BOARD OF DIRECTORS PUBLIC MEETING

Tuesday 5th February 2019 commencing at 10:00

Venue: Large Meeting Room, Institute in the Park

AGENDA

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
PATIENT STORY (10.00 am-10.15am)						
1	18/19/292	1015	**Apologies**	Chair	To note apologies.	For noting
2	18/19/293	1016	**Declarations of Interest**	All	Board Members to declare an interest in particular agenda items, if appropriate.	For noting
3	18/19/294	1017	**Minutes of the Previous Meeting**	Chair	To consider the minutes of the previous meeting to check for amendments and approve held on: **Tuesday 8th January 2019**	Read Minutes
4	18/19/295	1020	**Matters Arising:**	Chair	To discuss any matters arising from previous meetings and provide updates and review where appropriate.	Verbal
5	18/19/296	1025	**Key Issues/Reflections**	All	Board to reflect on key issues.	Verbal
Delivery of Outstanding Care						
6	18/19/297	1100	**Serious Incidents Report**	H Gwilliams	To inform the Board of the recent serious incidents at the Trust in the last calendar month.	Read report
7	18/19/298	1110	**Global Digital Exemplar (GDE) update**	P Young/ C Fox	To update the Board on the programme.	Read report
8	18/19/299	1120	**Alder Hey in the Park Site Development update**	D Powell	To receive an update on key outstanding issues / risks and plans for mitigation.	Read report
9	18/19/300	1130	**Clinical Quality Assurance Committee: Chair's update:** - **Chair's verbal update from the meeting that took place on the 16.01.19**	A Marsland	To receive a verbal update from the January meeting.	Verbal update
Game Changing Research and Innovation						

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
10	18/19/301	1135	**Approve Terms of Reference for new Research Committee**	M Peak/ E Saunders	To approve the Terms of Reference	Read TOR
The Best People Doing Their Best Work						
11	18/19/302	1145	**People Strategy:** - **Health Education England report**	M Swindell	To provide an update.	Read report
Sustainability Through External Partnerships						
12	18/19/303	1200	**Register of Shareholder interests**	J Grinnell	To provide a monthly update	Read report
13	18/19/304	1210	**Joint Neonatal Partnership – Alder Hey and Liverpool Women's Hospital.**	A Bateman	To update the Board on progress.	Verbal
Strong Foundations						
14	18/19/305	1220	**Business Continuity Plan – Brexit**	J Grinnell/ L Stark	To update the Board as to preparations for a 'no deal' exit from the EU.	Verbal
			Lunch (12:30-13:00)			
15	18/19/306	1300	**2019/20 Control Total**	J Grinnell	To receive the budget setting for 2019/20.	Presentation
16	18/19/307	1310	**Programme Assurance update:** - **Deliver Outstanding Care.** - **Growing External Partnerships.** - **Solid Foundations.** - **Park Community Estates and Facilities.**	N Deakin	To receive an update on programme assurance including the 2018/19 change programme.	Read Report
17	18/19/308	1320	**Resources & Business Development Committee:** - **Approved minutes from the meeting held on 12th**	I Quinlan	To receive the approved minutes.	Read report

VB no.	Agenda Item	Time	Items for Discussion	Owner	Board Action	Preparation
			December 2018			
18	**18/19/309**	**1325**	**Corporate Report.** - **Monthly update by Executive Leads.**	J Grinnell/ H Gwilliams/ M Swindell	To note delivery against financial, operational, HR metrics and quality metrics and mandatory targets within the Corporate Report.	Read report
19	**18/19/310**	**1335**	**Board Assurance Framework**	Executive leads	To receive an update.	Read report
Any Other Business						
20	**18/19/311**	**1340**	**Any Other Business.**	All	To discuss any further business before the close of the meeting.	Verbal
Date And Time Of Next Meeting: Tuesday 5th March 2019 at 10:00am, Large Meeting Room, Institute in the Park.						

REGISTER OF TRUST SEAL
The Trust Seal was used during the month of **January 2019:** - UCLAN Agreement for Lease - UCLAN Lease

Alder Hey Children's NHS
NHS Foundation Trust

PUBLIC MEETING OF THE BOARD OF DIRECTORS

Minutes of the meeting held on **Tuesday 8th January 2019 at 10:00am,**
Large Meeting Room, Institute in the Park

Present:	Sir D Henshaw	Chairman	(SDH)
	Mr. A. Bateman	Chief Operating Officer	(AB)
	Ms K Byrne	Non-Executive Director	(KB)
	Mr C Duncan	Director of Surgery/Interim Joint MD	(ChrD)
	Mrs J France-Hayhurst	Non-Executive Director	(JFH)
	Dr A Hughes	Director of Medicine/Interim Joint MD	(AH)
	Mr J Grinnell	Director of Finance	(JG)
	Mrs H Gwilliams	Chief Nurse	(HG)
	Mrs A Marsland	Non-Executive Director	(AM)
	Mr I Quinlan	Vice Chair	(IQ)
	Mrs L Shepherd	Chief Executive	(LS)
	Mrs M Swindell	Director of HR & OD	(MS)
	Dame J Williams	Non-Executive Director	(JW)
In Attendance:	Mrs K Burnell	Public Governor	(KB)
	Ms L Cooper	Director of Community Services	(LC)
	Ms S Falder	Director of Clinical Effectiveness and Service Transformation	(SF)
	Mr M Flannagan	Director of Communications	(MF)
	Mr S Hooker	Public Governor	
	Mrs D Jones	Director of Strategy	(DJ)
	Prof L Kenny	Executive Pro Vice Chancellor	(PLK)
	Miss A Parsons	Governor, Volunteers	
	Mrs J Tsao	Committee Administrator (minutes)	(JT)
	Ms J Minford	Director of Clinical Effectiveness and Service Transformation	(JM)
	Mr D Powell	Development Director	(DP)
	Ms E Saunders	Director of Corporate Affairs	(ES)
	Ms G Smith	Staff governor	(GS)
Apologies:	Mrs C Dove	Non-Executive Director	(CD)
	Prof M Beresford	Assoc. Director of the Board	(PMB)

Agenda item:

264	David Porter	Consultant Microbiologist/Sepsis Lead
264	James Ashton	Nurse Specialist
264	Glenna Smith	Manager Medicine
265	Julie Grice	Consultant in Emergency Medicine/ HMRG Chair
266	Cathy Fox	Associate Director IM&T
266	Peter Young	Chief Information Officer
266	Kerry Morgan	GDE Programme Manager
271	Kerry Turner	Freedom to Speak Up Advocate
274	Lachlan Stark	Head of Performance and Planning
275	Natalie Deakin	Programme Assurance Manager

Patient Story
The Board welcomed 18 month old Luke and his parents to the Board.

Luke attended Alder Hey in October 2018 for a complex congenital heart operation, the surgery took over 17 hours to complete and Luke was supported on a vent machine for over 40 days. Mum spoke highly of staff who had looked after Luke saying clinical staff were very clear and concise when explaining Luke's complicated medical condition.

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Mum and dad had stayed at Ronald McDonald House and described how supportive it was to have somewhere to stay so close to the hospital.

A discussion was held on security of wards, receptions unmanned and visitors walking on to wards through secured doors. Hilda Gwilliams noted this had been raised last month and went through the actions taken to correct this.

Dad has a nosocmephobia anxiety in relation to being in a hospital setting. Mum said dad's condition had not been an issue here due to Alder Hey not feeling like you are in hospital surroundings.

On behalf of the Board the Chair thanked Luke and his family for sharing their experiences with the Board.

18/19/259 Declarations of Interest

There were none to declare.

18/19/260 Minutes of the previous meetings held on 4th December 2018

The Board APPROVED the minutes from the meeting held on 4th December 2018.

18/19/261 Matters Arising and Action Log

The Board noted all actions had either been added to the agenda for a further update or had been completed.

18/19/262 Key Issues/Reflections

A visit to announce the Long Term NHS plan had taken place yesterday by:
- Prime Minister Theresa May,
- NHS England Chief Executive Simon Stevens
- Secretary of State for Health and Social Care Matt Hancock
- Chair of NHS Improvement Baroness Dido Harding

A variety of senior leaders from across the health sector had also attended the launch of the plan in the Institute in the Park. The Chair and Chief Executed noted how well the event had gone and the positive response to Alder Hey garnered from stakeholders involved in the event. The Chair thanked the Communications team and all those involved in the organisation.

18/19/263 External Environment: the NHS Long Term Plan/Financial Settlement Strategic Partnership Update

Dani Jones and John Grinnell gave a presentation on the Long Term plan published the previous day and an early assessment of what this means for Alder Hey.

Dani Jones highlighted future service models, a focus on a strong start for children and young people, as well as the transition into adult care.

The Board noted good external partnerships in place and future progress to continue.

John Grinnell highlighted requirements for the end of year settlement. Changes to the tariff included an uplift of 2.7% net of 1.1% efficiency excluding:
- PSF, CQUIN, pensions
- 41% PSF into emergency tariff
- 50% CQUIN (1.25% into tariff)

Final tariff would be circulated at the end of quarter 4.

Resolved:

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The Board received the current position with regard to the Trust's response to the Long Term Plan and the financial settlement. Progress updates would be received at successive Board meetings as each aspect becomes finalised.

18/19/264 Sepsis Deep Dive

Dr David Porter, James Ashton and Glenna Smith on behalf of the Sepsis Steering Group updated the Board on the current position. David Porter led the presentation, which described the background to the issue, highlighting the following areas:

- One of the main features of the difficulty of diagnosing the infection Sepsis is symptoms are similar to other infections until late stages when Sepsis can become life threatening.
- Due to the difficulty of giving a diagnosis there is no national paediatric scoring system available.
- The 'Think Sepsis' campaign was launched to highlight awareness, to reduce missed diagnoses and prompt treatment. Negative effects include potential incorrect diagnosis, over use of antibiotics and a longer hospital stay.
- The Steering Group's achievements to date include: increase of 1.5 WTE Sepsis nurses, NICE guidance implemented in full, increased training, raised awareness and reviews of data submissions.
- Using data collated admission of antibiotics within 60 minutes of diagnosis is recommended. The data showed an increase in mortality if antibiotics are given after 3 hours of diagnosis.
- Next steps include; improving data accuracy, extend 60 minute clock in relation to admission of antibiotics from diagnosis, new technology, external advice and training of risks of over diagnosis.

Professor Louise Kenny noted progress of new technology noting projects Philips are leading on with potential to joint working. Louise Kenny agreed to share this contact with David Porter.
Action: PLK

Resolved:
On behalf of the Board the Chair thanked the team for the detailed presentation. It was agreed that a further update would be received at the July Board.
Action: DP, JA, GS,

18/19/265 Quarterly Mortality Report

Dr Julie Grice presented the report noting reviews take place within agreed timescales. Julie described the complexity of some cases highlighting the purpose of reviews is to note lessons learned. Reviews take place for both internal and external cases. Deaths that take place seven days after discharge are monitored.

National guidelines are being developed for cases with media interest. It was unknown when guidelines would be published.

Resolved:
On behalf of the Board the Chair thanked Dr Julie Grice for the quarterly mortality update.

18/19/266 Global Digital Exemplar Stocktake

Peter Young and Cathy Fox gave a presentation on progress to date. A number of programmes had expanded from their original scope including:

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- Interoperability - originally a system for Paediatrics only, now a solution for the entire STP, led by the Alder Hey team, incorporating a Patient Portal using NHS Login & NHS App for secure access to patient records.
- Replacement of the ImageNow document management system
- Introduction of standard clinical documentation
- ELIS – Emergency Theatre scheduling system
- Clinical correspondence automation
- eConsent solution
- Electronic Transcription to Community Pharmacists

Kerry Morgan updated the Board on progress against milestones, benefits and how they are measured.

Resolved:
The Chair thanked all those involved noting the GDE programme at Alder Hey has been recognised on a national level.

18/19/267 Alder Hey in the Park Site Development Update

David Powell provided his regular update to the Board with regard to the key components of the site as they currently stand.

Park
Engagement continues with the Friends of Springfield Park to develop the design of the Park.

Temporary Car Park
Planning permission for use of car park was still awaited, it was hoped this would be resolved in February 2019.

Resolved:
The Board received the Alder Hey in the Park Site Development update.

18/19/268 Serious Incident Report

The Board received and noted the contents of the Serious Incidents report for November 2018. During this reporting period there were no new or open serious incidents and three had been closed. There are no new/current safeguarding incidents or never events.

Hilda Gwilliams provided assurances on regular reporting to ensure all data is captured.

Resolved:
The Board received the Serious Incident report for November 2018.

18/19/269 Clinical Quality Assurance Committee

The Board received Anita Marsland's verbal update from the Clinical Quality Assurance Committee that took place on 11th December 2018 noting improved results against the PLACE survey.

Resolved:
The Board received and noted the approved minutes from the Clinical Quality Assurance Committee meeting that took place on 21st November 2018.

18/19/270 People Strategy Update

The Board received and noted the contents of the People Strategy report for November 2018. The following points were highlighted and discussed:

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- The outcome of a recent Employment Tribunal case in relation to disability discrimination had been found in the Trust's favour.

National Staff Survey 2018
Melissa Swindell highlighted the following outcomes from the initial National Staff Survey results:

- The completion target of 60% had been met. This is the highest completion rate seen at the Trust.
- In comparison to last years' survey there had been an 8% increase in staff recommending Alder Hey as a place to work.
- Results will be circulated with thanks to staff for completing the survey.
- The final results report would be available at the end of January 2019.

Ian Quinlan asked about the changes in place to see the improvement in responses. Melissa Swindell responded noting increased appraisals for conversations on the staff survey and a number of competition initiatives.

Resolved:
The Board received and noted:

- People Strategy update for November 2018
- Initial results from the National Staff Survey

18/19/271 Freedom to Speak up Stocktake

Erica Saunders and Kerry Turner updated the Board on progress to date. The National Guardian's Office had published the Annual Report in November 2018 key recommendations included:

- Refresher training every 12 months
- Guardians to assess possible conflicts of interest in their role and take action to address them
- Organisations should make an assessment of any groups that face particular barriers to speaking up and take action to ensure those barriers are tackled
- Organisations should make an assessment of the time required by a guardian to carry out their role effectively and provide the necessary ring-fenced time
- Time is provided to ensure that all organisations are represented at regional meetings.

Those recommendations not already addressed within the current action plan, which was devised in response to the Board guidance and self-review tool, will be incorporated into the work plan going forward.

Since the commencement of Freedom to Speak Up (FTSU) a total of 18 cases have been raised; of the eight closed cases, six members of staff indicated that they would use this route again and the other two individuals have subsequently left the organisation.

Kerry Turner and the FTSU team continue to increase their visibility at Junior Doctors Forum, Corporate Induction, Leadership training and participation at the Patient Safety meetings.

Resolved:
Board received progress against FTSU, next steps and FTSU Job Description.

18/19/272 Listening into Action: Disability, BAME and LGBTIQ Network Groups

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Margaret Eccleston, Chair of the Disability Network updated the Board on progress since her last report:

- Policies are reviewed with an agreed implementation plan at regular meetings.
- Adrian Hughes and Melissa Swindell are the Executive representatives on the Network.
- An intranet page is now available with support for staff and management.

Charles Otim Chair of the BAME Network reported challenges with attendance at meetings. A discussion was held on linking BAME members to shadow members of the Board.

As Alan Bridge Chair of LGBTIQ had not been able to attend the Board meeting due to on-call commitments, however Hannah Ainsworth updated the Board on Alan's behalf, advising that the profile of the group continues to be raised across the Trust.

Resolved:
The Board noted progress against Disability, BAME and LGBTIQ Network Groups.

18/19/273 Register of Company Shareholder Interests

Resolved:
As the register of company shareholder interests would be reviewed at the January Audit Committee it was noted the register would be presented at the February Board.

18/19/274 Business Continuity Plan – Brexit

Lachlan Stark presented the Brexit continuity plans in preparation for 29th March 2019.

Risk assessments had been carried out on supplies of medicines, vacancies, medical devices, clinical and non-clinical consumables with leads for each area. Suppliers have requested hospitals not to stock-pile.

165 members of staff have been identified as requiring additional visas. Each visa costs £65, agreement has previously been reached for Alder Hey to fund the cost.

Resolved:
The Board received the business continuity plan in relation to Brexit noting monthly updates would be received.

18/19/275 Programme Assurance Update

Natalie Deakin presented the Programme Assurance report for November 2018 highlighting the 2nd slide with a line showing projects that hadn't started.

Of the 21 projects rated in this report, for the overall delivery assessment: 10% are green rated with 57% amber and 33% red rated. These assessments show a deterioration over the past month; therefore, there is considerable work required now to meet the Alder Hey standards of programme management.

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

18/19/276 Resource and Business Development Committee

Resolved:
The Board received and noted the approved minutes from the Resource and Business Development Committee held on 28th November 2018.

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18/19/277 Corporate Report

Finance

The Trust is reporting a trading surplus for the month of £3m which is in line with plan. Income is ahead of plan by £0.7m but is offset by expenditure which is overspent by £0.7m in the month. The Use of Resources risk rating is 1 in line with plan and cash in the bank of £17.6m.

Quality

Hilda Gwilliams updated the Board on the two areas below:
Safe – There had been a reduction in moderate and above harm incidents including no category 3 or 4 pressure ulcers.

Due to the review of a number medication errors a report had been submitted to CQAC requesting increased support for Medication Safety Officers and a workforce review to implement pharmacy technicians in each inpatient area.

Caring – A compliments module to capture feedback from parents, carers and staff has been launched on Ulysses.

The ED waiting time target of 95% had been achieved for the month of December for the first time since 2013.

A discussion was held on improving clinical utilisation. It was agreed that a deep dive on this would be presented at the February Resource and Business Development Committee.

Action: AB

Resolved:

The Board received and noted the contents of the Corporate Report for month 8.

18/19/278 Board Assurance Framework (BAF)

The Board received the BAF update for December 2018. Erica Saunders highlighted:

- Risks around Brexit would be included going forward if required.

Resolved:

The Board received and noted the content of the BAF update.

18/19/249 Any Other Business

No Further business was discussed

Date and Time of next meeting: Tuesday 8th February 2019, 10:00am, Large Meeting Room, Institute in the park.

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Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update
Actions for January 2019							
			Matt Hancock, Secretary of State for Health and Social Care is opening the RE2 Bulding on 22.01.18 a session with the GDE team is to be organised	Mark Flannagan/ Peter Young	08.01.19		As Matt Hancock has sent his apologies the official opening has been delayed until Summer 2019. The January date was used to honour Tony Bell the late previous Chief Executive
No outstanding actions for February 2019							
Actions for March 2019							
4.9.18.	18/19/154.1	2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation	Liaise with Melissa Swindell, Medical HR and the Medical Education Team to look at resolving the issue around the management/inputting of data relating to new recruits.	Graham Lamont	5.3.19.		27.9.18 - An update will be provided during March's Trust Board meeting on the 5.3.19.
4.9.18.	18/19/154.2	2018 Annual Report for the Framework of Quality Assurance for Responsible Officers and Revalidation	Discuss the possibility of accessing/triangulating information relating to complaints, incidents and PALS concerns to enable doctors to use this data as part of the reflective element of the appraisal process.	Graham Lamont	5.3.19.		27.9.18 - An update will be provided during March's Trust Board meeting on the 5.3.19.
23.01.19	18/19/143.3	PFI	To update the Board on progress against pipes	Graeme Dixon/David Powell	5.3.19.		

Status	
Overdue	
On Track	
Closed	

Alder Hey Children's NHS Foundation Trust
Trust Board - Part 1
Action Log following the meeting on the 4.9.18

Meeting date	Ref	Item	Action	By whom?	By when?	Status	Update

BOARD OF DIRECTORS

Tuesday 5th February 2019

Report of:	Chief Nurse
Paper Prepared by:	Chief Nurse and Trust Risk Manager
Subject/Title:	Duty of Candour and Incident Management, including all incident investigations of moderate harm or above and Never Events
Background Papers:	Seven Steps to Patient Safety. National Patient Safety Agency 2004. Health and Social Care Act 2008 (Regulated Activities). Regulation 20 'Duty of Candour'. Serious Incident Framework. Supporting learning to prevent recurrence. NHS England 2015. Serious Incident Framework. Frequently asked questions NHS England 2016. Revised Never Events Policy and Framework (NHSI 2018) Never Events List 2018 Incident Investigation reports.
Purpose of Paper:	To provide Board assurance of compliance with external regulation, and national guidance, in respect of incident management, including duty of candour.
Action/Decision Required:	Note and approve current assurance position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	• **Patient Safety Aim** – Patients will suffer no harm in our care. • **Patient Experience Aim** – Patients will have the best possible experience • **Clinical Effectiveness** – Patients will receive the most effective evidence based care.
Resource Impact	n/a

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1. Background:

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

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

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

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

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

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

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

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

Current position

Table 1 shows the Trust's 2018/19 performance for serious incidents requiring investigation (SIRI). All SIRI investigations are monitored via the monthly performance assurance meetings with individual Divisions, focusing on the management of investigations, including lessons learned and assurance of progress with actions for improvement. In addition, a bi -monthly report of progress with actions, from SIRI investigations is presented to the Clinical Quality Steering Group, with exceptions reported to Clinical Quality Assurance Committee.

During this reporting period, there was one serious incident reported. There were no safeguarding incidents reported and no never events.

Table 2 shows the cumulative position; there is one open serious incident investigation.

Table 3 shows the Trust had one moderate harm incident during this reporting period; which complies with external requirements, including the regulatory requirement for duty of candour.

Table 4 shows there were no closed SIRI'S during this reporting period.

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

	SIRI (General)												
	2017/18				2018/19								
Month	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
New	2	4	0	0	0	1	1	1	1	0	0	0	1
Open	1	3	3	3	3	2	3	2	2	4	3	0	0
Closed	1	0	4	0	0	0	0	2	1	1	1	3	0
	Safeguarding												
Month	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
New	0	0	0	0	0	0	0	0	0	0	0	0	0
Open	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed	0	0	0	0	0	0	0	0	0	0	0	0	0
	Never Events												
Month	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
New	0	0	0	0	0	0	0	0	2	0	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
	Cumulative Position												
													1

Table 2 Ongoing serious incidents requiring investigation (cumulative):

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
StEIS 2018/30070	19/12/2018	Surgery	24 week gestation baby, transferred from Liverpool Women's Hospital for central line insertion. The baby had undergone previous surgery for NED and had previous line	Stefan Verstraelen, Head of Quality, Surgery **Nursing lead:** Joanna	Information gathering underway.	Yes	Completed

			insertion problems. The baby had many known co-morbidities. The baby died following transfer to the Intensive Care Unit at Alder Hey Children's Hospital.	McBride, Head of Nursing, Cardiac and Critical Care Services **Medical lead:** Peter Murphy, Consultant			

Table 3 Moderate harm incidents:

	Duty of Candour (excluding SIRIs)							
Reference Number	**Date investigation started**	**Type of investigation**	**Division**	**Incident Description**	**Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
32736	27/12/2018	After Action Review	Surgery	Patient attended theatre for repair of oesophageal atresia, balloon dilation performed with 12 to 15mm balloon. The Consultant Surgeon requested size 15 to 18mm balloon; however this was not available; the next size available was 20mm. Surgery was performed using a 20mm balloon; an oesophagram performed post-procedure was suggestive of oesophageal perforation. An X-ray of the	Paula Clements, Theatre Matron	After Action Review meeting held 04/01/2019, the report has been written and is in the first stage of the quality check process.	Yes	completed

				oesophagus was undertaken, which revealed a small leak.				

Table 4 Closed SIRIs:

On-going SIRI incident investigations							
Reference Number	**Date investigation started**	**Division**	**Incident Description**	**RCA Lead Investigator**	**Progress**	**60 working day compliance (or within agreed extension)**	**Duty of Candour applied**
Nil							

END

Trust Board

5 February 2019

Subject/Title	Global Digital Excellence (GDE) Programme Update
Paper prepared by	Peter Young, Chief Information Officer Cathy Fox, Programme Director for Digital Kerry Morgan, GDE Programme Manager
Action/Decision required	The Board is asked to note the updated progress of the Trusts GDE Programme the achievement of Milestone Four and the finalisation of Milestone 5
Background papers	N/A
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	IM&CT Strategy Significant contribution to the strategic objectives for:- - Clinical Excellence - Positive patient experience - Improving financial strength - World class facility

Alder Hey Children's NHS
NHS Foundation Trust

1.0 Executive Summary

The purpose of this paper is to provide the Board with an update on the progress of the Trusts Global Digital Exemplar (GDE) Programme; the achievement of Milestone 4 and the finalisation of Milestone 5.

2.0 Update of Progress

Since the previous update to the Board on 8 January 2019 The Trust continues to ensure phase five milestones are achieved; primary areas of work include:

Specialty Packages

We are now live within 25 specialties with an additional 7 due to go-live in January. We are required to deliver 33 specialties by 31st January 2019 for milestone 5. We are on track to deliver 32 packages by the end of January; 2 packages Cardiology and Cardiac Surgery have been agreed as work off items with NHS Digital and are due to go-live in February.

Benefits baseline: No digitised clinical pathways. Average length of stay 2.78 days. Individual specialty packages have bespoke benefits identified and are available to view in the SOPB on SharePoint.

Share2Care – Regional Interoperability

All 7 sites are connected to the platform; Three sites are operational and two other site to go operational soon, Once site started publishing clinic letter to live platform from December and all sites are working toward publishing clinic letter by end of Jan 2019. The Trust is working with the hosting team to finalise the migration plan. Connectivity with the LPRES platform (Lancashire & South Cumbria STP) was successfully tested and further testing is under way. Plans are underway to expand the platform to an additional 10 organisations across Cheshire and Merseyside STP as early as possible in 2019.

Benefits baseline: Pre-implementation survey undertaken. Findings identified that 0% of clinicians are able to access clinical information they need easily; 0% are satisfied with the current process for accessing clinical information from other Trusts. Time taken to collate information from other Trusts ranges from hours to days.

E-Consent

E-Consent will provide a means for patients and/or Legal Guardian to consent to treatment electronically. This will ensure an electronic signature can be given and consent can also be emailed to the patient and/or Legal Guardian.

Harriet Corbett, Consultant Urologist and clinical lead for the project, has been working closely with Wellbeing, provider of e-Consent, over the last few months in preparation for Urology to pilot the e-Consent system.

The system is now configured to a state whereby it is ready to be piloted. The 5 clinicians from Urology identified to pilot the system were trained on e-Consent on Thursday 10/01/19.

Testing of the system is scheduled to take place on Thursday 17/01/19. This is to test the system works as expected and identify any issues that need to be resolved prior to pilot go-live. This go-live date has been provisionally set for 18/02/19 as agreed with Harriet but yet to be approved by senior IM&T management.

The digital sign pads for the system are in the process of being tested.

Discussions are currently underway with the relevant parties both internally and externally to configure the system so that the completed consent forms can either be sent to the patients email address or a hardcopy sent to their home address.

Benefits baseline: E-consent taken in paper format; baseline timings to complete form to be calculated. Patient experience to be monitored throughout the pilot.

Voice Recognition

The Project Manager for VR is still in the process of visiting all specialities team meetings to update clinicians on VR and to identify clinicians that need additional 1:1 support as well as clinicians who have never used VR before and would like to give it a try. 12 specialities have been visited to-date (14/01/18) with more scheduled to be attended over the coming weeks.

An updated version of Fluency Direct is in the process of being tested by a small subset of clinicians. Positive feedback has been received from the clinicians who have been testing this since the 20th of December 2018 to confirm no new issues have occurred since using the updated version. As a result of this, the Project Manager has submitted a change request to IM&T's Change Board for the new version to be deployed to all staff by the end of January 2019.

In addition to this, M*Modal are still in the process of applying another update to the system which will further improve on the speech recognisers i.e. the back-end dictionaries to provide better recognition quality for the specialist medical terminology used at Alder Hey. This is by way of uploading 23,000 legacy Alder Hey letters into the system to improve the language models. This speech recogniser update is due to be released in February 2019, subject to testing.

M*Modal and members of IM&T are scheduled to complete further floor-walking in all clinics and clinicians offices for the whole of w/c 08/04/19 to inform clinicians of the system updates referenced above and support them further in using VR. By this date, it is anticipated that all PCs as per the PC replacement program being led by the Associate Director of Operational IT will have been replaced.

During the month of March 2019, the Project Manager will revisit the specialities team meetings to provide further updates on VR and inform them of the floor-walking plan for April 2019.

Benefits baseline: 54% positive response rate to 'Digital dictation is useful and helps with my clinical practice'.

3.0 Summary of Key Benefits

Project	Aim	Measurement	Baseline Position	Improvement Target	Actual Progress to Target (current)
Community Matrons Specialty Package	Improve efficiency in updating notes in the community	Time taken travelling from the community to the office base	Over 3 hrs/week travelling from community to office	Reduce by 3hrs/week	Achieved Dec-18
Community Matrons Specialty Package	Reduced mileage	Mileage travelling from the community to the office base	Over 3 miles/day travelling from community to office	Average saving of 3 miles per day per person	Achieved Dec-18
Community Matrons Specialty Package	Reduced car carbon footprint	Mileage travelling from the community to the office base	Over 3 miles/day travelling from community to office	0.12 tonnes CO2e	Achieved Dec-18

4.0 Milestone Assurance

The assurance review meeting for funding milestone 5 was held on 9 January 2019. In advance of the meeting, evidence in the form of project documentation was submitted for review. At the meeting the status of each deliverable was presented by the relevant Project Manager to highlight scope, achievements, benefits, risks and any outstanding items. In order to allow the external assurance team an insight into the impacts of the deliverables on quality and patient care, there were visits to view the PICU, Play Specialists and Community Paediatrics Specialty Packages.

5.0 Next deliverables

Work on milestone 5 is being finalised. By January 2019 Milestone 5 will deliver:

- **HIMSS level 6 gap assessment** took place on 11th December 2018. This highlighted a number of areas of good practice as well as where more work is needed. The draft report is due before Christmas which will be shared as

appropriate and from which an action plan will be developed to take us to full validation.

- **Bedside medication verification pilot:** BMV functionality has been created in the test system; a proof of concept pilot will be undertaken in ward 3C.
- **Complete a total of 33 Speciality Package deployments:** 32 specialties live by the end of January, 5 went live in December 2018 with a further 7 in January 2019.
- **GS1 Barcode deployment – Room locations:** Work is underway to implement GS1 barcode standards for location numbering to ensure compliance with the directive from the Department of Health.
- **Deployment of MESH - National Requirement:** Completed.
- **PDS Connectivity:** Purchased; implementation to be agreed.
- **Standard Documentation:** Standardised forms have been live since February 2018. Since their release the GDE team have undertaken a number of surveys and reviews of the documents to improve their ease of use and the new update is due to be released on 18th February 2019. There are 17 new forms, 5 of these are considered mandatory in documenting the corresponding clinical task.

6.0 Recommendations

The Board are asked note the progress of the Trusts GDE Programme; the on-going progress towards Milestone 5.

