation of their own appraisal portfolios, giving an overview of their performance. It also provides a formal record of compliance, which may be helpful should a designated body's systems and processes become subject to challenge at any stage.

As your Higher-Level Responsible Officer, I am writing to request that you complete and submit the mandatory return, the 2017/18 **Annual Organisational Audit** (AOA), for the period 1 April 2017 to 31 March 2018. The deadline for submission is **Friday 8 June 2018**. All responsible officers are also asked to present an **annual report** (FQA annex D) to their Board or equivalent management team. Following this, a **statement of compliance** with the regulations (FQA annex E) should then be signed off by the Chairman or Chief Executive Officer of the designated body's Board or management team

and submitted to me by **September 28, 2018**. Document templates can be found on the NHS England web pages - http://www.england.nhs.uk/revalidation/qa/.

In the accompanying email, there is a link to the electronic version of the **AOA**. Once the 'submit' button has been pressed, the information will be sent to a central database. The information you provide is collated by NHS England and following analysis of the data, a national report is produced. Individual designated bodies are not identified.

Each higher-level responsible officer will receive a detailed report for those designated bodies connected to them and each designated body will receive an individual comparator report personalised to them, indicating their return benchmarked against others in their sector and all designated bodies nationally.

Please note, in terms of the e-form:

- You should only use the link received from NHS England in today's email, as it is unique to your organisation. The link opens an electronic version of the AOA for completion.

- Once the link is opened, you will be presented with two buttons; one to download a blank copy of the AOA for reference; the second button will take you to the electronic form for submission.

- Submissions can only be received electronically via the link. Please do not complete hard copies, or email copies of the document.

- The form must be completed in its entirety prior to submission; it cannot be part- completed and saved for later submission.

- Once the 'submit' button has been pressed, the information will be sent to a central database, collated by NHS England.

- A copy of the completed submission will be sent to the responsible officer.

Further detailed guidance on completion and submission is available within the AOA form.

In summary, please may I ask that you:

1. Review your designated body's systems and processes against the core standards.

1. Complete and return the **Annual Organisational Audit** by **Friday 8 June 2018** for your 2017 - 18 year-end position.

2. Arrange for an **annual report** (template at Annex D) to be submitted to your Board or equivalent governance body, as detailed in the FQA documentation.

3. Complete and return a **statement of compliance** (template at Annex E) to me by **September 28, 2018.**

Kind regards

Dr Mike Prentice
Higher-Level Responsible Officer
NHS England

CC: Chairs and Chief Executives of Designated Bodies

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board

4th September, 2018

Report of:	External Programme Assurance
Paper Prepared by:	Joe Gibson, External Assurance and John Grinnell, Executive Sponsor
Subject/Title:	Programme Assurance Summary Change Programme
Background Papers:	Reports to the Trust Board as attached
Purpose of Paper:	To apprise the Trust Board of the Assurance status of the change programme and the actions that have been requested of Executive Sponsors
Action/Decision Required:	For information
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	The change programme is fundamental to the Trust's strategic direction' and links to all strategic objectives.
Resource Impact:	Nil

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Change Programme

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

1. The Change Programme for 18/19 (and beyond, as many of the work streams are multi-year initiatives) has seen further improvement across all the themes during the summer; the efforts of programme sponsors and their teams should be applauded while the impact of the Delivery Management Office (DMO) cannot be overstated as a key catalyst for this trend.
2. The positive effect on the assurance ratings can be seen from the dashboard excerpts attached to this report and – in the absence of sub-Committee meetings in August – this represents the current status across the programme.
3. The Delivery Management Office, in the person of the Change Programme Manager, will be assuming responsibility for assurance ratings from 1 Jan 19 and the next 3 months will see a gradual handover of that responsibility from the External Programme Assurance.
4. The CIP contributions from the Change Programme are shown at slide 3; the progress is tangible but further work is required to turn all schemes to fully developed (green) to reduce the risk of CIP delivery.

J Grinnell 22 Aug 18

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

1. This Board report comprises extracts from the assurance dashboard covering the 7 themes of the change programme (in the absence of sub-Committee reporting in August 2018): the 28 projects show 36% green, 54% amber and 10% red. This forms the best assurance picture for some considerable time; however, the aim is still to fully assure all programmes and sponsors should pursue that end.
2. The weekly 'Financial Sustainability Board' continues to conduct reviews of the forecast and contributions from each work stream comprising the change programme; the overall level of contribution from the change programme has improved but needs to be de-risked.
3. The transfer of responsibility for assurance ratings to the Change programme manager is dependent upon the recruitment of a fourth programme manager and timely MSP training for the DMO Team.

J Gibson 22 Aug 18

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

See CIP status at slide 3 of this pack. In sum, the 18/19 change programme forecast outturn CIP achievement at 14th August has remained consistent at £5.1m. A target FOT for 2018/19 is a minimum of £6m CIP delivery; further traction is required.

Change Programme

PROPOSED PROGRAMME 18/19

Trust Board

Alder Hey Children's NHS
NHS Foundation Trust

R&BD | WOD | CQAC | R&BD | R&BD

Programme Assurance Framework, DMO & Delivery Board

Growing Through External Partnerships
John — SG

1. CHD Liverpool Partnership
2. Aseptics

Pipeline
- Neonatal Services

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

1. Portering
2. Apprenticeships

Pipeline
- E-Rostering
- AHP Review

Deliver Outstanding Care
Hilda / Steve

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

Pipeline
- Models of Care
- Care of Complex Children

Global Digital Exemplar
John/Steve — PB

1. Speciality Packages
2. Voice Recognition

Strong Foundations — SG
John

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

RE&I

Park, Community Estate & Facilities
David — SG

1. Decomm. & Demolition
2. R&E 2
3. Alder Centre
4. Park
5. Residential Devel.
6. International Design & Build Consultancy
7. Retained Estate
8. Community Cluster

Game Changing Research & Innovation
David

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

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

Programme Contribution to CIP Status – as at 20 Aug 18

Weekly CIP Tracker as at 20th August 2018 by work stream

Workstream	Exec Sponsor	In Year Forecast				Recurrent Savings				Risk Rating (In Year)					
		Target £000's	Forecast Current £000's	Forecast Last Week £000's	Improvement £000's	Target £000's	Forecast Current £000's	Forecast Last Week £000's	Improvement £000's	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	2,500	1,458	1,458	0	2,500	1,770	1,770	0	866	117	475	0	1,042	2,500
Growing Through External Partnerships	Margaret Barnaby	800	0	0	0	800	0	0	0	0	0	0	0	800	800
The Best People Doing Their Best Work	Melissa Swindell	1,000	567	567	0	1,000	120	120	0	372	0	195	80	353	1,000
Game Changing Research and Innovation	David Powell	500	0	0	0	500	0	0	0	0	0	0	0	500	500
Strong Foundations	John G/Claire L	2,200	1,450	1,450	0	2,200	1,799	1,953	-154	942	60	448	402	347	2,200
Park, Community Estate & Facilities	David Powell	0	18	18	0	0	18	18	0	18	0	0	0	-18	0
Global Digital Exemplar (GDE)	Peter Young	1,000	0	0	0	1,000	0	0	0	0	0	0	0	1,000	1,000
Subtotal: Strategic Workstreams		**8,000**	**3,493**	**3,493**	**0**	**8,000**	**3,706**	**3,860**	**-154**	**2,199**	**177**	**1,118**	**482**	**4,024**	**8,000**
Divisional Business		-1,043	1,588	1,588	0	-1,043	1,325	1,325	0	1,344	74	171	409	-3,040	-1,043
Unidentified		0	0	0	0	0	0	0	0	0	0	0	0	0	0
Grand Total		**6,957**	**5,081**	**5,081**	**0**	**6,957**	**5,032**	**5,186**	**-154**	**3,542**	**250**	**1,289**	**891**	**984**	**6,957**

Key headlines:

- The forecast outturn CIP achievement for 2018/19 as at 14th August has remained consistent at £5.1m.
- The plans in progress or the amber schemes (£1.2m) included in the FOT of £5.1m require further review to turn to fully developed (green) to reduce the risk of CIP delivery.
- A target FOT for 2018/19 is a minimum of £6m CIP delivery
- Further traction is required on the following schemes will support the increased target:
  - Delivering outstanding Care – Outpatients project – confirmation of benefits realisation date required
  - Strong Foundations - Medicines optimisation project – confirmation of saving due mid September
  - GDE projects not included in the above workstreams

1.0 Deliver Outstanding Care – as at 9 Aug 18

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 18/19													
CQAC	**Best in Outpatient Care**	The Best in Outpatients Project aims to deliver an outstanding experience of outpatient services for children, families and professionals as well as safely increase the number of patients we see in clinic	Hilda Gwilliams										The project team is now fully in place and good minutes of meetings available with action notes tracked; a future schedule of meetings has been planned. The PID is detailed and clear but the targets do need some minor work to meet the assurance stanbdard. There is a comprehaensive milestone plan being tracked. A risk register is held and is up to date. There is an impressive approach to stakeholder engagement. **Last updated 7 Aug 18.**
CQAC	**Brilliant Booking and Scheduling**	To provide a booking system that puts patients and families first and meet the needs of clinicians that use it.	Adam Bateman										Project team meetings are scheduled, documented and well attended. The PID still requires work to fully define benefits. Benefits tracking plans are comprehensive but with some baselines still to be established. The Gantt Project Plan is now complete and being tracked but with several milestones delayed. There is a comprehensive suite of stakeholder engagement. The risk register is detailed with risks last reviewed on 7 Aug 18. EA/QIA signed off and uploaded. **Last updated 7 Aug 18.**
CQAC	**Comprehensive Mental Health**	Deliver improvements in mental health services to better meet the needs of children and young people. Be recognised as leading the way for CAMHS services nationally	Cath McLaughlin										Comprehensive Mental Health project team meetings: the Steering Group forms part of the CAMHS board agenda on first Thursday of each month while meetings to discuss each work stream and the milestones within each happen on a fortnightly basis; evidence of both meeting is on SharePoint. There is a comprehensive PID (although the PID high level milestones should project out to the end of the project cycle) and benefits are defined. A good milestone plan is in place and being tracked. Evidence is required of stakeholder engagement (the folder currently holds project team minutes). A Ulysses risk log has been completed but needs all fields to be completed. A signed EA/QIA has been uploaded. **Last updated 6 Aug 18.**
CQAC	**Patient Flow**	Improve our processes to enable timely implementation of clinical decisions, and support patients through their pathway efficiently: minimising delays and reducing time spent in hospital. This project consists of 3 workstreams; Expanding Day Surgery, Expanding Pre-Op Assessment and SAFER Bundle.	Adam Bateman										Evidence of SAFER Task Force minutes up to 5 July 2018. The PID needs further work on benefits and high level milestones. A detailed milestone plan has been uploaded for SAFER but milestone need further additions to due dates. Stakeholder engagement evidence is limited to a 'Black Marble' presentation, additional evidence is now required. A rcomprehensive risk register has been prepared but target risk scores are missing and also actions to reduce risk for some entries. An EA/QIA has been drafted for signature. **Last updated 6 Aug 18.**
CQAC	**Sepsis**	This project will ensure prompt recognition and management of the deteriorating patient and implementation of the Sepsis Pathway	Hilda Gwilliams										Project implementation meeting notes available to June 2018 with next meeting due 15 Aug. PID complete. Benefits defined, tracking/reporting of benefits has commenced but last up-dated figures are December 2017. From the benefits tracker on SharePoint: Time to Antibiotic Presecription from Diagnosis is against a threshold of 90% was at 63% (ED ONLY) and 73% (Inpatients ONLY) and target was for both to be 90% by March 2018. Training records for nurses were at 91% overall at February 2018. Milestone Plan for 2018/19 has been uploaded but last updated 18 Jun. Evidence has been provided for certain stakeholder engagement activities but there is no tracked communications plan (since 2017). Evidence now on SharePoint of risks on Ulysses system (last update May 2017). EA/QIA complete. **Last updated 6 Aug 18.**
CQAC	**DETECT Study**	Using smart technology to reduce critical deterioration	Hilda Gwilliams										Evidence of project team meetings has been uploaded to SharePoint. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed; however, the metrics are still required for the measurement of benefits. A detailed Gantt Chart is available (uploaded 17 Jul 18) and will now need tracking on SharePoint. There are materials uploaded which indicate stakeholder engagement but there is no communications plan in evidence. There is a risk register and it would benefit from being in Trust standard format. An EA/QIA has been drafted and needs sign-off. **Last updated 2 Aug 18.**

2.0 Growing through External Partnerships – as at 9 Aug 18

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
2.0 Growing Through External Partnerships 18/19													
R&BD 2.5	**CHD Liverpool Partnership**	The aim of this project is to deliver the potential Level One centre status for adult congenital heart disease across the NW/North Wales and Isle of Man; bringing together a partnership of 4 Liverpool providers.	Steve Ryan		🟢	🟢	🟡	🟡	🟡	🟡	**N/A**	**N/A**	Minutes of meetings and governance structure now uploaded to SharePoint. Following NHSE decision on 30 Nov 17, project documentation has been developed to provide a mobilisation plan. Milestone Plan uploaded, with tabs for various work streams, but is not being tracked on SharePoint. Benefits need to be further refined with evidence on SharePoint. Risk Register uploaded and risks not reviewed since 5 Apr 18. **Last updated 18 Jun 18.**
RABD 2.6	**Aseptics**	Validate and commission aseptic unit. To provide internal service which reduces outsourcing to minimal levels. Take unit to licence to offer income generating opportunities.	Mags Barnaby		🟢	🟡	🟡	🟢	🟢	🟢	🟢	🟢	Minutes of the Quality Management Meeting of the Aseptics Services Department are available and up to date. Scope is decribed by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' now dated 16 March 2018'. Targets and benefits are being closely tracked but not yet reaching aspired thresholds. A Gantt chart is in place and being tracked in accordance with the 'Exception Report' uploaded on 22 Jun 18; there are some minor delays to milestones and it as being closely tracked. Inceasing levels of evidence of stakeholder engagement now being uploaded. Audit of Aseptic Services has been uploaded to SharePoint. EA/QIA signed off. **Last updated 7 Aug 18.**

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

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
3.0 The Best People Doing Their Best Work 18/19													
WOD	**Apprenticeships**	To operationalise the Apprenticeship Strategy and realise the benefits of apprentiseship qualitifcations following introduction of the Apprenticeship Levy.	Melissa Swindell		●	●	●	●	●	●	●	●	Weekly project leads meeting notes are available on SharePoint to 3 Aug 18 and Steering Group to 2 Jul 18. A PID is available at v6 dated 28 May 18. A detailed Milestone Plan is available and is being closely tracked; some milestones have slipped and several open entries (left of the date line) need to be categorised as 'complete' or 'missed'. Comms/Engagement activities detailed in PID and a comms plan is in place with extensive stakeholder engagement materail in evidence. Evidence that risks are up-to-date on Ulysses is now on SharePoint. EA/QIA complete. **Last updated 6 Aug 18.**
WOD 3.2c	**Improving Portering Services Project**	The aim of this project is to deliver an effective portering service which meets all KPIs agreed by the Trust relating to all portering tasks and to ensure that the department has the right resource at the right times throughout the working day and week .	Hilda Gwilliams		●	●	●	●	●	●	●	●	Team meetings and briefing notes available. PID available which contains benefits and metrics. Milestone Plan available, shows significant slippage of the overall end date to 24 September 2018. The project is now subject to negotiations with Unions following rejection of the proposals by ballot on 20 Apr 18. The Trust will be meeting imminently with the Unions to try to agree a trial period and the project work will await the outcome of those discussions. Evidence available of Comms/ Engagement activities. Risks uploaded as per Ulysses Risk Log of 7 Aug 18. EA/QIA complete. **Last updated 7 Aug 18.**

4.0 Global Digital Exemplar – as at 9 Aug 18

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
4.0 Global Digital Exemplar 18/19													
R&BD 4.1	**GDE**	Create exemplars that can inspire others by really showing how information technology can deliver both improved patient outcomes and enhanced business effectiveness	Steve Ryan/ John Grinnell		🟡	🟢	🔴	🟡	🟡	🟡	🟢	🟢	Programme Board Minutes and Agenda only in evidence up to April 2018. GDE Action Log only to 12 Jun 18. PID of 28 Jun 17 v8 available. Overall benefits profile and schedule has now been finalised, 'Strategic Owner' column on SoPB still requires updating to reflect current trust executive appointments; internal CIP Tracker shows no financial benefit yet delivered in 2018 while SoPB proposes £2.08m cash realising benefits in 2018/19 (VfM Tracker). Milestone Plan on Dashboard, latest uploaded 6 Jun 18, shows some delivery dates missed; several milestones have RAG ratings that do not reflect the delivery dates. Stakeholder evidence has been uploaded with a register updated to May 2018 with Newsletters to 8 June 2018. Risk protocols vis-à-vis national and Trust sytsems have been harmonised but not updated on SharePoint since 14 Mar 18. **Last updated 12 Jun 18.**
R&BD 4.1a	**Speciality Packages**	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Steve Ryan/ John Grinnell		🟡	🟢	🟡	🔴	🟢	🟡	**N/A**	**N/A**	Overall benefits profile and schedule is shown on the SoPB tracker; internally, there are no financial benefits yet reported for 2018. Project Plan last updated 19 weeks ago, 27 March 2018, and many milestones outstanding are unreported. Stakeholder engagements entered to 8 Jun 18. Risk protocols vis-à-vis national and Trust systems are now harmonised and finalised. Risks and issues aggregated at GDE programme level but not updated since 4 May 18. **Last updated 13 Jun 18.** QIA/EA will be assured and assessed at project level.
R&BD 4.10	**Voice Recognition**	Deploy voice recognition solution in Medisec and Meditech	Steve Ryan/ John Grinnell		🟢	🟢	🔴	🟢	🟢	🟢	🟢	🟢	PID and detailed project workbook on SharePoint. Details of financial benefits on separate document, these have not been realised as planned. Project Plan is being kept up to date and the overall standard of the workbook is excellent. Comms/engagement activities detailed in PID, evidence required where possible. Risks detailed in workbook. EA/QIA has been signed and uploaded. **Last updated 6 Aug 18.**

