Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS MEETING

Tuesday 5th December 2017 commencing at 1000

Venue: Small Lecture Theatre, Institute in the park

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY						
Board Business						
1.		**1015**	**Apologies**	Chair	Ian Quinlan, Adam Bateman	--
2.	**17/18/187**		**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate	--
3.	**17/18/188**		**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **7th November 2017**	Read Minutes
4.	**17/18/189**	**1020**	**Matters Arising**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate	Verbal
5.	**17/18/190**	**1030**	**Key Issues/Reflections** • **Booking and Schedule Review.**	All A. Bateman	The Board to reflect on key issues.	Verbal
Game Changing Research and Innovation						
6.	**17/18/191**	**1040**	**Liverpool Health Partners/KPMG update** - **Liverpool Health Partners Review** - **Liverpool City Council – Child Friendly City** - **University – Children's Health and Well Being Clinical Review**	Michael Beresford	To update the Board on the Current position	Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
7.	**17/18/192**	**1050**	**Global Digital Exemplar (GDE)**	P Young	To update the Board on the programme	Read report
Strategic Update						
8.	**17/18/193**	**1100**	**External Environment** **Progress against strategic themes:** - **Liverpool Women's Reconfiguration Options/Neonatal** - **CAMHS Tier 4 Bid** - **Congenital Heart Disease** - **Acting as One – proposed MoU for corporate services**	L Shepherd C McLaughlin S Ryan J Grinnell	To update the Board on progress.	Verbal
Delivery of outstanding care						
9.	**17/18/194**	**1120**	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month	Read Report
10.	**17/18/195**	**1130**	**Clinical Quality Assurance Committee: Chair's update**	A Marsland	To receive and review the approved minutes from the meeting held: October 2017	Read report
11.	**17/18/196**	**1135**	**Mortality report Quarter 2**	S Ryan	To receive the quarterly report	Read report
12.	**17/18/197**	**1145**	**Infection Prevention and Control Quarter 2**	V Weston	To receive the quarterly report	Read report
13.	**17/18/198**	**1155**	**Complaints Quarter 2 report**	A Hyson	To receive the quarterly report	Read report
14.	**17/18/199**	**1205**	**Alder Hey in the Park update** - **Energy update**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
The best people doing their best work						
15.	**17/18/200**	**1210**	**People Strategy Update** - **September Workforce and**	M Swindell	To provide an update on the strategy and staff survey	Read reports

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			Organisational Key Issues report - **November Workforce and Organisational Key Issues report** - **Library and Knowledge Service Strategy**			
16.	**17/18/201**	**1220**	**Listening into Action**	K Turner	To present the bi annual update position.	Presentation
1230 – 1300 LUNCH						
Strong Foundations						
17.	**17/18/202**	**1310**	**Programme Assurance update**	J Gibson	To receive an update on programme assurance including the 2017/18 change programme	Read Report
18.	**17/18/203**	**1320**	**Corporate Report** - **Update to be received on recovery plan**	J Grinnell/ A Bateman/ 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 October 2017	Read report
19.	**17/18/204**	**1330**	**Board Assurance Framework**	E Saunders	To receive the BAF report.	Read report
20.	**17/18/205**	**1340**	**Audit Committee Minutes**	S Igoe	To receive the approved minutes from the meeting held on 5th October 2017.	Read report
Any Other Business						
21.	**17/18/206**	**1350**	**Any Other Business**	All	To discuss any further business before the close of the meeting	Verbal

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
Date And Time Of Next Meeting: Tuesday 9th January 2017 at **10:00am, Institute In The Park, Large Meeting Room**						

REGISTER OF TRUST SEAL
The Trust Seal was used during **November, 2017:** - Deed of release re: Haigh Road Waterloo - Joint Venture Agreement relating to Alder Hey Living Hospital Limited

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Confirmed Minutes of the last meeting held on **Tuesday 7th November 2017 at 10:00am,** Large Meeting Room, Institute in the park

Present:	Mr I Quinlan	Non-Executive Director (Chair)	(IQ)
	Mrs C Dove	Non-Executive Director	(CD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Dr S Ryan	Medical Director	(SR)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mr A Bateman	Acting Chief Operating Officer	(AB)
	Prof M Beresford	Assoc. Director of the Board	(PMB)
	Mr C Duncan	Director of Surgery	(ChrD)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Dr A Hughes	Director of Medicine	(AH)
	Mrs D Jones	Interim Director of Strategy	(DJ)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator	(JT)
	Mr M Flannagan	Director of Communications	(MF)
Observing:	Miss J Preece	Governance Manager	(JP)
Agenda item: 167	Rachel Greer	Associate Chief Operating Officer, Community	
167	Kate Brizell	General Manager, Community	
167	Chloe Lee	General Manager, Surgery	
167	Will Weston	Associate Chief Operating Officer, Medicine	
167	Adrian Hughes	Director of Medicine	
167	Cath Wardell	Associate Chief Nurse for Medicine	
167	Charlie Orton	Manager, Clinical Research	
173	Tim Crowley	Merseyside Internal Audit Agency Director	
173	Cath Hill	Director - AQuA	
179	Peter Young	Chief Information Officer	
Apologies:	Sir D Henshaw	Chairman (Chair)	(SDH)
	Mr S Igoe	Non-Executive Director	(SI)
	Mrs C McLaughlin	Divisional Director of Community Services	(CMc)

17/18/162 Declarations of Interest
None declared.

17/18/163 Minutes of the previous meetings held on 3rd October 2017
Resolved:

The Board received and approved the minutes from the meeting held on 3rd October 2017.

17/18/164 Matters Arising and Action Log

The Chair welcomed Dani Jones, Interim Director of Strategy, to her first Board meeting.

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

17/18/136 Key Issues/Reflections

Liverpool Community Health Services

Louise Shepherd reported on the management handover meeting of Liverpool Community Services to Merseycare held on 31st October 2017, noting that the meeting had been well-received and that Alder Hey looked forward to continuing to work in partnership to develop the integration agenda across the city.

17/18/137 External Environment

Liverpool Women's NHS Foundation Trust/ Neonatal Network

Whilst Neonatal Services are under review, both Liverpool Women's and the CCG have agreed to ensure they are content with the position before Liverpool Women's public consultant commences.

Congenital Heart Disease

The NHS England Board is due to meet on 30th November 2017 to agree a way forward.

17/18/167 Operational Plans

The three clinical divisions as well as the Research Business Unit and Corporate Services presented their deliverables at the half year point against the operational plans agreed at the beginning of the financial year.

Community

Achievements included the successful transfer of 120 staff from Liverpool Community Services to Alder Hey in April. During this time, concerns were highlighted with reference to capacity to maintain the 18 week waiting time target, however since the transfer the target has been maintained. The demand for CAMHS services is increasing and will continue to put pressure on this target being met. The team is working with commissioners to agree a resolution.

Other achievements included the successful implementation of a new leadership model, regular engagement meetings with staff resulting in a 50% completion rate of the staff survey (target was 49%) and 90% of PDRs, as well as continued partnership working with other trusts and local authorities.

Going forward the division is continuing to review and reduce the current £300K CIP gap as well as developing plans to support the division in 2018/19 with financial targets required.

Surgery

Children's day surgery services are number 1 in the country with 99.4% of parents recommending the services. The service continues to grow year on year

and the division highlighted difficulties with recruiting to a number of areas including Anaesthetics, Theatre Assistants and Middle Grade Doctors. The division is working with education providers and developing nurses in to Nurse Practitioners to reduce the gap.

A review of workforce skill and volume had been carried out, resulting in a reduction in the vacancy rate enabling three additional beds to be added to critical care. The division has achieved zero agency spend in the year to date, this has engaged national interest on how this has been achieved. A new management and governance system has been embedded, whilst over 90% of the department have received a PDR.

Surgery division is over-performing against its CIP target and is planning a £1m surplus at the end of the financial year. The division anticipated operational difficulties with the approaching winter period and national warnings of flu being higher than previous years.

Going forward patient flow continues to be monitored which is having a positive impact on cardiac services.

Medicine
ED access targets for quarter 1 and 2 were the highest in the country resulting in a congratulations letter from the Secretary of State.

Risks on the register have been reduced from 38 to 8 and continue to be monitored. An education piece on reducing pressure ulcers was implemented and has seen a constant reduction in the last four months.

The medical and nursing workforce gap had reduced enabling an increase in Emergency Department beds from 8 to 11. The division is building stronger relations with staff side and improving PDR rates and staff survey responses.

As the division met cancer targets for quarter 1, a successful application was submitted and awarded for additional GP sessions.

Improvement to pathways include: Sepsis, asthma and complex surgery as well as developing a 7 day working rota.

Medicine division CIP gap was originally £2m; £1.4m has been identified leaving a reduction to be sought for £600K. Following uncertainty around all activity coming through coding and capture correctly a review was currently under way.

Research
The Research division had just completed its second MHRA inspection; the final report was awaited and would be shared with the Board once received.

The team had overachieved against sustaining academic research, successfully securing funding for a further five years for the Clinical Research Facility (CRF). The Business Unit is in the country's top three for recruiting patients for clinical research studies. The aim for securing studies this year was agreed at ten; the division have already overachieved this by completing 14 and hope to double the

aim to 20 by the end of the financial year. An update on how payment is now being received earlier was received. Research on medical devices is rare and is being developed.

The Division is set to overachieve its CIP target of £130K. Proposals for the target to be divided across the divisions instead of being added to the corporate budget were being looked into although it was noted that this proposal would not take place within the next 4-5 years.

Corporate Services
Finance
Finance is on track to meet the set CIP and have met all the Key Performance Indicators.

Facilities
Reviews across this function had either taken place or are in progress to reduce the CIP gap of £200K. Staff engagement had been key to all reviews.

As the Trust had not met the target of 82.5% for the Patient Led Assessment of the Care Environment on disability it was agreed regular reports would be presented to Clinical Quality and Assurance Committee. The target had not been met mainly due to larger vehicles for wheel chair users not being able to fit into the multi-storey car park.
Action: HG

Human Resources
An update on the Alder Hey Academy was received; this included the fact that a lead had been appointed to this to ensure targets are met.

Improvements have been seen with PDR, Mandatory training rates and a reduction to payroll errors.

Nursing and Quality
Overspend contributing factors included termination of secondment arrangements and needing to accommodate staff returning when not expected. To continue supporting the plan to reduce the financial gap, a review of 'retire and return' arrangements was to take place.

The Board discussed the timeframe for complaint responses and ways to improve. Whilst this is regularly reported on to Clinical Quality and Assurance Committee (CQAC) and the Board it was agreed CQAC would lead a session on this.
Action: HG/AM

Estates
Since moving in to the new hospital energy consumption has been over the agreed rate. The team have been working with the energy providers since the move and have recently seen a reduction in the energy usage; this is expected to continue to reduce until the target is met.

Part of the old site was accommodating corporate services. This has been under a review and an update will be presented at the December Board.
Action: DP

Innovation
One of the products under development is the Alder Hey App. The go live date on the wards is later this month.

Additional
Additional events/incidents included: CQC Inspection, Cyber attack and Liverpool Community Health bid and management contract.

Resolved:
- The Board thanked all the divisions for presenting their achievements for the first half of the year.
- Going forward the divisions agreed to continue growing the external strategic plan and share learning across the divisions.
- The Board agreed to review the Trust's Strategic 3-5 Year Plan.

17/18/168 Serious Incidents Report

Hilda Gwilliams presented the report for September 2017. There had been two new SIRIs reported, five ongoing and three closed.

The first new incident was in relation to a patient who hadn't been identified as having sepsis and therefore not treated for it. External regulators are aware and have accepted the lessons learnt and processes in place. The patient's parents requested a number of questions to be answered within the Root Cause Analysis panel and this had been completed.

Following a near miss incident with PDA Stent services the procedure had been suspended until the team are confident the correct procedures are in place. Following a review, the service will be reinstated shortly. Positive feedback from commissioners had been received on the detection and management of this incident.

Resolved:
The Board received the Serious Incident Report for August noting:
- Two new SIRI, five ongoing and three closed. There had been no new, ongoing or closed safeguarding incidents reported.

17/18/169 Clinical Quality Assurance Committee: Chair's Update
CQAC Minutes 20th September 2017
Resolved:
The Board received and noted the approved minutes from the CQAC meeting held on 20th September 2017.

17/18/170 Alder Hey in the Park

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

Demolition

Demolition of the old site is in progress, phase one is due to be completed at the end of December 2017.

Residential
The project is currently on hold as discussions are being held with the Chair and the Mayor of Liverpool on the scale and selection of options.

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

Alder Centre
Building of the new Alder Centre is due to commence next year.

Springfield Park
The team continue to work with local schools and the National Woodland Trust to develop the park. A poetry competition has been launched to celebrate the partnership with the Woodland Trust.

International Design and Build Consultancy
Jersey design review is ongoing with weekly visits to Jersey by team members gathering data from clinical design workshops. This design review and development work looks very likely to extend beyond November and additional income should be achieved.

A contract had been prepared and exchanged with Xi'an, contract documents and drawings being translated via China centre prior to commencement of the design review which is now likely to start in February 2018 due to delays in Xi'an.

Community/CAMHS Estate Strategy
An update on the Community Cluster will be received at the December Board.

Resolved:
Board received an update on the current position.

17/18/171 CQC Action Plan

Following an unannounced CQC inspection earlier in the year, an action plan had been developed and submitted in accordance with CQC timeframes. The actions had been categorised as must and should do, with the 'should do' actions being monitored at divisional level.

Erica Saunders reported that a request had been submitted to the CQC for a formal ratings review; their process requires that this can only be done on the basis of their not having followed their own guidance when awarding ratings. The application for review is focused on specific domains. The CQC will take 50 days to respond to the request.

Nicholas Smith, newly appointed CQC Head of Inspection for Hospitals in the north was due to visit Alder Hey on 17th November 2017.

Resolved:

The Board received and noted progress against the CQC action plan and the request for a formal CQC review of the ratings awarded.

17/18/172 People Strategy update

Melissa Swindell presented the September report.

The annual staff awards were launched at the end of October, with the event taking place on the 19th January 2018.

Staff Survey closes at the beginning of December with a target of 50% completion rate. The rate is currently at 40%.

Following the Trade Union elections completed last month a new staff side Chair (Tony Johnson, Children's Health Park), Vice Chair (Kerry Turner, Listening into Action Lead) and Secretary (Clare Jones, Dietician) have all been elected for three year terms. Claire Dove, Chair of Workforce and OD Committee noted that a thank you letter would be sent to Mike Travis the outgoing Staff Side Chair.

Going forward staff would receive their payslips electronically. Positive feedback had been received as payslips and mandatory training are now available on mobile applications. This service is to be rolled out to Board members soon.

Resolved:

The Board:

- Received the People Strategy report for September 2017
- Approved the WRES Action plan to be presented at the Workforce and Organisational Committee in detail tomorrow.

17/18/173 Well-led Governance Review Terms of Reference

In June 2017 NHS Improvement (NHSI) issued guidance to update the 2015 well-led framework for governance reviews. The new guidance now applies to both NHS trusts and foundation trusts and has a broader developmental focus on leadership and governance with an emphasis on quality improvement.

NHSI strongly encourage providers to carry out developmental reviews or equivalent activities approximately every three years to ensure they identify potential risks before these turn into issues.

The guidance is broken down into eight Key Lines of Enquires and will support trusts prior to CQC Inspections.

Resolved:

- The Board received the Well-led Governance Review Terms of Reference.
- A timeline to ensure effective delivery of the review would now be agreed.

17/18/174 Programme Assurance Update

Resolved:

Projects within the five work-streams were now all rated amber or green.

17//18/175 Corporate Report

The Board received the report for September 2017.

Financial, Growth & Mandatory Performance Framework
For the month of September the Trust is reporting a trading deficit of £0.6m which is slightly ahead of plan. Income is ahead of plan by £0.1m mainly due to income relating to non-elective and critical care activity. An update on the recovery plan will be received at the December Board.
Action: JGri

Performance
The Trust is compliant with all NHSI standards for quarter 1 and quarter 2. September had been a difficult month with cancelled operations due to bed availability and continued pressure on booking and scheduling.

As agreed at the last Board Mags Barnaby and Hilda Gwilliams gave a presentation on a deep dive into Booking and Scheduling. The outcome is to review delivery of best practice and update the Board on initial findings at the January Board meeting.
Action: MB/HG

Patient Safety
Medication errors resulting in harm show continued improvement with only three in month.

Patient Experiences
There were four formal complaints in month, i.e. 31 year to date - very similar to last year's position. PALS contacts remain lower than last year although 121 attendances is the highest of any month this year

All in-patient survey measures have improved this month compared with last month. However 4 of these measures remain behind target. Friends and Family responses from A&E and Community remain low and still need to be improved.

Clinical Effectiveness
MRSA and Clostridium difficile infections remain at zero year to date.
Resolved:
The Board received the Corporate Report for Month 6.

17/18/176 Board Assurance Framework
As Alder Hey no longer manage the Liverpool Community Services contract risk 1.3 will be removed.

Resolved:
The Board received the content of the BAF.

17/18/177 Integrated Governance Committee
Resolved:
The Board received the approved minutes from the meetings held on 24th July and 27th September 2017.

17/18/178 Resource and Business Development Committee
Resolved:

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

17/18/179 Global Digital Exemplar

NHS Digital had visited Alder Hey and completed their assurance testing for the second milestone. Presentations and a number of demonstrations were given in relation to the individual GDE Projects. Feedback had been received requesting further information required subsequent to the inspection. Peter Young reported on NHS England advising that they are satisfied with progress and funding for the second milestone will be granted shortly.

Resolved:

The Board received and noted the content of the GDE paper.

17/18/153 Any Other Business

No other business was reported.

Date and Time of next meeting: Tuesday 5th December 2017, at 1:30pm, Large Meeting Room, Institute in the park.

Alder Hey Children's NHS
NHS Foundation Trust

Trust Board
5th December 2017

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

Project Delivery within November

Work is continuing to ensure Phase 3 milestones are met, namely:-.

SOPB
The Statement of planned benefits has been completed and submitted for NHS Digital to review. The feedback on progress has been positive and further engagement is underway to ensure clear baselines for all projects are in place.

Specialty Packages
System development by IM&T developers completed for four Specialty Packages, Gynaecology, Emergency Department are live, Rheumatology and Dietetics are now with the Clinical teams for testing and feedback.
Development underway on eight other the Specialty Packages, this includes the finalisation of three of the four Community Paeds phases.

Voice Recognition
The Voice Recognition project is now live within eleven specialties. The project team are now engaging with previous users to understand and concerns with the system and offer further one to one support. An Executive led review has taken place to ensure that lessions learnt are incorporated into the ongoing roll out of the system.

Paediatric Portal
The Paediatric Portal re-branded as 'Connected Care.' Scoping has been completed and development is underway to link key systems into the portal environment. The team have successfully transferred data from Meditech into the portal environment which is a huge achievement and a process which we can use as a foundation for future integration. Alder Hey's CIO is the interoperability lead across the STP and work has commenced on engaging other Trusts to act as a proof of concept for the Connected Care Project. An awareness session was held within the Digital Chatroom to engage clinicians with the Connected Care vision.

Clinical Terminology Software
IMO has been purchased and testing underway. Implementation is due in early January as part of the revised discharge process?

Data Migration
Task and Finish Group established in order to determine scope, first meeting held.

GDE Prescribing Projects (Dose Range Checking and Continuous Infusions Pilot)
A Task and Finish group has been established. The continuous infusions functionality has been demonstrated and will now be reviewed by the Junior Doctor group for feedback on 4 December 2017.

Communications
The GDE Programme now has its own visual identifier in the form of an overall DIGITAL@ALDERHEY logo as well as a set of icons for each of the workstreams.

This was showcased at the Digital Chatroom held on the 17th November 2017. The chatroom provided a number of different stalls delivering details and an opportunity to ask

questions on GDE Projects, this included Voice Recognition, Connected Care, Specialty Packages/Digitising Pathways and Alder Play. The chatroom will be held on a bi-monthly basis.

Upcoming Deliverables

- SOPB - On-going development of the Statement of Planned Benefits to support all projects. Service Managers and Clinical Leads have been invited to attend a benefits workshop which will be led by NHS Digital.
- PACs other O'logies project – Commence roll-out in both Gait Lab and Speech and Language Therapy. The go-live date for these is planned at the 8th December.
- Speciality Packages - Development to be completed on six packages by December 2017. These will include Community Paeds, Rheumatology, Dietetics, Tissue Viability, Emergency Department and Gynaecology.
- Speciality Packages – The Rheumatology blood-monitoring process is due to go live on the 4th December 2017.
- Specialty Packages – Next launch event scheduled for 7th December 2017.
- Voice Recognition - Due to go live in EEG and Urology, A&E, Respiratory by end of November 2017.
- Connected Care - Development of the Portal with view to full a pilot in February 2018.
- TCI – Theatre Pathway - Pathway re-design is underway and due to be piloted within General Surgery in February 2017.
- Point of Care Testing (POCT) – The point of care testing project will ensure the integration of blood gases, blood glucose, and urinalysis devices are interfaced into Meditech. Currently the results are transcribed by hand to note form. POCT will improve the accuracy and availability of patient results as they are transmitted into the system. Time efficiencies will be gained as the transcribing of results will no longer be required. Information Governance will significantly improve, data management will be on one platform and regular quality audits will be carried out; therefore the Trust aims to apply for the ISO:22870:2016 accreditation; no other paediatric Trust is accredited. The POCT scope has been defined and a pilot is due to commence in January.

Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
Voice Recognition	Safer handover of care between Trust & Primary Care	Average turnaround time for letters (working days)	16 working days	3 working days (Jun-18)	65% 7.5 days
		Longest waiting letter (working days)	19 working days	5 working days (Jun-18)	64% 10 days
Fast User	Improve efficiency when	Time taken to log into system	1:45	<0:10	100%

Switching	logging into systems in clinical areas – releasing time to care	(minutes) 4950 transactions per day	minutes	minutes	
Bi-directional interface with kiosks (Intouch & Meditech)	Improve efficiency in booking in for outpatient appointments, releasing time to cash up outpatient clinics	Average time taken to add an appointment to the InTouch system (minutes) 650 transactions per month	1:00 minutes	0:00 minutes (Sep-17)	100%

A Benefit Owner Workshop will be held by the Clinical Benefits Delivery Programme Manager from NHS Digital on 28th November 2017. This will provide Benefit Owners with a better understanding of their roles and responsibilities around benefits. The workshop will also focus on demonstrating the value of the projects; identifying potential improvements, setting targets and milestones to ensure gains are maximised.

Programme Assurance

NHS Digital attended Alder Hey and completed their assurance testing for the second milestone.

Feedback was been received and additional information has been provided and submitted for a final sign off.

Fast Follower

The Alder Hey *Fast Follower* Trust, Clatterbridge Cancer Centre, are currently undergoing 'due diligence' A site visit was successfully conducted on the 20th September 2017 with approval given for Clatterbridge to continue to the next stage and complete their funding agreement. The funding agreement has now been submitted for feedback and approval.

Next Steps

- Continue working towards the delivery of Milestone three (February 2018). The next NHS Digital assurance testing is planned and will take place on the 16th January 2018.

- Continue to work with Specialties to identify target benefits and support the monitoring of these benefits throughout the project lifecycle.

Recommendations

The Trust Board is asked to:-

1. Note the progress with the GDE Programme and ongoing work to progress towards the third milestone, due on 28th February 2017.

Peter Young

Chief Information Officer

27th November 2017

GDE Programme Dashb 31 May 2018 - Stage 2

Version 0.1 10/04/17

Project Ref	GDE?	Project Title	Project Description	Delivery Date	PROJECT RAG RATING: OVERALL PROJECT RAG status	% Progress
Workstream 1 - HIMSS level 7 EPR - System wide projects						
1B(a)	GDE	Voice recognition deployment	Deploy voice recognition solution in MEDITECH	November 2019 - Stage 2		25%
1B(b)	GDE	Voice recognition deployment	Deploy voice recognition solution in Medisec	November 2019 - Stage 2		25%
1C(a)	IM&T	Prescribing and Medicines Administration Enhancements	Warfarin	28 February 2018		75%
1C(b)	IM&T	Prescribing and Medicines Administration Enhancements	Antimicrobial	28 February 2018		35%
1C(c)	IM&T	Prescribing and Medicines Administration Enhancements	Bedside medication verification			5%
1C(d)	GDE	Prescribing and Medicines Administration Enhancements	Continuous infusions	Pilot - 28/02/2018		20%
1C(e)	GDE	Prescribing and Medicines Administration Enhancements	Dose range checking	28 Febraury 2018		5%
1E	GDE	MEDISEC enhancements	Tertiary letter improvements	28 February 2018		25%
1E(b)	GDE	MEDISEC enhancements	Inclusion of letters into ImageNOW	30 September 2017		100%
1F	GDE	POCT device integration	Integration of POCT devices into the MEDITECH system	28 February 2018		15%
1G	GDE	GS1 Barcodes	Enable technical solution for use of GS1 barcodes where appropriate	31 October 2018		5%
1H	GDE	Vital Sign device integration	Integration of Welch Alyn vital signs monitors into MEDITECH	31 May 2018 - Roll out		80%
1J(a)	GDE	Theatre improvements - Emergency List.	Emergency list solution	30 September 2017	Completed	Stage 1 100%
1J(b)	GDE	Theatre improvements - TCI to Theatre	TCI to Theatre improvements	28th February 2017 - Stage 2 - Pilot		25%
1K(a)	GDE	Internal interfaces Haemonetics	Haemonetics	28th February 2017 - Stage 2 - Implementation		10%
1K(b)	GDE	Internal interfaces ECM	ECM file import	30 September 2017		90%
1L	GDE	IMO implementation	Implementation of Clinical interface terminology software	28 Febraury 2018		70%
1M	GDE	Day Forward Scanning	Automate the production and scanning of records	30 September 2017		100%
1N	GDE	Historic data migration	Complete migration of historical data from MEDITECH 5 including Blood bank, bulliten and pathology	31 May 2018		22%
1O(a)	GDE	PACS Other Ologies	EEG - Consolidation of all clinical images into the PACS system	31 May 2018		
1O(b)	GDE	PACS Other Ologies	ECG - Consolidation of all clinical images into the PACS system	31 December 2017		75%
1O(c)	GDE	PACS Other Ologies	Gait Lab - Consolidation of all clinical images into the PACS system	31 December 2017		50%

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GDE Programme Dashb 31 May 2018 - Stage 2

Version 0.1 10/04/17

					PROJECT RAG RATING	
Project Ref	GDE?	Project Title	Project Description	Delivery Date	OVERALL PROJECT RAG status	% Progress
1O(d)	IM&T	PACS Other Ologies	SLT - Consolidation of all clinical images into the PACS system	31 December 2017		50%
1P	GDE	Encoder implementation	Implement integrated encoding software for the Clinical Coding team	Stage 1 - depoly coding solution 30 September 2017		95%
1R	GDE	Mobile Phlebotomy solution	Adaptation of COWs to allow sample labels to be printed at the point of care	31 March 2018		10%
1S	GDE	Infrastructure	Provision of additional hardware (subject to approval) to suppport clinical processes including fast user switching	30 September 2017		
1T	IM&T	Booking and Scheduling Enhancements	Develop an enhanced solution to support improvements to booking and scheduling processes	01 September 2018		10%
2V	GDE	Consent - Trust Wide	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	28 February 2018		TBC
Workstream 2 - Speciality Packages						
2A	GDE	Emergency Department	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	01 September 2017	Completed	100%
2B	GDE	Gynaecology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	01 September 2017	Completed	100%
2C	GDE	Rheumatology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	30 September 2017		60%
2D	GDE	Gastroenterology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	30 November 2017		25%
2E	GDE	Neurosurgery	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	03 November 2017		25%
2F	GDE	Respiratory	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	03 November 2017		10%
2G	GDE	CAMHS	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	19 October 2017		40%
2H	GDE	Community Paeds	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	24 October 2017		40%
2I	GDE	Dietetics	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	24 October 2017		70%
2J	GDE	Junior Doctors	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	01 December 2017		25%
2K	GDE	LTV	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	02 February 2018		TBC
2L	GDE	Pre-Op	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	02 February 2018		25%
2M	GDE	Chronic Pain	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	02 February 2018		20%
2N	GDE	Immunology & Infectious Diseases	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	02 February 2018		10%
2O	GDE	Transitional Care	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	02 February 2018		25%
2P	GDE	Community Matrons	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	02 February 2018		5%
2Q	GDE	Physiotherapy and Occupational Therapy	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	28 February 2018		TBC

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					PROJECT RAG RATING	
Project Ref	GDE?	Project Title	Project Description	Delivery Date	OVERALL PROJECT RAG status	% Progress
2R	GDE	Haematology	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	28 Febraury 2018		TBC
2S	GDE	Tissue Viability	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	28 February 2018		TBC
2T	GDE	Safeguarding /Rainbow	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	28 February 2018		TBC
2U	GDE	Anaesthetics	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	28 February 2018		TBC
2W	GDE	Vascular Access & OPAT	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	28 February 2018		TBC
3A	GDE	Connected Care	Provide secure access to multiple aspects of a pateint record in one place	Stage 1 Scope and commence procurement 28 February 2017		30%
Workstream 4 - Patient Portal						
4A	GDE	Patient Portal	To allow patients/families/carers secure access to patient records	28 February 2018		
Workstream 5: Interoperability & APIs						
5A	GDE	MESH	Implementation of MESH standard for message exchange	31 Ocotober 2017		100%
5B	GDE	EMIS to MEDITECH interface	Electronic access to primary care records	31 October 2017		10%
5C	GDE	GP Ordering for Diagnostics	To provide the ability for GPs to order Pathology investigations direct	31 March 2018		50%
5D	GDE	GP Ordering for Diagnostics	To provide the ability for GPs to order Radiology investigations direct	31 March 2018		50%
Workstream 6: Improving Patient Experience						
6A	GDE	PET App	Development of an App to improve patient experience	30 September 2017 - Stage 1, complete engagement phase for PET App 28th February 2018 - Stage 2 , build pilot for PET App		Stage 1 100%
Workstream 7: National Requirements						
7A	IM&T	e-Referrals	e-Referral paper switch off programme	01 October 2018		50%
7B	IM&T	Emergency Care Data Set	Emergency Care data set to be added as part of IMO	01 October 2017		100%
Workstream 8: Other						
8A	IM&T	Chemocare HL7 Interface	HL7 ADT Interface for Chemocare	01 March 2018		100%
8B	IM&T	R&E 2	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	01 June 2018		20%
8C	IM&T	Outpatient Coding	Outpatient Coding	01 September 2017		
8D	IM&T	Sepsis Management	Review of Sepsis Pathway	01 September 2017		100%
8D	IM&T	Data Centre back on site	Move of the Data Centre back onto site	01 January 2018		

GDE Programme Dashb(31 May 2018 - Stage 2

Version 0.1 10/04/17

					PROJECT RAG RATING	
Project Ref	GDE?	Project Title	Project Description	Delivery Date	OVERALL PROJECT RAG status	% Progress
8E	IM&T	A&E Capacity and Demand App	Deployment of an A&E waiting time app across the STP footprint	01 January 2018?		

Project	**Black** - Failed/ Gap Red - Project team/workbook requiring

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

Tuesday 5th December 2017

Report of:	Chief Nurse
Paper Prepared by:	Chief Nurse and Clinical Risk Manager
Subject/Title:	Serious Incidents Requiring Investigation
Background Papers:	n/a
Purpose of Paper:	This report summarises all the open serious incidents in the Trust and identifies new serious incidents arising in the last calendar month.
Action/Decision Required:	For information regarding the notification and management of SIRI's.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• **Patient Safety Aim** – Patients will suffer no harm in our care. • **Patient Experience Aim** – Patients will have the best possible experience • **Clinical Effectiveness** – Patients will receive the most effective evidence based care.
Resource Impact	n/a

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1. Background:

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

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

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

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

2. SIRI performance data:

SIRI (General)													
	2016/17						2017/18						
Month	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**
New	2	2	1	0	1	2	3	1	2	4	0	2	0
Open	3	2	2	1	1	2	2	4	4	6	8	5	3
Closed	1	3	2	2	0	0	2	1	0	1	2	3	4
Safeguarding													
Month	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**
New	2	0	0	1	2	2	0	0	0	1	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
Total closed	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**

3. Recommendations:

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

New SIRI Incidents reported between the period 01/10/2017 to 31/10/2017:								
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**72 hour review completed/ immediate actions taken and shared learning**	**Progress**	**60 working day compliance**	**Duty of Candour/ Being Open policy implemented**
Nil								

New Safeguarding investigations reported 01/10/2017 to 31/10/2017: For information							
Reference Number	**Date investigation started**	**CBU**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance**	**Being Open policy implemented**
Nil							

On-going SIRI incident investigations (including those above)							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour/ Being Open policy implemented**
2017/ 24137	29/09/2017	Medicine	Suboptimal care of deteriorating patient. Query sepsis pathway not followed. Complex patient with co-morbidities, known to Trust, attended for renal dialysis. Patient attended on 18/06/17, query septic during admission, staff recorded not concerned about the risk of sepsis and patient discharged as no clear cause of pyrexia. Patient returned 19/06/17 acutely unwell, patient transferred to PICU and sadly died on the 23/06/17.	Andrew Riordan, Consultant in Paediatric Infectious Diseases, Jeanette White, Matron, Amanda Turton, Head of Acute Care	Draft RCA report written and has been through first quality check, further work required. Report returned to author.	Yes	Yes
StEIS 2017/ 23222	19/09/2017	Surgery	Suspension of PDA stent service following near miss but well managed	Phil Raymond, Service Manager	Draft RCA report written, action plan being reviewed prior to sending the report to CCG.	Yes	N/A – no harm caused to patients.

			decomposition of a PDA stent and following previous incident in which a patient died (latter incident reported to StEIS previously, ref: StEIS 2017/9948).				
RCA 333 2016/17 **Internal**	28/03/2017	Medicine	The patient was brought to ED in November 2016 as an emergency with seizures and hypertension. Despite resuscitation and intensive care she died 2 days later. Subsequent post-mortem has revealed previously undiagnosed structural kidney disease which is the likely cause of the malignant hypertension. The child had presented to ED in June 2013 and October 2015 with a diagnosis of Bell's Palsy. Blood pressure should have been recorded on each of these occasions but was not recorded.	Amanda Turton, ED Manager	Further changes required in respect of root cause. Following these changes, report to be sent to family.	Internal	Being open completed, level of harm unknown.