Peter Young
Chief Information Officer 29 January 2019

ALDER HEY IN THE PARK PROJECT

HIGHLIGHT REPORT Site & Park Development

SRO: David Powell
Author: Sue Brown

Key

Colour	Meaning
Grey	Planned project timeline
Green	On track
Amber	up to 3 months delay
Red	Over 3 months delay

Week Commencing

Month	Weeks
Jul-18	3, 10, 17, 24, 31
Aug-18	7, 14, 21, 28
Sep-18	4, 11, 18, 25
Oct-18	2, 9, 16, 23, 30
Nov-18	6, 13, 20, 27
Dec-18	4, 11, 18, 25
Jan-19	1, 8, 15, 22, 29
Feb-19	5, 12, 19, 26
Mar-19	5, 12, 19, 26
Apr-19	2, 9, 16, 23, 30
May-19	7, 14, 21, 28

Workstream	Comments
The Park	The team have met with potential organisations to assess interest in the project and design of the park and have requested further work on the design for the partial reinstatement which will form phase one and due to deliver October with work commencing early summer. Engagement continues through design groups and the friends of Springfield Park, A workshop was held at the beginning of January with local engagement , this was followed up with a feedback presentation, sharing the ideas on the design of the future park which now has a south to north position. This was welcomed and the group where more positive on the trusts vision for Springfield Park.
Future Site Development	Currently this work is more focused on exploring opportunities and will commence once we know where we are with the future land use.
New Schemes: Institute Phase II	Universities are preparing for occupancy across various dates during 2019. The project manager continues to work with the Architectural advisor and Morgan Sindell to rectify the snagging issues since occupation of the building, this is making slow progress and may need executive intervention in order to speed up response times. Exterior and interior planting and landscaping was completed as planned by the 22nd January together with the demolition of the low level buildings opposite the entrance . Disabled parking places have also now been marked up.
New Schemes: The Alder Centre	Due proposed increase in costs, the development team have met with the design team and the proposed contractor as costs for the build continue to rise in December and January which potentially leaves a financial risk. A separate paper is being presented to Board for a decision on the way forward. The Alder centre has been included in the current tender for the Community Cluster construction.
New Schemes: Community Cluster	The tender for the construction contract has gone out to the market and tenders due the end of March 2019 with evaluation and appointment concluded in April . It is expected that negotiations will need to be ongoing on bringing the final constructions cost down in line with the budget and this will be completed in discussion with the Architects, QS and the contractor appointed. There has been a delay with the planning application as LCC required further reports on parking and highways management which have now been submitted, planning determination due 23rd April.
Site Clearance-Demolition and decommission Phase 2	Planned programme to commence February 2019 however some low rise building opposite the Institute phase one building have already been demolished ahead of plan. Decommissioning by the way of emptying the current old theatres has already commenced in prep for asbestos studies.
Site Clearance-relocation of on-site services/corporate teams	The Development Directorate have been working with departments and dept. leads who will eventually move into the newly planned Community Cluster developments in 2021 to finalise the current interim move plan. Movement of staff and departments commenced in December and will continue through until the end of March 2019 . Feedback to date from staff who have moved has been very positive. Additional long term planning will be required for a number of other services including Medical Records and Transcription Ongoing progress on the police station refurbishment will allow a move for IM&T in March 2019, as work is due to be completed by 28th February.
Site Clearance: Temporary car park	Car park in situ, just requires barrier installation and lighting, Barrier purchased, lighting will be ordered once planning approved. Planning submitted for temporary car park and new park phase 1. Planners are currently reviewing and have requested additional plans on the phasing of the park, plus a review of the Trusts 2013 Travel Plan , this has been submitted with determination along with the Community Cluster planning is expected 23rdApril. A weekly meeting is taking place to ensure we can open the car park as soon as possible, with appropriate lighting and routes in and out of the site clearly communicated to staff and visitors.

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BOARD OF DIRECTORS

Tuesday 5th February 2019

Report of:	Research Division
Paper Prepared by:	Professor Matthew Peak, Director of Research Erica Saunders, Director of Corporate Affairs
Subject/Title:	Research Management Board - Terms Of Reference
Background Papers:	Well Led Governance Review – MIAA/AQuA
Purpose of Paper:	- Support implementation of the research strategy within the Trust - Support integration of research into divisional and corporate operations - Monitor research strategy effectiveness through key performance measures
Action/Decision Required:	To APPROVE the attached terms of reference
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	Game Changing Research and Innovation
Resource Impact:	Not yet identified

RESEARCH MANAGEMENT BOARD- TERMS OF REFERENCE

Constitution	The Trust hereby resolves to establish a senior group to be known as the Alder Hey Research Management Board (RMB)
Purpose	The purposes of the group meeting are to: - Support implementation of the research strategy within the Trust - Support integration of research into divisional and corporate operations - Monitor research strategy effectiveness through key performance measures
Membership	Director of Research (Chair) - the Chair will be responsible for setting the agenda for meetings of the group Clinical Lead for Research (Deputy Chair) Clinical Research Division (CRD) Associate Chief of Operations NIHR Alder Hey Clinical Research Facility (CRF) Operations Manager Associate Directors of Research (x3 Divisions) NIHR Clinical Research Network Specialty Leads for Children and Paediatric Cancer Chief Operating Officer Representative of University of Liverpool Honorary Professors Clinical Academic (with CRF Thematic Leadership) Academic Trainee representative CRD Senior Nurse Senior Research Pharmacist Industry Partnership Manager Research Communications Lead Senior Research Finance Lead Senior HR Adviser for CRD CRD Business Intelligence Lead Member responsibilities: Members are selected for their specific role or because they are representative of a professional group/division/department. Members are expected to: - Ensure they have read papers prior to meetings - Attendance in line with the terms of reference - Contribute to discussions and decision-making - If not in attendance seek a briefing from another member who was present to ensure that they are informed about the meeting progress and actions - Represent their professional group or their professional group/division/department as appropriate in discussions and decision making - Disseminate and feedback the content and actions of meetings to colleagues in their professional group/division/department The Chair of the RMB shall have the power to co-opt additional permanent members either internally or external to the Trust.
Attendance	The members may nominate a deputy to attend on their behalf if they are unable to attend. However, this should only be in exceptional circumstances. Overall throughout the working year, each member is expected to attend in person in excess of 50% attendance at scheduled meetings. Secretarial support shall be provided to the RMB to take minutes of the meeting and

	give appropriate support to the Chair and RMB members.
Quorum	A quorum shall be when the Chair or nominated deputy and five members are in attendance.
Frequency/ Duration	Meetings shall normally take place on a quarterly basis for 1.5 hours and the RMB will meet not less than four times a year.
Authority	The RMB is authorised to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any member of staff in order to perform its duties and to call any employee to be questioned at a meeting of the Senior Team as and when required. It has the powers to approve operational policies and procedures and approve terms of reference of groups that pertain to this entity. The RMB may also request specific reports from individuals within as may be appropriate to the overall arrangements.
Duties	• To ensure the effective implementation of the research strategy within Alder Hey and explicitly linked to divisional delivery plans • To review/approve Trustwide business models to improve financial sustainability of research, including income redistribution • To assess the Trust's compliance with CQC standards for research on behalf of CQAC • To recommend mechanisms to support the career progression for aspiring researchers and academic trainees of all professions and within all divisions • To review the Trust's annual integrated business plan for research and its coherence with divisional business plans • To recommend investment in research infrastructure within clinical divisions and corporate services • To develop collective solutions to operational barriers to the continued increase in applied research volume within Alder Hey, including both commercial and non-commercial research • To ensure that there is effective internal communication of matters relevant to research
Reporting	**Groups that report into the RMB:** • CRF Senior Management Team • Paediatric Medicines Research Unit Board **RMB reports to:** • Research, Education, Innovation Strategy Partnership Group • CQAC
Other Matters	CRF Senior Team Terms of Reference to be reviewed every 2 years.

DATE: January 2019
REVIEW DATE: January 2021

Board of Directors

5th February 2019

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

1. Staff Engagement

Reward & Recognition

The Trust's Annual Star Awards will take place on Friday 8th February 2019 at the Titanic Hotel.

In total 240 nominations were received from across the Alder Hey community. A first round of judging by Alder Hey staff members brought the long list down to a truly exceptional shortlist of nominees. This shortlist was then scrutinised by a panel of staff and governors – as well as crucial input from patients and families – who had the difficult task of picking just one winner from an incredibly competitive field.

Every staff member shortlisted, and the person nominating them, has been invited to the Alder Hey Star Awards evening. They will also be joined by all past 'Star of the Month' winners, as well as colleagues from across the hospital who have been at the forefront of the Trust's responses to challenges over the past year.

Categories this year mirror those used last year, and are inspired by the Our Plan strategy:

- Delivery of Outstanding Care
- Best People Doing Their Best Work
- Game Changing Innovation
- Game Changing Research
- Sustainability Through External Partnerships
- Strong Foundations
- Living Our Values
- Volunteer of the Year
- Alder Hey Children's Charity Award*
- Chairman's Special Recognition Award*

*categories not open to nominations but awarded at the discretion of the Charity and Chairman respectively.

Staff Survey

Following the staff response to the staff survey (60%), the Trust received the initial results in December and has since provided an update to Board on the key themes and trends.

Full access to the data is expected by the end of January, which will allow the HR Team to break the results down by divisions, departments and staff groups and to undertake a full

analysis, allowing for the identification of more areas of good practice as well as areas for improvement.

Once received, the detailed reports for the Trust, divisions and departments will be made readily available to enable effective conversations to take place about how we work together to improve our results again next year.

Improving Staff Wellbeing

The Trust's Health and wellbeing steering group continue to meet monthly and are generating ideas and incentives to improve staff wellbeing and improving mental health.

The Trust is commitment to changing and challenging attitudes towards mental Health and currently in the process of signing up to the Employer Time to Change Pledge, which is run by Mental Health Charity, Mind.

The Trust is continuing to work with NHSI on the national programme of improving employee health and wellbeing and have been working in conjunction with the Economic Evaluation team in conducting research on the impact of local deprivation on sickness absence and the role of occupational health support services.

2. Workforce Sustainability and Capability

Agenda for Change New Pay Deal – Transition of Band 1 to band 2 staff

A project group has been established in partnership with Trade Union colleagues to focus on the implementation of key changes following the refresh of the NHS Terms and Conditions of Service (Agenda for Change).

NHS Employers have stated that the band 1 pay scale within the NHS will be phased out. From 1st December 2018 the Band 1 pay scale no longer exists for new recruits, all new starters who would have previously entered the Trust on band 1 pay scales will now be recruited to band 2.

On 19th December 2018 the Staff Council co-chairs agreed the national process for transferring existing band 1 staff to band 2, as well as supporting staff who choose to remain in band 1. The agreement also details a non-consolidated payment to be made to band 1 staff

Within Alder Hey there are 3 groups of staff identified that are currently on a band 1 and they sit within Hotel Services.

- Domestic Assistants

- Catering Assistants
- Linen Assistants

In conjunction with this, work is commencing to review the appraisal system in line with the changes to incremental progression which will come into force on the 1st April 2019.

Education, Learning and Development

Apprenticeships- The Apprenticeship Team have exceeded their annual target of 50 Apprentices by the end of March 2019. Currently there are 51 'live' Apprentices a further 5 who signed their Apprenticeship agreements in January, making a total of 56.

The Register of Apprenticeship Training Providers (RoATP) has opened and, due to improved quality measures, all existing Providers/Employer Providers must re-apply to remain on the Register.

The Apprenticeship Team are currently working on the Trusts application to remain on the register.

Mandatory Training- Mandatory training figures as of mid-January have increased slightly to 89.03% for Core Mandatory Training and 88.40% for Overall Mandatory Training.

The team have continued to ensure that staff and managers are aware of outstanding requirements and providing communication directly to individual's outstanding mandatory training.

We have seen a particular drop in compliance around Information Governance, due to a large number of expiries across a 2 month period when the national toolkit was taken offline last year and are working hard with the information governance lead to improve compliance with additional face to face sessions and communications to encourage e-Learning access.

Library Update- The Library & Knowledge service has successfully bid for £23k from the Health Care Libraries Unit to develop an APP for staff and trainees to coordinate learning experiences and to update the e-Learning room in the library to support training.

The annual submission against national standards for libraries, the Library Quality Assurance Framework (LQAF) has been assessed and we have maintained 96% compliance.

3. **Employee Relations**

Employee Consultations

<u>Portering organisational Change</u>

Following a further review meeting with management and the trade unions that took place on 20th June 2018, a trial period of the proposed changes to working practices was due to have commenced from November 2018 for a three month period, with full staff engagement. However the trial period was put in abeyance as alternative proposals have since been received by management from the portering team which management are in the process of reviewing including cost implications, with intention of responding to portering group/unions in January 2019.

Employee Relations Activity

The Trust's ER activity is currently 13 formal cases. There are 6 disciplinary cases; 4 Bullying and Harassment cases; 1 capability and 2 grievances. As part of the ongoing focus on staff health and wellbeing and attendance at work the HR team are currently supporting managers and staff in improving employee health and wellbeing and reducing sickness absence.

Employment Tribunal Cases

The Trust has received the judgement outcome of the ET Claim relating to disability discrimination and protected disclosure which was held at the Liverpool Employment Tribunal on 12th November 2018, concluding on 23rd November. The ET found in favour of the Trust and dismissed all claims by the claimant.

There will be a de-brief to identify both Trust wide and Divisional learning lessons.

The Trust has been notified of an Appeal to an Employment Tribunal claim that was resolved in favour of the Trust in December 2017. An update is awaited from the Trust solicitors

4. Corporate Report

The HR KPIs in the December Corporate Report are:

- Sickness rates have increased slightly this month from 5.62% to **6.09%** in December. The Rolling 12 month sickness figure has increased to **5.6%**
- Core Mandatory training compliance is at **89%**
- PDR compliance is at **90%**

BOARD OF DIRECTORS

Tuesday 5th February 2019

Report of:	Medical Education Board
Paper Prepared by:	G Cleary H Blackburn
Subject/Title:	Action Plan following HEENW Quality Visit
Background Papers:	HEE-NW quality review outcome report Action Plan Briefing Document
Purpose of Paper:	To inform Board of Action plan to be submitted to HEENW and propose strategies to deliver sustained quality improvement in medical education
Action/Decision Required:	(Recommendations)
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	
Resource Impact:	

Alder Hey Children's NHS
NHS Foundation Trust

Health Education England -

Quality Review Outcome Report Action Plan

Briefing for Trust Board February 2019

1. Background

The Trust has been the focus of GMC Enhanced Monitoring since 2015. Following the HEE quality review in May 2018 an urgent response was submitted to Board relating to dental trainees and arrangements for out of hours paediatric cover. Now a further action plan is to be submitted to HEE by 20 Feb 2019. Priority areas highlighted in the report are:

- Action point 3 - On call working, patient tracking, incident reporting, responsibility for patients and handover
- Action point 7 – improving the educational component of handover
- Action point 8 – induction of junior doctors
- Action point 9 - educational governance structures

2. Action Plan

Delivering on the proposed Action Plan requires engagement with clinical and management teams across the Trust. HEE recognise some solutions cannot be implemented immediately, especially where investment is required, but robust and clear actions are needed. The following have been identified as the key actions required:

- Actions required require short to medium term timescales.
- Immediately we have engaged our paediatric doctors in training to identify challenges and work together to implement change. The primary forum for consultation is the Junior Doctors Forum.
- Robust job planning to identify and protect educational supervision sessions and understand barriers is a key component of education delivery. Transparency and visibility of the education budget is essential and to date this has not been possible.
- An educational governance structure has now been agreed and a framework to ensure the delivery and monitoring of education must be established. An education committee is now in place to deliver this.
- The future models of care programme is key to developing the delivery of paediatric out of hours consultant care and this must reflect supervision and training of junior doctors out of hours and to patients with medical complexity. This is an opportunity rather than threat to clinicians
- The Education team will actively engage senior clinicians to understand barriers and recognise/share good practice where it exists
- We will ensure no geographical barriers exist due to physical locality of relevant teams. The potential of the Institute and Innovation Hub facilities need to be utilised
- Innovation is required. This may have financial implications with examples being (but not limited to) designation of certain clinics as “teaching clinics” and some theatre sessions as “teaching lists”.

- We must support and develop leaders in education via a range of mechanisms such as higher qualifications such as PGCE and diplomas through to local initiatives
- We should support and develop educational research

3. Conclusion

In their review HEE recognised several areas of excellent practice. The Education team believe this report can act as a template for driving quality improvement in education across the Trust. In some areas focusing on core elements of education and training requires improvement and getting this right will ensure progress to our goal of delivering a world class learning environment and culture. Preparing this report has given evidence there is exceptional talent and motivation within the Trust, but in many cases, there are barriers to this being expressed which will require a clear and concerted effort to overcome.

Gavin Cleary

Acting Director of Medical Education

January 2019

Action Plan – Postgraduate Educational Monitoring Visit

Trust Name: Alder Hey Children's NHS Foundation Trust

Date of Visit:	4 May 2018
Date Action Plan required:	25 May 2018
Response compiled by:	16 May 2018

Please do not embed any documents. Documented evidence should be referenced in the action plan and made available on request.

Number	HEE Quality Standards	Requirements
1	**1.1; 3.3**	**The Trust must investigate, review and set out plans to address any issues with;** **a) The surgical list pathway and the mechanism by which dental trainees alert others to relevant issues affecting consent or patient safety;** **b) The administration of follow-up clinics, particularly the booking system to ensure that patients undergoing multiple procedures have all the necessary follow-ups;** **c) The supervision of trainees involved in any surgical "piggy-backing" procedures, to ensure they supervised in line with standards.**

Trust response

We have met with the DCTs as a result of the report to understand the issues further. As a result we have taken on board the issues raised andworked with the DCTs on a range of solutions which we have agreed within the Paediatric Dentistry services.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
a) Surgical List Pathway The role of the DCT will change within the pathway.	Review of clinic templates to ensure DCT activity has ceased	Ongoing activity and review at 6 weeks	Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain

The DCT will undertake the pre-operative preparation including consent where appropriate, and then take part in the theatre huddle and receive supervised training in theatre with the consultant. The required clinic activity will be phased out over the next 6 weeks. The activity from the clinics will be provided by our speciality dentist.	Review with DCTs attendance in theatre, number of cases recorded in logbook, and any reflections on their experience of the process through educational supervision process .	From 2 months to end of placement Ongoing at ES meetings thereafter	Sharon Lee/Susana Dominguez Gonzalez/Rod Llewellyn / DCT trainees
How will you sustain quality improvement? We will review all our actions both within the team and with the DCT's to get feedback from them about any progress. By auditing and reviewing this process we hope to make things better for our DCT's training and experience here and also better for our patients.		Timeline 2 months in this placement and ongoing for future rotations	Responsibility Sharon Lee/Susana Dominguez Gonzalez/Jeanette Chamberlain
b) Outpatient processes In meeting with the DCT's the main issue seems to be getting follow up appointments	. Baseline audit to identify extent of problems	6 weeks	DCT /Jeanette Chamberlain

from when they have seen patients in A&E, as there is a lack of clarity in the process	Design and implement a new process of how we manage our follow up patients from A&E and cascade that to the department. And on basis of audit agree an initial target for improvement We have also asked the Meditech team to come to the department to offer some bespoke training to the department so everybody is clear how to use the system and to order follow up's.	2 months Date to be confirmed	Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain /DCT Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain
c) Piggy Backs. DCT's were not aware that they **should not** be doing Piggy Backs on a Monday or a Friday when there is not consultant cover	. Revised process to be agreed with DCT and written into the DCT handbook so it is explicit. (The only reason a Piggy Back should happen on a Monday and a Friday is when there is a request to review patient's teeth under anaesthetic (EUA). If there is a treatment plan in place which has been previously agreed with the Consultant, this would be fine to do. Redesign of the process for requesting Piggy Backs for treatment which we are in the process of communicating with the wider organisation.	6 weeks 2- 3 months	Sharon Lee/Susana Dominguez Gonzalez/Jeanette Chamberlain Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain /DCT

Number	HEE Quality Standards	Requirements
2	1.1	**The Trust must review the arrangements for out-of-hours paediatric cover and provide assurances that individual trainees on-call are not expected to respond to emergencies for both groups of patients.**

Trust response

During the past 12 months actions to reduce occurrences of gaps on the out of hours rota have proven mostly successful with an ongoing action plan in place working to eradicate instances of on call trainees responding to both specialist and acute emergency admissions. During the current rotation period there have been two occasions of trainees covering both patient cohorts. This is a significant reduction compared to last year.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
Recruitment of 3 Trust employed doctors to tier 1 rota	Reduction in number of additional out of hours shifts worked per trainee above core rota	September 2018	Service Manager Acute Care Lead Consultant – Out of Hours Rota
Recruitment of 3 Trust employed doctors to tier 2 rota	Reduction in number of additional out of hours shifts worked per trainee above core rota	September 2018	Service Manager Acute Care Lead Consultant – Out of Hours Rota
Refinement of the Escalation Policy to include clearly defined actions, emphasis on joint decision making and escalation process for times of	Timely, appropriate notification of rota issues and efficient implementation of actions to reduce likelihood of rota gap on shift	June 2018	Service Manager – Acute Care

disagreement			
Introduce robust use of the DRS rota management system	Reduce delay in action of rota changes	September 2018	Medical Staffing HR Manager
Finalise clear process for reporting absence and disseminate to teams	Accurate reporting of absence	June 2018	Service Manager – Acute Care
How will you sustain quality improvement?		**Timeline**	**Responsibility**
Monitoring of all actions through the Out of Hours Forum	Achievement of actions within determined timescales	Monthly	Director of Division of Medicine
Elicit feedback from trainees	Respond in a timely manner to concerns and issues	Monthly	Director of Division of Medicine

Health Education England

Quality review outcome report

Local office name:	Health Education England – North West
Organisation:	Alder Hey Children's Hospital NHS Foundation Trust
Placements reviewed:	Paediatrics trainees and educators; dentistry trainees and educators; psychiatry trainees; surgery supervisors.
Date of Review:	5 May 2018

Date of report:	01 February 2019
Author:	Martin Smith
Job title:	Quality Support Manager

Developing people for health and healthcare

www.hee.nhs.uk

Review context

Background

Our monitoring process:	HEE monitor the risks to educational quality within our placements. Where we see significant, increasing or sustained risks we will make appropriate interventions, as summarised in this review. Our reviews include both exploratory and supportive elements We explore evidence that the Provider has effective quality control mechanisms of its own, by looking for concerns and good practice. HEE's role in this is not to alert the Provider to issues, but to monitor the Trust's awareness and actions taken to address them. This report includes requirements and recommendations which intend to support the provider in developing its own quality control mechanisms. Further support is available through your Associate Dean and Quality Support Manager.
Reason for review:	Enhanced monitoring of paediatrics; other specialties where our monitoring suggested some risk.
No. of learners met:	9 paediatrics; 4 dental trainees; 2 psychiatry trainees;
No. of supervisors / mentors met:	5 paediatrics; 3 dental educators; 2 psychiatry.
Other staff members met:	5
Duration of review:	8 hours
Intelligence sources seen prior to review:	CQC reports; previous reviews and action plans; specialty reports; GMC survey results 2013-2017; QSG reports for the region; local intelligence from our network of educators.

Panel members

Name	Job title
Dr Andrew Watson	Deputy Dean for Quality – Review Panel Lead
Professor Simon Carley	Associate Dean with responsibility for supporting the Trust
Mrs Roisin Haslett	Associate Dean
Dr Joanne Rowell	Associate Dean
Miss Anne Begley	Associate Dental Dean
Peter Butterfield	Lay Representative
Martin Smith	Quality Support Manager (report)
Leanne Moore	Quality Support Coordinator

Executive summary

Background

Alder Hey Children's Hospital NHS Foundation Trust has been the focus of GMC Enhanced Monitoring since 2015, when risks around handover, induction and access to learning opportunities for paediatrics trainees first came to light. In our review of 2017 it became clear that many of these issues were being resolved through innovations at department level, but the quality of placements was found to be variable, and dependant on the department. Mechanisms to identify the areas for improvement and areas of good practice still needed to be developed.

HEE therefore focused on governance, setting out requirements to encourage and support the Trust in developing an educational quality control framework. We asked that the Trust identify suitable performance indicators to drive improvements in induction, handover, clinic access and to supplement the GMC Survey in measuring learner and educator satisfaction. The current review was scheduled to consider progress in developing this framework. In addition, we asked to meet psychiatry trainees, dentistry trainees and surgery supervisors, as the 2017 GMC Survey outcomes suggested a risk in these areas.

We met a very small proportion of paediatrics trainees during this review and from our meeting with senior educational leads, we heard little evidence of progress in resolving the enhanced monitoring concerns. We therefore cannot recommend that the GMC change the enhanced monitoring status of the Trust at this time. We heard from trainees that the invitation to our review did not mandate trainee attendance – we expect future reviews to be attended by all available trainees and the invitation to attend to be emphatic.

Learning Environment and Culture

We heard examples of a supportive and friendly organisation in keeping with our previous experience of this Trust. This was exemplified through trainees' praise for inter-speciality team working and for support from radiology, microbiology and other services, which we have included as good practice. The senior educational leaders we met were open and engaged about the issues we discussed. However, we received reports that dental trainees were advised not to raise issues with HEE because of the problems this created following the previous review: trainees did not want to be considered unhelpful and informed us it was better to keep a low profile for the duration of their placements.

The Panel heard many examples of dedicated and supportive staff - for example, many trainees told us that the support provided during recent protests was excellent.

Despite many examples of strong working relationships, we heard concerns regarding the joint care of patients. Ad hoc case discussions between specialties were held to establish the responsibility for patients. One example described a heated debate about oncology/surgery patients involving the MDT team and the on-call team. In another example, we heard a report of a doctor denying that a knee had developed sepsis to avoid accepting the referral. Tier 3 trainees perceived having to pick up the work of surgical departments for patients with complex surgical needs, particularly out of hours.

All trainees would recommend their placements to other trainees, except those working in neurology and gastroenterology, for the reasons described below. Whilst the senior OMFS trainee was very satisfied with

their placement, dental core trainees did not feel their placements delivered what they were led to expect. Psychiatry trainees had particular praise for their well-delivered placements.

Dentistry trainees described a cheerful atmosphere and close working relationships with relevant teams, like cardiology, which led to accommodating behaviour for the benefit of patients. Likewise, psychiatry trainees described fruitful relationships with the emergency medicine team.

We heard that systems and processes often frustrated staff, created confusion or simply did not work as intended. Paediatrics trainees expressed limited confidence in the Meditech system's ability to track patients. Handover was reported as safe, but at the expense of the time spent manually tracking patients where the system did not. We continue to have concerns regarding handover in paediatrics, and we have set a requirement to continue improvements in handover. Psychiatry trainees described effective patient management systems which appeared the exception to this.

Rotas were an acknowledged issue for the senior leaders, educators and trainees alike: we heard that the rota was unresponsive to trainee requests for leave, even with plenty of notice. Trainees did not perceive the rotas, managed by admin staff in emergency medicine, to be responsive to the learning needs within paediatrics, with decisions made based on service rather than competence. The Panel recognise that the Trust had considered a "3rd on-call" doctor to act as a "sweeper" where last-minute gaps had occurred. However, tier 1 paediatrics trainees expressed uncertainty about on-call working, which induction or written policies failed to clarify. We have set a requirement below to develop clear procedural outlines for induction, tracking and other key systems.

Regarding Trust induction, we heard that trainees were sent a programme in advance of starting which covered lectures, advanced paediatrics life support training (APLS), resuscitation and other relevant topics. Trainees reported receiving reminders for their APLS. Trainees were unsatisfied with the Meditech training and said that it would be better to include this in the departmental induction, as each department was using Meditech differently.

At our previous review we noted concerns with the Wi-Fi signal in the new premises – we heard that boosting the signal had not addressed the dropouts, and that the Trust were considering mobile-phone hotspots as an alternative. Our previous review also raised concerns about the paging system which was duplicating bleeps and worked inconsistently. In the current review, trainees reported some improvements, but that paging was still variable.

Our previous review also raised concerns regarding a place for doctors to meet, eat and discuss issues with other doctors who they otherwise might not meet. From trainees we heard that there had been little progress in addressing this.

We met child and adolescent psychiatry trainees following concerns raised in the 2017 GMC survey, but we met very positive and satisfied trainees during this review, and the 2018 survey provided evidence that the concerns arising during 2017 have now been addressed.

Educational Governance and Leadership

In previous reviews, HEE identified educational governance as a key area for development. From the evidence, progress in this area has been disappointing. Concerns identified in previous reviews do not appear to have been addressed: handover, for example, has appeared as a negative outlier in the GMC survey for seven years in a row. A requirement is set out below to support the Trust in developing an educational governance framework and we advise the Trust to consider this a priority amongst the requirements: good educational governance will ensure that concerns at departmental level are addressed. HEE will continue to monitor concerns in handover, induction, use of Meditech, the responsibility for patients and learning opportunities as examples of whether an effective educational governance structure is in place.

The Trust presented an outline of the governance structure, with the Medical Education Board (MEB) intended to link operational matters with the Board. However, we heard that these did not work as intended, with information having to be gathered informally and through “corridor conversations”.

The Trust has had difficulties in appointing a permanent college tutor, but the Panel understand that an appointment was made in September 2018, and we hope that the tutor will work closely with the Head of School to improve the delivery of curricula.

For clinical incident reporting, paediatrics trainees who had logged clinical incidents reported receiving an acknowledgement but limited individual feedback or support. Consultants confirmed that it was up to the consultant in charge how feedback would be provided to the trainee and conceded that it would vary from specialty to specialty. Consultants added that prescribing concerns involving trainees would always be fed back to them, but as educational or clinical supervisors, they were rarely made aware of incidents trainees had been involved in, or about incidents they themselves were involved in.

Dentistry trainees knew how to report clinical and educational concerns but informed us that they did not try to change the culture but reach the end of their placement. Dental educators confirmed that feedback is always requested at the end-of-placement interview with the educational supervisor, who would escalate concerns to the TPD. They added that they would never need to use the Trust’s own educational governance systems and had little involvement with the Trust education team.

Regarding organisational learning-from-mistakes, the Trust reported regular safety bulletins to update trainees. Trainees described open and friendly meetings of harm, with a review of incidents and a root-cause analysis approach to more serious incidents. Consultants informed us that these were departmental in scope, and they knew of nothing shared Trust-wide. The Panel also heard that multiple reviews would take place in the event of a patient’s death, but trainees reported that this was abandoned after a month. Regarding the concerns around responsibility for patients outlined in the above section, educators pointed out that a root cause analysis had been carried out and clear guidelines set out, but trainees appeared not to be aware of this.

All groups confirmed that email is the main mechanism for communicating important information, but also that trainees had reported “email fatigue” and the workload prevented reception of the messages sent. This often appeared to create uncertainty and misunderstandings about policy, areas for improvement and good practice. We have therefore set a requirement for the Trust to supplement important communications with face to face communication through the developing educational governance framework.
The GMC Training surveys are a critical source of information, but the Trust noted that rotation dates for

paediatrics trainees affect the GMC survey in a negative way, as trainees have not had enough time to orient themselves to their placements by March 22nd. It is the responsibility of the Trust to ensure that trainees are not confused about which placement they are reporting on. HEE has recommended on several occasions that the Trust carry out its own monitoring to supplement the GMC survey. The forthcoming National Education and Training Survey (NETS) may provide supplementary evidence regarding trainee satisfaction, but the evidence we have heard at this review correlates with the evidence from the GMC Survey.

Supporting and Empowering Learners

Paediatrics trainees informed the Panel that the Trust has supported them appropriately on return to training after a break or transition into LTFT training. Educators described a formal structure to pair returning trainees with experienced registrars as well as designated KIT (keep in touch) days, which educators described as particularly useful for those specialties with lots of academics. For returners, daytime working with a consultant was preferred before trainees were put back on call or the OOH rota. Surgery educators perceived LTFT trainees to be a problem, and some held very traditional attitudes to flexible working. We did not interview surgery trainees, but the Trust may wish to follow up to ensure these trainees are properly supported in their working arrangements.

Paediatrics trainees' access to clinics has been monitored by HEE for some time: trainees reported some timetabled clinics, but in certain departments (e.g. neurology and respiratory medicine) they would only get to clinic on their own initiative, and reported difficulty getting to the one clinic per fortnight implied by their curriculum, particularly at middle grades. Consultants also expressed dissatisfaction with clinics arrangements. The Trust presentation outlined the monitoring of attendance at teaching and the aim to extend this to clinics and theatre: the Panel very much support this approach, although monitoring did not appear to be extended to psychiatry teaching, according to trainees.

Psychiatry trainees described good support from supervisors, weekly educational meetings, graded experience to ease them into the role, plentiful learning experiences (although some struggled to reach the required number of emergency cases), proactive feedback and good online case notes which were always current and clear to trainees.