5.0 Park, Community Estate and Facilities (Part 1) – as at 9 Aug 18

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 18/19													
R&BD 5.1	**Decommission & Demolition**	The aim of the project is to move out from and make safe the old hospital ready for demolition	David Powell		🟡	🟢	🟡	🔴	🟡	🟡	🟢	🟢	PID available, however details of benefits requires review in line with revised/ updated dates. Milestone plan shows that all planned activities have now completed; confirmation required of the milestones dates for future activity. Details of communication/engagement activities to be confirmed and evidence provided where possible. Risks now on Ulysses but no updates to SharePoint. **Last updated 7 May 2018.**
R&BD 5.2	**R&E 2**	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell		🟡	🟡	🟡	🟡	🟡	🟡	🟢	🟢	Progress Meeting Notes available to February 2018. The R&E Commissioning Plans and notes of the related 'Agile' meeting are also available. PID available, benefits to be confirmed. Milestone Plan continues to show some significant delays with key milestones running late or not reported on. There is a key dependency on the 'Agile' working project which remains in 'pipeline' status; however, detailed evidence of the work of the 'Agile' group is now on SharePoint and stakeholders are being engaged. Issues Log uploaded, risks to be entered on Ulysses. Deatils of Catering options are also on SharePoint. EA/QIA completed and signed off. **Last updated 19 June 2018.**
R&BD 5.3	**Alder Centre**	To plan, develop and construct the new Alder Centre within the park setting	David Powell		🟢	🟢	🟢	🔴	🟢	🟢	🟢	🟢	Steering Group meeting notes available. Scope/approach defined in PID (revised recently). Benefits defined in PID. Milestone Plan has been revised recently - shows procurement of contrator has now been completed (although some 5 months off track); it is understood that construction that was due to start at the beginning on June (according to plans on SharePoint) has not yet commenced. Finalisation of design has been completed with start of build scheduled 2 months later than showing on the plan. Evidence of Comms/ Engagement activities. Risks to be confirmed on Ulysses. EA/QIA complete. **Last updated 4 Jun 18.**
R&BD 5.4	**Park**	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell		🟡	🟢	🟡	🟡	🟢	🟡	🟢	🟢	Steering Group reports available to 31 July 2018 and governance structure in place (notes from Steering Group should also be uploaded). Updated PID on SharePoint showing comprehensive suite of benefits and high level milestones through to end of project life cycle. An indication of progress against benefits targets (RAG rating or % confidence level achieved would be useful). There is a detailed Milestone Plan which would benefit from some further precision on re-scheduling of missed dealines; there is also an extremely informative 'Springfield Park Update' available. A comprehensive 'Engagement Ops Plan' is in evidence (this would benefit from status indicators). A Risk Register has been uploaded and risks last reviewed on 22 Jun 18. EA/QIA complete. **Last updated 3 Aug 18.**

5.0 Park, Community Estate and Facilities (Part 2) – as at 9 Aug 18

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 18/19													
R&BD 5.5	**Residential Development**	To create a high quality residential scheme that co-ordinates with the themes and activities within the wider park site	David Powell		🔴	🟢	🟢	🔴	🟡	🟢	🟢	🟢	Scope/approach and benefits defined in PID. Plan shows extended delays - now beyond 6 months - with planning permission and public consultation milestones missed; revised milestones are now showing on the plan. Evidence required of comms/engagement activities. Risks on Ulysses and require review (last review May 2017). EA/QIA complete. **Last updated 4 Jun 18.**
R&BD 5.6	**International Design & Build Consultancy**	To develop business in advising other health organisations - both nationally and internationally - with organisational new builds	David Powell		🟡	🟡	🟡	🔴	🟡	🔴	**N/A**	**N/A**	Work stream reports need to be augmented with evidence of notes/minutes of project meetings. Draft/outline PID on SharePoint. All project documentation to be fully developed including risk register. **Last updated 4 Jun 18.**
R&BD 5.7	**Hospital Moves**	To re-provide a high standard of working accommodation for those teams and services currently lodged in interim facilities on the retained estate	David Powell		🟡	🟢	🟡	🟢	🟢	🟢	🟢	🟢	A list of 'Commissioning Meeting' membership is available as well as project governance structure; however, there is no evidence of meetings available on SharePoint apart from the 'Records and Transcriptions' meeting. The PID dated 9 Jan 18 is available on SharePoint and provides a comprehensive summary of scope and approach. A high level critical path has been uploaded as well as an option for external provision of space. There is now a detailed Milestone Plan now uploaded onto SharePoint. A risk register is being maintained (important to have dates for 'risk raised' and 'last reviewed'). EA/QIA signed, important to review during the project as different accommodation options are decided upon. **Last updated 6 Aug 18.**
R&BD 5.8	**Community Cluster**	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell										Draft PID uploaded 1 Feb 2018, 'Initiation' Slides uploaded 27 Mar 2018. All other project documentation yet to be developed. **Last updated 27 Mar 18.**

6.0 Game Changing Research and Innovation – as at 9 Aug 18

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
6.0 Game Changing Research & Innovation 18/19													
RE&I 6.1	**The Academy**	To set up the Alder Hey Academy to establish/consolidate Alder Hey as a leading international provider of Education	David Powell		🔴	🔴	🟡	🟡	🟡	🟢	🟢	🟢	There is evidence of an 'Academy' team meeting up to 12 Apr 18 in so far as agendas have been uploaded; however, there is no evidence of the action notes that are required under the meetings ToRs. The PID is now out of date and needs to be refreshed. Benefits are off-track according to the tracker. Milestone Plan has been updated but only out to Mar 19 (so does not support delivery of revised benefits). Comms/ Engagement activities to be tracked with evidence provided where possible. Risks transferred to Ulysses and evidence is on SharePoint. EA/QIA signed by Execs, confirmation required that 2017 certificate relates also to 18/19 programme. **Last updated 7 Aug 18.**
RE&I 6.3	**Developing Apps and Products with Acorn Partnership**	To set up the Acorn Partnership charged with creating a pipeline for developing the Innovation Machine's Apps	David Powell		🟢	🟢	🟡	🟡	🟡	🟢	🟢	🟢	Evidence of meetings of a 'Project Delivery Group' to 5 July 2018. A revised PID has now been uploaded with key benefits and timelines updated. A high level Milestone Plan has been uploaded and is being tracked (last update May 18). No explicit measurement of benefits financial could be found (£450k Sep 18 and £450k Mar 19). Comms/Engagement activities have a plan but this should be updated regularly (weekly), no indication of whether 18 events since early June have been completed. Risks on Ulysses with evidence uploaded, the team need to check that these do encompass all the main risks to the Trust. EA/QIA has been completed and signed. **Last updated 5 Jul 18.**

7.0 Strong Foundations – as at 9 Aug 18

Project Ref	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT RAG status	An effective project team is in place	Scope and Approach is defined	Targets / benefits defined/on track	Milestone plan is defined/on track	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	Comments for attention of the Project Team, Steering Group and sub-Committee
7.0 Strong Foundations 18/19													
RABD 7.1	**Inventory Management**	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell										Documentation relevant to this specific type of project now on SharePoint. Detailed POD available with precise metrics. Plan updated, benefits profile shows project is on track to realise full benefits as projected. Evidence of stakeholder engagement has been uploaded (albeit relatively narrow). EA/QIA now signed off. **Last updated 7 Aug 18.**
RABD 7.2	**Procurement CIP**	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell										Documentation relevant to this specific type of project now on SharePoint. Plan last updated 2 Aug 18 (Graph tabe to be updated for 18/19 programme). Evidence of stakeholder engagement now uploaded but not extensive. EA/QIA signed off. **Last updated 2 Aug 18.**
RABD 7.3	**Medicine Optimisation**	To deliver the trust MO strategy and deliver quality improvements and financial benefits	Steve Ryan										Team structure now complete and actions notes of Steering Group available up 13 Jul 18. POD now uploaded, needs to show phasing of savings across the year to allow coherent feed into Trust CIP tracking. Plan uploaded, needs completion; tracking and completion of milestones for actions and benefits needs to be clear. Good stakeholder engagement evidence is emerging. A risk register needs to be uploaded. EA/QIA complete. **Last updated 7 Aug 18.**
RABD 7.5	**Coding and Capture**	To ensure the AH delivers a above average depth of coding and complies with the business rules whilst maximising income	Claire Liddy										Project team structure now complete. Minutes of Steering Group available up 26 Apr 18. POD uploaded and benefits baselines still to be established. Detailed benefits tracker uploaded, with savings starting to flow and forecast to meet target. Detailed Milestone Plan in evidence, tracked and up to date, with project actions over the full project cycle. Further evidence of stakeholder engagement required. Risk register in place and last reviewed on 1 Aug 18. It has been confirmed that the QIA signed of at end of 2017 applies to the 18/19 programme (and will be reviewed in Dec 18). **Last updated 7 Aug 18.**
RABD 7.6	**Energy**	To bring down energy cost and ensure budget forecast matches contractual target. Forecast budget for next 12 months for all fuels in line with contractual usage.Once the contractual target of 46.7 G has been achieved look at ways of reducing further by means of energy awareness for staff.	David Powell										Evidence of team meetings is available to June 18. The POD available available on SharePoint gives no details of financial benefits expected for 2018/19. The project plan for 18/19 contains only 6 actions (2 of these relate to usage monitoring and 2 relate to a compensation claim; more detail is required if this is to be considered a project). Evidence provided concerning risks is limited to the single BAF entry. QIA signed off for the 18/19 programme. **Last updated 1 Aug 18.**
RABD 7.7	**Catering**	To implement the recommendations from the Independent Catering review to improve the overall food service delivery at Alder Hey whilst reducing the financial loss current operating within the Catering Department.	Hilda Gwilliams										Evidence of the project team meeting planned for 15 Aug 18. The extensive and detailed 'Review of Catering Services – Final Version' dated January 2018 is serviing as a detailed PID. There is a 'Catering Project Benefit Tracker 2019/20' in development. A comprehensive Gantt chart plan has been prepared arising from the review but some activities still require an 'agreed way forward'. More evidence will be required in terms of stakeholder engagement. Risks need to be identified and managed. An EA/QIA has been drafted for signature. **Last updated 7 Aug 18.**

NHS
Alder Hey Children's
NHS Foundation Trust

Corporate Report July 2018

Safe

Incidents
Slight reduction in reporting noted during summer period. 1 incident resulting in moderate harm and 3 medication errors.

Never Events
Strong performance maintained; last event was 13 months ago.

Pressure Ulcers
No grade 3 or 4 pressure ulcers in month.

Highlight

- No grade 3 or above Pressure Ulcers in month.

Challenges

- Recognised lower level of incident reporting during holiday periods highlighted through weekly meeting of harm key message.

Caring

Complaints
Continuing trend in issues raised relating to ASD pathway in Community Services. Ongoing collaboration with CCG to decrease the wait times.

FFT
Slight improvement seen in FFT responses however needs to be a focus in ED and OPD, trial of new electronic devices currently being used in ED.

Highlight

- Slight decrease in PALs issues raised

Challenges

- Delay in diagnosis for ASD pathway.

Effective

To reduce cancellations we are having twice-weekly huddles as part of an improvement group 'patient flow: in control'. Applying lessons from SickKids, Toronto to reduce the number of cancellations for reason of no bed. We also plan to open the new post-operative cardiac unit in November 2018.

We are looking at ways to expedite the roll-out of the brilliant booking system programme in order to address low clinic utilisation. Recruitment challenges are delaying progress.

Highlight

- Deliver of 4-hour ED wait standard in context of rising demand

Challenges

- On the day cancellations of elective treatment

Responsive

Performance has been strong with delivery of the 4 hr ED standard, open pathways standard, cancer standard and diagnostic standard.

Highlight

- Delivery of open pathway 18 week s, cancer and diagnostic standards

The roll-out of the SAFER bundle will increase the number of patients with an expected date for discharge. On 3A and 4C we are now using 'My-Pad' to visibly show planned date for home.	**Challenges** • Increase the number of families who are aware of planned date of discharge

Research	
Steady recruitment to date this year with the overall number of open studies gradually increasing. Number of open commercial studies remains static. Awaiting opening and full implementation of the DETECT study which will recruit large numbers of patients. New leadership for NIHR Clinical Research Network Children from April 2018 following previous Speciality Leads standing down: it may take time to see an impact on performance through the new leadership regime while acclimatising to the role.	**Highlight** • Administering first ever 3D-printed ingestible tablet to a child in the CAT 3D study (joint project between Alder Hey and UCLan). • 2017/18 NIHR patient recruitment league table released: Alder Hey ranked 15th from 450 reporting organisations **Challenges** • Increasingly challenging to encourage investigators/departments to contribute to commercial research because of competing demands on time.

Well Led	
The Trust has been challenged in maintaining its elective run rate due largely to high levels of emergency activity. Mitigation plans are being put in place to manage the summer and winter plan in a way that doesn't continue to impact on elective care. Financial performance for the month was stronger with a break even delivered in month which was £0.3m ahead of plan. The quarter control total was delivered with a cumulative £1m deficit. The run rate now needs to improve in the remaining quarters to meet the £4.4m surplus for the year. Cash remains at £10m which is marginally behind plan although this has improved significantly in July. Capital expenditure is rated green although there are a number of schemes at risk of overspend which are being tracked through RABD. Significant progress has been made in identifying CIP schemes and we continue to focus on meeting the full year target. Mandatory training levels remain high which is positive. Of some concerns is progress on PDRs which look to be behind profile. Divisions have been asked to provide assurance that they will be on track by September.	**Highlight** • Progress made on CIP's • Mandatory Training • Pay Expenditure **Challenges** • PDR completion • Elective activity run rates • Domestic Cleaning Audit Compliance

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Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG			Comments Available
Total no of incidents reported Near Miss & Above	468	417	406	426	464	326	454	456	514	413	447	492	435		>=469	>=421	<421	✔
Clinical Incidents resulting in minor harm & above	97	64	73	71	88	51	84	80	94	83	78	95	87		<=87	<=97	>97	✔
Clinical Incidents resulting in moderate, semi permanent harm	3	0	2	0	3	2	2	0	1	0	1	3	1		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	0	1	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Grade 3)	2	0	0	0	0	1	2	0	0	0	1	0	0		0	N/A	>0	✔
Pressure Ulcers (Grade 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	4	2	2	1	4	3	2	5	6	4	2	4	3		<=2	N/A	>2	✔
Never Events	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔

The Best People doing their best Work

CARING

Alder Hey Children's NHS
NHS Foundation Trust

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG	Comments Available
Friends & Family A&E - % Recommend the Trust	100.0%	92.3%	93.2%	95.2%	89.1%	90.9%	89.8%	85.6%	86.4%	85.4%	82.6%	83.9%	86.3%		>=95 % >=90 % <90 %	✔
Friends & Family Community - % Recommend the Trust	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	87.5%	100.0%	97.7%	100.0%	96.8%	96.4%	92.2%		>=95 % >=90 % <90 %	✔
Friends & Family Inpatients - % Recommend the Trust	97.6%	94.2%	98.5%	97.9%	97.5%	97.3%	97.3%	96.6%	96.8%	93.7%	95.5%	94.9%	97.0%		>=95 % >=90 % <90 %	✔
Friends & Family Mental Health - % Recommend the Trust	93.3%	96.7%	96.3%	94.1%	96.0%	100.0%	77.8%	82.8%	100.0%	87.5%	82.6%	88.9%	100.0%		>=95 % >=90 % <90 %	✔
Friends & Family Outpatients - % Recommend the Trust	92.8%	92.0%	91.4%	95.8%	92.0%	97.7%	96.1%	91.8%	89.3%	90.3%	88.6%	86.9%	85.5%		>=95 % >=90 % <90 %	✔
Complaints	4	6	4	10	12	5	12	13	5	8	11	11	12		<=3 <=4 >4	✔
PALS	107	72	121	94	119	98	145	145	129	151	126	99	101		<=96 <=107 >107	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG			Comments Available
Sepsis: Patients treated for Sepsis - A&E	59.1%	68.8%	44.4%	54.5%	60.0%	57.1%	60.0%	42.3%	60.9%	66.7%	55.6%	57.1%	65.5%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis - Inpatients	66.7%	82.6%	72.4%	83.7%	85.4%	70.3%	74.1%	86.4%	79.2%	76.0%	72.7%	78.9%	71.4%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
% Readmissions to PICU within 48 hrs	0.0%	6.0%	4.5%	2.9%	2.4%	0.0%	2.4%	1.5%	4.1%	3.6%	2.5%	2.7%	5.3%		<=3 %	N/A	>3 %	✔
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	1	1	0	2	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	1	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	0	1	3	2	0	2	0	3	0	0	1	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - CLABSI - ICU Only	0	0	1	2	1	6	2	4	2	2	2	2	0		<=1	N/A	>1	✔
Hospital Acquired Organisms - Gram Negative BSI	1	1	0	2	3	2	1	1	3	2	0	1	0		<=1	N/A	>1	✔
Bed Occupancy (Accessible Funded Beds)	86.5%	74.7%	85.0%	85.1%	88.8%	78.9%	88.2%	89.3%	89.6%	90.3%	84.9%	88.5%	83.9%		<=89 %	<=93 %	>93 %	✔
ED: 95% Treated within 4 Hours	93.1%	98.3%	95.0%	94.5%	92.8%	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%		>=95 %	N/A	<95 %	✔
Average LoS - Elective (Days)	3.17	2.86	3.07	2.61	2.97	3.60	2.94	2.98	3.21	2.79	2.87	2.89	3.16		<=3.2	N/A	>3.2	✔
Average LoS - Non-Elective (Days)	2.15	2.20	2.09	2.01	1.98	1.97	2.10	1.99	2.10	1.96	2.01	2.01	1.84		<=2.1	N/A	>2.1	✔
Theatre Utilisation - % of Session Utilised	86.1%	87.5%	86.5%	86.4%	84.4%	86.0%	87.2%	85.6%	86.2%	88.0%	88.5%	87.8%	89.3%		>=90 %	N/A	<80 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	31	15	48	26	40	15	24	25	37	26	32%	44	39		<=22	N/A	>22	✔
28 Day Breaches	1	9	0	8	5	5	0	3	8	10	5	5	4		0	N/A	>0	✔
Clinic Session Utilisation	85.2%	84.2%	83.4%	85.0%	86.2%	82.5%	85.1%	83.7%	83.9%	83.3%	83.6%	84.8%	81.9%		>=90 %	N/A	<85 %	✔
Did Not Attend Rate	11.9%	13.1%	12.3%	12.0%	10.6%	12.2%	10.4%	10.7%	11.3%	10.7%	11.3%	11.6%	12.2%		<=12 %	<=14 %	>14 %	✔
Transcription Turnaround (days)	9.25	8.50	8.50	12.50	13.00	18.50	23.00	26.00	28.50	15.00	6.00	4.50	4.00		<=3	<=5	>5	✔