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

SIRI incidents closed since last report						
Reference Number	Date investigation started	CBU	Incident Description	RCA Lead Investigator	Outcome	Duty of Candour/Being open policy Implemented
StEIS 2017/ 19060	31/07/2017	Surgery	Grade 3 Pressure Ulcer - A 7 year old patient with a head injury sustained in a road traffic accident has a right sided below knee plaster of paris (POP) insitu. The patient has numerous abrasions from the accident including behind the right knee. The patient has now been confirmed as having a Grade 3 pressure ulcer behind the right knee thought to have been caused by friction from the plaster cast.	Kelly Black, Surgical Matron	Final report sent to CCG and family.	Yes
RCA 332 2016/17 **Internal**	28/03/2017	Medicine	During a complaint investigation it became apparent that some elements of the child's inpatient stay had not been managed as robustly as they should have been. During the 4 days of the child's stay there were a number of times where his clinical condition and monitoring	Dianne Topping, Senior Nurse	Final report sent to family.	Yes

			of vital signs triggered his PEWS score and required a review by a doctor - all required reviews do not appear to have taken place.			
StEIS 2017/ 18783	26/07/2017	Business Support	Following a Medisec update to facilitate the switch to electronic letters, it was identified that a software bug was introduced that resulted in letters not being sent to two GP practices for a period of 3 months. Any letters associated to patients of these practices were also not sent. No patient harm identified.	Martin Levine, Head of Clinical Systems	Following meeting with the CCG regarding incident and associated action plan, assurance provided to CCG, stepped down from StEIS.	N/A – No harm
StEIS 2017/ 14196	02/06/2017	Surgery	An unwell, query septic child was referred to the General Paediatric team for review by the Orthopaedic team. He had undergone bilateral hip surgery 5 days prior. He was referred as he was febrile and tachycardic. He was referred to the paediatric team around 6.30pm on 24/5/2017. Delay in patient being reviewed.	Sarah Wood, Consultant Surgeon Sue Tickle, Clinical Nurse Manager ICU	Final report sent to CCG and family.	Yes

Safeguarding investigations closed since last report
Nil

Clinical Quality Assurance Committee
Minutes of the last meeting held on Wednesday 18th October 2017
10.00 am, Large Meeting Room, Institute in the Park

Present:	Anita Marsland	(Chair) Non-Executive Director
	Louise Shepherd	Chief Executive
	Jeannie France-Hayhurst	Non-Executive Director
	Mags Barnaby	Interim Chief Operating Officer
	Pauline Brown	Director of Nursing
	Rachel Greer	Associate COO - Community
	Hilda Gwilliams	Chief Nurse
	Rob Griffiths	Deputy Director of Health Care Professionals
	Lachlan Stark	Head of Planning and Performance
	Steve Ryan	Interim Medical Director
	Erica Saunders	Director of Corporate Affairs
	Glenna Smith	General Manager – Medicine
	Adam Bateman	Acting Chief Operating Officer
	Catherine McLaughlin	Director of Community Services
	Tony Rigby	Deputy Director of Risk & Governance
	Melissa Swindell	Director of HR
	John Grinnell	Director of Finance
	Jo Williams	Non-Executive Director
	Christian Duncan	Director – Surgery
	Anne Hyson	Head of Quality - Medicine
	Sarah Stephenson	Head of Quality – Community
	Julie Williams	Governor
	Steve Igoe	Non-Executive Director
	Dave Walker	Interim Head of Quality - Surgery

In Attendance:

Joe Gibson	Programme Director
Hannah Ainsworth	Diversity & Inclusion
Matthew Peak	Director of Research
Simon Hooker	Governor
Valya Weston	Head Service/ Associate DIPC
Julie Creevy	Executive Assistant (Minutes)

17/18/53 Apologies:

Cathy Umbers	Associate Director of Nursing & Governance
Mark Peers	Public Governor
Will Weston	Associate Chief of Operations

17/18/54 Declaration of Interest
None declared

17/18/55 Minutes of the previous meeting held on 20th September 2017
Resolved:

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

17/18/56 Maters Arising and Action Log

Discussion took place regarding the vital importance of CQAC members attending CQAC meetings.

Action: LS to formally write to Divisional Directors to reinforce the importance of ensuring attendance going forward.

16/17133, 16/17/175, & 17/18/16

M Swindell confirmed that this item had been actioned and could now be removed from the action log.

Bespoke quality Metrics dashboard

LS confirmed that problems had been encountered with I.T/technical issues, the information had been mapped to the 'key lines of enquiry', JG agreed to address this issue further with IT, with a further update at the next CQAC meeting.

Action: JG to liaise with IT to resolve technical issue

17/18/57 CAMHS Review

Andrew Williams provided an update regarding the thematic review of Mental Health Services for Children and Young People which is aimed at part of CQC statutory duty and strategic commitment to encourage improvement. Review looked at the quality of care along a pathway. Majority of feedback received by CQC had been positive, comment had been made regarding the range of websites which was overwhelming with too many acronyms used.

Experience of care – a low number of patients had experienced dissatisfaction, with overwhelming positive feedback received.

This would be followed up with CCG, to discuss how to move forward.

CQAC agreed that it would be beneficial to have an action plan in place in order for CQAC to regularly review, with the action plan also being shared at CQPG to ensure key partners are signed up.

AM thanked AW for his helpful update.

17/18/58 Sepsis Update

G Smith confirmed that the September Sepsis data had been submitted to CQC. It was noted that time to antibiotics - 55 minutes for inpatients, ED patients – 64 minutes. IT challenges remain, the Trust had recently written to Meditech to address issues and had also been raised via a booked call with Meditech on 17th October 2017. It is envisaged that the Trust should receive a formal response during week commencing 23rd October 2017. A

further update following receipt of formal response would be provided at October 2017 CQAC meeting.

SR stated that he is optimistic that if the Trust does not receive a positive response from Meditech, then the GDE team are looking to implement a positive solution by November/December 2017.

HG confirmed that an audit is currently being undertaken, with findings expected at the end of October 2017.

CQAC agreed that the Trust is in an improved position, due to the Sepsis team and staff working extremely hard to focus attention on ensuring an improved position.

AM confirmed that Sepsis would continue to be included on the CQAC agenda for a monthly update.

AM thanked GS for the update.

17/18/59 Transgender Patients

AH presented the Gender Identity briefing, together with the draft Standard Operating Procedure (SOP) and gender identity patient information leaflet. CQAC noted the background, risks and next steps within the briefing. HA sought comments regarding progressing this issue for staff and patient interests.

CQAC agreed that a package of education/focussed education and training would be beneficial, for groups of teams treating transgender patients. CQAC members emphasised concern regarding accepting this proposal and highlighted the risk should this recommendation be accepted.

All agreed that a separate offline discussion would need to take place to address this issue further and feedback would be provided at future CQAC meeting.

Action: HG/SR & HA to meet to discuss this issue further.

AM thanked HA for her update.

17/18/60 Research Annual Report

MP presented the Research Annual Report.

Key issues as follows:-
Three domains by which to provide a framework for future reports conversations on research at CQAC:

- Effectiveness
- Safety
- Quality Assurance

Effectiveness:

Association between research intensity/volume and improved clinical outcomes has moved from anecdotal to evidential.
Therefore mechanisms to increase research volume are key enablers in the improvement of one dimension of quality/effectiveness (clinical outcomes).
Also direct examples where individual research project/programmes directly evaluating health services delivery, eg, Transitional Care, Early Warning Scores

Safety:
Discernible lack of evidence which underpins the processes in the organisation which relate to safety. This was very apparent when developing the NIHR PSTRC bid and trying to extract meaningful data from the organisation on measures of safety and evidence for processes in place.

In the realms of research, there are some specific areas of consideration:
Mechanisms to ensure the safe delivery of research
Key role of the CRF and its safety processes

Quality Assurance:
The considerations generally relate to the available systems in place to monitor and audit research delivery and safety within the organisation, resource dependency and integration (where possible) with other corporate audit and monitoring systems.

- Systems to monitor safety and quality
- MHRA Inspection findings which relate to quality assurance (and sponsor oversight)
- Capacity within the CRD to provide adequate QA function and meet the needs/demands of investigators requiring AH sponsorship
- Getting equitable access to the Trust's clinical audit resource to support CRD audit and monitoring needs

MP stated that further discussion would be required to redress the balance regarding research support required going forward.

Chair thanked MP for update.

17/18/61 Feedback from MHRA Inspection

Lucy Cooper provided feedback following the recent MHRA inspection which took place over a three day period commencing on 26th September 2017 to review systems and processes, with focus on Clinical trials which the Trust had responsibility for. CQAC noted that there were no critical findings during the inspection. Three major findings were identified, with the domains of major findings relating to: quality assurance; sponsor oversight; drug (IMP) accountability. Two of these related to available capacity within the infrastructure, while one issue was relating to the Pharmacy Department's interpretation of the GCP legislation.

LC confirmed that appropriate documentation had been developed, and highlighted the need to formally delegate to discharge to consultants.

LC confirmed that the Trust is awaiting the report which is due to be produced 25 working days following the inspection, with plans for a further update to CQAC once report is available.

Discussion took place regarding research pathway and the benefits of a discussion with MP/Jenny Wood & Martin Levine, it was noted that it would also be beneficial to undertake an offline discussion regarding Research Strategy with appropriate personnel.

Action: MP to have offline discussion with appropriate personnel.

Chair thanked LC for her update.

17/18/62 Programme Assurance Progress update

JG presented the Programme Assurance Update.
The latest forecast is savings of £0.4m, which had not changed since the previous update and was very low, and not sufficient to meet the financial objectives of the programme. The only projects currently forecasted savings are Best in Operative Care and Experience in Outpatients.

Deteriorating patient – 'Sepsis' – this had been re-energised and was now reflected as 'Green'.

Outpatients – continues to provide a high level of documentary evidence giving a sound assurance rating.

Best in Acute Care - Draft PID had been uploaded, potentially moving to Amber.

Primary Care Streaming – Draft PID was now uploaded onto SharePoint, with ongoing work remaining to ensure that all sections are completed.

7 Day Services (including out of hours) – Documentary evidence had been uploaded onto SharePoint, however this hadn't moved from Red as of yet.

CQAC noted that Exec sponsors needed to ensure that appropriate evidence is uploaded onto SharePoint and to ensure that there is a renewed focus on accelerating the projects.

Discussions had taken place regarding project support and how support will be provided in the future.

Both J Grinnell & J Gibson are currently working on assurance rating mechanism, with the need to expedite capability to drive projects forward.

Chair thanked JG for his update.

17/18/63 Corporate Report – Quality Metrics

Patient Experience
There were 4 formal complaints in month i.e 31 year to date – which is similar to last years position. Cumulatively PALS attendance remained lower than last year, although 121 attendances in September was the highest of any month this year.

All in-patient survey measured had improved during the month, compared with last month. However 4 of these measures remain behind target. Friends and Family responses from A&E and Community still needed to be improved.

CQAC noted that N Barnes was developing a GDE digital pathway.

Clinical Effectiveness
There were 6 recorded hospital infections in September, i.e. 26 infections year to date compared with 51 at this time last year, MRSA and Clostridium difficile infections remain at zero for the year. There were 5 in month acute readmissions of patients with long term conditions within 48 hours of discharge, a slight improvement on the previous month. For surgical patients with an estimated Date of Discharge (EDD), 4.1% (72 patients) were actually discharged later than the EDD. This had worsened slightly compared to the previous month, but is an improvement when compared to the same period last year.

Patient Safety
Medication errors resulting in harm remained lower than last year (16 year to date versus 25 last year), although 7 reported in September is an increase against recent months. There was 1 pressure ulcer reported in month, increasing the year to date position to 23 (vs 16 last year). Never events remain at zero for the year. Clinical incidents with harm remained significantly higher at 464 compared to 296 last year. A deeper analysis is ongoing to explore if this is simply improved reporting, or if there are any trends or areas causing a real increase in harm. There were 4 incidents resulting in moderate or higher harm in September and 2 SIRIs declared in month taking the total to 12 for the year.

17/18/64 Safeguarding Annual Report
J Knowles presented the Safeguarding Annual Report

Key achievements details as follows:-

- Effective management of the Safeguarding Service and appropriate escalation to ensure the Executive Team are sighted on all significant Safeguarding issues.
- Being able to demonstrate through the CCG Quality Assurance process a level of 'reasonable assurance' with an upward trajectory noted. Adult Safeguarding was classified as 'green' across all areas and

demonstrates an overall improvement from an 'amber' rating for 2015 - 16. Children Safeguarding has also shown a marked improvement across the year with four areas being classified as 'green' and only three areas classified as 'amber'. There have been no 'red' areas classified since the Quarter One submission.

- Working towards and achieving full safeguarding training compliance (90%) across all levels as set by the CCG.
- Collaborating closely with the CCG to further enhance service delivery of the LAC & Adoption services.
- In supporting the Healthy Liverpool Programme, playing a pivotal role to further develop Early Help systems, focusing on a whole family approach with discharge planning at the point of admission and improved integration between Acute and Community Services.
- Contributing to the development of the Community Transformation Agenda to enhance the safeguarding of children and young people across Merseyside.

Priorities for the forthcoming year:

- Provide strategic leadership to Liverpool Community Health Trust's Safeguarding Service.
- Review Safeguarding Training Strategy to enhance the Training programme to reflect key learning from local and National guidance.
- Complete all actions identified within Safeguarding Operational Plan.
- Further develop the Digitalisation of Statutory Services to enhance patient care.
- Continue to work with Community LAC & Adoption services to streamline patient pathways.
- Actively participate in the Healthy Liverpool Programme to further develop Early Help systems to identify and support vulnerable families.
- Continue to contribute to the development of the Community Transformation Agenda to progress a model of integration between the Acute Tertiary Services and Community Services to meet the needs of children, young people and their families across the whole continuum of need.
- Achieve compliance with outstanding recommendations from the Lampard Action Plan.

Discussion took place regarding the Lampard report, and whether the Safeguarding Team could benchmark against other Trusts.

Action: JK agreed to benchmark against other organisations and feedback to ES.

Chair on behalf of CQAC expressed thanks to the Safeguarding team for tremendous work to date given the daily challenges that the department face.

AM thanked JK for her update.

17/18/65 Board Assurance Framework

ES presented the BAF, key issues as follows:-

- BAF 1.1. – 'Failure to maintain appropriate levels of care quality in a cost constrained environment', - gaps had been reviewed and actions would be in place to address this risk.
- BAF 1.2 – 'Failure to deliver on all mandatory and compliance standards due to lack of engagement with internal throughput plans and targets' – process remains ongoing. ES confirmed that the Trust had lodged a formal request to CQC for a ratings review for Acute and CAMHS, with the Trust having to submit an action plan to CQC by end of October 2017, further update would be given at CQAC.

AM thanked ES for her update.

17/18/66 17/18/67Clinical Quality Steering Group – Key Issues Report/Notes of CQSG meeting held on 8th August 2017

Rob Griffiths presented the Clinical Quality Steering Group key issues report:-

Quarterly Key Issues Report from Weekly meeting of harm:

- CQAC noted that Annual Safeguarding Report would be escalated to Trust Board for review.

- A full review of the resuscitation service had been completed including a full Trust wide learning needs analysis. A subsequent business case had been approved by Operational Delivery Board and recruitment into new posts had commenced.

- Proposal for new policy ratification', - to enable a subcommittee to be formed to ensure adequate time is spent on reviewing and ratifying policies. CQAC were happy to support this approach, providing that the correct membership for the sub-committee was in place.

Chair thanked RG for his update and fully acknowledge the extensive support provided by CQSG.

17/18/68 Any Other Business

None.

17/18/69 Date and Time of Next meeting

10.00 am – Wednesday 15th November 2017, Room 20, 2nd Floor, Institute in the Park

Alder Hey Children's NHS
NHS Foundation Trust

TRUST BOARD REPORT

MORTALITY ASSESSMENT AT ALDER HEY
Medical Director's Mortality Report

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

Section two is the Quarter 2 Mortality report which includes a review of statistical analysis in PICU and Cardiac Surgery, followed by more detailed analysis of the place of death, teams involved and specifics about expected v observed deaths.

Section 1: Report from the Hospital Mortality Review Group (HMRG) Jan-Dec 2017

It has been a busy quarter for the hospital mortality group and a period of change as discussed in the last report. We have worked hard to embrace changes following the document released in December 2016 – 'Learning candour and accountability: review of the way NHS Trusts review and investigate deaths". In March 2017, the National Learning from Deaths Guidance was released. The UK has gone from one of the lowest paediatric mortality rates to one of the highest. 24% of deaths are thought to be preventable.

The HMRG process has been updated accordingly:

1) Identification of children with Learning disabilities
2) Informing of the LeDeR team in Bristol of any child mortality with learning disabilities and the lead for learning disabilities joining the group
3) Engagement with the bereavement team to ensure the families are aware of the process and are able to engage if they wish to
4) Improvement of communications within the Trust e.g. availability of trauma reviews, RCA recommendations
5) Identifications of mortality leads throughout the Trust
6) Policy rewritten

There is considerable work to be done and we need to ensure that learning is communicated across the Trust.

Outputs of the new mortality review process for hospital deaths for 2017:

Summary table:

Number of deaths (Jan. 2017 – Dec. 2017)	61
Number of deaths reviewed	37
Departmental/Service Group mortality reviews within 2 months (standard)	37/52 (71%)
HMRG Primary Reviews within 4 months (standard)	24/36 (67%)
HMRG Primary Reviews within 6 months	31/36 (86%)

There has been a considerable improvement in the primary reviews completed by the group (within the standard - 4 months), since the last report. The group has held 2 extended meetings to ensure that we cleared the backlog before winter. The figure in the table shows 67% but the performance is even better with 3 further cases having their reviews completed within 4 months. However, due to circumstances outside the group's control these cases have not been presented yet. If these were included in the figures HMRG would have completed would be 75%.
Now that paper notes are available this has made a significant difference to the reviewers, enabling the reviews to be done in a timely manner.

The outstanding cases are due to:

1) Cases awaiting coroner's inquest

2) RCA's waiting to be fed back to the clinicians/teams involved prior to discussion at HMRG

3) The group agreed that no case should be complete (preliminary discussions can be held) until all investigations involving the child are completed either internal or external.

Month	Number of Inpatient Deaths	HMRG Review Completed	Dept. Reviews within 2-month timescale	HMRG Reviews within 4-month timescale	HMRG Reviews within 6-month timescale	Discrepancies HMRG – Dept.	HMRG Review – Death Potentially Avoidable
Jan	4	4	4	0	3	2	3
Feb	5	5	5	4	5	2	
March	9	7	7	4	7	3	1
April	7	6	6	6	6	3	
May	4	4	4	4	4	1	
June	7	6	6	6	6	1	1
July	5	3	3	3	3		
August	6	2	2	1	1	1	
Sept	5						
Oct	9						
Nov							
Dec							

Discordant conclusions of the HMRG vs Departmental /Service Group Reviews

Since the previous mortality report there have been 13 cases where there have been discrepancies between the service group and the HMRG review.
In 9 cases the care was changed from adequate care to aspects of clinical care or organisational of care could have been better. In 3 cases the care was rated as higher than the service group review in 2 it was altered to examples of good practice.

In 4 cases the care was rated as adequate on the service review but the HMRG review assessed the care as aspects of care were less than adequate and different management would not be reasonably be expected to have altered the outcome. In 1 of the cases the care was rated by the service review that aspects of the care provided were less than adequate, and different management may have altered the outcome whereas the HMRG decided different management would not reasonably be expected to have altered outcome.

Potentially modifiable factors and actions

Since the last Trust Mortality Report there have been 4 in -hospital deaths where there are factors which may have played a role in the child's death:

1) The first one was a patient who had a complex underlying congenital heart condition and had multiple operations. After recent planned surgery the patient was admitted to PICU with intense cardiac support then renal support. Despite this there was continued to deterioration due to infection which was extremely resistant to a number treatments both. There were concerns about his neurology and MRI scan showed ischaemia. Over time there was no improvement despite all supportive treatment and the patient continued to

slowly deteriorate. Therefore, the decision was made with the full agreement of the family to withdraw care.
There had been a delay to the operation due to personal circumstances. The use of prophylaxis was discussed but in this case, would have made no difference due to the resistance of the organism grown.

2) A preschool child who was transferred by HEMS, following a severe traumatic brain head injury. Patient was discovered unresponsive following a fall from a first-floor window. Patient was take to the local hospital where patient was intubated, ventilated and underwent a CT scan which showed a large occipital fracture, intracranial contusion, haemorrhage and oedema. There was no local PICU bed available and thus Patient was transferred to AHCH. Patient was extremely unstable and had a low haemoglobin on arrival. Patient had EVD inserted but repeat scans showed that brain damage was worsening and Patient was treated medically on PICU with all possible treatments instituted. Unfortunately, Patient continued to deteriorate and the decision was made with the parents' full agreement to withdraw care but organ donation was made.
The inquest is still outstanding. The death is avoidable because Patient fell out of a window which could have been preventable.

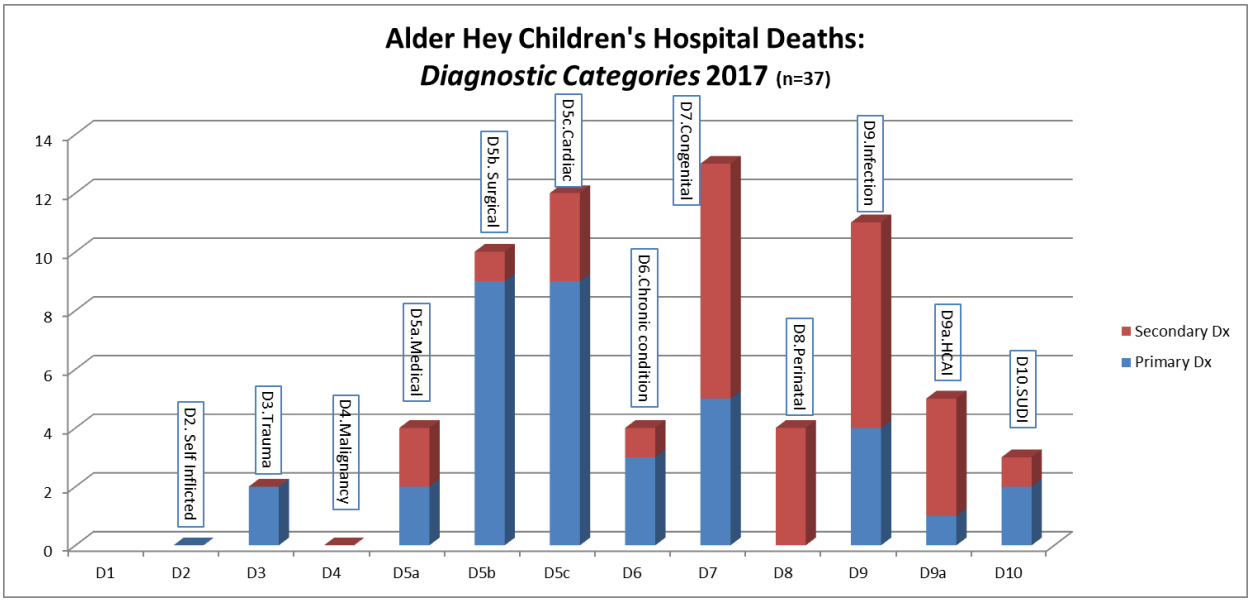
3) A patient died from a severe hypoxic ischaemic brain injury following a cardiac arrest at home. Patient had a 2-day history of very severe blood-stained diarrhoea and vomiting. The father found the patient breathing 'differently' and unresponsive. Patient had a 'massive' vomit and a respiratory arrest. The father started CPR and this was continued by the paramedics till arrival at hospital then transferred to AHCH but remained extremely unwell and pupils became fixed and dilated soon after arrival. CT showed severe ischaemia and the prognosis was extremely poor. There was discussion with the family and care was withdrawn to let the patient die peacefully.
Post mortem described the cause of death as acute haemorrhagic colitis of infective aetiology with electrolyte imbalance. No organism was identified.
HMRG identified this as a potentially avoidable death because when the patient arrived at the DGH electrolytes indicated renal failure highlighting the possibility that the patient may have been unwell for longer than thought. There were no underlying medical conditions.

4) A primary school age child with a complex neuromuscular disorder, was referred to AHCH for elective complex surgery. Unfortunately, there was a cardiac arrest with prolonged CPR during surgery. Despite findings consistent with a major hemorrhage requiring blood products no actual evidence of bleeding was found. The patient went to PICU

and had a CT of the brain which showed severe ischemia. Pupils were fixed and dilated and after discussions with the family the decision was made to withdraw care. There was an RCA because there were concerns raised that the child's deterioration post op had not been completely recognized by all members of the team. The post mortem showed that the child had a significant underlying cardiac abnormality and there was no evidence of any significant bleed.

Primary Diagnostic Categories

The chart below shows the deaths by primary diagnostic/disease category.



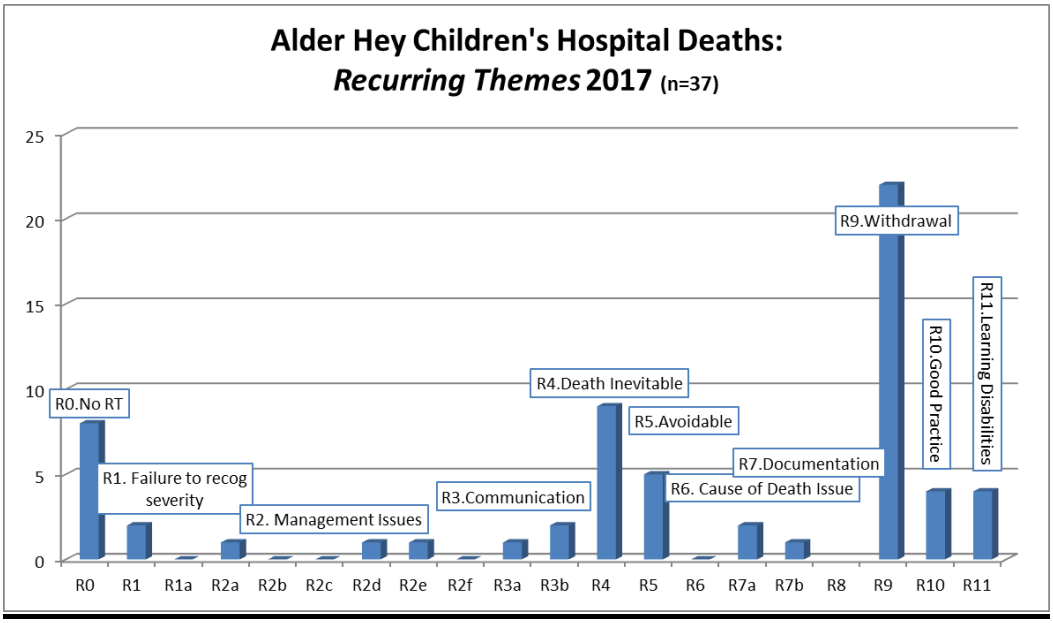
Diagnostic/Disease Categories (based on CEMACH categories - ref. *Arch Dis Child* 2011;96:922-6 + 927-31)

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

The commonest cause for deaths so far in 2017 are cardiac and surgical conditions both with 24%. This is not surprising as a number of children attend AHCH for full cardiac assessment and then are found to have inoperable conditions or have very significant lesions.

This is similar for the surgical cases as not infrequently premature babies are referred to AHCH for assessment of their NEC (necrotising enterocolitis - a condition which affects premature babies' gut). Sometimes they can be operated on but often they are too unstable and are managed conservatively or unfortunately die soon after their operation. There have been frequent discussions within the HMRG as to whether these children should be referred and transferred to AHCH but the teams involved carefully assess which children they accept and of course as a group we only see the children that unfortunately don't make it**.**

Primary Recurrent Themes



Recurring Themes

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

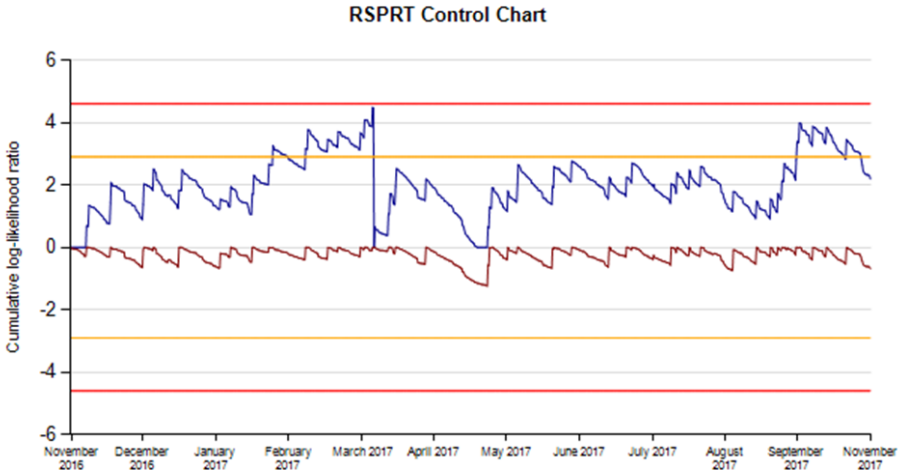
The commonest theme is withdrawal of care which is 59% which shows that we are being proactive and with the full agreement of families ensuring that children die as comfortably as possible and with dignity. Next highest, theme is death is inevitable before admission which was the case in 24% of cases. We identified 4 (11%) of the children with learning disabilities which is now a requirement as a Trust.

Section 2: Quarter 2 Mortality Report: July 2017 – September 2017

1) Statistical analysis of mortality:

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

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



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

This data is nationally validated because generated by PICANet.

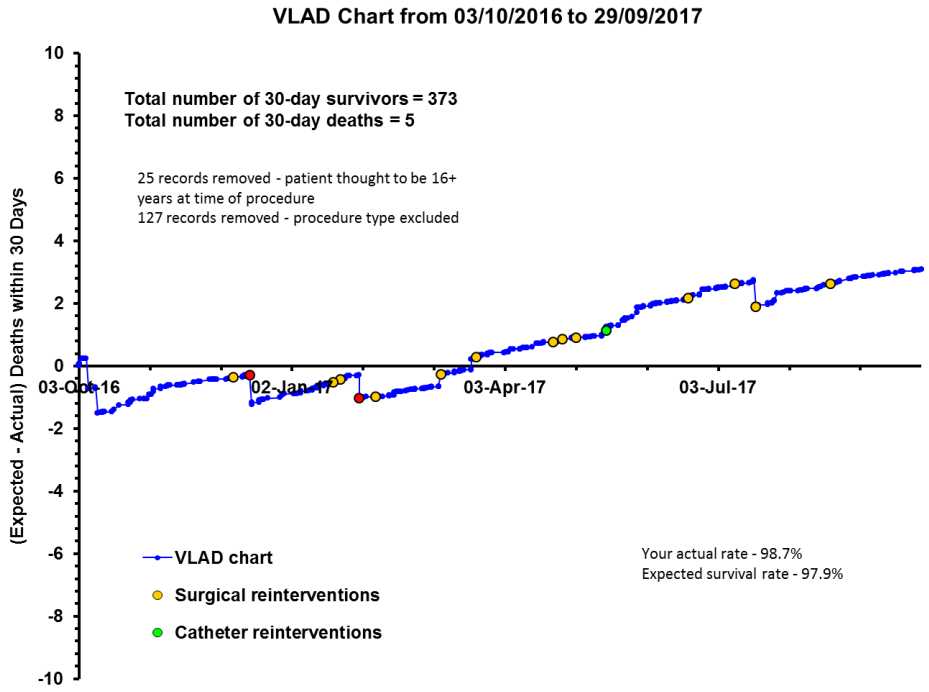
In the above RSPRT chart from Nov 2016 to Nov 2017- RSPRT resets in mid-March 2017 but since April 2017 has remained in the 'safe zone' until Sep 2017. We had n= 6 deaths in March 2017 and all the deaths have occurred in the patient group who belonged to "Death inevitable on PICU admission" in retrospect- (n=3 Out of hospital cardiac arrest, n=2 Preterm VLBW neonates with NEC + MOSF , n=1 Restrictive cardiomyopathy + MOSF). The second peak occurred between September and October where we had n=13 deaths. One death was of that a child with fulminant meningococcal sepsis who had refractory shock who died despite Extra-corporeal life support (ECLS). Rest of the n=12 deaths occurred in the patient groups who belonged to "Death inevitable on PICU admission (in retrospect) and Co-morbidities which have

obviously impacted on the SPRT trends. All PICU deaths + RSPRT trends are discussed in the following month and monitored regularly.

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

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

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

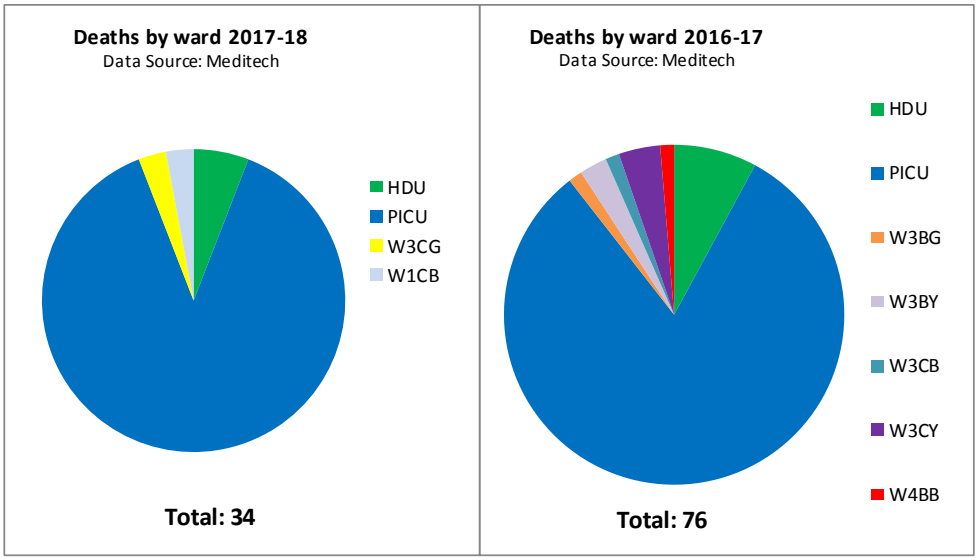


The VLAD chart above shows mortality is occurring lower than expected for the twelve months from October 2016 to September 2017. The survival rate at 30 days was 98.7% against an expected rate of 97.9%.

2) Real time monitoring of mortality

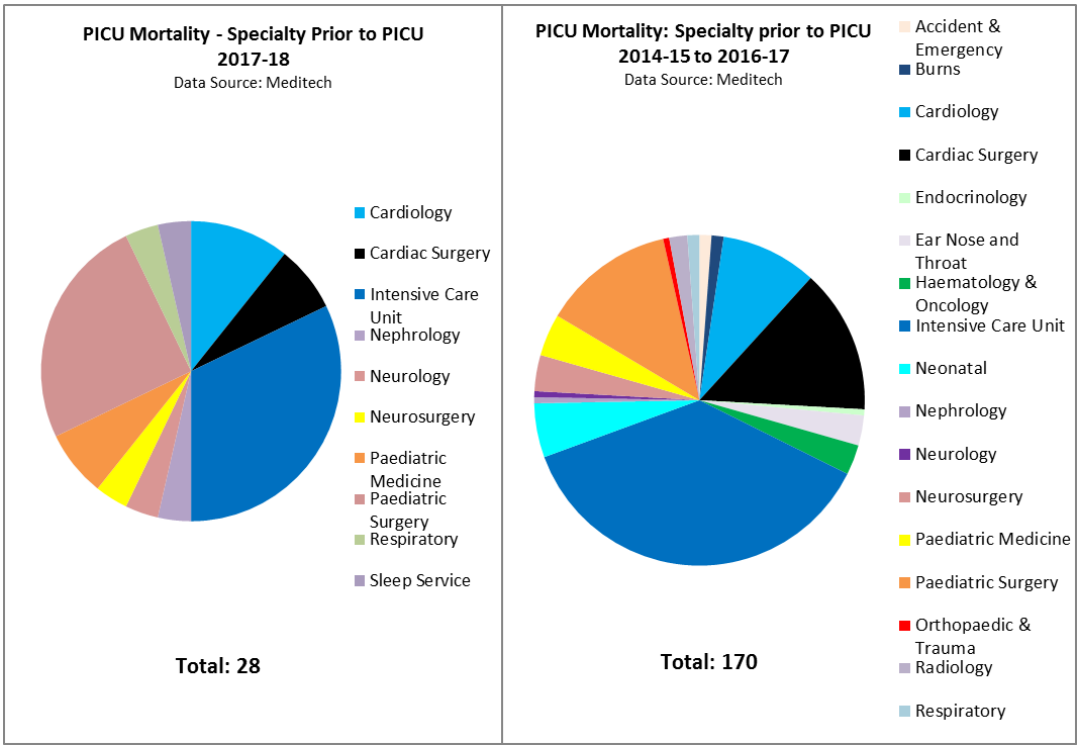
Mortality is now being monitored in real time and analysed by year, ward, specialty, deaths within 30 days from admission and over 30 days from admission.

i) Below are the charts showing mortality by ward for 2017-18, and the previous year 2016-17.