Regarding supervision: tier 1 trainees reported good supervision from senior trainees, including OOH and that educational and clinical supervisors were available: tier 2 trainees perceived educational supervision to be dependant on the supervisor – some would make time to meet trainees, but others would not. From the limited numbers of trainees met this would appear to be the cause of the poor scores for supervision in recent GMC surveys. Psychiatry trainees reported having to attend a ward without registrar cover for half a day each week: whilst this had been reported, they were uncertain whether any action was being taken to address this.

Paediatrics trainees reported guidance from their supervisors in covering necessary WPBAs, but that this was generally trainee-led rather that consultant-led and involved a considerable amount of trainee perseverance. When asked, trainees were uncertain whether they were any better or worse than average in their learning, as proactive feedback was reported to be limited. Pastoral care and careers advice were said to be available through the medical education manager.

From dental educators we heard that trainees had an initial assessment at induction then a further three

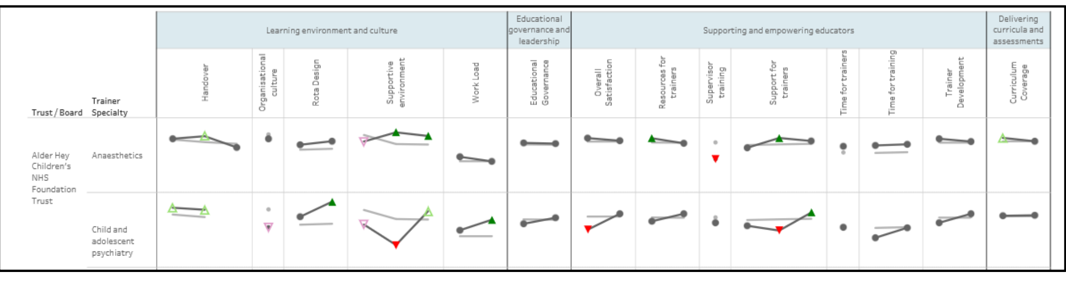
timetabled meetings through the year to discuss progress. Dental trainees informed the Panel that it was not always clear who was supervising them, although close supervision was in place when working on-call.

Paediatrics trainees were aware of the junior doctor forum, and some had attended it. Trainees said that concerns were heard, but they were unsure of subsequent actions, or whether their concerns would be escalated to the Board. An example was given about an idea to list all relevant teaching in the same place. Trainees mentioned taking the concept to the Innovation Hub and hoped that the Innovation Lead would develop this.

From middle-grade paediatrics trainees we heard of arrangements for trainees working OOH or at clinics to follow-up with supervisors. The hospital-at-night service was praised by trainees for the support provided out of hours: the Panel assume that this reflects the work of the OOH audit mentioned by senior leaders. Tier 3 trainees did not benefit from this arrangement though, and some reported not having seen their supervisors for weeks at a time. This group of trainees also expressed concerns that they would have to deal with parents who were sometimes angry that their children were not being seen by consultants in gastroenterology clinics (although they were supported before and after the clinic by consultants). When we asked consultants how they assessed trainee performance OOH, the response was that they knew because trainees had not phoned them during the night.

Supporting and Empowering Educators

We had asked to meet educators in certain specialties, as the 2017 GMC survey indicated that several groups were dissatisfied– in neurosurgery, plastic surgery and child and adolescent psychiatry. However, from our interviews with supervisors, it was apparent that at the time of our review, supervisors reported feeling much more satisfied and supported in their educator role. The 2018 GMC Trainer Survey (see below) supports this view, with child and adolescent psychiatry showing a marked improvement.



We heard about monthly educational meetings but learned that these are not always well attended by educators. With the difficulties in appointing a college tutor, the Trust has yet to establish an educator group around the tutor, but at the time of writing HEE understand a college tutor has been appointed and hope that these meetings will begin to engage educators and start to share good practice and effective ways of addressing concerns. It is hoped that the college tutor sets out to engage educators and bring them together as a group to discuss educational concerns and good practice, share solutions and feed into the developing governance framework.

Paediatrics consultants were provided 0.25 PAs per trainee, which they described as reasonable. Surgery

consultants reported that this time was not included in their job plans, and demonstrated disengagement with education, given the time invested in training and development as educators. A requirement has been set to address this.

We heard that most consultants are now trained as supervisors, and the Trust was focusing on orienting new consultants with the supervisory role. We heard that the consultant welcome pack was to be reviewed as there was no mention of education as a key component of a consultant's role.

Every educator we met was accredited in line with the GMC Standards, and moved into the role because of their enthusiasm for teaching and learning. We met a few consultants trained as appraisers, and who described the educational component of the appraisal process. Courses and development opportunities were available to all educators: except for those in surgery, all educators described feeling well prepared for their role.

At previous reviews, we heard that supervisor appraisals were monitored solely by the DME. At this review, we heard that the DME is now supported in this role by two additional educational leads, and that a sample of appraisals are now considered rather than all appraisals. We commend the Trust, given the evidence of engaged educators, effectively coordinated and well understood appraisal processes. We have now re-graded this risk to level 0 – no concerns.

When we asked how trainees would raise concerns about the quality of their supervision, the response was through the TPD and the school rather than the postgraduate medicine department. Given that we heard that the quality of educational supervision was variable, we have set a requirement to ensure that trainees can feed into trainer appraisals.

Curricula and Assessments

The Trust has a strong record for teaching, hosting regional training and STEP teaching. We heard that trainees had reviewed the STEP teaching programme against the curriculum, had good feedback from attendees and reported more engaged teachers. However, middle grade trainees reported that STEP teaching was no longer mandated as it was no longer possible for all to attend.

Tier 3 trainees described teaching as lacking relevance, often cancelled, and trainees were not sure who was responsible for organising teaching, or whether they were mandated to attend. We heard that paediatrics teaching had been affected by trainer absence.

Paediatrics trainees reported being directed toward the learning opportunities they required, and that plentiful specialist learning opportunities continue to be available. However, the Panel was left with the impression that some educators, including senior leads, equated training with teaching. The Trust is reminded that most training should occur in the workplace, with supervisors monitoring, assessing and feeding back on trainee performance.

Dentistry trainees recalled several obstacles to teaching: piggy-back procedures, bleeps for elective surgery, clerking and management of the ward were examples provided. We heard that teaching days at Aintree would often leave a single trainee at the Trust, and on occasion the senior trainee was also absent or on-call,

leaving this trainee to do the work of three.

Sustaining for the future

We heard from paediatrics trainees that ANPs were very effective and their work appreciated by trainees.

Whilst audit/QI was a curriculum requirement, and a key part of an effective quality strategy, middle grade paediatrics trainees reported having to complete it in their own time, and that administrative support was not always available.

Senior trainees were unaware of any opportunities to develop their leadership skills and reported no feedback from supervisors about their capability as leaders.

We had previously raised the issue of generalist vs specialist support, a unique issue for tertiary trusts like Alder Hey. We heard that specialist supervision is readily available, but generalist support harder to come by. The Trust had looked at the on-call rota from similar organisations, to ensure that trainees, particularly those working at middle-grades, have the generalist support they need to cover their curriculum. We heard that some specialist doctors “step-down” to assist with the general take. The evidence we heard suggests that specialist GRID trainees receive a lot of attention through teaching – yet the objective for all trainees on the paediatrics programme is a generalist paediatric CCT. Trainees valued the specialist learning opportunities available – they should be encouraged to value the generalist learning opportunities equally so.

From tier 3 paediatrics trainees, the Panel heard that generalists perceived that they are assigned all the patients: negotiations had taken place to define a generalist patient or a specialist patient, but these had stalled after a year and decisions were being made on an ad hoc basis.

Simulation training had been embedded in emergency medicine and was starting to be adopted within paediatrics.

Middle grade paediatrics trainees also referred to tertiary care for patients within the secondary care setting: trainees took care to explain that they never thought they were working beyond their competence, but that such cases would be easier if a consultant was available in the workplace

Good practice

Good practice is used as a phrase to incorporate educational or patient care initiatives that are worthy of wider dissemination, deliver the very highest standards of education and training or are innovative solutions to previously identified issues worthy of wider consideration.

Learning environment / Prof. group / Dept. / Team	Good practice	Related Domain(s) & Standard(s)
Radiology / microbiology	Several trainee groups praised the support services in place in the Trust, highlighting the radiology hotline and rapid responses and support from both radiology and microbiology teams. Members of these teams attended ward rounds and were said to be helpful and available.	
All	We heard of a very well developed multi-professional team spirit in place. We heard that trainees could rely on the teams around them for support and assistance, and a healthy culture of challenging without judgement was reported. Meetings were scheduled around multi-disciplinary themes, such as oncology.	

Requirements and recommendations

Patient / learner safety concerns

Any concerns listed will be monitored by the organisation. It is the organisation's responsibility to investigate / resolve.

Were any patient/learner safety concerns raised at this review?	YES
To whom was this fed back at the organisation, and who has undertaken to action?	
A letter was sent to the Chief Executive of the Trust within two weeks of the review, including the requirements below. A satisfactory action plan was returned within a further two weeks. We have now rated these patient safety concerns at risk level 1.	
AHCH_20180502_01	**Risk Category: 1**
The Trust must investigate, review and set out plans to address any issues with; **a) The surgical list pathway and the mechanism by which dental trainees alert others to relevant issues affecting consent or patient safety;** **b) The administration of follow-up clinics, particularly the booking system to ensure that patients undergoing multiple procedures have all the necessary follow-ups;** **c) The supervision of trainees involved in any surgical "piggy-backing" procedures, to ensure they supervised in line with standards.**	
AHCH_20180502_02	**Risk Category: 1**
The Trust must review the arrangements for out-of-hours paediatric cover and provide assurances that individual trainees on-call are not expected to respond to emergencies for both groups of patients.	

Educational requirements

Requirements are set where HEE have found that standards are not being met; a requirement is an action that is compulsory.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_03	*Trust wide*	*Doctors in training.*
		Risk Category: 3
a). The Trust must review the arrangements for on-call working, patient tracking, incident reporting, responsibility for patients and handover, to ensure that processes are clear and consistent across all departments. **b). The Trust must produce standard operational procedures for each of the above processes, ensuring that trainees and educators are aware of these (please refer also to Requirement 9 below)** **c). The Trust must monitor the arrangements above to ensure that departments are consistently carrying out their duties.**		
Related Domain(s) & Standard(s)		
Summary of findings	1. Systems, processes and guidelines were an emerging theme of this review. We heard many examples of unnecessary confusion and uncertainty as described throughout this report. The patient safety concerns we have already shared with the Trust centred around trainees' understanding of processes. 2. From HEE's work with many different organisations, we know that clear guidelines and streamlined processes will avoid unnecessary work, freeing up both trainee and consultant time for learning. 3. Trainees reported available guidelines that were usually specific to the department. In one example, a consultant had to email guidelines as the trainee was not allowed to access them through the intranet. 4. Trainees reported no access to an on-call timetable or on-call work schedules. 5. One paediatrics trainee reported being asked to work beyond their competence because of the complexities of on-call arrangements but added that their resistance was respected. We heard terminology like "3rd on-call" had confused some trainees new to the Trust. 6. Paediatrics trainees informed the Panel that the phone directory was unreliable. 7. Tier 3 paediatrics trainees perceived OOH arrangements to be over-complicated and the roles of consultants and registrars in this were still being worked out. There were also reported disagreements between generalists and specialists about how OOH arrangements should work. 8. The Panel heard that there were limited cross-cover arrangements in place, but there were some, and in such cases, trainees relied on guidelines as much as support from consultants. Trainees were at pains to stress that in very complex cases, consultants took care to ensure trainees understood the issues. 9. There was often confusion between specialties regarding who was responsible for patients, sometimes resulting in conflict. Trainees	

expressed concerns about patients who were not well enough for the general paediatrics wards but not unwell enough for specialist care. Tier 3 paediatrics trainees pointed to a high risk of harm to patients because they were unsure whether their priority was to treat newly admitted patients or those already in care.

10. From paediatrics educators, we heard that it was difficult for them to locate case notes, blood tests and other paperwork of a weekend.
11. Dentistry trainees perceived a lack of administrative support and an unreliable tracking system which would leave them searching for patients. Dental educators acknowledged that information sometimes did not reach trainees, despite the policy of emailing trainees as well as including details in the patient book.
12. Psychiatry trainees described good secretarial support and informed us that they had never lost track of patients. We heard that case notes were always accessible and up to date.
13. Dental educators reported having to re-record patient details as occasionally the wrong system would be used with incorrect codes.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_04	*Trust wide*	*Doctors in training*
		Risk Category: 2

The Trust must review the management of the rotas so that trainees can access learning opportunities in clinics, theatres and teaching, for those following both specialist or generalist learning pathways.

Related Domain(s) & Standard(s): *GMC R1.12*

Summary of findings

14. Further evidence for this requirement has been presented in the executive summary section of this report.
15. Tier 3 trainees informed the Panel that rotas were not adaptable for those following specialist learning routes, and so specialist trainees were unable to access learning opportunities required by their curriculum.
16. We heard that clinic arrangements were variable – for example, registrar-run respiratory medicine clinics had been cancelled as the trainees were required on the wards; diabetes clinic lists were included in the trainee's job plan, and attendance protected on the rota.
17. Paediatrics consultants added that clinic attendance was hampered because of a separate trainee list, and because it was sometimes difficult to find the space in which clinics can be held, so attendance at clinics was no longer mandated.
18. We heard from some trainees approaching CCT that they were carrying out lots of ward rounds, TTOs and phlebotomy. They described departments with limited numbers of tier 1 trainees, resulting in the tier 3 having to act down, reportedly at F1 level, to cover the service.
19. Dentistry trainees were unable to inform the Panel who managed their rotas. Paediatrics dentistry trainees described a strong focus on service, and perceived little opportunity to develop their skills or knowledge, despite the availability of suitable patients.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_05	*Paediatrics*	*Doctors in training*
		Risk Category: 1
The Trust must review out-of-hours working from an educational perspective, ensuring that trainees receive feedback on their work and educators have opportunities to assess the performance of trainees out of hours.		
Related Domain(s) & Standard(s)	*GMC R1.15; HEE 3.2*	
Summary of findings	20. While the Panel heard of very good arrangements for assessment and feedback of tier 1 trainees, this did not appear to extend to other grades.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_06	*Dentistry*	*Doctors / dentists in training*
		Risk Category: 2
a). The Trust must ensure that dental trainees are involved in educationally productive activities appropriate to their grade and curriculum. **b). The Trust must ensure that dental trainees feel empowered to raise concerns about their education or about clinical practice.**		
Related Domain(s) & Standard(s)	*GDC 6; GDC 7; GDC15*	
Summary of findings	21. Dental trainees informed the Panel that against their expectations, they spent a great deal of their time doing simple extractions and had little opportunity to cover the specialised learning opportunities within paediatric dentistry available. 22. We heard that dental trainees were reluctant to raise concerns and had been asked not to raise concerns with the Panel at the current visit.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_07	*Paediatrics*	*Doctors in training*
		Risk Category: 3
The Trust must continue to improve the educational components of handover.		
Related Domain(s) & Standard(s)	*R1.14*	
Summary of findings	23. The GMC have raised handover in paediatrics as a significantly sustained issue, and handover and induction were the original reasons for applying enhanced monitoring. Handover has been scored as a negative outlier for seven years running in the GMC survey. 24. From middle-grade trainees we heard that consultants would not normally attend handover, but that consultants would be available via telephone if required. 25. From core-grade trainees we heard that learning at handover was dependant on the consultant. 26. At weekends, handover was based on a written document and was not normally attended by a consultant. Trainees reported that the morning handover was attended by a consultant and had the most educational	

	value. The Panel heard that weekend paediatrics handovers were variable, not attended by consultants and without a sense-check. 27. Psychiatry trainees described handovers with emergency medicine as excellent: well timed and with emergency doctors ensuring all issues were covered and understood.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_08	*Trust wide*	*Doctors in training*
		Risk Category: 3

a). The Trust must ensure a consistent quality of inductions, using a monitored checklist of core elements, so that trainees are suitably prepared for working in their departments.

b). The Trust must ensure that all trainees, including those working nights in their initial placement, receive a departmental induction.

c). The Trust must ensure that trainees have time to complete their mandatory training.

Related Domain(s) & Standard(s)	*GMC R1.13; HEE 3.4*
Summary of findings	28. Induction has been a negative outlier in the GMC trainee survey for three years in a row and was one of the reasons for originally applying enhanced monitoring. 29. Trainees reported guidelines that were easy to locate in some departments, less easy in others (gastroenterology was given as an example). General guidelines are also covered in Requirement 3 above. 30. This requirement continues the requirements for induction previously set. 31. The previous action plan for induction, submitted by the Trust in July 2017, posited an induction checklist, and QI work with the junior doctors' forum had commenced. The Panel would like further assurance that those who do not attend an induction can be identified, and that the Trust's stated target, of 90% completion rate, had not addressed the risk of any one trainee missing induction and patients subsequently come to harm as a result. 32. All trainees we met had an induction before starting, with one exception who reported having an induction six weeks into the placement. Measured as a percentage of the trainees met, this is high enough to raise serious concerns. 33. Trainees who received a general paediatric induction reported this to be unclear regarding handover, and over-complicated regarding on-call. Psychiatry trainees echoed this view. 34. Dentistry trainees reported a prompt and effective Trust induction but did not have APLS. Departmental induction was said to be informal and did not leave trainees feeling prepared for work as it did not include a tour, introductions to key staff or the location of critical equipment. One trainee described having CPR training and an induction quite different from other dentists. 35. For their departmental induction, psychiatry trainees informed us that they were not expected when they arrived at the department for their induction.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_09	*Trust wide*	*Doctors in training*
		Risk Category: 3

a). The Trust must continue to develop educational governance structures.

b). The Trust must develop Trust-wide strategies, in partnership with educational forums, to address the concerns raised in this report – especially induction, handover and access to learning opportunities. These strategies should be based on the good practice identified in some of the departments within the Trust.

c). The Trust must continue to develop key performance indicators to measure the success of the above strategies.

Related Domain(s) & Standard(s)	*GMC R2.1; R2.4; HEE 2.1;*
Summary of findings	36. HEE are still concerned that the educational strategy at this Trust still needs to be developed. We have rated the risk as level 3 as this is a significant and sustained concern. 37. From psychiatry trainees, we heard of good governance arrangements, supporting our view that governance is departmental rather than Trust-wide. 38. The Panel heard that educators are asked, as part of their appraisal, about their awareness of the GMC survey and the action taken to address the issues this raises. Whilst this is good practice, it does not address the variable, departmental governance highlighted in the Educational Governance and Leadership section. 39. At the previous review, HEE set out a requirement for the Trust to develop key performance indicators to measure and drive improvements in education. At the time of writing, we have not seen any evidence that KPIs have been identified or shared. 40. Trainees informed the Panel that Meditech was used inconsistently in different departments. 41. We heard that the GoSW attended junior doctor forums, but trainees referred to a culture that did not encourage exception reports. Consequently, the impact of service on learning was not being monitored through the GoSW channel. None of the dentists we met knew of the GoSW or their role in managing exception reports. 42. Paediatrics trainees were frustrated that the issue regarding generalist vs specialist treatment described above had been raised on several occasions, and whilst the situation had improved, there was still uncertainty over the management of patients.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_10	*Trust wide*	*Doctors in training / educators*
		Risk Category: 2

The Trust must use their organisational structure to deliver important messages, lessons learned, good practice and key aims for improvements.

The Trust must ensure that educators are aware, via their appraisal or some other appropriate method, of the strategies and the key performance indicators identified to drive improvements.

Related Domain(s) & Standard(s)	*GMC R2.7; GMC R1.6*
Summary of findings	43. Throughout the day we heard that trainees are unable to read every email because they are too busy. 44. We also heard that trainees and educators were not aware of key messages, such as policies and guidelines. 45. Whilst emails and guideline documents are appropriate and necessary, the Trust already has a framework for communication: key messages

	should be brought to the attention of educators through appraisal and educator meetings, of trainees through meetings with educational supervisors. 46. When asked, educators were unable to tell the Panel how good practice was shared around the organisation.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_11	*Trust wide*	*Consultant educators*
		Risk Category: 1
The Trust must encourage and support educator forums to discuss concerns and good practice, share solutions and support each other in their educational work. These forums should be considered a key part of the developing educational governance framework.		
Related Domain(s) & Standard(s)	*GMC R1.6;GMC R2.16; GMC R4.5*	
Summary of findings	47. We met very engaged, hard working and supportive educators who were often frustrated by their own workload. 48. Dental educators reported no forum within the Trust in which they could meet and discuss educational matters, and they did not attend any educational committee meetings. 49. Surgery educators expressed disengagement with education, for the reasons outlined below.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_12	*Surgical specialties*	*Consultant educators*
		Risk Category: 2
The Trust must review job-planning for educators and take the necessary steps to ensure that job-planning is equitable across the Trust.		
Related Domain(s) & Standard(s)	*GMC R4.2; GMC R2.10*	
Summary of findings	50. Surgery supervisors reported little time for shop-floor teaching, with trainees in neurosurgery having to watch procedures rather than engage in them. They added that the template used for clinics did not allow time for teaching. We heard that WPBAs are only considered at ARCP as educators did not have time to include regular formative assessments. 51. Surgery educators reported that neurosurgery teaching was not available to trainees as they were too busy to arrange it. They added that Wednesday morning teaching was increasingly popular, though. 52. Surgery educators reported not having access to the 0.25 PA educational time that had been agreed, and which paediatrics educators were receiving.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_13	*Trust wide*	*Consultant educators*
		Risk Category: 1
The Trust must ensure that trainees are able to contribute to trainer appraisals, so that the Trust is aware whether trainers are able to carry out their educational role in addition to their service role.		

Related Domain(s) & Standard(s)	GMC R2.10; GMC R2.11
Summary of findings	53. Paediatrics trainees reported that many educational supervisors could make the time needed for educational meetings, but that many are not. 54. We heard that some paediatrics consultants are busy with delivering care and did not have the time to carry out educational summary and planning meetings with their trainees. 55. When asked how trainees would raise concerns about supervision, paediatrics and dentistry trainees informed us that they would go to their TPD rather than the postgrad education department. 56. The e-Portfolio used in paediatrics does not allow trainees to record meetings with their educational supervisor. 57. The reader is referred to the concerns raised by surgery educators in the section above.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_14	*Paediatrics*	*Doctors in training*
		Risk Category: 1
The Trust must ensure that trainees' leadership and general professional capabilities are developed, especially for those nearing CCT.		
Related Domain(s) & Standard(s)		
Summary of findings	58. The Panel heard from senior paediatrics trainees that no leadership or general professional skills development was available. 59. Senior paediatrics trainees expressed concerns at having to deal with parents who were concerned, and sometimes angry, that their child was not being treated by a consultant. 60. Encouraging leadership amongst senior trainees will help strengthen governance, quality improvement and communications and engage trainees. 61. Whilst external leadership and educator courses are available (such as the Cert. Ed.) these will normally only involve those with a professed interest. In-house courses and development opportunities will engage those who have aptitude they are unaware of.	

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_15	*Paediatrics*	*Doctors in training*
		Risk Category: 1
The Trust must continue to ensure that paediatrics trainees are supported in their generalist learning, through teaching, supervision and learning opportunities suited to the paediatrics curriculum.		
Related Domain(s) & Standard(s)	*GMC R3.6; GMC R5.4*	
Summary of findings	62. Generalist paediatrics trainees expressed frustration that they would be expected to care for most patients, some of whom they did not believe were generalist cases. As a result, they did not have time to cover the paediatrics curriculum. 63. As outlined elsewhere, and noted at previous reviews, we did not hear that generalist trainees perceived being supported in their work, especially	

	out of hours.

Reference no.	Programme / specialty:	Learner / professional group:
AHCH_20180502_16	*Trust wide*	*Doctors in training*
		Risk Category: 1
The Trust must ensure that trainees have a place to eat, meet and have discussions with others.		
Related Domain(s) & Standard(s)	*GMC R1.12e;*	
Summary of findings	64. The issues surrounding the new premises (a doctors' mess, wireless signal and the distance between some departments) were raised by trainees at our previous review, and were raised again at the current review	

Sign off and next steps

Report sign off

Outcome report completed by *(name)*:	Martin Smith
Visit Lead	Dr Andrew Watson
Visit Lead's signature	[signature]
Postgraduate Dean	Professor Jane Mamelok
HEE authorised signature:	pp. [signature]

Organisation staff to whom report is to be sent

Job title	Name
Chief Executive	Louise Shepherd
Medical Director	Dr Steve Ryan
Director of Medical Education	Dr Graham Lamont
Medical Education Manager	Helen Blackburn

Action plan

To be returned to HEE by *(date)*:	20 February 2019
To be completed by *(name)*:	

Appendix 1: HEE Quality Framework Domains & Standards

Domain 1 - Learning environment and culture

1.1. Learners are in an environment that delivers safe, effective, compassionate care that provides a positive experience for service users.
1.2. The learning environment is one in which education and training is valued and learners are treated fairly, with dignity and respect, and are not subject to negative attitudes or behaviours.
1.3. There are opportunities for learners to be involved in activities that facilitate quality improvement (QI), evidence based practice (EBP) and research and innovation (R&I).
1.4. There are opportunities for learners to engage in reflective practice with service users, applying learning from both positive and negative experiences and outcomes.
1.5. The learning environment provides suitable educational facilities for both learners and educators, including space, IT facilities and access to quality assured library and knowledge services.
1.6. The learning environment maximises inter-professional learning opportunities.

Domain 2 – Educational governance and leadership

2.1 The educational governance arrangements measure performance against the quality standards and actively responds when standards are not being met.
2.2 The educational leadership uses the educational governance arrangements to continuously improve the quality of education and training.
2.3 The educational leadership promotes team-working and a multi-professional approach to education and training, where appropriate.
2.4 Education and training opportunities are based on principles of equality and diversity.
2.5 There are processes in place to inform the appropriate stakeholders when performance issues with learners are identified or learners are involved in patient safety incidents.

Domain 3 – Supporting and empowering learners

3.1 Learners receive educational and pastoral support to be able to demonstrate what is expected in their curriculum or professional standards to achieve the learning outcomes required.
3.2 Learners are supported to complete appropriate summative and formative assessments to evidence that they are meeting their curriculum, professional standards and / or learning outcomes.
3.3 Learners feel they are valued members of the healthcare team within which they are placed.
3.4 Learners receive an appropriate and timely induction into the learning environment.
3.5 Learners understand their role and the context of their placement in relation to care pathways and patient journeys.

Domain 4 – Supporting and empowering educators

4.1 Those undertaking formal education and training roles are appropriately trained as defined by the relevant regulator or professional body.
4.2 Educators are familiar with the curricula of the learners they are educating.
4.3 Educator performance is assessed through appraisals or other appropriate mechanisms, with constructive feedback and support provided for role development and progression.
4.4 Formally recognised educators are appropriately supported to undertake their roles.
4.5 Educators are supported to undertake formative and summative assessments of learners as required.

Domain 5 – Developing and implementing curricula and assessments

5.1 The planning and delivery of curricula, assessments and programmes enable learners to meet the learning outcomes required by their curriculum or required professional standards.
5.2 Placement providers shape the delivery of curricula, assessments and programmes to ensure the content is responsive to changes in treatments, technologies and care delivery models.
5.3 Providers proactively engage patients, service users and learners in the development and delivery of education and training to embed the ethos of patient partnership within the learning environment.

Domain 6 – Developing a sustainable workforce

6.1 Placement providers work with other organisations to mitigate avoidable learner attrition from programmes.
6.2 There are opportunities for learners to receive appropriate careers advice from colleagues within the learning environment, including understanding other roles and career pathway opportunities.
6.3 The organisation engages in local workforce planning to ensure it supports the development of learners who have the skills, knowledge and behaviours to meet the changing needs of patients and service.
6.4 Transition from a healthcare education programme to employment is underpinned by a clear process of support developed and delivered in partnership with the learner.

Appendix 2: HEE Intensive Support Framework

Our monitoring is based around risk, and we use several sources, including the GMC Surveys, CQC and QSG reports and our own monitoring visits, to determine an estimated risk score. We provide a risk score with each requirement and will track and monitor the risk to see whether the actions taken are successful. We will amend the risk scores where we see evidence of changes (both positive and negative) and will always inform you of any changes.

Rating	Threshold
0	No evidence that HEE standards are not met
1	HEE standards not met, but action plan in place and provider consistently working to resolve.
2	HEE standards not met, and sustainable improvements not at pace, despite action plan.
3	Placements well below HEE standards, and sustained improvements not at pace, despite action plan.
4	Placements well below standards; serious risk to trainee or patient safety; escalation has not resolved the concern.

You can find full details of the HEE Quality framework, strategy and standards by following the link https://www.hee.nhs.uk/our-work/quality

Appendix 3: Abbreviations Used

ACAT	Acute care assessment tool
ACCS	Acute care common stem
AHP	Allied health professional
ALS	Advanced life support
AMU	Acute medical unit
ANLS	Advanced neonatal life support
ANP	Advanced nursing practitioner
AP	Assistant practitioner
APLS	Advanced paediatric life support
ARCP	Annual review of competence and progression
BLS	Basic life support
CAMHS	Child and adolescent mental health services
CCG	Clinical commissioning group
CCT	Certificate of completion of training
CfWI	Centre for workforce intelligence
CI	Clinical incident
CMT	Core medical training / trainee
CPD	Continuing professional development
CQC	Care Quality Commission
CPT	Core psychiatry training / trainee
CST	Core surgical training / trainee
CT	Core trainee
D&E	Diabetes and endocrinology
DGH	District general hospital
DME	Director of medical education
E&D	Equality and diversity
ENT	Ear, nose and throat (otolaryngology)
EOLC	End of life care

EPR	Electronic patient record
ESR	Electronic staff record
EWTD	European working time directive
F1	Foundation year 1
F2	Foundation year 2
FFT	Friends and family test
FOI	Freedom of information
GDC	General Dental Council
GMC	General Medical Council
GoSW	Guardian of safe working
GPhC	General Pharmaceutical Council
GPST	General practice specialist trainee
HCA	Health care assistant
HEE	Health Education England
HEE NW	Health Education England in the Northwest
HEI	Higher education institution
ICAT	Intensive care assessment tool
ICP	Integrated care pathway
ICU	Intensive care unit
IG	Information governance
IT	Information technology
JDAT	Junior doctors advisory team
KPI	Key performance indicator
LAS	Locum appointment for service
LAT	Locum appointment for training
LETB	Local education and training boards
LTFT	Less than full time
LWAB	Local workforce action board

MAU	Medical assessment unit
MD	Medical director
MH	Mental health
NETS	National education and training survey
NHSE	NHS Employers
NHSI	NHS Innovation and Improvement
NICE	National Institute for Health and Care Excellence
NMC	Nursing and midwifery council
O&G	Obstetrics and gynaecology
OOH	Out of hours
OOP	Out of programme
OT	Occupational therapist
PA	Physician associate
PG	Postgraduate
PHE	Public Health England
PICU	Paediatric intensive care unit
QA	Quality assurance
QC	Quality control
QI	Quality improvement
QSG	Quality surveillance group
RC	Royal college
RCA	Root cause analysis
RMN	Registered mental health nurse
RO	Responsible officer
SHO	OBSOLETE: Senior House Officer
SLA	Service level agreement
SPA	Supporting professional activities
ST	Specialist trainee
STP	Sustainability and transformation plan
SUI	Serious untoward incident
T&O	Trauma and orthopaedic
TTA / TTO	To take away / out (medication on discharge)
UG	Undergraduate
WPBA	Workplace-based assessments
WTE	Whole time equivalent

Postgraduate Educational Monitoring Visit Action Plan

Action points

Trust Name: Alder Hey Children's Hospital NHS Foundation Trust

Date of Visit:	5 May 2018
Date Action Plan required:	20 February 2019
Response compiled by:	Dr Cleary on behalf of Education Team

Please do not embed any documents. Documented evidence should be referenced in the action plan and made available on request.