Delivery of Outstanding Care

RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG	Comments Available
IP Survey: % Received information enabling choices about their care	95.7%	92.1%	96.5%	96.1%	94.9%	94.7%	94.4%	94.7%	93.1%	94.8%	91.6%	96.2%	94.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Treated with respect	99.4%	99.3%	99.5%	99.3%	99.8%	99.4%	100.0%	99.4%	99.8%	97.7%	98.8%	99.7%	99.7%		100 % >=95 % <95 %	✔
IP Survey: % Know their planned date of discharge	64.0%	53.9%	65.0%	57.4%	61.9%	62.5%	52.1%	59.0%	60.1%	60.5%	76.1%	63.7%	65.7%		>=90 % >=85 % <85 %	✔
IP Survey: % Know who is in charge of their care	92.9%	91.2%	92.8%	93.8%	94.9%	90.6%	93.6%	90.9%	91.6%	91.3%	90.9%	92.7%	94.7%		>=95 % >=90 % <90 %	✔
IP Survey: % Patients involved in play and learning	74.0%	65.7%	73.0%	72.6%	76.7%	76.4%	78.3%	79.6%	75.0%	74.9%	77.8%	74.4%	73.1%		>=90 % >=85 % <85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	92.0%	92.0%	92.1%	92.2%	92.0%	92.0%	92.2%	92.1%	92.1%	92.1%	92.0%	92.1%	92.0%		>=92 % >=90 % <90 %	✔
Waiting List Size										13,235	13,238	12,879	12,962		<=12905 N/A >12905	✔
Waiting Greater than 52 weeks	0	0	0	0	1	0	1	2	1	0	0	0	0		0 N/A >0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0%	100.0%	100.0%	100.0%	100.0%	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % >=95 % <100 %	✔
All Cancers: 31 day diagnosis to treament	100.0%	100.0%	100.0%	92.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % >=95 % <100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 % >=95 % <100 %	✔
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.3%	99.8%	99.8%	99.8%	99.2%	99.3%		>=99 % N/A <99 %	✔
Number of Super Stranded Patients (21+ Days)	30	31	27	26	33	29	35	26	32	34	27	32	29		<=32 N/A >32	✔
PFI: PPM%	99.0%	94.0%	88.0%	88.0%	98.0%	100.0%	98.0%	100.0%	98.0%	98.6%	99.0%	99.0%	96.0%		>=98 % N/A <98 %	✔

The Best People doing their best Work

WELL LED

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG	Comments Available
CIP In Month Variance (£'000s)	-72	37	5	-459	-433	-149	54	-410	864	-248	104	153	-238		>=0% >=-20% <-20%	✔
Control Total In Month Variance (£'000s)	-141	100	45	-688	418	218	243	17		-426	154	285	29		>=0% >=-20% <-20%	✔
Capital Expenditure In Month Variance (£'000s)	-292	786	70	1,623	-141	2,329	1,184	3,161	-887	1,090	-333	1,701	-462		>=-5% >=-10% <-10%	✔
Cash in Bank (£'000s)	11,263	10,405	9,116	10,872	6,753	8,171	6,712	10,201	12,244	12,406	10,455	9,455	23,910		>=0% >=-20% <-20%	✔
Income In Month Variance (£'000s)	-407	995	133	-16	3,837	455	1,893	1,080	19,658	218	591	425	998		>=0% >=-20% <-20%	✔
Pay In Month Variance (£'000s)	-202	-263	-148	-647	-716	-426	-538	-605	546	-17	-7	-38	-111		>=-1% >=-20% <-20%	✔
Non Pay In Month Variance (£'000s)	468	-633	60	-24	-2,703	189	-1,111	-458	1,368	-627	-431	-102	-858		>=0% >=-20% <-20%	✔
NHSI Use of Resources	3	3	3	3	3	3	3	3	1	3	3	3	3		<=3 N/A >3	✔
AvP: IP - Non-Elective										190	124	113	133		>=0 N/A <0	✔
AvP: IP Elective vs Plan										-85	-25	-102	-81		>=0 N/A <0	✔
AvP: Daycase Activity vs Plan										-95	-112	-93	-211		>=0 N/A <0	✔
AvP: Outpatient Activity vs Plan										988	520	766	319		>=0 N/A <0	✔
PDR	70.6%	75.9%	77.7%	79.7%	80.1%	79.6%	79.7%	76.1%	76.4%	1.3%	11.3%	31.1%	64.7%		No Threshold	
Medical Appraisal	79.2%	81.0%	8.0%	8.0%	11.6%	13.6%	24.0%	52.1%	67.6%	69.0%	69.0%	2.0%	4.0%		>=95 % >=90 % <90 %	✔
Mandatory Training	75.7%	74.8%	71.8%	73.6%	80.5%	86.2%	88.9%	94.1%	92.9%	92.1%	92.0%	92.1%	91.6%		>=90 % N/A <80 %	✔
Sickness	5.1%	5.0%	4.9%	5.4%	5.3%	5.8%	6.3%	5.5%	4.7%	4.4%	4.5%	4.8%	5.2%		<=4.5 % <=5 % >5 %	✔
Short Term Sickness	1.6%	1.3%	1.2%	1.7%	1.5%	1.7%	2.1%	1.7%	1.5%	1.3%	1.2%	1.3%	1.5%		<=1.5 % N/A >1.5 %	✔
Long Term Sickness	3.4%	3.6%	3.7%	3.7%	3.8%	4.1%	4.2%	3.8%	3.2%	3.1%	3.3%	3.4%	3.7%		<=3 % N/A >3 %	✔
Temporary Spend ('000s)	1,092	1,166	999	918	938	761	833	926	1,067	977	973	947	901		<=800 <=960 >960	✔
% of Correct Pay Achieved	99.4%	99.6%	99.6%	99.5%	99.6%	98.0%	99.6%	99.3%	98.9%	99.8%	99.4%	99.5%	99.5%		>=99.5 % >=99 % <99 %	✔
Staff Turnover	10.7%	11.0%	10.8%	10.9%	11.0%	11.5%	11.5%	11.5%	11.0%	10.8%	11.2%	11.0%	11.5%		<=10 % <=11 % >11 %	✔
Safer Staffing (Shift Fill Rate)	94.7%	92.8%	93.9%	93.2%	96.2%	93.9%	95.9%	94.2%	95.0%	96.4%	96.5%	94.8%	95.0%		>=90 % N/A <90 %	✔
Domestic Cleaning Audit Compliance	20.0%	20.0%	25.0%	75.0%	60.0%	65.0%	75.0%	85.0%	90.0%	90.0%	85.0%	65.5%	97.5%		>=85 % N/A <85 %	✔
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0 <=1 >1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS
NHS Foundation Trust

GROW THE FUTURE

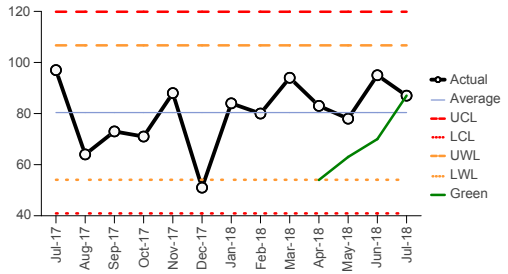
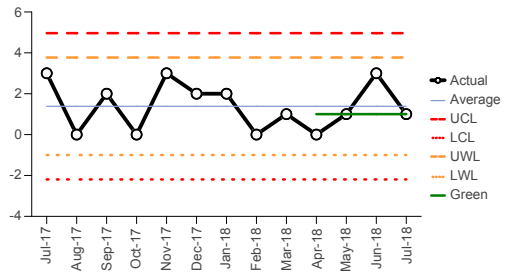
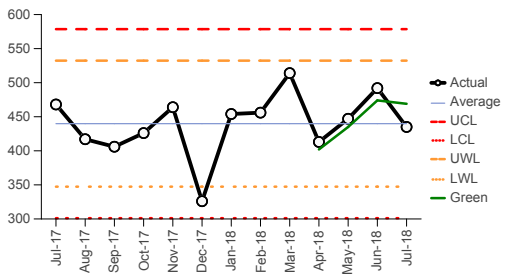
	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic										148	153	159	159		>=50	N/A	<50	✔
Number of Open Studies - Commercial										34	33	34	34		>=5	N/A	<5	✔
Number of New Studies Opened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

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

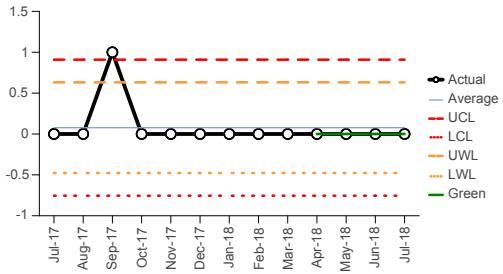
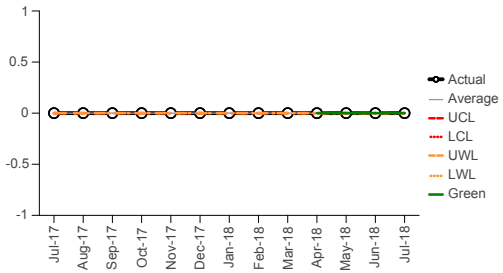
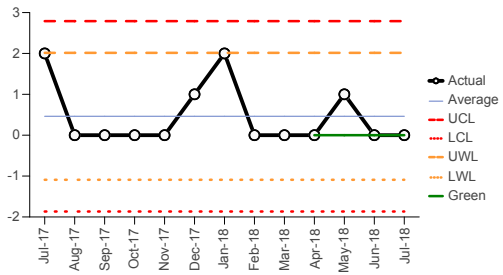
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor harm & above** Incidents reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (913). 18/19 aim is 10% less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	87	R >97 A <=97 G <=87		Standing Item at Division Integrated Governance meetings. Weekly incident reports circulated across divisions and corporate services for action. Will be included at QASG Divisions dashboards
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (16). 18/19 aim is 12 or less, annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	1	R >1 A N/A G <=1		No Action Required
Incidents: Increasing Reporting	**Total no of incidents reported Near Miss & Above** Total number of Incidents reported. The threshold is based on increasing on last year for the period Apr 17 - Mar 18 (4,241) 18/19 aim is more than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	435	R <421 A >=421 G >=469		Scoping exercise to determine levels of reporting across divisions and targeted training in low reporting areas. Monitor via divisions governance, weekly meeting of harm and CQSG governance dashboards

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

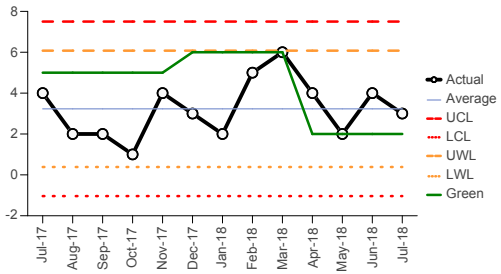
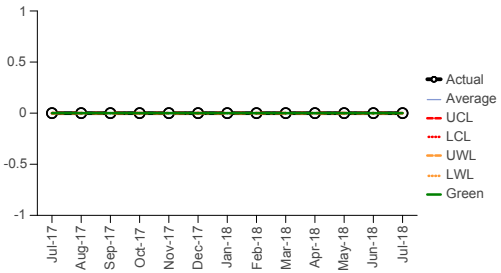
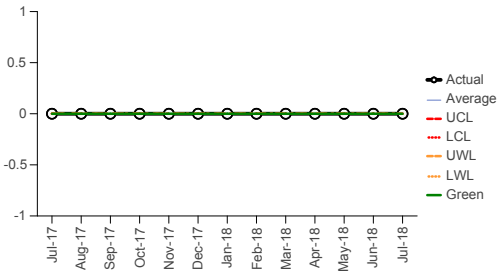
	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve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

Delivery of Outstanding Care

7.3 - QUALITY - SAFE

BRILLIANT BASICS

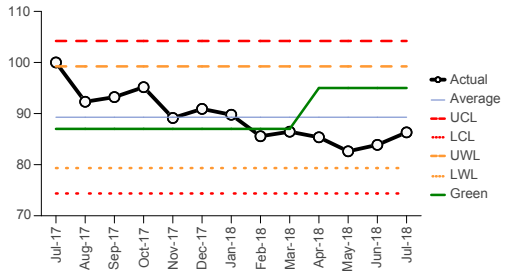
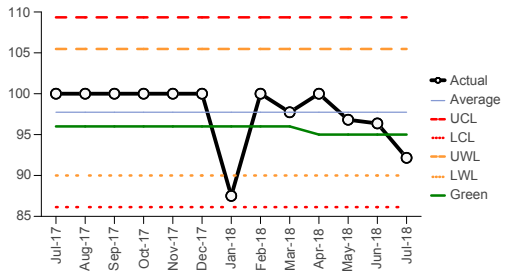
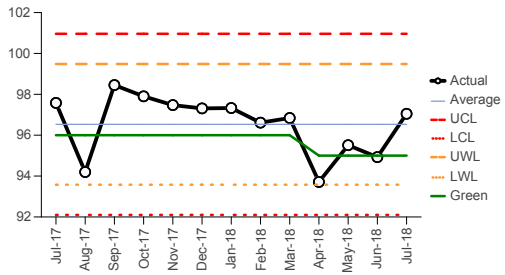
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Reducing Medication Errors	**Medication errors resulting in harm** Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (32). 18/19 aim is 2 avg per month, or less, per month (less than 24 annually) **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	3	R >2 A N/A G <=2		21/08/2018–Incidents are currently under investigation. No clear theme to the incidents as one was a parent administration error, another regarding gestational age and the other surrounding insulin administration. A safety alert has been produced to inform staff of gestational age and the Meditech team has been contacted to see if this can be highlighted on the prescribing system. Currently this is available in Test for orders. An RCA level 1 is ongoing to review the incident relating to insulin administration and to ensure appropriate plans are in place for parents post-operatively. AMR(MSO)
Never Events	**Never Events** Never Events. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Grade 4)** Pressure Ulcers of Grade 4. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

The Best People doing their best Work

8.1 - QUALITY - CARING

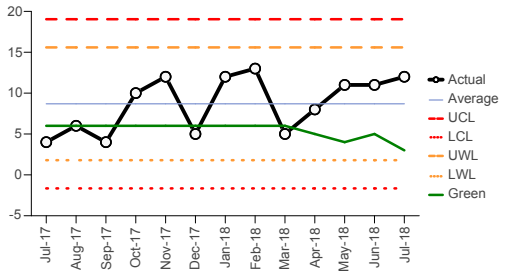
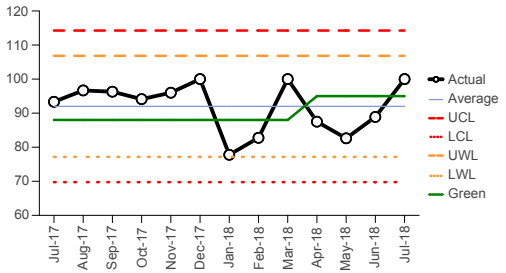
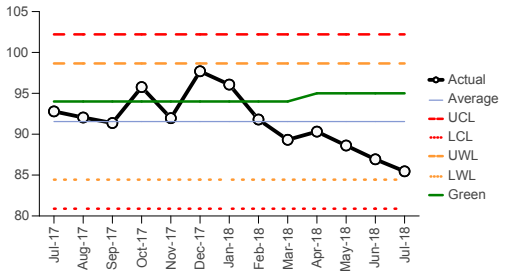
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family A&E - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on exceeding the National average in Nov 17. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	86.32 %	R <90 % A >=90 % G >=95 %		Positive feedback continues to grow A&E will continue to pilot the new innovative inclusive approach to collecting measures and evaluating the FFT programme. Concerns continue to be waiting times, no communication for the delay, and no Wi Fi. These have been added to the FFT high level/exception action plan and shared with the Heads of Quality. Actions and progress will be fed back to the patient experience quality/ lead by the Heads of Quality to monitor progress.
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	92.16 %	R <90 % A >=90 % G >=95 %		Further developments are in process to improve the quantity of responses for feedback in the community. This is being coordinated by the volunteering department and the Head of Quality. Volunteers will be contacting patients/families when discharged by telephone for feedback. Concerns are the wait for appointments this can be as long as 12 months.
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	97.05 %	R <90 % A >=90 % G >=95 %		The Positive feedback has continued to increase significantly. Concerns are patient's medication is not given on time, feedback has been disseminated to Heads of Quality for action and placed on the FFT high level/exception action plan

The Best People doing their best Work

8.2 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

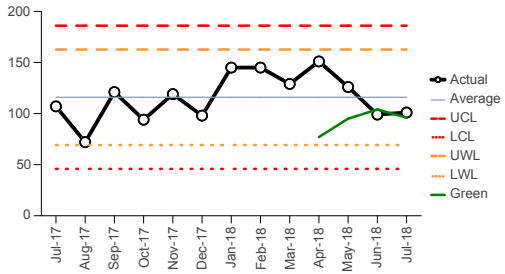
	Description	Performance	Threshold	Trend	Management Action (SMART)
Complaints	**Complaints** Total complaints received. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (90). 18/19 aim is to reduce by 25% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	12	R >4 A <=4 G <=3		July has seen the Division of Surgery receive 5 formal complaints. All are from different specialities with no identifiable themes
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	100 %	R <90 % A >=90 % G >=95 %		No further action required, action log feedback to Head of Quality for appropriate dissemination
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	85.45 %	R <90 % A >=90 % G >=95 %		Feedback continues to show the same themes 'The best positive care project' has been introduced to address the issues that arise each month. Concerns are families having to stand when waiting for their appointment, lack of communication around waiting times in clinics. No toys to play with. The new outpatient Matron is now in post and a play specialist will be supporting play along with volunteer support. This is highlighted on the FFT action log sent to all Heads of Quality. Actions and progress will be fed back by the Head of Quality to the patient experience quality/ lead to monitor.