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

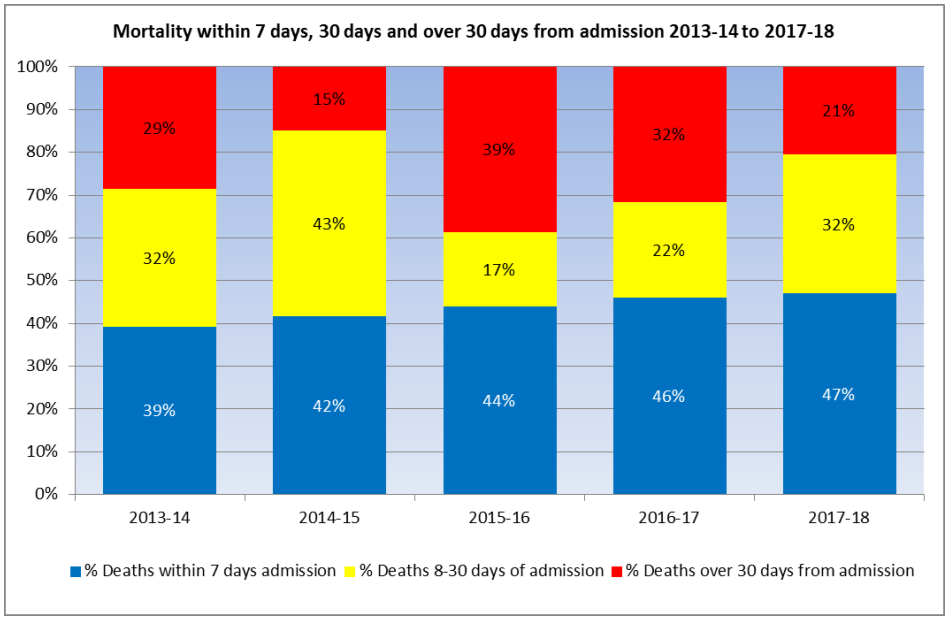
ii) Below are the charts showing mortality by specialty prior to PICU for 2017-18, and the previous 3 years 2014-15 to 2016-17.



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

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

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



The chart shows that usually the highest percentage of deaths occurs within 7 days of admission, around 40-44% of deaths occur within this time frame. In the current year 47% occurred within 7 days of admission, 32% occurred within 8-30 days from admission, and 21% deaths occurred over 30 days from admission.

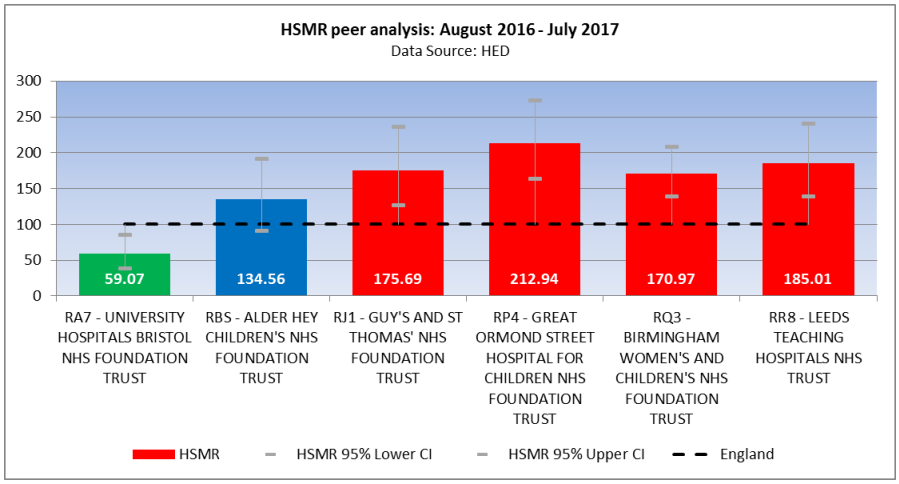
3. External Benchmarking

a) Hospital Standardised Mortality Ratio (HSMR) – HED

HED allows the Trust to monitor and benchmark a number of hospital performance indicators including mortality. The HSMR is the ratio of the observed number of in-hospital deaths divided by the number that is expected, and is based on 56 diagnoses. Although the scores are based on a basket of diagnoses that are more commonly found in adults, it allows a comparison of the performance of Alder Hey against other Trusts.

The peer group Alder Hey will be assessed against are Trust's with a similar patient case mix. This is still a work in progress. On this occasion we have included Trusts with comprehensive children's services including cardiac surgery. Patients aged 0-17 years have been selected to ensure adults are excluded from the HSMR. All specialties are included; therefore those Trusts with Neonatal Units may have a higher relative risk of mortality than expected. The Trust with the closest profile to Alder Hey is Birmingham Children's Hospital. Guys and Leeds both have neonatal units. It is not clear what Bristol include in their submitted data.

The chart below compares HSMR for Alder Hey against its peers for the period August 2016 to July 2017.

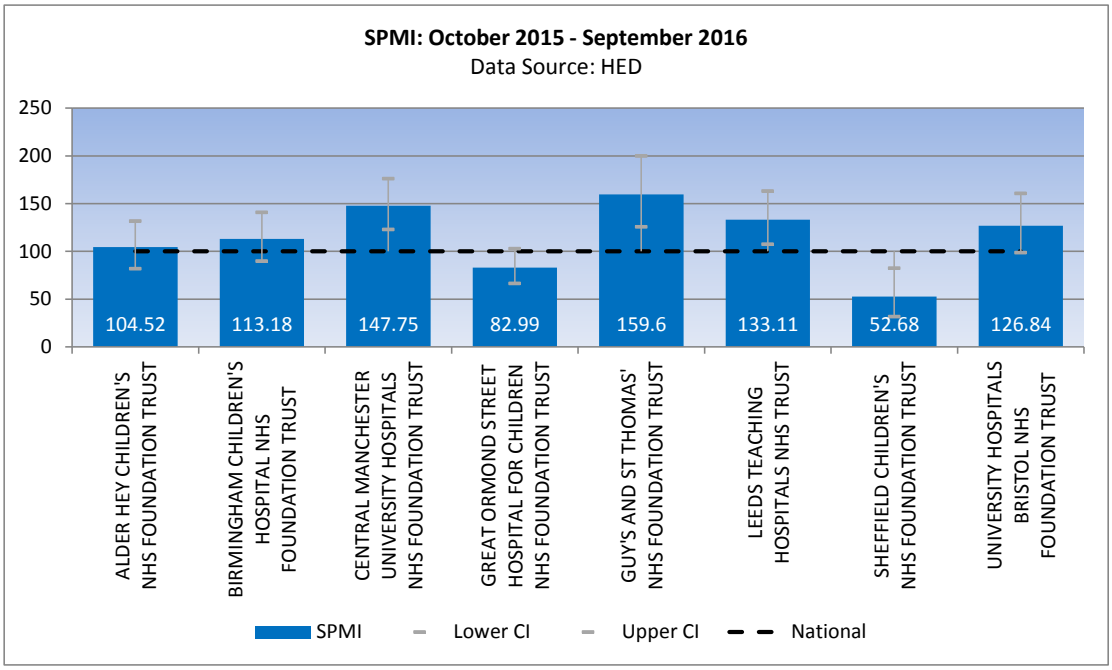


A figure of 100 means that the outcome is completely expected compared to England. A figure greater than 100 indicates the risk of the outcome is greater than expected. A figure less than 100 indicates the risk of the outcome is less than expected.

The above chart shows that the relative risk of mortality for Alder Hey was higher than expected compared to England, as were the peer group with the exception of University Hospitals Bristol NHS Foundation Trust.

Statistically significant higher than expected compared to England

HED has developed a Standardised Paediatric Mortality Index (SPMI); this is a paediatric specific ratio of the observed to expected in-hospital deaths (multiplied by 100). A value of greater than 100 indicates higher mortality level than the average NHS performance, and a value of less than 100 indicates lower mortality level. The expected deaths are calculated from logistic regression models with a case-mix of: age, sex, ethnicity, trust type, emergency surgery flag, chronic condition flag, paediatric risk category, paediatric life-limiting conditions flag and diagnosis group. Diagnosis groups where there are less than 10 death events are excluded from the model. Children up to and including the age of 15 are included. The model is available in pre-release and the most recent data available is for the period 1 October 2015 to 30 September 2016.



The chart shows that Alder Hey has a higher mortality level than the average NHS performance with 72 deaths against 68.9 expected deaths.

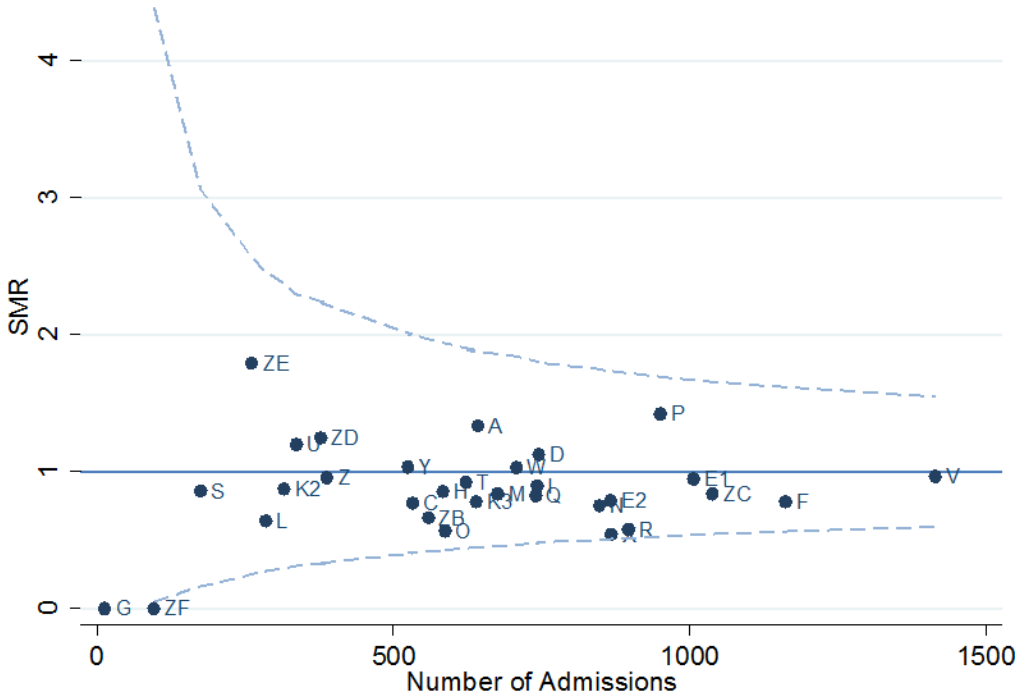
b) External benchmarking against comparator organisations for specific patient groups in addition to HED.

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

PICU

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

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



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

Conclusions

This has been a busy time for the HMRG and everybody has worked hard to clear the backlog and we are now reviewing the cases within the 4-month target that we set ourselves as a standard for the first time in about 2 years.
The mortality reviewing process is undergoing changes within the Trust and we need engagement across all teams with the appreciation that it is a vital part of our roles to review each child's death and learn from it.

The learning is the aspect that we need to focus on next to ensure that the learning we gain from each death is disseminated across the Trust in an effective and consistent manner. This is a significant challenge to achieve but otherwise the rest of the process of reviewing deaths is diminished.
The National Guidance for reviewing paediatric mortality cases has just been released and it is now possible to feedback on it and we are involved and will need to see how it impacts on what we have established and are trying to achieve.

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

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

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

Alder Hey Children's NHS
NHS Foundation Trust

IPC REPORT
Current Q3 2017-18
(1st April – 27th November 2017)

This report provides the Board with the challenges for delivery of the Infection Prevention & Control Work Plan 2017-18.

Table 1 shows the total number of hospital acquired bacteraemia each quarter.

Bacteraemia	Q1	Q2	Q3 (up to 27/11/2017)
MRSA	0	0	2 (PICU,3C)
MSSA	3 (HDU,PICU,3A)	4 (1C, 1C, 4B, PICU)	2 (3C,3B)
E.coli	1 (1C)	1(PICU)	2 (1C,3C)
Klebsiella	1 (1C)	0	3(4B,4B,3C)
Pseudomonas	0	1 (HDU)	0
Outbreaks	0	0	2

Table 1: Hospital acquired bacteraemia 2017-18

2 outbreaks were identified in November 2017:

- A measles outbreak, 8 cases identified all admitted from the community. 1 potential hospital acquired case (staff member).
- Norovirus outbreak, 19 patients and 11 staff affected (no specimen confirmation).

As of November 27th 2017 **72%** (60/83) of the total of deliverables have been completed. **27%** (22/83) of the total deliverables are in progress (amber). **1%** (1/83) classified as red. Please see table 2 below for RAG rating and table 3 shows the deliverables classified as red.

At the beginning of October 2017 a new objective was added, ***objective number 12 – Gram negative bacteraemia***. The objective includes 7 deliverables therefore taking the number of deliverables to 83 in total.

Reporting Period	No of objectives	No. of deliverables	Red	Amber	Green
Q1	11	76	8% (6)	39% (30)	53% (40)
Q2	11	76	3% (2)	34% (26)	63% (48)
Q3 (up to 27/11/17)	12	83	1% (1)	27% (22)	72% (60)

Table 2: Deliverables RAG rating

Table 3: Current Red Objectives

Objective	Plan & Priority Activities 2017-18	Lead Member	Deliverable	Q1	Q2	Q3	*Comments*
IPC Staffing	IPC Doctor – Consultant Microbiologist	Dr Richard Cooke (RC)	RC retired July 2017, appoint new DIPC				***Q1*** *- Current IPC Dr to retire in July 17, position advertised but not filled.* ***Q2*** *- Current IPC Dr has retired, no IPC Dr in place (on risk register). Post currently being advertised as of 30/09/17.* ***Q3*** *- No appointment for IPC Dr post.*

Alder Hey Children's NHS
NHS Foundation Trust

Infection Prevention & Control Annual Work Plan 2017-2018

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

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

Alder Hey Children's NHS
NHS Foundation Trust

Infection Prevention & Control Annual Work Plan 2017/18

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
1. IPC Staffing								
IPC Code: 1,3,4,8,9 **Trust Values:** Excellence Togetherness	DIPC – Consultant Microbiologist	Dr Richard Cooke (RC)	RC to retire July 2017, appoint new DIPC					***Q1*** *- Current DIPC to retire in July 17, position advertised but not filled.* ***Q2 -*** *Current DIPC has now retired Dr Steve Ryan to take on post of Interim DIPC. Post to be revised and re advertised in September.* ***Q3 –*** *No appointment for Microbiology Consultant post. Steve Ryan continues as Interim DIPC.* ***Q4***
	Interim DIPC	Dr Steve Ryan (SR)						
	IPC Doctor – Consultant Microbiologist	Dr Richard Cooke (RC)	RC to retire July 2017, appoint new DIPC					***Q1*** *- Current IPC Dr to retire in July 17, position advertised but not filled.* ***Q2 -*** *Current IPC Dr has retired, no IPC Dr in place (on risk register). Post currently being advertised as of 30/09/17.* ***Q3*** *- No appointment for Microbiology Consultant post.* ***Q4***
	Associate DIPC	Val Weston (VW)						
	Lead Nurse IPC	Jo Keward (JK)						
	IPC Specialist Nurse (Band 7)	Claire Oliver (CO)						
	0.4 Surgical site Specialist nurse(Band 7)	Lisa Moore (LM)						
	0.6 IPC Data Analyst (band 5)	Carly Quirk (CQ)						
	Clinical assistant (band 3)	Vickie Lam (VL)						

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	PA/Admin assistant (band 4)	Post Vacant						***Q1*** *- Associate DIPC in discussion with finance and Chief Nurse with regards to this post.* **Q2** *- Admin hours have been sourced to assist with the flu campaign. Discussion ongoing with regard to permanent post.* **Q3** *– Post awaiting authorisation.* **Q4**
	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 December 2016.	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							

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Trust to report a variety of pathogenic organisms/ infections to PHE for monitoring purposes							
	MRSA/ MSSA/VRE/E.coli Bacteraemia	Microbiology, IPC Team and a 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.					***Q2*** *- Meeting held to review RCA documentation and process for ECOLI bacteraemia. Ongoing whole health economy meetings, following new guidance from NHS England, continue to discuss actions and way forward for ECOLI strategy – associate DIPC attending relevant meetings.* ***Q3*** *– Invited to North West Alliance next meeting 30th November 17. PIR bacteraemia process now in place.*
	Clostridium difficile/PTP	Microbiology and IPC Team	To identify, communicate and instigate investigations by the clinical teams for all cases. All cases to be reviewed under the Post Infect Review (PIR) and Root Cause Analysis (RCA) processes, through a Review Panel and to disseminate lessons learned for the process and actions required and monitored. To instigate an incident meeting with					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			clinical team for all hospital acquired cases. Disseminate lessons learned for the process and actions required and monitored.					
	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.					***Q2** – Business case in development for rapid PCR testing, to improve identification of cases and speed up screening results, to be presented at the next IRG Meeting. Rapid testing will facilitate appropriate cubicle utilisation, improve patient flow and the winter planning process.* ***Q3** – Awaiting progress*
	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					**Q1 –** To encourage greater ownership of surgical site infection data by specific teams. **Q2 –** *First SSI action plan meeting took place 21/08/2017. Second meeting to be held16/10/2017. Now incorporated into Theatre Safety Board.* **Q3 –** *Engagement from team has meant that no data no data was submitted for this quarter. Meeting to be arranged to discuss a way forward.* **Q4**

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			required and monitored.					
	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.					
3. Hand Decontamination								
IPC Code: 1,2,4,5,6,7,8 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Development of new hand hygiene posters for all clinical areas to update the hand hygiene process by incorporating the washing of the wrist area.	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Development of new hand hygiene poster incorporating further steps of hand hygiene					**Q1** – *The need has been identified to update hand hygiene posters and work has begun on exploring how this can be done with hand hygiene company.* **Q2** – *Meetings continue whilst roll out of new hand hygiene products continues.* **Q3** – Hand hygiene posters now available. **Q4**
	Introduction and dissemination of new hand hygiene posters for all clinical areas.	IPC Team & link nurses	New Hand Hygiene Posters to be distributed and displayed					**Q1** – *The need has been identified to update hand hygiene posters and work has begun on exploring how this can be done with hand hygiene company.* **Q2** - *Meetings continue whilst roll out of new hand hygiene products continues.* **Q3** – *Roll out commenced.* **Q4**

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Piloting and introduction of new hand hygiene audit technology incorporating PPE	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Pilot commenced on PICU/HDU feedback positive.					**Q1 –** *Regular feedback to ward staff and medics with current results and highlighting areas of improvement. Certificates for staff identified.* **Q2 –** *Plan to roll out successful pilot into other areas within the hospital.* **Q3 –** *Commencement of roll out to begin this quarter.* **Q4**
		CO	Capturing PPE usage and education to staff re usage on PICU/HDU.					**Q1 –** *Pilot capturing of PPE use to commence July 2017.* **Q2 –** *Awaiting trial of technology from outside company.* **Q3** *- Awaiting trial of technology from outside company.* **Q4**
	Introduction of non-compliance proforma	CO/AF/ST	Management of non-compliance with hand hygiene.					**Q1 –** *Pilot commenced on PICU* **Q2 –** *Non-compliance proforma now being used within PICU.* ***Q3*** *-*
	Introduction of new hand hygiene audit technology as part of monthly audit indicators	Lead Infection Prevention & Control Nurse, IPC Team& link nurses	Dissemination of new hand hygiene audit technology to link personnel through meetings and training					**Q1 –** *Dissemination to link personnel.* **Q2** *- Agenda item at link nurse study day 30/10/17. Considering other hand hygiene app technology.* **Q3 –** *To commence roll out in other areas of the Trust. Areas to be identified.* **Q4**
	Introduction of hand hygiene technique assessment on an annual basis for all clinical staff.	IPC Team& link nurses IPC Team & IPC link nurses & ward managers	IPC Team to train link nurses, link nurses to assess staff. Ward manager responsible for ensuring that staff are trained and records are kept.					**Q1 –** *Training sessions have commenced further sessions planned for Q2.* **Q2 –** *Some areas commenced annual assessment. Will be incorporated in the ANTT annual assessment for trained staff.* **Q3 –** *Introduction of Sure Wash technology by new hand hygiene company.* **Q4**

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Hand hygiene awareness week	JK	Develop PID					**Q1 –** *Development commenced.* **Q2 –** *Hand hygiene summit held 19/10. Plan developed to involve patients and improve children's hand hygiene to include development of posters and films.* **Q3 –** *Talks about a new hand hygiene patient initiative continue with hand hygiene company.* **Q4**
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.					**Q1 –** *To review policies for the year and develop policy programme.* **Q2-** *Policies reviewed and updated as necessary via IPC team meetings. During August IPCC meeting the following policies were approved ;Data & Surveillance Policy, Control of Aspergillus Policy and Urinary Catheter Policy. Remaining updated polices will be reviewed at Oct IPCC.* **Q3 –** *CJD Policy, Packaging and handling of specimens policy, Linen Policy, ANTT policies and guidelines approved at October IPCC. Measles policy to be approved at December IPCC.* **Q4**
	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					
5. ANTT								
IPC Code: 1,2,3,4,5,6 & 9	Monitor Trust wide compliance and increase	Sara Melville(SM) (IV team lead)	Provide updated compliance figures to the relevant care					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
Trust Values: Excellence Openness Respect Together Innovation	compliance rates.		groups and for IPCC.					
			Include ANTT compliance scores in IV Newsletter and IPCC Report.					**Q1** – *To develop a system for monthly IV Newsletter for ANTT compliance.* **Q2** – *Compliance scores now included.*
	Update current ANTT Policy	SM/Associate DIPC/ CO/ ZB	Review new guidelines and update policy and procedures to reflect this.					**Q1** – *All new evidence based standards reviewed.* **Q2** – *Policy updated sent to IPC team for comment prior to approval at IPCC in October 2017.* **Q3** – *Now ratified.*
	Review role and responsibilities of Link Nurses.	SM/IV team	To review role and responsibilities of Link Nurses.					**Q1** – *To await review and update of current ANTT policy.* **Q2** – *Discussions have been commenced on the role and responsibilities of the link nurses in line with new ANTT policy.* **Q3** – *Now incorporated into key trainer role.* **Q4**
	Provide Key Trainer training.	SM	Key trainer training days are provided are provided 4 times per year.					**Q1** – *To develop key trainer programme. To await review and update of current ANTT policy.* **Q2** – *ANTT key trainer sessions are organised for 9th October, 3rd and22nd November and 4th December. We need to organise updates sessions quarterly for key trainers for next year.* **Q3** – *Key trainer dates set for 2018.*
	ANTT stickers for yearly compliance.	SM	ANTT stickers to be provided for all staff following ANTT training and compliance.					**Q1** – *Discussions have taken place with B Braun to provide ANTT stickers.* **Q2** –*ANTT Stickers from bbraun are on order and should arrive soon.* **Q3** – *Now being distributed*.
	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** – *To attend ANTT conference and IV forum updates* **Q2** – *SM attended North West IV Forum meeting at Alder Hey 26th September 2017.* **Q3** – *Next meeting 5th December.*

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
6. Training								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	To ensure that IPC staff and kept updated with IPC evidence based practice.	Lead IPC Nurse	To ensure that a member IPC Team the North West Infection Prevention Society (IPS) meetings at least once per year.					**Q1 –** *To ensure that a member of the IPC team attends IPS meetings at least once per year.* **Q2 –** *Lead nurse to attend next IPS North West meeting at Whiston Hospital.* **Q3 –** *Team unable to undertake due to demand on the service. However a member of the team did attend the annual IPS national conference.*
		Associate DIPC	To regularly attend local HCAI whole health economy meetings.					**Q1 –** *Explore area in whole health economy where Alder Hey can participate.* **Q2 –** *Associate DIPC has attended ECOLI bacteraemia meeting held at Liverpool CCG.*
		Associate DIPC/Lead IPC Nurse	To attend local and national IPC/relevant conferences as the service will allow					**Q1** **VW** has attended; *3M IV Global Leadership summit, EWMA and the 3M North West IV Forum – Speaker.* ***JK** has attended HIS Spring Meeting and Don't panic conference.* ***CO** has attended the 3M North West IV Forum* **Q2 –** *Members of IPCT to attend IPS National conference. 3M North West IV Forum meeting to be held at Alder Hey September 2017.* *VW to attend CLABSI's National Round Table 22nd August 2017.* *VW is to present at All Wales Advancing Vascular Access and OPAT Conference.* *JK to attend Paediatric Infectious Diseases study Day, Manchester, September 2017.* *CO attending H&S Executive Mask fit testing course July 2017.* **Q3** - *VW presented at; 3M National IV Leadership Summit, National IPS IV Forum Conference, Oxford IV Therapy Day. LW has attended One Together Study Day in Birmingham.*

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
								Q4
		Lead IPC Nurse	To attend Vaccinator training or undertake on line update					
	To ensure that Trust staff are kept updated with IPC evidence based practice: Please see plan below.							
	Induction	Lead Nurse IPC/CO	At least once per month					
	Mandatory	Lead Nurse IPC/CO	For all clinical staff yearly (monthly sessions) & work book Non-clinical 3 yearly – work book					***Q2**- Lead nurse has updated both clinical and non-clinical workbooks- August 2017.*
	ANTT Key Trainers	SM						**Q1** *– To develop key trainer programme. To await review and update of current ANTT policy.* **Q2** *–ANTT key trainer sessions are organised for 9th October, 3rd and 22nd November and 4th December.* **Q3** *– Training sessions scheduled for 2018.*
	Volunteer IPC Training	CO/VL	Quarterly					
	Hotels Services IPC training	VL	At least once per quarter					**Q1** *– Meetings have taken place with hotel services and a programme is to be developed for IPC training for all hotel services staff.* **Q2** *– Presentation developed and awaiting dates from Hotel Services Leads for delivery. Dates arranged to commence Oct 2017.* **Q3** *– Training has now commenced.* **Q4**
	Link Personnel	IPCT	Bi-monthly					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Fit Testing Key Trainers	CO	Annually					**Q1** – *New IPC lead appointed attending training June 17.* **Q2** – *Fit testing training programme commenced.* **Q3** – *Fit testing continues as capacity allows.* **Q4**
	Flu vaccinator Training	Lead Nurse IPC	Annual (4 sessions per year)					***Q2*** *– Vaccinator update sessions commenced and will be completed end of September 2017.*
	Ad hoc training	IPCT	As required					
7. 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. IPC Audit programme Medical Divison 2017 Surgical divison audit programme Aug revis	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 monthly report and the IPCC. All lessons learnt are disseminated To the relevant staff and other agencies as Appropriate in a timely manner.					**Q1** – *Due to appointment of Associate DIPC (commenced May 17) audit programme temporarily delayed.* **Q2** – *New monthly spot check audits developed and trialled. Roll out to commence September 2017.* *IPC Leads for each division to attend risk and governance meetings to discuss results.* **Q3** – *Development of an IPC dashboard which will incorporate IPC monthly audits, domestic audits and estates and facilities audits. These will be commenced on a monthly basis and discussed at risk and governance meetings and IPCC.* **Q4**

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
8. Antimicrobial Prescribing								
IPC Code: 1,3,4,5,6,7 & 9 **Trust Values:** Excellence Openness Respect Together Innovation	Antimicrobial Stewardship (AMS) ward rounds	Antimicrobial Pharmacist	Appointment of replacement Antimicrobial Pharmacist					**Q1 –** *Interviews for the post taking place June 2017.* **Q2 –** *New Antimicrobial Pharmacist commenced September 2017.*
			AMS ward rounds (x3/week)					
	AMS Committee meetings		AMS Committee (meet at least quarterly)					
			Introduce mandatory AMS training package					**Q1 –** *Need for AMS training package to be developed.* **Q2 –** *Meeting to be arranged.* **Q3 –** *Associate DIPC to discuss with antimicrobial pharmacist and AMR lead for the Trust.* **Q4**
9. Communication								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Respect Together Innovation	IPC bi-monthly report	JK	IPC bi-monthly report disseminated to medical and nursing staff.					
	Communication with the Whole Health Economy	VW	To attend HCAI/IPC meetings across the local area.					**Q1 –** *Explore area in whole health economy where Alder Hey can participate.*
	Communication with other Trusts and agencies such as Public Health England (PHE)	IPCT	To attend local meetings. Communication and information gathering with other Trusts and agencies to assist in IPC investigations.					
	Update IPC intranet page	CQ/VL	To attend Trust Intranet training. VW to identify a lead to update intranet. This is a restriction presently due to					**Q1 –** *Not attended intranet training due to capacity in IPC (admin vacancy).* **Q2 –** *Lead established. Training completed intranet page currently being updated.*

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
			the admin vacancy.					**Q3 –** *Intranet page updated*
10.Information Technology								
IPC Code: 1,2,3,4,5,6,7,8,9 & 10 **Trust Values:** Excellence Openness Innovation Together	Enhance use of Meditech	JK/IPCT	Exploration of Meditech system with PA. Develop a plan of where we are now with our process uses Meditech and a plan of where we would like to be.					**Q1 –** *First meeting has taken place in May 17. IPC Lead nurse and Team to map out requirements.* **Q2** *- Requirements now mapped out need to schedule next meeting.* **Q3 –** *Discussion has taken place to develop an electronic alert system as part of this work. Awaiting development.* **Q4**
11.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.	IPCT						**Q1 –** *Due to appointment of Associate DIPC (commenced May 17) audit programme temporarily delayed.*
	Escalate issues to DIPC as necessary.	Associate DIPC	Regular meetings with DIPC					**Q1 –** *Weekly meetings with current DIPC. Further meetings going forward on a 2 weekly basis with new DIPC.* **Q2 –** *2 weekly meeting continue between DIPC and Associate DIPC.*
	To review new equipment /environmental utilisation	IPCT	Ad hoc meetings as required.					**Q1 –** *Meetings are attended as requested however at times IPC are not informed.* **Q2 –** *IPCT now invited to new procurement meetings, building services and Interserve meetings.*
	Decontamination	Lead Nurse IPC Associate DIPC to attend as required.	To attend scheduled meetings. To provide expert advice and support as required.					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	Water Safety	Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Health & Safety/IPC/Interserve & Building services	Associate DIPC/ Lead Nurse IPC	To attend scheduled meetings. To provide expert advice and support as required.					**Q1** – *Request to attend these meetings has been made awaiting date of first meeting.* **Q2** – *VW attends these meetings*
	Hotel services	Lead Nurse IPC Associate DIPC to attend when required.	To attend scheduled meetings. To provide expert advice and support as 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.					**Q1** – *Due to appointment of Associate DIPC (commenced May 17) Lead Nurse has been unable to attend recently.* **Q2** – *JK attends these meetings*
	Integrated Governance Committee	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
	Medical Devices Committee	DIPC/ CO	To attend scheduled meetings. To provide expert advice and support as required.					
	Trust quality meetings	Associate DIPC Lead Nurse IPC to	To attend scheduled meetings. To provide expert advice and support					

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
	• ***CQAC*** • ***CQSG*** • ***CQPG***	deputise. IPCT to attend ad hoc for training purposes.	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*** *– To speak to relevant clinicians with regards to introduction of the OneTogether programme for surgery.* ***Q2*** *–Is included in SSI action plan.* ***Q3*** *– Staff have attended an update 23rd November 2017.* ***Q4***
	Trust board	DIPC/ Associate DIPC	To attend scheduled meetings. To provide expert advice and support as required.					
12. Gram Negative Bacteraemia – Commenced Q3								
1,3,4,5,6,7,8 & 9 Excellence Innovation Respect Together Openness	Adherence with regards to gram negative bacteraemia targets	DIPC/ Associate DIPC	To attend whole health economy meetings to develop robust action plans to tackle gram negative bacteraemia reduction targets.					***Q3*** *– Associate DIPC has attended several meetings and is involved in developing whole health economy action plans across the Liverpool region.* ***Q4***
		IPC Data Analyst	Ecoli, Klebsella spp, Pseudomonas aeruginosa bacteraemia data is now to be inputted on the MESS data system. Also retrospective data from April 2017 needs to be inputted.					***Q3*** *– Retrospective data has now been added to the PHE data capture system and is entered ongoing on a monthly basis.*

IPC Code & Trust Values	Plan & Priority Activities 2017-18	Lead Members	Deliverables	Q1	Q2	Q3	Q4	Comments
		IPCT	PIR proforma to be developed for the new PIR review process.					***Q3 –*** *PIR developed and to be trialled* ***Q4***
		DIPC/ Associate DIPC	PIR reviews to be commenced for all named gram negative bacteraemia.					***Q3 –*** *To commence dates booked for reviews.* ***Q4***
		IPC Data Analyst	Trust wide situation reports to be developed to share lessons learnt.					***Q3 –*** *Situation reports in development.* ***Q4***
		Associate DIPC	PIR reviews to be shared across the whole health economy and NHSI.					***Q3 –*** *Meetings arranged to discuss progress.* ***Q4***

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 have been identified to target for 2017/18. Trust wide Action Plans will be developed with other key stakeholders from the Trust to implement and progress these actions.

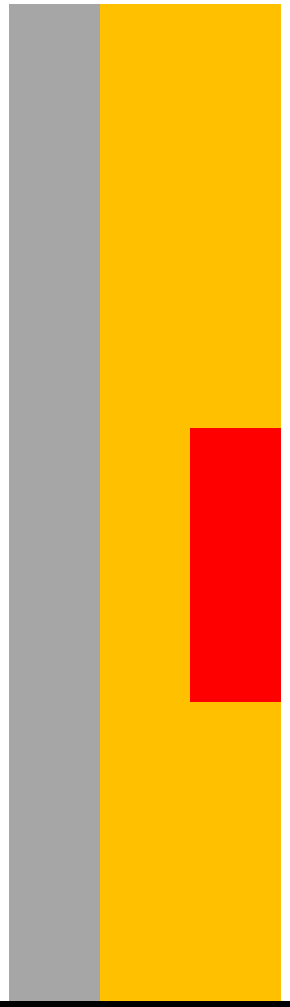
Key Themes	Infection Prevention and Control Lead	Other Specialist Nurses from the Service	Update
Methicillin Sensitive Staphylococcus Aureus (MSSA) Bacteraemia	Claire Oliver	Sara Melville (Lead Nurse –IV)	
Surgical Site Infections (SSI)	Lisa Moore	Ellen Buckley (Tissue Viability Nurse)	This will now be reported via the Theatre Safety Board.
Environmental Cleanliness	Jo Keward	Vickie Lam (IPC Clinical assistant)	
Prevention of pressure ulcers	Val Weston	Ellen Buckley (Tissue Viability Nurse)	

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 at the December meeting.