Number	HEE Quality Standards	Requirements
1	Cat 1	**The Trust must investigate, review and set out plans to address any issues with;** **a) The surgical list pathway and the mechanism by which dental trainees alert others to relevant issues affecting consent or patient safety;** **b) The administration of follow-up clinics, particularly the booking system to ensure that patients undergoing multiple procedures have all the necessary follow-ups;** **c) The supervision of trainees involved in any surgical "piggy-backing" procedures, to ensure they are supervised in line with standards.**
Trust response		

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The Education team have held constructive meetings with the dental team and produced an action plan.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
a) Surgical List Pathway The role of the DCT will change within the pathway. The DCT will undertake the pre-operative preparation including consent where appropriate, and then take part in the theatre huddle and receive supervised training in theatre with the consultant. The required clinic activity will be phased out over the next 6 weeks. The activity from the clinics will be provided by our speciality dentist.	Review of clinic templates to ensure DCT activity has ceased Review with DCTs attendance in theatre, number of cases recorded in logbook, and any reflections on their experience of the process through educational supervision process	Ongoing activity and review at 6 weeks From 2 months to end of placement Ongoing at ES meetings thereafter	Sharon Lee/ Chris Sweet Sharon Lee/Chris Sweet /Rod Llewellyn / DCT trainees
How will you sustain quality improvement?		**Timeline**	**Responsibility**
We will review all our actions both within the team with the DCT's to get feedback from them about any progress. By auditing		2 months in this placement and ongoing **for** future rotations	Sharon Lee/Chris Sweet /Rod Llewellyn / DCT trainees

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and reviewing this process we hope to make things better for our DCT's training and experience here and better for our patients.			
b) Outpatient processes In meeting with the DCT's the main issue seems to be getting follow up appointments from when they have seen patients in A&E, as there is a lack of clarity in the process	Baseline audit to identify extent of problems Design and implement a new process of how we manage our follow up patients from A&E and cascade that to the department. And on basis of audit agree an initial target for improvement We have also asked the Meditech team to come to the department to offer some bespoke training to the department, so everybody is clear how to use the system and to order follow up's. Revised process to be agreed with DCT and written into the DCT handbook so it is explicit.	6 weeks 2 months Date to be confirmed 6 weeks	DCT /Jeanette Chamberlain Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain /DCT Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain Sharon Lee/Susana Dominguez Gonzalez/Jeanette Chamberlain
c) Piggy Backs. DCT's were not aware that they **should not** be doing Piggy Backs on a Monday or a Friday when there is not consultant cover	(The only reason a Piggy Back should happen on a Monday and a Friday is when there is a request to review patient's teeth under anaesthetic (EUA). If there is a treatment plan in place which has been previously agreed with the Consultant, this would be appropriate. Redesign of the process for requesting Piggy Backs for treatment which we are in the process of communicating with the wider organisation.	2- 3 months	Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain /DCT

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Number	HEE Quality Standards	Requirements
2	Cat 1	**The Trust must review the arrangements for out-of-hours paediatric cover and provide assurances that individual trainees on-call are not expected to respond to emergencies for both groups of patients.**

Trust response

During the past 12 months actions to reduce occurrences of gaps on the out of hours rota have proven mostly successful with an ongoing action plan in place working to eradicate instances of on call trainees responding to both specialist and acute emergency admissions. During the current rotation period there have been two occasions of trainees covering both patient cohorts. This is a significant reduction compared to last year.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
Recruitment of 3 Trust employed doctors to tier 1 rota	Reduction in number of additional out of hours shifts worked per trainee above core rota	September 2018	Service Manager Acute Care Lead Consultant – Out of Hours Rota
Recruitment of 3 Trust employed doctors to tier 2 rota	Reduction in number of additional out of hours shifts worked per trainee above core rota	September 2018	Service Manager Acute Care Lead Consultant – Out of Hours Rota
Refinement of the Escalation Policy to include clearly defined actions, emphasis on joint decision making and escalation process for times of	Timely, appropriate notification of rota issues and efficient implementation of actions to reduce likelihood of rota gap on shift	June 2018	Service Manager – Acute Care

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disagreement			
Introduce robust use of the DRS rota management system	Reduce delay in action of rota changes	September 2018	Medical Staffing HR Manager
Finalise clear process for reporting absence and disseminate to teams	Accurate reporting of absence	June 2018	Service Manager – Acute Care
How will you sustain quality improvement?		**Timeline**	**Responsibility**
Monitoring of all actions through the Out of Hours Forum	Achievement of actions within determined timescales	Monthly	Director of Division of Medicine
Elicit feedback from trainees	Respond in a timely manner to concerns and issues	Monthly	Director of Division of Medicine

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Number	HEE Quality Standards	Requirements
3	CAT 3	**a). The Trust must review the arrangements for on-call working, patient tracking, incident reporting, responsibility for patients and handover, to ensure that processes are clear and consistent across all departments.** **b). The Trust must produce standard operational procedures for each of the above processes, ensuring that trainees and educators are aware of these (please refer also to Requirement 9 below)** **c). The Trust must monitor the arrangements above to ensure that departments are consistently carrying out their duties.**
Trust response		
The Trust has intensively reviewed the arrangements for paediatric on-call working, patient tracking, incident reporting, responsibility for patients and handover.		

There is a major project underway in the Trust led by Chief operations Officer and Director of the Medical Division to review and change the delivery of acute paediatric care. This is referred to as "future models of care"

Terms of reference for the project is as follows:

1. To examine the data on safety, workload, effectiveness and patient experience of general paediatric and high dependency care
2. To agree the standards of care all general paediatric and high dependency patients should receive
3. To design a new model of care for general paediatric and high dependency patients
4. The model of care that is recommended should be designed such that it:
4.1 Achieves the standards of care that are defined following fulfilment of point 2. above
4.2 Reduce the number of children who experience preventable deterioration
4.3 Improves the response to a child who has deteriorated
4.4 Offers attractive and fulfilling jobs and careers to the people working in it
4.5 Seizes opportunities to redesign the model of care using innovative practice
4.6 To meet national medical staffing standards for general paediatrics, HDU and PICU across 7 days
4.7 Understand the workforce, timescales and costs of implementation
4.8 Delivers value for money for the taxpayer
5. To provide a report to the Alder Hey Executive Team on the review of general paediatric and high dependency care, including a recommendation on the future model of care
6. To provide a policy document that teams follow to make it clear to families, medical teams, and non-medical colleagues which consultant is in charge of a patient's care and who is the first responder to a child who deteriorates. The Policy will set out the thresholds and pathways for general paediatric and specialty patients

The Medical Education Team has engaged with the project to ensure the needs of doctors in training working on-call and out of hours are met.

It is clear to the Trust that the reduction in numbers of trainees entering paediatrics will not change in coming years. A long-term integrated workforce plan is needed. A working group is established and led by Dr Hughes (divisional director of medicine and interim medical director). This plan is likely to include the training and deployment of non-medical practitioners (such as, but not exclusively, advanced paediatric nurse practitioners) to support service delivery and ensure trainee doctors receive both high-quality education and training associated with a positive experience of training.

During the patient safety section of induction, there is a short video demonstrating how to complete an incident form. This is to re-inforce the information that is delivered by the DME during his welcome talk.

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At induction the incoming trainees are given verbal and written information about their individual roles and responsibilities for out of hours cover. This document provides specific information for each grade of doctor on call. It also covers handover arrangements.			
Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Future models of care group	A sustainable way of working will be implemented that will to ensure that all trainees are fully supported on call to allow them to fulfil their curriculum requirements	End of March2019	AH
How will you sustain quality improvement?		**Timeline**	**Responsibility**

Number	HEE Quality Standards	Requirements
4	CAT 2	**The Trust must review the management of the rotas so that trainees can access learning opportunities in clinics, theatres and teaching, for those following both specialist and generalist learning pathways.**
Trust response		
The paediatric rota continues to present significant challenges to the Trust and trainees alike. The Trust continues to intensively review and manage the paediatric on call rota and recognises that challenges strongly correlate with the sense of low morale amongst the trainee workforce. A dedicated working group has been established to manage the paediatric rota led by senior clinicians, with junior doctor representation and reporting to divisional medical director. The reduction in trainee numbers will continue and the trust is exploring new workforce plans to reduce the impact of the decrease in trainee numbers. Challenges for trainees have been identified by meetings of the rota group, junior doctor forum and out of hours group. Each group has significant junior doctor input. Challenges are summarised as follows: Increasing complexity of patients		

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Increasing parent/carer demands and expectation with increased expressed emotion including challenge and occasional hostility towards out of hours medical team

Rota gaps arising for multiple reasons including sickness, maternity, consultant appointment in the case of senior trainees. Paediatrics has a high number of LTFT trainees, and this will continue in the future. Job sharing and childcare arrangements can be challenging for trainees and Trust alike

Delivery of training across grades, with focus of higher specialist and GRID trainees. The rota is EWTD compliant but very difficult to deliver GOLD compliance for Grid trainees

The challenges for trainees are of course also challenges for the Trust with the addition of:

Late notice withdrawal from rota after publication

Significant cost pressure of locum / additional duty payments

Ensuring services remain safe

Actions completed to date since the HEENW quality visit are as follows:

A new D3 rota tier (middle grade) (08:00-16:00 weekend and 16:00 – MN weekday)

Nursing roles – bleep holder and CSN (overnight), business case for rapid response team approved, ANP in post ward 4C. This role will eventually participate as part of the on-call team.

Publication and dissemination of new roles and responsibilities document and new escalation policy for unexpected rota gaps

Although the majority of training occurs in the workplace, access to learning opportunities is essential to the delivery of high-quality education and training. An audit has been commissioned and will be led by an academic clinical fellow (medical education) to further understand challenges limiting trainee’s access to learning opportunities in general and speciality paediatric clinics. The Education Team will engage the Board in making educational supervision more robust, defined and accountable within consultant job plans. Innovative plans including designating specific teaching clinics and theatre sessions will be presented to

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Board. The Trust has held constructive meetings with lead employer to help understand policy with regards to sickness reporting and trainees requesting change of duty due to pregnancy. As a result, all trainees requesting change of duty due to pregnancy will be referred to lead employer occupational health. This has not been Trust policy previously. A SOP for sickness reporting is to be shared with trainees at induction.			
Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Model developed to ensure that trainees can access clinics or other relevant teaching	Trainee satisfaction – they will achieve the clinical requirements for their level of training.	On-going	Clinical Directors
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Ensure that the model is monitor and embed requirements' into clinical training programme.	On-going	Education Team

Number	HEE Quality Standards	Requirements
5	**CAT 1** **3.2**	**The Trust must review out-of-hours working from an educational perspective, ensuring that trainees receive feedback on their work and educators have opportunities to assess the performance of trainees out of hours.**
Trust response		
The Trust recognises that out of hours working provides many educational opportunities. A feedback tool has been developed by Dr Deakin (consultant general paediatrician) that is available on the Trust extranet. The web form will document feedback information that will be collated by the Education team and sent to		

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the ES to provide feedback for the trainee regarding their progress. The form will be used for all trainees at all levels. College Tutors will engage with trainees and educators to highlight the training opportunities out of hours			
Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Implementation of feedback tool	Education Team will monitor feedback tool use and share with educational supervisors	Currently be piloted- roll out from March	Education Team
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Increased submission of feedback to share with trainees.	On-going	Education team

Number	HEE Quality Standards	Requirements
6	CAT 2	**a). The Trust must ensure that dental trainees are involved in educationally productive activities appropriate to their grade and curriculum.** **b). The Trust must ensure that dental trainees feel empowered to raise concerns about their education or about clinical practice.**
Trust response		
Following meetings with the Education team, the Dental team have made the following action plan: 1. ES will discuss roles and educational expectations versus their skills and knowledge 2. All trainees are informed at induction who and how they can raise concerns. ES will re-inforce the message 3. Dental dept. will use the trust induction checklist. This will be monitored by the Education team.		

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Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
ES meeting will be used to discuss activities during placement	This activity will be reviewed throughout placement and logged in portfolio	On-going during placement	Educational supervisors
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Meeting plans and discussion with ES	On-going	Educational Supervisors

Number	HEE Quality Standards	Requirements
7	CAT 3	**The Trust must continue to improve the educational components of handover.**

Trust response

The Trust recognises the fundamental importance of handover of to ensure the delivery of safe and high-quality care. The educational value of handover is also recognised, and the Trust has is to develop this by the use of new functionality within the electronic patient record. The Education Team will improve the handover facilities in the designated area and has established a working group to implement an EPR tool alongside other structured processes for handover.

Paediatric handovers summarised as follows:
For acutely admitted patients coming in under the care of general paediatrics there is a formal handover daily at 8am (followed by the post take ward round) and again at 4pm. Both of these are consultant supervised. There is a final (informal) handover between the consultant general paediatrician and the first on middle grade doctor before the consultant leaves (usually after 7pm but often later). There is a formal handover between out going day on-call team and the incoming night on-call team at 9pm lead by the most senior trainee. The first and second on teams meet together. There is no consultant presence at this handover. The consultant general paediatrician also contact the overnight first on middle grade doctor by phone at approximately 10pm to discuss any concerning issues/deteriorating patients. Consultant presence augments the educational component of handover. Trainees are encouraged to use these opportunities for work-based assessments such as ACAT, Leader, RCPCH handover tool. In addition, the bespoke Trust feedback form (hosted on extranet and uploaded to medical education team) can be used to send feedback on trainees at handover (and other workplace settings)

There is a formal handover of specialty patients at 4.30pm for the incoming second on-call team. This is not currently attended by a consultant, but this is under review. There is a formal HDU huddle at 5pm attended by the second on team and attended by the HDU consultant. This is to review HDU patients (ones to watch, possible discharges) and for the HDU staff to be made aware of 'ones to watch' on the wards and potential admissions therefore to HDU.

Weekend handover notes are now recorded in the EPR – to include weekend plan / escalation plan / tasks to be completed and we have received informal positive feedback from trainees regarding this

Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Consultant led handover utilising handover tool and integration with hospital electronic patient record (EPR)	Trainees will report in GMC survey and feedback during placements	On-going	Medical/ Specialty Consultants
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	GMC report should reflect the improvement	Annual review	Education team

Number	HEE Quality Standards	Requirements
8	**CAT 3** **3.4**	**a). The Trust must ensure a consistent quality of inductions, using a monitored checklist of core elements, so that trainees are suitably prepared for working in their departments.** **b). The Trust must ensure that all trainees, including those working nights in their initial placement, receive a departmental induction.** **c). The Trust must ensure that trainees have time to complete their mandatory training.**
Trust response		

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The Trust acknowledges this requirement and will ensure a consistent quality of inductions, using a monitored checklist, so that trainees are suitably prepared for working in their departments. This will be monitored by the education team and by feedback from trainees following Trust and departmental induction.

a). The Trust has produced a checklist of core elements to be completed by each trainee following generic and departmental induction

b) The Trust will request evidence that a departmental induction has taken place

c) The Education team will run regular reports and identify what mandatory training is outstanding and inform educational supervisors to ensure trainees have time to complete modules.

Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Local induction checklist information will be collated by Education team	Reviewing information and contacting depts. to ensure that trainee has been inducted in accordance with Trust requirements. Review reports from lead employer to identify what mandatory training remains outstanding.	Review checklists – 1 week after induction 6 months- before each induction	Education team
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Embed process into induction with ES	On-going	Education team

Number	HEE Quality Standards	Requirements
9	CAT 3	**a). The Trust must continue to develop educational governance structures.** **b). The Trust must develop Trust-wide strategies, in partnership with educational forums, to address the concerns raised in this report – especially induction, handover and access to learning opportunities. These strategies should be based on the good**

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	2.1	practice identified in some of the departments within the Trust. c). The Trust must continue to develop key performance indicators to measure the success of the above strategies.

Trust response

We recognise the importance of education governance structures. It is an area which requires development across the organisation, to provide the Board with assurance on the high quality of multi professional teaching that our Trust should have. To this end, we have been developing a more comprehensive infrastructure and governance framework to support trainees of all professions.

A new Education Governance Framework has recently been agreed with the Director of HR and OD and the Medical Director, alongside the Terms of Reference for the refreshed Education Governance Committee which will report into the Workforce and OD Committee. This multi-disciplinary Committee will oversee the quality of education delivery and ensure that education is key role on the agenda of the individual Divisions. We are awaiting the recruitment of the substantive DME who will lead the development of an education strategy.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
Appoint DME	DME will lead the development of education within the trust to produce a strategy to support the Trust's vision	April 2019	Medical Director/ HR Director
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	The strategy will be used to monitor KPIs	On-going	DME

DRAFT

Number	HEE Quality Standards	Requirements
10	CAT 2	**The Trust must use their organisational structure to deliver important messages, lessons learned, good practice and key aims for improvements.** **The Trust must ensure that educators are aware, via their appraisal or some other appropriate method, of the strategies and the key performance indicators identified to drive improvements.**

Trust response			
The Education Team have engaged with multiple stakeholders including doctors in training in the preparation of this report with the DME reporting progress directly to the Head of HR. The trust has disparate mechanisms to disseminate messages. The Education team will work with the Communications dept. to ensure that key messages, lessons learned etc are disseminated in a more transparent and accessible way. The Trust plans and standards are listed on the Allocate appraisal system. Before each appraisal cycle begins reminder, information will be sent to CDs to ensure that key messages have been relayed to relevant staff. The education team will hold education update meetings twice each year with consultants to ensure that key messages are disseminated appropriately.			
Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Use extranet to create page to allow trainees to access information at convenient times.	An informed workforce with appropriate access to relevant information. This should result in a reduction in queries from trainees and staff.	On-going	Education Team
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Regular review of information	On-going	Education Team

Number	HEE Quality Standards	Requirements
11	CAT 1	**The Trust must encourage and support educator forums to discuss concerns and good practice, share solutions and support each other in their educational work. These forums should be considered a key part of the developing educational governance framework.**
Trust response		

DRAFT

Grand round will be utilised by the education team with education related topics to be led by college tutors or DME to ensure that all consultants are updated with changes or information that they are required to know. The information would also be available via our extranet for staff to access at a convenient time.

Paediatric Educators Forum – all medical specialty education & training reps meet once a year and discuss issues (STEP teaching programmes - plans for Educational Supervision).

The Education Team led by the DME will engage on a minimum bi-monthly or quarterly basis with all the clinical teams to discuss concerns and share good practice. This may include attendance at team consultant other relevant meetings. Alternatively, the Education Team will consider ad hoc meetings with educators following a review of feedback if such meetings would be beneficial.

Surgical college tutor has met with the neurosurgery team to improve engagement. They will be encouraged to review services to ensure that education can be delivered, and appropriate time is documented in their job plans.

Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Education team led Grand Round twice per year Extranet page with relevant support College tutors to meet regularly to discuss concerns and share good practice	The ES will be more informed and be able to support their trainees.	August/ February	Education Team
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Regular meetings with educational supervisors.	Two meetings per year with each clinical service to be reviewed by	Education team

DRAFT

		education team and ES	

Number	HEE Quality Standards	Requirements
12	CAT 2	**The Trust must review job-planning for educators and take the necessary steps to ensure that job-planning is equitable across the Trust.**

Trust response A new job planning policy has recently been agreed with LNC. The intention is that all educational supervisors will have the relevant time within their plans to deliver supervision.			
Need more information re job planning consistency panel			
Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Annual job planning cycle	All ES will have educational role identified within job plan and reflect number of trainees supervised	Effective from 1 April 2019, and will be reviewed by Divisional leads	Divisional Directors
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Annual job planning cycle	On-going	Divisional Directors

Number	HEE Quality Standards	Requirements

DRAFT

13	CAT 1	**The Trust must ensure that trainees are able to contribute to trainer appraisals, so that the Trust is aware whether trainers are able to carry out their educational role in addition to their service role.**

Trust response

We have reviewed the trainee comments in this action point and note the focus is primarily on supervisors being unable to meet with trainees and trainees being unsure of how to raise concerns. All trainees are informed who their ES will be before induction. We have also amended our induction check list to capture the dates of the three main meeting requirements. (Induction, mid-point and end meetings)

Education team will collate dates of meetings and email ES and trainee to confirm that meetings have taken place.

The new job planning policy should alleviate the issue.

The DME will engage with HEE regarding trainee contribution to trainer appraisals as we are concerned that anonymity may limit open feedback.

Trainees are informed at induction that the education team should be contacted in relation to educational supervision issues and they will disseminate to the PG Tutor.

All consultant appraisers are reminded that reflection on educational roles is mandatory at appraisal

Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Ensure that ES role is included in job plan. Use induction to inform trainees of escalation process	Monitored by Education team	On going	Education Team
How will you sustain quality improvement?		**Timeline**	**Responsibility**
Job planning via annual cycle	Monitored by Education Team	On going	Education Team

DRAFT

Number	HEE Quality Standards	Requirements	
14	CAT 1	**The Trust must ensure that trainees' leadership and general professional capabilities are developed, especially for those nearing CCT.**	
Trust response			
We have appointed a new Associate RCPCH college tutor who is a START examiner. She will meet with the STEP 3 trainee lead to review the content of the curriculum and develop an action plan to ensure that we are meeting the needs of the trainees in relation to leadership and CCT requirements. We circulate all leadership courses from external sources.			
Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
Use extranet to advertise programmes and opportunities for trainees to attend Review topics for STEP 3 programme to ensure that it meets trainees expectations	Increase in study leave applications to attend external leadership courses. Feedback and evaluation for STEP 3 programme	On-going Mid- February	Education Team Maw Tan and Lubna Wajid
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Act upon feedback and review programme regularly	On-going	STEP team

DRAFT

Number	HEE Quality Standards	Requirements

15	CAT 1	**The Trust must continue to ensure that paediatrics trainees are supported in their generalist learning, through teaching, supervision and learning opportunities suited to the paediatrics curriculum.**

Trust response

We believe that on the whole trainees are supported to cover their paediatric curriculum through the Trust's educational processes. We have developed a feedback form for consultants to feedback OOH if a trainee undertakes a particular WBA or other training that will fulfil their curriculum needs.

The Trusts response to the comment about concerns that were raised due to the high volume of patients that they see and feel that this does not allow them to fulfil their curriculum requirements. We have a task and finish group who are in the process of reviewing consultant paediatricians out of hours roles and responsibilities. The outcomes will be shared with all specialties to ensure that the new model of care is fully embedded within the Trust.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
Feedback form to be used to collect trainee feedback	Education team will collate information and disseminate each week to relative ES. Gaps will be noted, and appropriate action discussed with DME and PG tutor	Pilot from February 2019.	Education team
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Regular review of information and feedback via the education feedback tool developed by Dr Deakin	Pilot from February 2019.	Education team

Number	HEE Quality Standards	Requirements
16	CAT 1	**The Trust must ensure that trainees have a place to eat, meet and have discussions with others.**

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Trust response			
The Trust recognises and acknowledges that facilities available to trainees in this regard are not of the standard required and this area was overlooked in the new build. A major review of facilities for trainees to meet, handover, eat and have discussions is underway and potential space to be developed has been identified. The Education team are in discussion with relevant furniture suppliers and junior doctors to improve facilities in the current mess areas. We have identified potential space to acquire for additional facilities but as this requires building work we are in discussion with Estates and other relevant individuals.			
Corrective action	**How will you demonstrate quality improvement?**	**Timeline**	**Responsibility**
New multipurpose furniture and improved IT equipment Possible room extension	Trainee input to development and feedback	End of March 2019	Education Team
How will you sustain quality improvement?		**Timeline**	**Responsibility**
	Trainee satisfaction- reported through junior Dr forum and GMC survey.	June 2019	Education Team

DRAFT

Action Plan – Postgraduate Educational Monitoring Visit

Trust Name: Alder Hey Children's NHS Foundation Trust

Date of Visit:	4 May 2018
Date Action Plan required:	25 May 2018
Response compiled by:	16 May 2018

Please do not embed any documents. Documented evidence should be referenced in the action plan and made available on request.

Number	HEE Quality Standards	Requirements
1	**1.1; 3.3**	**The Trust must investigate, review and set out plans to address any issues with;** **a) The surgical list pathway and the mechanism by which dental trainees alert others to relevant issues affecting consent or patient safety;** **b) The administration of follow-up clinics, particularly the booking system to ensure that patients undergoing multiple procedures have all the necessary follow-ups;** **c) The supervision of trainees involved in any surgical "piggy-backing" procedures, to ensure they supervised in line with standards.**

Trust response

We have met with the DCTs as a result of the report to understand the issues further. As a result we have taken on board the issues raised andworked with the DCTs on a range of solutions which we have agreed within the Paediatric Dentistry services.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
a) Surgical List Pathway The role of the DCT will change within the pathway.	Review of clinic templates to ensure DCT activity has ceased	Ongoing activity and review at 6 weeks	Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain

The DCT will undertake the pre-operative preparation including consent where appropriate, and then take part in the theatre huddle and receive supervised training in theatre with the consultant. The required clinic activity will be phased out over the next 6 weeks. The activity from the clinics will be provided by our speciality dentist.	Review with DCTs attendance in theatre, number of cases recorded in logbook, and any reflections on their experience of the process through educational supervision process .	From 2 months to end of placement Ongoing at ES meetings thereafter	Sharon Lee/Susana Dominguez Gonzalez/Rod Llewellyn / DCT trainees
How will you sustain quality improvement? We will review all our actions both within the team and with the DCT's to get feedback from them about any progress. By auditing and reviewing this process we hope to make things better for our DCT's training and experience here and also better for our patients.		Timeline 2 months in this placement and ongoing for future rotations	Responsibility Sharon Lee/Susana Dominguez Gonzalez/Jeanette Chamberlain
b) Outpatient processes In meeting with the DCT's the main issue seems to be getting follow up appointments	. Baseline audit to identify extent of problems	6 weeks	DCT /Jeanette Chamberlain

from when they have seen patients in A&E, as there is a lack of clarity in the process	Design and implement a new process of how we manage our follow up patients from A&E and cascade that to the department. And on basis of audit agree an initial target for improvement We have also asked the Meditech team to come to the department to offer some bespoke training to the department so everybody is clear how to use the system and to order follow up's.	2 months Date to be confirmed	Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain /DCT Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain
c) Piggy Backs. DCT's were not aware that they **should not** be doing Piggy Backs on a Monday or a Friday when there is not consultant cover	. Revised process to be agreed with DCT and written into the DCT handbook so it is explicit. (The only reason a Piggy Back should happen on a Monday and a Friday is when there is a request to review patient's teeth under anaesthetic (EUA). If there is a treatment plan in place which has been previously agreed with the Consultant, this would be fine to do. Redesign of the process for requesting Piggy Backs for treatment which we are in the process of communicating with the wider organisation.	6 weeks 2- 3 months	Sharon Lee/Susana Dominguez Gonzalez/Jeanette Chamberlain Sharon Lee/Susana Dominguez Gonzalez/J Chamberlain /DCT

Number	HEE Quality Standards	Requirements
2	1.1	**The Trust must review the arrangements for out-of-hours paediatric cover and provide assurances that individual trainees on-call are not expected to respond to emergencies for both groups of patients.**

Trust response

During the past 12 months actions to reduce occurrences of gaps on the out of hours rota have proven mostly successful with an ongoing action plan in place working to eradicate instances of on call trainees responding to both specialist and acute emergency admissions. During the current rotation period there have been two occasions of trainees covering both patient cohorts. This is a significant reduction compared to last year.

Corrective action	How will you demonstrate quality improvement?	Timeline	Responsibility
Recruitment of 3 Trust employed doctors to tier 1 rota	Reduction in number of additional out of hours shifts worked per trainee above core rota	September 2018	Service Manager Acute Care Lead Consultant – Out of Hours Rota
Recruitment of 3 Trust employed doctors to tier 2 rota	Reduction in number of additional out of hours shifts worked per trainee above core rota	September 2018	Service Manager Acute Care Lead Consultant – Out of Hours Rota
Refinement of the Escalation Policy to include clearly defined actions, emphasis on joint decision making and escalation process for times of	Timely, appropriate notification of rota issues and efficient implementation of actions to reduce likelihood of rota gap on shift	June 2018	Service Manager – Acute Care

disagreement			
Introduce robust use of the DRS rota management system	Reduce delay in action of rota changes	September 2018	Medical Staffing HR Manager
Finalise clear process for reporting absence and disseminate to teams	Accurate reporting of absence	June 2018	Service Manager – Acute Care
How will you sustain quality improvement?		**Timeline**	**Responsibility**
Monitoring of all actions through the Out of Hours Forum	Achievement of actions within determined timescales	Monthly	Director of Division of Medicine
Elicit feedback from trainees	Respond in a timely manner to concerns and issues	Monthly	Director of Division of Medicine

Register of Company Shareholdings
As at 31st January 2019

Changes made since last reporting period:

Changes highlighted in blue

1. Change of Company Name:

Previous Name	New Name	Date of Change	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
Alder Hey Sensors Ltd	Asthma Buddy Ltd	13th September 2018	18/05/2017	No	30.10%	10188710	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Alder Hey Medical Ltd	Doctors Hours Ltd	13th September 2018	18/05/2017	No	30.10%	10188794	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Alder Hey Digital Ltd	Bloom Revalidation Ltd	13th September 2018	18/05/2017	No	30.10%	10189548	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Alder Hey Diagnostics Ltd	Digital Audiology Technology Ltd	13th September 2018	18/05/2017	No	30.10%	10189060	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Alder Hey Analytics Ltd	Fresh Wellness Ltd	13th September 2018	30/06/2017	No	30.10%	10259396	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Cofoundery Enterprise 02 Ltd	Conquer Kids Phobia Ltd	13th September 2018	27/04/2017	No	30.00%	10746202	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

Previous Name	New Name	Date of Change	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
Cofoundery Enterprise 04 Ltd	Blood Sense Ltd	13th September 2018	27/04/2017	No	30.00%	10746341	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Vericell	Sample Tracker Ltd	13th September 2018	27/04/2018	No	30.00%	10746420	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Cofoundery Enterprise 08 Ltd	Reel Medical Technologies Ltd	13th September 2018	27/04/2018	No	30.00%	10746455	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

2. Change to Significant Control

Company Name	Change Made	Date of Change	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
Physiopal Digital Ltd	Alder Hey has significant control of company	2nd August 2018	27/06/2018	No	30.00%	10838856	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

3. Filing of Company Accounts

Company Name	Date Accounts Filed	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
Asthma Buddy Ltd	14th December 2018	18/05/2017	No	30.10%	10188710	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Doctors Hours Ltd	14th December 2018	18/05/2017	No	30.10%	10188794	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Bloom Revalidation Ltd	14th December 2018	18/05/2017	No	30.10%	10189548	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Digital Audiology Technology Ltd	13th 17th December 2018	18/05/2017	No	30.10%	10189060	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Fresh Wellness Ltd	14th December 2018	30/06/2017	No	30.10%	10259396	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Conquer Kids Phobia Ltd	20th November 2018	27/04/2017	No	30.00%	10746202	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Blood Sense Ltd	20th November 2018	27/04/2017	No	30.00%	10746341	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Remedy MedPass Ltd	21st November	27/04/2018	No	30.00%	10746292	Boundary Street,	Commercial	App development and	Managed through 3rd	Active

Company Name	Date Accounts Filed	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
	2018					Liverpool		commercialisation	party	
Sample Tracker Ltd	21st November 2018	27/04/2018	No	30.00%	10746420	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Reel Medical Technologies Ltd	21st November 2018	27/04/2018	No	30.00%	10746455	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Acorn Partners Ltd	18th December 2018	18/05/2018	No	27.5%	10188842	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

4. New Companies formed with Alder Hey as Shareholder

Company Name	Date AH became SH	AH Director	Shareholdings	Company No	Address	Nature	Purpose	Filing	Status
Kids COPD Monitoring Ltd	13/12/2018	No	40.1%	11112790	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Pik Kit Ltd	14/12/2018	No	40.1%	11112815	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Kids Medicine Complaince Ltd	14/12/2018	No	40.10%	11112938	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

The following companies have been set up on companies house through the ACORN partnership, however Alder Hey have not yet become shareholders:

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose
Hygenie	Alder Hey not yet a shareholder	No	Alder Hey not yet a shareholder	11055776	Boundary Street, Liverpool	Commercial	App development and commercialisation
Cofoundary Enterprise 36	Alder Hey not yet a shareholder	No	Alder Hey not yet a shareholder	11112857	Boundary Street, Liverpool	Commercial	App development and commercialisation

ACORN Partnership

It has been agreed under the authority of Audit Committee that a multidisciplinary workshop will take place to review the ACORN partnership which will take place in February. The outcome of this workshop will be reported to the Trust Board in March.