The Best People doing their best Work

8.3 - QUALITY - CARING

Alder Hey Children's NHS Foundation Trust

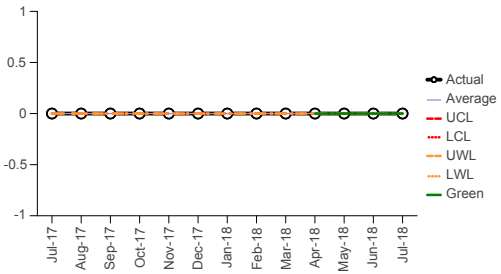
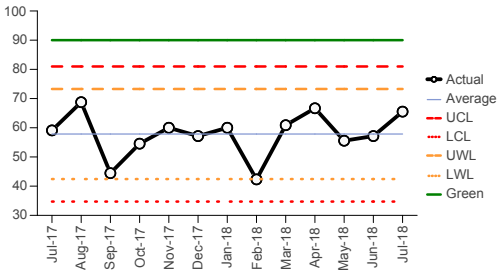
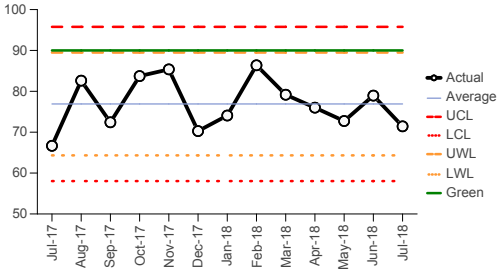
BRILLIANT BASICS

	Description	Performance	Threshold	Trend	Management Action (SMART)
PALS	**PALS** Total number of PALS contacts. Threshold is based on a 10% Reduction on 17/18 (1336). 18/19 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	101	R >107 A <=107 G <=96		A slight reduction of PALS concerns received compared to the same time period last year

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

Alder Hey Children's NHS Foundation Trust

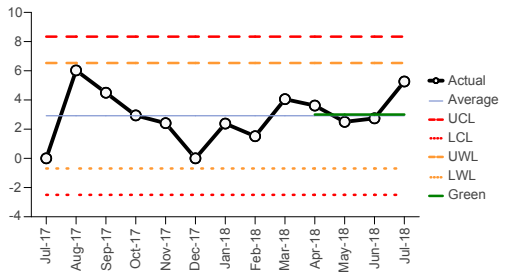
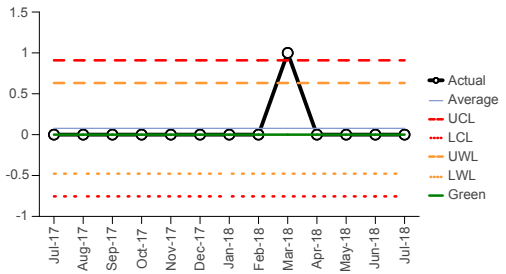
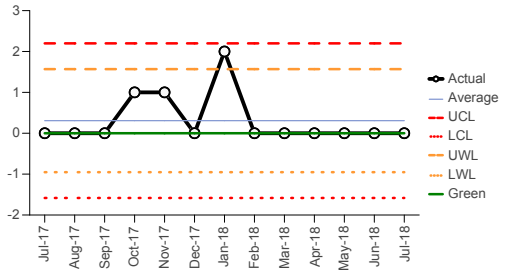
	Description	Performance	Threshold	Trend	Management Action (SMART)
Mortality	**No of children that have suffered avoidable death** Total number of children that have suffered avoidable death. Figures provided by HMRG group. The threshold for 18/19 is zero. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	65.52 %	R <90 % A N/A G >=90 %		Change in data collection now means that all patients given IV Antibiotics for sepsis in ED will now be included. It has been highlighted by the ED sepsis nurse specialist that a number of cases were not included in the previous data sets as they did not have an initial sepsis concern raised by the nurse. Now that all patients treated for sepsis with or without a nursing sepsis concern will be included this will make the data/reporting more specific whilst trying to ensure accuracy in relation to targets. It is hoped the figures for ED will show an increase just from this difference in data
Sepsis	**Sepsis: Patients treated for Sepsis - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	71.43 %	R <90 % A N/A G >=90 %		Change in data collection method now looking all cases where IV Antibiotics were given due to a clinical indication of sepsis with or without an initial nursing sepsis concern. Therefore an overall increase in the number of cases reviewed, however making our data/reporting more specific whilst trying to ensure accuracy in relation to targets. All nursing and clinical staff to be made aware of this slight change to ensure that all staff still recognise the importance of timely administration of IV Antibiotics if there are sepsis concerns raised either by nursing staff or clinicians.

Delivery of Outstanding Care

9.2 - QUALITY - EFFECTIVE

BRILLIANT BASICS

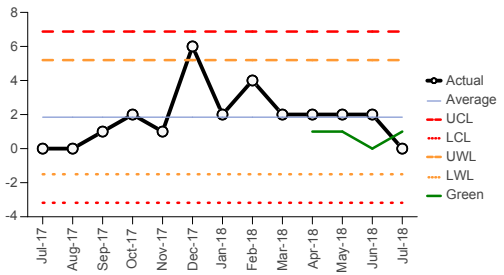
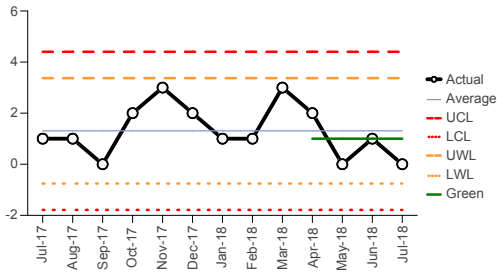
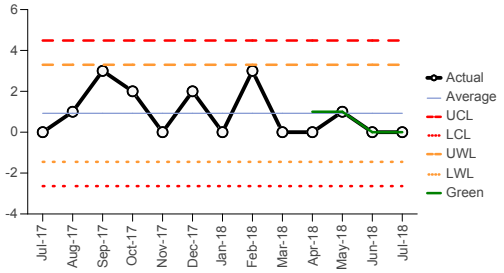
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	5.26 %	R >3 % A N/A G <=3 %		4 readmissions in 76 live discharges. The national PICANet dataset quotes a mean range for PICU readmission of 0-3% annually (not monthly). It is not unusual to see peaks and troughs across the year. Please note Please note PICANet readmission data includes HDU in many centres where HDU is co-located with PICU. if we excluded HDU from this data the incidence would half. On review two cases were not preventable. Two were complex cardiac patients discharged to high dependency areas, but with a known risk for PICU readmission in that group.
Reducing Infections	**Hospital Acquired Organisms - C.difficile** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	0	R >0 A N/A G 0		No Action Required

Delivery of Outstanding Care

9.3 - QUALITY - EFFECTIVE

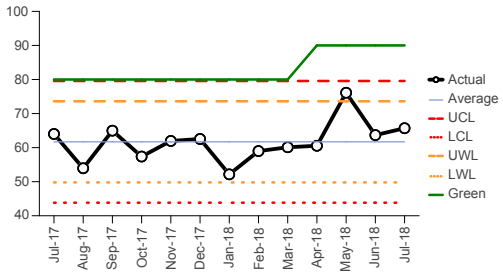
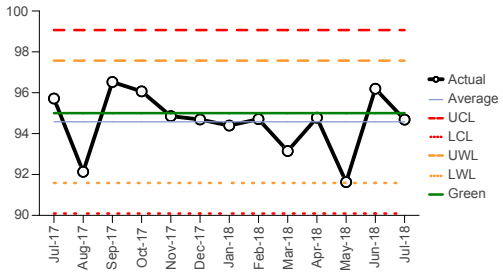
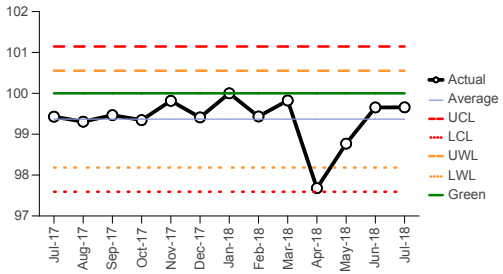
Alder Hey Children's NHS Foundation Trust

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

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

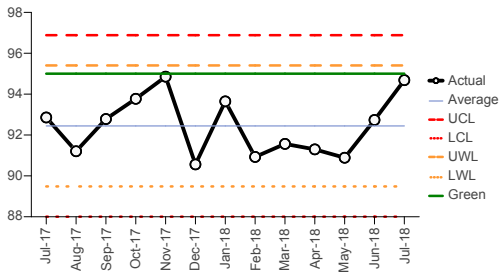
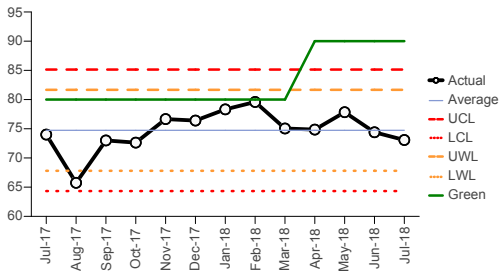
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	65.69 %	R <85 % A >=85 % G >=90 %		FFT exception action plan has been disseminated to the Heads of Quality and relevant managers for discussions and actions to be considered. Due to holidays no update on the progress has been returned to the patient experience/quality lead for monitoring. A new idea for volunteers to hold a bleep so they can collect medicines from pharmacy to reduce waiting times and free up beds will be piloted in September. Further information will be available in the August report.
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	94.68 %	R <90 % A >=90 % G >=95 %		Discussions have taken place between the medical Director and the Forum to discuss ways to improve the flow of patient care. Patient stories will be used
Inpatient Survey: Respect	**IP Survey: % Treated with respect** Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 18/19 is 100%. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	99.66 %	R <95 % A >=95 % G 100 %		Concerns have been raised around how a family has been spoken to in outpatients this has been shared with the new matron for further action

Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

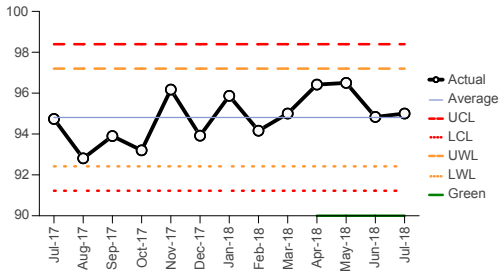
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	94.68 %	R <90 % A >=90 % G >=95 %		This continues to improve concerns are all still staff are not communicating when their is a change of shift this has been shared with the heads of quality for discussion at the divisional monthly meetings
Inpatient Survey: Play and Learning	**IP Survey: % Patients involved in play and learning** % of children / families that report engaging in play / learning. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** CQAC	73.07 %	R <85 % A >=85 % G >=90 %		An 18 month strategy plan is in the process of being developed to identify areas of concern and achievable actions to be in place. This will be led by the patient experience/quality lead and supported by the play manager, patient experience team and volunteers. Referrals are now being recorded which will see an increase in financial benefits; in return staff resources will increase and enable more engagement. Extra play materials will be sourced through the charity. Volunteers will continue to support play activities.

The Best People doing their best Work

11.1 - QUALITY - WELL LED

Alder Hey Children's NHS Foundation Trust

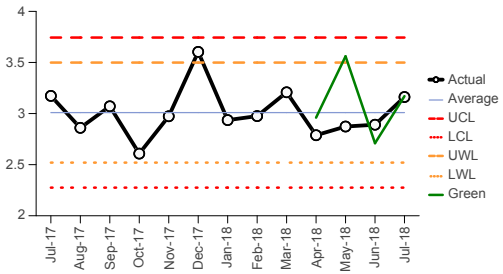
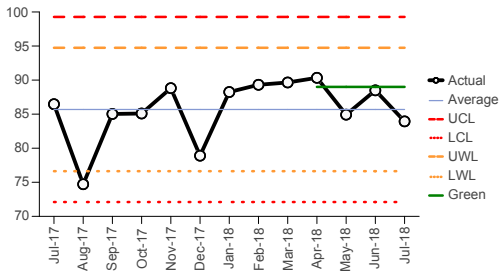
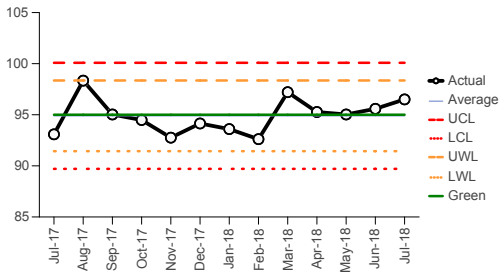
	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	95 %	R <90 % A N/A G >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

Alder Hey Children's NHS
NHS Foundation Trust

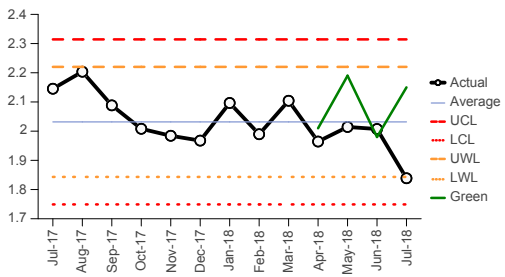
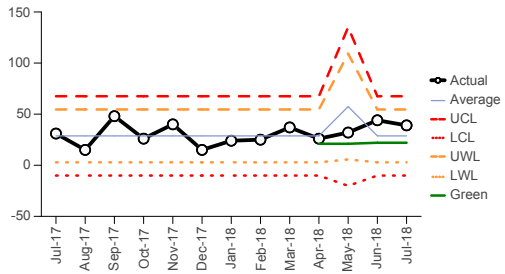
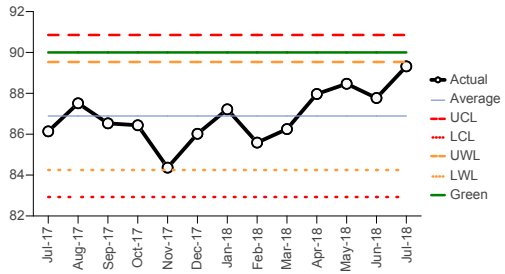
	Description	Performance	Threshold	Trend	Management Action (SMART)
LoS: Elective	**Average LoS - Elective (Days)** Average Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	3.16	R >3.2 A N/A G <=3.2		No Action Required
Bed Occupancy	**Bed Occupancy (Accessible Funded Beds)** Percentage of funded beds that are occupied in accessible wards 3A, 4A, 3C and 4C, this is based on 3 occupnacy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	83.94 %	R >93 % A <=93 % G <=89 %		No Action Required
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	96.50 %	R <95 % A N/A G >=95 %		No Action Required

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

BRILLIANT BASICS

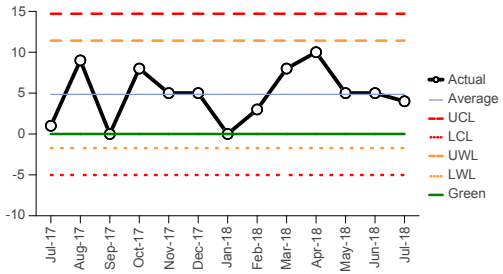
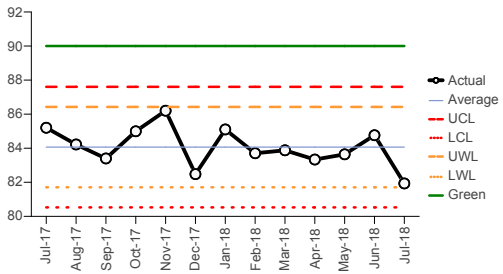
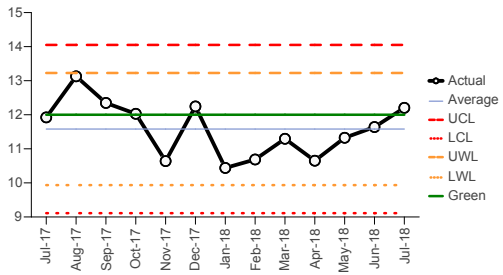
Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	1.84	R >2.1 A N/A G <=2.1		No Action Required
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 25% based on 17/18 overall performance. **Exec Lead:** Adam Bateman **Committee:** RABD	39	R >22 A N/A G <=22		17 patients cancelled due to no bed - weekly forward look in place to review next weeks elective activity and plan accordingly. Weekly cardiac list planning meeting also in place. Reduction in patients cancelled due to emergency list pressures due to additional trauma capacity allocated from mid July which continues until September.
Theatre Utilisation	**Theatre Utilisation - % of Session Utilised** Threshold is based on the productive theatre improvement measures at greater than or equal to 90% utilisation of theatres. **Exec Lead:** Adam Bateman **Committee:** RABD	89.32 %	R <80 % A >=80 % G >=90 %		Improvement in month for 11/19 specialties. Specialty specific improvements planned with services such as rheumatology. Forward look meetings in August commenced between PCO's and surgical admissions team to plan ahead for future theatre lists, confirming list order and ensuring list is full to reduce short notice cancellations.