Alder Hey Children's NHS
NHS Foundation Trust

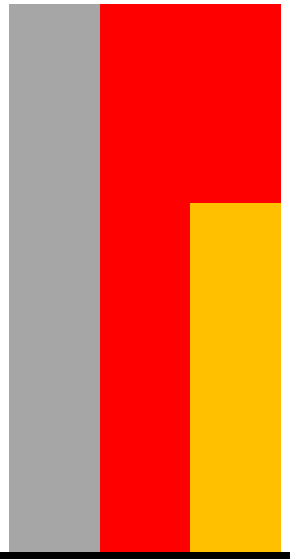
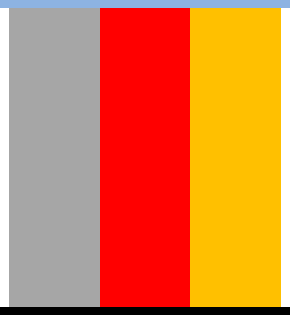
Pressure Ulcer Action Plan 2017-19

Deliverable	Lead Person	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19	Comments
1. For all appropriate nursing staff to be competent in the management of patients who are at risk/ have existing pressure ulcers.										
a) Development of TNA to identify the level of training required within each clinical area	Lead Tissue Viability Nurse/Ward Managers									***2017-18*** ***Q1 - N/A*** ***Q2-*** *Identified that all nursing staff should complete eLearning package as minimum and higher risk areas have classroom sessions also annually.*
b) Electronic Learning Package for pressure ulcers to be disseminated to ward staff for nursing staff to complete as a baseline	Lead Tissue Viability Nurse									***2017-18*** ***Q1 - N/A*** ***Q2*** *- Link sent to all ward managers to disseminate package for staff to complete. Completion record to be monitored locally.* ***Q3 -*** *Associate DIPC to meet up with Learning and Development to scope out the practicalities of monitoring completed training.* ***Q4*** ***2018-19*** ***Q1 Q2*** ***Q3*** ***Q4***
c) Implementation of competency assessment tool initially with TV link nurses with a view to wider roll out depending on speciality	Lead Tissue Viability Nurse									***2017-18*** ***Q1 - N/A*** ***Q2 -*** *Requires protected time for staff members to have one to one assessment of competency but this has not progressed. To pilot on PICU TV link nurses. 8.9.17- copy of possible framework sent to education team on CCU for review* ***Q3 - 1****.11.17- no response from education team- further email sent to chase up. Following action plan meeting on 22/11/2017 agreement reached to pilot on Burns Unit.* ***Q4***

d) Uploading of Electronic learning package onto ESR to enable reporting on compliance and improve accessibility to learning for staff	Lead Tissue Viability Nurse/Learning and Development Officer		***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4*** ***2017-18*** ***Q1 - N/A*** ***Q2*** *- Elearning package sent to LDO for upload- 20.5.17- further email sent to LDO to check progress* ***Q3*** *- 1.11.17 email sent to LDO to check progress. Associate DIPC to liaise with Learning and Development.* ***Q4***
e) Commencement of classroom learning session for pressure ulcer prevention and management via monthly clinical skills day	Lead Tissue Viability Nurse/Learning and Development Officer		***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4*** ***2017-18*** ***Q1 -N/A*** ***Q2****- Flyer to advertise classroom session sent to J.Downes for upload* ***Q3 - L****ack of TVN to deliver classroom session as of 24.11.17. To be progressed once a new TVN is appointed.* ***Q4***
f) Pressure Ulcer Prevention and Management education (initial and yearly update) to be made mandatory for all appropriate nursing staff	Lead Tissue Viability Nurse/Director of Nursing		***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4*** ***2017-18*** ***Q1 - N/A*** ***Q2*** *- Email sent to Associate Director of Nursing and Governance, Director of Nursing and Chief Nurse on 20.6.17 to identify how this will be mandated.* ***Q3****- Associate DIPC to follow up with progression.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***

2. All relevant record keeping templates to be reviewed and implemented			
a) Application for GDE funding to support review of pressure ulcer related electronic templates on Meditech6.	Lead Tissue Viability Nurse		***2017-18*** ***Q1 - N/A*** ***Q2 -*** *Application made and sent to software development team.* ***Q3-*** *service review approved*
b) Pressure ulcer related templates to be reviewed on Meditech6/BadgerNet	Lead Tissue Viability Nurse/IM&/Badger EPR Development Nurse		***2017-18*** ***Q1 - N/A*** ***Q2*** *-6.7.17 – initial meeting with IM&T to discuss application requirements. meeting for GDE review arranged for 4.10.17* ***Q3****- 1.11.17meeting to discuss requirements. Development of care pathways progressed. To be rolled out once new TVN appointed.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) Review of clinical record keeping in OPD in relation to Pressure Ulcer prevention and management	Lead Tissue Viability Nurse/OPD Lead Nurse/HoQ		***2017-18*** ***Q1 - N/A*** ***Q2 -*** *21.6.17 Meeting arranged with Lead Nurse for OPD to discuss issues. Potential cost pressure in association with access/availability of IT equipment for record keeping in dept. 6.7.17- meeting cancelled by OPD to prioritise voice recognition. Email sent to rearrange* ***Q3-*** *1.11.17- to be captured in GDE TV review of documentation* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) Review of CCNT record keeping in relation to pressure ulcer prevention and	Lead Tissue Viability Nurse/Team		***2017-18*** ***Q1 - N/A*** ***Q2 -****Initial meeting with Homecare TL/ CCNT TL and HoQ to devise actions required within both services. Further meeting planned when*

management	Leader/HoQ		*education delivered to team re pressure ulcer prevention and management. 28.6.17- Wound assessment and management training delivered to 4 CCNT staff. 9.8.17- email sent to Home Care TL and CCNT TL to chase up dates for training. 8.9.17- chased up with HoQ* ***Q3 -*** *1.11.17- email sent to HoQ to arrange training date. Discussed at action plan meeting 22/11. Quality Lead for Community to scope out what provisions are available in the community.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
3. To ensure that patients under the primary care of Alder Hey in the community will receive a pressure ulcer risk assessment on the first visit			
a) Implementation of Pressure Ulcer Risk assessment tool within CCNT and Community Matron record keeping with associated guidelines for completion	*Lead Tissue Viability Nurse/Team Leader/HoQ*		***2017-18*** ***Q1 - N/A*** ***Q2- 8.9.17- delayed due to lack of training delivered so far to CCNT and Homecare*** ***Q3 -*** *1.11.17- email sent to HoQ to arrange training date. Discussed at action plan meeting 22/11. Quality Lead for Community to scope out what provisions are available in the community.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
4. To ensure there will be adequate provision of enhanced knowledge and skill around pressure ulcer prevention and management across the organisation 24hours a day 7 days a week.			
a) Development of options appraisal to outline possibilities and associated	*Lead Tissue Viability Nurse*		***2017-18*** ***Q1 - N/A*** ***Q2-*** *Options to be agreed with Associate DIPC. Unable to meet until 16.10 17*

risks/benefits			***Q3*** *- 1.11.17- TVN to meet with AssDIPC to discuss. Agreed progression of new TVN service. Recruitment to be progressed.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) *Implementation of agreed option to support adequate business continuity plan within the Tissue Viability Service.*	*Associate DIPC/DoN*		***2017-18*** ***Q1*** *- N/A* ***Q2****- 4.9.17- TV Lead nurse now working notice period of 12 weeks due to complete 25.11.17. 8.9.17- work-stream currently sat with Associate DIPC and DoN. Action owner amended.* ***Q3****- Tissue Viability Service proposal drafted and to be sent to Chief Nurse and Director of Nursing for discussion. Agreed progression of new TVN service. Recruitment to be progressed.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
5. To ensure Alder Hey patients managed in the community with wounds have access to advanced level of tissue viability specialism when need is identified			
a) *Task and finish group to be arranged (lead to be identified) to look at tissue viability service provision for Alder Hey Community patients.*	*Associate DIPC/DoN*		*2017-18* ***Q1*** *- N/A* ***Q2*** *- see action 4b* ***Q3*** *- Discussed at action plan meeting 22/11. Quality Lead for Community to scope out what provisions are available in the community.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***

Alder Hey Children's NHS
NHS Foundation Trust

MSSA Bacteraemia Action Plan 2017-19

Deliverable	Lead Person	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19	Comments
1. To do a retrospective audit of MSSA bacteraemia from 2016 – 2017.										
a) To arrange a lead person to undertake the audit.	***Graham Lamont***, Lead for Medical Education									***2017-18*** ***Q1*** *- N/A* ***Q2*** *– Graham Lamont contacted. Awaiting response.* ***Q3****– Graham Lamont contacted. Awaiting response.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Audit to identify specific risk factors and issues which can be addressed within this action plan.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) Template to be devised for the 2016-17 audit and thereon to be used for all MSSA bacteraemia data collection.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3***

										Q4
2. To format and introduce a new MSSA Bacteraemia PIR process.										
a) To format a new PIR document to be used for all identified hospital acquired MSSA bacteraemia.	***Val Weston***, Associate DIPC									***2017-18*** ***Q1*** - *N/A* ***Q2*** – *New PIR document formatted by IPC Team.*
b) To pilot the new form and adjust as required.										***2017-18*** ***Q1*** - *N/A* ***Q2*** – *New form to be used for first 5 MSSA cases.* ***Q3*** - *New form has been implemented*
c) To introduce a new PIR process involving the DIPC and Associate DIPC in the review process. Both clinicians and nursing staff involved in the patients' care will be required to fill in PIR document and present the case at the review meetings.										***2017-18*** ***Q1*** - *N/A* ***Q2*** – *Dates arranged for first cases.* ***Q3*** – *PIR review process has commenced attended by nursing staff but not attended by clinicians.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) Lessons learnt from review meetings will be disseminated through Medical and Surgical Divisional risk and governance structure.										***2017-18*** ***Q1*** - *N/A* ***Q2*** – *Awaiting process to be set up.* ***Q3*** – *Process now set up. Lesson learnt to be disseminated via a situation report to the divisions.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***

3. To ensure that ANTT is standardised and implemented throughout the Trust for all clinical staff.										
a) Provide updated compliance figures to the relevant care groups and for IPCC.	***Sara Melville***, Lead Nurse for Vascular Access Team ***Anna Hulse***, Lead Nurse for ANTT									***2017-18*** ***Q1 - N/A*** ***Q2 - Complete***
b) Include ANTT compliance scores in IV Newsletter and IPCC Report.										***2017-18*** ***Q1 –N/A*** ***Q2*** *- Compliance scores now included.*
c) Review new guidelines and update policy and procedures to reflect this.										***2017-18*** ***Q1 - N/A*** ***Q2*** *- All new evidence based standards reviewed. Policy and guidelines updated and have been sent to IPC Team to review before approval at IPCC in October.* ***Q3*** *-- approved at IPCC awaiting ratification at CQSG December 2017* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) To review role and responsibilities of Link Nurses.										***2017-18*** ***Q1 - N/A*** ***Q2*** *– Role and responsibilities of link nurses reviewed and added into the new policy.* ***Q3*** *-Approved at IPCC awaiting ratification at CQSG December 2017.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
e) Key trainer training days are provided are provided 4 times per year.										***2017-18*** ***Q1 - N/A*** ***Q2*** *- Key trainer programme developed. ICU key trainer sessions August 2017, further key trainer days scheduled for October 2017.* ***Q3*** *– Key trainer days 9th Oct, 3rd & 22nd Nov and 4th Dec for the wards. Theatres 1st & 15th Dec. Dates for 2018 to be set up.*

f) ANTT stickers to be provided for all staff following ANTT training and compliance.										***2017-18*** ***Q1 - N/A*** ***Q2*** *- Stickers now available will be distributed as key trainer programme advances. More stickers are also on order.* ***Q3****-stickers are being given to key trainers at training sessions.*
g) Attend annual ANTT conference and to attend North West IV forum meetings.										***2017-18*** ***Q1 - N/A*** ***Q2*** *- North West IV Forum meeting held at Alder Hey 26th September 2017 Attended by SM, CO & VW.* ***Q3****- ANTT conference attended by Zara Burns 24th November 2017. Next IV Forum meeting 5th December 2017.*
4. To ensure that all vascular access practices comply with national standards.										
a) To introduce a Trust wide IV Access & Therapy group.	***Val Weston***, Associate DIPC ***Sara Melville***, Lead Nurse for Vascular Access Team ***Claire Oliver***, IPC Nurse Specialist									***2017-18*** ***Q1 - N/A*** ***Q2*** *–TOR completed and IV access therapy group meetings have commenced.* ***Q3****- meetings are ongoing*
b) To establish a clear reporting mechanism between clinicians who insert vascular access devices and the IV Team.										***2017-18*** ***Q1 - N/A*** ***Q2*** *– Meetings have commenced with Theatre to implement the process.* ***Q3****-Work continues to identify processes and mechanisms to assist in the documentation via Meditech and Badger.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) To develop a system to monitor the documentation of all vascular access devices.										***2017-18*** ***Q1 - N/A*** ***Q2*** *– IV team have commenced weekly ward rounds but capacity is limiting this.* ***Q3*** *- weekly wards rounds continue as capacity allows. Work continues to identify processes and mechanisms to assist in the documentation via Meditech and Badger.* ***Q4*** ***2018-19*** ***Q1***

										Q2 ***Q3*** ***Q4***
d) To develop an audit system to ensure that best practice is adhered to by clinicians for patients with a vascular access device.										***2017-18*** ***Q1 - N/A*** ***Q2*** *– If care plans are instigated then could report through Meditech.* ***Q3-*** *To explore mechanisms to be utilised by clinicians in Meditech and Badger. if care plans not initiated then are being implemented by Iv team on ward round.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
e) Review line data which exists on the current Badger system. Following review, work with Badger Team to improve line care pathway.										***2017-18*** ***Q1 - N/A*** ***Q2*** *– This is the next process to be reviewed following relaunch completion of ANTT within PICU. This has been discussed.* ***Q3-****To identify and develop a care pathway to be utilised on the Badger System.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
5. Introduce vessel health and preservation (VHP) into the Trust.										
a) To develop a specific paediatric version of the VHP framework for use at Alder Hey. To discuss the introduction of the specify VHP framework at the IV Access & Therapy Group	***Val Weston***, Associate DIPC ***Sara Melville***, Lead Nurse for Vascular Access									***2017-18*** ***Q1 - N/A*** ***Q2*** *– First draft of VHP framework completed and awaiting review by IV access and therapy group.* ***Q3*** *– VHP draft to be discussed at December meeting of the IV access and therapy group.* ***Q4*** ***2018-19*** ***Q1***

	Team									***Q2*** ***Q3*** ***Q4***
b) To develop a project plan to introduce VHP into the Trust. This project plan will be monitored through the IV Access & Therapy Group and will report into the IPCC.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3****-SM has initiated GDE programme with possible implementation in Jan 2018* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) To identify two areas within the Trust to trial the new VHP framework.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3****- Through GDE will be tested through meditech. Awaiting GDE programme development.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) To monitor and evaluate these pilot studies to inform and adjust as necessary before VHP is rolled out across the Trust.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** *- Awaiting GDE programme development.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
6. To accurately assess wounds for signs of infection										
a) To review all tissue viability	Lead Nurse									***2017-18*** ***Q1 - N/A***

related Meditech 6 templates.	Tissue Viability									***Q2*** ***Q3*** *– Template developed awaiting appointment of new TVN Specialist to implement across the Trust.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) To identify key staff on departments and wards to act as tissue viability champions.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** *– Link nurse already exists. Associate DIPC to identify and develop a link nurse system.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) To develop or source a trainee programme to deliver tissue viability training.										***2017-18*** ***Q1*** *- N/A* ***Q2*** *– ELearning package available. Other training resources to be explored.* ***Q3*** *– To explore how eLearning package can be recorded on the ESR system with L&D.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) To ensure that all wounds are considered in the PIR process.										***2017-18*** ***Q1*** *- N/A* ***Q2*** *– Wound section incorporated into the PIR documentation.*
7. To ensure that all vascular access device related infections are reported in a timely manner.										

a) To develop a robust data capture system for all vascular access device infections.	***Carly Quirk***, IPC Data Analyst									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3 –*** *Report now available in Meditech to assist with bacteraemia rate info. Discussions underway with IPCT, Theatres and IV team to explore data capture system for all lines inserted in theatre.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Data captured will be reported through the IV Access and Therapy group and the IPCC.										***2017-18*** ***Q1 - N/A*** ***Q2 –*** *Data will be reported once the data capture system is set up.* ***Q3 -*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) Data captured will also be reported across the Trust via Medical and Surgical governance structures.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3 -*** *Data will be reported once the data capture system is set up.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) All MSSA bacteraemia are reported via the MESS system										***2017-18*** ***Q1 - N/A*** ***Q2 –*** *Process in place.*

Alder Hey Children's NHS
NHS Foundation Trust

Environmental Cleanliness Action Plan 2017-19

Deliverable	Lead Person	Q1 17-18	Q2 17-18	Q3 17-18	Q4 17-18	Q1 18-19	Q2 18-19	Q3 18-19	Q4 18-19	Comments
1. To develop a comprehensive cleaning policy										
a) To agree, update and expand the existing cleaning policy.	***Lesley Cooper**, Domestic Services Manager.*									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3**- Meetings have commenced to update policy. Cleaning policy needs to be revised. Further meetings have been arranged.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) To disseminate current policy to other members of the environmental cleanliness action plan for comments for update.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3** – Policy disseminated to members.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) To send new cleaning policy to IPCC for approval and ratification at CGSG.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3** – Unable to progress until policy finalised.* ***Q4*** ***2018-19*** ***Q1*** ***Q2***

										Q3 ***Q4***
d) Validation of cleaning standards following a deep clean.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** *– Unable to progress until policy finalised.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
2. To standardise products and restrict the purchasing of unauthorised items.										
a) Generate report to look at usage of items from across the Trust.	***Lesley Cooper****, Domestic Services Manager.* ***IPC Team*** ***Procurement Team***									***2017-18*** ***Q1 - N/A*** ***Q2–*** *Report generated by Procurement*
b) Rationalise the cleaning products and consumables across the Trust.										***2017-18*** ***Q1 –N/A*** ***Q2 -*** ***Q3–*** *Meetings commenced to rationalise products and formalise formulary. Paper towels are being trialled on 3C commencing 1/12/17. Hand gel and soap roll out continues. Projected to be completed by March 2018. Trials of cleaning products and wipes have taken place and finalisation scheduled for end of Nov 2017.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) Issue formulary to all wards and departments across the Trust in conjunction with cleaning manual.										***2017-18*** ***Q1 - N/A*** ***Q2 -*** ***Q3 – Unable to progress currently.*** ***Q4*** ***2018-19*** ***Q1***

										Q2 ***Q3*** ***Q4***
3. To establish a quarterly housekeeping meeting with all housekeepers.										
a) Establish Regular housekeeping meetings with TOR.	***Val Weston,*** *Associate DIPC*									***2017-18*** ***Q1 - N/A*** ***Q2*** - ***Q3-To arrange commencement of housekeeper meetings*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Conduct a housekeeper stock taking training session.	***Materials Management***									***2017-18*** ***Q1 - N/A*** ***Q2*** - ***Q3*** – *Training sessions to be discussed with procurement manager as to how this can be implemented. Central review of stock levels pending meetings with housekeepers and ward managers.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) Conduct housekeeper IPC /cleaning training session.	***Vickie Lam*** IPC Clinical Assistant ***Tommy Curran*** *Domestic Supervisor*									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** – *To arrange commencement of housekeeper IPC Training. Lead personnel identified and to meet to arrange content of training.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***

4. To develop multi-disciplinary working between IPC, building services and Interserve.										
a) Establish regular multi-disciplinary walk rounds to identify issues.	***Val Weston***, *Associate DIPC*									***2017-18*** ***Q1 - N/A*** ***Q2 –*** *Draft TOR completed and sent for comments. Walk rounds to commence Oct 2017.* ***Q3 –*** *Walk arounds to commence 13/12/17. TOR agreed. Walk arounds scheduled on a monthly basis going forward. Findings/actions to be shared with this group and ward managers. Results will be imbedded into IPC dashboard and circulated through divisions.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Develop TOR	***Chris Gildea***, *Building Services*									***2017-18*** ***Q1 - N/A*** ***Q2 –*** *TOR completed*
c) Develop a template	***Jo Keward***, *Lead Nurse IPC*									***2017-18*** ***Q1 - N/A*** ***Q2 – Template completed***
d) Establish better communications between interested partied involved in the annual PPM's	***Graeme Dixon*** *Building Services*									***2017-18*** ***Q1 - N/A*** ***Q2 –*** *Meetings to discuss have been arranged.* ***Q3 –*** *5 year plan in place GD to forward plan to IPC/Domestic Services and to co-ordinate communications between interested parties.(Interserve, IPC, Domestics Services, General Managers, service managers and ward managers).* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
5. Auditing and Communication										

a) Establish Monthly building services audits **(See section 4)**	***IPC Team*** ***Building Services*** ***Interserve***									***2017-18*** ***Q1 - N/A*** ***Q2 –*** *Weekly walk rounds to commence Oct 2017.* ***Q3 –*** *results of walk arounds to be communicated via IPC dashboard.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Establish IPC monthly audits	***IPC Team***									***2017-18*** ***Q1 - N/A*** ***Q2 –****Monthly sport checks commenced in September 2017.* ***Q3 -****Results of walk arounds to be communicated via IPC dashboard.* ***Q4-***
c) Establish Cleaning audits	***Lesley Cooper*** *Domestic Service Manager*									***2017-18*** ***Q1 - N/A*** ***Q2 -*** *Cleaning audits already in existence but need to be established on a regular basis.* ***Q3*** *- Results of cleaning audits to be communicated via IPC dashboard.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) Establish a quarterly quality control audit.	***Jo Keward,*** *Lead Nurse IPC* ***Lesley Cooper,*** *Domestic Services Manager.*									***2017-18*** ***Q1 - N/A*** ***Q2 – Quarterly quality control audits established.***
e) Establish a yearly IPC audit.										***2017-18*** ***Q1 - N/A*** ***Q2 – Yearly IPC audits established***
f) All audits disseminated to all	***Carly Quirk,***									***2017-18***

divisions	*IPC Data Analyst*									***Q1 - N/A*** ***Q2 – Disseminated via IPC dashboard***
g) PLACE – To ensure that PLACE reports are disseminated to all staff in a timely manner.	***Val Shannon,*** *Volunteer Manager*									***2017-18*** ***Q1 - N/A*** ***Q2 – Awaiting communication of PLACE audits.*** ***Q3 – VW to contact VS to ensure that IPC is included in feedback meetings.*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
6. To ensure the cleanliness of robots and waste trucks are maintained.										
a) Monitor cleanliness of the floors where robots and waste trucks travel.	***Mark Deveraux***, Head of Soft Services									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3-*** *Develop a process to monitor cleanliness of floors to be incorporated into relevant IPC/Cleaning/Building services audits. VW to set up sub group to discuss problems with current system.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Provide audits results assurance.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3 –*** *To be addressed following subgroup* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) Develop a cleaning process for										***2017-18*** ***Q1 - N/A***

robots and waste trucks										***Q2*** ***Q3*** *- To be addressed following subgroup* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
7. Sinks										
a) Establish a group to regularly monitor sink drainage	***Val Weston***, Associate DIPC ***Lesley Cooper***, Hotel Services Manager									***2017-18*** ***Q1 - N/A*** ***Q2 –*** *Group established and monitoring process has commenced in high risk areas.* ***Q3 –*** *Trial of sink traps on 4C to commence December 2017.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Develop and distribute signage for hand hygiene sinks.										***2017-18*** ***Q1 - N/A*** ***Q2 – Signage in place.***
c) To provide a solution to sink blockages across the Trust.										***2017-18*** ***Q1*** *- N/A* *Q2 –Investigation into solutions to prevent sink blockages. Issues highlighted and identified in conjunction with Interserve.* *Q3- To establish with water safety group whether sink traps need to be purchased.* ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) Establish clear cleaning										***2017-18*** ***Q1 - N/A***

protocol for sinks.										***Q2 –Draft sink cleaning protocol developed.*** ***Q3 – Awaiting revision once sink blockage solution is established.*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
e) Dissemination and training in new sink cleaning protocol.										***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3 - Awaiting revision once sink blockage solution is established.*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
8. Baths										
a) Develop a clear plan for bathing facilities across the Trust	***Kelly Black***, Surgical Matron ***Val Weston***, Associate DIPC									***2017-18*** ***Q1 - N/A*** ***Q2 – Plan to be developed*** ***Q3 – Plan agreed to retain at least 1 bath per floor.*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Establish a cost for removal of identified baths.	***Building Services***									***2017-18*** ***Q1 - N/A*** ***Q2 – Plan to be developed*** ***Q3 – Awaiting quote from company. CG to share cost of turning bathrooms into storage space in the interim.***
c) Proposal for removal of identified baths to be	***Kelly Black***, Surgical Matron									***2017-18*** ***Q1 - N/A*** ***Q2***

presented to relevant groups for action.	***Val Weston***, Associate DIPC									***Q3 – Proposal along with costings to be presented to relevant groups for action following quote from coampny.*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) Monitoring and cleaning of baths until proposals are finalised.	***IPC Team & Building Services***									***2017-18*** ***Q1 – Water Testing of baths established. Cleaning protocols established and monitored via audit process.***
13. Waste Stream – This action is a work stream for 2018/2019.										
a) Establish a task and finish group for waste management	***John Foley,*** Waste Manager ***Jo Keward,*** Lead Nurse IPC									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Review Trust wide external waste audit programme	***Task and Finish Group***									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
c) Commence internal waste audit	***John Foley,*** Waste Manager ***Jo Keward,***									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** ***Q4***

	Lead Nurse IPC									***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) Report on internal waste audit, highlighting action that will then need to be taken.	***John Foley,*** Waste Manager ***Jo Keward,*** Lead Nurse IPC									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
e) Develop an action plan to progress findings	***John Foley,*** Waste Manager ***Jo Keward,*** Lead Nurse IPC									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
14. Bed/Cot cleaning process										
a) Establish a bed wash cleaning process sub group	***Val Weston***, Associate DIPC									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3 – VW to set up sub group.*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
b) Develop a robust process for cleaning of beds, cots and	***Jo Keward***, Lead Nurse IPC									***2017-18*** ***Q1 - N/A*** ***Q2 – Bed/Cot cleaning protocol developed.***

incubators. (In the ward environment).	***Lesley Cooper***, Hotel Services Manager									
c) Disseminate process	***Jo Keward***, Lead Nurse IPC ***Lesley Cooper***, Hotel Services Manager									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3 – Process to be disseminated via ward manager and matron meetings.*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***
d) Establish an auditing process to monitor cleanliness of bed, cot and incubator standards.	***Jo Keward***, Lead Nurse IPC ***Lesley Cooper***, Hotel Services Manager									***2017-18*** ***Q1 - N/A*** ***Q2*** ***Q3 – Will be progressed via the sub group.*** ***Q4*** ***2018-19*** ***Q1*** ***Q2*** ***Q3*** ***Q4***

Alder Hey Children's NHS
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Report of	Director of Nursing
Paper prepared by	Complaints & PALS Manager
Subject/Title	Quarter 2 2017 – 2018 Complaints & PALS report
Background papers	n/a
Purpose of Paper	To receive the Current Complaints Performance report and update regarding previous concerns.
Action/Decision required	The Board / Group are asked to note the report.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Deliver **Clinical Excellence** in all of our services
Resource Impact	None

Quarter 2:- July 2017 – September 2017

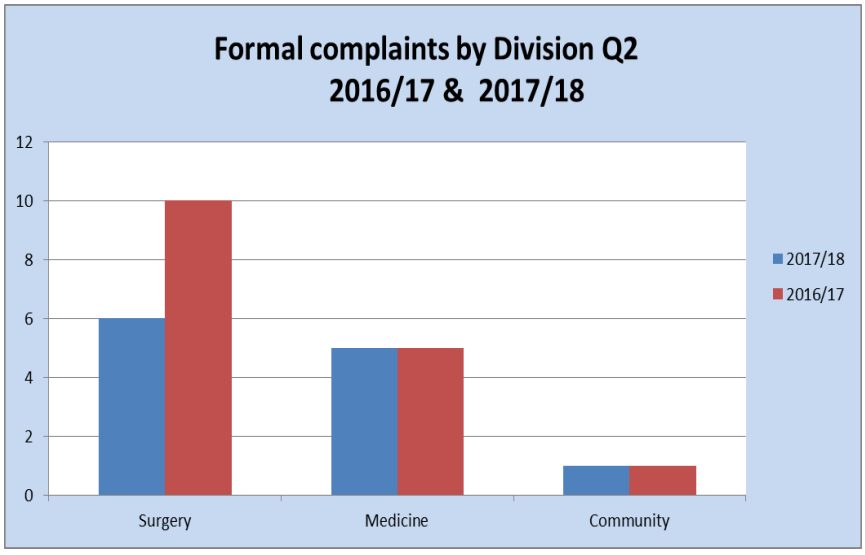
Complaints summary

The Trust received 13 formal complaints during this period. One complaint from this quarter was subsequently withdrawn from the process at the complainants request. No complaints started as an informal concern (PALS) within this reporting period. As a result of the recent Divisional restructure we are unable to provide internal benchmarking data by Division to demonstrate improvements or decline in numbers of negative feedback being received. Comparison will be presented for the Trusts position.

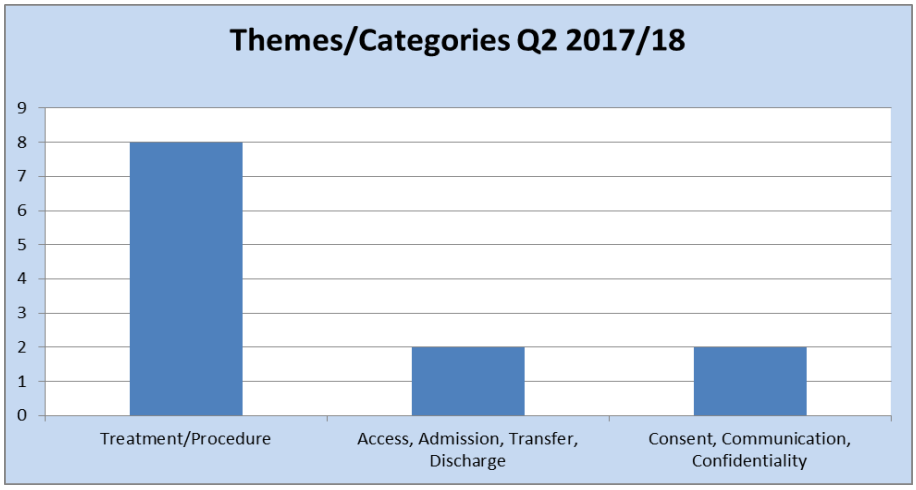
In 2016/17 Q2 the Trust received 17 formal complaints – this is therefore a decrease of 24%. The main category of complaints received continues to be "Treatment/procedure" (67%). This relates to parents questioning whether the care their child has received is appropriate. The second category of complaints received is "Communication/consent" (16%) – parents leave the hospital and remain unclear regarding what treatment pathway their child is receiving or indeed what care has been delivered to them whilst they have been in the hospital. Whilst there is no actual evidence to align these two categories of feedback there is some indirect correlation between effective communications at the time of the care we are providing.

Complaints by Division in Quarter 2

The following graph demonstrates the amount of complaints received within each Division during Quarter 2 2017 – 18. Due to the devolved Governance model and Divisional restructure it is difficult to display comparison data for the Divisions from this time period last year however a manual extraction has been undertaken to attempt to display a graph.



Q1 themes and categories

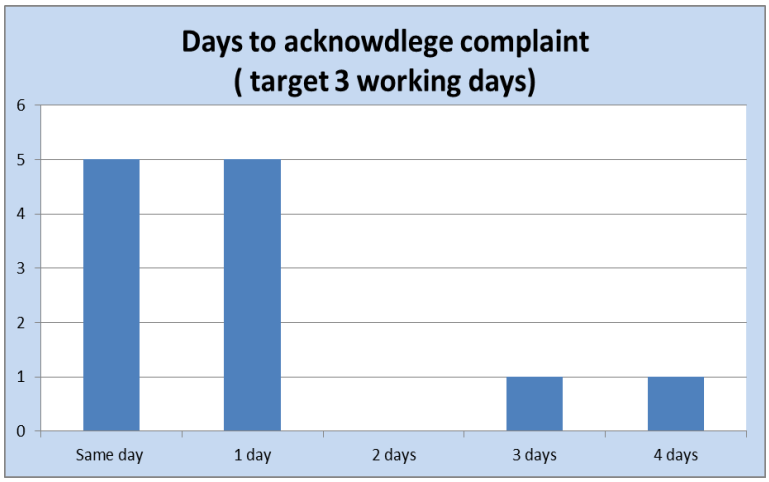


The table above demonstrates the continued challenges faced regarding the diagnosis and treatment pathway made for children yet queried by parents/carers. This quarter we can also see concerns raised relating to communication/consent and issues relating to access/admission arrangements.

Report against three day acknowledgement

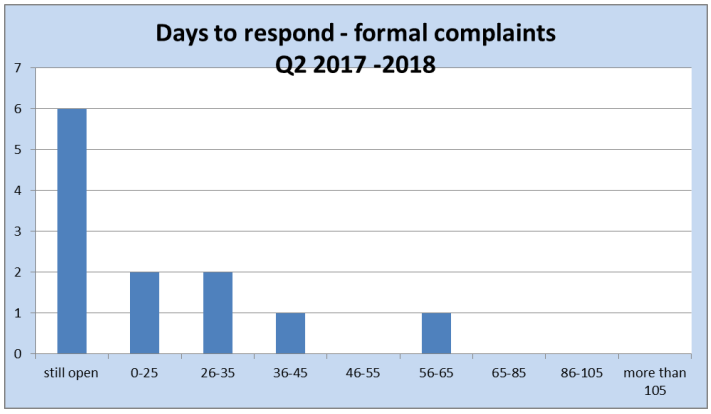
The Trust has three working days to formally acknowledge a complaint; this can be in an email or by phone. The Trust has a generic formal complaint acknowledgement letter that is sent out to the complainant; this includes a named contact for the complainant to contact should they require to do so (including the direct phone number) and the date the response is expected to be with them. The letter also includes information relating to the services offered by Healthwwatch Advocacy.

In Q2 one complaint was not acknowledged until day 4. The delay was caused by clarification whether this was to be investigated as an incident using the RCA process or as a complaint.



The Trusts internal timeframe for responding to complaints is 25 working days, however if the complaint is complex and multi organisational we can discuss this with the complainant and negotiate an extended timeframe with them and agree a new date for response.

Mersey Internal audit agency (MIAA) has requested in their latest review that we make alterations to the timeframes graph as depicted below.



Withdrawn complaints –
SO02705 – Dad making complaint regarding sons in patient stay on ward. Met with Matron and Trust Complaints lead and after a very robust meeting, Dad requested to withdraw the complaint as he was satisfied that his concerns where being listened to and managed. Dad was provided with contact details should he wish to discuss this any further or to make contact and observe the improvements that had been discussed being implemented on the ward.

Complaint outcome
2 complaints where upheld within this quarter and 3 where not upheld. 1 complaint was partially upheld and 6 complaints are still ongoing.
All complainants are fully up dated regarding any delays in response timeframes.

Upheld complaints from July 2016 are now uploaded onto the Trusts external facing web page- this is the link to access the web page. http://www.alderhey.nhs.uk/your-visit/

This information is taken from complaints that have been responded to within the previous calendar month. These are complaint upheld with actions required as part of the response. All complaints are logged onto the Trust action plan that is taken to the Clinical Quality Steering group for discussion and dissemination to the Clinical Business Units.

Referrals to Parliamentary & Health Service Ombudsman

PHSO are planning to investigate a case from 2014 – all records have been submitted as requested and additional information has recently been submitted (Cardiac surgery and Childrens Community Nursing Team)

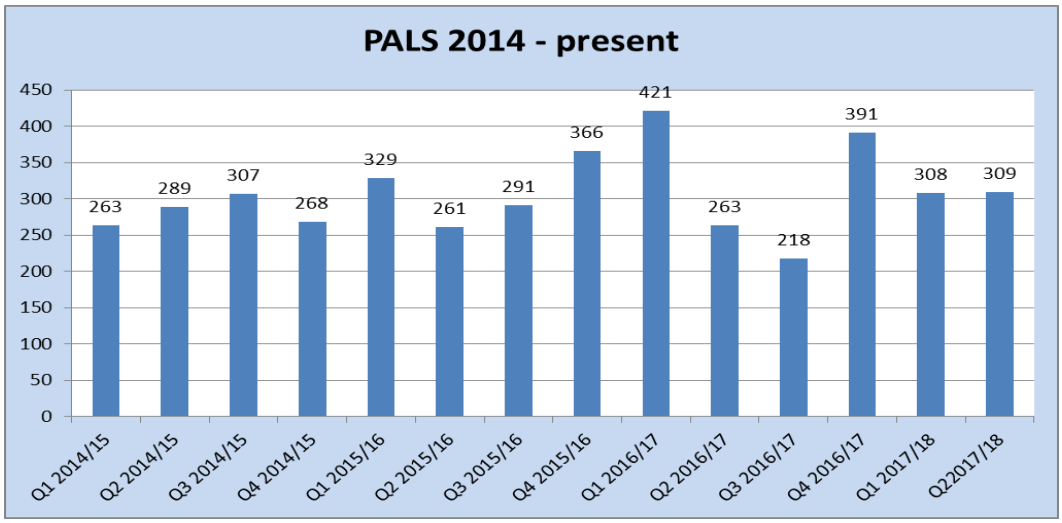
Contacted to discuss another complaint – advised the Trust would request no further resolution appropriate and that the PHSO investigate as the next stage should the family request this.