Full Master Company Register as at 31st January 2019:

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Alder Hey Ventures LTD	27.06.17	David Powell	100% wholly owned subsidiary	10837212	AH	Commercial No employees	Commercial, innovation, product development and exploit IP	Confirmation statement: 12.07. YE: 30.06.18 Accounts due: 27.03.19	'Active' Not used Not consolidated
Alder Hey Living Hospital LTD	24.04.17	John Grinnell Sir David Henshaw David Powell	50% JV with Alder Hey Children's Charity AH significant control	10835638	AH Charity	Commercial No employees	App development and commercialisation	Confirmation statement: 23.04.18 YE: 31.03.18 Accounts due: 31.12.18	'Active' used Equity investment materiality
Asthma Buddy Ltd	18/05/2017	No	30.10%	10188710	Boundary Street, Liverpool	Commercial	Peer to Peer support for information on Asthma App development and commercialisation	Managed through 3rd party	Active
Doctors Hours Ltd	18/05/2017	No	30.10%	10188794	Boundary Street, Liverpool	Commercial	Junior doctors hours monitoring App development and commercialisation	Managed through 3rd party	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Bloom Revalidation Ltd	18/05/2017	No	30.10%	10189548	Boundary Street, Liverpool	Commercial	Nurse revalidation App development and commercialisation	Managed through 3rd party	Active
Digital Audiology Technologies Ltd	18/05/2017	No	30.10%	10189060	Boundary Street, Liverpool	Commercial	Digitised gaming hearing test App development and commercialisation	Managed through 3rd party	Active
Fresh Wellness Ltd	30/06/2017	No	30.10%	10259396	Boundary Street, Liverpool	Commercial	Mental health support app App development and commercialisation	Managed through 3rd party	Active
Conquer Kids Phobia Ltd	27/04/2017	No	30.00%	10746202	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Blood Sense Ltd	27/04/2017	No	30.00%	10746341	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Physiopal Digital Ltd	27/06/2018	No	30.00% - person with significant control	10838856	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

Name	Date of Incorporation	AH Director	Shareholdings	Company No	Address	Nature	Purpose & Product Description	Filing	Status
Remedy Medpass Ltd	27/04/2018	No	30.00%	10746292	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Sample Tracker Ltd	27/04/2018	No	30.00%	10746420	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Reel Medical Technology Ltd	27/04/2018	No	30.00%	10746455	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Acorn Partners Ltd	18/05/2018	No	27.5%	10188842	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Kids COPD Monitoring Ltd	14/12/2017	No	40.1%	11112790	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Pik Kit Ltd	15/12/2017	No	40.1%	11112815	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active
Kids Medicine Compliance Ltd	15/12/2017	No	40.1%	11112938	Boundary Street, Liverpool	Commercial	App development and commercialisation	Managed through 3rd party	Active

Programme Assurance Summary

Change Programme

Programme Summary (to be completed by **Head of Programme Management**)

1. This Board report comprises extracts from the assurance dashboard covering 6 of the 7 themes of the change programme as reporting to the Board sub-Committees: CQAC 16 January, WOD 23 January and R&BD 23 January.
2. Of the 24 projects rated in this report, for the **overall delivery** assessment: 8% are green rated with 59% amber and 33% red rated. These assessments show no signs of improvement after a marked deterioration in the 2 months previous; therefore, there is considerable work required now to meet the Alder Hey standards of programme management. Executive Sponsors should support their project teams to attain greater confidence in delivery.
3. Of the projects being rated for the **overall governance** position over 50% are green rated for governance with just two projects red rated in this domain.
4. The attention of Exec Sponsors is now also required to initiate the pipeline projects which have remained in the pipeline for numerous months.

N Deakin 29 Jan 19

CIP Summary (to be completed by **Finance Department**)

CIP Position as at 16th January 2019 by work stream

		In Year Forecast			Risk Rating (In Year)					
Workstream	Exec Sponsor	Target £000's	Forecast £000's	Gap £000's	Implemented (Posted) £000's	Fully Developed £000's	Plans in Progress £000's	Opportunity £000's	Gap £000's	Total £000's
Deliver Outstanding Care	Adam B/Hilda G	2,500	1,083	-1,417	906	112	65	75	1,342	2,500
Growing Through External Partnerships	Dani Jones	800	0	-800	0	0	0	0	800	800
The Best People Doing Their Best Work	Melissa Swindell	1,000	1,033	33	769	0	264	30	-63	1,000
Game Changing Research and Innovation	David Powell	500	0	-500	0	0	0	0	500	500
Strong Foundations	John G/Claire L	2,200	1,589	-611	1,365	11	214	134	477	2,200
Park, Community Estate & Facilities	David Powell	0	18	18	18	0	0	0	-18	0
Global Digital Exemplar (GDE)	Peter Young	1,000	176	-824	176	0	0	47	777	1,000
Subtotal: Strategic Workstreams		8,000	3,900	-4,100	3,235	123	542	286	3,815	8,000
Divisional Business		-1,043	1,921	2,964	1,898	23	0	259	-3,223	-1,043
Unidentified		0	0	0	0	0	0	0	0	0
Grand Total		6,957	5,821	-1,136	5,133	146	542	545	591	6,957

Change Programme 18/19

Trust Board

Programme Assurance Framework, DMO & Delivery Board

R&BD

Growing Through External Partnerships

John

1. Aseptics

Imminent Pipeline

- Neonatal Services

WOD

The Best People Doing Their Best Work

Melissa/Hilda

1. Portering SG
2. Apprenticeships
3. Catering

Imminent Pipeline

- E-Rostering
- AHP 2023 & Beyond

CQAC

Deliver Outstanding Care

Hilda / Steve

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

Park, Community Estate & Facilities

David

SG

R&BD

1. R&E2
2. Alder Centre
3. Park
4. Hospital Moves
5. Community Cluster
7. Residential Development

Game Changing Research & Innovation

David

RE&I

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

Strong Foundations

John

SG

R&BD

1. Inventory Management
2. Procurement CIP
3. Energy
4. Coding & Capture
5. Medicines Optim'tion

Global Digital Exemplar

John/Steve

R&BD

1. Speciality Packages
2. Voice Recognition

PB

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

Programme Assurance Summary
Delivering Outstanding Care

Work Stream Summary (completed by Independent Programme Assurance)

The governance ratings for the 'Delivering Outstanding Care' programme have improved once again this month with 6 out of the 7 projects now rated green for governance. Models of Care remains the only project red rated for governance.

The overall delivery ratings have not changed from the previous months ratings. Exec Sponsors should now use these ratings as an indication of which projects now need their input.

For the Sepsis project, now that the governance issues are being resolved, the ratings for overall delivery should be addressed. Agreement of the new target thresholds and a detailed plan for 'year 2' is now required.

Models of Care requires urgent attention from the Exec Sponsor as the project is now red rated for all project management standards.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 9 Jan 19

Programme Assurance Framework

Delivering Outstanding Care (completed by independent Programme Assurance)

Sub-Committee	CQAC	Report Date	9 Jan 19
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Gwilliams/Bateman/Cooper

Current Dashboard Rating (sheet 1 of 2):

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 18/19														
CQAC	Best in Outpatient Care	The Best in Outpatients Project aims to deliver an outstanding experience of outpatient services for children, families and professionals as well as safely increase the number of patients we see in clinic	Hilda Gwilliams	Green	Green	Green	Green	Green	Green	Green	Amber	Amber	Green	The project team is now fully in place and evidence of Steering Group meetings available (to 13 Dec 2018).PID is detailed and clear. Benefits are being tracked and positive trends are seen in 3 out of the 5 metrics however none have yet reached their targets. There is a comprehensive milestone plan being tracked. A risk register is held and is up to date to 2 Jan 19. There is a planned approach to stakeholder engagement but a lack of evidence as to whether planned actions have been delivered. A comprehensive newsletter is available for December. EA/QIA signed and uploaded. **Last updated 7 Jan 19.**
CQAC	Brilliant Booking and Scheduling	To provide a booking system that puts patients and families first and meet the needs of clinicians that use it.	Adam Bateman	Green	Green	Green	Green	Green	Green	Green	Amber	Amber	Amber	Project team meetings are scheduled and documented up to 8 Jan 19. A comprehensive PID is available. Benefits tracking plans are comprehensive and some metrics are tracked weekly but too early to ascertain whether positive trends will be maintained. Specialty plans for Gastro, Spinal, Community and Audiology; these are being closely tracked, but with several milestones delayed. There is a comprehensive suite of stakeholder engagement updated to 26 Nov 18. Risks are detailed and are within their review period. EA/QIA signed off and uploaded. **Last updated 8 Jan 19.**
CQAC	Comprehensive Mental Health	Deliver improvements in mental health services to better meet the needs of children and young people. Be recognised as leading the way for CAMHS services nationally	Lisa Cooper	Green	Green	Green	Amber	Green	Green	Green	Green	Amber	Green	Comprehensive Mental Health project team meetings: the Steering Group (evidence to 6 Dec 18) forms part of the CAMHS board agenda on first Thursday of each month while meetings to discuss each work stream and the milestones happen on a fortnightly basis (evidence to 17 Dec 18). There is a comprehensive PID (although the PID high level milestones should project out to the end of the project cycle) and benefits are defined but further clarity is required on tracking of benefits and December's metrics are now required. A good milestone plan is in place and being tracked. A stakeholder analysis has been completed but further evidence required of wider stakeholder engagement. Risks are on Ulysses and are within their review period. A signed EA/QIA has been uploaded. **Last updated 8 Jan 19.**
CQAC	Patient Flow	Improve our processes to enable timely implementation of clinical decisions, and support patients through their pathway efficiently: minimising delays and reducing time spent in hospital. This project consists of 3 workstreams; Expanding Day Surgery, Expanding Pre-Op Assessment and SAFER Bundle.	Adam Bateman	Green	Green	Green	Amber	Green	Green	Green	Amber	Amber	Green	Evidence of SAFER Task Force evidence, for 3A & 4C, 3C & Burns up to 20 December 2018. The PID refinement of benefits and high level milestones was completed on 31 Oct 18. A benefits 'dashboard' has been uploaded on 6 Nov 18 with many trajectories now positive. A detailed milestone plan has been uploaded for SAFER and is being tracked; this needs to be extended beyond March 2019 if appropriate. Stakeholder engagement evidence is limited, additional evidence is now required. All risks on Ulysees and within review date. An EA/QIA has been signed. **Last updated 7 Jan 19.**

Programme Assurance Framework

Delivering Outstanding Care (completed by independent Programme Assurance)

Sub-Committee	CQAC	Report Date	9 Jan 19
Workstream Name	Delivering Outstanding Care	Executive Sponsor	Hughes/Gwilliams

Current Dashboard Rating (sheet 2 of 2):

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
1.0 Deliver Outstanding Care 18/19														
CQAC	Models of Care	**What:** Consultant led delivery of patient pathways is currently suboptimal for some patients. Care is not always organised around needs of the following patient cohorts: 1) Complex patients (Surgery & Medicine) 2) HDU 3) Specialities 4) General Paediatrics 5) Medical Management of Non-Complex Surgery Patients **Why:** To improve consistency of the management of deteriorating and high dependency patients (in terms of consultant lead, patient pathway and time of day / day of week)	Adrian Hughes											Brief notes of 'EDU Model' delivery group of 1 Nov 18 with an 'Outline' of the model. Brief notes of the 'HDU Model' meeting of 1 Nov 18. There is now a draft PID which will need the support of the Executive Sponsor and wider team to complete. There are some analyses in the benefits folder but no clear metrics for success. There is a single slide high level plan Oct 18 - Apr 20 but no detailed/trackable milestone planning in evidence. No evidence of stakeholder engagement and communications. There is a detailed risk register but risks not reviewed since 19 Jan 18 . Risks now required on Ulysees. No signed EA/QIA. **Last updated 20 Dec 18.**
CQAC	Sepsis	To improve working within and across clinical teams.	Hilda Gwilliams											Sepsis Steering Group minutes to 14 Nov 18 with agendas and minutes. 'Year 2 PID' now uploaded but still in draft form. New benefits / targets now need to be signed off at Programme Board. Milestone Plan for 'year 2' PID now needs to be developed as current milestone plan on SharePoint is not being tracked and needs further meaningful milestones beyond March 2019. The communications plan 2018-20 gives a high level list of activities but there is no tracked (for completion) milestone plan. All risks are within review date on Ulysses system. EA/QIA complete. **Last updated 27 Dec 18.**
CQAC	DETECT Study	Using smart technology to reduce critical deterioration	Hilda Gwilliams											Evidence of project team meetings has been uploaded to SharePoint up to the minutes of the meeting of 4 Dec 18. A high level description of the scope is available in a 7 slide pack and a detailed PID has now been completed. Benefit metrics are outlines however not being tracked. A detailed Gantt Chart is available (uploaded 3 Dec 18) and will now need tracking on SharePoint. There are materials uploaded which indicate stakeholder engagement, including a presentation to Grand Round 5 Oct 18, but there is no communications plan in evidence. Risk register is in place and risks were last reviewed on 6 Dec 18. Risks now need to be inputted on to Ulysees. EA/QIA signed and uploaded. **Last updated 4 Jan 19.**

Programme Assurance Summary
Growing Through External Partnerships

Work Stream Summary (to be completed by Independent Programme Assurance)

The governance of the 'Aseptics' project is now being maintained to a good standard; however, the project should continue its efforts to address the challenges it faces to deliver associated benefits as well as ensuring timescales are realistic and adhered to.

Dani Jones has now been assigned as Exec Sponsor for the Strengthening External Partnerships Programme replacing Mags Barnaby.

The Programme Board now need to review the pipeline projects in this programme as the 'Neonatal Services' project has featured in the pipeline for a number of months.

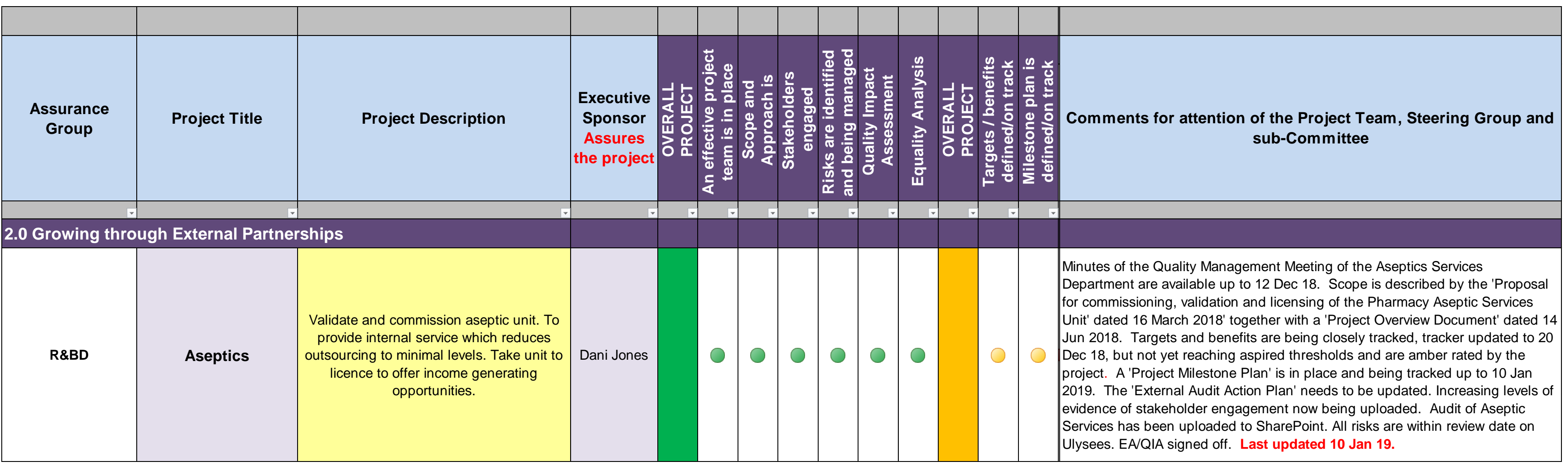
Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 16 Jan 19

Programme Assurance Framework

Growing Through External Partnerships

Sub-Committee	R&BD	Report Date	16 Jan 2019
Workstream Name	Growing Through External Partnerships	Executive Sponsor	Dani Jones

Current Dashboard Rating:



Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
2.0 Growing through External Partnerships														
R&BD	Aseptics	Validate and commission aseptic unit. To provide internal service which reduces outsourcing to minimal levels. Take unit to licence to offer income generating opportunities.	Dani Jones											Minutes of the Quality Management Meeting of the Aseptics Services Department are available up to 12 Dec 18. Scope is described by the 'Proposal for commissioning, validation and licensing of the Pharmacy Aseptic Services Unit' dated 16 March 2018' together with a 'Project Overview Document' dated 14 Jun 2018. Targets and benefits are being closely tracked, tracker updated to 20 Dec 18, but not yet reaching aspired thresholds and are amber rated by the project. A 'Project Milestone Plan' is in place and being tracked up to 10 Jan 2019. The 'External Audit Action Plan' needs to be updated. Increasing levels of evidence of stakeholder engagement now being uploaded. Audit of Aseptic Services has been uploaded to SharePoint. All risks are within review date on Ulysees. EA/QIA signed off. **Last updated 10 Jan 19.**

Programme Assurance Summary

The Best People doing their Best Work

Work Stream Summary (completed by Independent Programme Assurance)

The 'Apprenticeships' project continues to be managed to a particularly high standard of project management with consistently strong evidence available on the SharePoint site.

The 'Improving Portering Services' project has now been re-profiled to accommodate a working trial of the new model from Oct 18 to Jan 19; however, there is little evidence on SharePoint to suggest that the trial of the new model has started. A review of the project in January 2019 is recommended to chart the course of the project through the next year and its eventual closure.

The 'Catering' project has recently moved under 'The Best People doing their Best Work' programme and with this comes a full assurance review of all project management standards. Overall, the project displays a good standard of assurance evidence with some attention now required to ensure that milestones remain on track.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 16 Jan 19

Programme Assurance Framework

The Best People doing their Best Work (completed by independent Programme Assurance)

Sub-Committee	WOD	Report Date	19 Jan 19
Workstream Name	The Best People doing their Best Work	Executive Sponsor	Swindell/Gwilliams

Current Dashboard Rating (sheet 1 of 2):

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
WOD	Apprenticeships	To operationalise the Apprenticeship Strategy and realise the benefits of apprentisehip qualitifcations following introduction of the Apprenticeship Levy.	Melissa Swindell	Green	Green	Green	Green	Green	Green	Green	Green	Green	Green	Project leads meeting notes are available on SharePoint to 14 December 2018 and Steering Group to 26 November 2018. A PID is available at v6 dated 28 May 18. The benefits tracker is in place and being tracked through Dec 18 with metrics on track. A detailed Milestone Plan is available and is being closely tracked; although some milestones have slipped, this is not having an adverse impact of the outcomes/benefits and therefore the rating is green. Comms/Engagement activities detailed in PID and a comms plan is in place with extensive stakeholder engagement material in evidence. Risks are up-to-date on Ulysses. EA/QIA complete. **Last updated 8 Jan 19.**
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	Green	Amber	Green	Green	Green	Green	Green	Amber	Amber	Red	Team meetings and briefing notes available. PID available which contains benefits and metrics. The Milestone Plan has now been updated, albeit showing significant slippage of the original end date, to complete by May 2019. This follows negotiations with Unions following rejection of the proposals by ballot on 20 Apr 18. The Trust has agreed with the Unions to agree a trial period from Oct 18 with a view to implementing the new system in Feb 19,however these dates have slipped. Evidence available of Comms/ Engagement activities. Risks are up-to-date on Ulysees.EA/QIA complete. **Last updated 15 Jan 19.**
R&BD	Catering	To implement the recommendations from the Independent Catering review to improve the overall food service delivery at Alder Hey whilst reducing the financial loss current operating within the Catering Department.	Hilda Gwilliams	Green	Green	Green	Green	Amber	Green	Green	Amber	Amber	Amber	Evidence is available for the project 'Steering Group' meetings up to 21 Nov 18. The extensive and detailed 'Review of Catering Services – Final Version' dated January 2018 is serving as a detailed PID. There is a detailed 'Catering Project Benefit Tracker 2019/20' with all benefits tracked to Nov 18. A comprehensive Gantt chart plan has been prepared arising from the review which has been monitored up to 12 Dec 18, and is largely on track. Evidence of stakeholder engagement is available on SharePoint. Risks have been identified and are being managed with one risk requiring further attention. **Last updated 3 Jan 19.**

Alder Hey Children's NHS
NHS Foundation Trust

Programme Assurance Summary
Global Digital Exemplar

Work Stream Summary (completed by Independent Programme Assurance)

The GDE 'Statement of Projected Benefits' continues to estimate £2.08m cash realising benefits for 2018/19. The Trust CIP tracker is now forecasting the first contribution of £176k from the GDE initiatives; clearly there needs to be a continued focus on closing this gap between expectation and delivery.

Overall, the 'Speciality Packages' project governance has improved this month, focus should remain on the delivery of the 33 speciality packages by 31st January 2019.

The 'Voice Recognition' project is 'red' rated for delivery, due to the difficulty in realising the planned benefits, albeit there continues to be a high standard of project management.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 16 Jan 19

Programme Assurance Framework

Global Digital Exemplar (Completed by Assurance Team)

Sub-Committee	R&BD	Report Date	16 Jan 2019
Workstream Name	Global Digital Exemplar	Executive Sponsors	John Grinnell

Current Dashboard Rating:

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
4.0 Global Digital Exemplar 18/19														
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	John Grinnell											Programme Board Minutes and Agenda in evidence up to 18 Dec 2018. Overall benefits profile and schedule has now been finalised, 'Strategic Owner' column on SoPB still requires updating to reflect current trust executive appointments; internal CIP Tracker shows just £176k forecast in 2018 against a target of £1m, while the SoPB proposes £2.08m cash realising benefits in 2018/19 (VfM Tracker). Milestone Plan 'GDE Programme Workbook v8.1' would benefit from exact dates for milestone to be completed. Stakeholder evidence has been uploaded with all risks within review date on Ulysees. **Last updated 16 Jan 19.**
R&BD	Speciality Packages	Delivery of electronic clinical documentation workflow designed to reflect best practice protocols and pathways	John Grinnell						N/A	N/A				Effective project team document has been updated. PID is available. Overall benefits profile and schedule is shown on the SoPB tracker; however a more updated version is now required as the version on SharePoint was last updated in March 18. Project Plan was last updated on 10 Jan 2019 and indicates that the majority of speciality packages look likely to be delivered by the end of Jan 19. Stakeholder engagements entered to 16 Oct 18. Comprehensive risk log updated to 21 Dec 18. QIA/EA will be assured and assessed at project level. **Last updated 16 Jan 19.**
R&BD	Voice Recognition	Deploy voice recognition solution in Medisec and Meditech	John Grinnell											PID and detailed project workbook on SharePoint. Details of financial benefits on separate document, these have not been realised as planned. Project Plan is being kept up to date and the overall standard of the workbook is excellent. Comms/engagement activities are detailed in workbook but evidence required where possible. Risks register is held and up to date in workbook as of 16 Jan. EA/QIA has been signed and uploaded. **Last updated 11 Jan 2019.**

Programme Assurance Summary

Park, Community Estate and Facilities

Work Stream Summary (to be completed by Independent Programme Assurance)

The new 'Development Site 2018-2021 Milestone Plan covers 3 main areas and has high level milestones out to 2021:

- **Park Developments**: comprising 3 work streams
- **Schemes (includes all new developments)** - with 5 projects:
  - R&E Phase II
  - Community Hub and DJU
  - Alder Centre
  - Neonates
  - Kilby House
- **Site Clearance** - with 7 projects: Demolition; Car Parks (milestones awaited); Park Re-provision; Residual Estate; Medical Records/Transcription; Police Station; Neuro Building.

The above re-structure of this programme of work now needs to be agreed with the executive sponsor and endorsed by the Programme Board.

The 'Community Cluster' project is now rated on the dashboard after it's initiation on to the change programme was agreed at Programme Board in March 2018.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 16 Jan 19

Programme Assurance Framework
Park, Community Estate and Facilities

Sub-Committee	R&BD	Report Date	16 Jan 2019
Workstream Name	Park, Community Estate and Facilities.	Executive Sponsor	David Powell

Current Dashboard Rating:

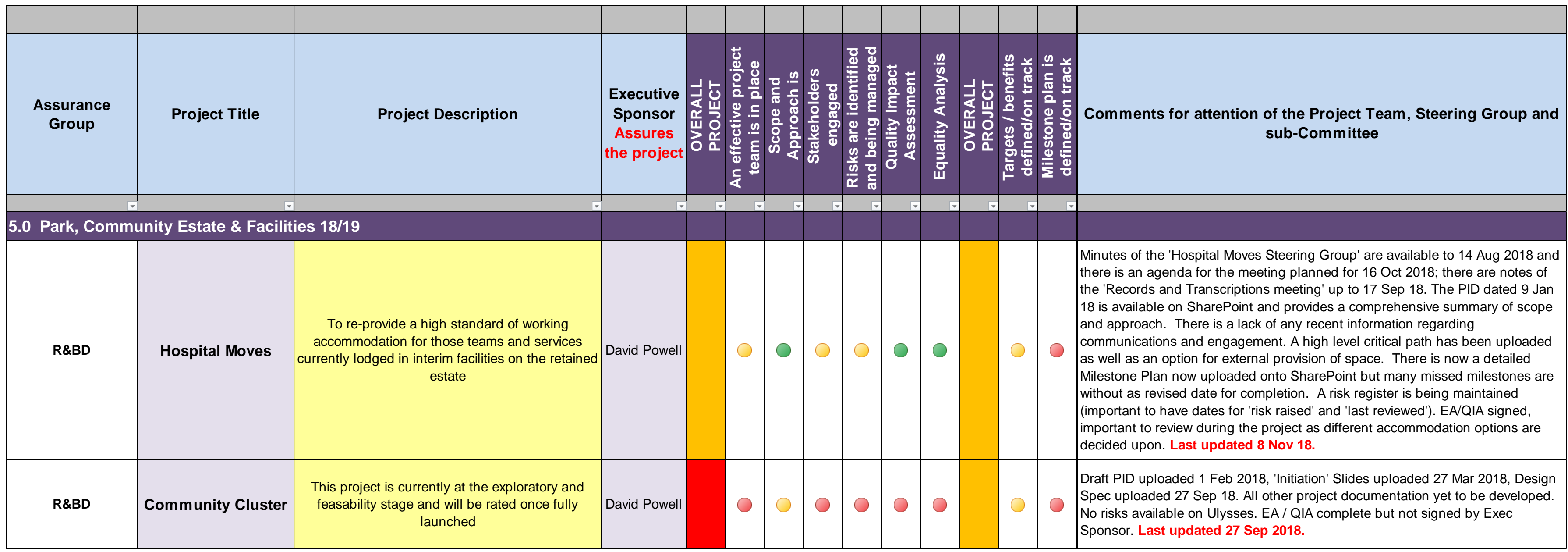
Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 18/19														
R&BD	R&E 2	The aim of the project is to complete Phase 2 of the RI & E building to a world class standard	David Powell	Amber	Amber	Amber	Amber	Amber	Green	Green	Red	Red	Amber	There is no evidence of any meetings for over 3 months. The R&E Commissioning Plans and Mobilisation Plans are available to 9 Oct 2018. PID available, benefits still to be confirmed. Milestone Plan continues to show some significant delays with key milestones running late but is being tracked up until 9 Oct 18. Risks are still to be entered on Ulysses however there is an risk register albeit some sections are incomplete. There is a comprehensive issues log uploaded to SharePoint. EA/QIA completed and signed off. Closure report due to Programme Board on 31 Jan 19. **Last updated 25 October 2018.**
R&BD	Alder Centre	To plan, develop and construct the new Alder Centre within the park setting	David Powell	Amber	Amber	Green	Amber	Amber	Green	Green	Amber	Green	Red	Steering Group agenda for 21 Nov 18 but no minutes on SharePoint. Scope/approach defined in PID. Benefits defined in PID but no evidence of the tracking of benefits. Milestone Plan has been revised recently but shows the commencement of building work has slipped significantly from original planned date. No recent evidence of Comms/ Engagement activities. Risks are on Ulysees but are now overdue their review date. EA/QIA complete. **Last updated 16 Jan 2019.**
R&BD	Park	To set up a JV with LCC & the local community to create a world class Springfield Park that complements & adds value to the New Alder Hey in the Park & the local area	David Powell	Green	Amber	Green	Green	Amber	Green	Green	Amber	Amber	Green	Steering Group reports available to 21 November 2018.Updated PID on SharePoint showing comprehensive suite of benefits and high level milestones through to end of project life cycle. An indication of progress against benefits targets (RAG rating or % confidence level achieved would be useful). There is a new and detailed Milestone Plan together with a PowerPoint to illustrate high level milestones out to Oct 19; there is also an extremely informative 'Springfield Park Update' available. A comprehensive 'Engagement Opportunities Plan', Oct 18, is in evidence (this would eventually benefit from status indicators). Risks are on Ulysees with one risk requiring further attention as past review date. EA/QIA complete. **Last updated 14 Jan 2019.**

Programme Assurance Framework

Park, Community Estate and Facilities

Sub-Committee	R&BD	Report Date	16 Jan 2019
Workstream Name	Park, Community Estate and Facilities.	Executive Sponsor	David Powell

Current Dashboard Rating:



Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
5.0 Park, Community Estate & Facilities 18/19														
R&BD	Hospital Moves	To re-provide a high standard of working accommodation for those teams and services currently lodged in interim facilities on the retained estate	David Powell	Amber	Amber	Green	Amber	Amber	Green	Green	Amber	Amber	Red	Minutes of the 'Hospital Moves Steering Group' are available to 14 Aug 2018 and there is an agenda for the meeting planned for 16 Oct 2018; there are notes of the 'Records and Transcriptions meeting' up to 17 Sep 18. The PID dated 9 Jan 18 is available on SharePoint and provides a comprehensive summary of scope and approach. There is a lack of any recent information regarding communications and engagement. A high level critical path has been uploaded as well as an option for external provision of space. There is now a detailed Milestone Plan now uploaded onto SharePoint but many missed milestones are without as revised date for completion. A risk register is being maintained (important to have dates for 'risk raised' and 'last reviewed'). EA/QIA signed, important to review during the project as different accommodation options are decided upon. **Last updated 8 Nov 18.**
R&BD	Community Cluster	This project is currently at the exploratory and feasability stage and will be rated once fully launched	David Powell	Red	Red	Amber	Red	Red	Red	Red	Amber	Amber	Red	Draft PID uploaded 1 Feb 2018, 'Initiation' Slides uploaded 27 Mar 2018, Design Spec uploaded 27 Sep 18. All other project documentation yet to be developed. No risks available on Ulysses. EA / QIA complete but not signed by Exec Sponsor. **Last updated 27 Sep 2018.**

Programme Assurance Summary
Strong Foundations

Work Stream Summary (to be completed by Independent Programme Assurance)

This programme of work to address 'business as usual' improvements has benefitted from inclusion in the assurance framework in its early stages but the delivery issues now need to be managed within the respective areas of business. Fundamentally, the topics concerned are not transformational change programmes.