Delivery of Outstanding Care

12.3 - PERFORMANCE - EFFECTIVE

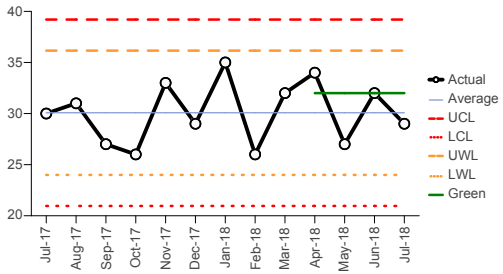
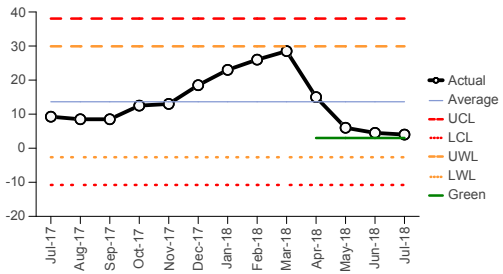
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Operation Breaches	**28 Day Breaches** Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	4	R >0 A N/A G 0		2 patients not rebooked within 28 days due to capacity pressures in the service. Others are due to administrative process and error which has been identified and discussed with administrative teams and will therefore not reoccur
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and DNAs. **Exec Lead:** Adam Bateman **Committee:** RABD	81.93 %	R <85 % A >=85 % G >=90 %		2 significant drivers are affecting utilisation. Seasonal reduction due to school holidays has resulted in a predictable reduction in performance and the roll out of the Brilliant Booking System which is rolling out the Bi-Directional texting which provides service users with the ability to cancel their appointment. This system is dependent upon staff to backfill the slots as the come available which is currently being implemented. September utilisation is predicted to increase.
DNAs	**Did Not Attend Rate** The target of 12% is a local target aligned to outpatient improvement workstreams (Hybrid Booking, Patient Demogrpahic Checking and bidirectional automate text reminders). **Exec Lead:** Adam Bateman **Committee:** RABD	12.20 %	R >14 % A <=14 % G <=12 %		DNA rate slightly above threshold, this performance is in line with seasonal variation of school summer holidays.

Delivery of Outstanding Care

12.4 - PERFORMANCE - EFFECTIVE

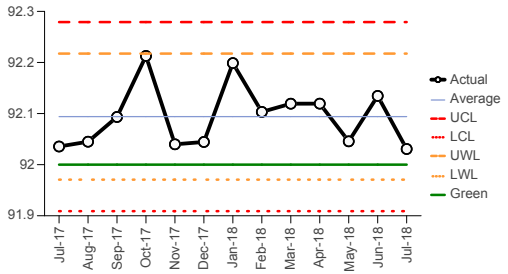
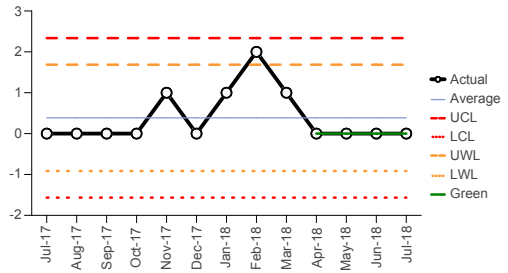
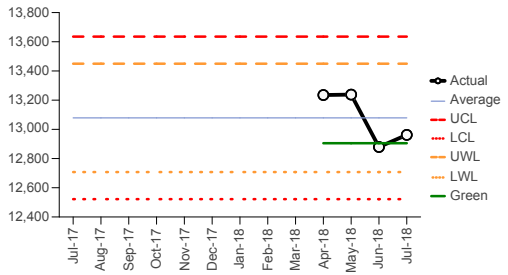
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. This excludes patients on ICU/HDU/NEO and Cardiac HDU. **Exec Lead:** Adam Bateman **Committee:** RABD	29	R >32 A N/A G <=32		30 day +LOS numbers continue to fall including & excluding those on DJU and Critical Care. B/C submitted to provide extra support to enable increased vigilance of 21 day+ children, however this was not agreed. Further work was requested to secure support from Medical and Surgical divisions. Case to be re-presented/submitted in next 2 weeks. Key worker allocation process delayed. This together with successful B/C are the most critical actions/interventions, with the co-ordinator/administrator post being vital in enabling additional scrutiny/co-ordination of the 21+ cohort.
Transcriptions	**Transcription Turnaround (days)** Days from dictation to typing clinic letters for services transcribed by Transcription service. Based on working day average. This is also monitored externally by our local commissioners. **Exec Lead:** Adam Bateman **Committee:** RABD	4	R >5 A <=5 G <=3		Turnaround time is reported from date of activity to date transcribed. The delay in turnaround was as a result of a delay in dictations. There were also issues with a new version of medisec which impacted on productivity, which is now resolved.

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

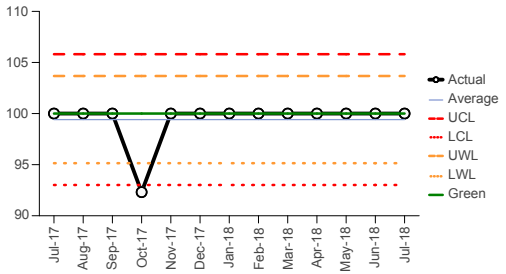
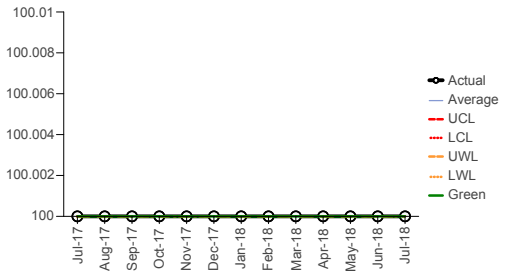
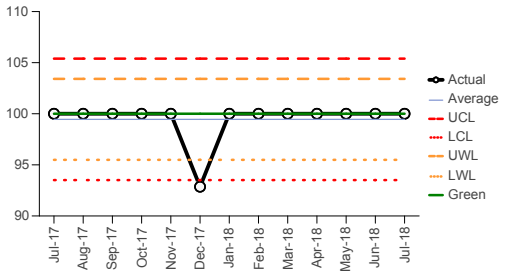
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.03 %	R <90 % A >=90 % G >=92 %		No Action Required
Waiting Times	**Waiting Greater than 52 weeks** Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 18/19 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R >0 A N/A G 0		No Action Required
Waiting Times	**Waiting List Size** National threshold as part of the 18/19 NHSI plan. The target is to reduced the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12962	R >12905 A N/A G <=12905		Waiting list size has seen a modest increase but is predominantly due to seasonal variation as the impact of annual leave and summer holidays is felt through the hospital. No further action required at this point as activity will increase as school holidays conclude at the end of August.

Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

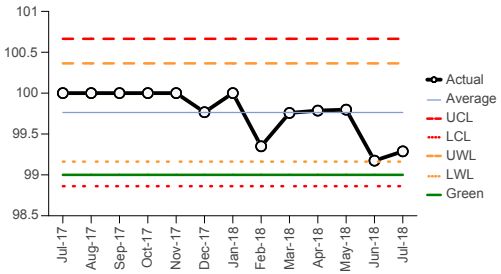
Alder Hey Children's NHS
NHS Foundation Trust

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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	99.29 %	R <99 % A N/A G >=99 %		No Action Required

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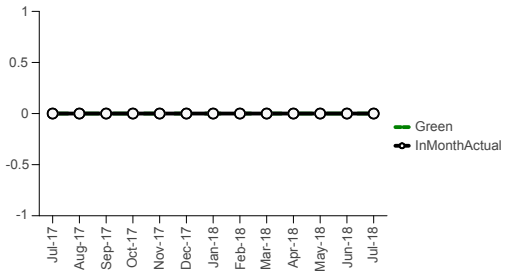
14.1 - PERFORMANCE - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

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

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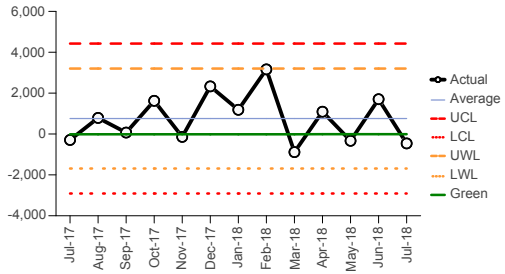
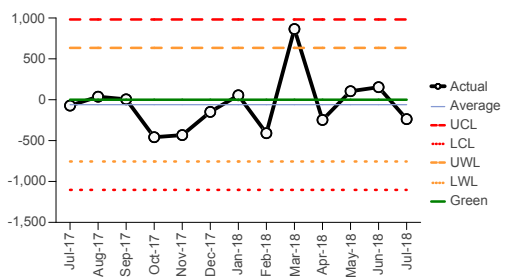
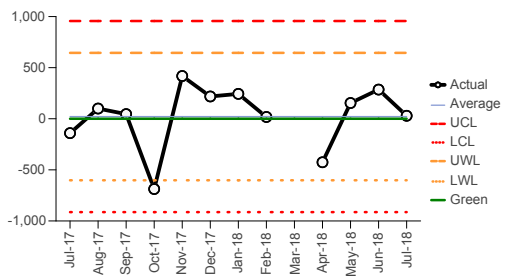
15.1 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Capital Expenditure In Month Variance (£'000s)** Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-462	R <-10% A >=-10% G >=-5%		In July the expenditure on capital was higher than the budget by £462k. This relates to the timing of expenditure and will be recitifed in future months.
Finance	**CIP In Month Variance (£'000s)** Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-238	R <-20% A >=-20% G >=0%		The CIP performance in July was £207k behind the plan. The forecast CIP for the year is £5.2m which is 74% of the target CIP of £6.9m. All Divisions and Departments are reviewing schemes and opportunities to ensure the CIP target is achieved in the year.
Finance	**Control Total In Month Variance (£'000s)** Variance from Control Total plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	29	R <-20% A >=-20% G >=0%		No Action Required

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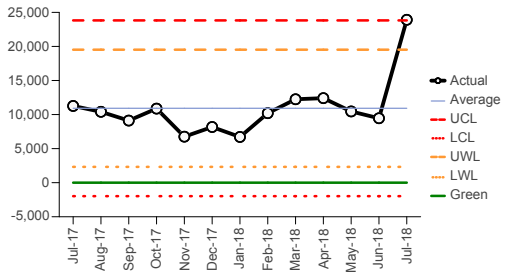
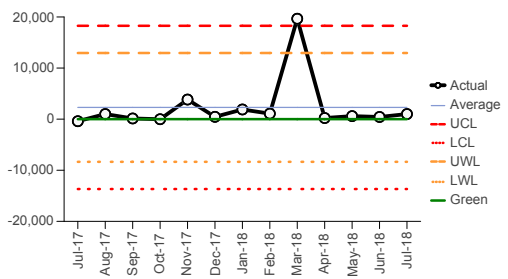
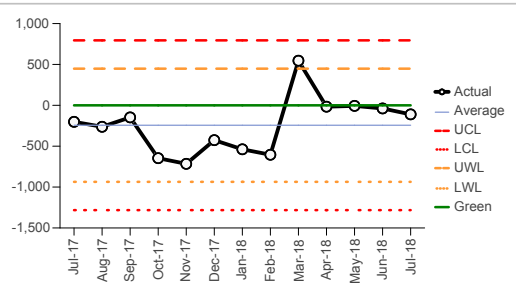
15.2 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**Cash in Bank (£'000s)** Variance from Cash plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	23,910	R <-20% A >=-20% G >=0%		No Action Required
Finance	**Income In Month Variance (£'000s)** Variance from income plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	998	R <-20% A >=-20% G >=0%		No Action Required
Finance	**Pay In Month Variance (£'000s)** Variance from pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-111	R <-20% A >=-20% G >=-1%		Pay costs for the month of July exceeded the budget by £111k due to expenditure on premium cost temporary staffing. Work is ongoing with the Divisions and Finance and HR departments to reduce these costs.

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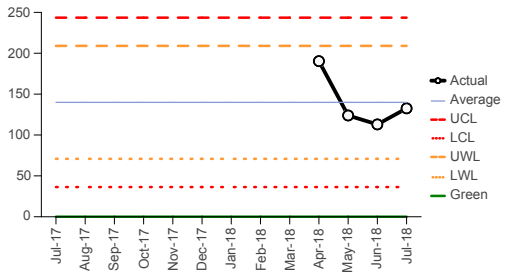
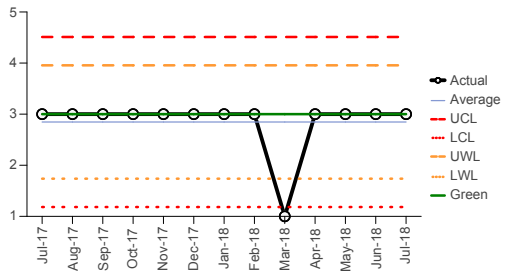
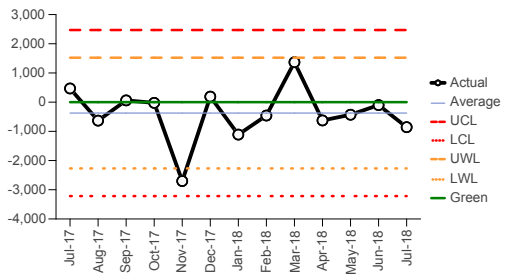
15.3 - FINANCE - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: IP - Non-Elective** Actvity vs Plan for Inpatient Non-Elective Activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	132.56	R <0 A N/A G >=0		No Action Required
Finance	**NHSI Use of Resources** NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	3	R >3 A N/A G <=3		No Action Required
Finance	**Non Pay In Month Variance (£'000s)** Variance from non pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-858	R <-20% A >=-20% G >=0%		Non Pay costs exceeded budget in July by £858k. Approximately half of this overspend was offset by additional income and the remainder relates to expenditure in clinical and non clincal areas including Theatres and Critical Care.

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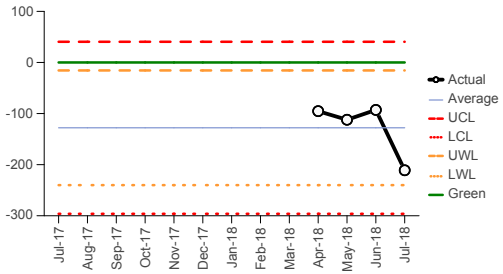
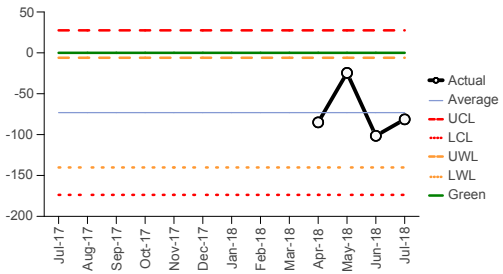
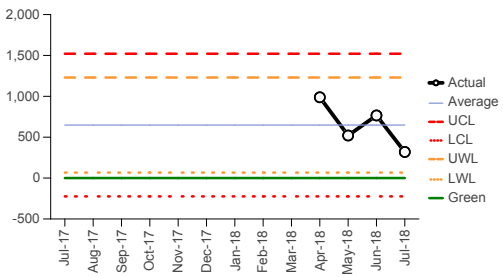
15.4 - FINANCE - WELL LED

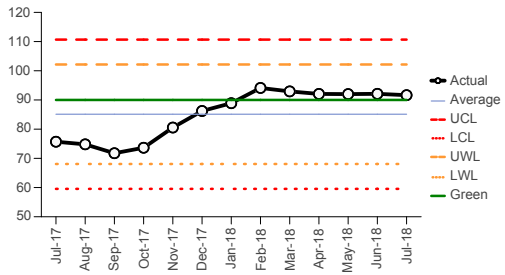
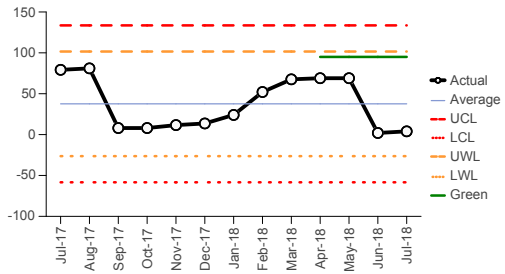
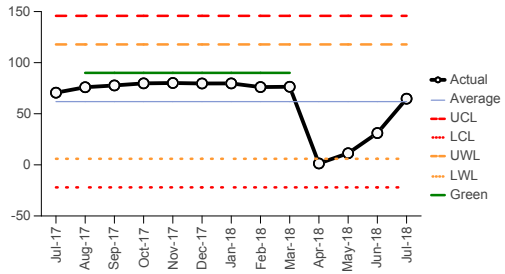
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Finance	**AvP: Daycase Activity vs Plan** Actvity vs Plan for Daycase activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-211.04	R <0 A N/A G >=0		The most significant adverse variance is in dentistry (84 spells), followed by oncology (53), rheumatology (45) and ENT (35).
Finance	**AvP: IP Elective vs Plan** Actvity vs Plan for Inpatient Elective activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-81.37	R <0 A N/A G >=0		The most significant adverse variance is in ENT (40 spells); considerably ahead of the next laregst variance which is in nephrology (16).
Finance	**AvP: Outpatient Activity vs Plan** Actvity vs Plan for Outpatient activity. The threshold is based on achieving plan or higher. **Exec Lead:** John Grinnell **Committee:** RABD	319.08	R <0 A N/A G >=0		The most significant adverse variances are in respiratory (253 attendances) and ophthalmology (213).