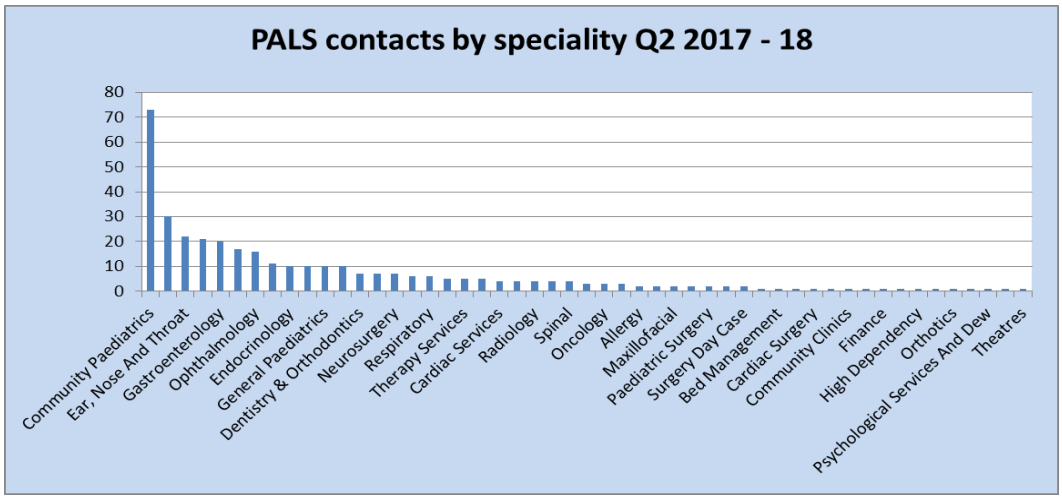
PALS summary

In Q2 2017 -2018 PALS contacts received have remained fairly static at 309 contacts. There are a number of contacts within PALS that are dealt with / assistance provided but are not formally logged on Ulysses. There are also some concerns that may take several hours to investigate with a variety of required communications.

The staff who work on the Concierge desk also assist in dealing with concerns – currently these are also not logged, however training has now been delivered to these staff and the concerns will be logged directly on to Ulysses enabling a wider appreciation of all of the issues we should be aware of.

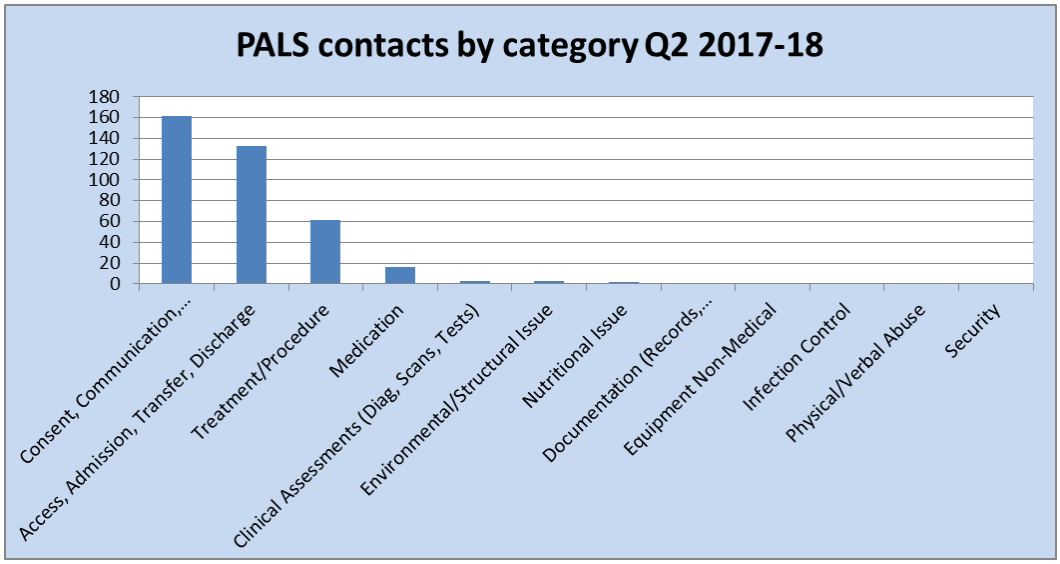
Fig 3- PALS contacts from 2014/15 – Q2 2017/18
The table shows a significant increase in contacts compared to the previous years Q2 contacts – an average rise of 16%.





The table above clearly demonstrates the significant amount of PALS contacts received by Community Paediatrics within this quarter. A review into this amount of contacts and the supporting infrastructure to respond to these in a reasonable timeframe is required.

The table below shows the top three this quarter as being the issues that have been most concerning in previous quarters. Concerns relating to poor or miss communication of treatment pathways or general communication issues remains the highest category.



Key actions & lessons learnt from PALS during Quarter 2

The main issues identified within Q2 relate to communication issues - parents contacting the PALS office asking for clarity relating to their child's treatment plan or pathway of care.
The Trust ran a new educational programme in October addressing communication skills. Staff who attended where nominated as a result of a complaint or incident involving communication issues, had requested this as part of their PDR or had been observed to require support in managing difficult situations within their role. Early feedback from the session looks very positive.

PALS and complaints are communicated and fed back to senior staff at the three Divisional Risk & Governance meetings /Quality meetings to ensure appreciation of current trends are fully disseminated and actions can be taken to look at specific areas of concern.

Compliments

Compliments are now recorded on the Ulysses system and shared with the relevant team**s.**
Recent email compliment

Dear PALS,

I am writing this in relation to a recent visit to Alder Hey with my nephew.

My nephew has multiple disabilities his name XXXXXXX age 5.
I attended ED with his mum on 6th July 2017.
We were so impressed with the advanced nurse practitioner Katie Barnes.
She was rushed off her feet but still managed to be amazingly kind and empathetic.
She is a credit to your Hospital and the nursing profession. We want to thank her for her compassion and friendliness and inform her that her hard work is much appreciated.

We also had an outpatient appointment on the 17th July 2017 with urology nurse specialist Sarah Doyle.
Sarah was so inviting and kind. She was an expert in her field and really did treat us with an empathetic concerning manner.

She is a devoted professional who really made a difference. She again is a credit to the nursing profession and we thank her very much for her expert consultation.

Yours Sincerely

Sara

END

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development	Period: October 2017 11																					SRO: David Powell Author: Sue Brown
Programme 2017/18	Jul-17					Aug-17				Sep-17				Oct-17					Nov-17			
Week Commencing	3	10	17	24	31	7	14	21	28	4	11	18	25	2	9	16	23	30	6	13	20	27	
Decommissioning & Demolition (Phase 1 & 2)																							Programme progressing on track and advance to demolish to M/N block now agreed as part of phase one. No issues with dust have arisen, monitoring continues as per plan. The management plan is in place covering both : 1. demolition of retained estate; 2. R&E II construction, levels have remained safe to date. Removal of top ashphalt layer in main car park has been completed. Tempory move of the coding team to neuro building to ensure safety of staff whilst M/N blocks are demolished. Parking plan for the short to medium term currently being discussed with LCC planners
Residential																							Community Engagment continues to progress in relation to the scale of the scheme. once resolved the appointment of the prefferred bidder (Elect) will follow. Bidder working with LCC planners to ensure all consultation material is acceptable within the rules of the planning process to ensure that the final scheme has a high level of acceptance to all parties.Preffered bidder (elect) has submitted a planning pre-application. Consultation still on hold awaiting further discussion with Mayor Anderson and LCC planners. Alternative development land options being considered and tested as an alternative if the scheme cannot progress as expected.
Research & Education Phase II																							Research and Education phase II build remains on track, contract with Morgan Sindell still awaiting final agreement. University partners yet to sign sign off financial agreements. Although this was expected at the end of August or beginning of September, it still remains outstanding to date although all details are agreed in prinicipal.
Alder Centre																							On Track. Dicussions and regular meetings in process and progressing with the Appointed Architect and users to refine the design.Initial planning meeting taken place between Architects and LCC to submit planning, Planning will be submitted on 23rd November as per programme plan. Service users have been engaged throughout the refining of the desgn including some family input.
Park																							Tree charter marker national sculpture installation due in Springfield Park before end November. Poetry Competition has been launched in partnership with University of Liverpool. Writers delivering on-ward workshops. Winning poems will be printed and permanently displayed in park. Winners announced 24/11. Poems received from India and across Europe. Celebration event involving local youth services to be launched with support from Local MP Additional park clearance to commence imminently. Comms plan for park being finalised. Presentation delivered at National Tree Charter event, Lincoln Cathedral. Contact made with Dr William Bird. Woodland walk grant (28k) being signed off, work to start imminently- (includes accessible path, seating and interpretation). Forest School continuing with pilot arrangements underway with CAMHS. Continued meetings with residents. Friends of Springfield Park to relaunch with support from Edge Hill University via Alder Hey. Volunteering scheme to commence in park December
International Design & Build Consultancy																							Contract prepared and exchanged with XI'AN, contract documents and drawings being translated via china centre prior to commencment of the design review which is now likely to start in February 2018 due to delays in XI'AN. Jersey design review is ongoing with weekly visits to Jersey by team members gathering data from clinical design workshops. This design review and development work looks very likely to extend beyond November and additional income should be achieved. Sharepoint documentation still to be fully developed.
Community Cluster Building																							RIBA design competition launched for Community Cluster Building including , Neurological Assessment, Community Paeds, Psychology, orthotics and Police station in phase one. There is also the option for phase two which could include the Dewi Jones re location from Alder Park and a new and separatley funded Sandfield Park School. There will be potential in the future for addition of a small rehabilitation unit if the Trust wishes to pursue the option.SQQ response 97 submitted, evaluation planned for friday 17th with final ITPN document required to be issued to successful bidders by 27th November. all potential changes to the contents of the buildling must therefore be decided by 20th November. Sharepoint documentation still to be fully developed.
Estates Strategy/Corporate Offices																							Currently exploring and conducting a financial analysis of proposed developments and locations for Community services where current premisies have recieved notification of end of tenancy.Also financial analaysis of all options forpossible relocation to off site premises for CAMHS and Coroprate services as well as exploring any viable options for keeping services on site. Sharepoint documentation still to be fully developed

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Alder Hey Children's NHS
NHS Foundation Trust

Board of Directors

5th December 2017

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

Section 1 - Engagement

Reward & Recognition

In response to the monthly Star Awards, a total of 17 nominations were received during October. The winner was voted for by the panel (comprising a range of staff and staff side) and arrangements are in the process of being made for presentation by an Executive Director. All past and present winners are displayed on the board in the Atrium.

The annual staff awards were launched at the end of October with the entry closing date for end November, with the event taking place on the 19th January 2018. Categories have been identified and a separate independent judging panel has been selected to also include a patient/patient representative.

'Fab Change Week' was held 13th-17th November, with feedback from staff showing the event was well received. The Reward And Recognition Group will be looking to continue this as an annual event.

Staff Survey

The 2017 Staff Survey campaign started in September and has progressed in recent weeks. The Trust's Staff Survey Strategy group have continued with a targeted communications campaign with activities that focus on completion of the survey by all and reminding staff of previous actions from last year's survey. The strategy group have met weekly to review completion rates, engage with managers / teams and updated managers on their teams completion rates. The survey closes on 1st December and the target this year is to reach 50%. The communications campaign is demonstrating a level of success; as at 30th November 2017 we have exceeded our response rate of 50%, at 53%.

Section 2 - Availability of key skills

Employee Consultations

Trust Nursery

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

Hotel Services

Domestics and Portering staff (Portering and Portering Supervisors) organisational change programmes were initiated on 9 June 2017 which consisted of proposed reductions of staff (Portering Supervisors) and review of shift patterns/rotas in the other groups. The three consultations were due to conclude on 24 July 2017. A number of issues were raised by staff and staffside during the consultation in each of the staffing groups and further investigation is being undertaken by management requiring an extension to each of the consultations until 17th November 2017. Dates for domestics' group meetings have been scheduled for 17th November 2017 to review feedback from staff on updated draft rotas, and next steps within the consultation process to be confirmed. A further management/staffside meeting is to take place relating to porters on 15tht November 2017 to review a recent independent audit on

work activity and to agree next steps within the consultation process including timelines for completion.

An external review has been commissioned to focus on the structures within the Catering Department, analysing the costs and potential opportunities that may be available. Following receipt of the report, expected during December 2017, it may be necessary to undertake an organisational change process.

Home Care Service/Complex Care – Community Division

The Organisational Change of the seven Band 3 HCA's has now concluded with all at risk employees securing suitable alternative employment within the Trust.

It has been identified that a further three band 3 HCA's have been identified as at risk. During Aug 2016 three were temporarily transferred on same T&C's with a 12 month review from Home Care to Community Paeds as a result of the expiry of packages. The expiry date has now lapsed and no further packages have been introduced within Home Care. The HCA roles in Community Paeds consists of band 2 duties therefore requiring a further organisational change. Arrangements are now in place to commence consultations.

Two further HCA's have also been affected for the same in the **Complex Care Group** formally the LCH arm of the Home Care Service. Consultations have taken place on 19th October with end consultations scheduled for mid-November and both individuals being allocated to the risk register.

Education, Learning and Development

Apprenticeships

The first cohort of internally delivered apprenticeship qualifications for our existing staff commenced in October 2017 with Healthcare Support and Team Leading. We have over 30 staff currently enrolled. Work is still ongoing to develop this qualification portfolio further with Blackburne House as a support to ensure the apprenticeship strategy remains on track. We have appointed an expert in the field to support us with the next stage of the strategy, to employ newly recruited apprentices.

Mandatory Training

Detailed mandatory training reports by subject, department and team continue to be distributed across the Trust, with all managers expected to increase compliance with mandatory training in each of their teams, and hit the 90% compliance target by the 31st January 2018. We have seen a great deal of effort put into increasing compliance, and all areas showed an increase last month.

Section 3 - Structure & Systems

Employee Relations Activity

By the end of October the Trusts ER activity was at 20 cases. These are 2 disciplinary cases; 3 Bullying and Harassment cases (plus 2 cases moved to informal stages); 5 grievances (plus 1 case moved to informal stage); 2 final absence dismissal cases; 1 formal capability cases; 3 MHPS Capability cases (not reported previously) and 4 Employment Tribunal (ET) cases

Employment Tribunal Cases

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

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

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

- An ET Claim dated 10th October 2017 relating to disability discrimination and protected disclosure response submitted on 13th November with a pre- hearing scheduled for 13th December 2017.

Corporate Report

The HR KPIs in the October Corporate Report are:

- Sickness has increased to 5.4%
- Corporate Induction has decreased to 69.2% compliance
- PDR compliance has increased to 87.3%
- Mandatory training compliance has increased slightly to 75.5%

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

Section 4 - Health & Wellbeing

Staff Fab Change Week

The week of the 13th-17th November was NHS Fab Change week, and we linked our activities over the week to the work we have been doing on the 'recognition' agenda, which also links to one of the five key themes of this year's Fab Change Week, Health & Wellbeing. The recognition group, made up of a range of staff from across the Trust, organised a whole range of activities from providing advice on pensions, smoking cessation, staff benefits to beauty therapists offering hand massages and manicures! The simple message was one of appreciation and thanks to staff, aswell as asking staff to pledge to make simple changes in their own areas.

Staff really welcomed and engaged with the event, and the feedback, especially the numbers of staff pledging to make their own change, was fantastic. We aim to make this an annual event, in response to staff feedback on just how much they valued the sentiment, and the offers.

Equality & Diversity

The inaugural meeting of the Disability Network was held in early November, following the LiA 'Big Conversation'. The network have agreed their priorities and how they want to work together, and it was a very positive start to raising the issues about the challenges of having a disability in the workplace.

Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

5th December 2017

Workforce & Organisational Development Committee (WOD) – Chairs Note

1. Purpose of the Report

The purpose of this report is to update the Board on the key issues raised at the WOD Committee held in September 2017.

2. Key Issues

The following issues were raised and discussed at the Workforce & Organisational Development Committee on the 29th September 2017; the minutes of the meeting will be submitted to the January 2018 Board for noting.

- The Committee **noted** the recommendations for The Best People Doing Their Best Work – Programme Assurance.
- The Committee received a verbal Apprenticeship update on the latest developments and **noted** the comments made.
- The Committee received a report charting the key objectives of the Staff Survey and **noted** the content of the report.
- The Committee **approved** the Library Strategy.
- The Committee received a report outlining the operational and strategic activity taking place with Leadership and Management Development and noted the **progress** made.
- The Committee received a Social Value Report and **noted** the content of the report.
- The Committee received the Corporate Objectives for the Trust - half year stock-take and **noted** the content.
- The Committee received an update of the Workforce Leading Indicators and **noted** the content.
- The Committee **ratified** the First Aid Policy and **approved** the EIA.
- The Committee received the Uniform & Dress Code Policy for information and **noted** the content.

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 29th September 2017.

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Alder Hey Children's NHS
NHS Foundation Trust

BOARD OF DIRECTORS

5th December 2017

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1. Purpose of the Report

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2. Key Issues

The following issues were raised and discussed at the Workforce & Organisational Development Committee on the 8th November 2017; the minutes of the meeting will be submitted to the January 2018 Board for noting.

- The Committee noted the outcome of the recent Staff Side election.
- The Committee **noted** the recommendations for The Best People Doing Their Best Work – Programme Assurance.
- The Committee received a verbal Staff Survey update and noted the progress made.
- The Committee received a Mandatory Training report outlining the progress made to support the Trust target to achieve 90% compliance for all Mandatory Training. The Committee noted the progress made and supports the ongoing efforts to reach the target.
- The Committee received an update of the Workforce Leading Indicators and **noted** the content.
- The Committee received the WRES Action Plan, Data and Reporting Template and approved the content of the reports.
- The Committee **ratified** the Disciplinary Policy and **approved** the EIA.
- The Committee **ratified the** Supporting Staff policy and approved the EIA.
- The Committee **ratified** the Capability Policy and **approved** the EIA.

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 8th November 2017.

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Alder Hey Children's NHS
NHS Foundation Trust

"Quality is everybody's business"
"Let's make it better….together"

Library and Knowledge Service Strategy 2017-2021

Name of document	Library and Knowledge Management Service Strategy
Version	V1
Target staff	Trust staff and students on placement
Reviewed by	Medical Education Board
Approved by	Workforce and Organisational Development Group
Date approved	September 2017
Author	Medical Education and Revalidation Manager
Date issued	
Review date	August 2021

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Mission Statement 3
Strategic Objective 1 - Library Resources 4
Strategic Objective 2 - Quality and Marketing 4
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Strategic Objective 4 – Research and Education 6
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Purpose of Document

The purpose of this document is to provide an overview of the strategic developments for the service which have been derived from the local and national drivers for the NHS. As the Trust embarks upon the next phase of our future, realising the vision for our patients and staff by building the Children's Health Park, this three year strategy, aligned to the four domains of the Trust vision, will ensure that we support the Trust as a world class research and teaching healthcare facility.
The strategic aims of this document are to ensure that staff have the appropriate access to a Library and Knowledge service to support their learning needs that will enable them to deliver evidence based services that underpin clinical excellence.

Quality at the heart of everything we do.

Aim 1 - Patients will not suffer harm in our care
AIM 2 - Patients will have the best possible experience
AIM 3 - Patients will receive the most effective evidence based care

The trust has developed a new strategy to ensure that patients and families receive the best possible care. The three aims listed above will all be underpinned by the library service. We will use the six impact objectives in the Knowledge for healthcare evaluation framework to underpin this strategy.

Mission Statement

To deliver a quality service for all users that is effective and efficient, supporting user's information, CPD and lifelong learning needs. The service will underpin and support excellence in patient care in accordance with the values and the Trust's aims.

Strategic Objective 1 - Library Resources

Organisations are more effective in mobilising evidence and internally generated knowledge

The library and knowledge service will provide access to evidence based information and resources in a timely and effective manner to support decision making and patient care. Improve and broaden access to journals, databases and books, print and electronic format, to support education, training personal and professional development. Provide CBUs with business information to develop services in accordance with local, regional and national guidelines to improve patient experience in line with the Trust's vision.

Actions

- Continue to provide access to evidence based information to support decision making and patient care. Purchase access to a database that will provide synthesized evidence to support patient care.
- Review journals and books, print and electronic, to support education, personal and professional development – usage statistics and user recommendation and annual survey.
- Review library Charter in consultation with users to develop new quality measures that reflect the use of virtual and physical resources.
- Continue to survey all staff to ensure that we have the right resources to enable the delivery of excellent patient care.
- Promote the NW OPAC to enable staff to access a broader range of resources.
- Create a web portal tailored to the needs of all staff groups
- Provide support to staff to develop evidence based patient information.

Strategic Objective 2 - Quality and Marketing

Enhanced quality of healthcare library and knowledge services

The work undertaken by our staff is fundamental to ensuring that we focus all of our processes towards creating a quality service. The provision of a quality library and knowledge service is key driver to support the Trust's agenda to be the best paediatric hospital in Europe and the world. To ensure that the service maintains the highest quality we will adhere to the 48 standards that are contained within the NHS Library Quality Assurance Framework LQAF.
The LQAF is a requirement of the Learning Development Agreement (LDA) which governs the funding for training and education for Trusts. Use our marketing strategy to publicise and promote our resources.
Actions

- Complete annual Library Quality Assurance Framework to ensure that our service is meeting user needs by bench marking against all NHS libraries.

- Increase access e-resources to allow users to retrieve information anywhere in the Trust to enable them to deliver patient centred services at the right time in the right place.

- Liaise with IT to ensure that we are utilising the most up to date web browsing technology to support our users.

- Market the service and resources to all staff and students using a variety of methods including social media such as Facebook, Blogging, Pinterest and Twitter to communicate with users.

- Survey users to inform decision making and future developments of the service.

Strategic Objective 3 – Partnerships

Patients, carers and the public are empowered to use information to make health and well-being choices

Improved consistency and increased productivity and efficiency of healthcare library and knowledge services

Partnership working is the norm in delivering knowledge to healthcare

The impact of NHS organisational changes both locally and nationally requires the service to develop new ways of delivering the information that our users require. The development of more community, outreach and virtual focused services the will be sought to ensure that all users have equitable access to our services and resources. The aim is to increase the number of registered users particularly those that are virtual users in the Library.

Partners include:

Clinical Business Units,
All Stakeholders – including HEI
Patient Information Service
Paediatric Library Alliance
Local, Regional and National networks

Actions

- Develop a tri-partnership between Alder Hey Library, Patient Experience department, Liverpool City Library services.

- Stakeholders - liaise with users and groups with vested interest in library service.

- Patient Information, - develop strategy with PI manager to develop information prescriptions for patients.

- Focus on Outreach service to support staff to deliver high standards of care using the latest available evidence.

- Develop the partnership with the Paediatric Library Alliance in order to broaden access to paediatric resources.

- Develop a retention strategy for paediatric resources that will clearly state which Trust will retain which particular resources. The emphasis will be to retain historical material that will underpin our research strategy.

- Attend Local Cheshire and Mersey libraries group meetings, participate in the regional Library and Information Health Network NW (LIHNN) and National network meetings that are pertinent to library services.

Strategic Objective 4 – Research and Education

Increased capability, confidence and capacity of library and knowledge services workforce

The library service will continue to support the International research and Education strategic aim to give children a healthier future. All staff and students on placement will need to access resources and specialist training that will support their development to become great talented people. The service will develop new and innovative methods of delivering information to support different learning and information needs.

Actions

- Utilise Trust intranet/ Internet to support sharing and learning.

- Support staff undertaking e-learning. Liaise with E-Learning trainer to ensure that staff can access e-learning programmes.

- Support library staff to undertake training via local networks to support knowledge needs of our customers.

- Provide comprehensive training on literature search strategy and other research methods for users to ensure that they can undertake effective searches, evaluate the quality of the information and manage their own current awareness needs.

- Train staff to critically appraise and evaluate information to ensure that practice is evidence based and evidence utilised is of highest quality.

- Training will enable users to use resources that are purchased locally and collaboratively, and the national accredited resources that are accessed via Athens.

- Review new e-resources, books journals, point of care tools.
- Purchase E books and digital resources to enable staff to access information at the right time, at their convenience.
- Knowledge Management is important for all staff to ensure that they are informed of new and emerging health technologies, Innovation, Best practice and guidelines.
- Library staff will produce Horizon scanning bulletins creating, capturing and sharing evidence to support patient care, which are distributed on a national level.
- Implementation and review of the strategy.
- The strategy will be delivered by an implementation plan which will be reviewed annually. The strategy will be reviewed annually to ensure that actions are met or changed to respond to service needs.

References

1. Inspiring Quality ,Alder Hey Strategy Document for 2017-2020
2. Department of Health (2010) *Liberating the NHS: Developing the Healthcare Workforce*, London
3. Department of Health (2010) *An Information Revolution: Consultation on proposals*, London
4. *Hill, Peter (2008) Report of a National Review of NHS Health Library Services in England: from knowledge to health in the 21st Century.*
5. *Health Education England (2015) Knowledge for healthcare: a development framework for NHS library and knowledge services in England 2015-2020.*
6. *NHS Strategic Health Authority Library Leads – SHALL (2010) NHS Library Quality Assurance Framework (LQAF) England*
7. *NHS North-West (2011) Liberating the NHS: developing the healthcare workforce – NHS northwest response to workforce consultation*
8. HCLU's Vision, Mission and Strategic Aims for 2015-16
9. HEE (2014) *Framework 15 – Health Education England Strategic Framework 2014-2029*
10. Department of Health (2013) *Education Outcomes Framework*
11. GMC (2013) *Shape of Training: Securing the future of excellent patient care*
12. *Mid Staffordshire NHS Foundation Trust Public Inquiry* (2013) Chaired by Robert Francis QC.
13. Professor Sir Bruce Keogh KBE (2013)*Review into the quality of care and treatment provided by hospital trusts in England: overview report*
14. Patient Information Forum (2013) *Making the Case for Information: the evidence for investing in high quality health information for patients and the public.*

Alder Hey Children's NHS
NHS Foundation Trust

'a healthier future for children and young people'

Change Programme Assurance – Update – December 2017

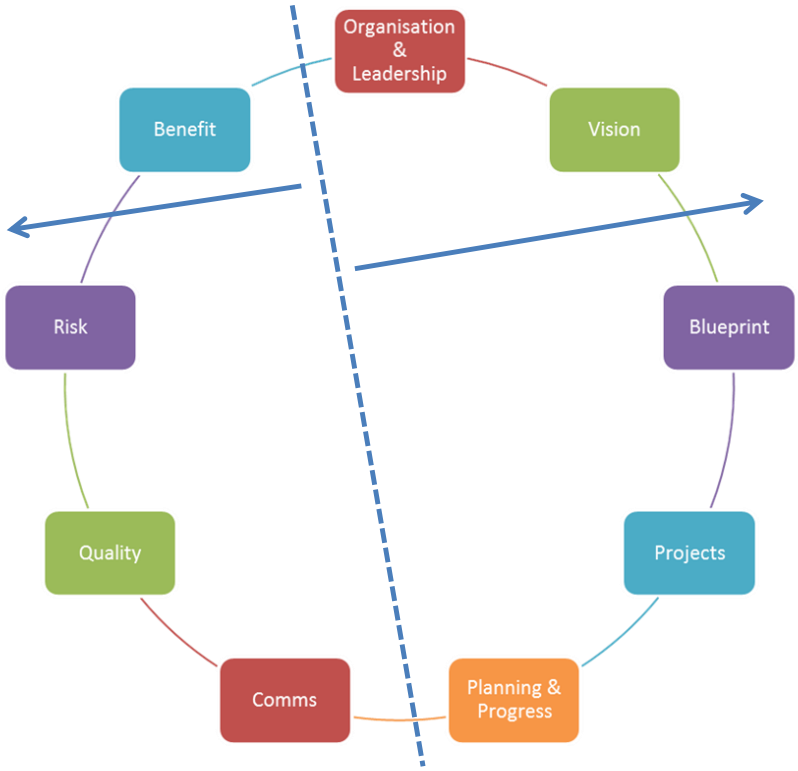
1. Introduction

This document provides the Board of Directors with a concise update on the evolution of the assurance framework for the current change programme at Alder Hey Children's Foundation Trust. It builds upon recent work sponsored by the Programme Board and Executive Team. The paper re-introduces the concept of a deliverable known as the 'High Level Plan'; **it is important to note that the High Level Plan is the personal assessment of the Executive Sponsor of each programme/project and relates purely to the delivery of benefits at defined milestones.**

2. The Domains of Programme Management

Progress against the nine domains of programme management can be simply summarised at figure one below:

These four domains have all commenced; however, further work is required to attain a robust and consistent standard. This is particularly true in terms of metrics and KPIs which is the current focus of Executive Sponsors.



These five domains are established; the work now is to raise, incrementally, standards of planning and compliance. Teams need to embrace the value of project working and use of SharePoint system as an efficient data exchange.

Figure One: Nine domains of programme management

This 'Programme Assurance Update' will provide a brief synopsis of the building blocks of assurance in use at Alder Hey since the end of May 2013 and as evolved since the move into the new hospital in October 2015[1].

3. The Programme 'SharePoint' site and dashboard – 'ground truth'

The programme has a dedicated 'SharePoint' site (a work based intranet) where each of the some forty programmes and projects upload and update all of the 'key' documents relating to that change initiative. These 'live' documents are reviewed and quality rated twice a month by the Programme Assurance Framework. The output of this review is the programme 'dashboard', a ratings based matrix showing the assurance status; this is the 'ground truth' of the programme, the projects' own evidence of progress against an agreed standard of working.

3.0 The Best People Doing Their Best Work 17/18 £TBC																				**Business Case Form**
WOD 3.1a	WOD	Staff Engagement & Development - Apprenticeships	To operationalise the Apprenticeship Strategy and realise the benefits of apprenticeship qualifications following introduction of the Apprenticeship Levy.	Melissa Swindell	Paula Davies	N/A	Paula Davies	Esme Evans	Kerry Morgan	Joe Gibson										Reports to Workstream Steering Group. PID available, financial benefits to be completed. Milestone Plan available - shows significant slippage (Operational Plan and Financial Levy mapping) of btween 4-6 months; updated Sep 17. Comms/Engagement activities detailed in PID and Delivery Plan - evidence required where possible. Risks up-to-date on Ulysses. EA/QIA complete. **Last updated 28 September 2017**
WOD 3.1b	WOD	Staff Engagement & Development - Engagement & Communication	To create an environment which supports the 4 key enablers of engagement which are: Strong Strategic Narrative; Employee Voice; Organisational Integrity; and Engaging Managers	Melissa Swindell	Fleur Flanagan	N/A	Fleur Flanagan	Esme Evans	Kerry Morgan	Joe Gibson										Reports to Workstream Steering Group. Draft PID on SharePoint, to be finalised. Details of benefits, metrics and tracking to be finalised. Milestone Plan now being updated. Comms Plan within PID, activities to be tracked. Risks identified, to be entered onto Ulysses. EA/QIA to be finalised and signed in accordance with process. **Last updated 17 November 2017**
WOD 3.2a	WOD	Workforce Reviews - Specialist Nurse Review	To support the development of a capable, sustainable workforce; sufficiently flexible to meet the changing needs of our services in the hospital & the community	Hilda Gwilliams	Pauline Brown	Lead Nurses	Pauline Brown	Andy McColl	Elaine Morgan	Joe Gibson										Reports to Workstream Steering Group not continuing, need uploading. PID on SharePoint. Benefits contained within PID, however financial benefits to be confirmed. Milestone Plan not updated since 26 Jun 17. Comms/engagement activities limited at present. Risks were up-to-date on Ulysses. EA/QIA complete. **Last updated 21 June 2017**
WOD 3.2b	WOD	Workforce Reviews AHP Review	To support the development of a capable, sustainable workforce; sufficiently flexible to meet the changing needs of our services in the hospital & the community	Hilda Gwilliams	Cath Wardell/ Brigid Doyle	Heads of Services	TBC	Sandra Davies	Phil Johnston	Joe Gibson										**Agreed at Programme Board and Exec Team in October/November 2017 that this project should proceed to initiation; date for project launch awaited from Exec Sponsor.**
WOD 3.2c	WOD	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	Mark Devereaux	N/A	Natalie Deakin	Cristina Puccini	Karl Edwardson	Joe Gibson										Team meetings and briefing notes available. PID available which contains benefits and metrics. Milestone Plan available, shows significant slippage of the overall end date, updated 21 November 2017. Evidence available of Comms/ Engagement activities. Risks captured on Risk Log and these require review. EA/QIA complete. **Last updated 21 November 2017**
WOD 3.2d	WOD	Improving Domestic Services Project	The 3 key areas of weakness outlined in the recent review - Leadership, Systems and Processes and Technical Cleaning - will now form the basis of our 'Improving Domestic Services Project'. Each of these areas of weakness will become a work stream within the project and using recommendations outlined in the review, the aim will be to deliver an effective domestic service by working 'smarter not harder'.	Hilda Gwilliams	Lesley Cooper	Pauline Brown	Natalie Deakin	Cristina Puccini	Karl Edwardson	Joe Gibson										Team meetings and briefing notes available. PID available which contains benefits and metrics. Milestone Plan available - shows significant slippage of the overall end date, updated 21 November 2017. Evidence available of Comms/Engagement activities. Risks captured on Risk Log and reviewed 24 October 2017. EA/QIA complete. **Last updated 21 November 2017**
WOD 3.4	WOD	Temporary Staffing	A task and finish group has been established to provide the organisation with improved information/processes and controls which will help the organisation address issues of effective workforce planning and reduce temporary spend.	Melissa Swindell	Alison Chew/ Sharon Owen	Pauline Brown	Alison Chew/ Sharon Owen			Joe Gibson										POD uploaed with EA/QIA drafted for signature. Milestone Plan required and evidence of project team meetings. **Last updated 7 September 2017.**
WOD 3.5	WOD	e-Rostering		Hilda Gwilliams						Joe Gibson										**Agreed at Programme Board and Exec Team in October/November 2017 that this project should proceed to initiation; date for project launch awaited from Exec Sponsor.**
4.0 Global Digital Exemplar 17/18 £TBC																				
R&BD 4.1	R&BD	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	Peter Young	Nik Barnes	Jenny Wood	Claire Liddy (with Neil Morris)	Elaine Morgan	Joe Gibson										Overall benefits profile and schedule has now been finalised. Further stakeholder evidence to be uploaded and register maintained. Risk protocols vis-à-vis national and Trust systems have been harmonised. **Last updated 22 November 2017.**
R&BD 4.1a	R&BD	Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	Steve Ryan/ John Grinnell	Peter Young/ ACOOs	Lead from each Division/ Speciality	Lead from each Division/ Speciality & IT Lead	Andy McColl (with Bus Acc)	Elaine Morgan	Joe Gibson										Overall benefits profile and schedule still to be finalised. Risk protocols vis-à-vis national and Trust sytsems to be harmonised and finalised. **Last updated 10 November 2017.** QA/EA will be assured and assessed at project level.
R&BD 4.10	R&BD	Voice Recognition	Deploy voice recognition solution in Medisec and Medisch	Steve Ryan/ John Grinnell	Will Weston	Nik Barnes	Hannah Thompson/ Mandy Burns	Sandra Davies	Elaine Morgan	Joe Gibson										PID and detailed project workbook on SharePoint. Details of financial benefits on separate document. Detailed milestone plan available, shows actions on track. Comms/engagement activities detailed in PID, evidence required where possible. Risks detailed in workbook. EA/QIA has been signed and uploaded. **Last updated 3 November 2017.**

Figure Two: Illustration of the Alder Hey 'programme dashboard'

The dashboard, Figure Two, gives each programme/project an overall red / amber / green (RAG) rating; this overall rating is a reflection of the sub-ratings attributed to seven clear and pragmatic questions that the evidence must answer, as follows:

- Is an effective project team in place?
- Is the scope and approach of the project defined?
- Are the targets / benefits defined / on track?
- Is the milestone plan defined / on track?