Natalie Deakin, Head of Programme Management and Independent Programme Assurance – 16 Jan 19

Programme Assurance Framework
Strong Foundations

Sub-Committee	R&BD	Report Date	16 Jan 2019
Work stream Name	Strong Foundations	Executive Sponsor	JG/AH/CL/DP

Current Dashboard Rating:

Assurance Group	Project Title	Project Description	Executive Sponsor Assures the project	OVERALL PROJECT	An effective project team is in place	Scope and Approach is	Stakeholders engaged	Risks are identified and being managed	Quality Impact Assessment	Equality Analysis	OVERALL PROJECT	Targets / benefits defined/on track	Milestone plan is defined/on track	Comments for attention of the Project Team, Steering Group and sub-Committee
R&BD	**Inventory Management**	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell	N/A										Detailed POD available with precise metrics. Plan has now been updated and shows no outstanding actions. Financial benefits are being recorded comprehensively and are up to date in a benefits tracker combined with the Procurement CIP Project. **Last updated 13 Dec 18.**
R&BD	**Procurement CIP**	The Procurement CIP scheme is an annual project aimed at ensuring that best value is obtained in respect of the supply of all goods and services purchased by the Trust.	John Grinnell	N/A										Detailed POD available with precise metrics. Plan and benefits measurement have now been updated on SharePoint. The last update did show the project is on track to realise full benefits as projected. **Last updated 13 Dec 18.**
R&BD	**Medicine Optimisation**	To deliver the trust MO strategy and deliver quality improvements and financial benefits	Adrian Hughes	N/A										Team structure now complete and actions notes of Steering Group available up 13 Jul 18. POD now uploaded, needs to show phasing of savings across the year to allow coherent feed into Trust CIP tracking. Plan uploaded but now requires dates for expected completion of actions. Benefits tracker now needs updating as last evidence on SharePoint is now over 3 months old. Good stakeholder engagement evidence is emerging. A risk register has been uploaded. EA/QIA complete. **Last updated 11 Jan 19.**
R&BD	**Coding and Capture**	To ensure the AH delivers a above average depth of coding and complies with the business rules whilst maximising income	Claire Liddy	N/A										Detailed Benefits Tracker uploaded and detailed Milestone Plan in evidence; however both documents were last updated on SharePoint over 3 months ago and new, up to date, versions are required now for assurance. It has been confirmed that the QIA signed of at end of 2017 applies to the 18/19 programme (and will be reviewed in Dec 18). **Last updated 12 Sep 18.**
R&BD	**Energy**	To bring down energy cost and ensure budget forecast matches contractual target. Forecast budget for next 12 months for all fuels in line with contractual usage.Once the contractual target of 46.7 G has been achieved look at ways of reducing further by means of energy awareness for staff.	David Powell	N/A										Monthly energy committee minutes available until 13 Nov 18. The POD available on SharePoint gives no details of financial benefits expected for 2018/19. The project plan for 18/19 contains only 6 actions and was last updated July 2018 (2 of these relate to usage monitoring and 2 relate to a compensation claim; more detail is required if this is to be considered a project). QIA signed off for the 18/19 programme. **Last updated 17 Dec 18.**

Resources and Business Development Committee
Draft Minutes of the meeting held on: Wednesday 18th December 2018 at 9:30am in Large Meeting Room, Institute in the Park

Present	Ian Quinlan (Chair)	Non-Executive Director	(IQ)
	Adam Bateman	Interim Chief Operating Officer	(AB)
	John Grinnell	Director of Finance	(JG)
	Claire Liddy	Director of Operational Finance	(CL)
	Dame Jo Williams	Non- Executive Director	(DJW)
In attendance	Sue Brown	Associate Director for Development	(SB)
	Mark Flannagan	Director of Communications	(MF)
	Dani Jones	Director of Strategy	(DJ)
	David Powell	Development Director	(DP)
	Erica Saunders	Director of Corporate Affairs	(ES)
	Julie Tsao	Committee Administrator (*minutes*)	(JT)
Apologies	Claire Dove	Non-Executive Director	(CD)
	Phil O'Connor	Deputy Director of Nursing.	(POC)
Agenda Item:	Graeme Dixon	Head of Building Services	(GD)
	Cathy Fox	Associate Director IM&T	(CF)

18/19/127 Apologies

The Chair noted the apologies above.

18/19/128 Minutes from the meeting held on 28th November 2018

Resolved:

Dame Jo Williams highlighted a number of admin errors. Julie Tsao agreed to review and amend.

Action: JT – Completed

Subject to the above amendment RABD approved the November minutes.

18/19/129 Matters Arising and Action log

RABD went through the actions noting completed actions and agreed a timescale for any areas requiring a further update.

Due to a number of pressing items it was agreed RABD would focus on:

- Five Year Capital Plan

All other non urgent items would be accepted as read.

Claire Liddy asked for 'Budget Setting' to be included on agendas going forward.

Action: JT

18/19/130 Top 5 Risks/Key Priority Areas for 2018/19.

RABD received the latest slides on the three areas below:

CIPs
Capital Programme
PFI

18/19/131 PFI Monitoring Contract

Pipework

A discussion was held around on going pipework issues and process being put in place to correct and prevent any further issues.

David Powell highlighted the outcome of the independent report that had been completed:
- If the chemical balance mantaince regime for the pipes was correct there would not be further corriosion.
- If incorrect new pipes may be required. RABD was given assurance that if this was ever reccomened RABD would be asked to agree before work was commenced.

Water Safety Committee
At the last meeting Interserve had presented an action plan of next steps being taken to ensure water across the Trust is within HTM Guidelines due to the Trust still having a low number of positive results for Pseudomonas. As a result, filters are now being changed on a more regular basis to reduce the risk further. Interserve had been asked to submit a progress report by the end of December, Graeme Dixon agreed to contact Interserve to ensure progress was being made.
Action: GD

Resolved:
The Committee noted the Building Services report for month 8.

18/19/132 **Finance Report**
The Trust is reporting a trading surplus for the month of £3m which is in line with plan. Income is ahead of plan by £0.7m but is offset by expenditure which is overspent by £0.7m in the month. The Use of Resources risk rating is 1 in line with plan and cash in the bank of £17.6m.

Dame Jo Williams asked if there had been any further progress with the Welsh contract. No updates on changes to the last position had been received. There remains a HRGv risk.

Resolved:
The Committee noted the contents of the Finance report for month 8.

18/19/133 **5 Year Capital Plan**
Claire Liddy presented the Affordability – 5 Year Capital Requirements highlighting several judgements made over the next 5 years. A number of the assumptions are high risk, if approved high risk assumptions would have a downside mitigation plan against them in case assumptions didn't go as planned.

A lengthy discussion took place on how risks could be reduced or were areas should be more ambitious. It was noted some areas of risk are out of the Trust's control.

Claire Liddy presented and went through a slide of 4 options to close the financial gap. A discussion took place around priorities and a divisional engagement exercise was agreed to take place before the end of March 2019.

Resolved:

RABD agreed options would require a wider discussion and would NOT BE APPROVED today.

18/19/134 **Programme Assurance**
Resolved:
RABD received the latest assurance report.

18/19/135 **Marketing and Communications Activity Report**
Resolved:
RABD received and noted the contents of the Marketing and Communications Activity report.

18/19/136 **Board Assurance Framework (BAF)**
Resolved:
RABD received and noted the BAF cover report for month 8.

18/19/137 **Corporate Report**
Resolved:
The Committee received and noted the Corporate Report for month 8.

18/19/138 **Reference Cost Report**
It was agreed to defer this item until the January RABD.
Action: JT

18/19/139 **Global Digital Exemplar**
Since the last update received in November, progress for phase five milestones to be achieved continues. The assement is due to take place on 9th Janaury 2019.

Gaps had been identified in the level 6 HIMSS Assessment. An action plan was currently in progress to move to level 7 by the end of March 2019 when a further assessment will be carried out.

Dame Jo Williams asked for assurance on how the additional work was being managed. John Grinnell responded noting support from divisions.

The Chair asked if there were still issues with the voice recognition programme. Cathy Fox said there was, a new software was being added to PCs to try to resolve.

Resolved:
RABD note the progress of the Trusts GDE Programme; the finalisation of Milestone 4 and on-going progress towards Milestone 5.

18/19/125 **Any Other Business**
No other business was reported.

Date and Time of Next Meeting: Wednesday 23rd January 2019, 9:30am – 12:30pm, Large Meeting Room, Institute in the park.

NHS
Alder Hey Children's
NHS Foundation Trust
Corporate Report December 2018
BRILLIANT BASICS
GROW THE FUTURE

How Did We Do?

Executive Summary **Month: December** **Year: 2018**

Delivery of Outstanding Care

Safe

The safe domain reports a **Clinical Incidents resulting in Unexpected Death;** this incident is currently under investigation. Duty of Candour has been completed in line with regulation 20. The 72 hour review report has been completed in line with National Standards and Trust policy and submitted to the CQC and CCG.

Highlight

- Strong clinical incident reporting continues with an in month reduction in medication errors and minor harm related incidents.

Challenges

- The target set for incidents resulting in minor harm remains a challenge thus requiring further consideration when agreeing the harm reduction plan for 2019/20.

The Best People Doing their Best Work

Caring

Overall feedback from CYP and their families remains positive.

Highlight

- ED performance improved by 10% in month following a challenging year and a focused work stream addressing concerns identified in the survey findings.

Challenges

- Although OPD and ED have seen improvements these areas remain a challenge in terms of achieving a 95% response rate.

Delivery of Outstanding Care

Effective

Performance against national standards remains strong with delivery of Emergency Department, access and cancer standards.

In outpatients we are focused on use of clinic time. There are some entrenched processes and arrangements that drive under-utilisation of some clinics. A deep-dive review is being undertaken and will be presented to RABD in February

Over the medium terms we will in 2019-20 prioritise the use of digitally-enabled consultations to reduce unnecessary trips to hospital where appropriate.

Highlight

- The ED waiting time standard of 95% was achieved
- Reduction in operations cancelled on the day

Challenges

- Outpatient utilisation

Delivery of Outstanding Care

Responsive

- Our work on the SAFER will contribute to an increase in patients knowing their planned date of discharge. From January 2019 wards 4A, Burns, 3C and 4B will embed use of the bundle

Highlight

- Waiting time and cancer standards were all achieved
- The waiting list size reduced

Challenges

- Percentage of patients who know their expected date of discharge
- CYP involved in play remains a challenge however a task and finish group has been established to improve performance across all areas.

The Best People Doing their Best Work

Well Led

- December was a strong month financially seeing us over achieve our control total by £0.6m which meant we met our Q3 plan which was critical for attaining our PSF payments. Year to date we now stand at a £12.5m surplus against a £12.4m

Highlight

- Q3 Control Total met
- CIP Delivery & Forecast

plan (this includes match PSF funding). The in month position was supported by someone off gains one of which was an insurance claim for drugs store losses. The year end forecast is now £1.5m short of our control total which is an improvement of £0.3m from last month however remains a key area of focus to close the gap in Q4. • CIP performance has improved and the forecast for the Divisions is now £5.8m which is just £0.2m short of our revised plan to deliver a full year savings programme of £6m. • Our Cash balances are £23.1m and our capital plan is now looking like it will be £2m less than our original plan due to slippage on the Alder Centre and Cluster schemes. A revised forecast has been submitted to NHSi on this basis. • Our UoR rating is 1 which is the lowest risk. • Day case rates continue to be of concern and an area of focus for the Operational Team to improve throughput • Our sickness rates were above 6% which is also of concern. A health and well-being initiative across the Trust is underway as we seek for a sustainable improvement in our staff's health. Temporary spend and pay in general continue to be a pressure.	• PDR target continues to be met • Use of Resources Rating 1 (best) **Challenges** • Sickness levels above 6% • Pay costs overspending • Day case rates continue under plan

Game Changing Research and Innovation

Research and Development

• Progress against implementing the MHRA inspection findings CAPA has been good. • The development of a joint research service is well underway. • The Business/financial model for the CRD has not moved on significantly and a financial gap is anticipated this year. • Fewer numbers of commercial contracts than anticipated have come to the Trust • A higher than usual level of rejections of expressions of interest to run studies has resulted in fewer new studies opening. • Fluctuations and inertia in the research nurse workforce has resulted in a dip in performance.	**Highlight** • Leading the development of a joint research service for Liverpool • Implementing the MHRA inspection CAPA plan is going well • New CRF manager and Industry manager have been appointed and 4 research fellows are in post. • A review of structure has concluded with a business case for investment in workforce ready for consideration. **Challenges** • Closing the financial gap • Organisational change relating to nurse leadership • Performance against targets is not good this year

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Delivery of Outstanding Care

SAFE

Alder Hey Children's NHS
NHS Foundation Trust

	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	Last 12 Months	RAG			Comments Available
Total no of incidents reported Near Miss & Above	325	453	456	513	413	446	490	432	447	452	478	460	349		>=327	>=293	<293	✔
Clinical Incidents resulting in minor harm & above	52	84	82	93	83	76	90	84	80	92	95	95	72		<=47	<=52	>52	✔
Clinical Incidents resulting in moderate, semi permanent harm	2	2	0	1	0	1	1	1	1	2	0	1	1		<=1	N/A	>1	✔
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Clinical Incidents resulting in catastrophic, death	0	0	0	0	0	0	0	0	0	0	0	0	1		0	N/A	>0	✔
Pressure Ulcers (Category 3)	1	2	0	0	0	1	0	0	0	0	0	0	0		0	N/A	>0	✔
Pressure Ulcers (Category 4)	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Medication errors resulting in harm	3	2	5	6	4	3	4	3	4	4	2	5	2		<=2	N/A	>2	✔
Never Events	0	0	0	0	0	0	0	0	2	0	0	0	0		0	N/A	>0	✔

The Best People doing their best Work

CARING

	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	Last 12 Months	RAG			Comments Available
Friends & Family A&E - % Recommend the Trust	90.9%	89.8%	85.6%	86.4%	85.4%	82.6%	83.9%	86.3%	88.2%	85.5%	80.0%	80.6%	90.1%		>=95 %	>=90 %	<90 %	✔
Friends & Family Community - % Recommend the Trust	100.0%	87.5%	100.0%	97.7%	100.0%	96.8%	96.4%	92.2%	100.0%	100.0%	93.2%	100.0%	100.0%		>=95 %	>=90 %	<90 %	✔
Friends & Family Inpatients - % Recommend the Trust	97.3%	97.3%	96.6%	96.8%	93.7%	95.5%	94.9%	97.0%	97.0%	98.3%	98.2%	97.9%	98.2%		>=95 %	>=90 %	<90 %	✔
Friends & Family Mental Health - % Recommend the Trust	100.0%	77.8%	82.8%	100.0%	87.5%	82.6%	88.9%	100.0%	89.9%	89.4%	84.7%	97.5%	100.0%		>=95 %	>=90 %	<90 %	✔
Friends & Family Outpatients - % Recommend the Trust	97.7%	96.1%	91.8%	89.3%	90.3%	88.6%	86.9%	85.5%	89.7%	90.0%	90.3%	91.4%	91.7%		>=95 %	>=90 %	<90 %	✔
Complaints	5	12	13	5	8	11	11	13	14	11	12	6	7		<=4	<=5	>5	✔
PALS	98	147	145	129	151	126	99	100	100	125	132	115	71		<=88	<=98	>98	✔

Delivery of Outstanding Care

EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	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	Last 12 Months	RAG			Comments Available
Sepsis: Patients treated for Sepsis - A&E	57.1%	60.0%	42.3%	60.9%	66.7%	55.6%	57.1%	65.5%	68.2%	54.5%	65.4%	57.6%	51.9%		>=90 %	N/A	<90 %	✔
Sepsis: Patients treated for Sepsis - Inpatients	70.3%	74.1%	86.4%	79.2%	76.0%		78.9%	71.4%	72.5%	75.7%	70.2%	76.2%	73.3%		>=90 %	N/A	<90 %	✔
No of children that have suffered avoidable death - Internal	0	0	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
% Readmissions to PICU within 48 hrs	0.0%	2.4%	1.5%	4.1%	3.6%	2.5%	2.7%	6.5%	0.0%	2.7%	1.0%	1.1%	3.3%		<=3 %	N/A	>3 %	✔
Hospital Acquired Organisms - MRSA (BSI)	0	2	0	0	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - C.difficile	0	0	0	1	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Hospital Acquired Organisms - MSSA	2	0	3	0	0	1	0	0	0	1	2	0	1		<=1	N/A	>1	✔
Hospital Acquired Organisms - CLABSI - ICU Only	6	2	4	2	2	2	2	0	1	0	2	1	3		<=4	N/A	>4	✔
Hospital Acquired Organisms - Gram Negative BSI	2	1	1	3	2	0	1	0	1	2	2	2	2		<=2	N/A	>2	✔
Bed Occupancy (Accessible Funded Beds)	78.9%	88.2%	89.3%	89.6%	90.3%	84.9%	88.5%	83.9%	76.2%	79.9%	85.8%	85.3%	73.7%		<=89 %	<=93 %	>93 %	✔
ED: 95% Treated within 4 Hours	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%		>=95 %	N/A	<95 %	✔
Average LoS - Elective (Days)	3.60	2.94	2.98	3.21	2.79	2.87	2.89	3.13	2.80	2.79	3.05	2.90	3.58		<=3.6	N/A	>3.6	✔
Average LoS - Non-Elective (Days)	1.97	2.10	1.99	2.10	1.96	2.01	2.01	1.85	2.03	1.73	2.05	1.97	1.92		<=2.0	N/A	>2.0	✔
Theatre Utilisation - % of Session Utilised	86.0%	87.2%	85.6%	86.2%	88.2%	88.6%	87.9%	89.3%	87.0%	86.6%	86.7%	87.3%	85.9%		>=90 %	>=80 %	<80 %	✔
On the day Elective Cancelled Operations for Non Clinical Reasons	15	24	25	37	26	33	44	35	18	12	28	38	21		<=21	N/A	>21	✔
28 Day Breaches	5	0	3	8	10	5	6	6	7	1	0	6	5		0	N/A	>0	✔
Clinic Session Utilisation	82.5%	85.2%	83.7%	84.0%	83.6%	83.9%	84.9%	82.2%	82.9%	84.2%	82.9%	84.2%	81.7%		>=90 %	>=85 %	<85 %	✔
Did Not Attend Rate	12.2%	10.5%	10.7%	11.3%	10.6%	11.5%	12.1%	12.5%	13.6%	11.4%	11.7%	10.7%	12.9%		<=12 %	<=14 %	>14 %	✔
Transcription Turnaround (days)	18.50	23.00	26.00	28.50	15.00	6.00	4.50	4.00	1.00	4.00	1.50	2.00	2.50		<=3	<=5	>5	✔

RESPONSIVE

	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	Last 12 Months	RAG			Comments Available
IP Survey: % Received information enabling choices about their care	94.7%	94.4%	94.7%	93.1%	94.8%	91.6%	96.2%	94.7%	94.7%	96.3%	96.4%	95.1%	96.7%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Treated with respect	99.4%	100.0%	99.4%	99.8%	97.7%	98.8%	99.7%	99.7%	99.6%	99.5%	99.6%	100.0%	99.6%		100 %	>=95 %	<95 %	✔
IP Survey: % Know their planned date of discharge	62.5%	52.1%	59.0%	60.1%	60.5%	76.1%	63.7%	65.7%	60.6%	55.3%	60.2%	69.0%	59.4%		>=90 %	>=85 %	<85 %	✔
IP Survey: % Know who is in charge of their care	90.6%	93.6%	90.9%	91.6%	91.3%	90.9%	92.7%	94.7%	91.6%	94.9%	92.2%	92.2%	92.5%		>=95 %	>=90 %	<90 %	✔
IP Survey: % Patients involved in play and learning	76.4%	78.3%	79.6%	75.0%	74.9%	77.8%	74.4%	73.1%	74.8%	73.7%	74.3%	72.5%	68.2%		>=90 %	>=85 %	<85 %	✔
RTT: Open Pathway: % Waiting within 18 Weeks	92.0%	92.2%	92.1%	92.1%	92.1%	92.0%	92.1%	92.0%	92.0%	92.1%	92.1%	92.1%	92.0%		>=92 %	>=90 %	<90 %	✔
Waiting List Size					13,235	13,238	12,879	12,962	12,925	12,884	12,961	12,934	12,859		<=12905	N/A	>12905	✔
Waiting Greater than 52 weeks	0	1	2	1	0	0	0	0	0	0	0	0	0		0	N/A	>0	✔
Cancer: 2 week wait from referral to date 1st seen - all urgent referrals	92.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%		100 %	N/A	<100 %	✔
All Cancers: 31 day diagnosis to treament	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
All Cancers: 31 day wait until subsequent treatments	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		100 %	N/A	<100 %	✔
Diagnostics: % Completed Within 6 Weeks	99.8%	100.0%	99.3%	99.8%	99.8%	99.8%	99.2%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%		>=99 %	N/A	<99 %	✔
Number of Super Stranded Patients (21+ Days)	29	35	26	32	34	27	32	29	32	29	32	28	24		<=32	N/A	>32	✔
PFI: PPM%	100.0%	98.0%	100.0%	98.0%	98.6%	99.0%	99.0%	96.0%	98.0%	100.0%	98.0%	99.0%	100.0%		>=98 %	N/A	<98 %	✔

The Best People doing their best Work

WELL LED

	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	Last 12 Months	RAG			Comments Available
CIP In Month Variance (£'000s)	-149	54	-410	864	-248	104	153	-238	-137	175	-174	-285	151		>=0%	>=-20%	<-20%	✔
Control Total In Month Variance (£'000s)	218	243	17		-426	154	285	29	-396	359	-463	-48	564		>=0%	>=-20%	<-20%	✔
Capital Expenditure In Month Variance (£'000s)	2,329	1,184	3,161	-887	1,090	-333	1,701	-462	-129	2,907	-751	1,041	1,032		>=-5%	>=-10%	<-10%	✔
Cash in Bank (£'000s)	8,171	6,712	10,201	12,244	12,406	10,455	9,455	23,910	21,519	20,023	20,315	17,580	23,136		>=0%	>=-20%	<-20%	✔
Income In Month Variance (£'000s)	455	1,893	1,080	19,658	218	591	425	998	741	263	624	684	142		>=0%	>=-20%	<-20%	✔
Pay In Month Variance (£'000s)	-426	-538	-605	546	-17	-7	-38	-111	-311	51	-372	-74	-267		>=-1%	>=-20%	<-20%	✔
Non Pay In Month Variance (£'000s)	189	-1,111	-458	1,368	-627	-431	-102	-858	-825	95	-715	-659	689		>=0%	>=-20%	<-20%	✔
NHSI Use of Resources	3	3	3	1	3	3	3	3	3	2	2	1	1		<=3	N/A	>3	✔
AvP: IP - Non-Elective					5	6	5	20	9	-2	49	63	111		>=0	N/A	<0	✔
AvP: IP Elective vs Forecast					7	13	16	9	18	10	33	-6	-15		>=0	N/A	<0	✔
AvP: Daycase Activity vs Forecast					-22	-3	6	-11	-2	20	-86	-66	-163		>=0	N/A	<0	✔
AvP: Outpatient Activity vs Forecast					975	567	483	498	524	1,050	1,894	1,950	8		>=0	N/A	<0	✔
PDR	79.6%	79.7%	76.1%	76.4%	1.3%	11.3%	31.1%	64.7%	82.3%	88.8%	90.1%	90.1%	90.1%		>=90 %	>=85 %	<85 %	✔
Medical Appraisal	13.6%	24.0%	52.1%	67.6%	69.0%	69.0%	2.0%	4.0%	6.3%	100.0%	100.0%	100.0%	100.0%		>=95 %	>=90 %	<90 %	✔
Mandatory Training	86.2%	88.9%	94.1%	92.9%	92.1%	92.0%	92.1%	91.6%	88.6%	88.1%	89.7%	89.7%	89.0%		>=90 %	>=80 %	<80 %	✔
Sickness	5.9%	6.3%	5.6%	4.7%	4.4%	4.6%	4.8%	5.3%	5.2%	5.4%	5.5%	5.5%	6.0%		<=4.5 %	<=5 %	>5 %	✔
Short Term Sickness	1.7%	2.1%	1.7%	1.5%	1.3%	1.2%	1.3%	1.5%	1.3%	1.4%	1.5%	1.6%	1.6%		<=1.5 %	N/A	>1.5 %	✔
Long Term Sickness	4.2%	4.3%	3.9%	3.2%	3.1%	3.4%	3.5%	3.8%	4.0%	4.0%	4.0%	3.9%	4.4%		<=3 %	N/A	>3 %	✔
Temporary Spend ('000s)	761	833	926	1,067	977	973	947	901	1,082	820	998	971	883		<=800	<=960	>960	✔
Staff Turnover	11.5%	11.5%	11.5%	11.0%	10.8%	11.2%	11.0%	11.5%	10.8%	11.3%	11.2%	11.1%	10.1%		<=10 %	<=11 %	>11 %	✔
% of Correct Pay Achieved	98.0%	99.6%	99.3%	98.9%	99.8%	99.4%	99.5%	99.5%	99.5%	99.4%	99.4%	99.5%	99.5%		>=99.5 %	>=99 %	<99 %	✔
Safer Staffing (Shift Fill Rate)	93.9%	95.9%	94.2%	95.0%	96.4%	96.5%	94.8%	95.0%	93.9%	93.1%	93.2%	95.3%	94.2%		>=90 %	N/A	<90 %	✔
Domestic Cleaning Audit Compliance	65.0%	75.0%	85.0%	90.0%	90.0%	85.0%	65.5%	97.5%	85.0%	93.8%	60.0%	90.0%	90.0%		>=85 %	N/A	<85 %	✔
Performance Against Single Oversight Framework Themes	0	0	0	0	0	0	0	0	0	0	0	0	0		0	<=1	>1	✔

Game Changing Research & Innovation

R&D

Alder Hey Children's NHS Foundation Trust

GROW THE FUTURE

	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	Last 12 Months	RAG			Comments Available
Number of Open Studies - Academic	0	0	0	0	148	153	159	159	156	115	143	136	123		>=50	N/A	<50	✔
Number of Open Studies - Commercial	0	0	0	0	34	33	34	34	37	27	31	28	27		>=5	N/A	<5	✔
Number of New Studies Opened - Academic	0	0	0	0	5	2	5	7	2	3	6	8	2		>=4	N/A	<4	✔
Number of New Studies Opened - Commercial	0	0	0	0	3	0	0	1	2	3	2	0	0		No Threshold			
Number of patients recruited	0	0	0	0	272	308	245	288	249	238	195	296	158		>=417	N/A	<417	✔

Delivery of Outstanding Care

7.1 - QUALITY - SAFE

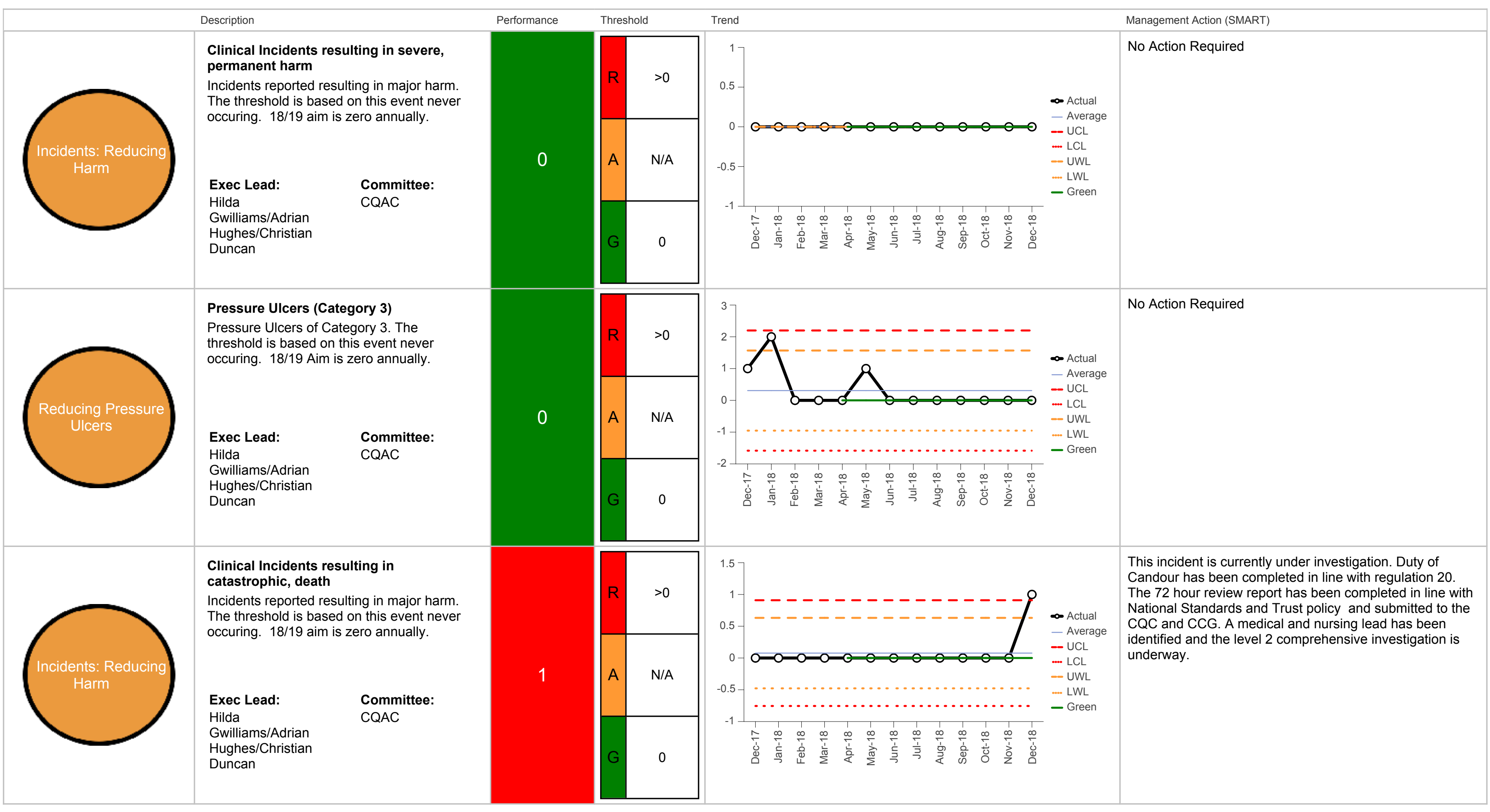
	Description	Performance	Threshold		Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in minor harm & above** Incidents reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (913). 18/19 aim is 10% less than last year for the same month. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	72	R A G	>52 <=52 <=47		Weekly 'Patient Safety Meeting review and monitoring progress with actions. Monthly Head of Quality analysis reports including lessons learned presented to Divisional Governance Assurance Committee and Clinical Quality Steering group.
Incidents: Reducing Harm	**Clinical Incidents resulting in moderate, semi permanent harm** Incidents reported resulting in moderate harm. The threshold is based on achieving a 10% reduction on the period Apr 17 - Mar 18 (16). 18/19 aim is 12 or less, annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1	R A G	>1 N/A <=1		No Action Required
Incidents: Increasing Reporting	**Total no of incidents reported Near Miss & Above** Total number of Incidents reported. The threshold is based on increasing on last year for the period Apr 17 - Mar 18 (4,241) 18/19 aim is more than last year for the same month to demonstrate a learning culture. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	349	R A G	<293 >=293 >=327		No Action Required

Delivery of Outstanding Care

7.2 - QUALITY - SAFE

Alder Hey Children's NHS Foundation Trust

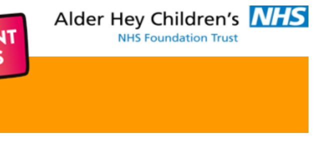
BRILLIANT BASICS



	Description	Performance	Threshold	Trend	Management Action (SMART)
Incidents: Reducing Harm	**Clinical Incidents resulting in severe, permanent harm** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R: >0 A: N/A G: 0		No Action Required
Reducing Pressure Ulcers	**Pressure Ulcers (Category 3)** Pressure Ulcers of Category 3. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R: >0 A: N/A G: 0		No Action Required
Incidents: Reducing Harm	**Clinical Incidents resulting in catastrophic, death** Incidents reported resulting in major harm. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1	R: >0 A: N/A G: 0		This incident is currently under investigation. Duty of Candour has been completed in line with regulation 20. The 72 hour review report has been completed in line with National Standards and Trust policy and submitted to the CQC and CCG. A medical and nursing lead has been identified and the level 2 comprehensive investigation is underway.