The Best People doing their best Work

16.1 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Training	**Mandatory Training** This is a Trust target that measures the 6 core mandatory training modules that are required of all staff (Safeguarding L1, Moving and Handling, Information Governance, Equality and Diversity, Fire Safety and Health and Safety) **Exec Lead:** Melissa Swindell **Committee:** WOD	91.64 %	R <80 % A >=80 % G >=90 %		No Action Required
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	3.95 %	R <90 % A >=90 % G >=95 %		The appraisal window is open from April –January 2019. We will only be reporting on substantive posts. We currently have 246 Consultants and SAS Drs in substantive posts. Of these 5 appraisals have taken place in July - 237 are still valid for the last appraisal year. The numbers will begin to increase as we move forward. The majority of appraisals will take place between September – January.
Personal Development	**PDR** Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	64.72 %	No Threshold		

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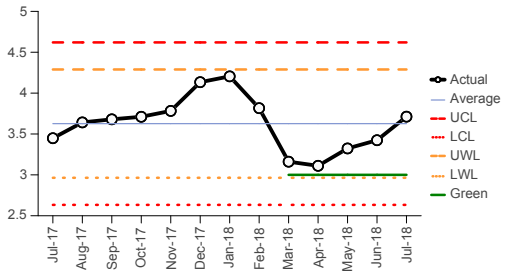
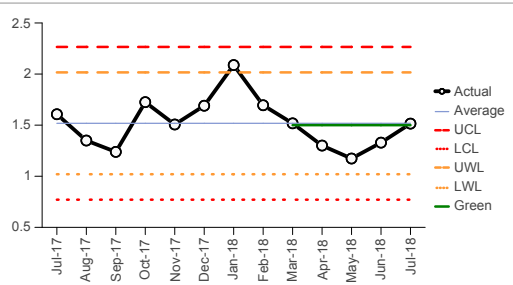
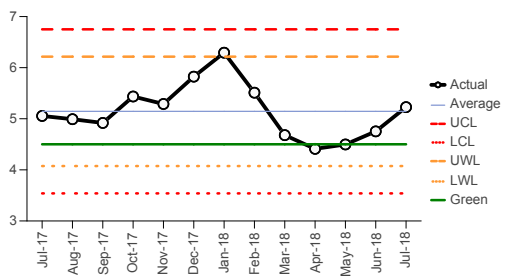
16.2 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Long Term Sickness** % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	3.71 %	R >3 % A N/A G <=3 %		Please see comment for overall sickness percentage
Sickness	**Short Term Sickness** % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.52 %	R >1.5 % A N/A G <=1.5 %		Please see comment for overall sickness percentage
Sickness	**Sickness** % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	5.23 %	R >5 % A <=5 % G <=4.5 %		Sickness has been steadily increasing since May 2018 with the largest change in July within the Division of Medicine, sickness absence rose to 5.85% up 1.4% from June. This can be explained due to an increase in absences in Stress and Fracture Injuries. The HR Team continue to work with managers to address any issues and support employees.

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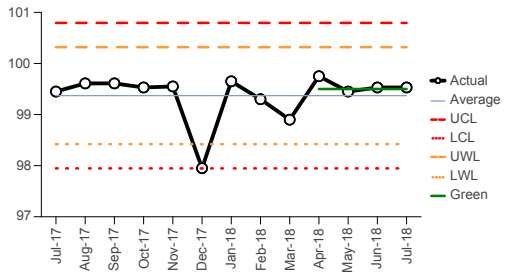
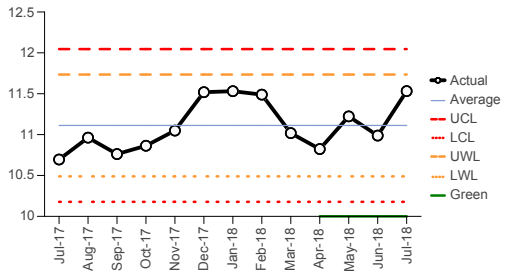
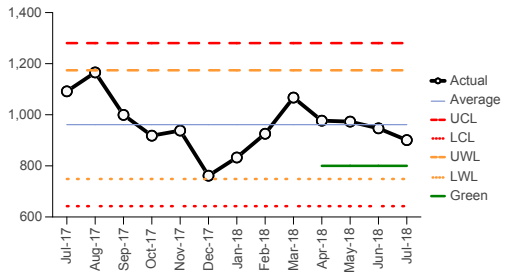
16.3 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS

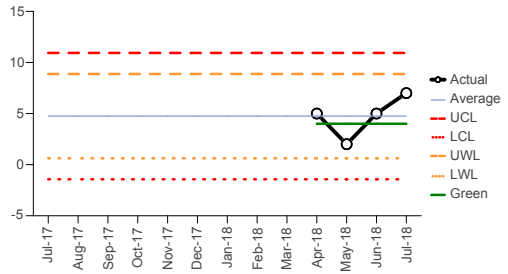
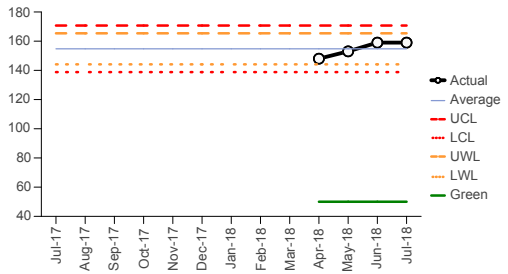
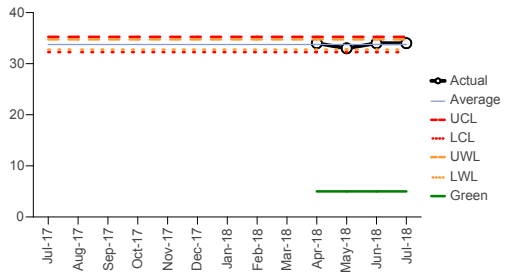
	Description	Performance	Threshold	Trend	Management Action (SMART)
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.53 %	R <99 % A >=99 % G >=99.5 %		No Action Required
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	11.53 %	R >11 % A <=11 % G <=10 %		Staff Turnover has increased slightly for the Trust in recent months, the staff group with the highest turnover is nursing. NHS Improvement is holding Retention Masterclasses in October 2018 covering a range of retention themes/initatives and offering networking opportunities with other NHS Trusts. Our Trust Lead Nurses have been invited to attend and feedback on some strategies to improve our staff retention rates.
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	900.67	R >960 A <=960 G <=800		Temporary spend has reduced this month but still above threshold. This is being reported to weekly sustainability group. The main reason for temp spend is sickness which remains higher than our target. A group has been set up to review health and wellbeing which is expected over time to reduce rates of absence and in turn temp spend. Other temp spend is a result of hard to fill positions, the exploration of a Drs bank is currently being looked into.

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

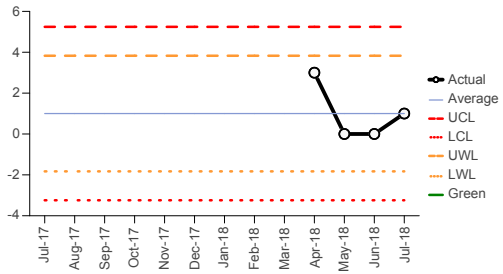
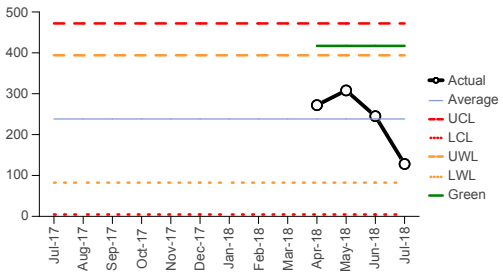
	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Academic** Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	7	R <4 A N/A G >=4		No Action Required
Clinical Research	**Number of Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	159	R <50 A N/A G >=50		No Action Required
Clinical Research	**Number of Open Studies - Commercial** Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	34	R <5 A N/A G >=5		No Action Required

Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

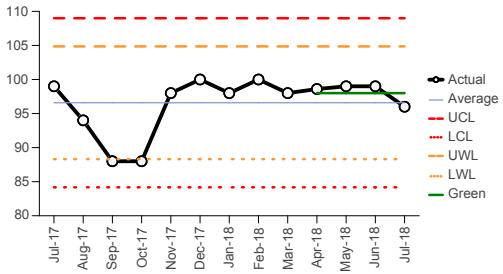
GROW THE FUTURE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	1	No Threshold		
Clinical Research	**Number of patients recruited** Number of patients recruited in month. **Exec Lead:** Matthew Peak **Committee:** REIC	128	R <417 A N/A G >=417		There are future plans to open higher recruiting studies in the near future which will push us towards our target.

Delivery of Outstanding Care

18.1 - FACILITIES - RESPONSIVE

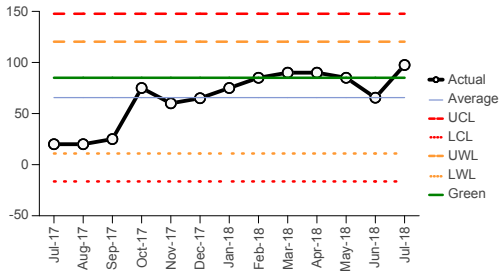
Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	96 %	R <98 % A N/A G >=98 %		Interserve have reported that all PPM was completed within a week of the failure (first week in August)

The Best People doing their best Work

19.1 - FACILITIES - WELL LED

Alder Hey Children's NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Steve Ryan **Committee:** RABD	97.50 %	R <85 % A N/A G >=85 %		No Action Required

All Divisions

SAFE

	COMMUNITY	MEDICINE	SURGERY	RAG
Total no of incidents reported Near Miss & Above	44	134	199	No Threshold
Clinical Incidents resulting in minor harm & above	2	22	48	No Threshold
Clinical Incidents resulting in moderate, semi permanent harm	0	0	1	No Threshold
Clinical Incidents resulting in severe, permanent harm	0	0	0	0 N/A >0
Clinical Incidents resulting in catastrophic, death	0	0	0	0 N/A >0
Pressure Ulcers (Grade 3)	0	0	0	0 N/A >0
Pressure Ulcers (Grade 4)	0	0	0	0 N/A >0
Medication errors resulting in harm	0	1	2	No Threshold
Medication errors resulting in moderate, sever harm or death	0	0	0	0 N/A >0
Never Events	0	0	0	0 N/A >0
Acute readmissions of patients with long term conditions within 28 days	0	0	0	No Threshold

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	4	3	5	No Threshold
PALS	22	28	20	No Threshold

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
Readmissions to PICU within 48 hrs	0	0	0	No Threshold
% of acute readmissions within 48 hrs of discharge (exc Oncology)	0.0%	1.5%	1.2%	<=1.5 % N/A >1.5 %
Readmissions within 48 hrs	0	30	20	No Threshold
Outbreak Acquired Organisms - Other	0	0	0	0 N/A >0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0 N/A >0
Hospital Acquired Organisms - MSSA	0	0	0	0 N/A >0

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
Hospital Acquired Organisms - RSV	0	0	0	No Threshold
Hospital Acquired Organisms - CLABSI - ICU Only			0	No Threshold
Outbreak Infections	0	0	0	No Threshold
Referrals Received (Total)	1,073	1,869	4,145	No Threshold
ED: 95% Treated within 4 Hours		96.5%		>=95 % N/A <95 %
Average LoS - Elective (Days)		3.86	2.73	No Threshold
Average LoS - Non-Elective (Days)		1.29	2.56	No Threshold
Theatre Utilisation - % of Session Utilised		83.0%	90.4%	>=90 % >=85 % <80 %
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.3%	3.0%	<=0.8 % N/A >0.8 %
On the day Elective Cancelled Operations for Non Clinical Reasons	0	3	36	No Threshold
28 Day Breaches	0	2	2	0 N/A >0
Clinic Session Utilisation	79.3%	81.4%	82.7%	>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	16.4%	16.4%	12.4%	<=5 % <=10 % >10 %
Did Not Attend Rate	12.7%	12.5%	11.9%	<=12 % <=14 % >14 %
Incomplete Pathway Forms in Outpatients	1,198	4,642	8,630	No Threshold
Referral Turnaround (days to log)	5.38	3.37	4.68	No Threshold
Referral Turnaround (Consultant to Action)	8.67	7.44	8.36	No Threshold
Coding average comorbidities	2.33	3.36	3.60	No Threshold
CAMHS: DNA Rate - New	9.3%			<=6 % <=8 % >8 %
CAMHS: DNA Rate - Follow Up	14.7%			<=10 % <=16 % >16 %

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Received information enabling choices about their care		91.0%	96.6%	>=95 % >=90 % <90 %
IP Survey: % Treated with respect		99.0%	100.0%	100 % >=95 % <95 %
IP Survey: % Know their planned date of discharge		58.3%	69.5%	>=90 % >=85 % <85 %
IP Survey: % Know who is in charge of their care		94.0%	95.1%	>=95 % >=90 % <90 %

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
IP Survey: % Patients involved in play and learning		71.4%	74.0%	>=90 % >=85 % <85 %
RTT: Open Pathway: % Waiting within 18 Weeks	92.2%	89.7%	92.9%	>=92 % >=90 % <90 %
Waiting List Size	898	3,482	8,573	No Threshold
Waiting Greater than 52 weeks	0	0	0	0 N/A >0
Diagnostics: % Completed Within 6 Weeks		99.3%	100.0%	>=99 % N/A <99 %
Number of Stranded Patients (7+ Days)		34	15	No Threshold
Number of Super Stranded Patients (21+ Days)		25	4	No Threshold
CAMHS: 2 Appointments within 6 weeks	0			No Threshold
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	18.00			No Threshold
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	0.00			No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	16.00	0.00	0.00	No Threshold
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	30.00	0.00	0.00	No Threshold

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG
Control Total In Month Variance (£'000s)	62	223	81	>=0% >=-20% <-20%
Income In Month Variance (£'000s)	39	606	311	>=0% >=-20% <-20%
Pay In Month Variance (£'000s)	18	-42	-49	No Threshold
Non Pay In Month Variance (£'000s)	5	-341	-180	>=0% >=-20% <-20%
AvP: IP - Non-Elective		93	39	>=0 N/A <0
AvP: IP Elective vs Plan	0	-27	-56	>=0 N/A <0
AvP: OP New	-84.43	-239.27	277.35	>=0 N/A <0
AvP: OP FollowUp	201.44	-439.23	-239.76	>=0 N/A <0
AvP: Daycase Activity vs Plan		-80	-132	>=0 N/A <0
AvP: Outpatient Activity vs Plan	117	-679	38	>=0 N/A <0

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG
PDR	58.8%	67.2%	64.4%	No Threshold
Mandatory Training	94.2%	91.3%	90.3%	>=90 % >=80 % <80 %
Actual vs Planned Establishment (%)	89.8%	91.4%	96.8%	No Threshold
Sickness	3.1%	5.5%	5.5%	<=4.5 % <=5 % >5 %
Attendance (HR)	96.9%	94.5%	94.5%	>=95.5 % >=90 % <90 %
Short Term Sickness	0.6%	1.8%	1.4%	<=1.5 % N/A >1.5 %
Long Term Sickness	2.5%	3.7%	4.1%	<=3 % N/A >3 %
Temporary Spend ('000s)	131	227	445	No Threshold
Staff Turnover	14.0%	11.6%	10.4%	<=10 % <=11 % >11 %
Safer Staffing (Shift Fill Rate)	101.0%	99.0%	91.9%	>=90 % >=80 % <90 %

Medicine

SAFE

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	5	7	8	4	4	6	3	3	0	1	1	4	0		No Threshold

CARING

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

EFFECTIVE

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	1	0	2	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	1,879	1,602	1,610	1,813	1,890	1,520	1,891	1,842	1,955	1,831	1,933	1,999	1,869		No Threshold
ED: 95% Treated within 4 Hours	93.1%	98.3%	95.0%	94.5%	92.8%	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%		>=95 % N/A <95 %
Average LoS - Elective (Days)	3.05	2.90	3.06	2.89	3.33	4.06	3.54	3.22	3.17	3.23	2.67	4.01	3.86		No Threshold
Average LoS - Non-Elective (Days)	1.65	1.49	1.63	1.39	1.41	1.50	1.75	1.57	1.50	1.52	1.55	1.59	1.29		No Threshold
Theatre Utilisation - % of Session Utilised	76.9%	81.8%	82.0%	81.5%	79.6%	82.5%	79.9%	80.6%	83.5%	75.4%	75.5%	78.0%	83.0%		>=90 % >=80 % <80 %
Clinic Session Utilisation	85.4%	85.4%	84.8%	85.4%	86.7%	84.6%	85.5%	86.9%	85.5%	84.8%	82.8%	84.3%	81.4%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	14.7%	13.4%	13.4%	14.0%	13.3%	15.3%	15.3%	17.6%	17.5%	13.5%	14.2%	12.8%	16.4%		<=5 % <=10 % >10 %
Did Not Attend Rate	11.5%	11.9%	11.2%	11.8%	9.7%	11.5%	9.5%	9.6%	11.2%	10.1%	10.9%	12.2%	12.5%		<=12 % <=14 % >14 %
Coding average comorbidities	3.14	3.05	3.57	3.43	3.42	3.92	3.86	3.49	3.34	3.52	3.35	3.54	3.36		No Threshold