[1] Guide to Programme Management Standards, Issue 4.1, Audit Ctte 29 Apr 16.

- Are the stakeholders engaged?
- Are the risks identified and being managed?
- Is a quality impact assessment underway / complete?

The answers to these questions promote actions to bring each project to the required standard with the aim of providing transparent, evidenced based, assurance.

4. The High Level Plan

While the dashboard provides an evidence based assurance rating as to the quality of project management in place, each project should also be underpinned by a milestone plan showing the expected benefits and the date of delivery of those benefits. The relative timescales of the projects, against a monthly Gantt chart, are summarised on this High Level Plan.

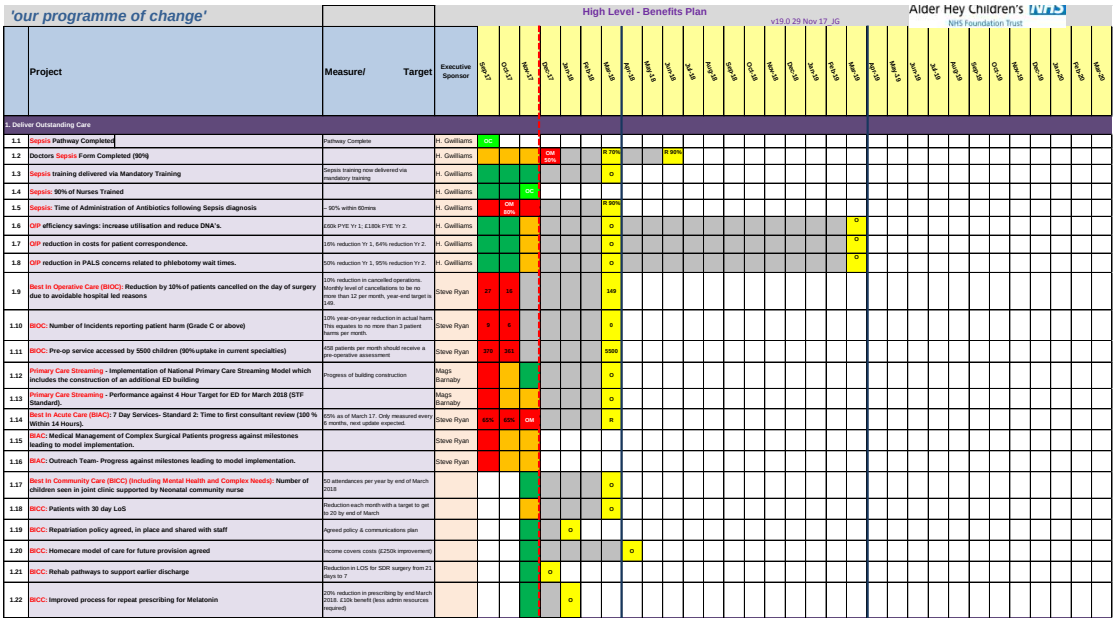


Figure Three: Illustration of the Alder Hey 'programme plan'

The High Level Plan, Figure Three, shows a summary of the projected benefits of the project in the left hand column and the date (against the Gantt chart calendar) when the delivery of these benefits is planned to occur. Given the number of projects, and metrics associated with each project, this is necessarily a summary view to give the Programme Board and Trust Board sufficient oversight. It is important to note that while the dashboard is an objective assessment by the assurance framework, **the High level Plan is the personal assessment of the Executive Sponsor of each programme/project and relates purely to the delivery of benefits.**

5. Current Status

Turning to the current status, a credible assurance framework will often reflect (in terms of RAG ratings) the challenges of an ambitious programme of change in a complex and resource constrained environment; however, there are a number of opportunities to improve the current position:

a. Leadership of Change[2]: Executive Sponsorship needs to be constant and effective in terms of:
   i. Assuring the Programme Board on the content of projects and delivery
   ii. Facilitating the Divisions by providing advice and guidance
   iii. Securing resources to give projects a professional support service
   iv. Assisting the Divisional management with risk management and mitigation
b. Delivery of Benefits[3]: The rationale for each project within each programme needs to be crystal clear in terms of the measurable benefit with 'SMART' attributes:
   i. **S**pecific - a detailed metric with a data source identified
   ii. **M**easurable - a baseline and target figure
   iii. **A**chievable - analyses/evidence that show this can be done
   iv. **R**ealistic - in particular with respect to timescales and compliance
   v. **T**imed – sensible timescales that take into account the risks sand issues
c. Capability to Deliver[4]: The illustrative model below tells us that successful delivery is wholly dependent upon having the right set of capabilities in place. Any significant weaknesses in the capability generated to deliver projects, at any level of the programme, are likely to impact negatively upon delivery.

The aim is to ensure that the right people are in a team and a clear and transparent project resourcing process is in place. All members of the project teams must be committed to the vision and plan; moreover, impacted stakeholders should be willing to put in the additional effort required to deliver the programme.

6. Action on Current Status

Actions underway to improve the assurance status:

a. Executive Sponsors have held a review meeting chaired by the Chief Executive, as SRO, to 're-group' around change programme delivery.
b. The High Level 'Benefits Plan' – previously used prior to the hospital move – has been brought back into use to provide a summary of benefits delivery.

[2] Guide to Programme Management Standards, Issue 4.1, Audit Ctte 29 Apr 16, pp. 5-7
[3] Guide to Programme Management Standards, Issue 4.1, Audit Ctte 29 Apr 16, pp. 35-37
[4] Guide to Programme Management Standards, Issue 4.1, Audit Ctte 29 Apr 16, pp. 16-17

c. The Programme Board will continue to refine it's working since being re-introduced mid-year; the application of robust 'programme gates' will ensure projects are conceived and delivered in line with the overall Alder Hey goals and objectives.
d. A 'PMO' structure is being re-established - on a model to provide direct support for delivery - to ensure that the organisation has sufficient programme and project management capacity to underpin delivery.
e. Divisional managers will receive sufficient training to give them the skills and confidence to manage projects alongside normal duties.
f. Where appropriate, Clinical Directors will become the 'Executive Sponsors' for programmes and projects under their sphere of authority.

These actions are already well in hand and have demonstrably improved the knowledge of, and grip on, the programme in recent weeks. It is important that this approach is sustained and that the Programme Board becomes the place where shared ownership - Divisional, Corporate and Executive – and compliance with standards become the hallmarks of the change programme.

Joe Gibson
External Programme Assurance **29 Nov 17**

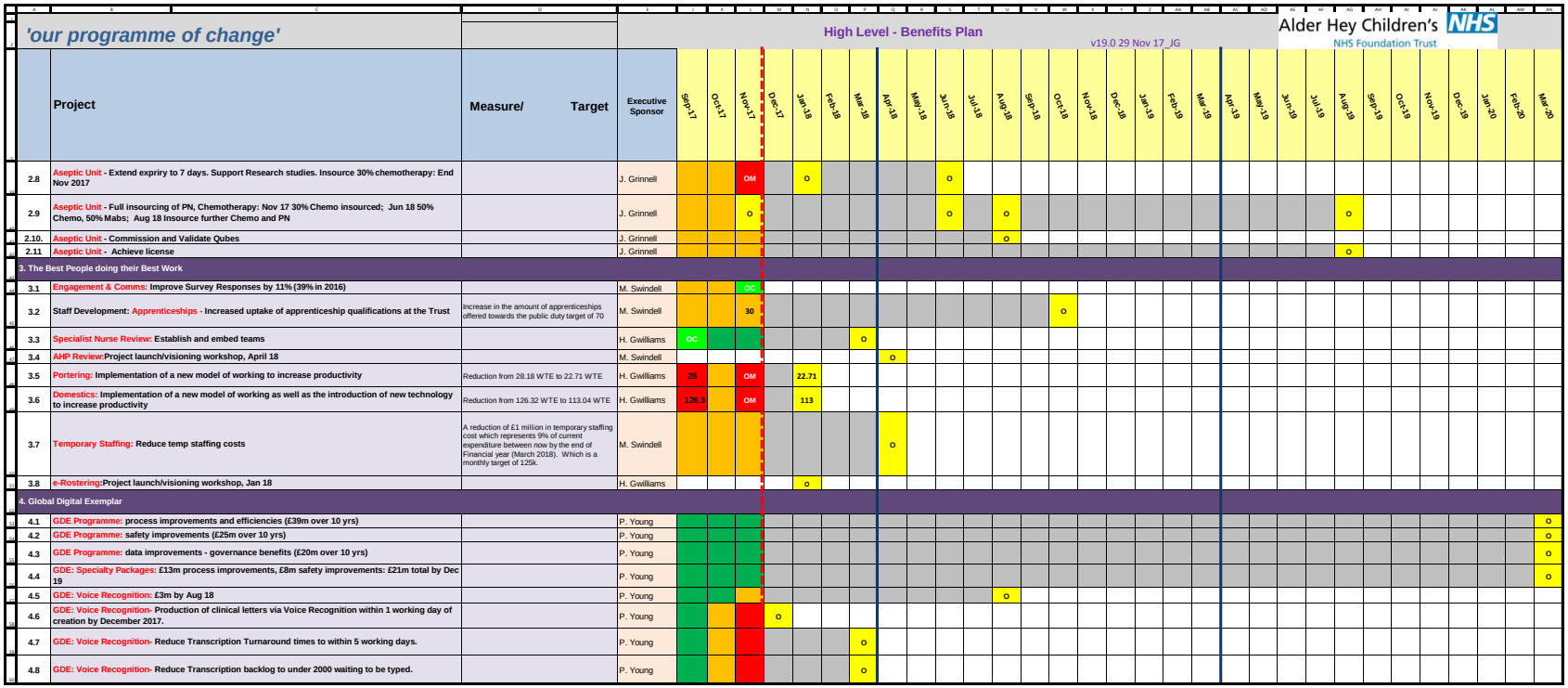
Appendix: High Level Plan

'our programme of change'

High Level - Benefits Plan

v19.0 29 Nov 17_JG

	Project	Measure/ Target	Executive Sponsor	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
1. Deliver Outstanding Care																																	
1.1	Sepsis Pathway Completed	Pathway Complete	H. Gwilliams	OC																													
1.2	Doctors Sepsis Form Completed (90%)		H. Gwilliams				OM 50%			R 70%			R 90%																				
1.3	Sepsis training delivered via Mandatory Training	Sepsis training now delivered via mandatory training	H. Gwilliams							O																							
1.4	Sepsis: 90% of Nurses Trained		H. Gwilliams			OC																											
1.5	Sepsis: Time of Administration of Antibiotics following Sepsis diagnosis	– 90% within 60mins	H. Gwilliams		OM 80%					R 90%																							
1.6	O/P efficiency savings: increase utilisation and reduce DNA's.	£60k PYE Yr 1; £180k FYE Yr 2.	H. Gwilliams							O												O											
1.7	O/P reduction in costs for patient correspondence.	16% reduction Yr 1, 64% reduction Yr 2.	H. Gwilliams							O												O											
1.8	O/P reduction in PALS concerns related to phlebotomy wait times.	50% reduction Yr 1, 95% reduction Yr 2.	H. Gwilliams							O												O											
1.9	Best In Operative Care (BIOC): Reduction by 10% of patients cancelled on the day of surgery due to avoidable hospital led reasons	10% reduction in cancelled operations. Monthly level of cancellations to be no more than 12 per month, year-end target is 149.	Steve Ryan	27	16					149																							
1.10	BIOC: Number of Incidents reporting patient harm (Grade C or above)	10% year-on-year reduction in actual harm. This equates to no more than 3 patient harms per month.	Steve Ryan	9	6					0																							
1.11	BIOC: Pre-op service accessed by 5500 children (90% uptake in current specialties)	458 patients per month should receive a pre-operative assessment	Steve Ryan	370	361					5500																							
1.12	Primary Care Streaming - Implementation of National Primary Care Streaming Model which includes the construction of an additional ED building	Progress of building construction	Mags Barnaby							O																							
1.13	Primary Care Streaming - Performance against 4 Hour Target for ED for March 2018 (STF Standard).		Mags Barnaby							O																							
1.14	Best In Acute Care (BIAC): 7 Day Services- Standard 2: Time to first consultant review (100 % Within 14 Hours).	65% as of March 17. Only measured every 6 months, next update expected.	Steve Ryan	65%	65%	OM				R																							
1.15	BIAC: Medical Management of Complex Surgical Patients progress against milestones leading to model implementation.		Steve Ryan																														
1.16	BIAC: Outreach Team- Progress against milestones leading to model implementation.		Steve Ryan																														
1.17	Best In Community Care (BICC) (Including Mental Health and Complex Needs): Number of children seen in joint clinic supported by Neonatal community nurse	50 attendances per year by end of March 2018								O																							
1.18	BICC: Patients with 30 day LoS	Reduction each month with a target to get to 20 by end of March								O																							
1.19	BICC: Repatriation policy agreed, in place and shared with staff	Agreed policy & communications plan						O																									
1.20	BICC: Homecare model of care for future provision agreed	Income covers costs (£250k improvement)									O																							
1.21	BICC: Rehab pathways to support earlier discharge	Reduction in LOS for SDR surgery from 21 days to 7					O																										
1.22	BICC: Improved process for repeat prescribing for Melatonin	20% reduction in prescribing by end March 2018. £10k benefit (less admin resources required)						O																									
2. Growing through External Partnerships																																	
2.1	Neonatal service - % of families who would recommend the service	5% increase in families who would recommend the service	Steve Ryan														O																
2.2	Neonatal Service Number of patients being transferred from LWH to AH and back again for paediatric surgery		Steve Ryan														O																
2.3	International Health & Non-NHS: Delivery of AJCH Partnership £116k recurrent fm Apr 17		J. Grinnell	OM						R																							
2.4	International Health & Non-NHS: Expansion non NHS patient activity: recurrent target set £60k		J. Grinnell				O																										
2.5	International Health & Non-NHS: Establishing commercial capability - target 10 visits		J. Grinnell						O																								
2.6	CHD Partnership - Including Stoke Partnership	Level 1 adult congenital heard disease services commence in Liverpool. Leading indicator of additonal 2,514 outpatients appointments per annum and 209 per month	J. Grinnell										O																				
2.7	Aseptic Unit - Respond to external audit: end Nov 2017		J. Grinnell			OC							O																				



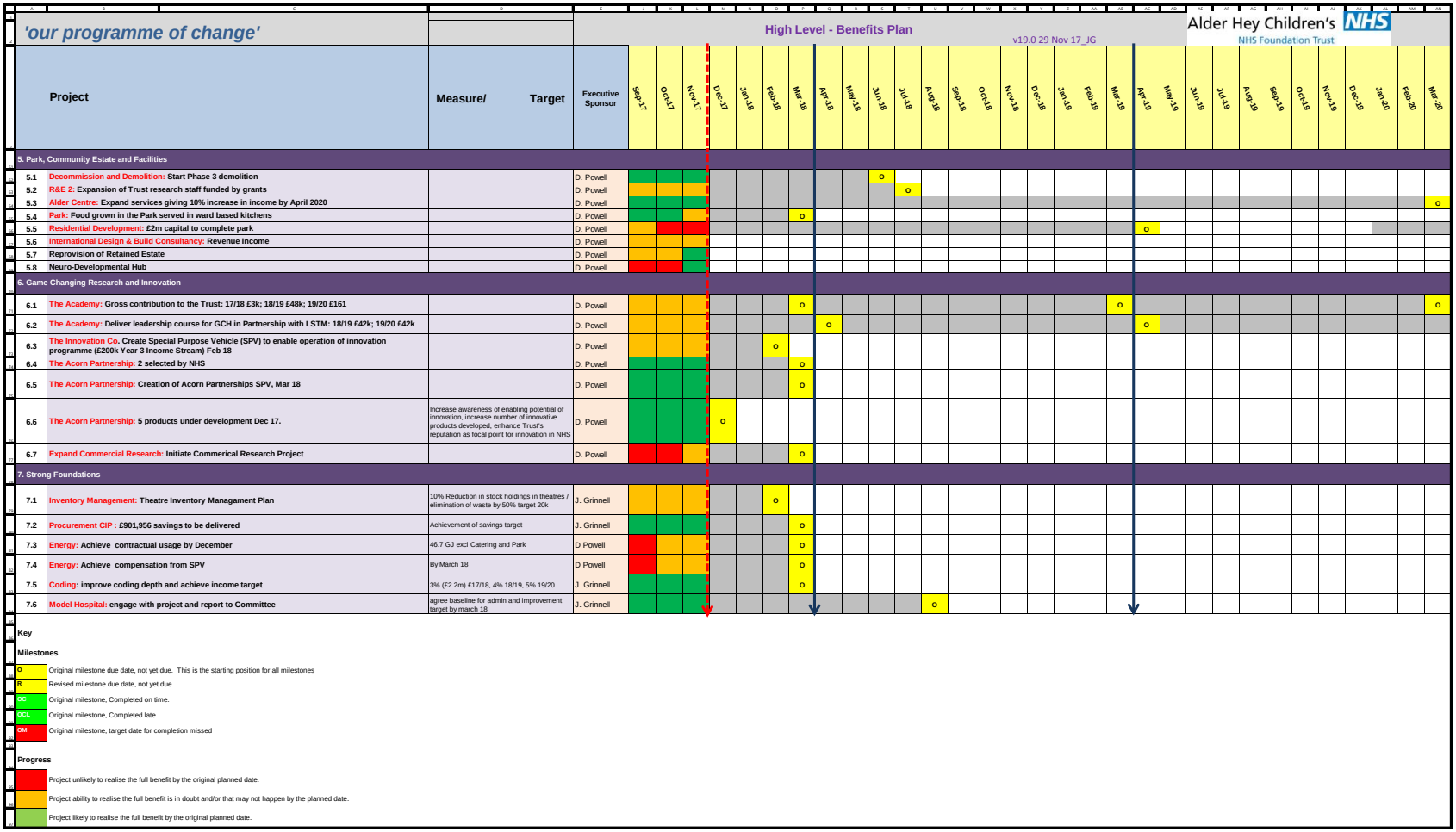
'our programme of change'

High Level - Benefits Plan

v19.0 29 Nov 17_JG

Alder Hey Children's NHS Foundation Trust

	Project	Measure/ Target	Executive Sponsor	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
2.8	Aseptic Unit - Extend expriry to 7 days. Support Research studies. Insource 30% chemotherapy: End Nov 2017		J. Grinnell			OM		O					O																				
2.9	Aseptic Unit - Full insourcing of PN, Chemotherapy: Nov 17 30% Chemo insourced; Jun 18 50% Chemo, 50% Mabs; Aug 18 Insource further Chemo and PN		J. Grinnell			O							O		O											O							
2.10.	Aseptic Unit - Commission and Validate Qubes		J. Grinnell												O																		
2.11	Aseptic Unit - Achieve license		J. Grinnell																							O							
3. The Best People doing their Best Work																																	
3.1	Engagement & Comms: Improve Survey Responses by 11% (39% in 2016)		M. Swindell			OC																											
3.2	Staff Development: Apprenticeships - Increased uptake of apprenticeship qualifications at the Trust	Increase in the amount of apprenticeships offered towards the public duty target of 70	M. Swindell			30											O																
3.3	Specialist Nurse Review: Establish and embed teams		H. Gwilliams	OC						O																							
3.4	AHP Review:Project launch/visioning workshop, April 18		M. Swindell								O																						
3.5	Portering: Implementation of a new model of working to increase productivity	Reduction from 28.18 WTE to 22.71 WTE	H. Gwilliams	28		OM		22.71																									
3.6	Domestics: Implementation of a new model of working as well as the introduction of new technology to increase productivity	Reduction from 126.32 WTE to 113.04 WTE	H. Gwilliams	126.3		OM		113																									
3.7	Temporary Staffing: Reduce temp staffing costs	A reduction of £1 million in temporary staffing cost which represents 9% of current expenditure between now by the end of Financial year (March 2018). Which is a monthly target of 125k.	M. Swindell								O																						
3.8	e-Rostering:Project launch/visioning workshop, Jan 18		H. Gwilliams					O																									
4. Global Digital Exemplar																																	
4.1	GDE Programme: process improvements and efficiencies (£39m over 10 yrs)		P. Young																														O
4.2	GDE Programme: safety improvements (£25m over 10 yrs)		P. Young																														O
4.3	GDE Programme: data improvements - governance benefits (£20m over 10 yrs)		P. Young																														O
4.4	GDE: Specialty Packages: £13m process improvements, £8m safety improvements: £21m total by Dec 19		P. Young																														O
4.5	GDE: Voice Recognition: £3m by Aug 18		P. Young												O																		
4.6	GDE: Voice Recognition- Production of clinical letters via Voice Recognition within 1 working day of creation by December 2017.		P. Young				O																										
4.7	GDE: Voice Recognition- Reduce Transcription Turnaround times to within 5 working days.		P. Young							O																							
4.8	GDE: Voice Recognition- Reduce Transcription backlog to under 2000 waiting to be typed.		P. Young							O																							



	Project	Measure/ Target	Executive Sponsor	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20
5. Park, Community Estate and Facilities																																	
5.1	**Decommission and Demolition:** Start Phase 3 demolition		D. Powell										O																				
5.2	**R&E 2:** Expansion of Trust research staff funded by grants		D. Powell											O																			
5.3	**Alder Centre:** Expand services giving 10% increase in income by April 2020		D. Powell																														O
5.4	**Park:** Food grown in the Park served in ward based kitchens		D. Powell							O																							
5.5	**Residential Development:** £2m capital to complete park		D. Powell																				O										
5.6	**International Design & Build Consultancy:** Revenue Income		D. Powell																														
5.7	**Reprovision of Retained Estate**		D. Powell																														
5.8	**Neuro-Developmental Hub**		D. Powell																														
6. Game Changing Research and Innovation																																	
6.1	**The Academy:** Gross contribution to the Trust: 17/18 £3k; 18/19 £48k; 19/20 £161		D. Powell							O												O										O
6.2	**The Academy:** Deliver leadership course for GCH in Partnership with LSTM: 18/19 £42k; 19/20 £42k		D. Powell								O												O										
6.3	**The Innovation Co.** Create Special Purpose Vehicle (SPV) to enable operation of innovation programme (£200k Year 3 Income Stream) Feb 18		D. Powell						O																								
6.4	**The Acorn Partnership:** 2 selected by NHS		D. Powell							O																							
6.5	**The Acorn Partnership:** Creation of Acorn Partnerships SPV, Mar 18		D. Powell							O																							
6.6	**The Acorn Partnership:** 5 products under development Dec 17.	Increase awareness of enabling potential of innovation, increase number of innovative products developed, enhance Trust's reputation as focal point for innovation in NHS	D. Powell				O																										
6.7	**Expand Commercial Research:** Initiate Commerical Research Project		D. Powell							O																							
7. Strong Foundations																																	
7.1	**Inventory Management:** Theatre Inventory Managament Plan	10% Reduction in stock holdings in theatres / elimination of waste by 50% target 20k	J. Grinnell						O																								
7.2	**Procurement CIP :** £901,956 savings to be delivered	Achievement of savings target	J. Grinnell							O																							
7.3	**Energy:** Achieve contractual usage by December	46.7 GJ excl Catering and Park	D Powell							O																							
7.4	**Energy:** Achieve compensation from SPV	By March 18	D Powell							O																							
7.5	**Coding:** improve coding depth and achieve income target	3% (£2.2m) £17/18, 4% 18/19, 5% 19/20.	J. Grinnell							O																							
7.6	**Model Hospital:** engage with project and report to Committee	agree baseline for admin and improvement target by march 18	J. Grinnell												O																		

Key

Milestones

O	Original milestone due date, not yet due. This is the starting position for all milestones
R	Revised milestone due date, not yet due.
OC	Original milestone, Completed on time.
OCL	Original milestone, Completed late.
OM	Original milestone, target date for completion missed

Progress

	Project unlikely to realise the full benefit by the original planned date.
	Project ability to realise the full benefit is in doubt and/or that may not happen by the planned date.
	Project likely to realise the full benefit by the original planned date.

Corporate Report

Oct 2017

Corporate Report

Alder Hey Children's NHS
NHS Foundation Trust

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Executive Summary

Oct 2017

Alder Hey Children's NHS Foundation Trust

Is there a Governance Issue?

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

Highlights

The Trust is compliant with incomplete & diagnostic standards despite the higher than planned NEL admissions and ED attendance. Winter Plan is now operational which means that we have started to increase capacity and responsiveness to managing winter attendances and ensure we are Flu ready. Clinical Utilisation Review system is now operational to assist with the management of flow. We have achieved higher levels of activity that the previous year, seeing increased referrals into the hospital and providing enough OP capacity to manage this and support CQUIN requirements for E-booking.

Challenges

The Trust winter plan has now formally commenced. Continuing higher than planned levels of Non Elective admissions for surgery and medicine in conjunction with high levels of ED attendance have made October a challenging month following in a similar vein from September. This has impacted upon flow which in conjunction however the mitigating actions have supported flow outwith ED. This has meant that cancelled operations have reduced and positively affects theatre utilisation. Despite this 28 day relist breaches have increased due to specialty specific challenges. ED 4 hour standard failed for the month due to small number of high volume breach days and change in counting for GP streaming.

Patient Centred Services

Deterioration noted in performance in metrics due to challenging operational conditions. High levels of NEL admission and ED attendance have continued to test the hospital and deterioration noted with theatre and OP utilisation. Theatre productivity hampered by cancelled operations on the day and when split surgical and medical performance has deteriorated. OP utilisation also requires further review as medical & surgical division utilisation has improved but community has worsened. ED metrics have worsened considerably reflecting departmental challenges due to volume. DNA rates have improved but true performance maybe masked by cashing up challenges within clinics. This is being addressed through the OP improvement group.

Excellence in Quality

There was 1 MRSA bacteraemia reported in October, which is subject to a full RCA. Total HAIs remains lower than last year. Acute readmission of patients with long term conditions has improved with only 2 reported in month. Also the number of surgical patients discharged later than plan has reduced from 72 last month to 36 in October. There were 10 formal complaints in October, the highest in any month this year.
Continued effort is needed to improve 'Patients aware of their planned date of discharge' (57.4%) and 'Patients involved in play & learning' (73%) are. Work is also needed to improve level of F&F feedback in A&E and in Community. Medication errors with harm remain low at 13 ytd. There were 3x grade 2 or higher pressure ulcers reported in October and staff are reminded to be vigilant and keep reporting. The cumulative increase in clinical incidents associated with harm was flagged last month. A review of the recorded harm levels has shown this to be in minor harm incidents.

Financial, Growth & Mandatory Framework

For the month of October the Trust is reporting a trading surplus of £0.3m which is £0.7m behind plan.

Income is in line with plan but shortfalls in elective and outpatient income are offset by over performance in non elective activity and pass through drugs and devices costs (which are offset by expenditure). Elective activity is behind plan by 13%, non elective is ahead by 24% and outpatient activity is behind by 5%.

Pay budgets are 0.6m overspent for the month relating to use of temporary staffing and the impact of unachieved savings targets. The Trust is behind plan with the CIP target by £0.5m to date. Cash in the Bank is £10.9m. Monitor Use of Resources rating of 3 in line with plan.

Great Talented Teams

The Trust position on sickness absence increased in October rising to 5.08%. Whilst the PDR window closed end of July there continues to be an increase and as of Oct was 87.3%. Mandatory training increased slightly to 76% but still below the 90% target, there has been a significant push across the organisation in respect of increasing compliance across depts and individuals so it is hoped that this will increase at a much higher rate between now and end of Jan 18, with action plans being established. Developments are also still underway in respect of increasing methods of undertaking training.

Leading Metrics

Oct 2017

Alder Hey Children's NHS
NHS Foundation Trust

Patient Centered Services

Metric Name	Goal	Sep 2017	Oct 2017	Trend	Last 12 Months
ED: 95% Treated within 4 Hours	95.0 %	95.0 %	94.5 %	▼	
RTT: 90% Admitted within 18 weeks		86.8 %	89.2 %	▲	
RTT: 95% Non-Admitted within 18 weeks		89.4 %	90.3 %	▲	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.1 %	92.2 %	▲	
Diagnostics: Numbers waiting over 6 weeks		0	0	–	
Average LoS - Elective (Days)		3.1	2.6	▼	
Average LoS - Non-Elective (Days)		2.1	2.0	▼	
Daycase Rate	0.0 %	71.3 %	71.2 %	▼	
Theatre Utilisation - % of Session Utilised	90.0 %	86.5 %	86.2 %	▼	
28 Day Breaches	0.0	0	8	▲	
Clinic Session Utilisation	90.0 %	85.0 %	85.7 %	▲	
DNA Rate	12.0 %	10.6 %	10.3 %	▼	
Cancelled Operations - Non Clinical - On Same Day		48	25	▼	

Excellence in Quality

Metric Name	Goal	Sep 2017	Oct 2017	Trend	Last 12 Months
Never Events	0.0	0	0	–	
IP Survey: % Received information enabling choices about their care	90.0 %	96.5 %	96.1 %	▼	
IP Survey: % Treated with respect	100.0 %	99.5 %	99.3 %	▼	
IP Survey: % Know their planned date of discharge	80.0 %	65.0 %	57.4 %	▼	
IP Survey: % Know who is in charge of their care	95.0 %	92.8 %	93.8 %	▲	
IP Survey: % Patients involved in play and learning	80.0 %	73.0 %	72.6 %	▼	
Pressure Ulcers (Grade 2 and above) YTD		23	26	▲	
Total Infections (YTD)	49.0	26	36	▲	
Medication errors resulting in harm (YTD)	35.0	12	13	▼	
Clinical Incidents resulting in harm (YTD)	343.0	459	536	▼	

Great and Talented Teams

Metric Name	Goal	Sep 2017	Oct 2017	Trend	Last 12 Months
Corporate Induction	100.0 %	85.0 %	69.2 %	▼	
PDR	90.0 %	86.2 %	87.3 %	▲	
Medical Appraisal	100.0 %	8.0 %	8.0 %	–	
Sickness	4.5 %	4.9 %	5.4 %	▲	
Mandatory Training	90.0 %	74.4 %	75.5 %	▲	
Staff Survey (Recommend Place to Work)		39.6 %	TBC		
Actual vs Planned Establishment (%)		93.2 %	94.4 %	▲	
Temporary Spend ('000s)		999	918	▼	

Financial, Growth and Mandatory Framework

Metric Name	Sep 2017	Oct 2017	Last 12 Months
CIP In Month Variance ('000s)	5	-459	
Monitor Risk Ratings (YTD)	3	3	
Trading Surplus/(Deficit)	-456	317	
Capital Expenditure YTD % Variance	-3.5 %	-56.6 %	
Cash in Bank (£M)	9.1	10.9	

Exceptions

Oct 2017

Alder Hey Children's NHS Foundation Trust

Positive (Top 5 based on % change)

Metric Name	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Last 12 Months
Average LoS - Elective (Days)	3.0	3.0	3.0	2.6	3.4	2.8	3.0	3.6	2.7	3.2	2.9	3.1	2.6	
Average LoS - Non-Elective (Days)	1.7	1.9	1.9	2.0	2.1	1.9	2.0	2.2	2.0	2.1	2.2	2.1	2.0	
DNA Rate	11.5%	11.9%	14.6%	12.9%	12.7%	10.6%	12.7%	12.7%	12.5%	12.4%	12.5%	10.6%	10.3%	
Temporary Spend ('000s)	894	800	550	1,442	813	1,037	948	917	883	1,092	1,166	999	918	
Medication errors resulting in harm (YTD)	31	39	44	52	57	66	1	2	3	7	9	12	13	

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

Metric Name	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Last 12 Months
Theatre Utilisation - % of Session Utilised	85.1%	85.1%	84.1%	86.6%	87.0%	86.8%	87.2%	87.3%	88.2%	86.1%	87.5%	86.5%	86.2%	
PPM%	93.3%	94.5%	95.8%	94.6%	96.2%	97.3%	93.1%	95.5%	95.0%	98.4%	98.6%	96.9%	98.4%	
Cancelled Operations - Non Clinical - On Same Day	22	28	12	17	29	31	7	57	19	31	15	48	25	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	
Total Infections (YTD)	60	69	75	84	93	104	6	9	13	15	20	26	36	

Challenge (Top 5 based on % change)

Metric Name	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Last 12 Months
Medical Appraisal	11.0%	16.7%	48.4%	57.2%	64.8%	87.0%	77.7%	77.7%	33.3%	79.2%	81.0%	8.0%	8.0%	
Sickness	5.4%	5.4%	5.5%	5.4%	5.3%	4.7%	4.5%	4.6%	4.6%	5.0%	4.9%	4.9%	5.4%	
Pressure Ulcers (Grade 2 and above) YTD	18	22	26	28	29	32	2	7	12	20	22	23	26	
Mandatory Training	75.4%	75.3%	76.1%	77.2%	78.8%	75.4%	76.1%	76.0%	76.2%	78.2%	77.2%	74.4%	75.5%	
Clinical Incidents resulting in harm (YTD)	363	442	503	565	634	738	60	131	210	309	378	459	536	

Patient Safety

Oct 2017

Alder Hey Children's NHS
NHS Foundation Trust

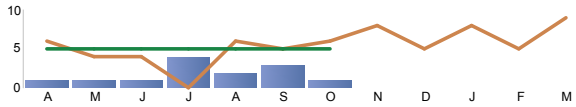
Summary

There was 1x medication errors associated with harm recorded in October compared to 3 in September. This is 13 in year compared to 31 last year. There were 3x grade 2 or higher pressure ulcers reported in October, i.e. 26 year to date compared to 18 last year. Clinical incidents associated with harm fell slightly from 81 last month to 77 in October. This is 536 ytd compared to 363 last year. This was previously flagged as a significant increase and a review of the recorded harm levels has shown this to be in minor harm incidents. Staff are reminded to keep reporting, paying attention to the level of harm reported, if any. Two readmissions to PICU within 48 hrs is lower than Aug & Sept.