Delivery of Outstanding Care

7.3 - QUALITY - SAFE



	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Pressure Ulcers	**Pressure Ulcers (Category 4)** Pressure Ulcers of Category 4. The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required
Never Events	**Never Events** Never Events. The threshold is based on this event never occuring. 18/19 aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required
Reducing Medication Errors	**Medication errors resulting in harm** Medication errors reported resulting in minor, moderate, major or catastrpohic (death) harm. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (32). 18/19 aim is 2 avg per month, or less, per month (less than 24 annually) **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	2	R A G	>2 N/A <=2		No Action Required

The Best People doing their best Work

8.1 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family A&E - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on exceeding the National average in Nov 17. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	90.11 %	R <90 % A >=90 % G >=95 %		This is a huge increase from November, work is continuing around communication on the waiting time using the board, this is being led by the patient experience team
Friends & Family	**Friends & Family Community - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	100 %	R <90 % A >=90 % G >=95 %		No Action Required
Friends & Family	**Friends & Family Inpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	98.25 %	R <90 % A >=90 % G >=95 %		No Action Required

Chart 1 (A&E): y-axis 75, 80, 85, 90, 95, 100; x-axis 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; legend: Actual, Average, UCL, LCL, UWL, LWL, Green

Chart 2 (Community): y-axis 85, 90, 95, 100, 105, 110; x-axis Dec-17 to Dec-18; legend: Actual, Average, UCL, LCL, UWL, LWL, Green

Chart 3 (Inpatients): y-axis 92, 94, 96, 98, 100, 102; x-axis Dec-17 to Dec-18; legend: Actual, Average, UCL, LCL, UWL, LWL, Green

The Best People doing their best Work

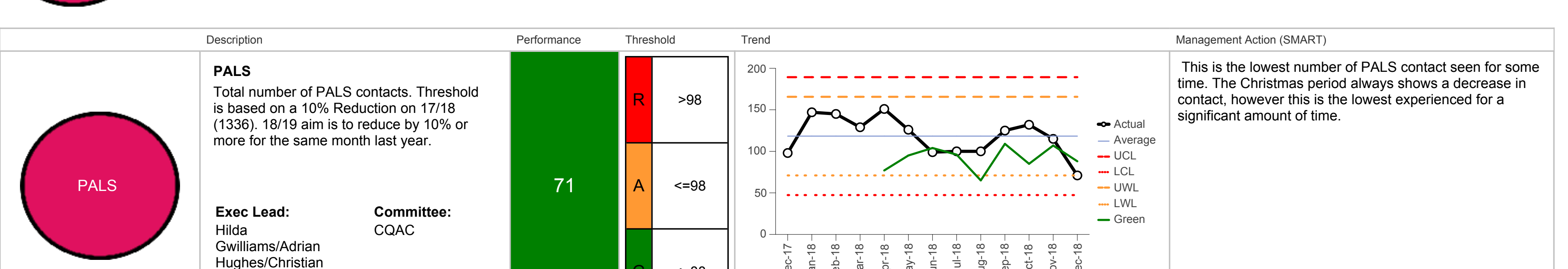
8.2 - QUALITY - CARING

	Description	Performance	Threshold	Trend	Management Action (SMART)
Friends & Family	**Friends & Family Outpatients - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	91.67 %	R <90 % A >=90 % G >=95 %	Chart: Dec-17 to Dec-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	The Best in Outpatient Care Project (2018-2019) have been working hard to improve experience in Outpatients, for the children and families who visit the department. Areas of focus were defined by using the Family and Friends Test data as a baseline for how are families are feeling and understanding what improvements they want to see Improved. The areas of focus are Play and Distraction in the waiting areas, Improved Play and Distraction for Phlebotomy, Improved patients flow, improved booking process, improved communication and access to check in machines in the Atrium
Friends & Family	**Friends & Family Mental Health - % Recommend the Trust** Percentage of Friends and Family positive responses, trustwide, that would recommend Alder Hey for treatment. Threshold is based on maintaining a consistently high standard across all areas. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	100 %	R <90 % A >=90 % G >=95 %	Chart: Dec-17 to Dec-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Complaints	**Complaints** Total complaints received. The threshold is based on achieving a 25% reduction on the period Apr 17 - Mar 18 (90). 18/19 aim is to reduce by 25% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	7	R >5 A <=5 G <=4	Chart: Dec-17 to Dec-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	November and December have seen a marked reduction in formal complaints.Medicine have receievd 4 complaints , with Community and Surgery both receiving one each.

The Best People doing their best Work

8.3 - QUALITY - CARING

Alder Hey Children's NHS
NHS Foundation Trust



	Description	Performance	Threshold		Trend	Management Action (SMART)
PALS	**PALS** Total number of PALS contacts. Threshold is based on a 10% Reduction on 17/18 (1336). 18/19 aim is to reduce by 10% or more for the same month last year. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	71	R	>98		This is the lowest number of PALS contact seen for some time. The Christmas period always shows a decrease in contact, however this is the lowest experienced for a significant amount of time.
			A	<=98		
			G	<=88		

Delivery of Outstanding Care

9.1 - QUALITY - EFFECTIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sepsis	**Sepsis: Patients treated for Sepsis - Inpatients** Percentage of Sepis Patients receiving antibiotic within 60 mins for Inpatients. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	73.33 %	R: <90 % A: N/A G: >=90 %		Data collection figure 73.3%. Review of the year 2018 and key themes identified. Groups/workstreams identified for IM administartion and also case review on specific patients as identified (prescription time to administration time). New posters and education regarding sepsis with increased awareness about accurate timely documentation as this is a priority area. Trust is sepsis aware we now need to learn how we can improve our data to give accurate reflection of treatment times.
Mortality	**No of children that have suffered avoidable death - Internal** Total number of children that have suffered avoidable death with issues relating to care provided in Alderhey. Figures provided by HMRG group. The threshold for 18/19 is zero. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R: >0 A: N/A G: 0		No Action Required
Sepsis	**Sepsis: Patients treated for Sepsis - A&E** Percentage of Sepis Patients receiving antibiotic within 60 mins for ED. 18/19 aim is 90%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	51.85 %	R: <90 % A: N/A G: >=90 %		Sepsis team aware of the increasing dependency of patients and clinical deterioration of patients presenting to ED. Many patients presenting with warning signs of sepsis but also suggestive of respiratory viruses. The systems in place to help identify concerns and this has increased the 'potential' sepsis cases. Documentation and electronic recording still proving difficult to ascertain accurate timelines for patient treatment. This is being looked at as currently the overall % figure is felt to be inaccurate. More support from IT required.

Delivery of Outstanding Care

9.2 - QUALITY - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
PICU Re-admissions	**% Readmissions to PICU within 48 hrs** % of discharges readmitted to PICU within 48hrs sourced from PICANet [Paediatric Intensive Care Audit Network]. Threshold agreed with PICU is based on the reported range nationally from all UK PICUs, most recent published range (16/17) was 0-3% averaged over a calendar year. Data is presented as monthly incidence for the purpose of this report. Annual average for this site was 2.4% **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	3.28 %	R A G	>3 % N/A <=3 %		There are nationally acknowledged seasonal variations to PICU readmissions within 48 hours of discharge. Our annual incidence for this calendar year is <2%. The national reported range for all PICUs reported in the PICANet annual report is 0 to 3%.
Reducing Infections	**Hospital Acquired Organisms - MRSA (BSI)** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required
Reducing Infections	**Hospital Acquired Organisms - C.difficile** The threshold is based on this event never occuring. 18/19 Aim is zero annually. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	0	R A G	>0 N/A 0		No Action Required

Trend chart legend: Actual, Average, UCL, LCL, UWL, LWL, Green. X-axis: 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.

Delivery of Outstanding Care

9.3 - QUALITY - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Reducing Infections	**Hospital Acquired Organisms - CLABSI - ICU Only** Hospital Acquired Organisms - CLABSI on ICU Ward Only. 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	3	R	>4		No Action Required
			A	N/A		
			G	<=4		
Reducing Infections	**Hospital Acquired Organisms - Gram Negative BSI** Gram - Negative BSI to include E Coli, Klebsiella and Pseudomonas . 18/19 aim is to reduce by 10% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	2	R	>2		No Action Required
			A	N/A		
			G	<=2		
Reducing Infections	**Hospital Acquired Organisms - MSSA** Hospital Acquired Organisms - MSSA . 18/19 aim is to reduce by 25% or more. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	1	R	>1		No Action Required
			A	N/A		
			G	<=1		

Delivery of Outstanding Care

10.1 - QUALITY - RESPONSIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
Inpatient Survey: Choices	**IP Survey: % Received information enabling choices about their care** Percentage of patients / families that report receiving information to enable them to make choices. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	96.65 %	R A G	<90 % >=90 % >=95 %		No Action Required
Inpatient Survey: Respect	**IP Survey: % Treated with respect** Percentage of children / families that report being treated with respect. Thresholds are based on previously defined local targets. The 18/19 is 100%. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	99.58 %	R A G	<95 % >=95 % 100 %		This has been put on the exception action plan and will be discussed at the monthly DIG meetings, further actions will be available as to how the teams will address this issue
Inpatient Survey: Date of Discharge	**IP Survey: % Know their planned date of discharge** Percentage of children / families that report knowing their planned date of discharge. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	59.41 %	R A G	<85 % >=85 % >=90 %		The SAFER programmes have implemented 'My Pads' on each ward. This is a daily plan for each patient 'I am to go home on ________ at ________' and also 'Before I go home I will need to ______________'. This is filled out daily by the nurse looking after the patient this will be implemented on all wards by Sep 2019.

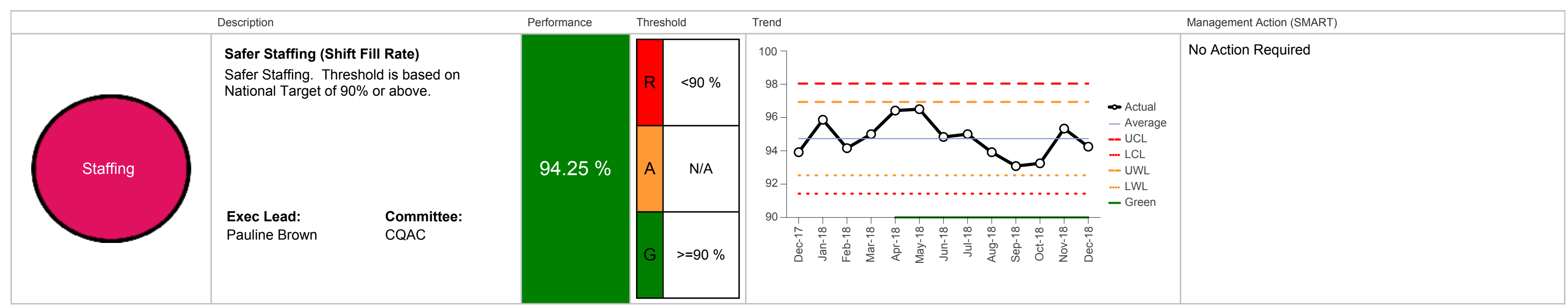
Delivery of Outstanding Care

10.2 - QUALITY - RESPONSIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
Inpatient Survey: Play and Learning	**IP Survey: % Patients involved in play and learning** % of children / families that report engaging in play / learning. Thresholds are based on previously defined local targets. The 18/19 aim is 90% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	68.20 %	R <85 % A >=85 % G >=90 %		Develop internet page that can be accessed before admission, information on play to be communicated through different channels: posters, social media, digital, to include, When & where play/entertainment is happening on the wards, Play Sessions, POD, entertainers, Therapy Dog, Arts for health, Volunteering, Themed activities, Cinema. Family Friends Test cards to be completed with the Children Young People by the play team following a play activity. Volunteers will ask the Children & Young people if they require any play. Medical students to undertake play activities at the bedside.
Inpatient Survey: In Charge of Care	**IP Survey: % Know who is in charge of their care** % of children / families that report knowing who is in charge of their care. Thresholds are based on previously defined local targets. The 18/19 aim is 95% or above. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** CQAC	92.47 %	R <90 % A >=90 % G >=95 %		Ward staff continue to introduce themselves further detail will be reported as to what wards are not giving this information this will be reported in February.

The Best People doing their best Work

11.1 - QUALITY - WELL LED



	Description	Performance	Threshold	Trend	Management Action (SMART)
Staffing	**Safer Staffing (Shift Fill Rate)** Safer Staffing. Threshold is based on National Target of 90% or above. **Exec Lead:** Pauline Brown **Committee:** CQAC	94.25 %	R: <90 % A: N/A G: >=90 %		No Action Required

Delivery of Outstanding Care

12.1 - PERFORMANCE - EFFECTIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
Bed Occupancy	**Bed Occupancy (Accessible Funded Beds)** Percentage of funded beds that are occupied in accessible wards 3A, 4A, 3C and 4C, this is based on 3 occupancy readings measured throughout the day. Threshold is based on National NHS Guidance on safe staffing and occupancy levels. **Exec Lead:** Adam Bateman **Committee:** RABD	73.68 %	R A G	>93 % <=93 % <=89 %	Chart: Dec-17 to Dec-18; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
ED 4 Hour Standard	**ED: 95% Treated within 4 Hours** Threshold is based on National Guidance set by NHS England at 95%. **Exec Lead:** Adam Bateman **Committee:** RABD	95.34 %	R A G	<95 % N/A >=95 %	Chart: Dec-17 to Dec-18; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required
LoS: Elective	**Average LoS - Elective (Days)** Average Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	3.58	R A G	>3.6 N/A <=3.6	Chart: Dec-17 to Dec-18; Actual, Average, UCL, LCL, UWL, LWL, Green	No Action Required

Delivery of Outstanding Care

12.2 - PERFORMANCE - EFFECTIVE

	Description	Performance	Threshold	Trend	Management Action (SMART)
LoS: Non-Elective	**Average LoS - Non-Elective (Days)** Average Non Elective Length of Stay (days). 18/19 aim is to not increase Length of Stay for the same month last year. **Exec Lead:** Adam Bateman **Committee:** RABD	1.92	R: >2.0 A: N/A G: <=2.0	Chart: Dec-17 to Dec-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
Theatre Utilisation	**Theatre Utilisation - % of Session Utilised** Threshold is based on the productive theatre improvement measures at greater than or equal to 90% utilisation of theatres. **Exec Lead:** Adam Bateman **Committee:** RABD	85.93 %	R: <80 % A: >=80 % G: >=90 %	Chart: Dec-17 to Dec-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	Seasonal reduction in utilisation expected due to Christmas Holidays. Expected improvement in January, e.g. w.c. 7th January theatre utilisation is 92.3%. A weekly review of day surgery utilisation takes place each Monday with feedback sent out to all clinical teams. Bidirectional texting is in place with the day surgery/inpatient admission team and effectiveness is being monitored through Best in Operative Care to improve attendance rate.
Cancelled Operations	**On the day Elective Cancelled Operations for Non Clinical Reasons** Performance is measured for on the day cancelled elective operations for non clinical reasons. This based on National Guidance. Threshold aims to reduce cancellations by 25% based on 17/18 overall performance. **Exec Lead:** Adam Bateman **Committee:** RABD	21	R: >21 A: N/A G: <=21	Chart: Dec-17 to Dec-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required

Delivery of Outstanding Care

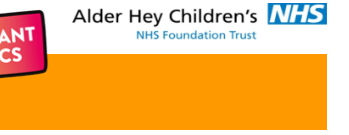
12.3 - PERFORMANCE - EFFECTIVE

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold	Trend	Management Action (SMART)
DNAs	**Did Not Attend Rate** The target of 12% is a local target aligned to outpatient improvement workstreams (Hybrid Booking, Patient Demogrpahic Checking and bidirectional automate text reminders). **Exec Lead:** Adam Bateman **Committee:** RABD	12.88 %	R >14 % A <=14 % G <=12 %		Seasonal variation normally adversely affects December performance. In conjunction with an anticipated reduction in attendance with high DNA's we have seen abnormal variance in a number of specialties that requires further investigation. These specialties are gynae, surgery, palliative care, speech therapy & dentistry. Plans are currently being developed with Comms to positively promote attendance and not to DNA. Bi Directional texting will be rolled out by the end of January to all specialties.
Clinic Utilisation	**Clinic Session Utilisation** Threshold is based on a resonable expectation utilising clinics at 90% or greater to take into account short notice cancellations and DNAs. **Exec Lead:** Adam Bateman **Committee:** RABD	81.71 %	R <85 % A >=85 % G >=90 %		Seasonal variation normally adversely affects December performance. Utilisation has been reduced due to higher than anticipated levels of DNA's which are currently being reviewed plus patients with missing outcomes which means that they are not included as an attendance. Bi directional texting rollout is continuing and will be complete by the end of January; B&S team are backfilling when capacity comes available however access to urgent slot access remains a challenge and being managed with the COO/Divisions.
Operation Breaches	**28 Day Breaches** Standard is when a patients operation is cancelled by the hospital last minute for non-clinical reasons, the hospital will have to offer another binding date with 28 days. This is based on national guidance. **Exec Lead:** Adam Bateman **Committee:** RABD	5	R >0 A N/A G 0		Breaches occurred in ENT, urology and dentistry. There has been difficulty relisting within 28 days due to theatre list cancellations from reduced anaesthetic cover. There is an action plan in place for anaesthetic provision which improves from January. Potential 28 day breaches are monitored by the division on a weekly basis

Delivery of Outstanding Care

12.4 - PERFORMANCE - EFFECTIVE

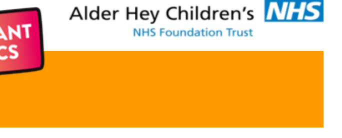


	Description	Performance	Threshold		Trend	Management Action (SMART)
Stranded Patients	**Number of Super Stranded Patients (21+ Days)** National measure as part of the 18/19 NHSI plan. The target is to reduce the number of stranded patients 21 or more days from March 2018. This excludes patients on ICU/HDU/NEO and Cardiac HDU. **Exec Lead:** Adam Bateman **Committee:** RABD	24	R	>32	Chart: Dec-17 to Dec-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
			A	N/A		
			G	<=32		
Transcriptions	**Transcription Turnaround (days)** Days from dictation to typing clinic letters for services transcribed by Transcription service. Based on working day average. This is also monitored externally by our local commissioners. **Exec Lead:** Adam Bateman **Committee:** RABD	2.50	R	>5	Chart: Dec-17 to Dec-18 (Actual, Average, UCL, LCL, UWL, LWL, Green)	No Action Required
			A	<=5		
			G	<=3		

Delivery of Outstanding Care

13.1 - PERFORMANCE - RESPONSIVE

	Description	Performance	Threshold		Trend	Management Action (SMART)
RTT	**RTT: Open Pathway: % Waiting within 18 Weeks** Percentage of patients waiting within 18 weeks. Threshold is based on previous national target of 92%, this is applied in order to maintain monitoring of measure. **Exec Lead:** Adam Bateman **Committee:** RABD	92.04 %	R A G	<90 % >=90 % >=92 %		No Action Required
Waiting Times	**Waiting List Size** National threshold as part of the 18/19 NHSI plan. The target is to reduced the total waitlist size from March 2018. **Exec Lead:** Adam Bateman **Committee:** RABD	12859	R A G	>12905 N/A <=12905		No Action Required
Waiting Times	**Waiting Greater than 52 weeks** Total number of more than 52 weeks for first treatment. The threshold is based on this event never occuring. 18/19 aim is zero annually. There is a financial and contractual penalties in the failure to achieve this. **Exec Lead:** Adam Bateman **Committee:** RABD	0	R A G	>0 N/A 0		No Action Required



Delivery of Outstanding Care

13.2 - PERFORMANCE - RESPONSIVE

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

Delivery of Outstanding Care

13.3 - PERFORMANCE - RESPONSIVE

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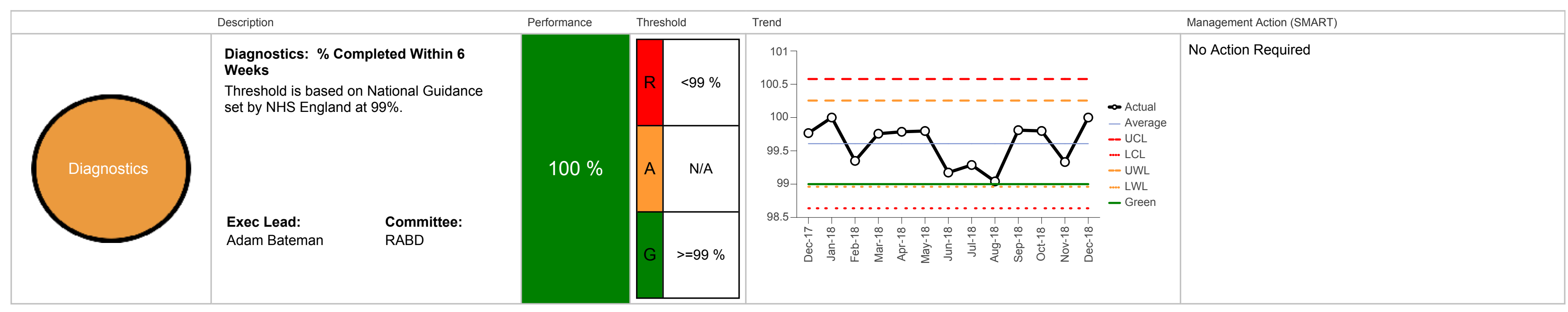
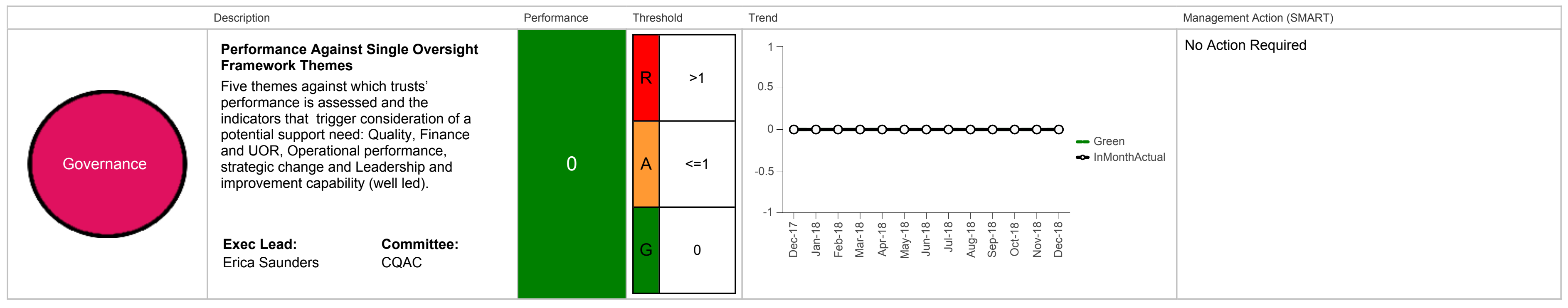
NHS Foundation Trust



	Description	Performance	Threshold		Trend	Management Action (SMART)
Diagnostics	**Diagnostics: % Completed Within 6 Weeks** Threshold is based on National Guidance set by NHS England at 99%. **Exec Lead:** Adam Bateman **Committee:** RABD	100 %	R	<99 %		No Action Required
			A	N/A		
			G	>=99 %		

The Best People doing their best Work

14.1 - PERFORMANCE - WELL LED

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

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15.1 - FINANCE - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Control Total In Month Variance (£'000s)** Variance from Control Total plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month. **Exec Lead:** John Grinnell **Committee:** RABD	564	R	<-20%		No Action Required
			A	>=-20%		
			G	>=0%		
Finance	**CIP In Month Variance (£'000s)** Variance from Sustainability plan (CIP). Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	151	R	<-20%		No Action Required
			A	>=-20%		
			G	>=0%		
Finance	**Capital Expenditure In Month Variance (£'000s)** Variance from capital plan. Variation between months is usual and the threshold of + or - 5% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	1,032	R	<-10%		No Action Required
			A	>=-10%		
			G	>=-5%		

The Best People doing their best Work

15.2 - FINANCE - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Cash in Bank (£'000s)** Variance from Cash plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	23,136	R	<-20%		The cash in the Trust bank account in December was £2.5m less than plan. This was due to a timing issue in the receipt of income from universities for the lease of buildings.
			A	>=-20%		
			G	>=0%		
Finance	**Income In Month Variance (£'000s)** Variance from income plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	142	R	<-20%		No Action Required
			A	>=-20%		
			G	>=0%		
Finance	**Pay In Month Variance (£'000s)** Variance from pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	-267	R	<-20%		Expenditure on staff was overspent in the month by £0.3m This was due to the premium cost of temporary staffing.
			A	>=-20%		
			G	>=-1%		

The Best People doing their best Work

15.3 - FINANCE - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**Non Pay In Month Variance (£'000s)** Variance from non pay plan. Variation between months is usual and the threshold of + or - 20% is viewed as reasonable to be rectified the following month **Exec Lead:** John Grinnell **Committee:** RABD	689	R A G	<-20% >=-20% >=0%	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; Dec-17 to Dec-18	No Action Required
Finance	**AvP: IP - Non-Elective** Actvity vs Forecast for Inpatient Non-Elective Activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	110.81	R A G	<0 N/A >=0	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; Dec-17 to Dec-18	No Action Required
Finance	**NHSI Use of Resources** NHSI Use of Resources Metric indicates financial sustainability of the Trust. This varies from 1 to 4 with 1 being the highest score possible and 4 being the lowest **Exec Lead:** John Grinnell **Committee:** RABD	1	R A G	>3 N/A <=3	Chart: Actual, Average, UCL, LCL, UWL, LWL, Green; Dec-17 to Dec-18	No Action Required

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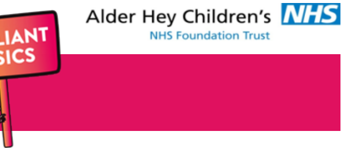
15.4 - FINANCE - WELL LED



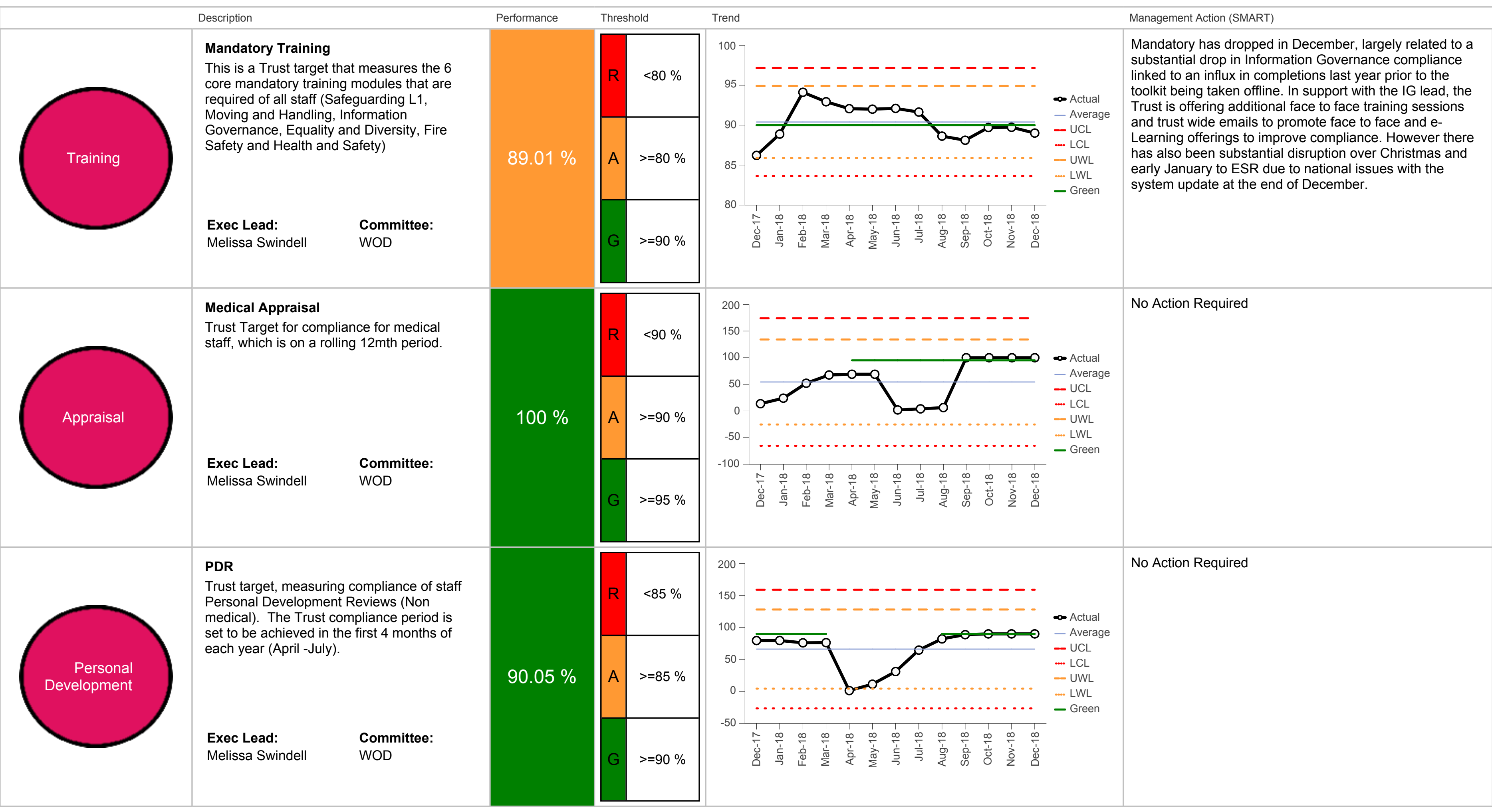
	Description	Performance	Threshold		Trend	Management Action (SMART)
Finance	**AvP: Daycase Activity vs Forecast** Actvity vs Forecast for Daycase activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-162.51	R A G	<0 N/A >=0		Significant adverse in-month variances in oncology (down 116 spells) and dentistry (down 72).
Finance	**AvP: Outpatient Activity vs Forecast** Actvity vs Forecast for Outpatient activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	7.75	R A G	<0 N/A >=0		Significant in-month adverse variances in orthopaedics (down 137 attendances), paed surgery (down 109) and respiratory medicine (down 95).
Finance	**AvP: IP Elective vs Forecast** Actvity vs Forecast for Inpatient Elective activity. The threshold is based on achieving forecast or higher. **Exec Lead:** John Grinnell **Committee:** RABD	-14.83	R A G	<0 N/A >=0		Significant adverse in-month variance in ENT (down 43 spells).