RESPONSIVE

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	93.6%	93.3%	94.2%	92.7%	91.2%	92.6%	92.9%	93.0%	89.8%	90.0%	90.2%	89.5%	89.7%		>=92 % >=90 % <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.8%	100.0%	99.8%	99.8%	99.1%	99.3%		>=99 % N/A <99 %

WELL LED

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-649	155	-21	-464	529	-52	611	461		127	122	408	223		>=0% >=-20% <-20%
AvP: IP - Non-Elective										130	53	63	93		>=0 N/A <0
AvP: IP Elective vs Plan										-29	-11	-42	-27		>=0 N/A <0
AvP: OP New										-78.43	-201.04	-7.23	-239.27		>=0 N/A <0
AvP: OP FollowUp										-54.36	-171.18	-57.63	-439.23		>=0 N/A <0
AvP: Daycase Activity vs Plan										2	-13	-40	-80		>=0 N/A <0
AvP: Outpatient Activity vs Plan										-133	-372	-65	-679		>=0 N/A <0
PDR	73.8%	79.7%	82.2%	84.0%	85.0%	84.0%	84.0%	81.5%	81.5%	2.2%	13.4%	35.5%	67.2%		No Threshold
Mandatory Training	79.0%	78.3%	75.7%	77.3%	82.2%	86.6%	88.9%	94.7%	93.8%	92.7%	92.8%	92.4%	91.3%		>=90 % >=80 % <80 %
Sickness	4.7%	3.8%	4.1%	5.0%	5.3%	5.1%	5.6%	4.9%	4.3%	3.8%	3.9%	4.3%	5.5%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	323	326	250	186	242	207	211	276	316	246	276	196	227		No Threshold

Surgery

SAFE

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

CARING

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
Complaints	1	2	2	3	0	2	2	3	2	1	2	1	5		No Threshold
PALS	31	14	30	21	25	16	26	24	20	25	36	28	20		No Threshold

EFFECTIVE

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	1	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	1	0	0	0	0		0 N/A >0
Referrals Received (Total)	3,520	3,408	3,427	3,515	3,525	2,668	3,339	3,490	3,677	3,763	4,082	3,806	4,145		No Threshold
Average LoS - Elective (Days)	3.10	2.91	3.03	2.36	2.76	3.30	2.62	2.88	3.14	2.40	2.94	2.55	2.73		No Threshold
Average LoS - Non-Elective (Days)	2.86	2.96	2.74	2.90	3.17	3.18	2.67	2.89	3.31	2.63	2.78	2.63	2.56		No Threshold
Theatre Utilisation - % of Session Utilised	87.7%	88.6%	87.3%	87.3%	85.2%	86.6%	88.3%	86.4%	86.8%	90.2%	90.5%	89.4%	90.4%		>=90 % >=80 % <80 %
Clinic Session Utilisation	86.2%	84.8%	83.2%	85.2%	87.0%	82.9%	86.2%	83.6%	85.1%	84.2%	85.0%	86.0%	82.7%		>=90 % >=80 % <85 %
OP Appointments Cancelled by Hospital %	12.0%	12.9%	11.8%	12.3%	13.2%	13.3%	12.9%	14.0%	12.7%	11.1%	12.3%	12.2%	12.4%		<=5 % <=10 % >10 %
Did Not Attend Rate	10.9%	11.8%	11.5%	11.4%	10.2%	11.6%	10.2%	10.0%	10.2%	9.5%	10.6%	10.9%	11.9%		<=12 % <=14 % >14 %
Coding average comorbidities	3.18	3.11	3.18	3.13	3.18	3.06	2.99	3.18	3.24	3.11	3.31	3.50	3.60		No Threshold

RESPONSIVE

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

WELL LED

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	82	532	-167	-506	-610	-489	-634	-715		-167	32	-23	81		>=0% >=-20% <-20%
AvP: IP - Non-Elective										60	70	49	39		>=0 N/A <0
AvP: IP Elective vs Plan										-57	-16	-61	-56		>=0 N/A <0
AvP: OP New										450.34	577.63	492.48	277.35		>=0 N/A <0
AvP: OP FollowUp										206.57	-402.75	-443.28	-239.76		>=0 N/A <0
AvP: Daycase Activity vs Plan										-99	-101	-57	-132		>=0 N/A <0
AvP: Outpatient Activity vs Plan										657	175	49	38		>=0 N/A <0
PDR	87.6%	91.1%	90.1%	89.5%	88.1%	89.5%	89.5%	83.3%	83.3%	1.1%	10.0%	33.5%	64.4%		No Threshold
Mandatory Training	79.1%	77.0%	73.0%	73.8%	80.9%	85.8%	89.3%	93.5%	91.5%	90.2%	89.9%	90.9%	90.3%		>=90 % >=80 % <80 %
Sickness	4.7%	4.7%	4.6%	5.1%	4.8%	6.0%	6.3%	4.9%	4.0%	4.3%	4.7%	5.4%	5.5%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	511	554	429	479	383	331	408	434	514	468	420	480	445		No Threshold

Community

SAFE

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

CARING

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

EFFECTIVE

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	978	810	878	1,231	1,122	974	1,150	1,032	1,001	857	1,091	844	1,073		No Threshold
Average LoS - Elective (Days)			14.00												No Threshold
Clinic Session Utilisation	79.1%	76.9%	79.9%	82.9%	80.4%	73.3%	77.7%	75.7%	72.1%	75.2%	79.1%	78.2%	79.3%		>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	13.3%	17.1%	15.9%	15.2%	16.7%	17.0%	12.3%	13.5%	17.3%	16.1%	10.9%	17.1%	16.4%		<=5 % <=10 % >10 %
Did Not Attend Rate	15.6%	19.5%	16.8%	14.2%	13.4%	15.7%	12.6%	14.1%	14.5%	14.6%	14.0%	12.8%	12.7%		<=12 % <=14 % >14 %
Coding average comorbidities		4.50	2.00	3.00	3.50		5.00		3.33	5.00	2.33		2.33		No Threshold

RESPONSIVE

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	94.6%	96.5%	96.1%	96.3%	96.8%	97.3%	97.3%	96.5%	96.7%	97.1%	96.1%	95.3%	92.2%		>=92 % >=90 % <90 %

WELL LED

	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-69	-136	-55	-64	-72	-86	-161	43		-108	-70	30	62		>=0% >=-20% <-20%
AvP: IP Elective vs Plan										0	0	0	0		>=0 N/A <0
AvP: OP New										-25.37	-25.35	-35.17	-84.43		>=0 N/A <0
AvP: OP FollowUp										273.02	339.12	341.57	201.44		>=0 N/A <0
AvP: Outpatient Activity vs Plan										248	314	306	117		>=0 N/A <0
PDR	71.0%	82.8%	87.4%	90.4%	88.8%	90.4%	90.4%	83.9%	83.9%	0.4%	9.3%	31.9%	58.8%		No Threshold
Mandatory Training	74.5%	75.3%	74.6%	75.1%	80.3%	86.7%	89.8%	96.8%	95.7%	95.4%	95.0%	94.1%	94.2%		>=90 % >=80 % <80 %
Sickness	6.4%	6.3%	7.0%	5.8%	5.6%	6.7%	6.0%	5.8%	5.9%	4.5%	5.0%	3.7%	3.1%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	146	169	195	141	167	131	146	136	202	166	180	142	131		No Threshold

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday, 4 September 2018

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, Clinical Risk Manager
Subject/Title	2018/19 Board Assurance Framework Update (August 2018)
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF update report
Action/Decision required	The Board is asked to discuss and note the changes to the Board Assurance Framework – August position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Alder Hey Children's NHS Foundation Trust

Board Assurance Framework 2018/19

1. Purpose

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

2. Review of the BAF

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

BAF Risk Register - Overview at 29 August 2018

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

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

Changes since July 2018 Board meeting

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

External risks

- ***Business development and growth (MB)***
  Trust Board agreed Clinical Sustainability Strategy which was re-named Strategic Plan 2018-2021.

- ***Mandatory and compliance standards (ES)***
  All key national indicators met for the month; transcription issues resolved.

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

Internal risks:

- ***New Hospital Environment (DP)***
  Review of consolidated report with sub plans for fire and ceilings.

- ***Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations (HG)***
  CQC action plan submitted on time; substantial assurance received on Divisional Integrated Governance audit report from Mersey Internal Audit Agency (MIAA).

- ***Financial Environment (JG)***
  CIP identified has plateau at £5m against £6.8m plan. Efforts continue with £6m looking deliverable. Main concerns now relate to Divisional forecast gap of £6.8m and level of Spec Comm overperformance which is now subject to a formal activity notice.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***
  Planning application for park extension. Handover of Institute Phase 2.

- ***IT Strategic Development (JG)***

Replacement infrastructure in situ. Continued positive feedback from NHSE. Programme on track with revised approached for VR in place.

- ***Workforce Sustainability & Capability (MS)***

  Full review of BAF risk assessment and update of actions including mandatory training, workforce planning training, sickness absence and recruitment in Community.

- ***Staff Engagement (MS)***

  Staff engagement plan being rolled out with support from psychology services and dedicated staff sessions.

- ***Workforce Diversity & Inclusion (MS)***

  BAF risk assessment reviewed and revised to reflect current position. comprehensive diversity and inclusion action plan developed and presented to Board for approval.

- ***Research, Education & Innovation (DP)***

  Innovation prioritisation exercise.

Erica Saunders
Director of Corporate Affairs
29th August 2018

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
1. Annual QIA assurance report and change programme assurance report 2. Risk assessments etc and associated risks monitored via the Integrated Governance Committee. Trust Board informed via Integrated Governance Committee minutes. Divisional Integrated Governance Committee minutes. 3. Clinical Quality Assurance Committee, Trust Board and Divisional Governance minutes 4. Corporate report/quality section, Trust Board and Divisional Quality Board minutes. 5. Minutes from Trust Board, Clinical Quality Assurance Committee, Executive Committee, Weekly meeting of harm group, Clinical Quality Steering Group, Divisional Integrated Governance Committees. Also MIAA audit report. 6. Reports and minutes from Clinical Quality Assurance Committee and Divisional Integrated Governance Committees. 7. Annual Medical Appraisal Report and Nurse staffing report to Trust Board biannually and associated minutes. 8. Board and sub-board committees minutes and associated reports. 9. TO BE ADDED 10. IPC action plan and Trust Board, Clinical Quality Assurance Committee, Integrated Governance Committee, Divisional Quality Board minutes. 11. Nursing Workforce report and associated Board minutes. 12. Nursing Workforce report and associated Board minutes. 13. Patient survey reports and associated action plans, Trust Board, Clinical Quality Steering Group, Workforce and Organisational Development Committee, Divisional Quality Board minutes. 14. Audit committee reports and minutes. 15. CQC action plan monitoring via Board and sub board committees	2. High risks reporting to Clinical Quality Assurance Committee and Divisional Integrated Governance Committee minutes do not provide assurance of monitoring and risk reduction. 15. CQC action plan in development, in response to the findings from the CQC inspection report June 2018.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Executive lead to agree with Chairperson of committee and Director of Corporate Affairs process for review and challenge at the Clinical Quality Assurance Committee	
Robust action plan to be developed, implemented and monitored via the Trust Board, Board subcommittees and individual services.	

Executive Lead's Assessment
AUG 2018: CQC action plan submitted on time; substantial assurance received on Divisional Integrated Governance audit report from Mersey Internal Audit Agency (MIAA).

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• Operational Delivery Board taking action to resolve performance issues as they emerge	• Emergency Planning & Resilience meetings in pace
• Divisional Executive Review Meetings taking place monthly with 'three at the top'	• Regulatory status with: NHSI, CQC,NHSLA, ICO, HSE, CPA, HTA,MHRA etc.
• Compliance tracked through the corporate report and Divisional Dashboards.	• Risks to delivery addressed through Operational Board, RBD, CQAC, WOD, IGC & CQSG and then through to Board
• Early Warning indicators now in place	• Weekly performance meetings in place to track progress
• 6 weekly meetings with commissioners (CQPG)	• Divisional leadership structure to implement and embed clinically led services
• Weekly Exec Comm Cell overseeing key operational issues and blockages.	• Refresh of Corporate Report undertaken for 2018/19

Assurance Evidence	Gaps in Controls/Assurance
Regular reporting of delivery against compliance targets through assurance committees & Board. Monthly reporting to the Board via the Corporate Report. NHSI quality concern rating Operational effectiveness measures (key risks with early warning measures) to RABD Compliance assessment against NHSI Provider Licence to Board Divisional/Executive performance reviews Exceptions discussed / resolved at Ops Board Quarterly review meeting and report to NHSI	Critical Care bed capacity Some areas remain fragile e.g. ED 4 hour target. Assurance required to underpin Divisional reporting on CQC standards Work with CCG to manage demand & develop / fully utilise existing capacity across PC Proactive management of patient flow making better use of trend analysis data

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Monitor the use of surgical beds to ensure full activity plan delivered	Elective programme being monitored on a weekly basis however significant pressure from NEL orthopaedic cases experienced during June has proved challenging.
Plans to ensure performance sustained across the year need to be embedded and maintained	Review of hospital flow underway
New model to deliver required number of CCAD cases agreed at Board on 22/5/18. COO to lead implementation.	

Executive Lead's Assessment

APRIL 2018: All compliance targets achieved at end of April. Trust is projecting a financial risk rating of 1. No governance concerns
MAY 2018: No compliance concerns at this stage in the month
JUNE 2018: All external mandatory targets met; focus required to ensure elective programme remains on track given demand pressures
AUGUST 2018: All key national indicators met for the month; transcription issues resolved.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 1.3	**Strategic Objective:** Delivery Of Outstanding Care		Risk Title: New Hospital Environment		
Related CQC Themes: Safe					
Exec Lead: David Powell	**Type:** Internal, New		Current IxL: 4-4	Target IxL: 4-2	Trend: WORSE

Risk Description	
Sale of PFI Project co. whilst a number of commissioning risks are still present could lead to lack of focus and problems in maintaining safe environment	
Existing Control Measures	
• Monthly issue meetings	• Monthly liaison meetings
• Regular reports to IGC	• Liaison minutes reported to Trust Board monthly
• Building Management Services Risk Register	
Assurance Evidence	**Gaps in Controls/Assurance**
Maintenance of Issues List Issues Review Meeting Escalation to Liaison meeting Red Button escalation mechanism Help Desk monitoring reports	Some repeat/overlap reporting Some lack of clarity over risk ownership/H&S role
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Replacement programme for pipe work to be agreed with builder	Report received from Project Co. Agreed to present at October Board
COO updating Action Plan to address key water safety issues	
Interserve developing water safety action plan	Project Co. agreement to scope out water cross-over test. Exercise planned for sept 2018
Whole Hospital review of fire stopping	
Review of various risk elements and consolidation into single report with external validation.	
Complete Fire Notice action plan	
Create action Plan for addressing ceiling tile falls	Proposed plan submitted to Project co. for consolidation

Executive Lead's Assessment

APRIL 2018: Clutch of commissioning issues still to be resolved including pipework corrosion, water temperatures, delay in achieving operating theatre temperature control. Are currently under review with some attendant action plans still requiring completion.
Next steps-complete reviews and agree all action plans for outstanding issues.
MAY 2018: Interim report on Pipework received. Commercial plan meeting in diary for June. Fire-stopping review under way
JUNE 2018: Consolidated report in production; review meeting with Project Co and refresh of action plan. Outcome to be reported 24/07/2018
AUG 2018: review of consolidated report with sub plans for fire and ceilings

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description
Failure to deliver consistent, high quality patient centred services due to not having the right people, with the right skills and knowledge, in the right place, at the right time.

Existing Control Measures	
• Workforce KPIs tracked through the corporate report and divisional dashboards	• Bi-monthly Divisional Performance Meetings.
• Mandatory training fully reviewed in 2017, with a new system of reporting linked to competencies on ESR; enabling better quality reporting.	• Mandatory training mapped to Core Skills Framework. Online portal enables all staff to see their compliance on their chosen IT device.
• Permanent nurse staffing pool	• HR Workforce Policies
• Attendance management process to reduce short & long term absence	• Wellbeing Steering Group established
• Large-scale nurse recruitment event 4 times per year	• Training Needs Analysis linked to CPD requirements
• Apprenticeship Strategy implemented	• Engaged in pre-employment programmes with local job centres to support supply routes
• Engagement with HEENW in support of new role development	• People Strategy

Assurance Evidence	**Gaps in Controls/Assurance**
Regular reporting of delivery against compliance targets via corporate & divisional reports Monthly reporting to the Board via the Corporate Report Reporting at ward level which supports Ward to Board Reporting to HEE People Strategy report monthly to Board Programme Board reporting	Not meeting compliance target in relation to mandatory training in some areas Sickness Absence levels higher than target. Lack of standard methodology to workforce planning across the organisation

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
L&D to undertake full review of mandatory training; comms, process and quality. See date for progress update.	
Undertake review of recruitment methods to support Community Division in recruiting hard to reach posts	
Undertaking a sickness absence review in 2018Working with Trade Unions to refresh the policy, understand further the drivers for high sickness absence	
ensure a minimum of 50 learners enrolled on apprenticeship pathways.	
Training required for HR Business Partners and Advisers in workforce planning methodologies	

Executive Lead's Assessment
AUG 2018: Full review of BAF risk assessment and update of actions including mandatory training, workforce planning training, sickness absence and recruitment in Community.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.2	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Staff Engagement		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-1	Trend: STATIC

Risk Description

Failure to improve workforce engagement which impacts upon operational performance and achievement of strategic aims.