17/18 16/17 Threshold

Medication Errors

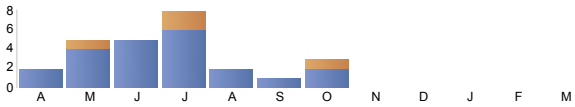
Medication errors resulting in harm (YTD) — 13 (goal: 35.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	2	3	7	9	12	13					
16/17	6	10	14	14	20	25	31	39	44	52	57	66

Pressure Ulcers

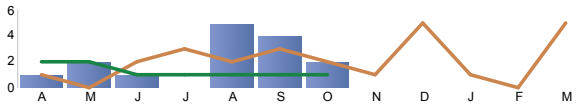
Pressure Ulcers (Grade 2 and above) YTD — 26 (Est. Baseline)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	7	12	20	22	23	26					
16/17	3	6	8	9	11	16	18	22	26	28	29	32

Readmissions to PICU within 48 hrs

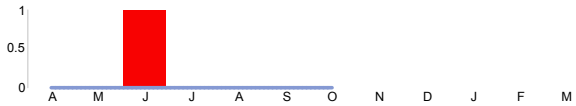
Readmissions to PICU within 48 hrs (YTD) — 15 (goal: 9.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	1	3	4	4	9	13	15					
16/17	1	1	3	6	8	11	13	14	19	20	20	25

Never Events

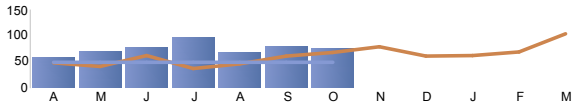
Never Events — 0 (goal: 0.0)



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

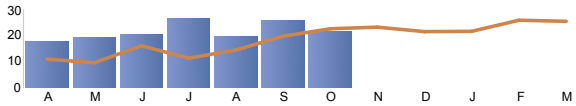
Incidents

Clinical Incidents resulting in harm (YTD) — 536 (goal: 343.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	60	131	210	309	378	459	536					
16/17	48	89	151	188	234	295	363	442	503	565	634	738

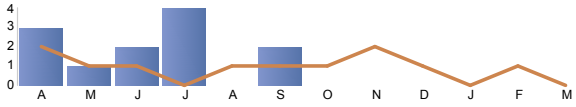
% of Total Clinical Incidents that resulted in Harm — 22.1 %



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	18	19	20	22	21	22	22					
16/17	11	10	12	12	12	13	15	16	16	17	17	18

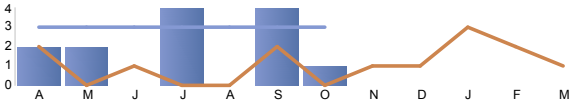
Serious incidents requiring investigation

Serious Incidents Requiring Investigation (Total) — 0



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3	4	6	10	10	12	12					
16/17	2	3	4	4	5	6	7	9	10	10	11	11

Clinical Incidents resulting in moderate, severe harm or death (YTD) — 13 (goal: 21.0)



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	2	4	4	8	8	12	13					
16/17	2	2	3	3	3	5	5	6	7	10	12	13

Patient Experience

Oct 2017

Alder Hey Children's NHS Foundation Trust

Summary

There were 10 formal complaints in October, the highest number in any month so far this year. Staff are encouraged to continue to deal with patient / carer matters locally wherever possible. The cumulative number of PALS attendances has reduced from 752 last year to 699 this year. Continued effort is needed to keep improving the metrics 'patients are aware of their planned date of discharge', (currently at 57.4% versus 65% last month), and 'patients involved in play and learning' which is around 73%. Also discussions are underway to improve F&F feedback from A&E and Community areas.

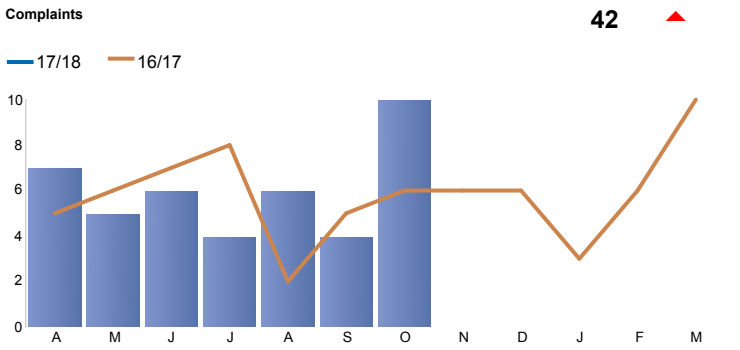
Inpatient Survey

Metric Name	Goal	Sep 2017	Oct 2017	Trend	Last 12 Months
% Know who is in charge of their care	95.0 %	92.8 %	93.8 %	▲	
% Patients involved in play and learning	80.0 %	73.0 %	72.6 %	▼	
% Know their planned date of discharge	80.0 %	65.0 %	57.4 %	▼	
% Received information enabling choices about their care	90.0 %	96.5 %	96.1 %	▼	
% Treated with respect	100.0 %	99.5 %	99.3 %	▼	

Friends and Family

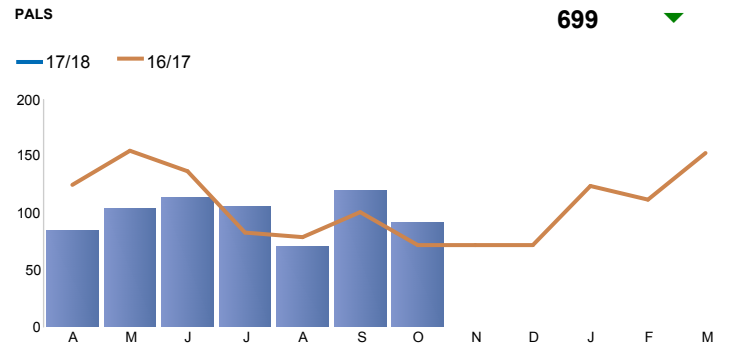
Metric Name	Required Responses	Number of Responses	Sep 2017	Oct 2017	Trend	Last 12 Months
A&E - % Recommend the Trust	250	62	93.2 %	95.2 %	▲	
Community - % Recommend the Trust	29	4	100.0 %	100.0 %	–	
Inpatients - % Recommend the Trust	300	667	98.5 %	97.9 %	▼	
Mental Health - % Recommend the Trust	27	17	96.3 %	94.1 %	▼	
Outpatients - % Recommend the Trust	400	566	91.4 %	95.8 %	▲	

Complaints



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	7	12	18	22	28	32	42					
16/17	5	11	18	26	28	33	39	45	51	54	60	70

PALS



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	86	191	306	413	485	606	699					
16/17	125	280	417	500	579	680	752	824	896	1,020	1,132	1,285

Clinical Effectiveness

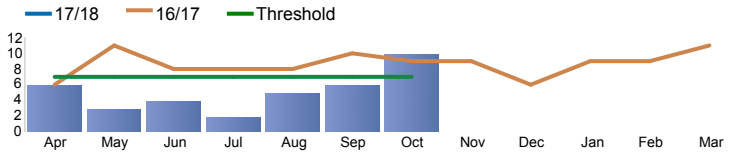
Oct 2017

Alder Hey Children's NHS Foundation Trust

Summary

There were 10 healthcare acquired infections reported in October, including one case of MRSA bacteraemia. This will undergo a full Root Cause Analysis. Clostridium difficile has remained at zero. There were 2 readmissions of patients with long term conditions within 28 days. This has improved from 8 last month and an average of 6 over each of the last 6 months. Surgical patients discharged later than their EDD has reduced significantly from 72 reported last month to 36 in October. There was an increase in hospital deaths in October with 9 reported, 8 of which were on ICU.

Infections



YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	6	9	13	15	20	26	36					
16/17	6	17	25	33	41	51	60	69	75	84	93	104

Total Infections (YTD)

36 ▲ (goal: 49.0)

Hospital Acquired Organisms - MRSA (BSI) (YTD)

1 ▲ (goal: 0.0)

Hospital Acquired Organisms - C.difficile (YTD)

0 – (goal: 0.0)

Outbreak Infections (YTD)

2 –

Cluster Infections (YTD)

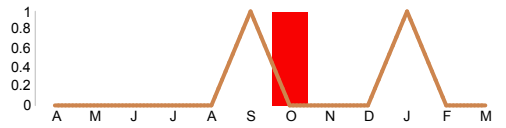
0 –

Legend

17/18
16/17
Threshold

Hospital Acquired Organisms - MRSA (BSI)

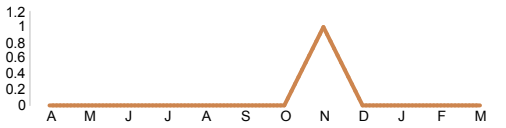
1 ▲ (goal: 0.0)



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

Hospital Acquired Organisms - C.difficile

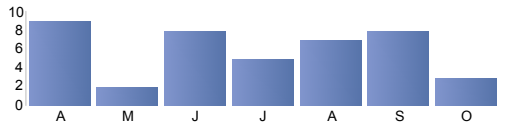
0 – (goal: 0.0)



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

Acute readmissions of patients with long term conditions within 28 days

42 (Est. Baseline)

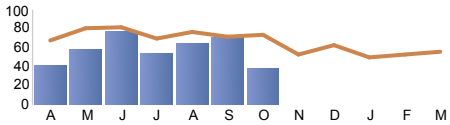


YTD	Apr	May	Jun	Jul	Aug	Sep	Oct
17/18	9	11	19	24	31	39	42

Admissions & Discharges

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

412 (Est. Baseline)

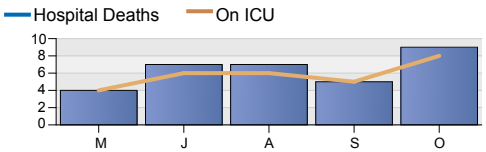


% of patients with an estimated discharge date discharge later than planned (only surgical)

3.8 % (Est. Baseline)

YTD	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
17/18	3.3%	3.6%	4.0%	3.8%	3.9%	4.1%	3.8%					
16/17	5.1%	5.4%	5.5%	5.4%	5.4%	5.3%	5.3%	5.1%	5.1%	4.9%	4.8%	4.7%

Mortality in Hospital



Deaths in Hospital

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

Access

Oct 2017

Alder Hey Children's NHS Foundation Trust

Summary

Incomplete pathway and diagnostic standards achieved for October despite challenging for ED & NEL admissions with notable increases for surgery and medicine. Cancer 31 day standard failed due to 1 patient exercising choice to delay treatment. Activity higher than the same period last year and hospital utilisation has increased.Referrals increased against the same period last year with C&B capacity available to meet demand. No patients waiting greater than 52 weeks.

18 Weeks

RTT: 90% Admitted within 18 weeks 89.2 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.4%	88.0%	89.5%	88.3%	89.2%

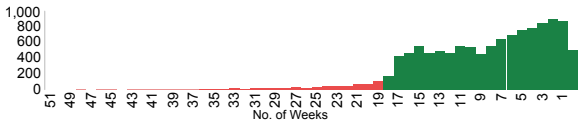
RTT: 95% Non-Admitted within 18 weeks 90.3 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
86.6%	88.9%	89.1%	89.2%	90.3%

RTT: 92% Waiting within 18 weeks (open Pathways) 92.2 % (goal: 92.0 %)

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

Open Pathways Weekly Profile Oct 2017



0-18 Wks	19-36 Wks	36-51 Wks
11,321	694	133

Cancer

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

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

All Cancers: 31 day wait referral to treament 92.3 % (goal: 100.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
100.0%	100.0%	96.4%	100.0%	92.3%

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

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

Diagnostics

Diagnostics: % Completed Within 6 Weeks 100.0 % (goal: 99.0 %)

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

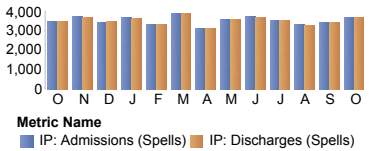
Waiting Times Failed 0

Waiting Times Passed 7

Number of Diagnostics

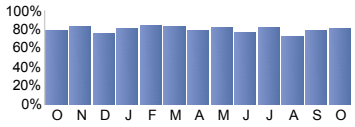
375

Admissions and Discharges



Bed Occupancy

Bed Occupancy (Funded Beds) 82.4 %



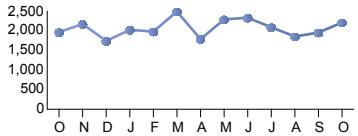
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
80.2%	83.9%	80.1%	79.3%	82.4%

Provider

Convenience and Choice: Slot Availability 99.7 % (goal: 96.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
99.2%	97.0%	98.0%	98.4%	99.7%

Referrals Received (GP)



Emergency Department

Oct 2017

Alder Hey Children's NHS
NHS Foundation Trust

Summary

October 2017 was a challenge and resulted in a failure regarding the four hour target (94.5% meaning a four hour breach for 303 patients), the second time this calendar year. There were 5494 attendances (the largest number in the last 12 months) and a particular struggle with green category patients. A recent refocus within the Department towards green patients will help to reduce breaches for subsequent months. Focus continues on winter planning and supporting the introduction of the enhanced primary care streaming model.

ED

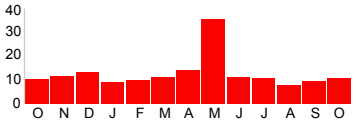
ED: 95% Treated within 4 Hours — 94.5 % (goal: 95.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
93.1%	96.7%	96.0%	95.3%	94.5%

ED: Total Time in ED (95th Percentile) — 269.4 mins (goal: 240.0 mins)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
838.8	714.0	717.0	753.0	269.4

ED: Longest Wait Time (Hrs) — 11.0 (goal: 0.0)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
36.0	30.6	61.3	28.5	11.0

ED: Number Treated Over 4 Hours

303

ED to Inpatient Conversion Rate

15.4 %

Oct 2017

ED

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

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

ED: 60 minute 'Time to Treat Decision' (Median) — 84.5 mins (goal: 60.0 mins)

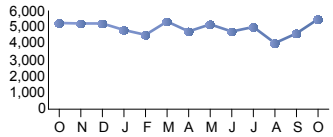
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
239.0	227.0	247.5	206.0	84.5

ED: Percentage Left without being seen — 3.8 %

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
3.1%	2.3%	3.0%	2.8%	3.8%

ED: Number of Attendances

5494 Oct 2017



Ambulance Services

Ambulance: Acute Compliance — 79.7 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
83.3%	90.1%	88.4%	84.2%	79.7%

Ambulance: Average Notification to Handover Time (mins) — 3.6 mins (goal: 15.0 mins)

Ambulance: Patients Waiting between 30 and 45 minutes — 1

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
5.0	11.0	9.0	4.0	1.0

Ambulance: Patients Waiting between 45 and 60 minutes — 1

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
4.0	2.0	2.0	1.0	1.0

Productivity & Efficiency

Oct 2017

Alder Hey Children's NHS Foundation Trust

Summary

Continued high levels of Non Elective admissions for surgery and medicine in conjunction with higher than planned ED attendance have made Oct a challenging month. Winter plan commenced which has supported flow which has improved productivity. This has meant that cancelled operations have decreased however theatre utilisation has decreased slightly with 28 day breaches increasing notably within ENT due to capacity challenges. OP utilisation has been maintained from September

Length of Stay

Average LoS - Elective (Days) 2.6

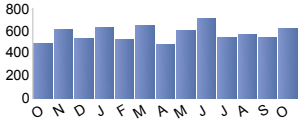
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
3.0	2.9	3.1	3.0	2.6

Average LoS - Non-Elective (Days) 2.0

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

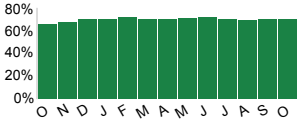
Day Case Rate

Daycases (K1/SDCPREOP) 634



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
1,653	1,820	1,819	1,674	634

Daycase Rate 71.2 % (goal: 0.0 %)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
68.6%	71.2%	71.9%	70.8%	71.2%

Bed Refusals

Bed Refusals 0 (goal: 0.0)

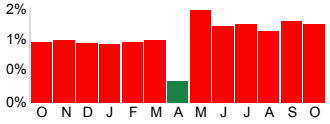
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0	1	0	0	0

Theatres / Surgery

Theatre Utilisation - % of Session Utilised * 86.2 % (goal: 90.0 %)

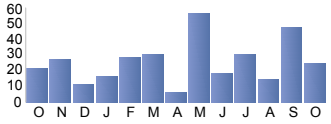
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
84.8%	86.8%	87.6%	86.7%	86.2%

Cancelled Operations - Non Clinical - On Same Day (%) (YTD) 1.3 % (goal: 0.8 %)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.9%	1.1%	1.2%	1.4%	1.0%

Cancelled Operations - Non Clinical - On Same Day 25



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
62	77	83	94	25

28 Day Breaches 8 (goal: 0.0)

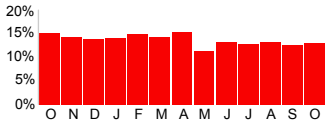
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
11	8	11	10	8

Outpatients

Clinic Session Utilisation * 85.7 % (goal: 90.0 %)

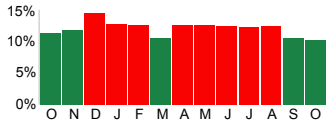
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
85.4%	85.9%	85.8%	85.1%	85.7%

OP Appointments Cancelled by Hospital % 13.2 % (goal: 5.0 %)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
14.6%	14.6%	13.3%	13.0%	13.2%

DNA Rate 10.3 % (goal: 12.0 %)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
12.6%	12.0%	12.6%	11.8%	10.3%

OP: New/Follow Up 2.6

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

Facilities

Oct 2017

Alder Hey Children's NHS Foundation Trust

Summary

During October we have audited all Very High risk Areas and approx. 60% of High Risk Areas. For next month we intend to increase our compliance

Facilities

Cleanliness Performance VH 97.2 % (goal: 98.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
96.7%	97.7%	99.7%	96.9%	97.2%

Cleanliness Performance H 96.5 % (goal: 95.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
95.7%	94.0%	94.6%	96.0%	96.5%

Cleanliness Performance S 85.5 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
96.3%	96.5%	90.3%	84.6%	85.5%

Cleanliness Performance L 75.0 % (goal: 75.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
100.0%	100.0%	90.0%	75.1%	75.0%

Facilities

Audit Compliance 75.0 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
77.0%	40.0%	6.7%	21.7%	75.0%

Facilities - Other

Routine Maintenance Resolution 95.1 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
99.7%	96.6%	92.6%	95.7%	95.1%

PPM% 98.4 % (goal: 85.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
94.4%	96.1%	94.8%	97.9%	98.4%

CAMHS

Oct 2017

Alder Hey Children's NHS Foundation Trust

Summary

Liverpool pathway is at 11 weeks, Sefton pathway is at 18 weeks. Capacity issues at choice remain a concern. The success of a bid to support crisis care will enable the team to split choice into the localities and better manage the demand into the system, in coming months and will see the wait reduce. Work continues around capacity being managed within templates, this will support a more robust DNA process.

Waiting Times

CAMHS: Avg Wait to Partnership Appt (Weeks)- Liverpool Specialist 15.0

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	43.0	51.0	15.0

CAMHS: Avg Wait to Partnership Appt (Weeks)- Sefton Specialist 26.0

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	43.0	51.0	15.0

Eating Disorder Pathway

Routine EDYS Pathway Average Wait in Weeks 2

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	6.0	5.0	1.7

Urgent EDYS Pathway Average Wait in Weeks 1

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
0.0	0.0	1.0	0.1	0.7

DNA Rates

CAMHS: DNA Rate - New 13.6 % (goal: 10.0 %)

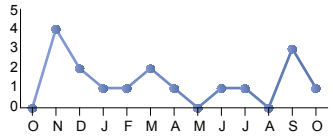
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
13.4%	13.6%	14.0%	18.2%	13.6%

CAMHS: DNA Rate - Follow Up 12.1 % (goal: 14.0 %)

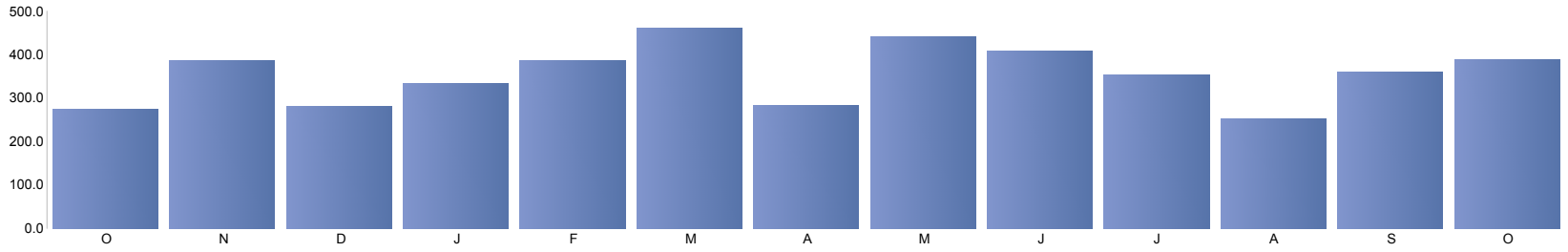
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
16.1%	17.5%	17.7%	17.5%	12.1%

Tier 4 Admissions

CAMHS: Total Admissions to DJU 1



CAMHS: Referrals Received



External Regulation

Oct 2017

Alder Hey Children's NHS Foundation Trust

Summary

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

Monitor - Governance Concern

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

Monitor - Risk Rating

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

Monitor Oct 2017

Metric Name	Goal	Sep 17	Oct 17	Trend
ED: 95% Treated within 4 Hours	95.0 %	95.0 %	94.5 %	▼
RTT: 90% Admitted within 18 weeks		86.8 %	89.2 %	▲
RTT: 95% Non-Admitted within 18 weeks		89.4 %	90.3 %	▲
RTT: 92% Waiting within 18 weeks (open Pathways)	92.0 %	92.1 %	92.2 %	▲
Monitor Risk Ratings (YTD)	2.0	3	3	–
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	100.0 %	100.0 %	100.0 %	–
All Cancers: 31 day wait referral to treament	100.0 %	100.0 %	92.3 %	▼
All Cancers: 31 day wait until subsequent treatments	100.0 %	100.0 %	100.0 %	–
Hospital Acquired Organisms - C.difficile	0.0	0	0	–

Monitor - 18 Weeks RTT

RTT: 90% Admitted within 18 weeks

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.4%	88.0%	89.5%	88.3%	89.2%

RTT: 95% Non-Admitted within 18 weeks

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
86.6%	88.9%	89.1%	89.2%	90.3%

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

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

Monitor - All Cancers

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

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

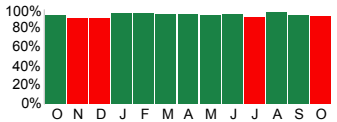
All Cancers: 31 day wait referral to treament

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
100.0%	100.0%	96.4%	100.0%	92.3%

All Cancers: 31 day wait until subsequent treatments

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

Monitor - A&E 4 Hour Target



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
93.1%	96.7%	96.0%	95.3%	94.5%

Monitor - C difficile

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

Monitor - Data Completeness

No Data Available

Workforce

Oct 2017

Alder Hey Children's NHS Foundation Trust

Summary

The Trust position on sickness absence increased in October rising to 5.08%. Whilst the PDR window closed end of July there continues to be an increase and as of Oct was 87.3%. Mandatory training increased slightly to 76% but still below the 90% target, there has been a significant push across the organisation in respect of increasing compliance across depts and individuals so it is hoped that this will increase at a much higher rate between now and end of Jan 18, with action plans being established. Developments are also still underway in respect of increasing methods of undertaking training.

Staff Group Analysis

Sickness Absence (rolling 12 Months)

Staff Group	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Last 12 Months
Add Prof Scientific and Technic	5.8%	5.2%	5.0%	5.9%	4.9%	3.6%	3.6%	3.9%	4.6%	4.2%	4.9%	2.9%	
Additional Clinical Services	6.9%	7.0%	6.6%	5.5%	5.7%	7.2%	7.4%	7.3%	7.7%	6.1%	5.7%	7.4%	
Administrative and Clerical	4.5%	4.7%	4.6%	5.0%	3.3%	2.8%	2.3%	2.4%	3.8%	4.4%	4.1%	4.6%	
Allied Health Professionals	3.3%	4.3%	2.3%	2.2%	3.5%	2.9%	3.2%	3.8%	3.2%	3.0%	3.2%	3.8%	
Estates and Ancillary	8.6%	10.9%	9.1%	7.4%	8.9%	10.7%	9.2%	9.1%	10.8%	14.7%	12.3%	13.2%	
Healthcare Scientists	1.9%	2.0%	1.7%	3.7%	2.3%	1.0%	3.3%	4.0%	4.6%	1.5%	3.1%	2.9%	
Medical and Dental	2.0%	1.6%	2.3%	2.4%	1.6%	1.1%	1.3%	1.3%	1.6%	1.6%	1.7%	1.9%	
Nursing and Midwifery Registered	6.2%	6.1%	6.4%	6.1%	5.5%	5.1%	5.4%	5.3%	5.1%	4.8%	5.0%	5.8%	
Trust	5.4%	5.6%	5.4%	5.2%	4.7%	4.5%	4.6%	4.6%	5.0%	5.0%	4.9%	5.4%	

Staff in Post FTE (rolling 12 Months)

Staff Group	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Last 12 Months
Add Prof Scientific and Technic	199	198	198	197	201	197	199	201	200	197	199	199	
Additional Clinical Services	368	367	370	373	376	391	393	392	400	397	413	414	
Administrative and Clerical	574	573	586	589	586	611	621	618	624	626	624	622	
Allied Health Professionals	126	130	132	132	131	208	209	212	214	215	218	222	
Estates and Ancillary	190	190	189	189	189	187	185	184	184	183	182	182	
Healthcare Scientists	106	108	107	107	107	107	107	109	110	110	108	108	
Medical and Dental	246	245	245	246	243	243	242	246	240	247	249	251	
Nursing and Midwifery Registered	971	970	972	981	970	968	970	971	964	959	1,013	1,018	

Staff in Post Headcount (rolling 12 Months)

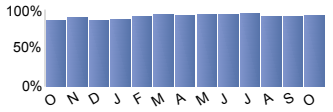
Staff Group	Nov 16	Dec 16	Jan 17	Feb 17	Mar 17	Apr 17	May 17	Jun 17	Jul 17	Aug 17	Sep 17	Oct 17	Last 12 Months
Add Prof Scientific and Technic	220	218	218	217	221	218	220	223	223	219	220	219	
Additional Clinical Services	431	430	434	439	442	469	470	468	477	473	490	492	
Administrative and Clerical	671	670	677	679	673	700	709	708	713	714	711	709	
Allied Health Professionals	155	161	163	163	161	257	258	261	263	264	266	270	
Estates and Ancillary	238	238	236	236	236	234	231	231	230	229	228	228	
Healthcare Scientists	116	118	117	117	117	117	117	119	119	119	119	117	
Medical and Dental	285	284	284	287	284	285	285	288	283	289	293	294	
Nursing and Midwifery Registered	1,097	1,093	1,095	1,105	1,094	1,093	1,095	1,096	1,090	1,085	1,138	1,144	

Finance

Temporary Spend ('000s) 918

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
2	3	3	3	1

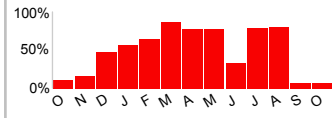
Actual vs Planned Establishment (%) 94.4 %



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
88.8%	92.2%	94.8%	94.3%	94.4%

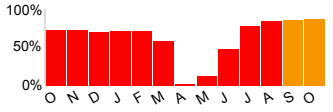
Appraisals

Medical Appraisal 8.0 % (goal: 100.0 %)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
25.5%	68.5%	76.9%	57.8%	8.0%

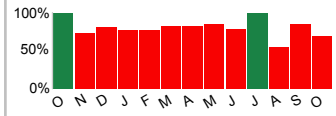
PDR 87.3 % (goal: 90.0 %)



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
72.3%	67.2%	21.0%	83.1%	87.3%

Training

Corporate Induction 69.2 % (goal: 100.0 %)



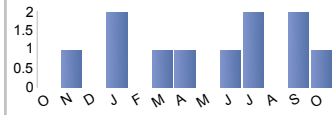
Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
84.0%	79.5%	82.6%	81.0%	69.2%

Mandatory Training 75.5 % (goal: 90.0 %)

Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
75.6%	77.1%	76.1%	76.6%	75.5%

Health and Safety

RIDDOR 1



Q3 16/17	Q4 16/17	Q1 17/18	Q2 17/18	Q3 17/18
1	3	2	4	1

Performance by CBU

Oct 2017

Alder Hey Children's NHS Foundation Trust

Operational

Metric name	COMMUNITY	MEDICINE	SURGERY
Clinic Session Utilisation	84.1%	87.4%	85.2%
Convenience and Choice: Slot Availability	100.0%	99.4%	99.8%
DNA Rate (Followup Appts)	10.2%	10.5%	9.3%
DNA Rate (New Appts)	14.6%	12.4%	10.5%
Referrals Received (GP)	406	722	1,080
Temporary Spend ('000s)	141	186	479
Theatre Utilisation - % of Session Utilised		81.5%	87.1%
Trading Surplus/(Deficit)	284	131	2,634

Patient

Metric name	COMMUNITY	MEDICINE	SURGERY
Average LoS - Elective (Days)		2.9	2.4
Average LoS - Non-Elective (Days)		1.4	2.9
Cancelled Operations - Non Clinical - On Same Day	0	2	23
Daycases (K1/SDCPREOP)	1	76	552
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%
Hospital Initiated Clinic Cancellations < 6 weeks notice	19	32	27
OP Appointments Cancelled by Hospital %	15.2%	14.2%	12.3%
RTT: 90% Admitted within 18 weeks		94.2%	88.0%
RTT: 92% Waiting within 18 weeks (open Pathways)	96.3%	92.7%	91.6%
RTT: 95% Non-Admitted within 18 weeks	87.9%	89.0%	91.2%

Quality

Metric name	COMMUNITY	MEDICINE	SURGERY
Cleanliness Scores			
Hospital Acquired Organisms - C.difficile	0	0	0
Hospital Acquired Organisms - MRSA (BSI)	0	0	1
Medication Errors (Incidents)	37	187	306

Workforce

Metric name	COMMUNITY	MEDICINE	SURGERY
Corporate Induction	33.3%	70.0%	85.0%
Mandatory Training	75.1%	77.3%	73.8%
PDR	90.4%	84.0%	89.5%
Sickness	5.5%	4.9%	5.1%

CBU Performance - Community

Oct 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Key issues for the Community remain the focus on the delivery of the ASD pathway and reducing waiting times, this is challenging as demand is increasing and is above the level agreed. Work with colleagues in the CCG to understand this more and to agree actions for the future.

In terms of efficient ways of working, a review of DNA's including the reasons why and adherence to the policy is also on-going.

Delivery of financial recovery actions monitored weekly within Division.

Support Required

Cross divisional support on system wide pathway improvements required to ensure credible CIP plan going forward.

Continued IM&T support to enable staff to work effectively in the community.

Operational

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
Theatre Utilisation - % of Session Utilised														
Clinic Session Utilisation	78.4%	80.5%	74.1%	75.9%	80.3%	83.0%	79.1%	81.9%	79.9%	79.3%	76.9%	86.4%	84.1%	
DNA Rate (New Appts)	15.6%	12.8%	18.8%	15.5%	12.1%	11.8%	15.9%	16.0%	19.3%	17.4%	17.5%	13.2%	14.6%	
DNA Rate (Followup Appts)	13.9%	12.4%	17.7%	16.5%	15.6%	13.3%	15.2%	14.5%	15.9%	15.2%	17.4%	13.4%	10.2%	
Convenience and Choice: Slot Availability	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%			100.0%	100.0%	100.0%	
Referrals Received (GP)	307	394	298	268	336	385	230	387	323	320	232	330	406	
Temporary Spend ('000s)	37	60	47	77	72	150	67	103	116	146	169	195	141	
Trading Surplus/(Deficit)	355	341	415	410	256	442	343	414	299	224	145	263	284	

Patient

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
RTT: 90% Admitted within 18 weeks														
RTT: 95% Non-Admitted within 18 weeks	77.4%	78.0%	80.2%	75.3%	73.1%	88.4%	87.9%	85.4%	91.8%	91.4%	93.1%	87.3%	87.9%	
RTT: 92% Waiting within 18 weeks (open Pathways)	82.5%	85.9%	92.3%	92.8%	93.1%	94.4%	94.0%	97.4%	94.3%	94.6%	96.5%	96.1%	96.3%	
Average LoS - Elective (Days)		22.00										14.00		
Average LoS - Non-Elective (Days)														
Hospital Initiated Clinic Cancellations < 6 weeks notice	23	29	1	9	19	8	15	3	12	5	13	8	19	
Daycases (K1/SDCPREOP)	0	0	3	0	0	0	0	2	0	1	0	0	1	
Cancelled Operations - Non Clinical - On Same Day	0	0	0	0	0	0	0	0	0	0	0	0	0	
OP Appointments Cancelled by Hospital %	22.3%	17.0%	15.4%	14.2%	20.3%	20.8%	23.1%	14.7%	18.9%	13.5%	17.4%	16.3%	15.2%	
Diagnostics: % Completed Within 6 Weeks														

Quality

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
Medication Errors (Incidents)	24	26	27	29	30	31	3	5	8	10	17	26	37	
Cleanliness Scores														
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
Corporate Induction	100.0%	72.7%	87.5%	87.5%	87.5%	100.0%	82.9%		88.9%	100.0%	57.1%	100.0%	33.3%	
PDR	82.1%	81.4%	75.4%	77.2%	76.4%	67.0%	0.0%	5.7%	26.5%	71.0%	82.8%	87.4%	90.4%	
Sickness	7.6%	8.8%	7.1%	7.1%	6.9%	5.9%	5.1%	5.6%	5.7%	6.4%	6.2%	6.5%	5.5%	
Mandatory Training	71.1%	70.9%	72.1%	75.8%	78.0%	57.1%	57.1%	56.1%	55.2%	74.5%	75.3%	74.6%	75.1%	

CBU Performance - Medicine (Part 1)

Oct 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

Operational: Theatre Utilisation substandard and the 5key areas have been challenged to investigate . Division continues to struggle financially- despite identifying further savings, emergent pressures have counted majority of this progress. Elective activity continues above plan, with underperformance against plan for daycase, elective and outpatients (despite increases in activity on last month for all three). Patient: 18 week target & Diagnostics unreported. Hospital clinic cancellations increased and will be scrutinised. Workforce: Sickness worsened despite improvements on some key wards.