The Best People doing their best Work

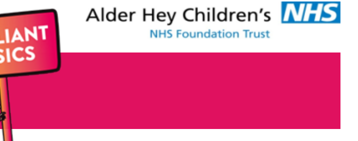
16.1 - HR - WELL LED

Alder Hey Children's NHS Foundation Trust

BRILLIANT BASICS



	Description	Performance	Threshold		Trend	Management Action (SMART)
Training	**Mandatory Training** This is a Trust target that measures the 6 core mandatory training modules that are required of all staff (Safeguarding L1, Moving and Handling, Information Governance, Equality and Diversity, Fire Safety and Health and Safety) **Exec Lead:** Melissa Swindell **Committee:** WOD	89.01 %	R A G	<80 % >=80 % >=90 %		Mandatory has dropped in December, largely related to a substantial drop in Information Governance compliance linked to an influx in completions last year prior to the toolkit being taken offline. In support with the IG lead, the Trust is offering additional face to face training sessions and trust wide emails to promote face to face and e-Learning offerings to improve compliance. However there has also been substantial disruption over Christmas and early January to ESR due to national issues with the system update at the end of December.
Appraisal	**Medical Appraisal** Trust Target for compliance for medical staff, which is on a rolling 12mth period. **Exec Lead:** Melissa Swindell **Committee:** WOD	100 %	R A G	<90 % >=90 % >=95 %		No Action Required
Personal Development	**PDR** Trust target, measuring compliance of staff Personal Development Reviews (Non medical). The Trust compliance period is set to be achieved in the first 4 months of each year (April -July). **Exec Lead:** Melissa Swindell **Committee:** WOD	90.05 %	R A G	<85 % >=85 % >=90 %		No Action Required



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16.2 - HR - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Sickness	**Sickness** % of staff who have been absent from work due to sickness, this is broken down into LTS & STS in further metrics **Exec Lead:** Melissa Swindell **Committee:** WOD	6.04 %	R >5 % A <=5 % G <=4.5 %		Sickness continues to be on an upward trend, with the number of long term sicknesses increasing. Absences relating to Anxiety, Stress & Depression account for 37% of all absences in December, this is followed by Injury, Fracture (6.7%) and Cough, Cold, Flu (6.6%). Action plans are in place for areas with significant absence. In addition a full review of all absences has been undertaken with individual action plans in place.
Sickness	**Short Term Sickness** % of Trust staff who have been absent from work due to sickness lasting less than 28 days **Exec Lead:** Melissa Swindell **Committee:** WOD	1.63 %	R >1.5 % A N/A G <=1.5 %		See above comment for overall sickness
Sickness	**Long Term Sickness** % of Trust staff who have been absent from work due to sickness lasting 28 days or more **Exec Lead:** Melissa Swindell **Committee:** WOD	4.41 %	R >3 % A N/A G <=3 %		See comment above for overall sickness

The Best People doing their best Work

16.3 - HR - WELL LED

	Description	Performance	Threshold		Trend	Management Action (SMART)
Payroll	**% of Correct Pay Achieved** An agreed service Level target with the Trust payroll provider. **Exec Lead:** Melissa Swindell **Committee:** WOD	99.46 %	R	<99 %		Correct pay continues to sit just below target. Bi-Monthly contractual meetings take place between ELFS, HR and Finance to ensure any issues are picked up and remedied promptly
			A	>=99 %		
			G	>=99.5 %		
Staff Turnover	**Staff Turnover** Trust Target which is based on a rolling 12mth period **Exec Lead:** Melissa Swindell **Committee:** WOD	10.05 %	R	>11 %		32% of leavers came from the Division of Medicine this month, with just under half being Nursing staff. Across the Trust 27% of leavers this month came from the Nursing staff group.
			A	<=11 %		
			G	<=10 %		
Temporary Spend	**Temporary Spend ('000s)** Indicates the expenditure on premium temporary pay spend and monitors the reduction. **Exec Lead:** Melissa Swindell **Committee:** WOD	882.83	R	>960		Business Partners together with Finance Accountants and Ass COOs regularly review status in Divisions and advise on actions as appropriate. Monthly temporary staffing reviews also take place with the Director & Deputy Directors of HR & Finance.
			A	<=960		
			G	<=800		

Game Changing Research & Innovation

17.1 - RESEARCH & DEVELOPMENT - WELL LED

Alder Hey Children's NHS
NHS Foundation Trust

	Description	Performance	Threshold		Trend	Management Action (SMART)
Clinical Research	**Number of New Studies Opened - Academic** Number of new academic studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	2	R A G	<4 N/A >=4		a dip in academic studies opening in december is expected as the academic year runs august - july with very little activity occurring in december.
Clinical Research	**Number of Open Studies - Commercial** Number of commercial studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	27	R A G	<5 N/A >=5		No Action Required
Clinical Research	**Number of Open Studies - Academic** Number of academic studies currently open. **Exec Lead:** Matthew Peak **Committee:** REIC	123	R A G	<50 N/A >=50		No Action Required

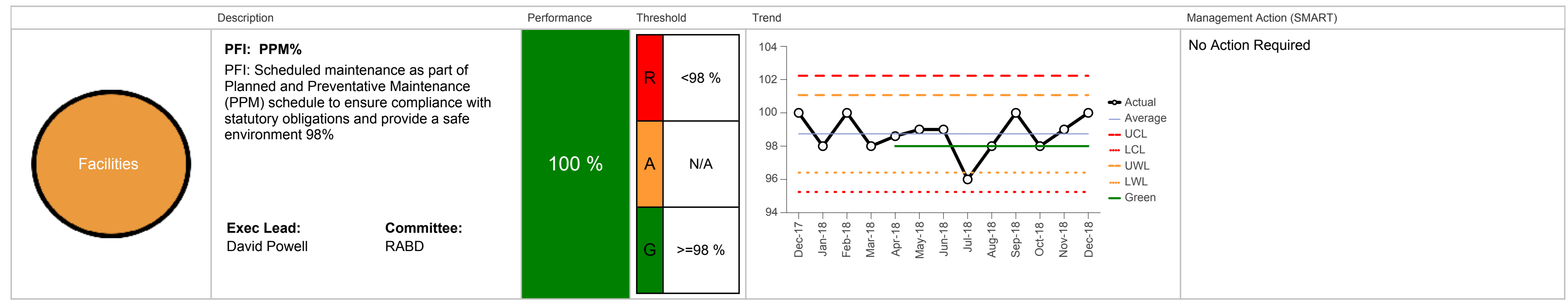
Game Changing Research & Innovation

17.2 - RESEARCH & DEVELOPMENT - WELL LED

	Description	Performance	Threshold	Trend	Management Action (SMART)
Clinical Research	**Number of patients recruited** Number of patients recruited in month. **Exec Lead:** Matthew Peak **Committee:** REIC	158	R <417 A N/A G >=417	Chart: Dec-17 to Dec-18; Actual, Average, UCL, LCL, UWL, LWL, Green	Patient recruitment is low this year and a large study is yet to open (DETECT). Without a large, high recruiting study open that target will not be met. A full portfolio review has taken place and red-amber rated studies looked at. some potential solutions have been identified and some studies are to close. The performance will be shared with research nurses in a team meeting for them to pick up on amber or red rated studies and pro-actively try to improve the recruitment rate. The portfolio will be looked at on a monthly basis.
Clinical Research	**Number of New Studies Opened - Commercial** Number of new commercial studies opened in month. **Exec Lead:** Matthew Peak **Committee:** REIC	0	No Threshold	Chart: Dec-17 to Dec-18; Actual, Average, UCL, LCL, UWL, LWL, Green	

Delivery of Outstanding Care

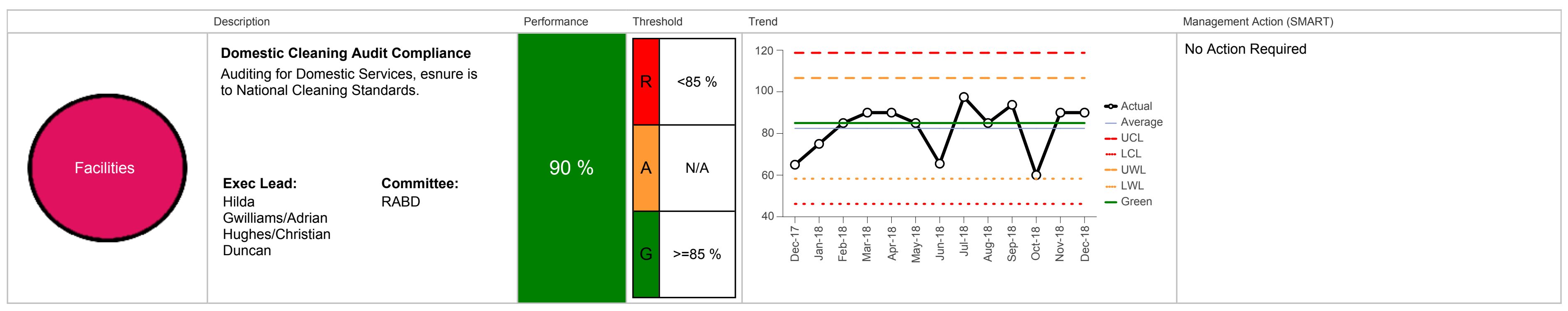
18.1 - FACILITIES - RESPONSIVE



	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**PFI: PPM%** PFI: Scheduled maintenance as part of Planned and Preventative Maintenance (PPM) schedule to ensure compliance with statutory obligations and provide a safe environment 98% **Exec Lead:** David Powell **Committee:** RABD	100 %	R	<98 %		No Action Required
			A	N/A		
			G	>=98 %		

The Best People doing their best Work

19.1 - FACILITIES - WELL LED



	Description	Performance	Threshold		Trend	Management Action (SMART)
Facilities	**Domestic Cleaning Audit Compliance** Auditing for Domestic Services, esnure is to National Cleaning Standards. **Exec Lead:** Hilda Gwilliams/Adrian Hughes/Christian Duncan **Committee:** RABD	90 %	R	<85 %		No Action Required
			A	N/A		
			G	>=85 %		

All Divisions

SAFE

	COMMUNITY	MEDICINE	SURGERY	RAG		
Total no of incidents reported Near Miss & Above	35	97	177	No Threshold		
Clinical Incidents resulting in minor harm & above	2	14	47	No Threshold		
Clinical Incidents resulting in moderate, semi permanent harm	0	0	0	No Threshold		
Clinical Incidents resulting in severe, permanent harm	0	0	0	0	N/A	>0
Clinical Incidents resulting in catastrophic, death	0	0	1	0	N/A	>0
Pressure Ulcers (Category 3)	0	0	0	0	N/A	>0
Pressure Ulcers (Category 4)	0	0	0	0	N/A	>0
Medication errors resulting in harm	0	0	2	No Threshold		
Medication errors resulting in moderate, sever harm or death	0	0	0	0	N/A	>0
Never Events	0	0	0	0	N/A	>0
Acute readmissions of patients with long term conditions within 28 days	0	3	0	No Threshold		

CARING

	COMMUNITY	MEDICINE	SURGERY	RAG
Complaints	1	3	0	No Threshold
PALS	11	21	16	No Threshold

EFFECTIVE

	COMMUNITY	MEDICINE	SURGERY	RAG		
Readmissions to PICU within 48 hrs	0	0	0	No Threshold		
Readmissions within 48 hrs	0	39	11	No Threshold		
% of acute readmissions within 48 hrs of discharge (exc Oncology)		1.9%	0.8%	<=1.3 %	N/A	>1.3 %
Outbreak Acquired Organisms - Other	0	0	0	0	N/A	>0
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	N/A	>0
Hospital Acquired Organisms - C.difficile	0	0	0	0	N/A	>0
Hospital Acquired Organisms - MSSA	0	0	1	No Threshold		

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
Hospital Acquired Organisms - RSV	0	4	9	No Threshold		
Hospital Acquired Organisms - CLABSI - ICU Only			3	No Threshold		
Outbreak Infections	0	0	0	No Threshold		
Referrals Received (Total)	755	1,706	2,782	No Threshold		
ED: 95% Treated within 4 Hours		95.3%		>=95 %	N/A	<95 %
Average LoS - Elective (Days)	3.00	3.54	3.38	No Threshold		
Average LoS - Non-Elective (Days)		1.45	2.92	No Threshold		
Theatre Utilisation - % of Session Utilised		87.0%	85.8%	>=90 %	>=85 %	<80 %
Cancelled Operations - Non Clinical - On Same Day (%)	0.0%	0.0%	2.3%	<=0.8 %	N/A	>0.8 %
On the day Elective Cancelled Operations for Non Clinical Reasons	0	0	21	No Threshold		
28 Day Breaches	0	0	5	0	N/A	>0
Clinic Session Utilisation	76.3%	80.7%	83.1%	>=90 %	>=85 %	<85 %
OP Appointments Cancelled by Hospital %	24.2%	15.6%	13.6%	<=5 %	<=10 %	>10 %
Did Not Attend Rate	11.4%	13.3%	13.1%	<=12 %	<=14 %	>14 %
Incomplete Pathway Forms in Outpatients	667	4,162	7,402	No Threshold		
Referral Turnaround (days to log)	5.33	3.19	4.45	No Threshold		
Referral Turnaround (Consultant to Action)	7.52	4.99	5.44	No Threshold		
Coding average comorbidities		3.72	3.90	No Threshold		
CAMHS: DNA Rate - New	7.9%			<=6 %	<=8 %	>8 %
CAMHS: DNA Rate - Follow Up	13.6%			<=10 %	<=16 %	>16 %

RESPONSIVE

	COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Received information enabling choices about their care		94.1%	98.5%	>=95 %	>=90 %	<90 %
IP Survey: % Treated with respect		100.0%	99.3%	100 %	>=95 %	<95 %
IP Survey: % Know their planned date of discharge		55.9%	62.0%	>=90 %	>=85 %	<85 %
IP Survey: % Know who is in charge of their care		91.2%	93.4%	>=95 %	>=90 %	<90 %

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
IP Survey: % Patients involved in play and learning		61.8%	73.0%	>=90 %	>=85 %	<85 %
RTT: Open Pathway: % Waiting within 18 Weeks	78.3%	92.7%	93.7%	>=92 %	>=90 %	<90 %
Waiting List Size	1,162	3,295	8,320	No Threshold		
Waiting Greater than 52 weeks	0	0	0	0	N/A	>0
Diagnostics: % Completed Within 6 Weeks		100.0%	100.0%	>=99 %	N/A	<99 %
Number of Stranded Patients (7+ Days)		22	16	No Threshold		
Number of Super Stranded Patients (21+ Days)		15	9	No Threshold		
CAMHS: 2 Appointments within 6 weeks	0			No Threshold		
Urgent EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold		
Routine EDYS Pathway Average Wait in Weeks	0	0	0	No Threshold		
Routine Eating Disorders (EDYS) Pathway Average Wait in Days	18.00			No Threshold		
Urgent Eating Disorders (EDYS) Pathway Average Wait in Days	0.00			No Threshold		
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Liverpool Specialist	16.00	0.00	0.00	No Threshold		
CAMHS: Avg Wait from referral to Partnership Appt (Weeks)- Sefton Specialist	18.00	0.00	0.00	No Threshold		

WELL LED

	COMMUNITY	MEDICINE	SURGERY	RAG		
Control Total In Month Variance (£'000s)	118	69	-255	>=0%	>=-20%	<-20%
Income In Month Variance (£'000s)	265	25	49	>=0%	>=-20%	<-20%
Pay In Month Variance (£'000s)	0	-129	-2	No Threshold		
Non Pay In Month Variance (£'000s)	-148	173	-303	>=0%	>=-20%	<-20%
AvP: IP - Non-Elective		43	68	>=0	N/A	<0
AvP: IP Elective vs Forecast	0	-29	13	>=0	N/A	<0
AvP: OP New	-15.24	66.49	-491.94	>=0	N/A	<0
AvP: OP FollowUp	129.39	-140.55	130.60	>=0	N/A	<0
AvP: Daycase Activity vs Forecast		-72	-91	>=0	N/A	<0
AvP: Outpatient Activity vs Forecast	114	-74	-361	>=0	N/A	<0

Alder Hey Children's NHS
NHS Foundation Trust

All Divisions

	COMMUNITY	MEDICINE	SURGERY	RAG		
PDR	93.0%	89.2%	90.0%	>=90 %	>=80 %	<85 %
Mandatory Training	90.9%	90.0%	88.0%	>=90 %	>=80 %	<80 %
Actual vs Planned Establishment (%)	90.7%	96.2%	98.6%	No Threshold		
Sickness	5.2%	5.9%	6.6%	<=4.5 %	<=5 %	>5 %
Attendance (HR)	94.8%	94.1%	93.4%	>=95.5 %	>=90 %	<90 %
Short Term Sickness	1.7%	1.6%	1.9%	<=1.5 %	N/A	>1.5 %
Long Term Sickness	3.5%	4.3%	4.7%	<=3 %	N/A	>3 %
Temporary Spend ('000s)	121	197	484	No Threshold		
Staff Turnover	13.5%	8.7%	10.0%	<=10 %	<=11 %	>11 %
Safer Staffing (Shift Fill Rate)	99.0%	97.2%	91.9%	>=90 %	>=80 %	<90 %

Medicine

SAFE

	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	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	6	3	3	0	1	1	4	0	3	2	4	6	3	No Data Available	No Threshold

CARING

	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	Last 12 Months	RAG
Complaints	2	3	4	3	0	7	4	3	3	5	6	1	3		No Threshold
PALS	30	37	30	39	51	31	27	28	23	21	34	19	21		No Threshold

EFFECTIVE

	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	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	2	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Referrals Received (Total)	1,523	1,903	1,853	1,961	1,839	1,947	2,009	1,902	1,566	1,670	2,073	1,969	1,706	No Data Available	No Threshold
ED: 95% Treated within 4 Hours	94.1%	93.6%	92.6%	97.2%	95.3%	95.0%	95.6%	96.5%	98.4%	93.7%	90.9%	93.8%	95.3%		>=95 % / N/A / <95 %
Average LoS - Elective (Days)	4.06	3.54	3.22	3.17	3.23	2.66	4.01	3.84	2.85	3.18	2.89	3.08	3.54		No Threshold
Average LoS - Non-Elective (Days)	1.50	1.75	1.57	1.50	1.52	1.55	1.59	1.28	1.45	1.35	1.54	1.64	1.45		No Threshold
Theatre Utilisation - % of Session Utilised	82.5%	79.9%	80.6%	83.5%	75.4%	75.6%	78.6%	83.0%	77.8%	84.8%	81.8%	80.9%	87.0%		>=90 % / >=80 % / <80 %
Clinic Session Utilisation	84.7%	85.5%	87.1%	85.7%	84.8%	83.2%	84.6%	81.6%	81.7%	84.7%	83.2%	84.4%	80.7%		>=90 % / >=80 % / <85 %
OP Appointments Cancelled by Hospital %	15.3%	15.2%	17.6%	17.5%	13.5%	14.1%	12.8%	16.3%	15.6%	13.8%	14.5%	14.2%	15.6%	No Data Available	<=5 % / <=10 % / >10 %
Did Not Attend Rate	11.5%	9.6%	9.6%	11.1%	10.0%	11.0%	12.6%	12.3%	13.6%	12.3%	12.2%	10.7%	13.3%		<=12 % / <=14 % / >14 %
Coding average comorbidities	3.92	3.86	3.49	3.34	3.52	3.35	3.54	3.40	3.52	3.54	3.57	3.57	3.72	No Data Available	No Threshold

RESPONSIVE

	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	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	92.6%	92.9%	93.0%	89.8%	90.0%	90.2%	89.5%	89.7%	90.2%	91.1%	89.9%	91.5%	92.7%		>=92 % / >=90 % / <90 %
Diagnostics: % Completed Within 6 Weeks	100.0%	100.0%	99.8%	100.0%	99.8%	99.8%	99.1%	99.3%	99.0%	99.8%	99.8%	99.3%	100.0%		>=99 % / N/A / <99 %

WELL LED

	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	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-52	611	461		127	122	408	223	75	178	-115	15	69		>=0% / >=-20% / <-20%
AvP: IP - Non-Elective					-4	1	2	8	-3	-10	75	69	43		>=0 / N/A / <0
AvP: IP Elective vs Forecast					-8	1	-2	-8	-5	-2	-19	-23	-29		>=0 / N/A / <0
AvP: OP New					355.00	-19.08	6.48	-44.36	87.30	122.27	56.41	112.17	66.49	No Data Available	>=0 / N/A / <0
AvP: OP FollowUp					68.00	61.48	33.85	-3.40	72.82	99.78	208.62	263.28	-140.55	No Data Available	>=0 / N/A / <0
AvP: Daycase Activity vs Forecast					-1	-3	-1	-14	-5	10	-56	-78	-72		>=0 / N/A / <0
AvP: Outpatient Activity vs Forecast					423	42	40	-48	160	222	265	375	-74		>=0 / N/A / <0
PDR	84.0%	84.0%	81.5%	81.5%	2.2%	13.4%	35.5%	67.2%	85.5%	88.6%	89.2%	89.2%	89.2%		>=90 % / >=85 % / <85 %
Mandatory Training	86.6%	88.9%	94.7%	93.8%	92.7%	92.8%	92.4%	91.3%	87.9%	87.6%	89.4%	90.4%	90.0%		>=90 % / >=85 % / <80 %
Sickness	5.1%	5.6%	4.9%	4.3%	3.7%	4.0%	4.3%	5.7%	5.1%	5.2%	5.1%	5.2%	5.9%		<=4.5 % / <=5 % / >5 %
Temporary Spend ('000s)	207	211	276	316	246	276	196	227	261	212	217	261	197		No Threshold

Surgery

SAFE

	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	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	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	Last 12 Months	RAG
Complaints	2	2	3	2	1	2	1	5	3	1	1	1	0		No Threshold
PALS	16	26	24	20	25	36	28	20	22	27	27	27	16		No Threshold

EFFECTIVE

	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	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Hospital Acquired Organisms - C.difficile	0	0	0	1	0	0	0	0	0	0	0	0	0		0 / N/A / >0
Referrals Received (Total)	2,668	3,347	3,494	3,680	3,770	4,090	3,832	4,247	3,372	3,218	3,634	3,741	2,782	No Data Available	No Threshold
Average LoS - Elective (Days)	3.30	2.62	2.88	3.14	2.40	2.94	2.55	2.68	2.72	2.66	2.97	2.72	3.38		No Threshold
Average LoS - Non-Elective (Days)	3.18	2.67	2.89	3.31	2.63	2.78	2.63	2.61	2.72	2.49	3.15	2.68	2.92		No Threshold
Theatre Utilisation - % of Session Utilised	86.6%	88.3%	86.4%	86.8%	90.5%	90.6%	89.5%	90.4%	88.7%	86.9%	87.4%	88.3%	85.8%		>=90 % / >=80 % / <80 %
Clinic Session Utilisation	83.0%	86.2%	83.5%	85.1%	84.2%	85.0%	86.0%	82.8%	83.8%	84.4%	82.9%	84.6%	83.1%		>=90 % / >=80 % / <85 %
OP Appointments Cancelled by Hospital %	13.3%	13.0%	14.0%	12.7%	11.2%	12.2%	12.2%	12.3%	12.6%	14.3%	13.5%	12.8%	13.6%	No Data Available	<=5 % / <=10 % / >10 %
Did Not Attend Rate	11.6%	10.2%	10.1%	10.3%	9.6%	10.6%	11.1%	12.0%	12.9%	10.6%	11.6%	10.8%	13.1%		<=12 % / <=14 % / >14 %
Coding average comorbidities	3.06	2.99	3.18	3.24	3.11	3.31	3.50	3.63	3.65	3.66	3.60	3.58	3.90	No Data Available	No Threshold

RESPONSIVE

	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	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	91.3%	91.4%	91.3%	92.6%	92.3%	92.5%	93.1%	92.9%	92.7%	93.1%	93.6%	94.1%	93.7%		>=92 % / >=90 % / <90 %
Diagnostics: % Completed Within 6 Weeks	95.0%	100.0%	92.6%	94.7%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%		>=99 % / N/A / <99 %

WELL LED

	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	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-489	-634	-715		-167	32	-23	81	-63	-308	0	-211	-255		>=0% / >=-20% / <-20%
AvP: IP - Non-Elective					9	4	2	12	12	8	-26	-6	68		>=0 / N/A / <0
AvP: IP Elective vs Forecast					15	10	16	15	22	12	50	17	13		>=0 / N/A / <0
AvP: OP New					141.79	-86.48	-22.69	-78.39	-46.33	121.38	-162.10	59.67	-491.94	No Data Available	>=0 / N/A / <0
AvP: OP FollowUp					104.22	248.98	44.98	40.98	36.98	237.98	1,126.03	782.98	130.60	No Data Available	>=0 / N/A / <0
AvP: Daycase Activity vs Forecast					-23	-2	3	2	3	8	-30	10	-91		>=0 / N/A / <0
AvP: Outpatient Activity vs Forecast					246	162	22	-37	-9	359	964	843	-361		>=0 / N/A / <0
PDR	89.5%	89.5%	83.3%	83.3%	1.1%	10.0%	33.5%	64.4%	83.6%	90.7%	90.0%	90.0%	90.0%		>=90 % / >=85 % / <85 %
Mandatory Training	85.8%	89.3%	93.5%	91.5%	90.2%	89.9%	90.9%	90.3%	87.2%	87.8%	88.6%	87.8%	88.0%		>=90 % / >=85 % / <80 %
Sickness	6.0%	6.3%	4.9%	4.0%	4.3%	4.7%	5.5%	5.5%	5.7%	6.0%	6.5%	6.0%	6.6%		<=4.5 % / <=5 % / >5 %
Temporary Spend ('000s)	331	408	434	514	468	420	480	445	509	373	529	485	484		No Threshold

Community

SAFE

	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	Last 12 Months	RAG
Acute readmissions of patients with long term conditions within 28 days	0	0	0	0	0	0	0	0	0	0	0	0	0	No Data Available	No Threshold

CARING

	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	Last 12 Months	RAG
Complaints	1	3	2	0	2	2	3	5	5	3	2	2	1		No Threshold
PALS	14	34	50	33	32	28	20	21	26	43	36	40	11		No Threshold

EFFECTIVE

	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	Last 12 Months	RAG
Hospital Acquired Organisms - MRSA (BSI)	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Hospital Acquired Organisms - C.difficile	0	0	0	0	0	0	0	0	0	0	0	0	0		0 N/A >0
Referrals Received (Total)	977	1,152	1,033	1,004	859	1,091	849	1,079	662	689	968	1,058	755	No Data Available	No Threshold
Average LoS - Elective (Days)												1.00	3.00		No Threshold
Clinic Session Utilisation	73.3%	77.7%	75.7%	72.2%	75.2%	79.1%	78.4%	79.4%	80.2%	79.4%	82.2%	81.1%	76.3%		>=90 % >=85 % <85 %
OP Appointments Cancelled by Hospital %	17.0%	12.3%	13.5%	17.2%	16.1%	10.8%	16.8%	16.2%	23.3%	22.3%	17.7%	22.7%	24.2%	No Data Available	<=5 % <=10 % >10 %
Did Not Attend Rate	15.7%	12.7%	14.3%	14.4%	14.5%	14.5%	14.2%	13.9%	15.7%	12.5%	10.8%	10.5%	11.4%		<=12 % <=14 % >14 %
Coding average comorbidities		5.00		3.33	5.00	2.33		2.33	8.00	4.00	2.00	2.67		No Data Available	No Threshold

RESPONSIVE

	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	Last 12 Months	RAG
RTT: Open Pathway: % Waiting within 18 Weeks	97.3%	97.3%	96.5%	96.7%	97.1%	96.1%	95.3%	92.2%	92.7%	87.3%	87.1%	78.8%	78.3%		>=92 % >=90 % <90 %

WELL LED

	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	Last 12 Months	RAG
Control Total In Month Variance (£'000s)	-86	-161	43		-108	-70	30	62	-144	87	54	-61	118		>=0% >=-20% <-20%
AvP: IP Elective vs Forecast					0	0	0	0	0	0	0	0	0		>=0 N/A <0
AvP: OP New					-25.37	-26.35	-34.17	-76.43	-82.03	-73.35	38.51	50.41	-15.24	No Data Available	>=0 N/A <0
AvP: OP FollowUp					275.02	349.12	350.57	241.44	6.42	73.01	201.38	249.88	129.39	No Data Available	>=0 N/A <0
AvP: Outpatient Activity vs Forecast					250	323	316	165	-76	0	240	300	114		>=0 N/A <0
PDR	90.4%	90.4%	83.9%	83.9%	0.4%	9.3%	31.9%	58.8%	78.7%	87.9%	93.0%	93.0%	93.0%		>=90 % >=85 % <85 %
Mandatory Training	86.7%	89.8%	96.8%	95.7%	95.4%	95.0%	94.1%	94.2%	92.7%	91.2%	92.5%	91.4%	90.9%		>=90 % >=85 % <80 %
Sickness	6.9%	6.2%	6.0%	6.0%	4.8%	5.2%	3.9%	3.5%	3.4%	4.1%	4.0%	5.1%	5.2%		<=4.5 % <=5 % >5 %
Temporary Spend ('000s)	131	146	136	202	166	180	142	131	154	125	131	150	121		No Threshold

BOARD OF DIRECTORS

Tuesday, 5 February 2019

Report of	Director of Corporate Affairs
Paper prepared by	Executive Team, Clinical Risk Manager
Subject/Title	2018/19 Board Assurance Framework Update (January 2019)
Background papers	Monthly BAF updates/reports
Purpose of Paper	To provide the Board with the BAF update report
Action/Decision required	The Board is asked to discuss and note the changes to the Board Assurance Framework – August position.
Link to: ➢ **Trust's Strategic Direction** ➢ **Strategic Objectives**	➢ Delivery of outstanding care ➢ The best people doing their best work ➢ Sustainability through external partnerships ➢ Game-changing research & innovation
Resource Impact	Non achievement of the Trust's objectives could have a negative impact on the services provided by the Trust.

Board Assurance Framework 2018/19

1. Purpose

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

2. Review of the BAF

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

BAF Risk Register - Overview at 1st February 2019

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

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

Changes since January 2019 Board meeting

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

External risks

- ***Business development and growth (DJ)***
  Strategic planning process underway, in light of NHS Long Term Plan; system submission of 5yr plan Autumn 19. BAF risk review planned for April 19 in line with this. Partnership Board with Manchester scheduled for March; MOU, network review, Cardio and Neurosciences prioritised.

- ***Mandatory and compliance standards (ES)***
  ED performance remains fragile, slipping below the 95% threshold at the end of the month, having sustained well in the post-Christmas period. All Winter Plan measures remain in place and other access targets were achieved in month. The POCU model now fully operational for suitable cases.

- ***Developing the Paediatric Service Offer (DJ)***
  Business case for 22 neonatal cots approved in principle. C&M W&C Partnership refresh with emphasis on paediatric workforce as well as maternity. Paediatric Urgent Care presentation to Liverpool Provider Alliance delivered 18.1.19. Partnership bid for Cardiac ODN underway through CHIG.

Internal risks:

- ***New Hospital Environment (DP)***
  Final set of water surveys received.

- ***Achievement of Outstanding Quality for Children and Young People as defined by the CQC regulations (HG)***
  Re-instated annual Children and Young People Survey via PICKER Institute; awaiting a date for the next survey to be undertaken. Open recruitment day securing 25 WTE registered nurses and building on the opportunity of the successful 'Hospital' programme showcasing the Trust as a place to work.

- ***Financial Environment (JG)***
  Divisions have made progress with the forecast gap now at £1.6m from their control totals. Discussions progressing with commissioners to close year end agreements. The main risk lies with spec comm where there is a £1.8m difference which we are working on. Specific

transactions to support the PSF match are continuing and are forecast at this stage to deliver in gull however carry the risk of completion by end March.

- ***Failure to fully realise the Trust's Vision for the Park (DP)***

Session held with community groups on park design.

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

January milestones delivered and signed off by NHS Digital which releases next tranche of funds. Key next phase is got live of Standards Documentation in February which has a significant roll out programme. Discussions taking place with Clinical teams as to how we maximise the opportunity of the next phase of Digital Pathways. Revised operational structure in place and paying dividends.

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

Apprenticeships continue to progress; 56 learners enrolled to date.

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

Launch Mary Seacole leadership programme.

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

Reciprocal mentoring Scheme launched.

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

Draft paper circulated on management arrangements for RIE.

Erica Saunders
Director of Corporate Affairs
1st February 2019