Existing Control Measures

• People Strategy	• Wellbeing Strategy implementation
• Action Plans for Staff Survey	• Values and Behaviours Framework
• Staff Temperature Check Reports to Board (quarterly)	• Values based PDR process
• People Strategy Reports to Board (monthly)	• Listening into Action Guidance and Programme of work
• Staff surveys analysed and followed up (shows improvement)	• Reward and recognition schemes in place: Annual Awards, Star of the Month and quarterly Long Service Recognition Event, Annual Fab Staff Change Week.
•	• BME and Disability Staff Networks

Assurance Evidence	Gaps in Controls/Assurance
Monthly People Strategy Report to Board Outcomes from Annual Staff Survey reported to the Board. Staff Survey local departmental conversations PDR completion rates Values and Behaviours Framework Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data sent to Divisions on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board Wellbeing Strategy progress reported to WOD Board/sub-Board Committee minutes Minutes of Staff Networks Engagement through Editorial Board leadership for Alder Hey Life	Internal Communications Strategy and Plan Refreshed Leadership Strategy

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
L&D manager to undertake a review of the methodology, with a view to launching new system in June 18	
Group to be established and to roll-out the approach to HWB across the organisation	
Further to previous action email, please provide progress update.	
Please prepare outline strategy for discussion at away day on the 9th July 18.	
Further to last action email, complete strategy by end July.	

Executive Lead's Assessment

AUG 2018: Preparation underway for 2018 Staff Survey. Leadership Strategy in latter stages of development.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 2.3	**Strategic Objective:** The Best People Doing Their Best Work	Risk Title: Workforce Diversity & Inclusion		
Related CQC Themes: Well Led, Effective				
Exec Lead: Melissa Swindell	**Type:** Internal, Known	Current IxL: 3-4	Target IxL: 3-1	Trend: STATIC

Risk Description

Failure to proactively develop a future workforce that reflects the diversity of the local population, and provide equal opportunities for career development and growth for existing staff.

Existing Control Measures

• Wellbeing Strategy	• WOD Committee ToR includes duties around diversity and inclusion, and requirements for regular reporting.
• Wellbeing Steering Group	• Staff Survey results analysed by protected characteristics and actions taken by E&D Lead.
• HR Workforce Policies	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	• BME Network established, sponsored by Director of HR & OD
• Disability Network established, sponsored by Director of HR & OD	• Actions taken in response to the WRES
• Action plan specifically in response to increasing the diversity of the workforce, and improving the experience of BME staff who work at Alder Hey	•
•	•

Assurance Evidence	Gaps in Controls/Assurance
Monthly recruitment reports provided by HR to divisions Diversity and Inclusion Action Plan reported to Board Bi-monthly reporting to Board via WOD on diversity and inclusion issues Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication Equality Objectives	LGBTQ Network not yet in place
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Establish LGBTQ network	No progress due to capacity issues. Revised timeline for completion.

Executive Lead's Assessment

AUG 2018: BAF risk assessment reviewed and revised to reflect current position. comprehensive diversity and inclusion action plan developed and presented to Board for approval.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.1	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Failure to fully realise the Trust's Vision for the Park		
Related CQC Themes: Responsive, Well Led				
Exec Lead: David Powell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description
Failure to fully realise the Trust's vision for the Park and campus, in partnership with the local community and other key stakeholders as a legacy for future generations

Existing Control Measures	
• Business Cases developed for various elements of the Park & Campus	• Monitoring reports on progress
• Heads of Terms agreed with LCC for joint venture approved	• Redevelopment Steering Group
• Monthly reports to Board & RABD	

Assurance Evidence	**Gaps in Controls/Assurance**
Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Stakeholder events held/reported back to Trust Board Representation at Friends of Springfield Park Group Monthly Board report	Fully reconciled budget with Plan. Risk quantification around the development projects.

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Secure approval for plans to increase Park footprint	Planning for Park extension submitted 31/07/2018
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	On hold-Dependent upon residential scheme (revised target date no April 2018)

Executive Lead's Assessment
APRIL 2018: New Park manager appointed MAY 2018: Meeting arranged with Friends of Springfield Park to agree 1st park extension. JUNE 2018: 2nd round of user meetings on Community Cluster. Commissioning Programme for Institute under way. Implemented bi-weekly control group meetings on the Institute commissioning Aug 2018: Planning application for park extension. Handover of Institute Phase 2

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Marketing and Business Development Committee is being refreshed as a Growth Through Sustainable Partnerships Group. First meeting planned July 2018 . Business Development Plan reviewed monthly by RBDC via Contract Monitoring Report. Daily activity tracker and forecast monitoring performance for all activity. CIPs in new Change Programme subject to assurance and sub-committee performance management	Ability to respond swiftly to potential problems. Workforce constraints in specialised services. Early warning indicators for leading indicators. Potential delay to cardiac growth - current gap c. £0.8m forecast against 16/17 CIP target Growth through Partnerships to be included as part of Strategic elements of business planning in the next planning cycle
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Development of the international agenda	

Executive Lead's Assessment

APRIL 2018. Final Clinical and Sustainability Strategy to July Board.
MAY 2018: Detailed discussion at Execs (17 May). Further work up of detailed proposals for 18/19 to be completed by end of June and for July Trust Board.
JUNE 2018: Clinical sustainability strategy to be finalised at Board meeting on 3rd July. AUG 2018: Trust Board agreed Clinical Sustainability Strategy which was re-named Strategic Plan 2018-2021

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Key developments monitored through Divisions Monitored at refreshed 'Sustainability Through External Partnerships Steering Group'. Monthly to Board via RABD & Board Compliance with final national specifications Single Neonatal Services Business Case approved by NHS England	Inability to recruit to highly specialist roles due to skill shortages nationally. Trust has sought derogation in a number of service areas where it does not meet certain standards and is progressing actions to ensure compliance by due date. Potential elective underperformance due to cancelled sessions. Awaiting final results re. CHD service at national level. Working with partners including CMFT to progress transfer of adult CHD services and to support partners during transition. Go live due beginning of September 2018.

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Development of a single neonatal service business case across Alder Hey & LWH	Governance model developed and agreed by both trusts and NHS England including delivery model and work streams. MoU drafted and due to be approved by both boards in July 2018.
CHD Liverpool partnership - development of Level 1 status for adult congenital heart disease across North West / NW / Wales and Isle of Man, bringing together a partnership across 4 Liverpool providers. Partnership achieved November 2017.	
Strengthening the paediatric workforce	6 monthly audit of 7-day standards is subject to external scrutiny. Global Digital Excellence has improved measurement capability. Adrian Hughes is now leading as one of the top 5 Operational Priorities known as 'New Models of Care'. In addition, junior doctor numbers were bolstered during the winter which improved cover and consultant arrangements.
Agreement of key partnerships for sustainability 2018/19 achieved on 30th November 2017. Actions now in planning and delivery phase, with Executive Oversight provided by the CEO Oversight Group, and planning delivery through the joint CHIG Group. Delivery will take up to two years. In addition to support the Strategic Plan identify which existing and new Partnerships need to be strengthened and grown	

Executive Lead's Assessment

APRIL 2018: Trust Board Workshop to be scheduled for June 2018 to consider growth and sustainability scenarios to inform clinical and sustainability strategy.
MAY 2018: Workshop held on 17 May and next steps agreed
JUNE 2018: CEO now chair of Children's Transformation Board; Single Neonatal Service model moving to implementation phase. Level 1 CHD partnership in place and due to go live beginning of September 2018

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 3.4	**Strategic Objective:** Sustainability Through External Partnerships	Risk Title: Financial Environment		
Related CQC Themes: Safe, Effective, Responsive, Well Led				
Exec Lead: John Grinnell	**Type:** Internal, Known	Current IxL: 4-4	Target IxL: 4-3	Trend: STATIC

Risk Description

Failure to deliver Trust control total and financial risk rating

Existing Control Measures

• Organisation-wide financial plan.	• Monitor financial regime and financial risk ratings.
• Financial systems, budgetary control and financial reporting processes.	• Capital Planning Review Group
• Monthly performance review meetings with Divisional Clinical/Management Team and the Executive	• Financial Position (subject to regular monitoring).
• Weekly meeting with divisions to review forward look bookings for elective and day case procedures to ensure activity booked meets contract and recovery plans. Also review of status of outpatient slot utilisation	• Financial Recovery Board in place
• CIP subject to programme assessment and sub-committee performance management	

Assurance Evidence	Gaps in Controls/Assurance
Monthly Corporate Performance Report presented to both Board and the RABD. Specific Reports (i.e. NHSI Plan Review by RABD) Monthly Performance Management Reporting with General Managers. Internal and External Audit reporting through Audit Committee. Daily activity tracker to support divisional performance management of activity delivery Pay cost control 10 point plan introduced aimed at forecasting and tracking actions to reduce pay cost overspend run rate - updates to Execs, R&BD. Full electronic access to budgets & specialty performance results Weekly Financial Sustainability delivery meeting papers	Divisions improved financial control and effective recovery required in identified where slippage against agreed recovery trajectories occurring Ongoing cost of temporary staff Divisional recovery plans to hit yearend financial control targets to ensure delivery of overall Trust financial plan. 'Grip' on CIP CIP Position improved however Divisional forecasts still showing a potential £7m gap

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

Executive Lead's Assessment

JUNE 2018: Key risks highlighted as delivery of CiP (£2.5m gap), elective run rates/winter plan delivery and other emerging cost pressures. Total Divisional risk equates to c£8m and will be through divisional recovery supported by an effective winter plan and identification of non-recurrent measures. Mitigation plan to be tracked through RABD
AUG 2018: CIP identified has plateau at £5m against £6.8m plan. Efforts continue with £6m looking deliverable. Main concerns now relate to Divisional forecast gap of £6.8m and level of Spec Comm overperformance which is now subject to a formal activity notice.

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.1	**Strategic Objective:** Game-Changing Research And Innovation		Risk Title: Research, Education & Innovation		
Related CQC Themes: Responsive, Well Led					
Exec Lead: David Powell	**Type:** Internal, Known		Current IxL: 3-3	Target IxL: 3-2	Trend: STATIC

Risk Description

Failure to exploit new opportunities in research, innovation & education due to incomplete management systems.

Existing Control Measures

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

Assurance Evidence	Gaps in Controls/Assurance
Research Strategy Committee set up as a new Board Assurance Committee Research, Education and Innovation Committee established Secured ERDF funding for Innovation Team Innovation Board established	Sporadic meetings of RIE committee Governance structure for Innovation Board to be agreed Re-energise Research governance processes Reporting frameworks and standards for all services to be agreed/harmonised

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Develop a robust Academy Business Model	Framework refresh
Establish pipeline structure for work-streams (Acorn and Crucible)	Legal work complete on Crucible Contract
Execute contract for RIE with back to back arrangements with the Charity and HEIs	Final Documentation with solicitors prior to completion before move in to Institute Phase 2
Agree incentivisation framework for staff and teams	

Executive Lead's Assessment

APRIL 2018: REI committee refreshed and re-launched
MAY 2018: Revised plan for 2017/18 innovation activity
JUNE 2018: Innovation Refresh 2nd session
AUG 2018: Innovation prioritisation exercise

Board Assurance Framework 2018-19

Alder Hey Children's NHS Foundation Trust

BAF 4.2	**Strategic Objective:** Game-Changing Research And Innovation	Risk Title: IT Strategic Development		
Related CQC Themes: Safe, Caring, Effective, Responsive, Well Led				
Exec Lead: John Grinnell	**Type:** Internal, Known	Current IxL: 3-3	Target IxL: 3-3	Trend: STATIC

Risk Description

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

Existing Control Measures

• Key projects and progress tracked through the Clinical Systems Informatics Steering Group and RABD Committee	• Clinical Systems Informatics Project Group leading on stakeholder engagement - ad hoc groups on specific key topics as needed
• Forward Communications plan agreed and tracked at steering group.	• Board approval "Asset Owner" process in place to ensure organisational ownership of systems and system development
• Improvement scheduled training provision including refresher training and workshops to address data quality issues	• Formal change control processes now in place
• Executive level CIO in place	• Monthly update to Trust Board on GDE Programme
• GDE Programme Board in place & fully resourced - Chaired by Medical Director	• Clinical Engagement in IT Roadmap
• NHSE external oversight of GDE programme	• Resilience of underlying infrastructure
• A plan is now in place to develop new strategy and roadmap to present to board in Autumn 2018 including plan for user engagement. Plan will include the current GDE programme and beyond, as well as review of Meditech offerings beyond current contract.	

Assurance Evidence	**Gaps in Controls/Assurance**
Regular progress reports presented to RABD and Operational Board & Trust Board MIAA providing assurance role Board agreed change process Participate in Digital Alder Hey programme Internal Audit Reviews NHSE tracking of GDE Programme GDE Programme Board tracking delivery - Chaired by MD Plan presented to Ops Board June 18	IM&T Strategy out of date - update work in progress to produce Roadmap for October 19 Resilience of underlying infrastructure - replacement being installed

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Replacement equipment procured - being installed	
IT Roadmap to be concluded	Meeting held with Meditech to agree how we work more effectively going forward and have more onsite presence

Executive Lead's Assessment

APRIL 2018: ImageNow and bed management module key next phases of the programme. Clinical Advisory Group in place supporting these developments. Real progress being made on STP wide intra-operability platform
MAY 2018: No material changes to report in-month
JUNE 2018: Replacement underlying infrastructure ordered; Excellent feedback from NHSE on benefits realisation
AUG 2018: Replacement infrastructure in situ. Continued positive feedback from NHSE. Programme on track with revised approached for VR in place.

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

31st July 2018

Summer 2018 Election Results

In June 2018 the Trust issued election notifications for the following vacancies:

Public Governors in the following constituencies

Wider North West	X 1
North Wales	X 1
Merseyside	X 1

Patient and Carer Governors in the following constituencies

Rest of England and North Wales	X 1
Parent and Carer	X 1
Merseyside	X 2

Staff Governors in the following constituencies

Other Staff and Trust Volunteers	X1
Medical and Dental Practitioners	X1

Further to the deadline for nominations (23rd July), the following constituency was uncontested:

Elected unopposed:

Patient: Rest of England x 1	**Felix Blake**
Patient: Merseyside x1	**Bakare Aliu**
Public: North Wales x1	**Simon Hooker**
Public: Merseyside x 1	**Kal Ross**
Staff: Other Staff and Trust Volunteers x 1	**Anna Parsons**
Staff: Medical and Dental Practitioners x 1	**Sujata De**

No nominations were received for the following seats:

Wider North West x1
Patient: Parent and Carer x1
Patient: Merseyside x 1

These will roll-over into the 2018 Autumn By-election.

All terms of office are for a length of 3 years.

Erica Saunders
Director of Corporate Affairs

Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

Tuesday 4th September 2018

Report of	Director of Corporate Affairs
Paper prepared by	Director of Corporate Affairs
Subject/Title	Proposed Constitutional Change
Background papers	• Trust Constitution • Provider Licence
Purpose of Paper	To set out a proposal to amend the Trust's Constitution in response to a specific request from NHS Improvement.
Action/Decision required	The Board is asked to approve the amendment as set out in the paper
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	N/A

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Proposed Constitutional Change

1. Purpose

The purpose of this paper is to seek the Board's approval to amend the Trust's Constitution in relation to the composition of the Nominations Committee of the Council of Governors.

This change will be subject to approval by the Council of Governors at its meeting on 18th September 2018.

2. Proposed Amendment

At the end of July the Trust's Chief Executive received notification from NHS Improvement that following a review of foundation trust constitutions they had identified a number that are not strictly compliant with good governance as set out in the Code of Governance for FTs and Best Practice Guidance on Director-Governor interactions. These documents state that the CEO should not participate in the appointment of the Chair. The NHSI position - which will be clarified in amended guidance in due course - is that that CEOs should not be formal members of the Nominations Committee, although they may of course advise and offer views to the Committee as part of the process.

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

The proposed amendment to section 24 of the Trust constitution is set out below with propose revised wording in red script:

Board of Directors – appointment and removal of Chair and other Non-Executive Directors

24.1 The Council of Governors shall approve by a majority vote the recommendations of the Nominations Committee to appoint the Chair of the Trust and the other Non-Executive Directors, including the Senior Independent Director.

24.2 Removal of the Chair or another Non-Executive Director/Senior Independent Director shall require the approval of two thirds of the Council of Governors.

24.3 Membership of the Nominations Committee will consist of: -

The Chair of the Trust (or Vice Chair when the appointment of the Chair and his/her remuneration and allowances and other terms and conditions of office are being discussed);

~~The Chief Executive of the Trust~~;

One Appointed Governor;

Two Elected Governors (one of whom to be a staff Governor)

An external assessor, with the appropriate skills and experience, will be appointed by the Committee to advise the Committee as and when required. The Trust Chief Executive will participate in the activities of the Committee in an advisory capacity.
Members of the Committee may be required to undertake training and development commensurate with their responsibilities.

A quorum shall be at least two Governors.

24.4 Responsibilities of the Committee

To prepare job descriptions and/or person specifications detailing the skills, knowledge and experience required for the posts of Non-Executive Directors, taking into account the views of the Board of Directors and in particular the Chief Executive.

To determine and undertake the recruitment and selection process for Non-Executive Directors, which is rigorous and inclusive in nature.

To make recommendations to the Council of Governors as to suitable candidates for approval by the Council of Governors. The Council of Governors shall either appoint the recommended individual(s) or invite the Committee to make an alternative recommendation.

To consider whether to recommend to the Council of Governors the reappointment of the retiring Non-Executive Director.

To make recommendations to the Council of Governors as to the remuneration and allowances and other terms and conditions of office of Non-Executive Directors.

3. Recommendation

The Board is asked to approve the amendment to the Trust's Constitution as described above.

Erica Saunders
Director of Corporate Affairs
August 2018