Support Required

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Operational

Metric Name	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Last 12 Months
Theatre Utilisation - % of Session Utilised	80.1%	79.1%	80.1%	82.9%	79.1%	85.4%	81.1%	83.6%	84.6%	76.9%	81.8%	82.0%	81.5%	
Clinic Session Utilisation	86.6%	86.9%	83.9%	85.4%	87.0%	89.6%	86.8%	86.6%	84.8%	86.8%	87.0%	87.4%	87.4%	
DNA Rate (New Appts)	14.8%	12.5%	14.6%	14.1%	12.4%	10.0%	15.0%	12.6%	12.6%	12.9%	12.2%	10.4%	12.4%	
DNA Rate (Followup Appts)	13.5%	16.1%	18.6%	16.4%	17.0%	13.1%	16.6%	15.9%	13.9%	13.6%	12.8%	10.5%	10.5%	
Convenience and Choice: Slot Availability	98.1%	100.0%	99.6%	96.1%	86.5%	99.4%	98.0%	96.3%	100.0%	100.0%	98.0%	91.4%	99.4%	
Referrals Received (GP)	653	733	563	681	594	821	577	747	791	729	636	635	722	
Temporary Spend ('000s)	230	229	164	499	341	302	290	322	222	323	326	250	186	
Trading Surplus/(Deficit)	321	491	212	74	-113	1,012	-298	108	-152	-390	-302	94	131	

Patient

Metric Name	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Last 12 Months
RTT: 90% Admitted within 18 weeks	89.6%	93.1%	87.6%	92.6%	100.0%	91.5%	96.4%		95.7%	90.5%	95.5%	100.0%	94.2%	
RTT: 95% Non-Admitted within 18 weeks	88.6%	83.2%	84.7%	92.4%	89.3%	90.9%	90.9%	86.2%	88.8%	89.1%	87.3%	86.8%	89.0%	
RTT: 92% Waiting within 18 weeks (open Pathways)	95.1%	96.0%	96.7%	96.9%	96.0%	94.8%	94.9%	94.5%	94.0%	93.6%	93.3%	94.2%	92.7%	
Average LoS - Elective (Days)	3.27	3.25	3.66	3.64	3.22	3.20	3.50	3.40	2.94	3.05	2.90	3.06	2.89	
Average LoS - Non-Elective (Days)	1.29	1.54	1.53	1.44	1.69	1.57	1.62	1.60	1.51	1.65	1.49	1.63	1.38	
Hospital Initiated Clinic Cancellations < 6 weeks notice	22	41	29	41	37	27	20	18	23	17	16	21	32	
Daycases (K1/SDCPREOP)	52	46	65	68	63	70	58	70	103	70	71	63	76	
Cancelled Operations - Non Clinical - On Same Day	1	8	4	6	6	3	1	3	1	2	1	2	2	
OP Appointments Cancelled by Hospital %	14.7%	13.6%	14.2%	14.6%	15.0%	14.1%	17.4%	11.2%	13.4%	14.5%	13.4%	13.4%	14.2%	
Diagnostics: % Completed Within 6 Weeks	76.9%	99.1%	99.5%	100.0%	99.7%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Last 12 Months
Medication Errors (Incidents)	169	199	229	252	271	306	25	58	84	109	139	157	187	
Cleanliness Scores	95.8%	97.5%	97.0%	96.8%	96.8%	99.0%								
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	1	0	0	0	0	0	0	0	0	0	
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2017	Apr 2017	May 2017	Jun 2017	Jul 2017	Aug 2017	Sep 2017	Oct 2017	Last 12 Months
Corporate Induction	100.0%	85.0%	83.3%	75.0%	75.0%	68.8%		81.8%	61.5%	100.0%	50.0%	80.0%	70.0%	
PDR	79.7%	79.4%	77.6%	76.7%	75.7%	69.7%	2.9%	15.4%	41.3%	73.8%	79.7%	82.2%	84.0%	
Sickness	4.9%	4.6%	4.8%	4.9%	5.3%	4.5%	4.0%	4.7%	4.2%	4.6%	3.9%	4.3%	4.9%	
Mandatory Training	76.9%	76.3%	76.4%	77.3%	79.2%	79.7%	80.1%	80.0%	80.5%	79.0%	78.3%	75.7%	77.3%	

CBU Performance - Medicine (Part 2)

Oct 2017

Alder Hey Children's NHS Foundation Trust

Key Issues

Patient Category: Improvements in performance in every single metric. Still concern over MRI waiting times and access to theatres. Quality Category: Dip in turnaround times for urgent requests for pathology, which will be investigated.

Support Required

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Patient

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
Imaging - % Report Turnaround times GP referrals < 24 hrs	96.0%	95.0%	93.0%	96.0%	97.0%	87.0%	96.0%	91.0%	92.0%	90.0%	90.0%	86.0%	97.9%	
Imaging - % Reporting Turnaround Times - ED	88.0%	87.0%	88.0%	88.0%	93.0%	90.0%	80.0%	64.0%	76.0%	83.0%	82.0%	85.0%	96.7%	
Imaging - % Reporting Turnaround Times - Inpatients	87.0%	76.0%	80.0%	86.0%	89.0%	90.0%	78.0%	74.0%	79.0%	85.0%	85.0%	79.0%	97.8%	
Imaging - % Reporting Turnaround Times - Outpatients	93.0%	93.0%	94.0%	97.0%	98.0%	94.0%	92.0%	90.0%	92.0%	98.0%	98.0%	92.0%	89.5%	
Imaging - Waiting Times - MRI % under 6 weeks	88.0%	90.0%	92.0%	92.0%	86.0%	85.0%	71.0%	81.0%	67.0%	68.0%	77.0%	79.0%	93.7%	
Imaging - Waiting Times - CT % under 1 week	86.0%	84.0%	81.0%	81.0%	77.0%	87.0%	95.0%	89.0%	87.0%	87.0%	89.0%	87.0%	93.3%	
Imaging - Waiting Times - Plain Film % under 24 hours	95.0%	94.0%	94.0%	94.0%	92.0%	93.0%	93.0%	94.0%	93.0%	94.0%	92.0%	91.0%	98.9%	
Imaging - Waiting Times - Ultrasound % under 2 weeks	86.0%	85.0%	83.0%	83.0%	81.0%	87.0%	84.0%	88.0%	90.0%	91.0%	90.0%	87.0%	95.6%	
Imaging - Waiting Times - Nuclear Medicine % under 2 weeks	85.0%	100.0%	88.0%	88.0%	84.0%	93.0%	88.0%	95.0%	89.0%	100.0%	93.0%	72.0%	100.0%	
BME - High Risk Equipment PPM Compliance	90.4%	89.7%	93.0%	91.0%	91.1%	88.0%	80.2%	91.7%	91.6%	91.2%	90.1%	84.6%	90.2%	
BME - Low Risk Equipment PPM Compliance	77.0%	79.0%	80.0%	81.0%	80.8%	79.0%	100.0%	82.0%	81.9%	80.4%	75.5%	74.6%	70.9%	
BME - Equipment Pool - Equipment Availability	99.8%	100.0%	100.0%	99.8%	100.0%	100.0%	91.4%	99.8%	100.0%	100.0%	100.0%	100.0%	100.0%	
Pharmacy - Dispensing for Out Patients - Routine	45.0%	50.0%	51.0%	55.0%	50.0%	45.0%	57.0%	37.0%	60.0%	65.0%	63.0%	57.0%	61.0%	
Pharmacy - Dispensing for Out Patients - Complex	100.0%	97.7%	98.0%	100.0%	98.0%	98.0%	98.0%	100.0%	100.0%	96.0%	97.0%	100.0%	100.0%	
Comm Therapy - % 1st Contact times following Pt opt in < 12 weeks	100.0%	100.0%	100.0%	100.0%	100.0%	63.0%	63.0%	63.0%	54.3%	54.5%	80.0%	90.0%	100.0%	

Quality

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
Pathology - % Turnaround times for urgent requests < 1 hr	90.2%	89.0%	87.9%	87.5%	88.7%	87.9%	89.7%	89.9%	91.0%	88.1%	88.1%	91.0%	89.1%	
Pathology - % Turnaround times for non-urgent requests < 24hrs	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	99.9%	
Reporting times for perinatal autopsies in 56 Calendar Days	94.7%	100.0%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	
Blood Traceability Compliance	100.0%	99.6%	99.8%	99.7%	98.8%	99.6%	99.4%	100.0%	100.0%	99.5%	99.8%	99.8%	99.2%	

CBU Performance - Surgery

Oct 2017

Alder Hey Children's NHS
NHS Foundation Trust

Key Issues

We've seen a reduction in hospital acquired infections, showing progress within the division. Work will continue to fully achieve our 'preventing infection at every moment' strategy. There have been 3 pressure ulcers within critical care which could be a product of increased reporting. Cancelled operations decreased, there is a risk of impending winter pressures but we have implemented capped elective numbers to mitigate, though this adds risk to our budget position. Outpatient performance was significantly lower and there will be a deep dive undertaken to assess and increase run rate.

Support Required

We have a concern regarding the current typing turnaround times which are increasing week on week. There is also a concern that the pool are prioritising VR letters above any other routines which we feel needs an urgent review as this will be detrimental to those specialties who have not gone live. Our outpatient performance is lower than expected and whilst there is work we can do within the division, we would like to see an improvement in booking processes in order to reduce our DNA's and fill slots cancelled at 24 hours notice.

Operational

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
Theatre Utilisation - % of Session Utilised	86.0%	86.1%	84.8%	87.2%	88.5%	87.1%	88.3%	87.9%	88.9%	87.7%	88.6%	87.3%	87.1%	
Clinic Session Utilisation	86.6%	87.9%	84.2%	85.4%	85.3%	88.0%	87.7%	86.1%	85.9%	86.3%	84.9%	83.5%	85.2%	
DNA Rate (New Appts)	10.1%	11.7%	13.2%	12.4%	11.9%	9.8%	10.3%	11.7%	12.4%	11.6%	11.6%	9.8%	10.5%	
DNA Rate (Followup Appts)	8.7%	9.0%	11.1%	8.7%	9.4%	8.3%	9.9%	10.1%	9.7%	10.6%	10.6%	9.8%	9.3%	
Convenience and Choice: Slot Availability	97.4%	100.0%	98.7%	100.0%	99.8%	95.3%	98.2%	99.5%	96.0%	99.0%	100.0%	100.0%	99.8%	
Referrals Received (GP)	1,002	1,041	876	1,072	1,046	1,280	976	1,152	1,215	1,035	983	985	1,080	
Temporary Spend ('000s)	529	426	331	504	475	443	516	402	456	511	554	429	479	
Trading Surplus/(Deficit)	1,806	2,721	1,539	2,008	2,181	2,821	1,826	2,930	3,321	2,980	2,574	2,506	2,634	

Patient

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
RTT: 90% Admitted within 18 weeks	87.9%	88.9%	88.0%	86.8%	87.0%	87.2%	86.9%	90.3%	87.8%	88.8%	87.8%	85.0%	88.0%	
RTT: 95% Non-Admitted within 18 weeks	87.0%	88.6%	89.7%	92.8%	88.1%	89.1%	90.1%	89.8%	88.2%	88.1%	90.2%	90.7%	91.2%	
RTT: 92% Waiting within 18 weeks (open Pathways)	92.1%	91.3%	90.4%	90.6%	90.6%	90.9%	90.9%	90.8%	91.3%	91.2%	91.2%	90.9%	91.6%	
Average LoS - Elective (Days)	2.87	2.88	2.73	2.17	3.26	2.62	2.58	3.57	2.57	3.10	2.90	3.03	2.36	
Average LoS - Non-Elective (Days)	2.65	2.64	2.55	3.02	2.78	2.64	2.84	3.06	2.57	2.86	2.96	2.74	2.87	
Hospital Initiated Clinic Cancellations < 6 weeks notice	34	72	20	30	54	22	19	23	28	35	32	26	27	
Daycases (K1/SDCPREOP)	442	570	471	562	461	582	426	540	609	472	499	485	552	
Cancelled Operations - Non Clinical - On Same Day	21	20	8	11	23	28	6	54	18	29	14	46	23	
OP Appointments Cancelled by Hospital %	14.8%	14.6%	13.8%	14.0%	14.2%	13.7%	13.2%	11.2%	12.7%	12.0%	12.8%	11.8%	12.3%	
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	

Quality

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
Medication Errors (Incidents)	295	336	367	396	430	477	40	97	146	188	243	276	306	
Cleanliness Scores	95.1%	97.9%	96.0%	96.1%	96.2%	97.7%								
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	1	
Hospital Acquired Organisms - C.difficile	0	1	0	0	0	0	0	0	0	0	0	0	0	

Workforce

Metric Name	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Last 12 Months
Corporate Induction	100.0%	65.2%	71.4%	71.4%	71.4%	94.1%		90.0%	100.0%	100.0%	60.0%	71.4%	85.0%	
PDR	63.4%	63.3%	61.1%	63.4%	64.2%	45.1%	1.9%	11.2%	63.0%	87.6%	91.1%	90.1%	89.5%	
Sickness	5.7%	5.8%	5.5%	5.6%	4.9%	4.4%	4.5%	4.4%	4.7%	4.8%	4.6%	4.5%	5.1%	
Mandatory Training	75.3%	75.7%	77.0%	77.5%	78.7%	79.3%	80.6%	80.7%	81.5%	79.1%	77.0%	73.0%	73.8%	

3. Financial Strength

3.1 Trust Income & Expenditure Report period ended October 2017

	In Month			Year to Date			Full Year		
	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Actual £'000	Variance £'000	Budget £'000	Forecast £'000	Variance £'000
Clinical Income									
Elective	4,536	3,884	(652)	28,464	26,427	(2,037)	48,996	47,413	(1,583)
Non Elective	2,357	2,899	543	16,702	19,192	2,490	29,204	33,885	4,681
Outpatients	2,774	2,374	(400)	16,764	16,284	(480)	28,903	28,201	(701)
A&E	482	546	64	3,441	3,374	(67)	6,036	5,932	(104)
Critical Care	2,133	2,199	66	14,453	15,227	773	25,222	26,180	958
Non PbR Drugs & Devices	1,796	2,094	298	12,439	13,805	1,366	21,243	23,946	2,703
Excess Bed Days	388	218	(170)	2,717	2,402	(315)	4,658	3,963	(695)
CQUIN	261	287	25	1,828	1,856	28	3,134	3,337	203
Contract Sanctions	(10)	(7)	3	(73)	(51)	22	(125)	(80)	45
Private Patients	15	58	43	103	232	129	176	447	271
Other Clinical Income	3,037	3,318	282	20,910	21,726	816	37,094	39,428	2,334
Non Clinical Income									
Other Non Clinical Income	2,175	2,047	(128)	14,078	14,493	414	25,165	25,713	548
Total Income	19,943	19,916	(27)	131,827	134,967	3,140	229,707	238,366	8,659
Expenditure									
Pay Costs	(11,976)	(12,623)	(647)	(85,352)	(87,033)	(1,681)	(145,131)	(147,553)	(2,422)
Drugs	(1,636)	(1,775)	(139)	(11,275)	(12,977)	(1,702)	(19,228)	(22,275)	(3,047)
Clinical Supplies	(1,543)	(1,710)	(167)	(11,109)	(11,291)	(182)	(18,486)	(19,258)	(772)
Other Non Pay	(2,032)	(1,801)	231	(15,693)	(16,391)	(698)	(25,574)	(28,577)	(3,003)
PFI service costs	(329)	(321)	8	(2,303)	(2,168)	135	(3,948)	(3,730)	218
Total Expenditure	(17,516)	(18,230)	(714)	(125,731)	(129,860)	(4,129)	(212,367)	(221,393)	(9,026)
EBITDA	2,427	1,686	(741)	6,096	5,107	(989)	17,340	16,973	(367)
PDC Dividend	(114)	(114)	0	(796)	(797)	(1)	(1,365)	(1,365)	0
Depreciation	(540)	(500)	40	(3,765)	(3,470)	295	(6,409)	(6,114)	295
Finance Income	0	2	2	3	13	10	5	15	10
Interest Expense (non-PFI/LIFT)	(91)	(87)	3	(624)	(614)	10	(1,087)	(1,069)	18
Interest Expense (PFI/LIFT)	(675)	(675)	0	(4,724)	(4,724)	0	(8,098)	(8,098)	0
MASS/Restructuring	0	0	0	(247)	(284)	(37)	(247)	(284)	(37)
Gains/(Losses) on asset disposals	0	8	8	0	79	79	0	79	79
Control Total Surplus / (Deficit)	1,008	320	(689)	(4,057)	(4,689)	(632)	138	138	()
One-off normalising items									
STF Funding	0	0	0	0	93	93	0	93	93
Government Grants/Donated Income	1,357	577	(780)	7,072	4,180	(2,892)	12,750	7,695	(5,055)
Depreciation on Donated Assets	(175)	(175)	()	(1,221)	(1,201)	21	(2,089)	(2,068)	21
Fixed Asset Impairment	0	0	0	0	0	0	(1,536)	(1,536)	0
Reported Surplus/(Deficit)	2,190	721	(1,469)	1,793	(1,617)	(3,410)	9,263	4,321	(4,942)

Key Metrics	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Income £000	19,943	19,916	(27)	131,827	134,967	3,140	229,707	238,366	8,659
Expenditure £000	(18,935)	(19,596)	(662)	(135,885)	(139,657)	(3,772)	(229,569)	(238,229)	(8,660)
Control Total Surplus/(Deficit) £000	1,008	320	(689)	(4,057)	(4,689)	(632)	138	138	()
WTE	3,194	3,195	1	3,194	3,195	1			
CIP £000	974	515	(459)	3,099	2,788	(311)	8,000	5,749	(2,251)
Cash £000	1,414	10,872	9,458	1,414	10,872	9,458			
CAPEX FCT £000	2,868	1,245	1,623	13,982	7,193	6,789	28,972	24,036	4,936
Use of Resources Risk Rating	3	3	0	3	3	0	3	3	0

Activity Volumes	In Month			Year to Date			Full Year		
	Budget	Actual	Variance	Budget	Actual	Variance	Budget	Forecast	Variance
Elective	2,663	2,311	(352)	17,061	15,753	(1,308)	29,307	27,081	(2,226)
Non Elective	1,101	1,363	262	7,760	8,576	816	13,769	14,985	1,216
Outpatients	18,787	17,812	(975)	120,327	121,316	989	206,735	206,091	(644)
A&E	4,504	5,486	982	32,194	33,751	1,557	56,463	59,337	2,874

Alder Hey Children's NHS Foundation Trust
CAPITAL PROGRAMME 2017/18

	IN MONTH BUDGET	IN MONTH ACTUAL	IN MONTH VARIANCE	YEAR TO DATE BUDGET	YEAR TO DATE ACTUAL	YEAR TO DATE VARIANCE	FULL YEAR BUDGET	FULL YEAR FORECAST	FULL YEAR VAR TO REV BUDGET
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
ESTATES	**128**	**106**	**22**	**896**	**856**	**40**	**1,536**	**1,536**	**0**
RESEARCH & EDUCATION	**1,216**	**492**	**724**	**6,233**	**3,576**	**2,657**	**13,120**	**8,901**	**4,219**
ESTATES TOTAL CAPITAL	**1,344**	**598**	**746**	**7,129**	**4,432**	**2,697**	**14,656**	**10,437**	**4,219**
GDE, NETWORKING, INFRASTRUCTURE & OTHER IT	250	479	(229)	1,860	1,494	**366**	3,431	3,431	0
ELECTRONIC PATIENT RECORD	0	40	(40)	302	251	**51**	604	604	0
IM & T TOTAL CAPITAL	**250**	**518**	**(268)**	**2,162**	**1,745**	**417**	**4,035**	**4,035**	**0**
MEDICAL EQUIPMENT	104	95	9	1,029	574	**455**	1,529	1,529	0
NON-MEDICAL EQUIPMENT	0	()	0	220	108	**112**	220	220	0
CHILDRENS HEALTH PARK	1,032	16	1,016	1,917	117	**1,800**	5,347	5,347	0
ALDER HEY IN THE PARK TOTAL	**1,136**	**111**	**1,025**	**3,166**	**799**	**2,367**	**7,096**	**7,096**	**0**
OTHER	138	17	121	1,525	168	**1,357**	3,185	2,348	837
OTHER	**138**	**17**	**121**	**1,525**	**168**	**1,357**	**3,185**	**2,348**	**837**
CAPITAL PROGRAMME 17/18	***2,868***	***1,245***	***1,623***	***13,982***	***7,145***	***6,837***	***28,972***	***23,916***	***5,056***
FINANCE LEASES	***0***	***0***	***0***	***120***	***48***	***72***	***120***	***120***	***0***
CAPITAL PROGRAMME 17/18 INC FINANCE LEASES	***2,868***	***1,245***	***1,623***	***14,102***	***7,193***	***6,909***	***29,092***	***24,036***	***5,056***

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

SEPTEMBER 2017: HEI new recruits commenced September 2017 aligned to staff vacancies and winter plan.
OCTOBER 2017: 70 new starters have completed their preceptorship (4 weeks) and the COHORT now form part of the clinical rotas.
NOVEMBER 2017: October audit results for sepsis show month on month reducing time to treatment for suspected sepsis (mean time to antibiotics now 42 minutes); D&V outbreak on 4A well managed to prevent spread; measles outbreak on 4C also contained and managed in accordance with PHE requirements.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

SEPTEMBER 2017: ED performance back on track in August but dipping again in September; all other targets met.
OCTOBER 2017: ED performance currently below target for the month and the quarter; Division has a recovery plan but requires particular focus in the context of winter. Being addressed through Exec Comm Cell - weekly scrutiny.
NOVEMBER 2017: COO has gained agreement for Children's WIC activity to be counted in ED figures; performance now disaggregated by stream to enable closer management of 'greens'; discussions happening with UC24 re GP slots. Weekly Comm Cell has become routine practice with full team participation.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• Business Cases developed for various elements of the Park & Campus	• Alignment with the 'Alder Hey in the Park' vision and the 'Alder Hey Campus' visions
• Heads of Terms agreed with LCC for joint venture approved	• Redeveloped Steering Group
• Monthly reports to Board & RABD	

Assurance Evidence	Gaps in Controls/Assurance
Establishment of a Community Interest Charity to operate the park for AHCH and the local community Approved Business Cases for various elements of the Park & Campus approved Every Project has a dedicated Project Manager assigned to it End user consultation events held Highlight reports to relevant assurance committees and through to Board Representation at Springfield Park Shadow Board Stakeholder events held Representation at Friends of Springfield Park Group	Fully reconciled budget with Plan. Risk quantification around the development projects. Joint business case approval with LCC

Actions Required to Reduce Risk to Target Rating	Latest Progress on Actions
Approval of Business Case at LCC / Discuss park Heads of Terms with LCC	dependent upon residential scheme (target date no Sept 2017)
Income generation opportunities to be thoroughly explored (grant applications) and reconcile requirement for funding versus available	Draft Business Case prepared. Final requirement will depend upon contribution from residential scheme
Develop a Planning Process Communication Strategy	Strategy to be presented at July board

Executive Lead's Assessment

SEPTEMBER 2017: Public consultation delayed until outcome of LCH bid known.
OCTOBER 2017: Discussions continuing with LCC Mayor. Long list of options being produced
NOVEMBER 2017: Options paper sent to LCC

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

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

Executive Lead's Assessment
SEPTEMBER 2017: funding is now up to date, GDE project is green rated over all. The main risk that Board need to be aware of is the pace of realisation of benefits of the programme including specialty packages and VR. OCTOBER 2017: Programme remains green rated however challenges from NHSE regarding benefits realisation evidence and level of match funding NOVEMBER 2017: programme remains green rated. Benefits workshop with NHSE undertaken. NHSE challenging cashflow forecast however near an acceptable solution.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

Failure to deliver Trust control total and Risk rating Rating

Existing Control Measures

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

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

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

Executive Lead's Assessment

SEPTEMBER 2017: year to date on track. Forecast risk remains at £6.3m, largely driven by variances in medicine, facilities, estates and surgery. Recovery process implemented.
OCTOBER 2017: year to date on track. Forecast risk reduced to c £4.5m. Pressures remain in Medicine and Facilities. Recovery Plan in place with key actions tracked through Exec Commcell
NOVEMBER 2017: Forecast risk remains at £4.6m deficit (unmitigated) however recovery action plan demonstrating a mitigated position of £2.2m deficit (currently likely forecast). Further opportunities equate to further £2.2m which if realised will allow achievement of control. Financial Recovery Board in place beginning to show early signs of improved performance.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

SEPTEMBER 2017: Decision on bid expected early October 2017. Awaiting to hear from Dubai regarding phase 2 extension.
OCTOBER 2017: LCH Bid unsuccessful
NOVEMBER 2017: Strategy refresh scheduled for December 17. Acting director of strategy newly in post. Risk to be reviewed during December 17.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Strengthening the paediatric workforce	Now part of Change Programme and 7 day service as Best in Acute Care led by Steve Ryan.
Monitoring of action plans.	Now working with NHS England to secure a resolution for the North
Clear plan for delivery of strategic services (cardiac, neonatal, rehab, community care, primary care, Vanguard, CAMHS)	
Pro-active recruitment in identified areas.	Trust in discussion with Liverpool Women's re future service models for neonates and in discussion with Liverpool Heart and Chest re future model for cardiac service
Develop a strong Community Service offering for Children in Liverpool.	Management contract for LCH completed 31st October 17. LCH bid for services unsuccessful.

Executive Lead's Assessment
SEPTEMBER 2017: No change since last update. OCTOBER 2017: There are no further updates in terms of risk at this time (Neonates and Women's). NOVEMBER 2017: Strategy refresh during December 17 to include paediatric service offer priorities. Acting director of strategy newly in post. Risk to be reviewed during December 17.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

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

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

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

Executive Lead's Assessment

SEPTEMBER 2017: New nurse pool cohorts commenced their induction period. Recruitment team engaged with national RCN jobs fair.
OCTOBER 2017: Mandatory training action plan launched, with a target to achieve 90% by end Jan 18.
NOVEMBER 2017: Attendance at local recruitment fair. Nurse pool staff now embedded into wards. focus on sickness absence at divisional level. continued focus on increasing mandatory training.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description

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

Existing Control Measures

• Internal Communications Strategy.	• Refine Trust Values.
• Roll out of Leadership Development and Leadership Framework	• Action Plans for Engagement, Values and Communications.
• Medical Leadership development programme	• Staff Temperature Check Reports to Board (quarterly)
• Values based PDR process	• People Strategy Reports to Board (monthly)
• Listening into Action methodology	• Staff surveys analysed and followed up (shows improvement)

Assurance Evidence	Gaps in Controls/Assurance
Outcomes from Annual Staff Survey reported to the Board. PDR completion rates Quarterly Engagement Temperature Check reported to the Board. Quarterly Engagement Temperature Check local data now sent to CBUs on a quarterly basis to enable them to analyse data locally. Ongoing consultation and information sharing with staff side and LNC Progress reports from LiA to Board	Reward & Recognition schemes embedded
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Revised governance arrangements that underpin effective assurance mechanisms utilising the discipline and systems provided by Programme Management methodology	Change programme monitors Listening into Action deliverables

Executive Lead's Assessment

SEPTEMBER 2017: Medicine 100% compliance with local staff survey conversations, others on their way to full compliance. Staff Survey launched. 84% PDR compliance as at 25/09/16.
OCTOBER 2017: Staff Survey at 39% compliance 01/11/17 - same as the overall compliance for the whole of 2016. PDR compliance at 86%. Planning underway for Fab Staff Change week in November 2017.
NOVEMBER 2017: Staff Survey 51% compliance (28/11/17). Fab Staff Change week completed, with very positive feedback from staff. PDR remains at 86%, with community over 90%.

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

Risk Description	
Failure to proactively develop a future workforce that reflects the diversity of the local population	
Existing Control Measures	
• Equality, Diversity & Human Rights Group	• Workforce Committee re-enforced and includes recruitment and education
• Workforce Plan established	• Staff Survey results
• Workforce Planning Poilcy signed off at WOD June 2015	• Equality Analysis Policy
• Equality, Diversity & Human Rights Policy	
Assurance Evidence	**Gaps in Controls/Assurance**
Monthly recruitment reports provided by HR/Payroll provider Quarterly reports to the Board via WOD on the Workforce Strategy and Workforce Plan Monthly Corporate Report (including workforce KPIs) to the Board Taking forward actions for LiA - enabling achievement of a more inclusive culture Equality Impact Assessments undertaken for every policy & project Workforce Race Equality Standards EDS Publication	Recruitment Strategy to focus on specific groups
Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Workforce Planning Policy	Draft policy produced, however future work is to focus on identifying priority workforce needs in light of current financial position
Deliver on our new Recruitment and Retention Strategy to ensure an optimum workforce is in place and that the workforce reflects the diversity of the local community	Currently being drafted with action plan to support
Proactively utilise the EDS2 results to establish the composition of our workforce in order to target areas for improvement	Currently being refreshed with action plan to support
Executive Lead's Assessment	
SEPTEMBER 2017: Job Centre Plus initiative to support long term unemployed on work placements underway. 65 BTEC students from a range of local schools commenced induction. OCTOBER 2017: WRES action plan for Board approval. majority of actions are underway. BME network meetings on-going. NOVEMBER 2017: Disability Network launched, with first meeting in November. Trust attendance at local jobs fairs.	

Board Assurance Framework 2017-18

Alder Hey Children's NHS Foundation Trust

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

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

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

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

Actions Required to Reduce Risk to Target Rating	**Latest Progress on Actions**
Educational Partnerships to be cemented	Academy proposals agreed at execs
Develop a robust Academy Business Model	Agreed
Establish pipeline structure for sensors including finances	Proposal agreed in principle
Execute plan to increase research portfolio	Outline plan develped
Execute contract for RIE with back to back arrangements with the Charity and HEIs	UCLAN funding agreement signed

Executive Lead's Assessment
SEPTEMBER 2017: Head of Academy now in post. OCTOBER 2017: Focus on developing business plan for Innovation co. plus activating research workstream NOVEMBER 2017: Innovation Co papers taken through Board

Audit Committee

Minutes of the meeting held on **Thursday 5th October 2017**

Room 7, Mezzanine, Level 1

Present:	Mr S Igoe (Chair)	Non-Executive Director	(SI)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
In Attendance:	Mrs L Cobain	Assistant Director, MIAA	(LC)
	Mrs C Davies	Senior Manager, Ernst and Young	(CD)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs C Liddy	Deputy Director of Finance	(CL)
	Mrs V Martin	Counter Fraud Specialist, MIAA	(VM)
	Mrs M McMahon-Joseph	Senior Audit Manager, MIAA	(MMc)
	Mr H Rohimun	Executive Director, Ernst and Young	(HR)
	Mrs E Saunders	Director of Corporate Affairs	(ES)
	Mrs J Tsao	Committee Administrator *(minutes)*	(JT)
Item: 34	Mr S Ryan	Medical Director	
	Mr L Stark	Head of Planning and Performance	
	Miss L Fearnehough	Head of Technical Services	
	Mrs M Swindell	Director of HR & OD	
	Mrs H Gwilliams	Chief Nurse	
Apologies:	Mrs A Marsland	Non-Executive Director	

17/18/32 Minutes of the previous meeting held on 24 May 2017

Resolved:

The Committee approved the minutes of the previous meeting.

17/18/33 Matters Arising and Action list

The Chair welcomed Hassan Rohimun and Caroline Davies to their first Audit Committee. Hassan and Caroline are representing Ernst and Young following their successful bid for External Audit Services.

17/18/34 Internal Audit Progress report

Leads for the six audit reports had been invited to provide assurance against the reports.

Consultant Job Planning – Limited Assurance, update received by: Steve Ryan, Medical Director

The audit highlighted adverse gaps between the control mechanisms in place at the Trust for managing Consultants' Job Plans and those recommended within the best practice guidance issued by NHS Improvement in April 2017. Kate Bayley, Medical Staffing Manager is working through the recommendations and has advised they will be in place with agreed job plans by April 2018.

There is a Consultant Job Planning Policy in place at the Trust which makes reference to the 2003 Consultant Contract. The process for Mediation and Appeals is to be included in the policy and added to the Trust intranet.

CBU Performance Management, Limited Assurance, update received by: Lachlan Stark, Head of Planning and Performance

The review highlighted that, although the numbers of patients awaiting follow up appointments can be viewed on the Business Intelligence system, they are not formally reported to the Trust wide Weekly Performance Meeting, monthly EMT meetings and Trust Board. In addition, any exceptions in completing management of the next steps on Out-Patient appointments held (referred to as 'uncashed items') are not reported to these forums.

Patient Access Policy is currently on hold as new guidance on this is due to be published imminently.

Management have agreed implementation plans to address the findings and recommendations.

Cyber Security Baseline Assessment, update received by: Leanne Fearnehough, Head of Technical Services

Key themes and opportunities for improvement had been identified within 6 categories. An update was received on the recommendations implemented. Recommendations in progress included the ratification of the Information Security policy.

Malware Protection – one of the recommendations was to install a firewall to manage the Trust's MP solution (Sophos) as not all the alerts received are managed. A review had taken place to replace the firewall however implementation of this may cause further issues. A resolution was currently being sought. If there continued to be no resolution this risk would be added to the register.

CBU Sickness Metrics, Limited Assurance, update received by: Melissa Swindell, Director of HR &OD

The Sickness Absence Policy had recently been amended however the audit highlighted differences with interpretations of the policy equalling in non-compliance. Sharon Owens, Head of HR was leading on amending the areas open to interpretation. As the audit carried out solely reviewed areas with high sickness absence Melissa Swindell agreed to provide Audit Committee at the November meeting with an overall update.
Action: MS

Access to Health Records, Limited Assurance, update received by: Hilda Gwilliams, Chief Nurse

All requests are logged and tracked on the Meditech system and details of information sent to requestors are held on the department's secure drive. There is a process in place to allocate and manage workloads within the department which has seen the average time per request fall from an average of 8 hours to 4 hours in the last 3 years. Notwithstanding this, there are a number of opportunities to improve both efficiency and control.

Resourcing within the department is not currently sustainable in line with current practices / technology and anticipated increases in demand.

Resolved:
All leads were asked to provide action plans at the next Audit Committee on 24th November 2017.

Amendments to Audit plan
Resolved:
The Audit Committee approved the proposals to defer the following audit reviews:
Inventory Management – For the implementation of a new Inventory System to be fully operational by March 2018.
Risk Management Arrangements and Sustainability – To allow for a Trust internal review.
Estates Strategy – To ensure the Estates Strategy has been implemented.

17/18/35 Follow up Reviews
Resolved:
Audit Committee received progress on the 17 reviews and 57 recommendations that have now been completed.

17/18/36 Anti-Fraud Progress report
Audit Committee received an update on MIAA Anti-Fraud progress since April 2017:

As announced by the Department of Health in March, a new organisation is being created to tackle fraud, bribery and corruption within the health service in England. This will be known as the NHS Counter Fraud Authority (NHSCFA).

NHS Protect is still in operation and will continue to function until the NHSCFA is established. No official launch date has yet been set.

An article explaining time sheet fraud and how to prevent it had been circulated to staff.
Resolved:
Audit Committee received MIAA Anti-Fraud progress for April – September 2017.

17/18/37 Focused Quality Assessment of compliance against NHS Protect standards
17/18/38 for providers
Virginia Martin reported on the outcome of the assessment ratings:
Inform and Involve – Amber x 4 Standards
2.4 Staff awareness of the code of conduct
Guidance for the above standard has been revised. For the Trust to be able to comply with the revised guidance further resources are to be identified and are being looked into. Louise Cobain noted the difficulties for Trusts to resource the additional requirement and agreed to feedback on how this is being managed locally.
Action: LC

Alder Hey met or partially met the three other standards within this section.

Prevent and Deter – Green x 6 Standards

3.2 Use of available information and intelligence to identify anomalies that may be indicative of fraud, bribery and corruption and takes the appropriate action to address them.

No fraud was found in the sample of claims tested. Eight recommendations have been made to enhance and strengthen the trust's existing arrangements and will be reported on to the Audit Committee.

3.3 Issues, implements and complies with all appropriate fraud, bribery and corruption intelligence bulletins, prevention guidance and alerts issued by NHS Protect.

The recommendation requests records are kept of NHS Protect bulletins. Virginia Martin agreed to lead and action this.

Action

NHS Protect have also requested copies of approved Audit Committee minutes until sufficient assurance has been received.

Action: JT

Following the assessment an action plan had been submitted and approved by NHS Protect.

Virginia Martin noted her thanks to staff for their support John Grinnell thanked Virginia Martin for leading on the assessment.

Resolved:

Audit Committee received the outcome of the Quality Assessment of compliance against NHS Protect standards for providers.

17/18/39 Ernst and Young

Hassan Rohimun and Caroline Davies presented the Health Sector briefing paper for quarter 3. A discussion was held on implementation of the Sustainability Transformation Programme and Accountability Care System.

Resolved:

Audit Committee received the Health Sector briefing paper for quarter 3.

17/18/40 NHSI Quarter 1 Submission

Resolved:

Audit committee received the positive submission.

17/18/41 Board Assurance Framework

Resolved:

Audit committee received BAF.

17/18/42 Policy Register Report

Resolved:

Audit went through the policy register report noting outstanding policies. Erica Saunders agreed to discuss with the Executive team.

17/18/43 Review of losses and Special payments

Resolved:

Audit received losses and special payments paper for April - August 2017 and 2016 to enable Audit to compare to the previous year.

17/18/44 Any other business

No further business was discussed.

17/18/45 Meeting Review

Audit Committee agreed the meeting had gone well.

17/18/45 Audit Committee 2018/19

Resolved:

Audit Committee received and approved dates for 2018/19. Julie Tsao agreed to circulate to diaries.

Date and Time of next meeting: -

Thursday 23rd November 2017 2016 at 1400, Room 7, Mezzanine.